Ombudsman NT

Annual Report
2018/19
Part 1 – The Justice Continuum

Presented to the Chief Minister under section 152 of the Ombudsman Act for tabling in the Legislative Assembly

Annual Report 2018/19
Part One

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REPORT STRUCTURE

This annual report is divided into two parts.

This Part 1 – *The Justice Continuum* focusses attention on the enormous issues impacting on the Northern Territory justice system that have been identified in the course of Ombudsman complaints and investigations — the systemic issues that need to be addressed for there to be real progress in justice outcomes.

Part 2 – *Ombudsman Operations* describes the day to day operations of the Office and other Ombudsman functions undertaken during 2018/19.

PETER SHOYER
OMBUDSMAN
30 September 2019

CHAPTER 1 – THE CHALLENGE FOR SOCIETY

Before descending into the day-to-day challenges within the justice system and the complaint issues they give rise to, as identified in approaches to my Office, this Chapter provides a brief foreword to highlight the true nature of the obstacles that need to be overcome to enable effective outcomes for that system.

My 2017 report, *Women in Prison II*, pointed to a fundamental problem with isolated attempts to reform elements of the justice system. Involvement with the justice system is frequently an end point, flowing on from many years of disadvantage and disruption:[1]

> *There is no doubt that offending levels are linked closely with socio-economic conditions. Low incomes, poor education, and limited access to facilities and opportunities all contribute to an environment where crime is more likely.*
>
> *The criminal justice system is only one element in addressing the conditions and motivations that give rise to offending. In truth, it should be regarded as a strategy of last resort.*
>
> *The Victorian Ombudsman put it aptly:*
>
> > The statistics are compelling: the average prisoner, male or female, did not complete high school, was unemployed at the time of committing the crime and had a history of substance abuse. Many female prisoners are victims of some form of abuse, and over 40 per cent are homeless upon release. The children of prisoners are six times more likely to be imprisoned themselves – so it's not just this generation where the impact is hard felt. How do you address recidivism when prison is the place some people feel safest? And how can we reintegrate former prisoners into a society where many have always been marginalised? …
> >
> > … it is patently clear that long-term solutions do not lie within the walls of our prisons or with a single government department. The successful innovations elsewhere have come as a result of a concerted whole-of-government response. The state needs a comprehensive approach – across the justice system, education, health and housing – to focus on the causes of crime rather than its consequences. *[Investigation into the rehabilitation and reintegration of prisoners in Victoria, Victorian Ombudsman (2015), page 3]*
>
> *Given the high number of Territorians with low socio-economic status and the extraordinary dispersal of the population over many small remote communities, the challenges faced by the Territory in addressing these societal issues is overwhelming. The* Hamburger Report *stated:*
>
> > Clearly the Northern Territory's imprisonment rate indicates a social, economic, and law and order crisis of devastating proportions for the Territory as a whole and for Indigenous people in particular. It has been a longstanding crisis. …
>
> *This report does not (and could not hope to) examine all the steps society needs to take to address these broader problems. However, the unfortunate reality is that, unless and until they are addressed, the changes discussed in the report can only be partially effective.*

This might be described as proposing a 'cradle to grave' approach to justice issues. In fact, it extends beyond such an approach. There is clear evidence that conditions such as Fetal Alcohol Spectrum Disorder (FASD), acquired before birth can have devastating effects on the way an individual interacts with others, leading them to cause harm to others or at the very least, to regular exposure to the justice system.

[1] *Women in Prison II*, Volume 1, paragraphs 217-221.

Health, Housing, early childhood education and care, primary and secondary education, family and parent support, child protection and support for essential services are just some areas where action is needed if there is to be any realistic chance for improvement in justice outcomes.

This broad spectrum of responsibility cannot be isolated to any one level of government. If these issues are to be effectively addressed it requires substantial commitment from the Commonwealth and Northern Territory governments. Nor can there be a solution without substantial positive and ongoing contributions from non-government organisations and the support of every member of the community.

These are not issues where principled arguments about areas of responsibility or demarcation disputes can help. There must be multiple actions on multiple levels to address the disadvantage and disengagement that fosters the problems facing the justice system and the community in the NT.

With that perspective presented, the following chapters address issues raised by approaches and complaints in the more visible components of the justice system.

CHAPTER 2 – JUSTICE OVERVIEW

VICTIMS OF CRIME

While approaches about NT Police conduct and Correctional Services take up a major portion of the time of our Office, we also receive approaches regarding legislative and administrative schemes designed to help victims of crime. In that regard, the Crimes Victims Services Unit (CVSU) - a unit within the Department of the Attorney-General and Justice (AGD) plays a key role.

With respect to victims of crime, three recent developments are worthy of note.

Firstly, a review of the *Victims of Crime Assistance Act* is in progress. My Office contributed to that review and it is hoped that changes arising from the review will address at least some of the issues that have given rise to a large backlog in victims of crime applications (see discussion further below).

Secondly, the NT Redress Coordination Team is now a function of the CVSU. This team is responsible for coordinating the NTG's obligations under the National Redress Scheme for Survivors of Institutional Child Abuse and for oversight of the policy response. The team is rolling out a full suite of training to assist in meeting the NTG's requirements under the Intergovernmental Agreement, to provide support to people exposed to traumatic material due to their involvement in the National Redress Scheme. The suite includes training in vicarious trauma, understanding the impact of child sexual abuse on survivors, trauma informed care and resilience training.

Thirdly, a new *Charter of Victims Rights* has recently been released by the Attorney-General (https://justice.nt.gov.au/__data/assets/pdf_file/0010/718147/Charter-of-Victims-Rights-August-2019.pdf). The CVSU has oversight of the Charter. The five NTG Key Principles in the Charter are:

1. Victims' rights are a priority.
2. The safety and welfare of victims, their families and their property is our number one concern.
3. Every reasonable resource will be used to support victims.
4. Access to services will be simple, quick, coordinated and respectful.
5. Victims have a right to be heard by the justice system.

In previous years, I have reported on a large number of approaches received by our Office about the CVSU. The primary issue of complaint has been delay in processing applications, a significant number of which stretch back over a number of years. The main reasons given for delay have included:

- delays in obtaining necessary information from NT Police relevant to the disposition of applications;
- delays in obtaining information from health providers;
- delays in securing appointments with specialist health providers to assess victims, exacerbated when an appointment is made but the claimant does not attend;
- the advent of fresh applications which complicate consideration of earlier applications by the same person; and
- the build-up over time of an increasing backlog of applications which itself takes time to manage.

The CVSU has recently provided the following update:

- *The CVSU is continuing to work on constantly improving processes and reducing response times and the backlog of applications;*
- *Most applications the subject of Ombudsman complaints are now finalised – as at 13/9, 29 complaints over 46 files since 2016, with 33 finalised;*
- *Improvements that were ongoing over 2018/19 as follows:*
    - *Restructure fully implemented;*
    - *Focus for 2019/20 to seek additional resources to undertake backlog project – resources not confirmed but will implement project nevertheless;*
    - *Triaging project finalised – which has reduced the case load of applications officer. For example, the intake administration team is now responsible for requesting information from Police and Medical providers, prior to files being allocated to applications officers;*
    - *Older files being focussed on and new files assessed on a range of factors including vulnerability of the victim; seriousness of the offence; age of the victim, etc.*
    - *Now have AO5 dedicated to triaging and processing immediate applications and less complex applications;*
    - *The AO4 Applications Officer role has now been cemented into the team. Her role has been focussed on arranging medical appointments. Having one point of contact for all such matters and a more coordinated approach has improved the number of appointments being made and the quality of the reports being received.*
- *However, output of the unit continues to grow (see table below) and is expected to continue to grow over the next year. CVSU is now close to keeping up with the number of applications being received, and it is anticipated that reductions in backlog numbers will start to be realised in 2019/20;*

Year	*Applications received*	*No. of decisions made under Act*	*Total paid to victims*
2016/17	*426*	*213*	*$1.134m*
2017/18	*401*	*384*	*$2.78m*
2018/19	*428*	*390*	*$3.005m*

- *CVSU worked hard with Police in 17/18 to reduce the backlog of police requests. There was essentially no backlog for the last 6 months of 2018. However,* [the situation has since changed and] *the backlog in police requests continues to increase. At the end of August 2019, it was well over 200. There is concern that this will further impact on CVSU's ability to work towards addressing the backlog.*
- *CVSU continues to work with legal reps and other stakeholders – undertaking regular meetings and other contact in order to maintain relationships and communication channels and to work collaboratively on providing the best possible outcome to applications, taking into account their circumstances and levels of trauma;*
- [The introduction of the Redress Team] *has allowed the whole CVSU team to benefit from the training and to increase their ability to understand and respond to victims – furthermore it is hoped it will improve the mental health and culture in the office and the overall general well-being of staff;*
- *CVSU staff have also been closely involved in the Victims of Crime legislation review – contributing/assisting in the drafting of the issues paper; presenting at public consultation sessions undertaken across the Territory; and developing a comprehensive submission to that review as well as assisting in the public consultation process.*

The CVSU and AGD have put much effort into streamlining processes in relation to victim's assistance. CVSU has substantially increased the number of applications finalised and the amounts paid to victims. There were fewer complaints to my Office on this issue during the reporting period and many of the applications that gave rise to complaints have now been finalised. It is hoped that the focus on the backlog project in 2019/20 will have a material impact on the backlog, although the return of delays in provision of police reports is concerning.

However, even with this progress, the backlog remains very troubling. As at 28 August 2019, the number of applications made in 2017 or earlier (making them at least 20 months old) was 1,079.

As the Victims of Crime Charter makes it clear, the essence of support for victims of crime should be to provide '*simple, quick, coordinated and respectful*' service. Delay and complexity in dealing with such matters can do little to assist, particularly when dealing with victims who may be traumatised by violent crime.

The resources of CVSU are limited and its new functions (noted above), important as they are, are only likely to place further pressure on its ability to process victim assistance applications in a timely manner.

As indicated above, a legislative review is underway. It is crucial that structural hurdles that have contributed to the backlog are mitigated in the development of any new or amended legislation. It is also important to appreciate that, even if processes are improved for future applications, it will remain essential to address the existing backlog. These are matters that require the full attention of government.

ABORIGINAL JUSTICE AGREEMENT

Given the enormous overrepresentation of Aboriginal people in the NT justice system, the recent release by AGD of a draft Aboriginal Justice Agreement is welcome. It is a wide-ranging document that, when finalised, will guide agency operations in relation to many justice-related issues. It will be a valuable tool for this Office to consider when assessing complaints and responses to Ombudsman recommendations in the future.

The draft is prefaced by the following comments, among others:

> *Together, we can do more to keep people out of prison. We can reduce offending and reoffending, and provide alternatives to address the underlying causes of crime.*
>
> *Together, we can do more to keep our families safe and make our communities stronger.*
>
> *Together, we can improve justice services so that Aboriginal people who have contact with the justice system – as victims, offenders, witnesses, or professionals – are treated fairly, respectfully and without discrimination.*

The draft identifies three key aims:

1. *reduce reoffending and imprisonment rates of Aboriginal Territorians*
2. *engage and support Aboriginal leadership*
3. *improve justice responses and services to Aboriginal Territorians.*

It goes on to detail 23 strategies, including:

> *Establish an alternative to custody model*
>
> *Expand community-based, Aboriginal-led early intervention and youth diversion programs*
>
> *Expand community-based sentencing options*
>
> *Strengthen tailored and targeted case management for offenders*

Expand prison and diversion programs for Aboriginal women

Redesign key service delivery models

Improve communication about the justice system

Increase accessibility and uptake of complaint processes.

The draft Agreement is open for submissions until 31 March 2020.

NT Police Issues

Chapters 3 to 8 discuss aspects of police functions in detail. Set out below are some specific issues that have arisen from cases dealt with during the year.

Youth justice

Our Office has continued a focus on police treatment of young people. While most issues relating to the care and protection of children and their treatment in the youth justice system fall outside our jurisdiction, we do have a role to play in relation to police conduct in respect of youths.

In 2018/19, 17 of the more serious complaints (Category 1 and 2) were made on behalf of youths. Recurring issues complained about during the period (whether or not ultimately sustained) included:

- the extent of force used during apprehension and absence of consideration of the age or small stature of youths;
- failure to use arrest as an option of last resort;
- the length of time youths were detained in custody;
- failings with notification and involvement of responsible adults;
- failure to follow specific requirements of the *Youth Justice Act 2005*;
- failure to use interpreters and other defects with interview processes.

In this report, youth justice issues are discussed in:

- Chapters 5 and 6;
- Case studies 3 and 4 in Chapter 7; and
- the discussion in Chapter 8 of the implementation of police-related recommendations from the *Royal Commission into the Protection and Detention of Children in the Northern Territory*.

With changes to the *Youth Justice Act 2005* having been recently passed, it will be even more important for NT Police to comprehensively review its approaches, corporate documentation and training in relation to how police treat and interact with children.

Body worn video

I have previously stressed the enormous benefits of the body worn video-camera (BWV) in terms of fact finding in investigation of offences and complaints about police conduct. I have also pointed to the advantages of BWV as a moderator of behaviour for all concerned and the fact that it is just as likely to provide clear evidence that officer conduct is justified as not.

Notwithstanding this, there were still many instances during this period where officers failed to wear BWV equipment that they had been issued with or failed to turn it on at an appropriate juncture. In Category 1 and 2 matters finalised in 2018/19, issues regarding failure to appropriately utilise BWV gave rise to sustained allegations in over 20 complaints. In many of those cases, more than one officer failed to comply.

Numerous allegations have concluded with an Unresolved outcome, when BWV may well have provided a clear picture of the course of events.

It is accepted that a number of those cases related to a time when BWV was in the process of introduction. However, the days of BWV being viewed as a novel requirement for police are very much over.

The Commander, Professional Standards Command issued a broadcast to all sworn officers on 12 February 2019 reiterating that BWV must be switched on prior to and during any encounter where a police power is utilised. The Broadcast stressed that BWV is part of an officer's accoutrements and must be worn at all times. It also stated that failure to utilise BWV has been a factor in having adverse or undetermined findings against officers and the NT Police organisation and that failure to activate in line with the policy will be considered in the context of whether officers have committed a serious breach of discipline given repeated issues surrounding non-use.

I support this approach. I reiterate that turning on BWV sooner rather than later frees officers to attend to their other duties as well removing any ambiguity should their actions be challenged at a later date. Effective BWV use is a serious matter which our Office will continue to monitor closely.

Use of force

Allegations of excessive use of force are a common source of complaint, whether or not they are ultimately sustained. Given their functions, it is not surprising that police are frequently called on to use force. The primary question in relation to such allegations is whether the use of force was necessary, proportionate and reasonable — or excessive in the circumstances.

The cases discussed in Chapters 5 and 6, as well as 6 of the case studies in Chapter 7, contain a use of force element. Use of force allegations become even more problematic when, in the arrest or detention of a person, police use/draw a weapon or employ some form of restraint, for example, handcuffs or a spit hood. Of the use of force case studies in this report, all but one contains such an element.

I discussed use of force with particular reference to Taser use in my report on *Taser use and Management of NT Police conduct issues* (December 2017). In that report, I recommended that NT Police:

- review its guidance on special circumstances relating to Taser use;
- supplement General Orders/Instructions by additional guidance, illustrations and scenarios to better inform officers of the inherent risks of Taser use, particularly in relation to special circumstances;
- review training materials and courses to ensure substantial emphasis on consideration of alternatives to use of force and specific restrictions on use of accoutrements like Tasers and chemical sprays; and
- maintain a system for regular monitoring and reporting on Taser use to a senior executive officer responsible for oversight of all instances of Taser use.

Many of the recommendations in that report have equal or corresponding application to other weapons and devices used by NT Police.

Use of force matters must be considered in the context of the particular case. Resolution of these issues is greatly aided by having video and preferably audio footage. It is important to appreciate that officers frequently face rapidly emerging situations and may be called on to think and act within split second timeframes. It is imperative that we carefully and dispassionately review police conduct and hold police accountable for their actions but it is necessary to do so bearing in mind the environment in which they were operating at the relevant time.

Our Office will continue to monitor implementation of recommendations and individual instances of use of force brought to our attention by complainants.

Duty of care

NT Police are frequently called on to take vulnerable people into custody. Their vulnerability may arise from their youth, the effect of alcohol or other substances, their mental or other health conditions, the actions of police in detaining them or the life circumstances in which they find themselves. When taking a person into custody, Police have a responsibility, a duty of care, to the person.

Examples of issues arising around that duty of care are discussed in:

- Chapter 5 — regarding various aspects of the care of a youth who had attempted self-harm and exhibited violent behaviours to police and others;
- Chapter 6 — regarding the care of youths at the Darwin City watch house for several days after a disturbance at Don Dale Youth Detention Centre;
- Case study 3 in Chapter 7 — regarding the language and force used in respect of youths in a watch house, failure to conduct a proper search, failure to provide blankets in a timely manner and considerations of privacy when they were searched;
- Case study 4 in Chapter 7 — regarding continuing with an interview in the face of the youth complainant's assertions that he felt weak, tired and too nervous to continue;
- Case study 5 in Chapter 7 — regarding the escort of a detained person under the influence of a substance through a building and the tight application of handcuffs;
- Case study 6 in Chapter 7 — regarding the need to ensure comprehensive handover procedures for a sick or injured person when they are being transferred to another facility or to another organisation; and
- Case study 7 in Chapter 7 — regarding the need to ensure preparations are made to enable adequate aftercare in the event of use of OC spray at a remote site.

These cases illustrate the complexity of issues faced by NT Police who must frequently deal with people when their behaviour is at its worst but their need is at its greatest. Even so, meeting this duty of care must be recognised as an essential part of the role of every officer.

Police investigations

We receive a number of complaints each year about the adequacy of police criminal investigations and decisions made by police about whether to continue investigations and whether or not to prosecute in a particular case. Most of these are resolved by police providing information and explanation about the investigations that have taken place and their reasons for deciding whether or not to prosecute.

The matter discussed in Chapter 4 involved an investigative process where the complainant was held in custody for over 100 days before DNA results pointed to another possible offender and the charge against the complainant was withdrawn and he was released.

The investigation of the complaint identified a number of failings with the criminal investigation and gave rise to various recommendations for improvement. I raised issues regarding the need for earlier communication by police with the Director of Public Prosecutions (the DPP) and the impact of the length of time taken to obtain DNA results on both the effectiveness of the investigation and the liberty of the complainant. I recommended that NT Police:

- take steps to ensure the robust and effective conduct and governance of major investigations, in line with the findings and recommendations of the Coroner in a previous case and the Investigating Officer in this case;
- circulate a broadcast reminding all investigators of the importance of continuing disclosure to the DPP in a timely manner, in line with the DPP Guidelines, particularly in cases where an accused person is held in custody; and
- review the resources it provides for forensic testing and how it prioritises forensic testing in order to achieve the best practicable outcomes in terms of effectiveness and timeliness, particularly in cases where an accused person is held in custody.

With regard to the final recommendation, NT Police have advised that a review team has recently completed an 8 day site visit across the NT to conduct a Frontline Operational Review of the Forensic Science Branch. The Team comprised the Head of the WA Police Forensic Division and two technical specialists. Their report is due to be issued before the end of 2019.

Our Office will monitor and report on implementation of recommendations arising from the complaint.

CORRECTIONAL SERVICES ISSUES

Chapter 9 provides an overview of Correctional Services complaints and activity in that sphere in 2018/19.

Chapter 10 provides edited extracts from a report we prepared for the new Commissioner of Correctional Services, aimed at capturing the essential elements of more significant Corrections-related issues that have come to the attention of our Office in the past few years.

The report discussed strategic and general themes but also provided a large number of detailed examples relating to operational matters and suggestions for further action. It also dealt with a range of matters concerning complaint handling, monitoring and review.

Correctional Services has already taken steps to address many of these issues and is continuing to explore improvements to its systems and procedures. Our Office is working closely with Correctional Services in this regard.

Chapter 11 provides an update on progress of implementation of the recommendations from our report on *Women in Prison II*.

CHAPTER 3 – POLICE CONDUCT APPROACHES - 2018/19

Complaints about police conduct are addressed in detailed provisions of the *Ombudsman Act*. Conduct of a police officer is defined as any decision or act, or a failure to make any decision or do any act, by the police officer for, in relation to or incidental to, the exercise of a power or performance of a function of a police officer. The focus is therefore on conduct relating to the exercise of police functions or other official functions rather than private conduct.

The Act requires the Commissioner of Police and the Ombudsman to notify each other, upon receipt of a complaint, and to provide details of the complaint. It provides a framework for the investigation of complaints against police and defines the role of the NT Police Standards Command (the PSC).

The provisions of the Act are supplemented by a detailed Police Complaints Agreement entered into between the Commissioner of Police and the Ombudsman under section 150 of the Act. The agreement, as in force at 30 June 2019, is set out at Appendix A to Part 2 of this Report.

HOW POLICE CONDUCT APPROACHES ARE DEALT WITH

Enquirer assistance and preliminary inquiries

Many issues raised with the Office can be addressed simply by the provision of information. A person may be making enquiries about the scope of the Ombudsman's powers and processes or may be calling to seek information for a friend. They may be enquiring about an issue that is beyond the powers of the Ombudsman, for example, a court decision.

In other cases, NT Police can deal with minor matters as customer service inquiries that do not require classification as complaints.

In addition, there are matters where the Office will conduct preliminary inquiries with Police and determine that there is no basis on which to further pursue an enquiry or complaint.

The Ombudsman may decline to deal with a complaint under section 67 of the Act on a variety of grounds, including that the complaint is trivial or vexatious, that the complainant does not have a sufficient interest, that disciplinary procedures have commenced or charges have been laid against the officer in question, or that dealing with the complaint is not in the public interest.

Most approaches are finalised in the above ways without the need for a formal investigation.

Complaint assessment

Once a complaint against Police is determined to be within jurisdiction, the complaint is assessed in consultation with the PSC, according to the level of response considered necessary.

Careful consideration is given to the potential seriousness or importance of the complaint, whether it is appropriate for the Police to deal with the matter in the first instance, and the responsible allocation of resources.

The classification of complaints is intended to be flexible and, if necessary, may be changed according to the results of enquiries/investigations as they develop. The final decision on the classification of a complaint rests with the Ombudsman.

Complaint Resolution Process

The Complaint Resolution Process (CRP) is an informal process undertaken by NT Police where early personal contact between police officers and complainants may lead to a quick and effective resolution. A CRP may involve explaining to a person why a particular course of action was taken, the legal and practical considerations surrounding the incident or a simple apology. The CRP is a means of dealing with common complaints about practices, procedures, attitudes and behaviours and is not intended to be an approach focused on fault-finding or punishment.

Ideally the police officer and the complainant should be satisfied with the outcome but this may not always be achievable. Complainants are informed by Police that they can approach our Office if they are not satisfied with the outcome of the process. Outcomes of CRPs are provided to our Office.

There is provision for formal conciliation in the *Ombudsman Act*. Conciliation may only be undertaken by agreement between the parties. It is not intended to absolve police officers of any misconduct or action. The process is an alternative dispute resolution process which is directed at reducing the need for civil matters proceeding to the courts. In practice, matters that might be resolved by this process are dealt with as CRPs.

More serious complaints

For complaints that are assessed as more serious, there are a number of options for action. Categorisation is based on the allegation in the complaint. It does not represent an assessment of the credibility or validity of the complaint.

Most of these matters are investigated by PSC officers under the supervision of our Office as Category 1 or Category 2 complaints. Our Office identifies relevant issues for investigation in the course of categorisation. For both categories, a report is prepared on the investigation. Our Office monitors progress and reviews the draft investigation report prior to finalisation in order to identify any additional issues or further lines of enquiry and to query findings where necessary.

For Category 2 matters, NT Police correspond directly with the complainant to inform them of the outcome and complainants are advised that they can approach our Office if they are dissatisfied with that outcome.

For Category 1 complaints (involving more serious allegations), there are additional steps, including a formal Assessment by the Ombudsman of the investigation report and response of the Commissioner (or delegate). In these cases, our Office directly informs the complainant of the outcome.

If criminal proceedings or disciplinary procedures have been or will be commenced in relation to police conduct, our Office may discontinue investigation pending the outcome of those proceedings or decline to deal further with the matter (sections 107 and 67(1)).

In practice, I will consider this option on application by NT Police. In order to adopt this approach, I need to be satisfied that the proceedings will encompass all the substantive issues raised by the particular complaint. If satisfied that is the case, I may then defer further investigation until completion of the proceedings.

On completion of the criminal or disciplinary proceedings, NT Police advise our Office of the outcomes and I consider whether any further action is necessary.

The Ombudsman may also decide to commence an 'own motion' investigation or to directly investigate any Police complaint if satisfied it:

- concerns the conduct of a police officer holding a rank equal or senior to the rank of PSC Commander;
- concerns the conduct of a PSC member;
- is about the practices, procedures or policies of NT Police; or
- should be investigated by the Ombudsman for any other reason.

No investigations of this type were initiated during the reporting period.

Investigations

Both NT Police officers and Ombudsman officers have substantial powers to conduct investigations in relation to complaints about police conduct.

One question that may arise in the investigation of more serious police complaints is whether to recommend that disciplinary action or, in some cases, criminal proceedings should be commenced against an officer.

The criminal standard of proof, beyond a reasonable doubt, is higher than the level of satisfaction required to establish a breach of discipline, so different considerations apply when weighing the answers to these two questions.

NT Police investigators have a power to direct an officer to answer a question or provide information in relation to an alleged or suspected breach of discipline even if to do so might incriminate the officer or make the officer liable to a penalty - section 79A of the *Police Administration Act 1978* (the PAA).

However, the answer to such a question or the information provided is not admissible as evidence against the officer in civil or criminal proceedings in a court (section 79A(3)). This can mean that information provided by an officer about their conduct that can be used for the purposes of a disciplinary proceeding is not available for the purposes of a criminal prosecution.

If that information is central to establishing the case against an officer, this may mean that a breach of discipline can be established but there is no reasonable prospect of securing a criminal conviction.

Outcomes

For the less formal CRP process, the outcome may be recorded as Successful if the complainant advises they are satisfied or Unsuccessful if they do not. If a CRP is Unsuccessful, the complainant is advised that they can contact our Office to pursue any outstanding issues.

For more serious complaints, the following broad categories of potential findings are set out in the Police Complaints Agreement:

(a) **Unresolved** - Given differing versions, where the Ombudsman and PSC are unable to come to any conclusion about the allegation. This finding may be used in respect of allegations when the only available evidence is the complainant's version against that of the members or all witnesses provide a differing/inconsistent version;

(b) **No evidence to support the allegation** - Based on the material, there is no evidence to support the allegation. This finding may apply to an allegation of minor assault (e.g. push/slap) and there is no medical evidence to support the allegation, there are no witnesses to the incident, there is no video evidence or other members present, to positively support the fact that it did or did not occur;

(c) **Insufficient evidence to sustain the allegation** - Based on the material there is some evidence to support the complainant, but it is insufficient to sustain the allegation. This may apply where there is some evidence to support the allegation but the quality of the evidence is unreliable, or taking into account other evidence (e.g. the medical evidence or the evidence of the police), the evidence as a whole is insufficient to sustain the allegation;

(d) **Action / conduct was not found to be unreasonable given the circumstances** - This finding may be used in cases where a member may have done something unusual or *prima facie* questionable, but the surrounding circumstances are such that it is inappropriate to make an adverse finding against the member;

(e) **Police action / decision was reasonable** - This is a positive finding to the effect that the Ombudsman / PSC supports the action / decision by the police;

(f) **Allegation sustained** - Where there is sufficient evidence to sustain the allegation on the balance of probability; and

(g) **Allegation is found to be wilfully false** - Where an investigation into a complaint against Police reveals that the allegation was wilfully false, that finding will be brought to the attention of the Ombudsman to consider a prosecution under the Act. Any criminal charges arising from a wilfully false allegation will be referred to the Commander, PSC for action.

In addition to issues identified by complainants, our Office or PSC investigating officers may identify ancillary matters in the course of an investigation. Often these involve failure to undertake a particular procedure or adequately complete relevant records but they may nevertheless be serious issues.

Complaints may also give rise to ancillary issues regarding staff management and supervision where a complaint is substantiated against a more junior officer. In such cases, a supervisor may also be subject to appropriate guidance or action.

An investigation report may include recommendations that disciplinary or other action be taken in respect of particular officers or that more general action be taken in relation to matters such as police training, awareness, policies and procedures. Our Office may also make additional recommendations if we consider it necessary.

Disciplinary action in relation to an individual officer may be taken under Part IV of the PAA. For less serious disciplinary matters, there is also an option to take action in the form of Managerial Guidance under section 14C of the PAA. For other matters requiring guidance but not disciplinary action, an officer may be given remedial advice by a superior officer (which is documented on their record).

If a matter is deferred pending the outcome of criminal or disciplinary proceedings, our Office is advised of outcomes and any other action taken by NT Police in due course. We review the circumstances and the outcomes to ensure all relevant issues have been adequately addressed and consider whether there is a need to continue investigations.

Depending on its categorisation, either our Office or NT Police will advise the complainant of outcomes of the complaint. Our Office is limited in the information that we can disclose to a complainant regarding the outcomes of disciplinary proceedings (see *Ombudsman Act*, section 106(3)).

ACTIVITY DURING 2018/19

Approaches received

The table below sets out numbers of police conduct approaches received during 2017/18 and 2018/19 and approaches categorised (not all approaches require categorisation).

Received	2017/18	2018/19
Approaches	545	589
CRP	210	143
Category 2	47	34
Category 1	10	3

There was an increase of 44 in the number of police conduct approaches received in 2018/19 compared to the previous year. However, only 37 complaints received during the year were assessed as the more serious Category 1 or Category 2 matters, a reduction of 20 from the previous year.

Of those matters, 17 were made on behalf of youths, compared with 25 in the previous year. Fourteen Category 1 and 2 matters originated in Darwin/Palmerston/Top End Rural, 11 in Central Australia, 9 in the Katherine region and 3 in the Barkly region.

A substantial proportion of the increase in overall numbers relates to improved reporting of matters identified by sources within NT Police and dealt with by the NT Police Internal Investigations Division. In the past, not all matters that directly progressed to criminal or disciplinary proceeding were reported to our Office. All of these matters that are, or may fall, within the Ombudsman jurisdiction are now reported and recorded by our Office even if criminal or disciplinary proceedings have already commenced.

Our Office first considers whether these matters fall within jurisdiction. For example, some matters relate to purely private conduct that does not have a connection with official duties and there are also limits on the type of Ombudsman complaints that police officers can make about other officers. A complaint that falls outside Ombudsman jurisdiction may still form a basis for criminal or disciplinary action but this is a matter for NT Police to pursue.

In a substantial number of these cases that fall within our jurisdiction, our Office defers action prior to categorisation once we are satisfied that criminal or disciplinary action is being pursued. We then review outcomes at the conclusion of that action to decide whether any further action is necessary (see section 107 of the *Ombudsman Act* discussed above).

This more comprehensive reporting has therefore led to a substantial increase in the number of overall police conduct approaches received in 2018/19. Even so, there has been substantial growth in police conduct approach numbers in recent years, with a 21% increase since in 2014/15.

ISSUES AND OUTCOMES

Police conduct issues may be identified in a complaint to NT Police or our Office, by PSC or the NT Police investigating officer or by staff of our Office.

The most common issue raised by Category 1 and 2 complaints received in 2018/19 related to excessive use of force. Other issues raised included irregularities with arrest, failing to explain the reasons for arrest, concerns about searches for and seizure of alcohol, time spent in custody, irregularities with notification of adults, interviews and procedures, rude, offensive or threatening language or behaviour and failings in duty of care.

Internal Investigations outcomes

A number of matters that were deferred in light of criminal or disciplinary proceedings culminated in formal disciplinary outcomes. They dealt with issues such as:

- investigative failings;
- failure to make accurate/adequate records of investigations;
- conflict of interest in a matter that related to the officer;
- use of force on a child;
- use of OC spray on a person;
- failure to disclose information about another officer's conduct;
- inappropriate storage of a firearm;
- making an inappropriate Facebook post; and
- failing in duty of care.

Formal disciplinary outcomes in these cases included counsel and caution, formal written caution, good behaviour requirement of up to 12 months and transfer.

Other cases where remedial advice or training was recommended dealt with issues such as:

- failure to turn on body worn video;
- inadequate record keeping;
- failure to consult superiors before acting;
- failure to inform superiors of action taken;
- inappropriate information access/use;
- inadequate supervision;
- investigative failings; and
- Taser safety.

These cases also led to general recommendations for improvements to NT Police policies across a range of topics.

Category 1 and 2 complaint outcomes

Eleven Category 1 and 42 Category 2 complaints where finalised during 2018/19. Forty-four of those complaints involved a finding that at least one issue was sustained. This is a substantial increase from previous years but it should be noted that a number of these matters involved multiple individuals complaining about the same event. The 44 complaints with a sustained outcome related to 33 discrete events.

Twelve of those events involved an adverse finding on a substantive allegation by a complainant. The other 21 involved adverse findings on one or more ancillary issues identified by NT Police or my Office.

How finalised	2016/17	2017/18	2018/19
Category 1 - sustained	2	2	8
Category 2 - sustained	6	17	35
Deferred in light of disciplinary action / charges	1	2	1
Total	**9**	**21**	**44**

Twenty-one complaints involved sustained findings of failure to utilise body worn video equipment and 12 involved record-keeping failures.

The following table lists the number of cases involving other sustained issues of each type described. In some cases, complaints involved more than one issue. In some, there was more than one officer involved. Where there was more than one complaint about the same event, it is only counted once.

Sustained Issue Type	Cases
Arrest/custody – unreasonable force	6
Investigation – failure to undertake / inadequate / delay	6
Practice/procedure – failings in searches, accoutrements, knowledge of powers/law	6
Arrest – unlawful / inappropriate arrest /detention /fail advise reason	5
Custodial – failure to provide adequate care, eg, blankets, aftercare after spray	5
Behaviour – abuse/rudeness/insensitivity	4
Complaints against police – failure to take/adequately investigate complaint, failure to report questionable conduct	4
Practice/procedure – effecting rights of detainee, eg, interview, interpreters, notification	4
Behaviour – threatening language or behaviour	2
ID – failure to provide, not wearing	2
Custodial – personal safety / wellbeing – failure to monitor /safeguard	1

Case studies of some Category 1 and 2 Police conduct complaints investigated during the year appear in following chapters.

CHAPTER 4 –100 DAYS IN PRISON

The complainant was arrested for a serious offence and spent 103 days in custody before another suspect was identified through the results of DNA tests, and the charges against the complainant were withdrawn and he was released.

ARREST AND DETENTION

The complainant raised issues around his initial arrest and detention and time spent in custody before he was brought before a court. The Investigating Officer (IO) concluded that police conduct in this regard was reasonable but recommended that two officers be given managerial guidance in relation to particular issues.

I accepted the findings and recommendations of the IO on these issues. I accepted that, on the basis of the evidence then known to the relevant officers, there was sufficient evidence at the time of arrest on which to form a reasonable belief that the complainant had committed an offence which justified his arrest. This was a serious offence against the person and it was important to take timely action to obtain and preserve potential forensic and other evidence.

TIME TAKEN FOR DNA RESULTS

Evidence in the case was provided to the Forensic Science Branch 8 days after the incident. It took a further 77 days to obtain interim DNA results that pointed to an offender other than the complainant. The IO indicated that this timeframe is not considered abnormal for forensic requests and found that there was insufficient evidence to sustain the allegation of undue delay.

Forensic testing of 15 items was undertaken as a top priority. I accepted that there were a number of tests to be undertaken and that they were undertaken with priority according to the protocols of the Forensic Science Branch.

While I accepted there was no material issue with individual officer conduct, I went on to consider whether the time taken was reasonable from the perspective of the NT Police as a whole.

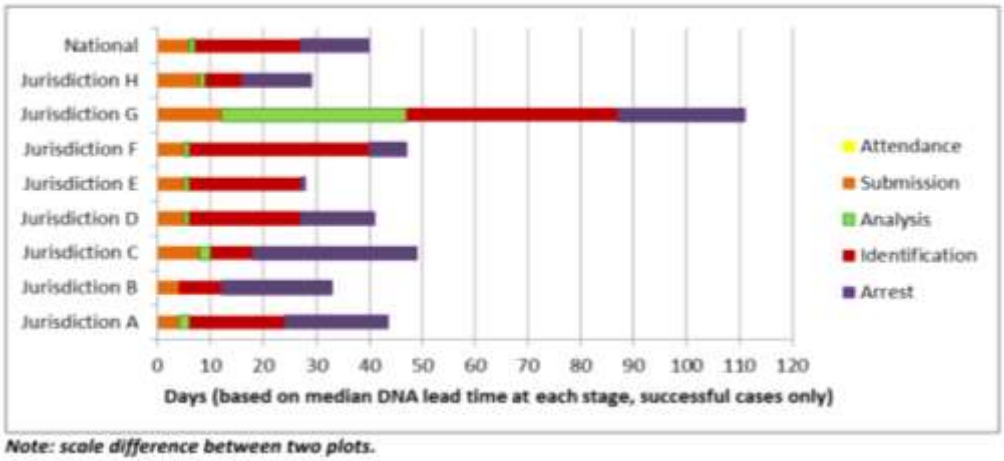
Delay in forensic testing is a regular cause for complaint throughout Australia and the world.[2]

[2] For example, *Forensic testing delays could leave innocent people in prison for months*, WAtoday (2017) https://www.watoday.com.au/national/western-australia/forensic-testing-delays-could-leave-innocent-people-in-prison-for-months-20171005-gyvb8l.html; *DNA lab's two-year lag hampers NSW forensic investigations*, Daily Telegraph (2009) https://www.dailytelegraph.com.au/dna-labs-two-year-lag-hampers-nsw-forensic-investigations/news-story/686cd394fb07687b16ebef0caca3f1a1?sv=d193ae27b04489bf6d1987d7574b044a; *Forensic backlog hampering Vic justice system* (2007) https://www.abc.net.au/news/2007-08-13/forensic-backlog-hampering-vic-justice-system/638536; *Police cite forensic lab cutbacks for delay in probe of suspected drunk driver after head-on crash* (2018) https://www.cbc.ca/news/canada/newfoundland-labrador/police-rnc-rcmp-forensic-lab-cutbacks-impact-1.4690743; *CJI: Forensic Science Service has not addressed delays*, BBC NI (2014) https://www.bbc.com/news/uk-northern-ireland-26159624; *Report to the Attorney General on Delays in Forensic DNA Analysis, National Institute of Justice* (2003) https://victimsofcrime.org/docs/dna-resource-center-documents/report-to-the-attorney-general-on-delays-in-forensic-dna-analysis-(2011).pdf?sfvrsn=6.

A 2016 report of the National Institute of Forensic Science Australia New Zealand[3] provides some basis for comparison of lead times in DNA analysis (although that comparison was undertaken in relation to burglary offences). That analysis showed a median national lead time of 3 days for analysis and 20 days for identification.[4]

The following table extracted from that report shows substantial variation in lead times between jurisdictions, with three achieving a combined median for analysis and identification of around 10 days, three around 20 days, another around 35 days and another around 66 days.[5]

Figure 19: Lead times (Median): By Jurisdiction (DNA)



Note: scale difference between two plots.

The time taken in this case does not compare favourably with the above median times, particularly when the seriousness of the offence is considered.

DNA results can inform the course of an investigation but usually only if they become available in a timely manner. Undue delay is the enemy of the investigative process and the interests of the individual held in custody.

There will always be a need to weigh the speed at which testing is done against the substantial cost involved in improving response times. More resources for testing means more resources diverted from other important functions. However, the significance of DNA results to modern investigative practice requires the implementation of systems that provide timely results in priority cases.

I concluded that it is important for NT Police to regularly review the resources it provides for forensic testing and the means by which it prioritises testing in order to achieve the best practicable outcomes, especially where an accused person is held in custody.

The complainant was held in custody for a further period after interim DNA results were made known to NT Police. During this time further police investigations were undertaken and the matter was considered by the DPP before a decision was made to withdraw the charge and release him. The IO concluded that the action was not unreasonable in the circumstances.

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[3] *End-To-End Forensic Identification Process Project Phase 2 – Final Report* (2016) ANZ Policing Advisory Agency, National Institute of Forensic Science ANZ. file:///P:/My%20Documents/3%20Government%20Relations/Individual%20agencies/Police/End%20to%20End%20Forensic%20Identification%20Process%20Project%20%20Phase%202%20-%20Final%20Report%20-%202016.pdf

[4] Page 6.

[5] Page 31. See also *Follow-up Performance Audit of Behind the Evidence: Forensic Services* (2013) Auditor General Western Australia: http://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/3910393a12f1687a792e6dab48257b8f0022171e/$file/393.pdf

OTHER EVIDENCE

The circumstances in which a prosecution will be commenced/continued are discussed in the Guidelines of the Director of Public Prosecutions (the DPP Guidelines):

> *2.1 The prosecution process should be initiated or continued whenever it appears that there is a reasonable prospect of conviction and it is in the public interest. There is a continuing obligation to review the decision to prosecute in light of relevant material and information as it becomes available.*
>
> *2.2 The question whether or not the public interest requires that a matter be prosecuted is resolved by determining whether:*
>
> > *(1) the admissible evidence is capable of establishing each element of the offence;*
> >
> > *(2) it can be said that there is no reasonable prospect of conviction by a reasonable jury (or other tribunal of fact) properly instructed as to the law; and*
> >
> > *(3) discretionary factors dictate that the matter should or should not proceed.*
>
> *…*
>
> *2.4 The second matter requires an exercise of dispassionate judgment which will depend in part upon an evaluation of the admissibility and weight of the available evidence and the persuasive strength of the Crown case. The resolution of disputed questions of fact is for the court and not the prosecutor. The assessment of prospects of conviction is not to be understood as usurping the role of the court but rather as an exercise of discretion in the public interest. It is a test appropriate for both indictable and summary charges.*

The DPP Guidelines include an obligation for continuing disclosure:

> *8.1 The Crown has a continuing obligation to make full disclosure in a timely manner of the prosecution case to the offender. This includes disclosure of all material which on sensible appraisal:*
>
> > *(1) is relevant or possibly relevant to an issue in the case and being either inculpatory or exculpatory material;*
> >
> > *(2) raises or possibly raises a new issue whose existence is not apparent from the evidence the prosecution proposes to use; and/or*
> >
> > *(3) holds out a real as opposed to a fanciful prospect of providing a lead to evidence which goes to either of the previous two situations.*

Continuing disclosure may provide information that forms a basis for a defendant to challenge continued prosecution or to make a fresh bail application.

DPP decisions of this type are not subject to review by the Ombudsman but there is an obligation on NT Police to disclose such matters to the DPP:

> *8.18 The duty on the prosecution to disclose material to the offender imposes a concomitant obligation on the police to notify the prosecution of the existence and location of all such material. If required police shall, in addition to providing the brief of evidence, certify that the prosecution has been notified of the existence of all such material.*

The results of the DNA tests clearly prompted re-consideration of the prosecution by the DPP. It was, however, necessary to consider whether police should have briefed the DPP on other emerging evidence sooner.

There were at least two important pieces of information that should have led to consideration of the police obligation of continuing disclosure prior to the receipt of the DNA results.

The first was the evidence of Witness A that they had seen unidentified males other than the complainant coming from the house in question. This fact (along with a description) was disclosed to Officer A in the early hours after the incident but not passed on or recorded in writing. It only resurfaced 47 days later when Witness A was formally interviewed. [The IO recommended and I agreed that Managerial Guidance be given to Officer A in regard to recording and reporting obligations pursuant to Police, Practice and Procedure.]

The second came to light on Day 12, when a key witness, who had initially informed police that there was no-one else in the house who was in a position to commit the offence, advised that they had seen another named male in the house at a relevant time.

If Officer A had, on the day after the incident, recorded and reported the information provided by Witness A about the two other males, it is likely that further investigations would have been prompted, including the immediate detailed interview of Witness A, with further enquiries following from the information provided.

Those lines of enquiry would have taken some time to investigate and (with the benefit of hindsight) would not have excluded the complainant from involvement or necessarily have pointed to the person subsequently charged. (This was not the person identified by the key witness on Day 12.)

The IO records that NT Police interviewed a large number of witnesses in the course of the investigation, with 37 statutory declarations obtained prior to the day the DNA results were received and a total of 97 to the time of the IO's report. The IO stated that none of them named the person subsequently charged with the offence as being in the vicinity of the house at the relevant time.

However, the new evidence complicating the investigation would have warranted the incident being declared a major crime from an early stage, which would likely have significantly increased the resources allocated and the expertise of the investigation team assigned to it.

It is problematic to conjecture in retrospect whether, if police had informed the DPP, the DPP would have considered it necessary to pass either piece of information on to the Defence or what a court might have made of an earlier bail application by the Defence based on the presence of others at the house. The decisions of the DPP, the Defence and the courts are not within the scope of this investigation.

However, the threshold for the NT Police disclosure obligation in the DPP Guidelines is not particularly high. The relevant test is, was this information that police should have disclosed to the DPP, so the DPP could consider whether it should, in turn, be disclosed to the Defence? Was it material which on sensible appraisal:

> *(1) is relevant or possibly relevant to an issue in the case and being either inculpatory or exculpatory material;*
>
> *(2) raises or possibly raises a new issue whose existence is not apparent from the evidence the prosecution proposes to use; and/or*
>
> *(3) holds out a real as opposed to a fanciful prospect of providing a lead to evidence which goes to either of the previous two situations.*

Given its relevance to potential lines of further enquiry, I consider Police should have passed information about the presence of other males in the house onto the DPP for consideration in a timely manner.

The failure to brief the DPP can be put down initially to Officer A's inaction but information about another named male in the house became available to police on Day 12 and evidence of two unknown men became available to relevant officers from around the 48 day mark, when Witness A was interviewed, over a month before the DNA results became known.

GENERAL COMMENT ON INVESTIGATION

The IO found considerable deficiencies in the conduct of the police investigation, relating to:

- Crime Scene Establishment / Management
- Crime Scene Examination
- Failure by an officer in charge of investigations to act according to his role and responsibilities
- Failure to hold a forensic case conference
- Poor Command / Control
- Failure to explore other lines of investigation, including other potential suspects.

The NT Coroner has previously made adverse comments on the conduct of police investigations of serious crimes. In *Inquest into the death of Sasha Loreen Napaljarri Green* [2018] NTLC 016 (*Green*), the Coroner reviewed an investigation 'of very poor quality', involving a 'preoccupation' with a particular version of events, failure to analyse evidence, a 'lethargy' at all levels of police and substantial delay in declaration of a Major Crime. He found that the 'investigation was undertaken by inexperienced officers in an incompetent fashion.'

In *Green*, the Coroner also pointed to two previous cases involving substantial investigative deficiencies.

The Coroner recommended, *inter alia*, that the Commissioner of Police do all things necessary to ensure:

- those that investigate major offences have the appropriate skill, experience and resources to undertake investigations to which they are tasked; and
- senior police undertake their roles in facilitating, supervising and providing governance in relation to all major investigations.

In the present case, concerns with the investigation were identified at an early stage, with a Commander being tasked to undertake a review within a week of the incident. In his review report, the Commander made eight recommendations, including the need to undertake numerous further avenues of enquiry to advance the investigation. The IO also made recommendations relating to training, other personnel-related issues, the dissemination of a broadcast on crime scenes and completion of remaining recommendations in the review report.

The deficiencies in this investigation were substantial and the comments and recommendations of the Coroner in *Green* are pertinent. However, many of those deficiencies were not relevant to any move to withdraw the charge against the complainant or secure his release.

Failure to bring the evidence discussed to the attention of the DPP may or may not have ultimately had an impact on the custody of the complainant or the withdrawal of the charge against him. However, that information should have been disclosed by police to the DPP in a timely manner.

It would have been far preferable from the complainant's point of view if the DNA tests and the decision to withdraw the charges following receipt of the results could have been expedited. Certainly, it was always in the broader interests of justice to obtain the DNA results as quickly as possible.

RECOMMENDATIONS

To supplement the recommendations of the IO, I recommended that NT Police:

- **take steps to ensure the robust and effective conduct and governance of major investigations, in line with the findings and recommendations of the Coroner in *Green* and the Investigating Officer in this case;**
- **circulate a broadcast reminding all investigators of the importance of continuing disclosure to the DPP in a timely manner, in line with the DPP Guidelines, particularly in cases where an accused person is held in custody; and**
- **review the resources it provides for forensic testing and how it prioritises forensic testing in order to achieve the best practicable outcomes in terms of effectiveness and timeliness, particularly in cases where an accused person is held in custody.**

With regard to the final recommendation, NT police advise that a review team has recently completed an 8 day site visit across the NT to conduct a Frontline Operational Review of the Forensic Science Branch. The Team comprised the Head of the WA Police Forensic Division and two technical specialists. Their report is due to be issued before the end of 2019.

NT Police advise that specific areas of review focussed on services relating to Crime Scene, Fingerprints and Firearms and included:

- Management and co-ordination of forensic effort across the agency.
- Physical material forensic processes and practices.
- Physical material retention and storage practices for items seized for a forensic purpose.
- Forensic Science Branch integration with:
    - Internal partners including investigation and prosecutorial teams.
    - External agencies including DPP, Coroner, WorkSafe and Legal Services.

The Review aims to provide a mechanism to enhance the quality of these frontline services and provide a constructive platform for improvements to forensic outputs and practices into the future.

Our Office will monitor and report on implementation of recommendations.

CHAPTER 5 –WATCH HOUSE INCIDENT

This case involved police dealing with a vulnerable female youth in a highly challenging situation. It was confronting on many levels, partly due to the limited options available to police. No findings were made against individual officers but recommendations were made to improve planning, guidance, training and equipment available for officers in the future.

The case involved a female youth arrested for assaulting a care worker. She had a significant history of involvement with police. There were various alerts on police systems relating to violent behaviour towards carers and police, attempts at self-harm and spitting.

Perhaps of most relevance for current purposes was an incident which had taken place in the previous year when she attempted self-harm in a watch house on a number of occasions by twisting items of clothing and a blanket one by one around her neck. On each occasion police had to enter the cell, with the complainant variously kicking, spitting at and attempting to bite them. In the course of the incident, officers were injured, including one female officer who suffered a fractured cheek bone. Eventually, no further female officers were available and male officers had to enter and remove clothing from the cell.

Behaviour of this type presented clear risks for:

- the complainant, through actual self-harm (intended or otherwise) or as a result of interaction with officers dealing with the situation caused by her self-harm attempts and subsequent behaviour; and
- officers who were required to respond to her actions.

Following that earlier incident, NT Police developed a detailed Custody Management Plan specifically for the complainant.

On the day in question, police located and detained the complainant without significant incident and she was placed in the cage of a police vehicle with handcuffs on. While she was in the cage, the complainant yelled abuse and made regular threats to officers. As they were travelling to the watch house, the complainant removed her handcuffs and started banging them on the cage. She again made threats to officers. Police stopped and consulted before deciding to continue to the watch house.

After the vehicle started again, the complainant removed her shirt and wrapped it around her neck, twisting it to attempt self-harm. The vehicle was stopped again and officers entered the cage. The complainant kicked an officer in the head. The officers used force to restrain the complainant while they secured her with two sets of handcuffs - one officer bent the complainant's foot and leg with considerable force for approximately 68 seconds in order to maintain control. The complainant was crying out and was clearly in discomfort. Once the complainant was secured with the handcuffs she was able to sit up and the police vehicle continued to the watch house. During that time, the complainant removed her shorts and partly removed her underpants.

The Officer in Charge of the watch house (the OIC) had no previous experience with the complainant but had some notice of her impending arrival and was able to review police records relating to her, including the Custody Management Plan. She was also able to discuss the situation with a senior Territory Families officer.

On the basis of that information, she decided to move the complainant directly to a padded cell and to remove her remaining clothing to minimise the potential for self-harm. At the watch house, a spit hood was used in the transfer of the complainant from the cage of the vehicle to the cell. The spit hood was in place for two minutes and 50 seconds.

There were two female officers in the watch house. They removed the complainant's clothing inside the cell but were assisted in maintaining control of the complainant during removal of the clothing by male officers.

The complainant was kept in the padded cell for the two hours and 17 minutes she was in the watch house. She was monitored by female officers while in the cell, with regular checks being undertaken, often as frequently as every few minutes. On one occasion towards the end of her time in the watch house, there was a 17 minute gap between checks. Nothing of note occurred during that time.

The OIC did not initially provide any clothing or blanket to the complainant. After 38 minutes in the cell, and following consultation with a Territory Families case worker, the OIC opened the cell door to provide her with a blanket. However, she declined to hand it over given the reaction of the complainant. After a further 6 minutes, she again moved to provide a blanket but again declined to do so given the reaction of the complainant. After a further 6 minutes and following a discussion with the complainant, she provided the complainant with a blanket and shortly after, a tear-resistant smock and underpants.

The OIC contacted both the Youth Justice Court and a youth detention centre in an effort to establish the best course of action. She was of the view that it would be best to transfer the complainant directly to the youth detention centre in a bid not to escalate her behaviour further. This was the ultimate outcome.

COMPLAINTS

The Investigating Officer (IO) considered issues relating to twisting the complainants' leg, use of the spit hood, use of the padded cell (including monitoring), removal of the complainant's clothing, the time spent without clothing or a blanket, and failure to conduct a health check.[6] In each case, he concluded that the conduct of police was either reasonable or that he was not prepared to find it unreasonable in the circumstances.

Before discussing those issues in my Assessment, I made a number of general comments. I noted that it is always essential for police to bear in mind that they are dealing with a young person. Their approach must take the age and maturity of the complainant into account. However, it was equally true that police had to take into account the risks that the complainant's behaviours presented to both herself and to police called on to deal with her.

I said that some might question how a substantial number of police would have difficulty in restraining a young person of medium build without presenting substantial risks to those involved. In fact, the need and natural inclination to take greater care in dealing with a young person can just as easily raise the risks. The evidence of the previous incident discussed above should be sufficient to dispel any doubts in this regard. I was satisfied that the risks discussed above were real and substantial.

In dealing with those risks and the behaviours of the complainant, police were faced with enormous challenges. Reviewing the available footage and audio, it is clear that in some cases, they express frustration. There is swearing and there are also attempts at humour. Sometimes the complainant may have been able to hear these comments/discussions but in most cases, she could not.

I said it was important to review those comments in light of the entire series of events. An isolated comment or action may always be drawn on to suggest that a particular decision was made to punish unruly behaviour or belittle a person in custody. On balance, while some of the comments were unhelpful, I did not consider that was the case here.

[6] Conduct involving a pat-down search on another date was also investigated and determined to be reasonable.

When the footage and audio was considered fairly in its entirety, I was satisfied that the intention of the officers concerned, and particularly the OIC, was to carry out their necessary functions in a manner that met the best interests of the complainant and promoted the safety of everyone involved. With regard to events in the watch house, police acted with the benefit of detailed information, a specific Custody Management Plan, in consultation with officers of Territory Families and within the confines of available resources.

TWISTING LEG

With regard to twisting the complainant's foot/leg, the body worn video footage (BWV) gives a reasonable view of the officer restraining the complainant. I was satisfied that it was necessary to use a level of force to control the complainant so that steps could be taken to restrain her from further efforts at self-harm. The complainant had a history of aggression, had been making a series of aggressive and threatening comments and had just kicked an officer in the head. She was clearly powerful enough to inflict injury and was willing to do so.

The leg hold was maintained for about 68 seconds, no more time than was necessary to secure the handcuffs and enable police to safely exit the cage. The pressure applied was nevertheless substantial and caused the complainant considerable discomfort. The IO concluded that the officer may have inadvertently used a higher level of force than was required, but there appeared to be no intent to cause harm to the complainant. He recommended that the officer and his supervisor review the BWV of the incident together to discuss this aspect of the incident and the potential that an unnecessary level of force was inadvertently used. I agreed with this recommendation.

SPIT HOOD

Two alerts on the police system and the Custody Management Plan referred to the complainant spitting. She had not spat at an officer on the day in question but was stated to have sputum and mucus on her, most likely from the attempt at self-harm. She had already threatened officers with aggression and had kicked one in the head.

A spit hood was applied for two minutes and 50 seconds while transferring the complainant from the police vehicle to the cell. There is no indication that the complainant was upset or discomforted by the spit hood. She did complain loudly on her way to the cell but this was when she placed weight onto her foot. She also complained about pain from her handcuffs.

The very idea of anyone being required to wear a spit hood is confronting. However, one should not treat lightly the risk of transmission of disease or the dislocation that can be caused to the lives of officers if they are spat on and thereby subjected to uncertainty, testing and other restrictions for extended periods until the chance of infection is confirmed or ruled out. In this case, the hood was used for a relatively short time, for a specific purpose, without apparent discomfort. While this option should be used sparingly, and only for as long as absolutely necessary, I accepted the IO's finding.

USE OF PADDED CELL

This issue raised three elements — the decision to place the complainant in a cell of that type, the decision to keep her in that cell for the entire time she was in the watch house and compliance with monitoring requirements.

Police have detailed instructions for management of self-harm and violence. The Custody and Transport Instruction requires that a person who has been placed in a padded cell not be left for any longer than absolutely necessary, that welfare checks be conducted at a minimum of every 10 minutes by entering the cell and talking to the person, and that the requirement to stay in the cell be re-assessed at each check.

The complainant had just attempted self-harm. The Custody Management Plan for the complainant stipulated that she be placed 'At Risk' in those circumstances. It raised placement in a padded cell as an option but did not require it. The OIC consulted with a senior Territory Families officer and determined that the best option was to place the complainant in a padded cell on her arrival at the watch house.

The OIC indicated that, even after the complainant had calmed down, she decided to keep her in the padded cell rather than move her and risk further escalation and altercations. After the time when she was provided with a blanket and clothing, the complainant did not appear to be distressed at being kept in the padded cell, although she was clearly keen to move out of the watch house. The padded cell provided an added degree of privacy for the complainant and any move to transfer her could have escalated her behaviour and given rise to a risk point where officers would have to physically interact with her.

The complainant was monitored regularly, although not by entering the cell. The OIC was concerned at the risks involved in entering the cell. The checks were undertaken by female officers looking through the glass window in the door or opening the top half of the door. Monitoring was also undertaken by way of viewing screens. On one occasion, the 10 minute maximum was exceeded. This occurred later in the period during which she was held. This is not ideal and compliance is important.

While there is no written record of checks or reassessments, I was satisfied the OIC regularly re-considered the best approach to care and management of the complainant but maintained the view that the risks to the complainant and to officers involved in moving her to another cell outweighed any potential benefits.

The IO recommended that a broadcast be promulgated to all sworn police officers reminding them that cell checks on people held in custody at Watch House cells must be undertaken within the required time frames as specified in the Custody and Transport Instruction. I further recommended that the broadcast stress the importance of keeping adequate records of checks and of required re-assessments.

REMOVAL OF CLOTHING

Having considered the information available, the OIC decided that all the complainant's clothing should be removed when she was placed into the cell. By this stage, the complainant had removed her external clothing and was only wearing her underwear.

The removal process took about 90 seconds. The complainant was put into a position where she was kneeling with the top half of her body bent over forward. Two female officers removed her underwear. They were initially assisted by two male officers who held the complainant in position, with a third entering the cell after about 40 seconds to give further assistance and remove the spit hood. Other male officers waited outside. Both items of clothing were removed within 70 seconds, with the removal of the spit hood taking a further 20 seconds.

Experience in other jurisdictions

A number of Australian and New Zealand independent review bodies have examined issues relating to removal of the clothing of individuals in custody.[7] They have largely related to the conduct of strip searches but they do provide useful background for consideration of this case.

[7] *Investigation into the strip searching procedures for women at the Hobart Reception Prison*, Ombudsman Tasmania (2017);
Attempted suicide at Auckland Custody Unit, Independent Police Conduct Authority, NZ (2018);
Report on the Investigation of an Incident at the East Perth Watch House on 7 April 2013, Corruption and Crime Commission, WA (2015);

In *The Strip Searching of Female Prisoners Report* (2014), the Queensland Ombudsman discussed the impact of strip searches on female prisoners (at pages 5-6):

> *There is an extensive body of literature finding that the female prisoner population has experienced significant levels of sexual abuse (both as children and adults). Relevantly, in 2006 the Anti-Discrimination Commission Queensland (ADCQ) published the* Women in Prison Report *(ADCQ report) noting that research indicates that female prisoners report having been sexually abused before the age of 16 (37%) at more than four times the rate of the general female population in Queensland (8.8%). Similarly QCS' own 2011 research found that the average female prisoner in Queensland has been affected by domestic violence and sexual abuse.*
>
> *Importantly, research also suggests that, due to the high levels of past sexual abuse among female prisoners, strip searches have the capacity to negatively impact (including re-traumatise) female prisoners more significantly than other parts of the population and may jeopardise attempts at rehabilitation.*
>
> *The ADCQ report reflects other research and standards when it explained:*
>
> > Being compulsorily required to strip-search in front of prison officers is a demeaning and humiliating experience for any human being, male or female … However, for a woman who has been sexually abused, strip-searching can be more than a humiliating and undignified experience. In some instances, it can re-traumatise women who have already been greatly traumatised by childhood or adult sexual abuse. The vast majority of female prisoners who spoke to ADCQ said strip-searching diminished their self-esteem as human beings and greatly emphasised feelings of vulnerability and worthlessness. Strip-searching can greatly undermine best attempts being made by prison authorities to rehabilitate women prisoners, through programs and counselling to rebuild self-esteem, cognitive and assertive skills.
>
> *In light of the known adverse impacts of strip searches on the female prisoner population, the relevant literature and standards recommend that strip searches should only be used when necessary and in the absence of an alternative.*

Further commentary may be found in the English Court of Appeal decision *Davies v Chief Constable of Merseyside Police* [2015] EWCA Civ 114, which considered the removal of clothing of a female of similar age to the complainant in the context of English and European law. The Court of Appeal found in favour of Police in the particular case but made the following general comment (at para 44):

> *I concur with the submissions made on behalf of the interveners that children in custody are vulnerable and that special care is required to protect their interests and wellbeing (see, in particular,* R (HC) v Secretary of State for the Home Department and Another *[2013] EWHC 982 (Admin) per Moses LJ at paragraphs 38 – 50). I am bound to express concern that it should have been thought appropriate immediately to remove the clothes of a distressed and vulnerable 14 year old girl without thought for alternative and less invasive measures to protect her from herself, but in the absence of challenge to the judgment on wider grounds it does not seem to me that the appeal can succeed.*

The following comments of the Tasmanian Ombudsman are also worth noting:[8]

> *35. The general pattern of the strip searches where force was used involved correctional and/or police officers forcing the detainee to lie face down on a mattress on the floor of an unoccupied cell. An officer held down the detainee's upper body and another officer held down the detainee's lower body using various holds and locks. An anti-suicide blanket was used to cover the detainee's body*

Investigation into deaths and harm in custody, Ombudsman Victoria (2014);
The Strip Searching of Female Prisoners Report, Ombudsman Queensland (2014);
Incident of self-harm at Christchurch Women's Prison and the issuing of strip gowns to prisoners at-risk of self-harm, Ombudsman NZ (2010).

[8] *Investigation into the strip searching procedures for women at the Hobart Reception Prison* (2017).

and a third officer then had the primary role of taking off the detainee's clothing. Sometimes there were additional officers assisting in holding the detainee, generally no more than four, and removing clothing from the cell. Once the search was concluded the officers left the cell, leaving the detainee naked with the anti-suicide blanket.

36. I observed a number of cases where only female correctional and/or police officers conducted the search. There were cases, however, when male correctional and/or police officers were involved. When my investigation officers met with correctional officers the male staff said they "hate" having to assist with strip searching females and they endeavour to be as professional as possible and maintain the woman's modesty and dignity. In every case I observed it was clear that officers were attempting to afford detainees some dignity as they all had an anti-suicide blanket draped over their bodies during the strip search.

37. It is not ideal for men to be involved in searches of non-compliant women but for safety reasons it sometimes does occur. It would be an absurd situation, for example, if during a compliant search that becomes violent, a male observing officer standing outside the cell, who is not in sight of the detainee, could not respond to assist his female colleague. If a detainee is non-compliant before the strip searching begins, but there are insufficient female correctional or police officers available, then male officers need to assist. Female correctional officers told my staff that they would not want male offices to feel they need to "hang back" when needed due to any perception that they might be behaving inappropriately.

38. If a man or men were involved in the strip search then it was generally a female officer who was taking the clothing off the female detainee. There were occasions when there were a number of staff involved in the search and staff who were not assisting with the strip search waited outside the cell, out of sight but within hearing range. There were other occasions where officers, both male and female, were within sight observing others conduct the search and removing clothing items which were passed to them.

39. A minimum of at least three officers were usually in the cell in the non-compliant strip searches. In one case there were up to eight police and correctional staff in the cell at once although generally only three or four officers were holding down the detainee. The other staff were either gathering jewellery as it was passed to them, removing clothing from the cell, observing or sweeping items from the cell. In this case it seemed unlikely that this many staff were necessary to be in the cell although I appreciate that before the detainee was safely restrained additional staff close at hand might have been required.

40. We were informed that the more people involved in restraining a detainee, the less pressure and force was required to hold that detainee in position. There are also health and safety implications if an individual cannot be safely restrained. During my officers' meeting with correctional officers it was also mentioned that the strength of some detainees was significant and comments were made about the impact of methamphetamine on some people's behaviour.

This case

I considered the decision to remove all of the complainant's clothing was a reasonable step in the circumstances of the case. Attempts at self-harm through use of clothing are not uncommon.[9] The complainant's behaviour in the past and on the day in question made it clear there was a real prospect that she might attempt to use any item of her clothing for that purpose.

[9] Cummins I, *A place of safety? Self-harming behaviour in police custody*, The Journal of Adult Protection, Volume 10 Issue 1, February 2008, "The most common method of self-harm was the making of a ligature either from the detained person's clothing in a third of cases (33.9%; n=57) or from the paper suit that they had been given to wear, in (26.2%; n=44) cases. (p. 43).

The Custody Management Plan for the complainant provided that, if removal of clothing is required, male officers assist female officers (due to the propensity for violence). That involvement was undertaken bearing in mind the outcome of the previous incident in which female officers had been assaulted and one had suffered a broken cheek bone.

I accepted that, given the behaviours exhibited by the complainant, it was necessary to exert considerable control over her in order to ensure that situation did not get out of hand. While there was a chance two officers could have removed the clothes if the complainant was compliant, there was also a real chance that she would violently object. It was necessary to have enough officers involved to ensure there was no potential for her to free any part of her body.

That being said, there was no absolute requirement for male officers to be involved and the Custody Management Plan could have been better worded in that regard. If there had been other female officers of suitable build and experience available, I consider they could have performed the task. However, there were only two female officers on hand in the watch house.

In a large, centrally located watch house, and with sufficient lead time, it may have been possible to put out a call to establish whether there might be other female officers within a short distance who could come into the watch house to assist. This may or may not have resulted in enough suitable female officers attending but it is an option that should be explored in the event of a similar situation in the future.

Without seeking to understate the situation, the complainant was bent over on her knees so that the intimate areas of her body were substantially obscured from the view of male officers. If enough suitable female officers are not present in an extraordinary situation like this, then I accept there is little choice but to utilise male officers.

The Tasmanian Ombudsman's comments refer to the practice of covering the person as far as possible with an anti-suicide blanket during removal of clothing to preserve some privacy. This step is also referred to in the WA Corruption and Crime Commission's report. This is a step that should be implemented unless the circumstances of the case preclude it. However, I acknowledge that, in the present case, introduction of a blanket as a cover while removing the underwear may have led to additional complications.

This was not a search undertaken to establish whether or not there might be evidence on the person of the complainant. In the view of the OIC, it was an essential step in meeting her duty of care to the complainant and minimising the risk to officers in the watch house. As the IO put it, "The safety of a youth self-harming who has a propensity for violent conduct and injuring female staff, would reasonably be considered extreme and urgent circumstances."

The IO noted that the Custody Management Plan has subsequently been reviewed by NT Police in consultation with Territory Families and amended in various respects including the following alteration, "*If her behaviour indicates she is attempting to self-harm using her clothing,* ***only female members are to remove her clothing for her own protection. Unless her behaviour is so violent as to require significant additional resources, males should only be present if no other options are available.***"

In addition, the IO recommended that a Joint Custodial Minimisation Plan being developed by NT Police and Territory Families be finalised as soon as practicable. I accepted the IO's finding and recommendation.

TIME SPENT WITHOUT CLOTHING OR BLANKET

The OIC did not initially provide any clothing or blanket to the complainant. Regular checks were conducted by female officers for the first 17 minutes. There was then a brief discussion among officers regarding providing a smock if the complainant was required to go to court. The OIC stated she would see how she responds to her case worker but expressed concern about her potential behaviour. Further checks were carried out and a Territory Families case worker arrived after 31 minutes.

At about 33 minutes, the OIC states to the case worker that she is very reluctant to give the complainant a smock or anything at the moment because her "*understanding is she will turn on* (indistinct)". The OIC told the case worker she could not enter the cell but could talk to the complainant through the door. From the time the case worker talked to her, the complainant regularly requested a blanket and said she was cold.

After 38 minutes, and following further consultation with the case worker, the OIC opens the cell half door to provide a blanket and says "Here's a blanket" and "But no bullshit with it". The complainant yells out "Shut the f… up. (indistinct) … Just f…ing throw it in." The OIC declines to do so, stating "No. That's not what you say when you want a blanket" and "I don't trust her at the moment".

The Territory Families case worker urges the complainant to calm down. After a further 6 minutes, the OIC again opens the half door to provide a blanket and the complainant yells something indistinct. The OIC says "Don't yell at me. Do you want to listen to me? This is my watch house, my rules." The complainant yells, "Get off me. Get away". The OIC again declines to provide a blanket. The complainant continues to call for a blanket.

After a further 4 minutes, the OIC engages with the complainant again through the cell door and they have a conversation. The complainant's responses are indistinct. In the course of the discussion, the OIC says "How do I know you are not going to choke yourself out with it. … I don't want to come in there and get it off of you and put all my members and get 'em kicked and spat at. … Alright you give me your word then." The complainant replied, "I'll never give you my (indistinct). I don't do that."

The OIC then provides the complainant with a blanket and shortly afterwards, a tear-resistant smock and her underpants. The total time the complainant was held without any cover was about 50 minutes.

I could locate few references in the literature to individuals being kept entirely naked for an extended period.[10] In many cases, there were references to people being kept naked but it transpired that they had been given a blanket or some other form of covering.

In a follow-up to the WA Corruption and Crime Commission's *Report on the Investigation of an Incident at the East Perth Watch House on 7 April 2013*, the WA Parliament's Joint Standing Committee on the Corruption and Crime Commission held a public hearing with the Police Commissioner on the CCC's report.

[10] Cf *Women in Prison* report, Anti-discrimination Commission Queensland (2004), pp71 and 99, where women in Crisis Support Units were stated to be routinely held in a totally naked state.
See also *Report on the Investigation of an Incident at the East Perth Watch House on 7 April 2013*, Corruption and Crime Commission, WA (2015) paras 136-150, where a woman was held naked in a padded cell for 20 minutes, purportedly due to concerns about self-harm but the CCC concluded there was another motive.
And *Attempted suicide at Auckland Custody Unit*, Independent Police Conduct Authority, NZ (2018), paras 50-52, where a man was held naked for about 30 minutes but only because he refused to put on a proffered tear-resistant gown.

The following extract from the transcript (page 37) is of some relevance:

> ***Hon ADELE FARINA****: Can I just raise the issue of keeping people naked in padded cells. Is that a usual practice?*
>
> ***Mr Parker*** [OIC, Perth Watch house]*: That is usually done for people who are attempting self-harm. Often people in that frame of mind will remove clothing, whether it be underwear, shirts, whatever, and tie it around their necks. The only response or action we can take for their safety is to remove their clothing.*
>
> *Because their clothing is removed we actually put them in a padded cell because it is private and it is a concealed area. They are kept in there for the minimum time, usually until they calm down, and then they are given clothing back or one of those Kevlar smocks I mentioned before, before they are taken back to the cell.*
>
> ***Hon ADELE FARINA****: What is the temperature in the padded cell?*
>
> ***Mr Parker****: The temperature is controlled throughout the Perth Watch House in any regard. It is a comfortable temperature; the temperature of this room here now.*
>
> ***Hon ADELE FARINA****: I have concerns about that because I do not think you need to remove every item of clothing, even if someone is at risk of self-harming, because you have them detained in cells and you do not remove every bit of clothing from them. I find that practice very concerning and I assume that the blanket was removed from the detainee as well when she was put in the padded cell?*
>
> ***Mr Parker****: In that time, because the blankets we had were not what they call suicideproof— they were tearable; people could tear them up if they had the strength. In regards to removing clothing, it does occur that people will try to get their underwear and twist it around their neck and try to choke themselves out.*

The complainant's Custody Management Plan provided that, if removal of clothing is required, a self-harm smock be provided to ensure modesty.

There is an immediate, instinctive objection to keeping anyone naked in a cell for an extended period. There would be few things in modern society that are more likely to eat away at the dignity and self-respect of an individual. However, there are situations when police dealing with people who exhibit the most challenging behaviours have no alternative but to choose between limited and confronting options.

I accepted that the OIC was motivated to reduce the risk of harm to the complainant and police. The complainant had attempted self-harm not by tearing clothing and attempting to hang herself but by twisting material around her neck, thereby potentially cutting off her air supply or injuring herself, e.g., her windpipe. If she did attempt this, police would have no choice but to move in to remove the item, putting themselves and the complainant at further risk.

This prospect had caused the OIC to remove all the complainant's clothing. There would be no point in doing so and then providing the complainant with other means to achieve the same end. The options open to the OIC were a standard blanket and a tear-resistant smock. The OIC was clearly concerned that the complainant might be able to use either for that purpose. While both where thicker than standard clothing, I accept that it was reasonable for the OIC to assess this as a realistic risk.

Attempts at self-harm through wrapping or twisting safety gowns or blankets, intact or torn, do occur. For example:

> *In October 2012, Prisoner J at the Dame Phyllis Frost Centre was found in the observation cell by prison staff attempting suicide, with her face discoloured and with a canvas gown tied tightly around her neck. Eleven days later, Prisoner J again attempted suicide by tying the canvas gown*

around her neck. Two days after this incident, Prisoner J again tied the canvas gown around her neck in an attempt to commit suicide.[11]

The OIC therefore had to assess the disturbing prospect of keeping the complainant naked in the cell for a period against the risk that the complainant would attempt self-harm and police would have to put themselves and the complainant at risk of harm to resolve the situation.

This was not an easy judgement to make. The OIC discussed the matter with the case worker. She clearly considered the issue on an ongoing basis. She made two efforts to provide a blanket but on each occasion she decided against such action following the agitated response of the complainant.

The padded cell at least provided a modicum of privacy for the complainant. There was a small window which was covered by a sheet that required lifting during regular checks. Otherwise, there was no direct view into the room. The only other viewpoint came if the top half of the door was opened or through monitor screens (discussed below).

The OIC eventually decided that the risk in providing a blanket (and shortly after a smock and underpants) had reduced sufficiently to take that option.

It is important to appreciate that this was a dynamic situation where the assessment of risk was likely to change. Another officer faced with the same situation might have taken a more cautious approach. Alternatively, someone else may have been moved to take the risk sooner. With the resources that were available to the OIC, a reviewer should not be too quick to substitute their own view for that of an experienced officer on the scene.

A major problem in dealing with these risks was the lack of confidence the OIC had in the existing options. My Office briefly investigated other options on the market that might preclude effective use as a ligature around the neck. Available options included lightweight paper smocks that would not be strong enough for use by person to choke themselves and substantially thicker blankets/smocks that could not be torn, bent or twisted for that purpose.

While these options might not be particularly comfortable, they may provide short-term options for cover, warmth and privacy without increasing the risk of self-harm. It is important that NT Police review available options. It may also be necessary to provide additional training to officers involved in watch house management to ensure they are confident with their use in potential self-harm situations.

A further issue raised by keeping the complainant naked for an extended period was the fact that there were two video screens from which the complainant was visible. One was on the external wall of the cell. This appeared to be clearly visible only to someone standing close to it. The other was on a computer monitor in the reception desk area. There was one brief instance of a male officer looking at the screen on the cell wall but the other monitor appears to have been potentially visible to male officers throughout, and was clearly viewed by a male officer on one occasion.

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[11] *Investigation into deaths and harm in custody*, Ombudsman Victoria (2014), para 275.
See also *Public hearing with the Police Commissioner on the CCC's report on an incident at the East Perth Watch House*, WA Parliament Joint Standing Committee on the Corruption and Crime Commission (2016), quoted above; *Incident of self-harm at Christchurch Women's Prison and the issuing of strip gowns to prisoners at-risk of self-harm*, Ombudsman NZ (2010); and
Cummins I, *A place of safety? Self-harming behaviour in police custody*, The Journal of Adult Protection, Volume 10 Issue 1, February 2008, "The most common method of self-harm was the making of a ligature either from the detained person's clothing in a third of cases (33.9%; n=57) or from the paper suit that they had been given to wear, in (26.2%; n=44) cases. (p. 43).

Where a person is kept naked, all reasonable steps should be taken to obscure screens from officers of the opposite sex. For example, it would have been a simple matter to tape a sheet of paper over each screen, blocking the view of male officers but easily allowing female officers to undertake regular checks.

The IO noted that the Custody Management Plan has subsequently been reviewed by NT Police and Territory Families and amended in various respects including the following alteration, "*Should her behaviour necessitate the removal of her clothing then a tear-resistant blanket or smock is to be provided to ensure her modesty as soon as it is safe to do so.*"

The IO recommended:

- NT Police investigate additional options for clothing / blankets that will minimise the potential they could be used to self-harm.
- A further review be conducted of the Custody Management Plan by NT Police and Territory Families as a result of this investigation, with the input of health professionals. Recommendations suggested:
    - In similar circumstances as to those faced in this case, where clothing was removed due to self-harm / suicide attempts and there is no other option than to keep her naked, additional steps should be made to ensure male Police Officers are not able to view the CCTV screens behind the reception desk, by covering them to ensure the complainant's modesty;
    - Only female Police Officers will conduct physical cell checks on the complainant in circumstances where she has had her clothing removed and there is no other option than to keep her naked in a cell. Only in extreme circumstances where no other female options are available should males conduct physical cell checks under these circumstances.

In light of the previous incident, NT Police took steps to prepare for a repeat incident by creating a Custody Management Plan. This was a laudable measure that involved considerable foresight. The current incident has shown that it could have been improved on, particularly with input from Territory Families and health professionals, and by providing additional clothing/cover options for watch houses.

FAILURE TO CONDUCT HEALTH CHECK / PROVIDE MEDICAL ASSISTANCE

This issue related to the failure to conduct the routine custody health check and identify and provide assistance with the complainant's sore leg. My Office also raised an issue with the failure to engage with a health professional in circumstances where the complainant had actually attempted self-harm.

There was no Custody Nurse available at the relevant time. The Custody Management Plan provided that the Child & Adolescent Mental Health Service (CAMHS) should be contacted if there was concerning behaviour around mental health or self-harm but this step was not taken.

With regard to conduct of a health assessment and seeking medical assistance, the OIC indicated that neither was a practical option in the circumstances. She indicated that the attitude of the complainant would have made any approach to the complainant to conduct a health assessment too risky and may potentially have worsened her behaviour. She said she would not have allowed anyone, including a health professional, into the cell to assess the complainant or treat a sore leg, given the risks involved.

I accepted that the conduct of a custody health assessment would have been problematic in the circumstances. The focus of the OIC was on securing the complainant's transfer to a youth detention centre as soon as possible (an aim which the complainant clearly shared).

With regard to recourse to professional health assistance, I accept that granting physical access in the absence of an emergency would also have been problematic. However, I consider it would have been preferable to have some form of health professional assistance on hand to offer advice and to provide immediate assistance if a previously latent injury manifested or the complainant made a further attempt at self-harm.

Contact with the CAMHS, in line with the Custody Management Plan, would have allowed the OIC to obtain advice from a mental health care professional regarding what options might be available for the immediate care of the complainant. To my mind, this was an important step that would likely have provided a greater level of assurance to the OIC regarding the care of the complainant.

The revised Custody Management Plan contains a similar provision regarding the CAMHS. Where a Custody Nurse is not present, it is important that NT Police have viable alternatives available. In this case, there was potential for either mental health issues or physical injury to manifest and NT Police needs to be fully prepared to deal with either eventuality. It is important for NT Police to consider whether there are further practical options to enhance health/medical support in cases like this.

It is also essential that, where events like this occur, there is a comprehensive handover to the court or custodial institution that is taking over the care of the individual. In this case, the OIC advised that she gave a detailed briefing to the youth detention centre by phone. Where a person has a serious injury or has attempted self-harm, it would be preferable to provide a briefing both orally and in writing.

RECOMMENDATIONS

More generally, this incident raises the need for police to carefully review the supporting materials and training available for officers who are called on to respond in challenging circumstances like this case. These reviews should be conducted with particular attention to the needs and behaviours of young people and people who are experiencing mental health issues.

To supplement and reinforce the recommendations of the IO, I recommended that NT Police:

- **review the complainant's Custody Management Plan in light of the PSC report and my Assessment and in consultation with Territory Families and relevant health authorities.**
- **investigate additional options for clothing / blankets that will minimise the potential for use in attempted self-harm, whether by hanging or choking.**
- **take all practical steps to promote the privacy of individuals when their clothing is removed. Except to the extent that risks to the individual or others preclude it, this should routinely include:**
    - **removal of clothing only by, and in the presence of, officers of the same sex as the individual;**
    - **use of a blanket to cover the person as far as possible during removal;**
    - **returning their clothing, or if this is not possible, another appropriate form of cover, as soon as possible;**
    - **ensuring that monitoring is only open to, and undertaken by, officers of the same sex as the individual.**
- **stress to relevant officers the importance of:**
    - **the importance of obtaining timely medical advice and assistance when dealing with At Risk individuals, particularly when they have attempted self-harm;**
    - **providing oral and written handover where a person has suffered a significant injury, has attempted self-harm or has been placed At Risk.**

- **consider the broader implications of these events for custody management in other situations and:**
    - **review/amend relevant guidance materials as required; and**
    - **consider the need for varied or additional training.**

Our Office will monitor and report on the implementation of recommendations.

CHAPTER 6 –DON DALE DISTURBANCE

On the evening of Tuesday 6 November 2018, police were called to deal with a disturbance at Don Dale Youth Detention Centre (Don Dale). At the time of the call, there were 25 youths in Don Dale, including one female. Four youths complained to our Office about the way Police dealt with the disturbance, their transfer to the Darwin City Watch house and their detention in the Watch house for approximately four days until they were transferred back to Don Dale.[12]

There was extensive CCTV and body worn video footage (BWV) at Don Dale and extensive CCTV coverage at the Watch house. This, along with documentation created at the time and subsequent information from relevant officers, provided considerable assistance in the investigation of complaints.

EVENTS AT DON DALE

This section gives an edited summary of the background provided by the Investigating Officer.

At the outset, three youths approached Youth Justice Officers (YJO) attempting to move them to their rooms, and removed a set of keys from one of the officers. Another YJO was assaulted by one of the youths who was now armed and the YJO attempted to get away. This officer was later taken to the Royal Darwin Hospital and treated for injuries to his hand and chest requiring suturing. It is alleged he was assaulted with a broken table-leg and threatened with a knife. With the keys, the three boys set about releasing other inmates and arming themselves with make-shift weapons, rocks and knives.

An official request for police assistance from Territory Families was signed at 7.15pm and the situation was from this point on under the control of NT Police. The Territory Response Group (TRG) and Police Negotiators were called out and a Forward Command Post established.

TRG officers were dressed in TRG uniform, ballistic vest and helmet. Officers were armed with a range of weapons, including M4 rifles and a variety of chemical OC and CS grenades to allow them the option to deploy less lethal weapons to prevent assaults or escape. They were given authorisation to use "*non-lethal force"*, if required to bring the situation to resolution.

As the evening progressed, groups of youths went through the facility, accessing buildings and removing mobile phones, computer tablets, clothing and other property. Some attempted a number of times to escape, managing to break through to the outer fence, but were held back by police. Significant damage was caused to buildings, windows smashed and fire extinguishers sprayed and thrown. A group of youths continued to approach the sally port area, throwing projectiles, bashing on the metal door with poles and on occasions, spraying fire extinguisher foam into the sally port through peep-holes in the doors, and covering police, Territory Families, St John Ambulance and Fire Brigade personnel with hydrant dust.

At about 8.45pm it became evident that a fire had been lit in the education building, with smoke and flames clearly visible. Youths threw rocks, D Cell batteries and sticks at police and yelled abuse at them as they moved through the facility. They later found power tools and used them to cut through fences and further damage property.

Police negotiators, using a medium range acoustic device (MRAD) or, in layman's terms, a loud speaker, from the guard tower, gave continuous instructions to the youth to surrender. Attempts were made to commence negotiations via a phone also, however these proved to be of limited success. Negotiators also attempted to communicate with youth at the fence-line however were spat on and sworn at in doing so.

[12] Aspects of youth justice other than police conduct do not fall within the jurisdiction of our Office.

During the course of the evening, media and some of the families of the detainees began to arrive at the Don Dale carpark. There were some in the crowd who were critical of police and became quite vocal that police weren't ensuring the youths' safety. Some believed they could talk the youth into surrendering and some also began to approach the perimeter fences and engage with the youth, yelling through the fences. Their actions and presence only increased tensions with the youth and so police resources were sent to dissipate the crowd and the decision was made to move them to the outer entrance to the Don Dale grounds.

The first 'emergency action' undertaken by the TRG officers was to enter the facility and rescue three of the YJOs who had locked themselves in a Block when they had been confronted with threatening youth and were unable to evacuate with the other staff, to the sally port area. In contact with officers by phone, the men were reporting that they had been threatened by a youth with a knife and were fearful for their lives. A planned response by the TRG officers enabled the three men to be safely removed and escorted back to the sally port area.

Shortly after this, TRG again entered the facility to facilitate the safe removal of the female detainee. During these actions, M4 rifles were pointed at detainees to illuminate them with the white light from the torches with the officers yelling "*drop the weapon*", "*show me your hands*" and "*move back*". The light aided officers in determining if the youth were holding anything (weapons or projectiles) and the green laser light that was also used, was, "*very effective in moving them back and away from the team, severely reducing the projectile threat*".

At 9:09pm the first detainee walked toward the sally port and surrendered himself. He was instructed to get onto the ground and to place his hands behind his back. He complied and flexi-cuffs were applied to his wrists. Once restrained and searched, he was assisted to his feet and escorted inside the sally port area.

It was decided to clear B-Block and secure it so that it could be used to contain the youth as they surrendered. The plan was to attempt to negotiate with the youth and convince them to surrender without having to use force. TRG officers moved out to B-Block and ensured it was cleared safe and secured in order to receive detainees. Some uniform officers and YJO were also escorted to B-Block to receive the youth and take custody of them.

At about 10pm, a group of 6 youths surrendered to police outside the front of B-Block. Each of the youths were made to get down on their hands and knees and crawl toward the waiting officers, one at a time. Once they neared police, the youth were instructed to lie down on their front and put their hands behind their backs. Each was then held in a three point hold-down whilst flexi cuffs were applied. They were then stood up and escorted inside B-Block to a vacant cell. Whilst this was occurring, TRG officers surrounded the area, ensuring the safety of all those involved whilst the process was undertaken. At this time, visibility was greatly impeded as there was billowing, toxic smoke being emitted from the fire from the education block, which had become fully engulfed and limited lighting in that particular area.

At 10:35 it was decided that the youth in B-Block were to be removed and escorted to the sally port. The concern was that given the fire's proximity to B-Block, and the likelihood of smoke being sucked into the building through the air conditioning ducts, it posed an unacceptable safety risk to the youth and staff inside. It was decided the youth would be driven to the Darwin City Police Watch house and secured there where they would be safe.

The youth were removed from B-Block, and escorted individually to the sally port area, where they were put into police vans and driven to the Watch house. B-Block was locked and secured to ensure that none of the remaining youth could gain access.

At approximately 10.49pm another four youths surrendered to TRG near the front of the sally port area. Rather than being told to crawl along the ground, as the first group were instructed to do, the youths were told to walk backwards toward the TRG officers one by one with their hands raised. The youth were secured, searched and taken into the sally port by TRG officers, with other officers standing guard to protect them from other freed youth.

Once again, the torches mounted on the rifles were used by the TRG officers to illuminate the youth as they approached police during the surrender process and to ensure they were not carrying any weapons or implements that could be used as a weapon.

Whilst negotiators continued to attempt to get the youths to surrender on their own accord, a plan was developed for TRG officers to systematically move through the facility and clear each block of buildings, securing the buildings behind them as they did so. Other TRG officers would maintain watch to ensure the officers were safe as these tasks were being undertaken.

It was also deemed prudent at this time to bring the TRG "Bear Cat" vehicle into the compound to aid a rapid response for TRG officers (with less lethal weapon options) to reach areas where youth were at risk of getting through the outer fence by using power tools. There was a concern that the youth were throwing projectiles at police outside the perimeter as cover for their escape attempts and General Duties police had limited less-lethal options to address the threat.

The detainees continued to act inappropriately inside the facility, with some climbing on rooves and throwing batteries at buildings. Windows in the watch tower were smashed by projectiles as were police vehicles parked on the outer perimeter. General Duties officers maintaining watch along the fence line had to be mindful of projectiles being thrown at them in the dark. Some of the youth had located a work room that contained power tools, including grinders and petrol.

At about midnight, youths started using the equipment on the outer perimeter fence. Sparks can be seen from the operation of a grinder on metal. A TRG officer called out at least twice for the youths to move away. They did not do so. The officer then threw a pocket tactical CS gas canister towards, although not directly at, them, causing them to scatter and run from the area. It appears that one youth was effected to some extent by the gas.

At about 12.30am a TRG officer was dispatched to the control tower with a shotgun loaded with 'bean bag' rounds and given a direction to use the weapon if the youth continued to try to cut through the fence or begin to throw projectiles again. He was directed to aim at the ground in front of the youths, rather than at them, to scare and deter them from what they were doing.

A Direct Action Plan was approved and TRG moved out into the facility at just before 1am. TRG were in teams that included armed officers maintaining a safe cordon as the team with keys slowly began to move through each building, clearing it and securing it behind them so the youth could not re-enter. There was an ongoing threat of being attacked by the youths as this exercise occurred. The TRG controller shouted out loudly to the youths, encouraging them to come forward to their location and that they would not be harmed. He also conveyed the message that police were moving toward them and it would be safest for them to surrender rather than having to be taken by force.

Soon after TRG had moved out from the sally port to implement the Direct Action Plan they were faced with a group of youths armed with poles and carrying bottles, believed by the officers to be 'Molotov cocktails'. The TRG controller called on a TRG officer armed with CS gas rounds to fire a shot and the first was deployed at about 1.08am. A further two shots were discharged about 30 seconds later, all three being fired into the air, along the roadway in the centre of the facility. The first shot hit a building above door, with the closest youth well out of line and behind a fence, about 5 metres away. The next two shots hit the base of the building and grass at the front of the building. All youths were well away by the time of the second shot but the sound caused them to retreat further.

At 1.45am the first of the remaining youths surrendered to police, with a further two surrendering shortly thereafter. The last of the youths surrendered at about 2.15am and were escorted to the sally port. Four youths were identified as having been sniffing petrol and were assessed by St John before being transported to the Royal Darwin Hospital for medical assessment. Two of these males were conveyed by ambulance. The other youths were transported to the Watch house.

DON DALE – COMPLAINTS AND COMMENTS

All four youth complainant's raised concerns about TRG officers pointing firearms towards them. The Investigating Officer (IO) concluded that the conduct of TRG officers in this regard was reasonable. TRG officers were called out to a situation where there had already been violent acts against YJOs and there were 24 youths at large within the centre. In the course of the evening, a number of youths armed themselves, threw items and damaged property. A building was set alight.

This was a volatile situation involving a large number of youths. There was clearly potential for youths to take aggressive action against officers. There was no easy or immediate way for police to be certain that a youth approaching them or other nearby youths would not act aggressively. The IO stated:

> *… police were mindful of the threat that each youth presented upon surrender, including the possession of volatile substances (petrol). Each were made to advance individually with their hands upon their heads, and then, when in close proximity to police, made to turn around and walk backwards (to ensure there were no hidden objects behind them) a short distance before they were physically taken into custody. All of these actions were undertaken to ensure the safety of all during the process.*
>
> *Territory Families had requested police assistance to handle a highly volatile situation and police were then authorised to take control to bring the situation to resolution. Given that Youth Justice Officers had been assaulted and threatened with being killed, some had been held in K-Block until rescued, the damage to property and the very real threat of harm and further damage, as well as escape, TRG and Police Negotiators were called upon. Police planning centred on convincing the youth to surrender peacefully and without having to use force; they engaged in continual negotiations and announcements asking the youth to do so. TRG were armed and dressed in protective clothing and are trained to deal with such situations and were directed to use non-lethal options to deter youth from injuring them. The success of an operation is assessed by the minimum amount of force used, and on this occasion, there were no injuries incurred to the youth in the process of bringing them back into custody.*

The footage shows that, at times, rifles were pointed directly at youths and at other times they were pointed towards a youth but trained on the ground in front of them. While the lights on the rifles may at times have assisted with identifying whether a youth held anything in their hands, the approach of holding the weapons in ready position pointing towards a person appears to have been routinely adopted when a youth was approaching or in the vicinity.

It was appropriate for TRG officers to come prepared for a full array of responses, including carrying rifles. It might be suggested that there was potential for more officers to carry non-lethal weapons as a first response. However, the exigencies of the situation and the need to be ready for any eventuality would probably always have meant that at least some officers would carry rifles and point them towards potential threats.

The precise mix and balance of non-lethal options and firearms carried by TRG members in a situation like this is a matter that requires careful consideration. It would certainly be worthwhile for police to deliberate on what (if any) effective alternative mixes and strategies might be available in the course of the recommended broad reflection exercise (see recommendation at the end of this chapter).

One youth also raised concerns about being effected by CS gas, which was deployed on two occasions. In the first case, a CS grenade was thrown in the general direction of a number of youths who were trying to break through an external fence with an angle grinder. The youth in question was one of the group which dispersed rapidly when the gas was deployed. The potential for breach of the outer perimeter fence and attempted escape by a significant number of the youths, with consequent danger to them, to the small number of officers patrolling the area and to others was real and substantial.

In the second case, officers moving into the facility to clear buildings were faced with youths moving towards them (although still at some distance) yelling abuse and armed with projectiles and weapons. Three gas rounds were fired in the direction of the youths in order to force them back from the officers. The first shot hit a building at least 5 metres from a youth who was behind a fence. That shot made the youths move away quickly and the sound of the other two shots, although they did not impact near any of the youths, forced them back further.

The IO considered that, at the time, the threat of the youths throwing containers of fuel was a major concern to the police and the use of a non-lethal deterrent such as CS gas provided a distance gap between them to inhibit the threat of harm by such weapons. The IO was not prepared to find the use of CS gas unreasonable. I accept that finding.

Youths also raised concerns about the manner of their apprehension by police. One was required to crawl along the ground towards officers when surrendering. The IO concluded that the conduct of police was not unreasonable. Two complained that zip ties were applied too tightly to their wrists, and two complained that inappropriate force was applied to their backs or heads when they were apprehended. The IO concluded that there was no evidence to support these complaints.

The actions of some of the youths, exacerbated by the release and participation of the others, gave rise to a highly dangerous situation with many potential risks. While not all youths exhibited violent or aggressive behaviour, many of them did. In dealing with them, even at the point they individually surrendered, Police could not be certain that they or others in the vicinity would not act aggressively.

This was a situation where there had been ongoing acts of violence and aggression from a range of youths. It would have been highly optimistic, if not foolhardy, for Police to assume that a youth approaching them no longer presented any risk. Police had to take necessary steps to minimise risk and be ready to react if something did happen.

EVENTS AT WATCH HOUSE

This section gives an edited summary of the background provided by the Investigating Officer.

The detainees were conveyed to the Darwin Police Watch house following the decision that they could not be further held at Don Dale for safety reasons. The initial plan to secure the youth in B-Block as they surrendered was abandoned when fire took hold of the education block and given its proximity to B-Block, the youth already held there were evacuated.

Following the surrender of the remaining youth, Don Dale was declared a 'crime scene' and the area was closed down for investigators (police and fire) to examine the area. It was later learned that there were asbestos concerns in the damaged building, making it further pertinent to keep people out from the area until it could be made safe. The following day, the incident was officially declared a 'Major Crime' and a team of Major Crime detectives were given carriage of the investigation.

On Wednesday 7 November, the Minister for Families approved the Watch house and the Peter McAulay Centre as youth detention centres under the *Youth Justice Act.* Following this, an Acting Superintendent of a Detention Centre was approved for premises including the Watch house. A Custody Management Plan was drafted providing the details of police and Territory Families staff responsibilities for youth whilst they were incarcerated at the Watch house. The youths were held at the Watch house until they were returned to Don Dale on the evening of Saturday 10 November.

Initially the majority of the youth were placed in one of the large holding cells at the back of the Watch house and on the male side. Three males were placed in a separate cell together due to their propensity to fight with some of the other detainees. On the morning of 7 November, the youths were moved to smaller cells and into more manageable groups of three and four. YJOs attended and assisted with the provision of meals, showering and fresh clothing. A medical assessment of each youth was organised to determine any injuries or medical complaints.

At about 2pm on 7 November, one of the detainees, whilst being escorted back from a shower, suddenly hit out at the police auxiliaries assigned to escort him. The incident required a number of police and Territory Families staff to gain control of him and he was segregated for a short time, to calm down. Following this incident, it was decided that, for safety reasons, TRG officers would be also brought in to assist with the custody of the youth.

Whilst the Watch house was now determined as a youth detention facility, it continued to operate as a watch house, receiving adults and youths on charges and for protective custody.

WATCH HOUSE – COMPLAINTS AND COMMENTS

Three youths complained about language used or threats made by officers. Officers denied making such comments and searches of audio-enabled CCTV (not all CCTV is audio-enabled) provided no supporting evidence in this regard. The IO found these complaints Unresolved.

Complaint was also made about the use of TRG officers in the Watch house. As noted above, TRG officers were brought in to provide additional support following the incident involving a youth detainee. The IO concluded that this action was reasonable.

One youth challenged the basis for police detaining him at Don Dale and holding him at the Watch house. The IO noted there was an onus on the police to return him to custody, given that he had been detained by an order of the Youth Justice Court, stating:

> *The action of conveying the detainees to the police watch house, rather than to leave them at* [Don Dale] *was a decision made … when the burning building, billowing toxic smoke and resulting from an arson committed by some of the youth present, made* [Don Dale] *unsafe for them to remain within. The classrooms that were burnt were later found to contain asbestos and the precautionary measure of conveying the detainees to the watch house further limited their exposure to toxic materials. The continuing detention at the watch house was a decision of the Minister for Territory Families.*
>
> [The youth] *was lawfully detained, there was no requirement for him to be held on a charge as the Warrant of Commitment was in force, and he was being held in a facility authorised as a Youth Detention Centre.*

The youths also complained about various conditions and restrictions at the Watch house, including having lights left on all the time, being handcuffed for a visit with a relative and being subject to regular searches. The IO concluded the actions of police were reasonable but acknowledged:

> *With regards to the custody of the youth at the Darwin Police watch house, it is agreed that the facilities were not ideal for the duration of their stay there. The circumstances were that a faction of the youth from* [Don Dale] *had caused significant damage at the centre rendering it unsafe for them to remain there and the Minister determined that the watch house could be used as a youth detention centre as an interim measure. Police and Territory Families appear to have operated under trying circumstances, whilst continuing to maintain 'business as usual'.*

With regard to lighting, the IO stated:

> *The premises is designed for short term custody episodes such as protective custody, arrests where interviews or further investigation is required, bail applications and domestic violence orders for example. It is not designed for longer-term incarcerations where persons are detained on remand or sentences. A number of people who are brought into the cells are often intoxicated (alcohol/drugs) and/or are highly emotional. In addition, a number of people who live itinerant life-styles with significant health issues are often apprehended and kept in the watch house. To this end, staff are trained to be highly vigilant to ensure the safety of those in the cells, including the identification of people who are deemed "at risk" (e.g. the sick, emotional, youth) and ensuring that regular checks are conducted on them. There are CCTV cameras in every cell, room and hall way, no fixtures that articles can be attached to and the lights are left on to assist monitoring of those detained within.*

As for handcuffing for a family visit, the IO noted:

> *It was the decision of those escorting him from the cell that he be handcuffed and searched upon being removed from the cells. He was part of a group in cell … that had been involved in unruly behaviour and was recognised as being actively involved in the riot activities at* [Don Dale]. *For the protection of staff and himself, it was a reasonable decision to ensure that he was restricted from taking possession of any items, attempts to escape, or to harm others.*
>
> *The room designed for meeting with lawyers is a two-way divided room, with separate entrances and the parties separated by a glass partition. There are 'grills' in the partition to enable dialogue between the parties. Although designed to restrict objects being passed from one person to the other, it remains a possibility. This room is also designed such that the parties have some semblance of privacy in that there is no CCTV or recording devices in there.*

Regarding searches, the IO stated they were conducted each time a youth was removed from a cell or returned to it, in line with Watch house procedures. Searches were by way of a clothed pat down search or by use of a metal-detector wand.

Two youths complained about having blankets, mattresses and toilet paper removed from their cell for periods of time. This occurred on two occasions after they placed paper over CCTV cameras to obscure vision. Water to the cell was also turned off for a period. On the first occasion, toilet paper was provided in limited quantities as required and blankets and mattresses returned after one hour and 17 minutes. Similar steps were taken in another cell whose occupants placed toilet paper over CCTV cameras and blocked the sink in their cell, causing flooding. The IO concluded:

> *The staff were restricted in what actions they could take and were still required to process and care for other persons coming into the watch house, whilst maintaining surveillance on the youth. These actions were reasonable in the circumstances and were only done so for short periods of time.*

Finally, considering the response to the disturbance as a whole and following discussions with our Office, the IO made the following general recommendation:

> *Given the number of stakeholders involved, it is recommended that a broad reflection exercise on lessons learned from this event be conducted. It involved a great deal of interplay and co-operation between general duties police, TRG, negotiators, Territory Families personnel, ambulance, fire, and watch house staff. It is recommended that representatives of all stakeholders meet as a group to look at what went right and recommend any improvements for the future.*

There is no doubt that the initial response to a large scale disturbance among detainees and particularly the ensuing need to safely and suitably accommodate them while Don Dale was unavailable, raised many issues for which there were no immediately achievable ideal solutions. Authorities did what they could with what they had.

There will always be limits to what can be achieved when responding to events of this magnitude. Few jurisdictions can maintain suitable custodial facilities in mothballs to prepare for such an eventuality. However, it is important that planning be undertaken to identify and formulate realistic options, second-best though they may be, so agencies are ready for action if the worst happens.

It is hoped that the recommended reflection exercise will contribute to emergency and business continuity planning for the future, both in relation to the way disturbances involving substantial numbers of youths or adults in custody are handled and responding to the aftermath of major damage or disruption to custodial facilities.

CHAPTER 7 – OTHER POLICE CASE STUDIES

Case 1 – Third party complaints

A person suffered a bleeding head wound when they fell to the ground after an officer grabbed and pulled on their arm. The incident took place in a shopping centre. The person who suffered the injury did not complain but two complaints were received from members of the public who witnessed the incident.

All three officers involved in this incident activated their body worn videocameras (BWV). Being able to view the incident in its entirety from different angles and hear what was said was very beneficial for the resolution of the complaint. Although the two complainant's were relatively close to the incident, the Investigating Officer (IO) and our Office had the advantage of being able to review the course of events in detail.

The officers attended at the request of security from the centre who had experienced some difficulties with the individual. When the officers arrived they were asked to assist with removal of the individual from the centre. While the area is generally accessible to the public, it is private property and police can assist with removal of a person at the request of centre management.

Police attempted to engage with the individual and directed him to leave the premises on a number of occasions. The individual initially gave little in the way of a response to police and appeared to be heavily under the influence of alcohol or another drug. After some delay, the individual rose, making an offensive gesture and then appeared to take offence at one officer telling him to mind his attitude, asking a similar question three times in a confrontational tone and moving towards the officer.

Another officer standing behind the individual was concerned that the individual might act against that officer. He first grabbed him on the upper arm just above the elbow. This was consistent with trying to pull him back or halt his progress towards the other officer, which was the stated intention of the officer.

However, the officer's hand quickly slid to the lower arm of the individual just below the elbow. Pulling in this direction was more likely to result in the individual falling, particularly when he was unsteady on his feet.

I accepted that, when force was used, the individual was exhibiting signs of aggression in the way he was facing the officers, in his language and in his motion towards the officer. I would not say he threatened any officer but his behaviour was confrontational. He may or may not have carried it further but the potential was there.

The injury to the individual's head was highly regrettable. However, the way he fell was probably contributed to by his impaired reflexes, and there is potential for injury in any use of force.

The IO found that the police action was not unreasonable given the circumstances. Based on the information available, I accepted the finding.

My Office explained the outcome to the complainants and thanked them for raising their concerns.

Case 2 – Drawing a firearm

Two complainants alleged that an officer drew his firearm and pointed it at them, told them 'don't come near me or I will shoot you', directed complainant 1 to get on the ground even though there was broken glass on the ground, handcuffed complainant 1 while still holding and pointing the firearm at him and continued to make threats to use the firearm while searching for complainant 2, who had run off.

Given that the officer and the two complainants were the only people present for much of the relevant time and there was no BWV footage available, the IO found the allegations relating to use of the firearm and threatening behaviour were unresolved.

The officer was one of a small number of officers in a remote community at the time. He sought to apprehend the complainants who were reported to be in the area. He went in pursuit of the complainants on foot and caught up with them in a secluded area of the community.

On the version of events of the officer, he was alone in a remote community, faced with two well-built males, both with known histories of violence, who knew he was trying to apprehend them, who turned and approached him with what he viewed as aggressive intent. He did not have a Taser. He had already run a substantial distance and was drained from the effort. He drew his firearm to dissuade them from any aggressive action. He did not point it at them. He gave a warning in measured terms. He denied making the threats alleged by the complainants.

On the other hand, the complainants painted a different picture. They said the firearm had been drawn before they turned to see the officer and that the officer threatened to shoot them if they approached him. They also described other threats made once one of them had run away.

The officer gave a clear, consistent and plausible version of events. He supplied a recorded walk-through of events and provided useful background information. There is evidence from him and from another officer regarding what was said after this incident and the respective physical locations of the subject officer and complainant 2 that raise some questions about the accuracy of the statements of the complainants regarding subsequent threats.

Drawing a firearm arm is a serious matter and should, where the circumstances allow, be considered carefully as a matter of last resort. From an officer safety perspective, there is always the potential that it will exacerbate a situation and bring the firearm into play against the officer if there is a struggle or an assailant takes charge of it. It may also lead to a situation where an officer has restricted his options to employ a less aggressive response. However, if matters transpired as the officer described in this matter, I would not consider a complaint of excessive use of force sustained in these circumstances.

Ultimately, the IO concluded and I accepted that there was not sufficient evidence on which to base a finding against the officer.

Case 3 – Apprehension and treatment of youths

This case study provides an example of a complaint that has been made regularly in recent times. A number of youths were apprehended following pursuit of a stolen vehicle. Their complaints to our Office related to the manner of their extrication by police officers from the vehicle, treatment outside the vehicle, transfer to a police vehicle, placement into the police vehicle, transport to the watch house and rude or offensive language used by officers.

Other cases have raised similar issues as well as issues relating to police smashing vehicle windows to obtain access and their failure to inform youths of reasons for arrest.

With regard to the initial apprehension, there was no available BWV or CCTV footage. There were a large number of youths and a large number of police involved. For many of the complaint allegations raised, this became a contest of a version of events put forward by the complainants and a contrasting version of events put forward by police officers.

For some allegations, the IO found that police conduct was not unreasonable or that there was insufficient evidence to support the allegation. However, for many allegations the finding was Unresolved. This, and many other complaints finalised during the year, point to the benefit of having BWV or CCTV footage as evidence to assist in resolving competing versions of events. The importance of officers ensuring adequate BWV coverage is discussed in Chapter 2.

In the circumstances, I repeat my previous comment (most recently at page 68 of my 2017/18 Annual Report) that , on any version of events, it is clear that substantial force was used in extricating the youths from the vehicles and in their treatment after this. While findings could not be made against individual officers, these cases squarely raise issues concerning treatment of youths.

Complainants in some of these cases expressed particular concern about the involvement and actions of Territory Response Group (TRG) officers. As I have previously stated, it is important that the response of every officer is proportionate to the circumstances in which they are operating.

I reiterate my recommendation that NT Police:

> *Take action to emphasise to officers the importance of recognising and acting on the fact that, in exercising their duty of care to children, and particularly young children, their needs and circumstances may differ appreciably from adults and there will frequently be times when a different approach is required to meet those circumstances.*

This particular case also raised issues regarding treatment of youths at a Watch house. CCTV footage clearly shows two officers substantially exceeding the bounds of appropriate conduct in respect of a number of the youths, from the perspective of the force and language used and their treatment of the youths. Both were subject to disciplinary proceedings under Part IV of the *Police Administration Act 1978 (*the PAA*)*.[13]

Other failings that gave rise to recommendations for remedial advice to officers included failure to turn on BWV, use of rude or offensive language, failure to conduct a proper search, failure to adequately respond to the conduct of the officers against whom disciplinary action was taken and inappropriate interaction with a complainant following the making of a complaint.

The IO recommended that a deficiency relating to pat down searches of male youths in the presence of other male youths and a female officer should be addressed through a review of the Custody and Transport Instruction. A failure by officers to report a complaint about police conduct gave rise to a recommendation for an internal broadcast on the issue.

The IO also recommended that there should be amendments made to the 'handcuffing' segment of the General Order - Operational Safety and Use of Force and that formal advice be sent to relevant police Commands as to the expectations of police in providing sufficient detail in completing custody documents, particularly when associated with youths in custody.

Our Office will be continuing to monitor and report on issues of this nature.

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[13] Disciplinary action in relation to an individual officer may be taken under Part IV of the PAA. For less serious disciplinary matters there is also on option to take action under section 14C of the PAA. For other matters requiring guidance but not disciplinary action, an officer may be given remedial advice by a superior officer (which is documented on their personal record).

Case 4 – Apprehension and detention in a remote community

This is another example of the benefits of having CCTV and BWV footage available. A range of complaints were made on behalf of a youth concerning arrests and detention in a remote community.

Excessive use of force (grabbed roughly around waist and back)

The IO reported that the complainant was armed with spears and pointing one of them directly at an officer. A relative of the complainant disarmed him, following which, he was arrested. The officer concerned stated that he had his OC spray in his hand (not used) therefore had only one arm free to contain the complainant. As such a 'bear hug' type hold was used. There is no record on the custody documents which would suggest any pain or injury to the complainant resulting from this arrest. The IO found the police action was reasonable.

Delay between arrest and formal interview

The complaint was that police officers did not conduct an interview with the complainant until the late evening, four hours after his apprehension, contrary to the *Youth Justice Act*. The IO found the police action was reasonable. Although there were deficiencies in record keeping, the IO ultimately accepted the explanations given for the time taken to commence the interview. The IO recommended both officers be provided with remedial advice regarding the record-keeping requirements of sections 137 and 138 of the PAA in order to rectify their future behaviours and conduct.

Interview

The IO considered the allegations in four parts:

a) Police continued to formally interview the complainant despite his assertions that he felt weak, tired, and too nervous to continue;
b) Police did not consider or make arrangements to utilise an interpreter for the interview;
c) Police failed to advise the complainant of his legal right to access legal representation;
d) Police interviewed the complainant late at night rather than consider interviewing the complainant at a later date.

The IO found allegations a), b) and c) sustained. With regard to allegation d), the IO did not find the action to be unreasonable given the circumstances, although this should be viewed in the context of the finding that the interview should have been delayed until the next morning. The IO recommended that two officers be provided with remedial advice:

- as to the expectations set by the General Order in order to rectify their future behaviours and conduct when conducting interviews with indigenous persons;
- in relation to section 3.1.1 of the General Order Q2 – *Questioning people who have difficulties with the English language – the Anunga Guidelines;*
- on the requirements set by both the *Youth Justice Act* and the *General Order – Youth* in relation to advice regarding the availability of legal representation.

Arrest as opposed to summons or youth diversion

The IO reported that police charged the complainant with the offences of 'go armed in public' and 'assault a member of the police force'. Both offences were punishable by imprisonment. Although the officer considered youth diversion, he ultimately determined that, due to a group of youths congregating outside the police station wanting to continue to fight with the complainant, issue of a summons or youth diversion were not reasonable options at the time. That course of action was supported by the on-duty Watch Commander.

If the complainant had been released, there was a real prospect that he and or others would have continued to fight, committing further offences and likely resulting in injury to one or more of them. The IO found the police action was not unreasonable in the circumstances.

Bail (detained overnight in custody contrary to sections 4(c) and (i) of the *Youth Justice Act*)

For reasons similar to those discussed above, the IO decided the police action not to grant bail was not found to be unreasonable in the circumstances. The IO found that the complaint regarding failure to provide advice regarding the availability of legal representation was sustained, noting that this should be addressed in remedial advice referred to above. The IO did not sustain a complaint that inappropriate bail conditions were set which were difficult for the complainant to comply with, concluding that the bail conditions were set by a Judge, not police.

No notification of arrest to responsible adult

The IO reported that the complainant was absent from the Watch house for a period of approximately 87 minutes while attending a medical clinic. There was no evidence to show that any attempts had been made to contact a responsible adult during that timeframe. The IO found the allegation sustained and recommended that the subject officers be provided with remedial advice regarding the requirements of the *Youth Justice Act* in order to rectify their future behaviours and conduct when informing responsible adults of a youth's arrest.

Other allegations (no evidence to support)

The IO found no evidence to support three allegations. With regard to an allegation that handcuffs were applied too tightly, the officer concerned advised he did not have his handcuffs (that issue was addressed as an ancillary matter). Another officer corroborated this evidence, stating that the complainant was not handcuffed. The complainant's brother stated handcuffs were not used on him or his brother and CCTV footage from the police station shows no handcuffs were in place.

The complainant also claimed he was pushed out of a police vehicle and onto the ground. The officers stated the complainant exited the vehicle of his own accord. The complainant's brother contradicted the allegation by stating the officers' assisted both he and his brother out of the paddy wagon by holding their wrists and helping them climb out. Although this also differs from the version provided by the officers, it did not support the complainant's allegation.

The complainant claimed that police turned off the camera to the complainant's cell while he was in custody. The complainant advised he saw the Sergeant touch a switch and the screen turned off. The IO reported that the officer concerned was correct in his assertion that the CCTV system cannot be manipulated locally as it is administered remotely. While it was possible the complainant was talking about the monitor screen being turned off, the subject officer was adamant this did not occur.

Wilfully false allegations

The IO found two allegations to be wilfully false. The complainant alleged he was taken into a cell and told to stand with his stomach against a wall with his arms outstretched, and that the officers hit the complainant with their batons on the back of each knee, once on the left ribs and once on the back of his right shoulder. The complainant said he was hit a total of four times and that he was crying and screaming 'help' but the officers just laughed at him. The IO and Ombudsman staff viewed the CCTV footage which completely negated this allegation. Medical reports did not support any injury to the complainant's knees, ribs or shoulders.

It was alleged that after the assault with the batons, the officers returned to the cell and pulled the complainant into a wheelchair and locked both his wrists and ankles onto the wheelchair before going to the clinic. The IO reported that CCTV footage from the police station does not support this allegation. Further, the police station does not have a wheelchair or any similar equipment within its inventory. Ombudsman staff viewed the relevant CCTV footage which shows the complainant walking out from his cell when going to the clinic.

Case 5 – Escalation and escort

One of the most important aspects of policing is people management and this is a prime example of a situation where an alternative approach could have seen a better outcome. Police responded to a report of domestic violence in a hotel room. In the course of police enquiries, there were a number of verbal exchanges between the complainant and officers in the hotel corridor, following which he was arrested for disorderly behaviour, physically restrained and escorted from the premises to a police vehicle. To reach the vehicle police escorted the complainant into a lift and for some way through the building while keeping him physically restrained.

The complainant alleged that police officers used language that was inappropriate and intemperate. The IO found that the language used by the officers was inappropriate in that it did not help in de-escalating the situation. Additionally, it was not compliant with the Code of Conduct and Ethics General Order or in line with the NTPFES Values.

The IO concluded it would also have been prudent for the officers, prior to arrest, to have given the complainant a clear warning that if he persisted in his behaviour he may be arrested, and then not to have engaged further in negative conversation with him. This would have alerted him to the potential consequence of continuing to argue and may have had the desired effect of de-escalating the situation. The IO recommended that the officers be given remedial advice in relation to this conduct.

The complainant also alleged excessive use of force in that handcuffs were applied too tightly, his head was bashed into an elevator wall and that he was thrown into the cage of a police vehicle. Although the physical restraint of the complainant through the confined spaces of the hotel did present challenges, the IO was not prepared to find the actions of the officers unreasonable.

Having reached that conclusion, the IO considered this was a case where it was important for the officers to reflect on the events and consider to what extent their approach to similar situations can be improved for the future to minimize the potential for harm or discomfort while still carrying out their functions effectively. The IO recommended that, in the course of the remedial advice referred to above, the officers have a full and frank discussion with their supervisor, with areas covered to include:

1. the need and capacity to take added care and time when escorting a person into or through confined spaces (in this case the lift and doorways), particularly when they may be under the influence of alcohol or drugs;
2. the inherent disadvantages in requiring or forcing a person to walk bent over with his head down at an extreme angle both in terms of discomfort for the person and maintaining control and stability for all involved;
3. the need and capacity to take added care and time when placing a person in the cage of a police vehicle, particularly when they may be under the influence of alcohol or drugs;
4. the need for use of force and escort holds to be utilised to the minimum extent necessary reflecting the circumstances of the particular case; and
5. the need to be alert to concerns expressed by a person being escorted about the level of pain or discomfort being experienced, and in such circumstances to give consideration to adjusting or moderating the escort hold if that is practicable.

Case 6 – Handover of injured or ill prisoners

Police attended at a private residence in response to a report of a domestic disturbance. The complainant was arrested for breach of a Domestic Violence Order. While being escorted to a police vehicle, he broke free and was pursued for some distance and re-apprehended. Allegations relating to his arrest, use of force and offensive language were investigated, with the IO finding the police conduct was reasonable, except for one allegation that was unresolved.

A further allegation related to the duty of care owed to the complainant and steps taken on the handover of the complainant to Correctional Services. On the day of the incident, the complainant was transported to hospital for assessment of an injured hand which was discovered to be broken. A follow-up appointment was made at another hospital and he was returned to the Watch house.

The appointment was recorded on a 'Fit for custody' report which the IO concluded had probably been passed on to Correctional Services staff when the complainant was transferred to their custody. The IO concluded that records regarding the appointment would have been available to correctional/health services staff. Ultimately, the complainant missed his appointment.

The IO concluded that the conduct of police was not found to be unreasonable in the circumstances but stated that custody sergeant handovers could have been more comprehensive. The IO recommended that the Divisional Superintendent send out a broadcast (email) to all police officers in the Division reminding them of their obligations under the Custody General Order.

On review, I accepted the finding and recommendation but noted that issues relating to handover of an injured person in custody have arisen previously. Given how important it is that handover be undertaken with due care and all necessary documentation and notice provided, I considered this issue required a more general approach. I expressed the view that it would be appropriate for NT Police to explore options for improvement of handover practices for injured or ill detainees.

Given the interests of the Department of Health and the Commissioner of Corrections in the matter, I suggested that this might best be pursued by way of a working group of relevant officers from each agency, with the ultimate aim of creating a memorandum of understanding or similar document setting out the expectations on agency officers on handover.

I recommended that NT Police explore options for improvement of handover practices for injured and ill detainees in consultation with health and correctional authorities.

In that regard, the Acting Police Commissioner has advised:

> *Handover practices for ill and injured detainees have been improved through amendment and update to policy and procedures. The NTPF Custody and Transport Instruction has been amended to ensure a more robust assessment process is undertaken when transferring a detainee to a medical facility.*
>
> *This process has also included the development of health handover form which is provided to the representative of the receiving agency. I am advised that although this process was primarily developed for handover of detainees to hospitals or other medical facilities, it is now also an accepted practice when handing over detainees to the Correctional Services Darwin Correctional Centre, and updates to the Custody and Transport Instruction will follow.*

Case 7 – Aftercare – pepper spray

A complaint raised the issue of appropriate aftercare following the use of pepper spray. The spray was deployed by the side of the road, a considerable distance from any urban area. Police had only limited amounts of water in their vehicle to assist with decontamination.

In line with a recommendation of the IO, a broadcast message was circulated reminding all officers of their obligation to provide adequate decontamination, aftercare and monitoring. It stated that police should place sufficient decontamination equipment in police vehicles if duties are being undertaken away from urban areas where availability of water is limited and medical assessment and care may be delayed.

CHAPTER 8 – YOUTH ROYAL COMMISSION

The final report of the *Royal Commission into the Protection and Detention of Children in the Northern Territory* was handed down in November 2017. It made a number of recommendations relevant to police administration and police conduct, areas that fall within the jurisdiction of the Ombudsman. I set out below a number of recommendations of particular relevance to NT Police.

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.*

Recommendation 25.2

1. *Northern Territory Police undergo training every two years to reinforce their obligations under the Police Administration Act (NT), Youth Justice Act (NT) and Police General Order – Arrest in relation to the exercise of their discretion to arrest children and young people.*
2. *Northern Territory Police collect data on the incidence of arrest of children and young people, the reasons for the use of arrest, rather than summons, the outcome of the charges laid against children and young people who were arrested, and prepare a report to be published annually.*
3. *The Northern Territory Commissioner of Police amend the Police General Order – Arrest to provide that children and young people must not be arrested at school unless there is a substantial risk the child or young person will abscond or reoffend if not arrested at school.*
4. *The Northern Territory Commissioner of Police review Police General Orders and police training to ensure police understand the basis on which charges may be laid against a child or young person.*
5. *Undertake a review of charging practices over the last three years with respect to children and young people.*

Recommendation 25.3

1. *The Northern Territory Government ensure all police cells are made suitable for detaining children.*
2. *Provision be made in either the Police Administration Act (NT) or the Youth Justice Act (NT) that children and young people may be held in custody without charge for no longer than four hours. Any extension up to a further four hours may only be granted by a Judge.*

Recommendation 25.4

1. *A custody notification scheme be introduced requiring police to notify a lawyer from an appropriate legal service as soon as a child or young person is brought into custody.*
2. *The Northern Territory Government commit to resource the custody notification scheme following the initial three-year funding from the Commonwealth Government, including funding the legal services to provide the custody notification scheme.*

Recommendation 25.6

1. The Youth Justice Act (NT) be amended to provide that a child or young person must not be interviewed by police:

- *until they have sought and obtained legal advice and assistance, or*
- *after exercising their right to silence.*

2. The Northern Territory Government take immediate steps:

- *to ensure the register of support persons established under section 14 of the Youth Justice Act (NT) includes people from Aboriginal Law and Justice Groups and/or other Aboriginal community bodies for each area of the Northern Territory*
- *to amend section 14 of the Youth Justice Act (NT) to require that a person may only be on the register of support persons if they have undertaken training by an approved provider on their role as a support person*
- *to ensure police provide support people who are not lawyers with information in an easily understood form, including orally, with the use of an interpreter if necessary, or by providing a document or showing a video explaining the support role and outlining what the support person can or cannot do to assist the child during the interview, and*
- *to ensure all decisions by police to use a support person from the register of support people are reviewed by a senior officer, including the steps taken to locate a member of the young person's family or an alternative support person.*

Recommendation 25.7

The Northern Territory Commissioner of Police refresh and reissue Police General Order – Youth promulgated 22 February 2007.

Recommendation 25.8

The Northern Territory Police Youth Diversion Unit be resourced to provide a comprehensive diversion service with adequate specialist staff members and facilities, to give effect to the principles of the Youth Justice Act (NT).

Recommendation 25.9

The definition of the 'serious offences' that exclude a young person from eligibility for diversion be reviewed, with a view to removing preclusion from diversion for less serious offending.

Recommendation 25.10

The Youth Justice Act (NT) be amended to remove the restriction on police consideration of diversion in section 39(3)(c).

Recommendation 25.11

The references to offences against Part V and Part VI of the Traffic Act (NT) be reviewed with a view to enabling children and young people charged with offences under these provisions to be eligible for diversion under section 39 of the Youth Justice Act (NT).

Recommendation 25.12

The Northern Territory Commissioner of Police amend Police General Order – Youth Pre-Court Diversion to remove the requirement that a child or young person must admit to committing an offence when an officer is considering them for diversion and require instead that the child or young person 'does not deny' the offence.

Recommendation 25.13

The Youth Justice Act (NT) be amended to require reports about a child or young person's participation in a diversion program be tendered in court and made available to the child or young person's legal representative.

Recommendation 25.14

Youth diversion programs in remote communities be developed and operated in partnership with, or by, Aboriginal communities and/or Aboriginal controlled organisations.

Recommendation 25.18

A formal administrative arrangement between the Office of the Director of Public Prosecutions and Police be developed to update bail and bail condition information to avoid erroneous arrest.

Recommendation 25.19

The Bail Act (NT) be amended:

1. to provide that a youth should not be denied bail unless:

a. charged with a serious offence and a sentence of detention is probable if convicted

b. they present a serious risk to public safety

c. there is a serious risk of the youth committing a serious offence while on bail, or

d. they have previously failed to appear without a reasonable excuse

2. to require that when imposing bail conditions the police and courts take into consideration:

a. the age, maturity and circumstances of the young person, including their home environment, and

b. the capacity of the young person to comply with the conditions

3. to require that at the time bail is granted to a young person, each bail condition and the consequences of breach of that condition be explained to the young person, taking steps to ensure their understanding, using interpreters or modified means of communication if necessary

4. to exclude children and young people from the operation of section 37B (offence to breach bail), and

5. to give police the power to:

a. issue an informal or formal written warning to a young person believed to have breached any bail condition, or

b. where a breach has occurred more than once, issue a summons to a young person who has breached bail requiring them to come before the court to determine the consequences of any breach.

Recommendation 25.20

The Commissioner of Police issue a Directive setting out:

- *guidelines for the police in relation to curfew checks, including the circumstances in which they should be used or avoided, and their frequency, and*
- *that police only arrest a child or young person for breach of bail where the breach occurs as a result of or in connection with further offending and after police have considered and rejected as inappropriate issuing a summons, or where the breaching conduct clearly indicates a materially increased risk of non-attendance at court or further offending.*

Recommendation 25.33

The Commissioner of Police by Directive require police to take all reasonable steps to obtain the contact details of a responsible adult for a young person taken into police custody and provide those details to the young person's legal representative as soon as possible.

In response to the report of the Royal Commission, the NT Government developed a plan to implement reforms to better support children, young people and families experiencing vulnerability and to deliver the recommendations of the Royal Commission. *Safe, Thriving and Connected: Generational Change for Children and Families 2018-2023* was published in April 2018. With regard to initiatives that specifically relate to Police, it states:

Initiatives Identified in Response to the Royal Commission

INITIATIVE	DESCRIPTION	RECS	PHASE
Arrest and Police Custody	NT Police has commenced a review of youth operations that aims to improve the organisational, legislative, policy and training structures and develop platforms that directly guide and influence police operations and interactions with young people and their communities. This work includes a review of General Orders to ensure police practice aligns with the Royal Commission recommendations.	25.02 25.03 25.06	Phase 2
Custody Notification	The establishment and funding of a Custody Notification Service (CNS) for Aboriginal people is a pre-existing Commonwealth and Northern Territory Government commitment. The CNS requires police to notify a lawyer from an appropriate legal service as soon as a child or young person is brought into custody in the Northern Territory. The Northern Territory Government is committed to providing ongoing funding for the CNS after the initial three year funding commitment from the Commonwealth Government expires, provided the model is feasible for the Northern Territory.	25.04 25.33	Phase 1
Police Diversion	Northern Territory Police, Fire and Emergency Services is developing a Youth Justice and Engagement Action Plan to promote partnerships with the community to deliver improved outcomes for at risk young people and their families to ensure a safe and resilient Northern Territory. The proposed outcomes of the Action Plan are: 1. Informed and contemporary workplace culture and practice; 2. Enabling community partnerships and connectedness; 3. Delivering appropriate and timely interventions – early and sustainable exits; 4. Diversion – continuation and expansion of restorative justice conferencing. Underpinning the Action Plan is a review of the current police youth justice and engagement services and the provision of contemporary youth justice and domestic and family violence awareness training to all Police Officers.	25.08 25.10 25.12	Phase 1
Youth Policing	The Northern Territory Government recognises the benefit of NT Police engaging and working with young people, their families and their communities to promote pro-social behaviours and divert youth at risk of offending. NT Police can also play an important role in sustaining positive change following youth justice interventions. The Northern Territory Government will review the current delivery of police youth justice and engagement services and investigate the establishment of a Police Youth Division to manage police services for young people who offend, are at risk of offending, or may be in need of care and protection. Regardless of the structure deployed, NT Police will introduce the required reforms to ensure Police work effectively and constructively with young people supported by targeted training, development and specialisation. The Northern Territory Government will investigate, with reference to other proposed youth justice system reforms, the possible establishment of Community Youth Teams (CYTs) to coordinate cross agency youth justice responses to young offenders at a local level. A CYT comprises frontline staff from Northern Territory Police Fire and Emergency Services and other key stakeholders in identified communities. The role of a CYT is to lead the development and implementation of community action plans to better engage the community and strengthen community safety.	25.01 25.07 25.18 25.20	Phase 1 Phase 2

Acknowledging that a number of recommendations require involvement from multiple agencies and that overall implementation is being managed by the whole-of-government Reform Management Office, I recently sought a further update on implementation of police-related recommendations.

In response, NT Police has advised:

> *The NTPF is working with multiple agencies under the umbrella of the Reform Management Office to progress police related recommendations. To date NTPF has completed and signed off the following recommendations:*
>
> *33.13 - Developed a protocol with Territory Families to manage children absconding from out of home care*
>
> *25.33 - Implemented a Custody Notification Service with NAAJA to address the requirements of this recommendation*
>
> *25.20 - Issued a broadcast direction outlining instructions for police in relation to curfew checks and how they should be used, which will also be reflected in the rewrite of the Youth General Order*
>
> *22.01 - Developed a protocol in relation to the police response to reports of criminal offending against young persons in detention that addresses this recommendation.*
>
> *In addition, NTPF has established a specialised Youth Division, developed an online training package containing components relating to; childhood and adolescent brain development, cognitive and intellectual disabilities including FASD; and the effects of trauma in accordance with recommendation 25.01. With the passing of the Youth Justice Act amendments the NTPF are well placed to complete the remaining recommendations within the next several months.*

My Office will continue to monitor implementation of police-related recommendations in so far as they relate to matters within our jurisdiction.

CHAPTER 9 – CORRECTIONS APPROACHES 2018/19

Correctional Services approaches increased from 401 in the previous year to 587. This is the second highest number of approaches on record, surpassed only by 608 approaches in 2014/15, the year that saw the transfer of prisoners to the new Darwin Correctional Centre (DCC).

In 2018/19, there were 426 approaches relating to DCC compared with 144 relating to Alice Springs Correctional Centre. Both centres saw appreciable increases in approaches over the previous year but DCC remains the source of the majority of approaches.

A list of the most common issues raised by approaches in 2018/19 is set out in the following table. Some approaches raised more than one issue. The table lists issues raised, not issues sustained.

Issue	Notes	No.
Complaint processes	Includes problems accessing Request to Attend Superintendent's Parade (RASP) forms and access to Superintendent	**93**
External contact	Includes issues with phones, mail and visits	**91**
Officer conduct	Includes rudeness, insensitivity, harassment, poor communication, inappropriate treatment of a vulnerable person	**78**
Classification / Housing	Includes issues about the classification of a prisoner, eg, high, medium, low security, as well as accommodation arrangements such as which area or block they are placed in and cell type	**77**
Health / welfare	Issues regarding health services are referred on to the Health & Community Services Complaints Commission but we deal with issues regarding how correctional officers implement health and medical advice	**69**
Money / buys	Any issues dealing with prisoner accounts and purchases	**53**
Food	Issues relating to quality or service of food. Includes issues relating to special dietary requirements	**49**
Condition of facilities		**38**
Misconduct proceedings		**26**
Work	Employment inside or outside prison	**24**
Recreation / Amenities	Matters relating to recreational activities and everyday aspects of living, eg access to publications, smoking, access to television, sporting and craft equipment	**20**
Personal safety/security	Assault, fight, threat by prisoner – Assault, excessive force, threat by prison officer – Housing prisoners together in a way that puts one or more at risk	**14**
Educational programs		**13**
Time spent outside		**9**
Prisoner property		**8**

There were marked increases in the number of approaches relating to complaint processes, officer conduct, food and condition of facilities compared with the previous year.

Our Office is working closely with Corrections to improve complaint processes and address the issues raised by the approaches being received.

The next chapter discusses issues raised relating to Correctional Services since 2016 and provides a number of examples of complaints made.

CHAPTER 10 – CORRECTIONS ISSUES

With the commencement of a new Commissioner of Correctional Services, I took the opportunity to prepare a detailed report aimed at capturing the essential elements of more significant Corrections-related issues that have come to the attention of my Office in the past few years.

The report discussed strategic and general themes but also provided a large number of detailed examples relating to operational matters and suggestions for further action. It also dealt with a range of matters concerning complaint handling, monitoring and review.

Corrections has already taken steps to address many of these issues and is continuing to explore improvements to its systems and procedures. Our Office is working closely with Corrections in this regard. We will continue to monitor and report on progress in relation to these issues.

Edited extracts from the report are set out below to provide examples of the themes and issues that have been identified. A number of the broader issues were also touched on in my report on *Women in Prison II*. Progress in relation to that report is discussed in Chapter 11.

STRATEGIC FOCUS ON REHABILITATION AND REINTEGRATION

In a submission to a review of Corrections in 2016, I made the following general comments on the strategic direction of Corrections:

> ***Greater emphasis on strategic goals***
>
> *In all strategic documentation, there is a clearly stated emphasis on reducing reoffending. The NTG Framing the Future strategic goal, Strong Society and the Pillars of Justice law and order reform strategy both have a strong focus on reducing re-offending.*
>
> *The Department's Strategic Intent 2013-16, sets out its purpose as "To contribute to community safety by reducing re-offending".*
>
> *This approach is unexceptionable and is wholeheartedly supported. Imprisonment, of itself, is simply not an effective mechanism for reducing crime. Current return to prison rates are staggering and cannot be seen as an endorsement of the effectiveness of the justice system as it stands.*
>
> *There is a problem in that, even with the considerable efforts undertaken by the Department to date, the reality is that the proportion of resources currently allocated to reducing re-offending does not reflect the Department's primary strategic purpose.*
>
> *There needs to be a fundamental change in the way we expend the vast resources allocated within the justice system, including the focus we place on reducing re-offending. The intention behind the strategic documentation must be matched by application of resources to innovative approaches to crime prevention, rehabilitation and reintegration. Approaches across all justice agencies must be integrated with that purpose in mind.*
>
> *We must be prepared to innovate, to trial a variety of new approaches and to match our measures to fit our unique and diverse prison environment. We must learn from other jurisdictions in Australia and elsewhere but adapt to the situation we face here. We must consult widely with community members who can add value to the process. We must recognise that sometimes a range of small solutions will get better results than a "one-size-fits-all" approach.*

In the correctional sphere, the entire prison environment needs to be aimed at promoting rehabilitation and reintegration. Facilities, policies, programs and operations need to be tailored to this end taking into account the diverse nature of the prison population.

Implementing new approaches will raise its own problems. Most fundamental of these will be changing public perceptions and expectations of the prison system. Errors will be made in the course of implementing new measures. Changes will be needed. Prisoners involved will from time to time do the wrong thing. This is a fact of life of developing and implementing new solutions but will provide ample opportunity for critics to attack innovative approaches.

There is currently a clear public emphasis on imprisonment as punishment without necessarily a deeper consideration of the role it can play in reducing future offending. Apart from the short term impact of removing an offender from the community, there is little evidence to show that imprisonment, by itself, has any significant impact on crime rates. And many members of the public express doubt as to the effectiveness of imprisonment as a tool for punishment in any event.

As recognised in the strategic documentation discussed above, the most significant impact that prison can have is through promoting rehabilitation and reintegration in order to reduce offending. The public must be engaged in discussion about the benefits of reducing crime in the future and how that can realistically achieved.

New approaches in support of rehabilitation and re-integration must therefore be accompanied by resolute political commitment to change and extensive dialogue with the public to engage them in the process of long term reform and improvement. This of itself will involve commitment of substantial resources to public communication to inform and transform community expectations.

I made related comments in 2017 in my report on *Women in Prison II*:

Focus on rehabilitation

The report notes the potential for the young women in prison today to contribute positively to their families and their communities in the future. However, it concludes the chances are that without substantial support and guidance many will instead be in and out of the justice and health systems for decades to come.

It states that we cannot, as a society, financially or morally afford to allow this situation to continue. If there is not a transformational shift in the correctional system towards rehabilitation and reintegration, the underlying contributors to offending and poor health will persist as a burden on the community.

The traditional correctional model does not work; certainly in so far as women are concerned. As a community, we need to acknowledge that things will only get better if we invest in the future of offenders. We need to explore alternatives to custody and create an environment in custody and afterwards that encourages and assists people to build better lives for themselves, their families and their community. We need to facilitate non-offending.

This requires long term investment not limited by annual reporting or electoral cycles. The whole structure of the correctional system has to be aimed at rehabilitation, breaking away from traditional stone wall models.

Courts and authorities must have a wide range of well-resourced options for dealing with less serious offenders. Many options will be non-custodial. Where a custodial term is considered essential, custodial environments need to be designed with women in mind to accommodate the limited risks they actually present.

Women in Prison II recognises that Government and Corrections are undertaking a variety of initiatives aimed at providing targeted and flexible options. It simply stresses that there is much more work to be done.

Reframing the public debate

The report states that Government and the community must be in this for the long haul. Different approaches must be trialled. False starts or missteps must be seen as part of the long term development process. In such a complex area, mistakes will be made. People will falter. These should be accepted as lessons for the future rather than signs of crisis or collapse.

We can gain considerable guidance from international bodies and other jurisdictions around the world. We can learn and adapt their approaches as well as developing our own unique initiatives. Indigenous stakeholders and communities have an essential role to play in this regard but Government must take the lead role.

If we fail to act now, with initiative and resolve, there is every indication we will need to revisit these same, and worse, issues in years to come.

It is clear that the NT Government (NTG), the Department and Correctional Services have undertaken and are continuing to undertake substantial work in relation to the strategic direction of Corrections, the justice system and broader underlying factors.

Addressing these factors will require many years of sustained work. However, it is vital that the fundamental basis for that work is established now and that sufficient resources are invested now to initiate essential system changes.

A DIVERSE PRISON POPULATION

In a 2016 submission, I stated:

Working on the basis of diversity in prison population

The prison environment is not homogenous. The Territory has distinct variations but the fundamental approach must be to recognise diversity in the development and review of all facilities, policies, procedures and programs. Particularly in the Territory, the Department cannot effectively perform its functions by taking a standardised approach to its work.

Indigenous prisoner population

In the 2016 submission, I also said:

Many of the priorities discussed here need to be viewed from the perspective of indigenous prisoners who make up the great majority of the prison population. In the Territory, they are not a small or even a substantial minority whose needs and culture should be taken into account in the development of policies and programs. They are the majority and policies and programs should be developed with them squarely at front of mind.

It is important to build a consultative framework that allows feedback about current programs and suggestions of more culturally appropriate facilities and programs from Indigenous prisoners. An example where this does not appear to have occurred was with the development of an industrial shed at the women's facility in Alice Springs. No consultation was undertaken in its development. Further, upon completion of the shed the prison did not have any staff to deliver training on how to use machines in the shed.

As another example, the current reception of Indigenous prisoners is not culturally tailored despite their overrepresentation within prisons. An Aboriginal specific Induction process could be developed in various Aboriginal languages. Ideally the induction process would be undertaken by an Aboriginal Liaison Officer (ALO).

Steps could also be taken to have Prison Officers routinely access the Aboriginal Interpreter telephone services for prisoners who are not confident with the English language, for the reception process and any discussion involving their case management, health or other issues of significance.

It is important to build a more culturally sensitive workforce by providing compulsory cultural awareness programs for all officers. These programs should not be run as a one-off induction process but rather as regular training programs to remind staff of the unique challenges faced by Indigenous prisoners.

The above are simply illustrations of steps that could be taken to meet the needs of the majority prison population. The focus should be on consultative development of relevant facilities, programs and policies which meet the needs of the majority.

Language

There is an incredible diversity of first languages within the prison population. Many prisoners, some of whom may be proficient in several languages but not in English.

Corrections co-operated with my Office by providing information for the purposes of the investigation that was finalised in my report, *Strangers in their own land: Use of Aboriginal Interpreters by NT public authorities.*[14]

The report contains numerous references to Corrections' utilisation of interpreters and efforts to cater for prisoners whose English-speaking capacity is limited. It makes general recommendations regarding NTG use of Aboriginal interpreters but also makes the following recommendations that are of direct relevance to Corrections:

3. NTG agencies participate in the development of the long term [NTG Master Plan] *and make long term support and financial commitments to raise the level of interpreter use to meet the real needs on Aboriginal Territorians.*

…

7. NTG agencies develop or produce revised agency language services policies and protocols aligned with the BPPs, the Indigenous BPPs, and NTG whole-of-government policies. The policies should include specific and detailed reference to Aboriginal language services (either included in one policy or in a stand-alone policy) and, in that regard, should place emphasis on:

a. Assigning clear responsibility within the agency for executive oversight and operational functions;

b. Promotion of Aboriginal interpreter use among staff and clients, with a cautionary approach along the lines, "When in doubt, use an interpreter";

c. Collaboration and co-operation with other government and non-government stakeholders to maximise the efficiency of interpreter use;

[14] http://www.ombudsman.nt.gov.au/sites/default/files/downloads/interpreter_services_investigation_report.pdf

d. Planning and adequate budgeting for Aboriginal interpreter use for all new programs (including rollout and evaluation) and regular review of existing programs to ensure adequate provision is explicitly made for ongoing needs;

e. Promotion of adequate preparation and support for Aboriginal interpreters;

f. Adequate training and guidance for agency staff in identifying the need for interpreter services and other relevant operational matters;

g. Encouragement for the engagement by the agency of bilingual and multicultural workers;

h. Record keeping that facilitates access to information about client needs and allows agency monitoring and review regarding the extent and consistency of provision of interpreter services;

i. Provision of complaint mechanisms that encourage and facilitate approaches from Territorians who are not fully proficient in English;

j. Extension of obligations to contracted service providers, including mechanisms that allow the agency to monitor and ensure compliance.

Implementation of these recommendations is even more important in a Corrections context where the huge majority of prisoners are Aboriginal. The report recognises the many challenges that face agencies, particularly in the context of the incredible variety of Aboriginal languages spoken by prisoners. However, translation of key documents into relevant languages and increased use of Aboriginal interpreters and bi-lingual staff should be a key goal for the future.

SCREENING AND SUPPORT

One area where Corrections can play an expanded role is in facilitating identification and initial support in regard to a range of factors which are likely to have a negative impact on prisoner behaviour while in custody and present obstacles to rehabilitation and reintegration.

This includes factors such as health and dental issues, mental health issues, hearing impairment and domestic and family violence issues. These problems require the support of other agencies and service providers but the prison environment provides an opportunity to identify and commence support and referral to address these issues.

Proactive screening and support for mental health issues

In the 2016 submission, I stated:

> *Likewise many prisoners have mental health issues or are at significant risk of developing mental health issues. If these are not addressed, prospects for re-integration are reduced and the chances of re-offending are increased.*
>
> *Crime and anti-social behaviour will not be reduced if there are not effective mechanisms in place to deal with these issues.*

From the perspective of prisoner management while in custody, reintegration following custody and reduction in reoffending, identifying mental health issues and providing support and referral is crucial.

Proactive screening for hearing impairment

I discussed this issue in *Women in Prison II*:

> *398. I have discussed previously the problems that can arise when a prisoner cannot speak English. In a similar way, prisoners with hearing problems face formidable challenges in the prison environment.*
>
> *399. This issue was considered by the Australian Senate Community Affairs References Committee in its 2010 report,* Hear Us: Inquiry into Hearing Health in Australia*.*
>
> *400. The Committee described the problem in the following terms:*
>
> > *8.83 Evidence was also presented to the committee that prison life for people with a hearing impairment, including Indigenous people, can be harder than it is for people with normal hearing ability. NAAJA noted in their submission that:*
> >
> > > *It is unquestionably the case that the experience of jail is significantly more severe on people with hearing impairments. Prisons operate with a heavy reliance on prisoners hearing commands, and responding as required. This includes the use of bells and sirens and following oral instructions.*
> >
> > *8.84 One witness supported NAAJA's view when he reported on his conversations with hearing impaired prisoners at Alice Springs Correctional Centre:*
> >
> > > *Several of the guys…told me that, because of their hearing loss, they often did not understand what guards wanted them to do, so they were in constant strife with the guards in the prison. We had a program to provide hearing aids to these guys, because they did not qualify for hearing aids from any other sources. Thank goodness, the Office of Hearing Services would donate returned hearing aids. We used those, and it made quite a difference in a lot of individual guys' lives now that they could hear and understand things. Their perception by guards and their perceived behaviour improved because they knew what was expected of them. So it all has to do with proper and clear communications.*
>
> *401. Although there was limited evidence as to the extent of hearing issues in prisons, the Committee noted:*
>
> > *8.75 The committee heard preliminary results from one study which found high levels of hearing loss and unhealed ear perforations among female Indigenous inmates. The preliminary results of that study indicate that 46 per cent of the women had a significant hearing loss, and that of those failing a hearing screening, 30 per cent had perforations of one or both eardrums.*
> >
> > *8.76 Notwithstanding the lack of hard data, anecdotal evidence from the NT seems to indicate that in that jurisdiction at least the prevalence may be very high indeed:*
> >
> > *Limited research work suggests that 85 to 90% of Indigenous prisoners have hearing loss.*
> >
> > *We know for a fact that out at the jail here [i.e. in Alice Springs] out of the 90 per cent of the Indigenous people who would be out there, 99 per cent of those would have a hearing loss. It is quite scary.*

402. The Committee recommended that:

> *… correctional facilities in which greater than 10 per cent of the population is Indigenous review their facilities and practices, and improve them so that the needs of hearing impaired prisoners are met.*

403. This is an issue that is likely to have substantial implications for prisoner health, compliance and prospects for rehabilitation. It is worthy of careful and ongoing investigation and action by Corrections.

Domestic and family violence

In *Women in Prison II*, there was discussion of the problems faced by many female prisoners who were victims of domestic violence or sexual abuse, noting rule 60 of the *Bangkok Rules*, which provides:

> *Appropriate resources shall be made available to devise suitable alternatives for women offenders in order to combine non-custodial measures with interventions to address the most common problems leading to women's contact with the criminal justice system. These may include therapeutic courses and counselling for victims of domestic violence and sexual abuse; suitable treatment for those with mental disability; and educational and training programmes to improve employment prospects. Such programmes shall take account of the need to provide care for children and women-only services.*

A number of existing programs offered by Corrections were referred to in that context. The Top End Women's Legal Service (TEWLS) has written to my Office with concerns about inadequate access to health services at Darwin Correctional Centre, in particular with regard to the provision of domestic violence counselling services.

TEWLS contends for the appointment of a Domestic and Family Violence Counsellor with experience in working with Indigenous women. This would certainly be a valuable addition to services at DCC.

OPCAT

The ratification by the Australian Government of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) means that Corrections and the NTG will face added scrutiny and, no doubt, additional resource demands in terms of compliance with recommendations from national preventive mechanisms.

HEALTH AND WELLBEING

Corrections implementation of health advice

A number of cases have arisen where guidance is given by a health professional in relation to the treatment or care of a particular prisoner but not followed through by prison officers.

Example

A prisoner returned from hospital (after a two week stay) with a medical certificate recommending he should have access to his bed/cell during the day to enable him to rest comfortably while awaiting further medical review. On returning to prison, he attended the prison's health service and was provided with another medical certificate recommending he have access to his cell during the day to rest until a further review.

The medical certificates were not implemented by prison authorities for security and staffing reasons. The prisoner advised he was allowed him to lie on the floor of an open area without a mattress or pillow, exposed to other prisoners.

The then prison policy on Medical Observations mainly provided guidance for prisoners requiring health care/monitoring under supervision of a health provider, and not under prison authorities.

My Office recommended that:

- Prison staff should consult with medical staff to discuss operational limitations, risks and identify any other suitable options that may be taken, with the resulting decision documented and filed appropriately;
- Corrections amend its existing policy or develop a new policy to provide guidance for staff to follow when dealing with these particular types of requests.

The then Commissioner agreed and undertook to implement the recommendations. Review of the policy took some time but my Office continued to pursue the matter and a new Commissioner's Directive was ultimately put in place.

There may be cases when following a treatment or care plan to the letter would compromise prison security or not be achievable for some other reason.

If for some reason there is a need to depart from a treatment or care plan, it is essential that there be immediate liaison between health professionals and senior prison staff to ensure that the health of the patient is not compromised. This should also be recorded and communicated to the prisoner.

Corrections has developed a number of Directives dealing with the role of its officers in the health care of prisoners. These go a substantial way to addressing most cases. However, the Directives do not cover every possible situation and appropriate health care of individual prisoners must be given priority. It is important that senior management have and exercise discretion to do what is necessary to ensure individuals are adequately cared for in line with recommendations of health professionals.

Care on transfer

In some cases, issues with handover of prisoners to or from Police, Corrections and health authorities have resulted in poor outcomes in terms of health care. It is understood a draft MOU is under development.

Hot and cold

The Territory climate is subject to extreme variations. A substantial number of complaints were received from Alice Springs in the course of an extended period of oppressive weather.

Example

Prisoner stated that Alice Springs has endured 14-15 days straight of temperatures over 40 degrees. He further explained that the buildings in the cottages are made from Besser Blocks and whilst there are up to 4 fans per dorm (2 fans in a two-up cell and one fan in a one-up cell), the air that is circulated by the fans essentially recycles within the room and it *"becomes like an oven"*. He said there is no relief from the showers as the water in the pipes is now warm from the constant high temperatures during the day.

Example

Complainant states that it is 45 degrees at ASCC with only fans for cooling. Complainant states that he fainted last night and 'had a fit' due to the temperature.

Complaints have also been raised about provision for cold weather.

Example

Prisoner complained about lack of hot water for showers in the prison. Prisoner claims this has been ongoing for two weeks, and as a result he has got a cold (runny nose) and has been frequently requesting Panadol from medical. Also states body odour has become an issue as the men have been reluctant to shower.

Corrections confirm that this occurs on a yearly basis and always around winter time. When the temperature dropped to -2, the water pipes at the prison 'froze over and burst' and took approximately one week to repair. They further advise that prisoners have simply overused the hot water and it takes time for the hot water systems to heat up again.

It is acknowledged that a number of short term measures have been adopted by Corrections to alleviate the heat situation. It is also acknowledged that extreme temperatures are experienced by the whole Alice Springs community during the summer and winter. However, it is important that Corrections take appropriate action to provide reasonable living conditions for prisoners in light of those ongoing extremes.

Hygiene

There was discussion of the problems caused by limited access to shower and toilet facilities in *Women in Prison II*. There is ongoing concern about limited availability.

There can be few things of more substance to the maintenance of human dignity and self-respect than the ready availability of hygiene facilities. The fact that some prisoners may misuse facilities or that there are structural deficiencies, does not provide a reasonable basis for failure to provide adequately for such a basic human right.

Community access

I have previously commented on the need to facilitate access to prisoners by family, friends and support persons:

> *For the welfare of prisoners, for the welfare of their families, for the promotion of rehabilitation and reintegration and for the promotion of the good order of the prison, all reasonable steps should be taken to facilitate access to the prison for family visits.*
>
> *This has been recognised in the substantial investment of resources in creating visitor facilities. It should also be recognised by taking all reasonable steps to facilitate access to prisons by public transport.*

Access can be advanced by various means, including:

- ensuring there are adequate and reasonably priced public transport options available;
- housing prisoners, as far as possible, in locations where loved ones and support persons can regularly access them (see discussion of Transfers below);
- where loved ones and support persons are not easily able to attend, providing ready access to video-conferencing systems to promote regular contact.

Access to support

There have been a number of complaints of delays of up to several weeks in access to prison support officers. It is important for Corrections to provide timely and adequate prisoner access to support officers.

USE OF FORCE AND RESTRAINTS

Complaints against officers regarding use of force and restraints arise from time to time. These are addressed on a case by case basis. It is important that use of force and restraints be subject to adequate reporting, review and critical analysis. These steps should include:

- systematic recording of events by the officer/s involved in a manner that promotes self-reflection regarding the options open and the justification for the choices made;
- initial review by a more senior officer, with issues of concern escalated where necessary;
- aggregation of data to enable analysis and identification of trends, including:
    - identification of increases and decreases in frequency of different uses of force and restraint in different facilities and parts of facilities;
    - identification of particular officers or units whose use of force or restraint fall outside normal parameters;
- regular reporting of analysis and trend outcomes to senior management for the purposes of discussion of issues raised and identification of potential actions to improve operations.

Sometimes restraints are used in hospitals. In that regard, it is important that officers only take such steps in cases of clear necessity and that, except where the circumstances require urgent action, they do so in consultation with medical staff to ensure there is no adverse impact on the condition of the patient.

A matter of some concern is that use of restraints in a hospital setting is not classified as a use of force that requires separate recording. While use of handcuffs to transport a prisoner might be regarded as routine, it would appear appropriate to record and monitor use of shackles and other restraints in a hospital setting.

In that regard, I drew attention to two reports from the South Australian Ombudsman that discuss use of restraints in hospital:

Department for Correctional Services – Unlawful shackling of a mental health patient in hospital (Feb 2017) - http://www.ombudsman.sa.gov.au/wp-content/uploads/Department-for-Correctional-Services-%E2%80%93-Unlawful-shackling-of-a-mental-health-patient-in-hospital.pdf

Department for Correctional Services – Unreasonable shackling of a prisoner in hospital (July 2016) - http://www.ombudsman.sa.gov.au/wp-content/uploads/Department-for-Correctional-Services-Unreasonabl-shackling-of-prisoner-in-hospital.pdf .

SEPARATE CONFINEMENT

I discussed separate confinement at pages 31 to 35 of *Women in Prison II*, Part 2. I referred to a range of international and national standards before commenting:

> *188. The gravity with which Parliament regards the keeping in seclusion of a person who may have mental health issues is recognised in the detailed provisions of the* Mental Health and Related Services Act. *Section 62 provides a prescriptive array of requirements for action and recordkeeping, and other mechanisms for ongoing monitoring and review whenever a person is kept in seclusion.*
>
> *189. To hold any prisoner in separate confinement beyond a limited period raises significant concerns. The* Nelson Mandela Rules *prohibit separate confinement for a prolonged period (defined as anything beyond 15 days). However, it appears there is one instance of a female prisoner being held in separate confinement in G Block for up to 25 days. It is important for Corrections to review that case to definitively establish the facts and develop alternative approaches to meet the needs of At Risk prisoners who require specialised care over an extended period.*
>
> *190. In any event, the* Nelson Mandela Rules *provide that separate confinement "shall be used in exceptional cases as a last resort, for as short a time as possible and subject to independent review." It is vital that separate confinement in any situation is utilised subject to those restrictions.*
>
> *191. One might think it unnecessary to cite the above range of standards and pronouncements to reinforce the obvious concern with holding a female 'At Risk' prisoner in separate confinement in a single cell in a male high security section. In most cases, separate confinement in these circumstances beyond a minimal time frame would appear more likely than not to exacerbate the condition of the prisoner and should be avoided at all costs. Any such confinement should be subject to meticulous record keeping and frequent review by a qualified health practitioner.*

There is considerable discussion and debate across Australia in relation to separate confinement within prisons and in youth detention facilities. See, for example, a recent report of the Victorian Ombudsman, *Investigation into the imprisonment of a woman found unfit to stand trial* (October 2018).[15]

This is an area that our Office has not yet had the opportunity to explore in detail but it is one which we will pursue in the future when priorities allow.

SECURITY

CCTV coverage

My staff conducted a review of CCTV coverage at DCC. In light of that review, recommendations were made for Corrections to:

- review and enhance procedures and practice documentation relating to the use and preservation of CCTV footage for the purpose of monitoring, management and review of incidents;
- ensure that current versions of documentation are readily available within relevant units;
- adopt use of enhanced capabilities of certain functions;
- consider installation of additional cameras in certain areas where there were potential blind spots and/or no coverage;

[15] https://www.ombudsman.vic.gov.au/getattachment/Publications/Parliamentary-Reports/Investigation-into-the-imprisonment-of-a-woman-fou/Web-PDF-investigation-into-the-imprisonment-of-a-woman-found-unfit-to-stand-trial.PDF.aspx. See also https://www.adelaidenow.com.au/news/south-australia/sa-ombudsman-wants-prisoner-held-in-solitary-confinement-for-66-days-to-be-compensated/news-story/8879416e21cc44c8c44203bde064e1db.

- evaluate the adequacy and frequency of maintenance audits and maintenance work on CCTV equipment; and
- consider whether there is any potential to extend the standard retention period for CCTV footage.

Staff presence

One case pointed to potential difficulties in relying too heavily on CCTV coverage as an alternative to physical presence. A prisoner suffered a significant injury in the course of an altercation that took place in a dining room at meal time when officers had departed following service of meals.

The absence of officers in a setting where a large number of prisoners where congregated raises issues concerning the maintenance of order. It is acknowledged that, in the individual case, the officers had competing priorities but there is every chance the physical presence of officers would have reduced the prospect of a physical altercation that led to significant injury.

Maintaining watch by way of CCTV coverage is one option but, given the size of the facility and the huge number of cameras that must be scrutinised by a small team, it has its limitations.

EXERCISE OF DISCRETION AND COMMUNICATION

In the 2016 submission, I stated:

> *Prison officers make a raft of decisions that can have substantial impact on the day to day lives of prisoners. It is not infrequent for prisoners who ask why a particular decision has been made (and indeed for the Office of the Ombudsman) to be provided with an answer along the lines, "for the good order of the prison".*
>
> *It is important that prison officers be aware that the power to exercise a discretion is bounded by certain legal requirements. For example, anyone exercising a discretion should:*
>
> - *exercise such powers in a fair manner, according to law; and*
> - *give any person who may be negatively impacted by a decision an opportunity to respond (before the decision if possible, or as soon as possible after the decision, if it must be implemented urgently).*
>
> *In addition it is likely to be far better for the good order of the prison if an officer exercising a discretion has thought through, recorded and to the extent appropriate, explained to the prisoner the reasons for the exercise of discretion.*
>
> *There is a need for substantial and ongoing education and awareness building for prison officers around the proper exercise of their powers and discretions.*

I also stated:

> *Often the complaints we receive from prisoners arise because there has been inadequate communication provided to the prisoner about the reasons why a decision was made. For example, we regularly receive complaints about prisoner transfers. Although there may be sound reasons provided to our office these are not clearly relayed to the prisoner. Similarly where there has been an altercation between two prisoners and the prisoner who did not initiate the altercation is moved, this is often viewed as a punitive measure because the reason for the relocation (often to protect that prisoner) is not fully explained.*
>
> *So, even if a discretion has been exercised on the basis of careful and lawful reasoning, issues may still arise if the reasons are not clearly communicated to the prisoner.*

This is one aspect of staff professional development that should be emphasised. See *Professional development for officers*, below.

Transfers

The Office has received a number of complaints regarding 'last minute' transfers between prisons.

Example

Prisoner called at 01:03pm claiming he was just advised by officers 20 minutes prior to "pack his swag" as he is being transferred to the ASCC. Prisoner states he was not provided a reason why he was being moved. Prisoner states he has no relations in Alice Springs and he does not know the local language in Alice. Prisoner was adamant he did not want to be moved.

After being advised of the response of Corrections, prisoner further vented his frustration about not being given the option to be relocated. He said people should have been asked if they want to go first instead. He indicated that he will have no support network in Alice Springs as he is currently receiving visits from family here in Darwin. At best, he will receive a phone call in Alice Springs and face to face interaction is much better.

Example

Complainant contacted our Office very distraught stating that her partner has just been transferred from DCC to ASCC with only 15 minutes notice. She explained that she has moved from Perth to Darwin 3 years ago, specifically to support the prisoner. She has made an hour drive with their children twice weekly for the last 3 years, without fail. She said prisoner has no support network in Alice Springs and she cannot afford to fly to Alice Springs on a regular basis to see him.

She said that the prisoner is currently serving time as he breached his parole and has no incidents recorded against him and cannot understand the reasoning for sending a prisoner away from his only support network. She explained that she was booked in to see him with the children on two upcoming days but he has not had the opportunity to say goodbye to his children. She said that he had been transferred to ASCC previously without notice and she was unable to speak to him for 2 weeks as this was the length of time it took for outside phone access to be activated. Complainant is concerned for her partner and feels that he may retaliate unnecessarily which may affect his upcoming parole.

It is appreciated that decisions on transfer are a necessary part of the overall management of the prison system and that there may be security concerns with giving substantial advance notice.

However, it is also important that decisions be made taking into account factors such as the importance of maintaining access to family members and supports. It would be preferable, where possible, to make decisions following consultation with prisoners so that they have an opportunity to have their say and point to any issues with transfer.

It may be beneficial to consider establishing a process where prisoners are consulted about any potential concerns or obstacles to transfer as a general practice, with their views recorded on IOMS, so consideration can be given to those views should a need for transfer arise at a later time.

If a decision is made to transfer, it would be preferable to give the prisoner at least some reasonable notice so that they can have some contact with loved ones and support persons prior to transfer. Where short notice is essential, priority should be given to ensuring that contact arrangements with loved ones and support persons are re-established as soon as possible.

CASE MANAGEMENT AND RECORD SYSTEMS

In the 2016 submission, I stated

> *… it is equally important to record reasons for a decision. Failure to do so at the time a decision is made can cause problems if the officer who made it is later absent or there is some dispute about the reasoning in the future.*
>
> *Records do not need to be copious or represent a huge burden on the officer concerned. They need to record the pertinent information. With existing records systems within the prisons, this should be part of the routine functions of officers.*
>
> *Recording can also be problematic in relation to general administration within the Department. Meetings can be held and agreements reached on general policy directions or for example, utilisation of facilities. Failure to adequately record outcomes leaves room open for future debate and dispute about matters which all thought were resolved. This is by no means unique to the Department but it is an ongoing challenge.*
>
> *A culture of good communication and record keeping saves time which will otherwise be wasted on unnecessary confusion and debate.*

PRISONER INFORMATION AND CONSULTATION MECHANISMS

Regular consultation

The benefits of direct prisoner consultation and involvement in decision-making cannot be overstated. Giving prisoners an avenue to raise and address issues in direct consultation with prison managers provides a forum for timely and relevant action and helps build the capacity and confidence of prisoners as decision-makers and problem solvers.

Likewise, regular consultation and involvement of community stakeholders helps build understanding and co-operation. Involvement of Aboriginal stakeholders is of fundamental importance given the make-up of the prison population.

The efforts of Corrections to establish and maintain regular forums are welcome.

PROFESSIONAL DEVELOPMENT FOR OFFICERS

Many of the issues discussed above can be addressed, at least in part, through professional development and training for Corrections staff.

Professional development should at all times emphasise the strategic priorities of Corrections and focus on establishing a platform for rehabilitation and reintegration which permeates the conduct and decision-making of officers.

Induction training should be supplemented by a broad, ongoing accreditation program to ensure that officers remain current with regard to necessary operational elements, new developments and the strategic direction of Corrections within the justice system.

Training and accreditation can be implemented by a variety of measures, including face to face sessions, group discussions and online media.

INTERNAL COMPLAINT PROCESSES

In the 2016 submission, I stated:

> *This is the area where the functions of the Ombudsman's office intersect with the operations of the PSU on a day to day basis. Our experience suggests that there are a number of ways in which the authority, powers and operations of the PSU and other relevant areas of the Department can be strengthened and enhanced.*
>
> *The Office of the Ombudsman has worked closely with the Department to facilitate improved internal complaint processes. There is essentially a three stage process – RASP (Request to Attend Superintendent's Parade) form, internal review by PSU and complaint to Ombudsman.*
>
> *It should be noted that this is the standard process. Prisoners have direct access to the Ombudsman's Office through phones in each cell block. If a matter is urgent or there is some difficulty in a prisoner following the routine process (for example, language difficulties) action can be taken immediately or an alternative process arranged.*
>
> *A three stage complaint process is commonly regarded as best practice. However, the second (internal review) stage currently operates informally. This stage should be formally recognised and adequately resourced. Further, numerous complaints regarding the RASP process indicate a lack of understanding by prisoners and perhaps prison staff. Additional steps should be taken to promote awareness of prisoners and staff regarding complaints processes.*

The report discussed a range of areas regarding internal handling of complaints and interaction between my Office, prisoners and Corrections officials which could be enhanced.

As can be seen from the fact that approaches relating to complaint processes top of the list of approach issues for 2018/19 (see the table in Chapter 9), this remains a live issue. My Office is working with Corrections to improve systems, with some enhancements already in place.

SERIOUS INCIDENT REPORTING AND REVIEW

In the 2016 submission, I made the following points regarding critical incident reporting and review:

> *There is a need for a stronger, comprehensive critical incident review policy. It must provide robust review processes, including external investigation and review in more serious cases.*
>
> *Responding promptly and effectively to such incidents is vital to the operations of the Department. It is important that the Department not cede responsibility for prompt management action on the basis that a Police investigation is being undertaken.*
>
> *There should be a standing committee to review critical incidents with one or more external representatives, eg, someone from NT Police or the Department of Attorney-General and Justice.*
>
> *There should be a routine procedure for engaging an external investigator, eg, a standing arrangement with the NT Police, an external consultant or an interstate corrections entity if the actions of the Commissioner (and if appropriate, other senior executive officers) are being investigated.*
>
> *Where actions of the Commissioner are a subject of report, the report should be provided to the Minister at the same time as the Commissioner.*

There have been cases in the past where Police involvement appears to have signalled a halt to consideration of an incident by Corrections.

While it is important not to prejudice Police investigations, there will often be a need for immediate consideration and action by Corrections in response to critical incidents. This may involve process and procedural changes to address identified problems and dealing with staff and prisoner issues arising from the incident. It is important that there be an effective internal process for identifying and responding to issues of immediate concern even if police enquiries are underway.

Police notification and interaction

Issues have also arisen concerning notification of Police and Police interaction with Corrections and prisoners regarding instances of possible assault and significant injury.

Example

Complainant was injured during a restrained escort at a correctional centre. A complaint of assault was made to police which took considerable time to progress and was ultimately not pursued by the complainant.

Because the incident was initially classified on the basis of "*threatening behaviour*" by the complainant, it was not immediately identified as requiring action or investigation by Corrections regarding the conduct of the officers concerned.

Incidents classified as "*assault*" must be reported to police irrespective of the wishes of those involved. As this incident was classified as a "*threatening behaviour*" incident, staff were not required to make a police report. It also meant the incident was not recorded as an "*assault*" with the Office of Misconducts. While an internal investigation was undertaken by the Office of Misconducts, it was conducted on the basis of a notifiable incident relating to an injury resulting from "*restraint*", not "*assault*".

Ultimately, a Corrections investigator recommended that escort holds and shackling be reviewed to improve safety, the officers involved undergo a full debrief with senior management and consideration be given to taking action in respect of one of the officers.

Example

Complainant alleged that Corrections officers failed to call police to interview him after he reported an alleged sexual assault by another prisoner. At the time of making his complaint, six months after the alleged incident, Complainant claimed he was still waiting to be interviewed and believed the matter had not been reported to police.

Corrections reviewed their records and identified a potential incident but there was no record of a complaint being made. Following the incident, prisoners were moved between accommodations but there were no reasons recorded for those moves.

Following the complaint to my Office, Corrections promptly contacted NT Police to report the matter. A police interview was arranged within two days of the complaint but the interviewing officer was unable to conduct it due to other operational requirements. It is not clear if the Office of Misconducts was aware the police interview did not take place, but no steps were taken by Corrections to arrange another police interview.

Complainant submitted two Prisoner Request Forms in the days after the postponed interview requesting to talk with police about the alleged assault. It appears that Complainant received no response to those requests until police attended to interview him seven weeks later.

The Complainant subsequently contacted this Office and stated the police member who interviewed him had advised that his complaint would be investigated. However, Police advised our Office that the complainant had stated that he no longer wished to pursue the matter. They stated that the interview had been recorded on body worn video (BWV) but the footage was no longer available due to the passage of time.

We recommended that police interview Complainant again with BWV to confirm his intentions. We also recommended that all prisoner accommodation transfers within a facility be recorded (including the reasons for transfer), noting that the Coroner's Inquest into the death of Vernon Bonson ([2018] NTLC 006) recommended the Commissioner of Correctional Services ensure that the reasons for transfer of prisoners within the correctional precinct are recorded.

It is important to consider whether further steps can be taken to improve the way matters of this nature are handled. In doing so, there are a number of points to note, including:

- the need to limit the risk that breaches of the law or discipline will be missed due to 'incident classification';
- the "*code of silence*" culture that can exist in correctional facilities - the problem of the unwillingness of potential victims to provide statements to Corrections staff or police - that may exacerbate the risk of breaches of law or discipline being overlooked;
- the importance of reporting incidents to police even in the absence of a willing complainant;
- the likely availability of supporting evidence in the form of CCTV footage and other witnesses means there may be potential to proceed against someone even in the absence of a willing complainant;
- it is essential that all steps in the process (including Police attendances) be adequately recorded in Corrections' systems.

Cases also point to conflicts between the understanding of Police and potential prisoner victims as to their intentions to pursue police complaints. Prisoner complainants have reported to this Office that they understood police were investigating their complaints, however police reported that complainants did not want any action taken. This is primarily a matter for Police, but it may be that video recording of police interactions inside the prison, by way of body worn video is a good option for recording interactions about pursuit or withdrawal of allegations and so determining the truth in these cases.

It is understood that there have previously been efforts to develop a memorandum of understanding between Police and Corrections to clarify responsibilities and procedures relating to the issues of this nature.

Use of audio and video technology

Both correctional centres have numerous CCTV cameras. Experience from investigations into Police conduct shows that having audio feed to bolster video footage substantially boosts the evidentiary value of these tools.

It is difficult to overstate the value of video and audio recordings in the investigation of complaints. In many cases, access to these materials can rapidly dispose of a complaint. In others, it can provide valuable evidence to further investigation of the complaint. The utilisation of these tools, including body worn video for individual officers, should be encouraged.

It is important that Corrections routinely access all potential CCTV sources in the course of its investigations and that all potentially relevant material be made available to our Office for the purposes of its investigations.

CHAPTER 11 –WOMEN IN PRISON II

Women in Prison II revisited similar issues to those discussed in a 2008 Ombudsman report, in the context of conditions faced by women in the Alice Springs Women's Correctional Facility. The investigation was initiated in light of a range of complaints about conditions and analysis which shows the number and proportion of female prisoners in the NT has grown rapidly in recent years. Combined with substantial growth in male prisoner numbers, this put enormous pressure on the correctional system and sub-standard conditions for female prisoners persisted.

The report noted that, in Alice Springs, rapid growth in numbers and limited facilities contributed to a broad range of problems for female prisoners, including:

- Chronic overcrowding (growing numbers in a limited space, inside a male prison)
- Housing and facility issues (wear and tear, not enough amenities)
- Limits on education and rehabilitation programs
- Limits on employment opportunities
- Issues with health care of prisoners, including 'At Risk' prisoners
- Problems with the basics (clothing, hygiene, food and recreational activities)
- Cultural issues for the predominantly Indigenous population
- Language and communication issues for the predominantly Indigenous population
- Inadequate arrangements for housing children with their mothers.

The report concluded that the fundamental purpose of the correctional system should be rehabilitation and that, in order to promote rehabilitation, solutions must be designed with specific prisoner groups in mind. To that end, there must be:

- solutions designed specifically for women;
- solutions designed specifically for Indigenous women;
- involvement of Indigenous stakeholders and communities in both design of solutions and delivery of solutions.

The report noted the potential for the young women in prison today to contribute positively to their families and their communities in the future. However, it concluded the chances are that without substantial support and guidance many will instead be in and out of the justice and health systems for decades to come.

It stated that we cannot, as a society, financially or morally afford to allow this situation to continue. The report called for a transformational shift in the correctional system towards rehabilitation and reintegration.

It concluded that, as a community, we need to acknowledge that things will only get better if we invest in the future of offenders. We need to explore alternatives to custody and create an environment in custody and afterwards that encourages and assists people to build better lives for themselves, their families and their community. We need to facilitate non-offending.

The report stated that the public debate must be reframed. Government and the community must be in this for the long haul. Different approaches must be trialled. False starts or missteps must be seen as part of the long term development process. In such a complex area, mistakes will be made. People will falter. These should be accepted as lessons for the future rather than signs of crisis or collapse.

This approach requires long term investment not limited by annual reporting or electoral cycles. The whole structure of the correctional system has to be aimed at rehabilitation, breaking away from traditional 'stone wall' models.

Courts and authorities must have a wide range of well-resourced options for dealing with less serious offenders. Many options will be non-custodial. Where a custodial term is considered essential, custodial environments need to be designed with women in mind to accommodate the limited risks they actually present.

IMPLEMENTATION OF OMBUDSMAN RECOMMENDATIONS

The Chief Minister's initial response to the report, stated on its tabling in the Legislative Assembly, is set out in my 2016/17 Annual Report.

In January 2018, the Chief Minister provided me with a detailed *Women in Prison Strategic Action Plan* prepared by Correctional Services.

In its most recent update to my Office, the Department of the Attorney-General and Justice (AGD) made the following general comments:

- *Work and reforms in Correctional Services responding to issues raised in past years have continued under the new Commissioner of Correctional Services, … including issues relating to the management of women in correctional centres. Significant work is underway to reform prison operating models as part of a wider reform project. The reform scope includes case management and offender programs.*
- *Government maintains its commitment to addressing recidivism and reduce incarceration rates, with the focus on Aboriginal Territorians which recognises the need to address justice requirements and responses for Aboriginal Territorians. Consequently, the Aboriginal Justice Agreement should be the primary mechanism supporting any implementation of recommendations of the Report.*
- *The Department continues to operate under significant budgetary restraints which require consideration in adopting the Report recommendations.*
- *The Department continues to support the need to ensure that female prisoners are not treated less favourably than their male counterparts.*

The first six recommendations in the Report are broad in nature:

1. ***The NT Government adopt a whole-of-government approach to reduce offending and recidivism and to promote rehabilitation of offenders, to include:***
    a. ***a common intent and set of shared objectives to reduce offending and recidivism;***
    b. ***appropriate governance arrangements, both at ministerial and departmental levels;***
    c. ***creation and publication of targets and performance measures common across justice, education, health and human service system agencies; and***
    d. ***improved collection, sharing and use of data across agencies to drive evidence based reforms and improved service delivery.***
2. ***Using justice reinvestment methodology, the NT Government pilot and evaluate local approaches to crime prevention and community safety in disadvantaged communities with the aim of reducing reoffending and increasing community safety.***
3. ***The NT Government, the Department and Corrections acknowledge and publicly promote rehabilitation and reintegration as the primary focus of the correctional system, in the best interests of the whole community in minimising future offending.***

4. ***The NT Government, the Department and Corrections acknowledge the importance of differentiating between the needs and characteristics of female prisoners compared with male prisoners in facility, policy and program development, as well as the importance of addressing the needs and characteristics of individual prisoners.***
5. ***The NT Government and the Department place strategic emphasis on further development of non-custodial options for dealing with female offenders by way of diversion and other programs both prior to entry into the justice system and by providing viable, well-resourced and timely program options for consideration by courts when dealing with offenders.***
6. ***The NT Government, the Department and Corrections fundamentally reconsider the approach to custody of female prisoners, with an emphasis on decentralisation, community and family support, ensuring that security matches the actual risk they present and providing an environment that facilitates rehabilitation and reintegration, including viable, well-resourced and timely accommodation and program options.***

In its most recent update, AGD advised in relation to those six recommendations:

As previously noted, the NT Government has a number of inter-related policy reforms that address the broader social issues which impact upon the justice system. All of the reforms focus on 5 or 10 year timeframes (or combination of both).

These include the:

- *Starting Early for a Better Future: Early Childhood Development in the Northern Territory 2018-2028;*
- *Safe, Thriving and Connected: Generational Change for Children and Families 2018-2023;*
- *Domestic Family and Sexual Violence Reduction Framework 2018-2028;*
- *NT Homelessness Strategy and Five Year Action plan 2018-2022;*
- *Remote Housing Program - Our Community, Our Future, Our Homes;*
- *Education NT Reform Strategy; and*
- *Local Decision Making Framework.*

A draft Aboriginal Justice Agreement has been developed following extensive consultation across the Northern Territory. … [The draft agreement has since been released for public comment: https://justice.nt.gov.au/__data/assets/pdf_file/0005/728186/Draft-Northern-Territory-Aboriginal-Justice-Agreement.pdf]

Underpinning the Agreement is the government's commitment to reasserting local power (local decision making) and increasing the role for traditional leadership in the Northern Territory justice system through partnering with Aboriginal Territorians. The three key principles of the Agreement are therefore a reduction in the rates of incarceration and recidivism of Aboriginal Territorians, engaging and supporting Aboriginal leaders and improving justice responses and services to Aboriginal Territorians. There will also be specific measures relevant to women in prisons.

Correctional services reforms also continue as a priority, including the implementation of the recommendations into the management of women in correctional centres. As you are aware, KPMG is currently preparing a report on operating models for Alice Springs and Darwin Correctional Centres that forms part of a wider reform project and includes the treatment of female prisoners. The reform scope was expanded to encompass analysis and improvements to case management and offender programs for both female and male prisoners.

The broader justice reform framework considerations, not already addressed in the ongoing correctional reforms, form part of the Aboriginal Justice Agreement rather than being duplicated through a separate justice reform framework. This removes duplication and recognises the priority and commitment of government in addressing justice needs and responses of Aboriginal Territorians. The Aboriginal Justice Agreement will be key to leading the NT government approach to reduce offending and recidivism and to promote rehabilitation of offenders supported by the extensive consultation undertaken in the development of the Agreement.

Many of the strategies identified in the draft Aboriginal Justice Agreement are relevant to women in prison but the following strategy specifically relates to women.

11. Expand prison and diversion programs for Aboriginal women Prison and diversion programs will be reviewed, redesigned and expanded to address the needs of Aboriginal women in contact with the justice system, including women on remand and those serving short sentences.	11.1 Review and expand current prison programs for Aboriginal women to include programs that are trauma-responsive, culturally competent and family-centered. Programs will be available to Aboriginal women on remand or those serving short sentences.	NT Government	Aboriginal women in prison have access to programs that address their needs and the underlying causes of offending and reoffending.
	11.2 Co-design trauma-responsive, culturally competent and family-centered programs to address the underlying causes of Aboriginal women's offending and reoffending.	NT Government and Aboriginal Territorians	

In relation to recommendation 2 in the Report, AGD further commented:

In addition, work is occurring to progress pilot residential rehabilitation facilities, including a specific facility for women, in partnership with Aboriginal communities. The facilities will provide customised, targeted and tailored rehabilitation to address personal need and criminogenic responses.

Recommendation 9 in the Report is also of general application:

9. Given the overwhelming proportion of Indigenous female prisoners, consideration and implementation of all recommendations be conducted in consultation with Indigenous communities and elders as well as prisoners and other stakeholders.

In relation to that recommendation, AGD advised:

The Aboriginal Justice Unit completed 120 consultations across the Northern Territory to capture content for an Aboriginal Justice Agreement, including consultation with prisoners and other stakeholders.

Recommendations 7 and 8 in the Report relate to specific and immediate concerns regarding the many issues raised in the report:

7. Corrections develop, in consultation with the Ombudsman, a detailed plan to pursue and address all of the issues raised in Chapter 8 and Volume 2 of this report. The plan should set out an initial response to each issue, a description of proposed actions to address the issue, the resource implications of those actions, the source of any additional funding required, measurable outcomes and a timeline for action. The plan should provide for action on priority issues within a matter of weeks or months but in any event should provide for implementation of all actions within two years of finalisation of this report. The broad topics covered by the plan will include:

a. ***overcrowding;***
b. ***housing and facility issues;***
c. ***education and rehabilitation programs;***
d. ***employment opportunities;***
e. ***health care;***
f. ***the basics (clothing, hygiene, food, and recreational activities);***
g. ***underlying supports (induction, legal assistance, making complaints and using interpreters); and***
h. ***children in prison.***

8. ***Corrections provide the Ombudsman with a copy of the initial plan within three months of the finalisation of this report, and updates on progress every three months thereafter. Corrections meet with the Ombudsman staff to discuss progress on each occasion.***

My Office has continued to pursue with Correctional Services the specific issues raised in Recommendation 7 and Volume 2 of my Report. I have met with the Commissioner of Correctional Services on a regular basis and ongoing updates have been provided, the most recent of which is reproduced on the pages that follow.

In addition to that update, the Commissioner commented:

> *… at the most recent Corrective Services Administrators' Council (CSAC) and the Corrective Services Minister's Council (CSMC) a number of female prisoner recommendations were made:*
>
> - *to develop evaluation frameworks for programs designed by women (which the NT is already undertaking):*
> - *to improve access to community and health services for vulnerable women when released from custody: and*
> - *for all jurisdictions to distribute Women in Prison action plans.*
>
> *…*
>
> *It should be noted that while your report was in relation to the Alice Springs Correctional Centre the NTCS consider both Correctional Centres should be the subject of reporting.*

It is accepted that many of the solutions to the issues discussed in *Women in Prison II* involve substantial investment of resources and must be addressed over the longer term. However, there are smaller steps that can be taken to address issues in the short to medium term.

I acknowledge the substantial work that the NTG and Correctional Services have undertaken to date. My Office will continue to monitor progress.

Corrections update on implementation of *Women in Prison II* recommendations

Sub-recommendation	Comment
Overcrowding	The infrastructure recommendations/development to address overcrowding in the ASCC is under review as part of the Female Offender Management Working Group (FOMWG). On 2 October 2018 ASCC staff attended the Townsville Women's Correctional Centre and Prison Farm to source ideas and knowledge to benefit the Female Sector. A Business Case was submitted 10th October 2018 to increase resources in the Female Sector proposed a two bedroom Mother and Babies Unit plus a two bedroom Transgender and Aged Unit. A submission to source funding for the required infrastructure includes a clinic, administration and accommodation. The "Rising Prisoner Numbers Committee'' has been reconvened and Terms of Reference are being developed. The first meeting was held on 14 August 2018.
Housing and facility issues	The 'At Risk' cell specifically for women at the Alice Springs Correctional Centre continues to be fully operational. Two shade sales have been erected in the Female Sector at Alice Springs, one is adjacent to the Low Security Unit and the other is in the Horticulture area. Shade was to installed outside the demountable however this has been halted pending a decision on new accommodation being installed in place of the aging demountable. Upgrades to the Female Sector bathrooms have been completed with the bathroom in the North Overflow Unit being painted and the South Overflow Unit being tiled.
Education and rehabilitation programs	Women of Worth Program (WOW) is funded by the Tim Fairfax Family Foundation and delivered by YWCA Darwin. WOW provides 6 months pre and 12 months post release support to women involved in the justice system, The aim of the program is to support women to reengage with the community and to reduce reoffending. The NTCS Programs, Services and Improvement directorate has been working with the YWCA, the WOW Coordinator and the external consultant they have engaged, to provide data on participants in the program, such that the consultant can assess the data from the program. The WOW program is funded until June 2019 to maintain the support to women in DCC until information from the evaluation is forthcoming. At the ASCC female prisoners can enrol in education programs, bible studies or, when available, legal clinics with Central Australian Women's Legal Services or programs from other service providers. Weekly education is delivered by the BUTE and the Safe, Sober, Strong program is delivered by the Prisoner Services Treatment Team. The KUNGA Case Management Program delivered by NAAJA in ASCC has funded facilitators to work with female prisoners six months prior to their release and to support them for up to twelve months post-release. The Italk 10 week program operates in the female industries area once per week. Italk is facilitated twice a week and is a multi-media initiative (computer, software, script creation, graphics, music, voice overs) where aboriginal women create work and personal stories for use within the correctional centre and external stakeholders. Some have been uploaded to You-tube.

	An intention for Italk is to eventually creating stories in different aboriginal language about woman's issues as informed by the FOMWG and the consultative councils. A Computer Hub has been established in the Female Industry Shed. There is potential for the use of a refurbished Transitional Housing Program house for female offenders post release to aid in their reintegration and rehabilitation. There are currently five (5) ASCC women employed in the TAP who attend the Horticulture Section Tuesday and Thursdays for practical and theoretical experience. A Hairdressing Salon and Computer Hub have been established in the Female Industry Workshop along with the computer hub. A small library has been established and the Manager, Prisoner Services has sourced healthy lifestyle options for the females additional to services such as exercise and physical activities.
Employment opportunities	In September the second White Card Training for female prisoners this year was delivered in the Female Sector. On Thursday 13th September five women commenced the practical component of Certificate 1 in Construction and are employed in the Transitional Accommodation Program (TAP) in ASCC. They undertake theory each Tuesday and their practical work experience is delivered in the Horticulture Section each Thursday. There are up to 20 females employed as breakfast packers in the Female Industry Workshop who provide packs for the prisoner population. Quick Smart Tutors are employed to deliver the program. Many of the woman prisoners are also employed in various employments throughout H Block of ASCC as: Block Cooks, Cleaners, Breakfast packers, Gardeners, and Laundry workers with 5 females employed in the Transitional Accommodation Program (TAP). The following programs are also or will be available in the future: • Upcoming Transitional Accommodation Program • Obtaining a job site White Card (Two courses completed in ASCC) • Obtaining a Working at Heights qualification • Obtaining a Certificate 1 in Construction • Obtaining a Certificate II Construction.
Health care	Templates have been developed for use between the health disciplines i.e. Forensic Mental Health, Aged and Disability, and others. These will be consistent across both DCC and ASCC for referring female prisoners and aim to develop information sharing. These will better affect how female prisoners are triaged in the mental health space. Special medical diets are available for female offenders with renal failure, cardiac and diabetic conditions including those who are lactating or pregnant. A Registered Nurse targets small groups of women and discusses healthy lifestyle choices which includes a referral to the Health and Recreation team for an individualised fitness routine. Sport and Recreation Officers also deliver alternative activities to the female prisoners with a health promotion focus. A partnership with Redink Australia has created pathways to improved health and wellbeing, socially inclusive and life-changing opportunities for female prisoners. They attend on a weekly basis and provide evidence based sport and art programs. Volunteers attend ASCC once a month with a team from the Amooguna community to play sport with Open and Low security female prisoners on the ASCC oval.

	The H Block (ASCC) observation cells (HC001) was refurbished and can now be used for female prisoners who are identified as 'At Risk'. If for any reason an 'At Risk' female prisoner cannot be housed in HC001, Deputy Superintendent ASCC approval is required before housing the female prisoner in any other area of ASCC. Upon Reception at ASCC every female prisoner receives an Immediate Risk Needs Assessment (IRNA) and is assigned a Default Security classification. The IRNA identifies their individual risk/needs i.e. At Risk status, history of offences, if there are cultural or payback issues, medical or psychological issues, physical and intellectual ability and substance abuse. At Reception or when practicable ASCC prisoners are seen by a Registered Nurse prior to being escorted to their housing. They are seen by a Doctor within 24 hours or where practicable following Reception. If there is an emergency situation an out of hours contact at the Alice Springs Hospital is called for advice. Pre and post release supported accommodation programs are facilitated with Drug and Alcohol Solutions Australia (DASA) where the special needs of female prisoners are managed and assessed relative to their suitability for referral to a program.
The basics (clothing, hygiene, food, and recreational activities);	The stock of female underwear was increased within the ASCC which allows for female prisoners to be supplied with the same allocation as Darwin (4 of each). This occurs on a daily basis when new receptions are processed into H Block. The issuing of laundry bags with identifying numbers to each prisoner continues to ensure underwear is washed in the relevant bag and not mixed with those of other prisoners nor misplaced. On reception each female prisoner is supplied with a "Welcome pack" which includes a toothbrush, toothpaste, soap and plates, bowl and cups. The prisoners are also issued with clothing relevant to their classification, towel and bedding. DCC provide hygiene products in communal toilets and are available via request. Sector 4 has approximately 85% female staff for prisoners to request items from as required. ASCC provide programs to female prisoners that are tailored to their needs and include life skills programs (Kunga Case Management Program for Aboriginal prisoners), drug and alcohol programs, Drink Driving Courses, First Aid, and individual counselling amongst others. In ASCC female prisoners played a major role in the 2018 NAIDOC Celebrations held in the Management Zone Sector. One of the women was the Master of Ceremonies and she and another woman playing guitar and performed Hip Hop songs.
Underlying supports (induction, legal assistance, making complaints and using interpreters)	Female Elders from the Elders Visiting Program continue to regularly visit the DCC and ASCC Women Sector to meet with Aboriginal female prisoners. As part of the cultural development for female offenders within the ASCC, an external Aboriginal female from Congress still forms part of the Cultural Advisory Group to provide wider community content. The ASCC Female Prisoner Representative Committee commenced on 22 August 2017 and meets bi-monthly. The DCC Female Prisoner Representative Committee has already been operating and meets bi-monthly.

	ASCC are exploring the possibility of conducting two family days a year, These could be held in the Visit Area for female prisoners and their families. These would probably link to significant celebrations such as Mother's Day. DCC will be taking the Low and Open rated female prisoners to the Howard Springs Recreation Park for a Mother's Day celebration involving their children. The activity is being held shortly after Mother's Day to ensure the facility is less crowded. A review of the ASCC Female Sector Induction Booklet has been conducted while DCC is currently reviewing its prisoner handbook. On the 14 May 2018, the low security female prisoners had an opportunity to have a three hour external visit with their children in a non-custodial environment. Five female prisoners attended the visit with ten children and six guardians in attendance. Three correctional officers and the sector 4 Prisoner Support Officer were also at the visit to assist with the security, the BBQ and any other issue that may occur. This special visit was conducted from 09:20hr to 12:10hr at the Howard Springs Nature Park (which is approximately 10Km from the Darwin Correctional Centre) with a sausage sizzle at 11:15hr. The Howard Springs Nature Park has several facilities for the children to keep themselves occupied with during the visit that allowed personal interaction between mother and child. Flyers continue to be placed in the Female Sectors of ASCC and DCC outlining the role of the Official Visitors. A prisoner newsletter is available at DCC which communicates relevant information. Next to the Prisoner Telephone System (PTS) there is a list which identifies pre-set numbers on the PTS related to prisoner complaints (legal, Health Commission, Ombudsman's Office etc). Additionally, at ASCC legal handbooks are given to prisoners on reception which give an overview of advocacy and associated matters. Every female prisoner attends an induction session with the Prisoner Support Officer which outlines the guidelines, procedures and services available within DCC and the Female Sector.
Children in prison	DCC have a Mothers with Babies Facility which aims to assist the mother to develop and maintain a functional relationship with her child pending the mother's release. Continuing the bond between mother and child during imprisonment may reduce the likelihood of reoffending. ASCC does not have a designated Mothers and Babies facility, however babies are accommodated with their mothers in the Low Security Unit of the Woman's Sector. A Child Care Plan is developed and reviewed relative to ongoing support and development needs of the mother and baby. Initiatives include the purchase of baby equipment and attendance at formal child care to benefit the baby's development. Grassed areas are available for mothers and babies in the Female Sector. Additional improvements will be explored through the FOMWG. The possible option to establish a Mother's and Babies Unit in front of H Block in ASCC by installing a standalone container/demountable is being explored … . This would allow one or two mothers and their children to be accommodated without isolating them from the general population while still ensuring the safety of the child or children.

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