THE SAFE HANDLING OF ALCOHOL OR OTHER DRUG AFFECTED PERSONS BY POLICE

BEST PRACTICE PROCEDURES

by

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July 1994

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PREFACE

This project is funded by a grant from the National Drug Crime Prevention Fund administered by the Drugs of Dependence Branch of the Commonwealth Department of Human Services and Health. The project was developed as a response to the priority target areas identified at the National Seminar of Law Enforcement Agencies held in Manly in July 1992. The consultancy brief itself was developed by a steering committee comprising officers of the Department of Human Services and Health and senior representatives of the Victorian, New South Wales and South Australian police services.

The project could not have been undertaken without the co-operation of all Australian police forces, including a large number of individual police officers who contributed their time and effort to providing much of the information contained in this report. Similarly, various State and Territory Health Departments or more specifically, agencies and key individuals specialising in drug and alcohol issues, including Aboriginal groups and those managing sobering up facilities, were also consulted and were instrumental in providing information relating to the safe handling of alcohol or other drug affected persons.

Finally, I wish to acknowledge the assistance of colleagues at the Australian Institute of Criminology, particularly Diana Nelson, Lynn Atkinson and David McDonald, from the Research Division and also Emily Owen, a visiting student from the School of Criminal Justice, Michigan State University. While I am deeply indebted to these people I must take full responsibility for any errors or omissions that may appear in the work.

INTRODUCTION

As the title suggests, the broad aim of this project is to present best practice procedures for police in their endeavour to handle with safety persons who are affected by alcohol or other drugs. This entails identifying policies and procedures which are likely to minimise harm when police come into contact with alcohol or other drug affected persons.

The topic, "safe handling of drug affected persons by police," covers considerations of safety both to police officers acting in the ordinary course of their duties as well as to intoxicated persons handled by police. The importance of the topic is exemplified by the findings of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) which showed that of 182 cases of indigenous and non-indigenous deaths in police custody between 1980 and 1988, 46 per cent were self-inflicted and 36 per cent were due to natural causes. Alcohol was implicated in nearly all deaths in custody and 53 per cent of deaths were for those who had been detained by police for public drunkenness.

As a result of the recommendations of the RCIADIC and in an attempt to reduce deaths in custody, significant and far reaching changes in policies and procedures have been introduced by police forces throughout Australia. Some jurisdictions have moved more quickly than others, but there can be no doubt that fundamental reforms have been implemented and continue to be fine-tuned. Accordingly it is hoped that these guideline procedures below will further contribute in assist in this reform process.

There are numerous examples of drug or alcohol affected persons who have died in police custody. Each time a death occurs, it raises the question as to whether police cells are suitable places in which to hold for any length of time, persons who may appear to be so affected by alcohol or other drug that they are unable to take care of themselves. Yet it is recognised and accepted that detaining such persons in police custody is sometimes necessary for their own protection and because there is available no other alternative facility in which they can safely be held.

Equally it must be recognised that confinement of persons is a risky procedure and injuries may occur in the course of handling alcohol or other drug affected persons. Further, intoxication or apparent intoxication of persons by drugs or alcohol may mask a serious health problem. So risky is the handling of such persons that ideally, all persons suspected of being under the influence of a drug or alcohol and who are to be detained by police should be medically examined either by a doctor or by a trained nurse shortly after their arrival at the watch-house. Further, alcohol or other drug affected persons are particularly vulnerable at the time of their detention and may be under considerable stress for various reasons. If left unsupervised and inadequately evaluated such people will be at continued risk while in detention.

A far from exceptional case such as that revealed in the Tasmanian coronial inquiry into the death of D.N. Glidden who died on 19 February 1990, helps to illustrate the problems faced by police throughout Australia. Glidden was suffering from a

subdural haematoma when he was taken into custody. His condition was such that, according to the medical evidence, it "would be very difficult for a lay person to tell if this condition was present as it can also be missed by medical people."[1] It was recognised also that further danger exists when a change in an alcohol or drug affected person's behaviour is wrongly attributed to the effects of the intoxication. Of particular interest however, was the observation that:

> ...it is quite clear that the holding of (intoxicated persons) in custody is a matter on which the authorities should give urgent attention if it is their wish that incidences such as this should be minimised or better still eliminated.[2]

In an ideal world, all persons taken into custody would be given a thorough medical examination prior to being detained in a cell.[3] This is not always practicable, particularly in remote areas, although the provision of a specialised medical service, such as the Forensic Nursing Service in Melbourne, with specially trained nurses who can evaluate the mental and physical condition of persons in police custody and dispense medication, is a step in the right direction. Similarly, in the East Perth lock-up, a registered nurse is on duty on Thursday, Friday, and Saturday nights between the hours of 8 pm and 3 am. Certainly if governments provided the funds necessary for adequate medical and psychiatric screening of detainees at watch-houses, the burden and sometimes unrealistic expectations placed on police could be alleviated substantially.

The policies and procedures that are set out below, many of which are already adopted by police (albeit not always in the same form of words), *are intended to provide direction for minimising harm to drug and alcohol affected persons while they are in police custody and also for minimising harm to police in the process of handling them.* With regard to the latter, police are constantly faced with the threat of injury from assaults from intoxicated persons, but even more insidious than this, there is the risk of accidental needle stick injuries and the risk of acquiring blood borne diseases such as Hepatitis B and C as well as HIV and AIDS.

It should be added also that there can be vast differences in policing strategies not only across State or Territory borders but within them. This is a reflection of community policing, which inevitably means that the approach taken in Darwin, for example, may be vastly different from the approach taken in Alice Springs, or again, policing in the Sydney suburb of Vaucluse may require a different approach to that of policing in Redfern. Similarly, different approaches will be dictated by the availability of human and physical resources. For example, police behaviour will be affected by such things as the geographical unpredictability of the custodial population, the number and availability of police patrols and vehicles to transport

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[1] Coronial inquiry into the death of D.N. Glidden, Hobart,

[2] Coronial inquiry into the death of D.N. Glidden, Tasmania

[3] Dr Wendell Rosevear, a medical practitioner and former chaplan who has worked in Queensland prisons, has called for medical screening of all inmates within 24 hours of arrest in terms of their medical and detoxificaion needs and their psychiatric and suicidal risks. 'Medical Care in Queensland Watchhouses', unpublished , May 1994.

persons, capacity (size and number) of police cells, preparedness of hospitals to treat drug and alcohol affected persons, availability of sobering-up shelters and so on.

Indeed one police officer interviewed pleaded that they should not be given guidelines for handling drug affected persons without providing them with the appropriate resources and facilities. Otherwise all that could be achieved is to "strap a copper up" and force them either to work to rule (and thus arguably, not provide a satisfactory service from the public's point of view) or breach the guidelines and risk being criticised or disciplined when things go wrong.[4]

Ultimately, the aim of harm minimisation must always be at the forefront of police activities, and in this regard despite jurisdictional differences, it is possible to identify some policies and procedural guidelines of universal application that if followed will contribute towards a safer community.

In this report, unless the context suggests otherwise, the term "drug affected persons" includes persons affected by alcohol or other drugs, or a combination of these. No distinction is made as to whether the intoxication of the person is the consequence of the ingestion of licit or illicit drugs. Note also that "watch-house" is used to refer to all police cell complexes and it is used interchangeably with the term "lock-up" and the term "member" refers to a serving police officer. Further, many of the policies and procedures concerning the safe handling of drug affected persons should be taken to apply with equal force to persons who may not be affected by drugs or alcohol but may exhibit similar symptoms to such persons.[5]

As will be seen, the report is divided into chapters dealing with discrete topics of relevance to the safe handling of alcohol or other drug affected persons. As a general rule, within each topic, statements setting out the key policies are presented before being followed by the procedures intended to achieve or implement those policies. Finally there is a commentary section intended to provide illustrations, add to or explain the rational for the preceding policies and procedures.

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[4] Having regard to some of the appalling facilities found in some capital city watch-houses or lock-ups , there is much to be said for the argument that the provision of adequate resources to complement these guidelines should now be given priority for consideration and action.

[5] For example, a person who is mentally ill, or a person who is a diabetic and is suffering from low blood sugar levels may sometimes manifest the overt behaviours of an alcohol or other drug affected person, and the steps required for identifying and dealing with such persons are covered by the same safe handling procedures.

THE EXERCISE OF DISCRETION

Police officers are often the first public officials who have the onerous responsibility of dealing with alcohol or other drug affected persons. It is often the police who introduce alcoholics or drug addicts to treatment programs, sobering-up facilities or call for emergency (ambulance) or other medical assistance for them. It is also the police who are expected to come to the aid of those who are at the receiving end of violent or potentially violent situations in which alcohol or other intoxicants play a part. Ultimately it is the police who must decide whether an offence has been committed and whether there are grounds for making an arrest because the person is suspected of committing a proscribed act of considerable seriousness or because the person would benefit from a period in protective custody.

In this regard, the police can be seen as the gatekeepers of both the health and criminal justice systems.

Policy

Intoxication should be handled as a health or social welfare, rather than a criminal justice, issue, and alcohol and other drug affected persons should be accorded the same consideration as any individual suffering from an illness.

The health of the person in custody is paramount and no police investigation should take precedence over it.[6]

Procedure

A member should not take into custody an alcohol or other drug affected person who has not committed an offence and who is not behaving in a disorderly manner and is not endangering the safety of himself or herself or any other person, or property.[7]

Without unduly compromising safety to himself or herself a member who handles an alcohol or drug affected person should always give precedence to the health or welfare needs of the person over criminal justice considerations.

Commentary

Humanitarian, health and safety aspects of police work should always be regarded as important notwithstanding the fact that the alcohol or other drug affected person may have committed an offence. An appreciation of these considerations will guide the exercise of police discretion.

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6 South Australia Police, General Order, Issue 24, December, 1992 at 8.2.

7 Adopted from General Order No. 503.3; Metropolitan Police Department, Washington, District of Columbia.

Policy

Members should be trained to recognise the signs of alcohol or drug related behaviour and understand that the presence of these may indicate increased risk of unpredictable or violent behaviour.

Procedure

Members should treat persons who show symptoms of being affected by alcohol or other drugs as potentially dangerous persons whose reactions are unpredictable and likely to change with little or no warning.

Members should regard the following signs as an indication that the person may be affected by alcohol or other drugs:

- *Bizarre, unexplained actions and behaviour*
- *Abnormally loud speech*
- *Bloodshot, watery eyes*
- *Staggering, unsteady gait*
- *Lack of motor skills or poor balance*
- *Dilated or contracted pupils*
- *Strong smell of alcohol*
- *Slurred perhaps nearly incoherent speech*
- *Agitated, angry and perhaps aggressive behaviour*
- *Drugs or drug paraphernalia on the person or nearby*
- *Hallucinations or delusions*
- *Extreme emotional displays, such as hysterical crying or laughing, for no apparent reason*
- *Soiled, dishevelled clothing and general appearance of having fallen repeatedly*
- *Needle tracks or marks on the body*
- *Swaying or nodding when standing*
- *Difficulty or confusion in following instructions or explanations.*[8]

Commentary

Often there will be a several signs indicating that the person may be under the influence of alcohol or other drug, and the more of these that are present the greater the probability that the person is under the influence. Note however that the presence of any one of the above indicators does not mean that the person must in fact be intoxicated. These same signs may equally indicate a need for urgent medical attention. The policy and procedures dealing with symptoms that mimic intoxication are considered next.

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[8] Garner, Gerald W, 'Caution: Impaired Subjects', *Police November, 1993*

Policy

Members should be aware of symptoms that mimic intoxication and seek medical attention for persons whom they suspect may be suffering from an illness or injury.

Procedure

Members should be aware that a person taken into custody may appear to be under the influence of alcohol or other drugs, but may in fact be suffering from an illness or an injury. Whenever a person is suspected of being so affected by alcohol or other drug , or is in any other condition such that he or she is unable to be roused; or further, if any reasonable doubt exists as to the state of the person's physical or mental health, then:

(1) That person should immediately be taken to the casualty area of the nearest hospital or medical centre or,

(2) arrangements should be made for medical attention to be given at the scene or at the place where that person is in custody.[9]

Note: If transportation of the person is required, reference also should be made to the section headed 'Transportation'.

Policy

When handling alcohol or other drug affected persons, members, in the exercise of their discretion, should choose the least restrictive or coercive option that is practicable, having regard always to the circumstances of the particular case.

Procedure

The power to arrest (or apprehend without arrest) and detain should not be used if, in the circumstances, the matter can be adequately dealt with by way of summons.

Further, an intoxicated person who has not (otherwise) committed an offence, should not be apprehended and detained in police custody unless:

- *the person is unable to take proper care of himself or herself, or*
- *the person is behaving in a way that is likely to cause injury to others or to damage property.*

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[9] Nothern Territory Police General Order P12 October, 1992 at para 2.

Prior to handling an alcohol or other drug affected person, a member should give consideration to the various alternative courses of action available to him or her and should select the most appropriate one that is consistent with the principle of harm minimisation.

Alcohol or other drug affected persons as well as persons who appear to be mentally ill should be approach with extreme caution. Members should take time to evaluate the situation and keep at a safe distance before deciding on an appropriate course of action.

In each case, subject to the availability of the listed options, and having regard to all the circumstances of the particular case, members should decide as to whether it is appropriate to:

- *take no action whatsoever against the person (on the basis that despite intoxication, the person's behaviour or condition does not appear to be sufficiently disruptive or serious as to justify interference on the part of police);*
- *persuade the intoxicated person or persons to desist from the offending behaviour, or to leave the scene on their own account (ensuring always, so far as is reasonable, that they do not then attempt to drive a motor vehicle);*
- *arrange for a taxi or other transport or in some circumstances convey the person home in a police vehicle;*
- *apprehend then release the person to the care of a responsible adult;*
- *apprehend and convey the person to an appropriate proclaimed place (other than a police station) or sobering- up or similar shelter;*
- *convey the person to the nearest hospital or health care facility;*
- *call for an ambulance; or*
- *arrest (or apprehend without arrest) and convey the person to the nearest police lock-up.*

A member should resist the temptation to restrain unaided, a person who is acting in a highly emotional or agitated manner. The person, if mentally ill or if affected by alcohol or other drugs (chemically induced analgesia) may be impervious to physical pain. In such cases it may require at least two or three members to restrain the person with an appropriate margin of safety to all concerned.

Commentary

If the power to arrest is exercised by police, or the person is otherwise detained by police, then a fairly onerous duty of care towards the person in custody is

enlivened..[10] Accordingly, as a matter of practice, police should always consider whether it is necessary or desirable to take alcohol or other drug affected persons into custody in the first place. This means that when a member is confronted with an alcohol or other drug affected person, thought should be given as to whether there are less obtrusive means (other than use of apprehension or arrest powers) for resolving the immediate situation. The course of action chosen does not mean that members should neglect their ordinary duties to protect persons or property, restore order as the case may require and where appropriate initiating legal action. However, apprehensions or arrests are not to be made as a form of punishment, or because the member finds it more convenient to arrest the person than adopt some other more appropriate alternative[11] or because the person is merely being abusive and annoys the member.[12]

The policies and procedures dealing with the exercise of police discretion, and particularly in relation to alcohol or other drug affected persons, are designed to reduce, or at least minimise, the number of people coming into police custody.

Release from custody at the earliest opportunity is important because it is recognised that police custody often involves detaining persons who are presumed innocent, that detention in police holding cells can, for many people, be an unduly stressful experience and that many deaths in custody (especially self inflicted) occur within the first few hours of arrest.[13] Of course, once the grounds for detention cease to apply the person should be permitted to walk free without delay.

With the decriminalisation of drunkenness in most Australian States and Territories, it has been increasingly recognised that alternative facilities need to be available to cater for alcohol and drug affected persons. Indeed most police cells are neither appropriate nor adequately equipped to do so.[14] The use of cautioning programs, summons and community based diversionary programs are ways by which reliance on police holding cells can and should be reduced. However, there is no power to direct that hospitals or other agencies must accept alcohol or other drug affected persons and where admission to such facilities is, for whatever reason, refused, police often have no alternative but to detain them for a short time

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[10] Most jurisdictions (with the current exceptions only of Victoria, Queensland, and Tasmania) allow police, subject to certain criteria, to apprehend and detain intoxicated persons in custody without arresting and charging them, although the period of the detention is strictly limited by legislation-usually a maximum of 8 hours with some variations, eg SA - 10 hours, NT - 6 hours.

11 . To take a person into protective custody as a pretext for doing a warrant search cannot be regarded as proper practice. see RCIADIC vol. 3 at p 34. Amongst other things it may lead to poor relations between police and detainees, create unnecessary tension and ultimately not contribute to the aim of promoting safe handling of alcohol and drug affected persons.

12 For example, the practice of police arresting for mere abuse or bad language is no longer acceptable. As Commissioner Wootten pointed out in the RCIADIC, at Chapter 21 p 10 ff:

> It is sure time that police learnt to ignore mere abuse, let alone simple 'bad language'.... It is particularly ridiculous when offence is taken at the rantings of drunks, as is so often the case.

13 .See generally, RCIADIC

14 See New South Wales Police Service, *Safe Custody Manual* at p 22.

in protective custody at a watch-house.[15] It is important that police do not take short cuts when dealing with intoxicated persons and ensure that where hospitalisation may be called for that they take detainees to a hospital in the first instance rather than proceeding to the police station or watch-house.

Some jurisdictions provide alcohol and other drug affected persons with the option of being detained in sobering up shelters rather than in police cells. The purpose of sobering-up shelters is to reduce the immediate threat of harm to the person apprehended (and also sometimes to protect other members of the community from the intoxicated person) without the stigma attaching to police custody, by providing short term care for the person in a less threatening environment ..[16] [17]

Of course when the sobering-up shelters are filled to capacity, much of the overflow will inevitably find its way back into police custody and police cells.

Policy

If members decide that it is appropriate to apprehend (or arrest) and detain an alcohol or other drug affected person, they must ensure that whilst in their custody, all reasonable steps are taken to minimise the harm, or risk of harm, occasioned to that person.

Procedure

Due care is to be taken to ensure that injuries are not caused, or aggravated, as a result of a person being subjected to apprehension or arrest and detention.[18]

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15 There have also been a number of significant changes in recent times that have reduced the extent of police involvement in the handling of alcohol and other drug affected persons. For example, in some jurisdictions Aboriginal Sobriety Groups have set up mobile assistance patrols for intoxicated persons. These patrols transfer people to their homes or care facilities and also respond to these facilities when an Aboriginal in their custody needs attention. RCIADIC vol. 3 p. 16 . In the Northern Territory, for example, the Night Patrols, run by indigenous Australians, provide an excellent service for intoxicated persons and helps reduce the burden on police. Sobering-up shelters are used extensively by the Night Patrols and by the police and it is generally only when the shelters are filled to capacity or where they refuse to take individuals who are violent or who have committed serious offences that police cells are used.

16 See NT Department of Health and Community Services , *Living with Alcohol,* Statistical Bulletin No 1, November 1993.

17 There is a perception that sobering-up shelters encourage repeat visits by intoxicated persons on the basis that these provide free food, laundry service, shower, and a clean bed in an environment where the person is free to leave at any time. The experience in the Northern Territory, where there are four such facilities (one each at Darwin, Alice Springs, Katherine, and Tennant Creek) that cater for about 14,000 admissions annually, has shown that the mean repeating rate at the different shelters varies between 1.9 and 3.5 admissions per individual per year. Note however that the shelters do not always accept apprehensions, and during 1992, 5% of all apprehensions were referred elsewhere, including to hospital, police cells or other treatment services. In country Western Australia, a study of three sobering-up shelters showed that the vast majority of people using sobering-up shelters were admitted once a year. A small hard-core group were admitted, on average, about once in two months.

18 ACT, Regional Instructions 26/91; at para 2.

Particular care must be exercised when detaining a person who appears intoxicated or in an impaired state of consciousness to establish that the person is not suffering from an illness or injury which has symptoms similar to alcohol or other drug intoxication[19].

If the detainee has a "medic alert" bracelet or necklace, it should not be removed unless there are prevailing circumstances. If it is removed, that fact should be recorded and highlighted in the detainee's property book and medical checklist. At the change of shifts, the outgoing shift should inform the incoming shift of that fact.[20]

When a person appears intoxicated and has submitted to a breath analysis test which is not indicative of alcoholic intoxication, or otherwise, where the person's behaviour is inconsistent with the amount of alcohol or other drug apparently consumed, medical attention shall immediately be arranged for that person.[21]

When an intoxicated child is taken into custody, members shall, depending on the degree of intoxication, seek medical advice or attention for that child. This should be in addition to notifying their supervisor and contacting the child's parents or guardian and requesting them to collect the child from the police station.

If the child's parents cannot be contacted, or will not collect the child, the child will be detained in custody under the direction of the custodial officer .[22]

Policy

Members should take particular care when handling persons who have in their possession a quantity of prescription drugs, or who have recently swallowed or injected such drugs.

Procedure

Members who find drugs (other than alcohol) in the possession of a drug affected person, should attempt to question the person or the relatives or associates of that person in order to ascertain the nature of the drug or drugs.

In addition to ascertaining the nature of the drug, members should seek to determine the quantity of alcohol or other drugs consumed and whether any drugs consumed are for a particular medical condition suffered by that person.

Members who suspect, observe, or have knowledge that an individual has swallowed or injected a quantity of drugs, the nature or effects of which are not known or are otherwise considered a real risk to the health of the person, shall

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19 Victoria Police Manual Operating Procedures at p 10-11.
20 Adapted from South Australia Police General Order, Issue 22, April 1992, at 16.7.
21 Rule 4.17.0, Metropolitan Toronto Police Department.
22 Based on the ACT Regional Instructions 21/93; at para 32 & 33.

immediately request an ambulance to transport that person to the nearest hospital.[23]

If reasonably practicable, members shall, with the detainee's authority or consent, contact the detainee's medical practitioner or the pharmacist who prescribed the drug in order to obtain information about the detainee's medical condition.[24]

Generally, the custodial officer should seek appropriate medical advice without delay where there is any dispute or uncertainty arising out of the nature of any drug or the necessity of the person to take any drug for medicinal purposes.

Note: If transportation of the person is required, reference also should be made to the section headed 'Transportation'. As for procedures relating to the taking of medication see also the section headed 'Necessities while in Custody'.

Commentary

The need for a policy dealing with alcohol or other drug affected persons who have recently taken drugs and who are found to be in possession of tablets is illustrated by the death of Paul Kearney.[25] The police failed to try to place Kearney in a facility such as a proclaimed place (other than a police station), and brought him to the police station where he was found to be in possession of more than sixty-six tablets. No medical advice was sought as to the nature of these tablets.

During Kearney's detention, police continued their checks of detainees and during one such check, an officer noted that Kearney was snoring, yet did nothing about it. Paul Kearney died of sleep apnea, asphyxiation due to the blockage of the upper airway contributed to by the excessive intake of alcohol and what was later discovered as doxepin. The two warning signs that police should have heeded (the tablets in his possession and snoring), were ignored.[26]

Policy

A custody officer should not accept into custody a person who is unconscious or not able to be easily roused.

Procedure

A custody officer shall not accept into custody a person who is unconscious or not able to be easily roused but instead shall:

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23 Based on Special Order, 88, no. 24 July 1988, Metropolitan Police Department, Washington, District of Columbia)

24 According to a WA police order for example, it is stated that, "A member will ensure that any medication is administered to a prisoner in accordance with the requirements of a dispensing physician and all dispensing will be recorded." see WA Police Lockup Manual Orders and Procedures, 22 March 1991 at F1020391.

25 Wootten, J.H., RCIADIC *Report of the Inquiry into the Death of Paul Lawrence Kearney.*

26 Ibid

> *immediately call for an ambulance or make sure that the person is conveyed to a hospital without delay.*[27]

Generally, whenever a person is so affected by alcohol or other drug, or is suspected of being intoxicated, or is in any other condition such that he or she is unable to be roused or if doubt exists as to the person's condition:

> *(1) that person shall immediately be taken to the nearest casualty area, hospital, or medical centre,*
>
> *(2) an ambulance should be called, or*
>
> *(3) arrangements should be made for medical attention to be given at the scene or at the place where the person is in custody,*

whichever is the most appropriate course of action, having regard to all the circumstances.[28]

Note: If transportation of the person is required, reference also should be made to the section headed 'Transportation'.

Commentary

If detention for the purposes of protective custody is indicated, it is up to members in the exercise of their duty of care, to have regard for and give priority to the detainee's health concerns. In many instances this will mean obtaining urgent medical attention at the earliest possible opportunity.

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27 Based on the ACT Regional Instruction 1/92, at p 17.

28 Northern Territory Police General Order P12, October, 1992 at para. 2.

DUTY OF CARE

Policy

A member who makes an arrest or otherwise takes a person into protective custody is responsible for the safe custody of that person until he or she is accepted into the custody of the custody officer or other authorised person or agency.

Procedure

Members should exercise care when taking into custody persons who appear to be affected by alcohol or other drugs. In particular members should reflect on the possibility that the persons detained may, in fact, have serious underlying medical conditions that could prove fatal if not attended to promptly.

Members should also be alerted to the possibility that an alcohol or drug affected person's mental or physical health may change or deteriorate rapidly. Accordingly their condition should be monitored during the period that they are held in custody.

Commentary

While there are many examples that could be selected, the death of Daniel Yock in November 1993 provides a good illustration, and one which received national coverage by the press and electronic media, of the need for police to exercise a duty of care when they handle alcohol or other drug affected persons. Mr. Yock, an eighteen year old Aboriginal dancer, died in hospital after being arrested following a short police chase. The cause of his death was disputed. Police officers were accused of beating and kicking Yock, which many thought may have contributed to his death. However, in evidence to the inquiry, Dr. Graham Neilson opined that emotional trauma, rather than physical trauma, triggered Yock's death.[29] The official autopsy found no evidence of a sustained violent assault, and government pathologist David Williams stated that Yock suffered from a history of fainting episodes and heart disease.[30]

According to the evidence presented at the hearing conducted by the Criminal Justice Commission of Queensland, Yock's fainting attacks in the past were over within two minutes, but because of the presence of alcohol, nicotine, and cannabis in his system, this recovery process was hampered. Therefore, recovery in the form of CPR needed to be started within five to ten minutes of the attack, otherwise permanent brain damage would have occurred.[31]

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29 "Yock May have Died of Fright,"*Canberra Times*, 24 Dec., 1993 at p 4
30 Roberts, Greg, "Behind a Death in Custody,"*Bulletin*, Dec., 1993 at p 20
31 "Yock May have Died of Fright,"*Canberra Times*, 24 Dec., 1993 at p 4

The police officers again came under fire over allegations that they had breached their duty of care. Witnesses stated that Yock was arrested and put into handcuffs face down on the ground, and began shaking and obviously needed help.[32] Further, while in the back of the police van, another youth, one of Yock's friends who was also arrested, stated that he called for help when he found Yock was not breathing and had no pulse. Upon arrival at the station, police found Yock had indeed stopped breathing and had no pulse. An attempt to revive him was made. He was taken to hospital where he died.

If indeed Yock's condition was seen or made known to police officers, they should not have transported him to a police station, but instead should have immediately called for an ambulance. It is of course easy to be wise after the event, but it is important, nevertheless, that police should be alert to the possibility of rapid changes in condition when dealing with intoxicated persons. The procedures presented in this section, and also in relation to the transportation of detainees should contribute to the prevention of tragedies such as occurred in Yock's case.

Policy

The custodial officer, who is the person responsible for the management and security of the watch-house, is responsible for safeguarding the detainee from the time the charge or protective custody is accepted at the watch-house until the time that the person is released from that custody.[33]

Procedure

The custody officer as with other members who have responsibility for the safe custody of detainees must exercise a duty of care towards the person in their custody

The standard of care that a member or custody officer must exercise toward a person in custody is that which a reasonable, prudent person would have exercised in similar circumstances. The exercise of care extends to the timely provision of medical or psychiatric treatment, adequate food, shelter, and other welfare needs of the person, compliance with standing instructions and training, and fair, decent and respectful treatment that maintains the dignity of the individual.[34]

Commentary

Members should accept and acknowledge that they owe a legal duty of care to persons in their custody and act accordingly. This means that each officer involved in the arrest, detention, or supervision of a detainee may be held legally accountable for the death or injury of the person caused by a breach of that duty.

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32 Roberts, Greg,"Behind a Death in Custody," *Bulletin*, , Dec., 1993 at p 20

33 Based on Northern Territory Police, General Order P12.

34 Dickens, Lesley et al., *Constable Development Program,, Study Notes and Readings, "Critical Issues in Policing"* NSW Police Academy at p 29

Likewise, Executive members of the Police Department have an obligation to ensure that officers are trained and aware of their care responsibilities. This duty begins once the person is taken into custody or detained (detaining an intoxicated person for breath testing, or stopping someone in order to search them etc. is included in detaining) and continues until the person is discharged from custody. This responsibility arises because when a person is detained, they are cut off from normal avenues of support, such as family and friends, and so rely on the police to care for them and provide for their safety, welfare and well-being.

The officer in charge of a watch-house is often referred to as the watch-house keeper. However in these guidelines he or she will be known as the "custody officer." There should be an experienced police officer, normally with the rank of a sergeant or senior sergeant supervising or acting as the custody officer. These officers should be trained in all facets of the management of the watch-house. The custody officer will normally be responsible for seeking medical attention or advice whenever there is a real concern for the mental or physical health of a person who is in custody at the watch-house.

It hardly needs saying that detainees should be cared for in a humane and dignified manner. Consider for example, what was said in the *Report of the Inquiry into the Death of Faith Barnes.*[35] The detainee, Barnes, was dragged into the prison yard and did not have (and did not have access to) blankets or pillows. Commissioner O'Dea stated that Barnes, "was certainly not treated in a humane and dignified manner, or with kindness and humane consideration.[36] Similarly in *Lazarou,* evidence was given that the detainee who was in a psychotic state, had spent three hours in a tiny cell hitting his head up to thirty times against the bars and walls, vomiting frequently and covering himself in his faeces. Further, it was reported that he frequently "plunged his head into the toilet bowl". The day was very hot, some 37 degrees and it was suggested that police did not give him drinking water.[37] Clearly a person in such a state should not be detained in a cell but should have been receiving urgent medical attention.

Policy

Prior to placing a person unsupervised into a police cell, the custodial officer or an authorised member, shall complete a screening form and risk assessment of the detainee.

Procedure

The screening form and risk assessment shall consist of a checklist of items designed to focus attention on the physical and mental condition of the detainee, thereby making it easier to identify and respond to the potential health problems

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[35] O'Dea, D.J., RCIADIC, *Report of the Inquiry into the Death of Faith Barnes;* see also at p 46 below.

[36] Ibid at p 28.

[37] "Prisoners Drank From Toilets, Says Coroner", *The Age,* 30 Dec., 1993 at p 3.

or injuries of the detainee and the attendant risks of placing the detainee into a holding cell.

The custody officer will take positive steps to identify any potential risk factors that may be manifested by the person's behaviour or appearance.

The custody officer should complete the medical checklist prior to placing the detainee into an appropriate holding cell. Amongst other things, custody officers should give consideration to the likelihood that the person may:

- *inflict injury upon himself or herself*
- *attempt suicide*
- *be assaulted by others while in custody*
- *be suffering from mental illness*
- *for whatever reason require medical attention.*

DETAINEE MEDICAL CHECKLIST

TO BE FOLLOWED FOR ALL DETAINEES AT ALL TIMES

DETAINEE'S NAME

Surname: _____ Given Names: _____

If you answer 'Yes' to any one of the following:
SEEK MEDICAL ATTENTION IMMEDIATELY

- Is the person unconscious or unable to be aroused? Yes ☐ No ☐
- Is the person unable to stand up without help, speak making sense or understand where he/she is? Yes ☐ No ☐
- Is the person excessively agitated? Yes ☐ No ☐
- Does the person see or hear things that are not there? Yes ☐ No ☐
- Is the person suggesting suicidal ideas or exhibiting suicidal behaviour? Yes ☐ No ☐
- Does the person show physical signs of significant trauma (eg. head injuries, bleeding from mouth or ears)? Yes ☐ No ☐
- Does the person complain of chest pains? Yes ☐ No ☐
- Is the person persistently vomiting? Yes ☐ No ☐
- Does the person have the shakes? Yes ☐ No ☐

If the detainee answers 'Yes' to any of the following:
CONSIDER THE NEED FOR MEDICAL ADVICE

- Are you taking any tablets, drugs, insulin or other medication? Yes ☐ No ☐
- Have you been treated for heart disease, diabetes, epilepsy or asthma? Yes ☐ No ☐
- Do you have any other medical or mental problems? Yes ☐ No ☐
- Are you receiving treatment? Yes ☐ No ☐

During the screening process is there evidence of:
(If 'Yes', SEEK MEDICAL ADVICE)

- Prior suicide attempts? Yes ☐ No ☐
- Confusion or extreme depression or trance-like staring? Yes ☐ No ☐
- Mood swings? Yes ☐ No ☐
- Pain, injury or illness? Yes ☐ No ☐
- A deterioration in condition since arrest? Yes ☐ No ☐

WARNING
Alcohol masks many serious medical conditions
Don't assume a detainee is 'just drunk'

RISK ASSESSMENT

Is the detainee:

- Highly intoxicated (Affected by alcohol and/or other drug)? Yes ☐ No ☐
- Depressed or highly agitated? Yes ☐ No ☐
- Threatening self harm or has a history of self harm? Yes ☐ No ☐
- A first time offender? Yes ☐ No ☐
- An Aboriginal or Torres Strait Islander? Yes ☐ No ☐

If you tick 'Yes' to any of these: ***CATEGORISE AS 'HIGH RISK'***
MAKE VERY FREQUENT OR CONSTANT INSPECTIONS

CHECKING THE DETAINEE

If, during any of your frequent inspections you find:

- A marked deterioration in the detainee's behaviour or condition
- Any previously undetected symptom of injury or illness (eg. alcohol withdrawal, a head injury due to a fall, breathing difficulties, snoring, vomiting, etc.)
- Any indication of possible mental illness (hallucination, disorientation, depression, persecution complex, fixed gaze, etc.)

MAINTAIN A HIGH LEVEL OF OBSERVATION
SEEK MEDICAL ADVICE PROMPTLY

ENSURE THAT AN INTOXICATED PERSON SLEEPS IN THE COMA POSITION

General Comments and Observations:

THE WELFARE OF THE DETAINEE IS A POLICE RESPONSIBILITY

CUSTODY OFFICER'S NAME:

Date:
Time:

Signature:

Commentary

Police are not, nor are they intended to be, medical practitioners, but they should be trained to recognise symptoms which are or may be indicative of the need to provide medical attention to persons in their custody. The Detainee Medical Checklist and the Risk Assessment forms are intended to assist police in making judgments concerning the need for medical attention for the detainee and also as a tool for determining the extent to which the person should be monitored while in detention.

Policy

Alcohol and other drug affected persons held in police custody by reason only of their state of intoxication should be detained only for the minimum amount of time necessary. This means that they should be dealt with expeditiously, and released as soon as the need for detention has ceased to apply. [38]

Generally it is inappropriate for police to do the work of prison officers and as soon as the necessary processing is complete those who are to remain in custody (eg persons remanded in custody and sentenced prisoners) should be transferred expeditiously into the custody of prison officers .

Procedure

Alcohol or other drug affected persons who are detained in protective custody may be released to a responsible adult person or as soon as the officer in charge has determined that they are capable of leaving because they do not, or no longer need protection, are not behaving disruptively, or are unlikely to injure themselves or others if allowed to go free.

Alcohol or other drug affected persons who have not committed an offence and are detained should be informed that a responsible person who is willing to take care of them may secure their release. In these circumstances detainees should be given a reasonable opportunity to contact a responsible person. [39]

Once the person has been sentenced to a term of imprisonment, he or she should be classified immediately as a sentenced prisoner and conveyed directly to the prison from the court or court complex. Unless police cells have been specifically designated as a police prison, or the sentence imposed is very short (eg measured in days rather than weeks) and having regard also to any transporting difficulties associated with the remoteness of the location of the watch-house from the nearest gaol, it is impractical to transport the person to the nearest prison reception centre, on no account should sentenced prisoners be detained in police cells.

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[38] Based on *Police and Criminal Evidence Act* s(66), April, 1991 at p 37.

[39] NSW Intoxicated Persons Act, 1979.

A holding cell is for the detention and safekeeping of persons in police custody. They include prisoners being interviewed, or awaiting court proceedings, detainees prior to their undergoing a breath analysis test, and those charged or about to be charged with an offence by the custody officer. Whatever their status, persons should not be kept in a holding cell without the permission of the officer in charge of the watch-house. [40]

Once the person has been placed into a holding cell, the obligation to monitor continues, and if there is any change in the detainee's condition, this should be noted and appropriate action taken.

Appropriate action may include:

- *calling a medical practitioner to examine or treat the person.*
- *calling an ambulance*
- *increasing surveillance*
- *moving the detainee to another cell*
- *releasing the detainee into the custody of a responsible adult person.*

A log should be kept indicating the times at which detainees are inspected in their cells and any unusual or relevant observations should be recorded. In particular, the log should contain the detainee's cell number, the date and inspection times, the identity and signature of the member carrying out the inspection and any notes relating to the assessment (or re-assessment) of the person's condition and the frequency of inspection.

Appropriate records should also be kept: of any visitors and telephone calls, any medical treatment recently administered, including the reason for the treatment, any medication prescribed (including nature, dose and frequency of taking the medication) and when and by whom it is administered to the detainee.

Commentary

There is sound argument that in remote areas of Australia it may be appropriate to allow sentenced prisoners or persons who have been refused bail to be detained in police lock-ups for short periods of time (ie measured in days rather than weeks). In such circumstances it is vital that the facilities are of a high standard, allowing for adequate natural light, proper ventilation, good food and exercise for detainees.

Regrettably, through no fault of police departments themselves, a significant proportion of watch-houses can only be described archaic and substandard,[41] a

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[40] Adopted from ACT Regional Instruction 1/92 at p 7

[41] A good example of what should not be done is found in a city watch-house that was visited by the author in March 1994. Over 50 prisoners, many of whom were the responsibility of the Prisons Department, were housed in the upstairs section of this watch-house. There was no natural light, and the majority of cells were small and overcrowded (generally sleeping 3 to a cell). The only ventilation for the entire floor was an air conditioner that blew air from one corner of the complex. The atmosphere was hot and stuffy because of the poor air circulation. At the time of visiting this facility two police officers were responsible for supervising all these

direct consequence of insufficient funding programs in this area over many years. Many watch-houses built last century and still in use, were not designed with the detainee's welfare in mind, nor has the architecture of watch-houses reflected sufficiently the need for safe working conditions for police. Certainly there is a need to improve the physical features of most watch-houses. This would contribute towards reducing stress in both members who must work in that environment and detainees who must stay there for a period of time against their will. A better designed environment would facilitate safer and more humane handling of alcohol and other drug affected persons and benefit both police and detainees.

As a general rule, police cells are not designed, nor are they appropriate, for holding people for other than short periods of time (in most cases for no more than 24 hours). Likewise, police should not be called upon to undertake the work of prison officers other than in the case of an absolute emergency or where it may be expedient and humane to do so. Thus, if it is impractical to transport a person to a remand centre or prison situated several hundred miles away and the anticipated period of the detention is relatively short, it may be better (and possibly safer) to detain the person in the police cell.

Clearly the longer that a detainee is held in police custody the greater the probability that something may go wrong and accordingly it is in the interest of members to proceed cautiously as well as expeditiously. There are many examples of what can happen if proper procedures are not followed. In a recent coronial inquiry into a death in custody, for example, the Coroner found serious breaches of the Commissioner's instructions by both senior and junior police who were working at a particular NSW police station on the 9th and 10th of June, 1992.[42] He found that the prisoner, freshly sentenced to four weeks imprisonment for a minor drug conviction, was taken into police custody rather than being transferred into the

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prisoners, and they also relied on the assistance of a trustee prisoner. There was no exercise yard or similar facilities for these prisoners, and for washing, each prisoner had to be escorted downstairs individually by the limited staff available. Aside from the inhumane conditions that the prisoners had to endure for up to 30 days, the working conditions for members could only be described as grossly substandard. Such an environment must inevitably produce a dangerous mix of stress on the part of police and inmates alike and therefore increase the risk of violent incidents.

A number of other capital city watch-houses visited were also substandard, and many could easily be more appropriately used as museums or symbols of a bygone age, rather than as a place to house, for however short a time, vulnerable, often highly stressed and depressed human beings. In one watch-house it is difficult to imagine how members could safely escort intoxicated and sometimes uncooperative detainees up and down steep flights of stairs when taking them to and from their cells. Another watch-house situated several kilometres from the City Police Station could be described as a dirty old building, cold in winter, and mosquito ridden, with minimal electronic surveillance equipment. It is clear that there are many watch-houses simply do not meet the standards required by the RCIADIC report and that police will have to continue to work in substandard facilities until such time as Governments can find the necessary capital to replace or up grade them to a more acceptable standard

42 *Phyllis Christine May*, findings delivered on 24 December 1993 at Westmead Coroner's Court.

custody of the NSW Department of Corrective Services.[43] While in police custody the deceased managed to hang herself with her pantihose.[44]

Amongst other things, the Coroner noted the deceased had not been identified as an at risk prisoner.[45] Thus, her admission form was a hopelessly inadequate record and should have contained all relevant information including her Aboriginal status. Further, a medical assessment had not been made before she was placed in the cell, she was placed in a cell on her own and all dangerous objects had not been removed.[46] According to the Coroner, under the guidelines applying to at risk prisoners, she should have been checked every five to twenty minutes.[47]

Policy

No action should be taken against any member of the police service, authorised person, any person engaged in the conduct of a proclaimed place or sobering -up shelter or any other person in respect of anything done or omitted to be done by him or her in good faith in the execution of his or her duties. [48]

Commentary

Such a provision should be written into legislation (where it does not already exist) in order to protect persons who act in good faith in the execution of their duties. Otherwise the duty of care that is placed on police and other persons may be unreasonably onerous.

Note however, that while the custody officer is not a medical practitioner and should not be expected to diagnose or treat persons who may require medical attention, the custody officer should develop an ability to recognise signs or symptoms which either, place the detainee into the category of high risk (and so require additional attention and surveillance), or identify the detainee as a person requiring medical attention. In order to assist this assessment, the custody officer

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[43] This, apparently, was an illegal practice, condoned by government ministers for a number of years.

[44] The cell complex in which she was detained was designated Category B, and intended for short term detainees and not for overnight detention. She was not taken to a Category A station because one was under repair and another was considered to be too busy and because the cells were thought to be too far from the charge room to permit adequate supervision. The cells to which the deceased was taken however, contained prominent hanging points and were unsafe and below the standards advocated by the RCIADIC. The pantihose had been looped around the main crossbar that was unmeshed and situated above the cell door 2.2 metres from the ground. She was checked as infrequently as every two hours before being found dead after fourteen hours in custody.

[45] She was wrongly identified as a Caucasian rather than as an Aboriginal person because of her white skin.

[46] The case received considerable adverse publicity for police in the press, see particularly the articles by N. Papadopoulos, "Breach of Regulations Contributed to Cell Death" in *The Sydney Morning Herald,* 27 December 1993 at p 2, and Col Allison "Prisoners held in unsafe cells, coroner told"*The Sydney Morning Herald,* 7 September 1993 at p 6.

[47] The Coroner also recommended that those who were yet to face the courts should be held at nominated police stations in safe cells with special monitoring equipment and computer operated alarm buttons in each cell. See also section headed "Inspecting People in Custody"

[48] NSW Intoxicated Persons Act, 1979.

should complete the detainee medical checklist prior to placing a detainee into an appropriate holding cell.

In addition, caring for persons in custody means treating them with respect by putting aside biases which might cloud thinking. As the RCIADIC noted:

> ..there is a strong police 'culture' which affects the attitudes of those in the service...The culture changes from time to time, but it seems obvious from the cases that commitment to prisoner care and safety was not a strong element in police culture in the 1980's, generally speaking, and there was a strong tendency to protect fellow officers from any suggestion of breach of a proper standard of care. Such attitudes make for poor performance.[49]

The Royal Commission described an example in the Northern Territory where a man was taken to the Berrimah cells rather than to the Darwin Sobering-Up Shelter. The officer could give no explanation as to why he had taken the man (who eventually died in Royal Darwin Hospital) to the cells. It seems that the officer concerned had placed the word "aggro" against the detainee's name in the protective custody register as an excuse for not taking him to the shelter. [50]

Not only are detainees owed a duty of care, but police departments and members also have a duty of care to each other.

"Duty of care" is not exclusive to members and persons in their custody. In all occupations, the employer owes a duty of care to their employees. Police departments are no exception. Within a police department, a duty of care is owed to employees by the department, all police officers to each other, and both the department and members of it owe a duty of care to the public.[51]

Policy

Police departments should provide and maintain a healthy, safe and welfare oriented workplace for members by:

- **providing a safe system of work, and maintaining safe and adequate plant and equipment,**
- **providing and maintaining appropriate supervision, and**
- **not exposing its employees to a risk of injury which is foreseeable and which, by the exercise of reasonable care, could be avoided.** [52]

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[49] RCIADIC, vol. 1 at pp 86-87.
[50] RCIADIC vol. 1 at p 87.
[51] Dickens, Lesley et al., *Constable Development Program,, Study Notes and Readings, "Critical Issues in Policing"* NSW Police Academy at p 25.
[52] Victoria Police Seminar, Occupational Health and Safety, Common Law Duty of Care at p 1.

Procedure

The police department should comply with relevant Codes and Regulations, ensure that there is appropriate supervision to maintain the aspects mentioned above, and encourage employees to participate in rehabilitative programs and make submissions concerning prevention of injuries.[53]

Police departments should provide information, education, and training that is necessary to enable employees to do their work in a safe manner.[54]

Equally, members should take steps to acquaint themselves and comply with the most recently proclaimed occupation health and safety standards of their department.

Commentary

Occupation health and safety legislation in each jurisdiction provides obligations of the kind outlined above on police departments throughout Australia. Where members have serious concerns about the implementation of such standards they should be brought to the attention of appropriate personnel who are in a position to bring about change.

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53 Victoria Police seminar, OH&S at p 2.
54 Victoria Police seminar, OH&S at p 6.

Procedure

Persons in an 'Impaired Conscious State' (eg the person is unable to give an appropriate verbal response when checked) should not be transported in a police vehicle unless:

1) *there is an urgent need for medical treatment, AND*

2) *there is likely to be an unacceptable delay in the arrival of medical treatment, AND*

3) *the person's condition is able to be constantly monitored, in particular the airways*[57]

Policy

When alcohol or other drug affected persons are transported, it should be done in a manner that causes the least risk of harm to both detainees and members.

Procedure

A person who is to be transported by ambulance and who exhibits bizarre or violent behaviour, or has been arrested, should be accompanied by a police officer in the patient compartment of the ambulance.[58]

When alcohol or other drug affected persons are transported to a police station or watch-house, they should be kept under observation to be sure they don't lapse into unconsciousness, harm anyone, destroy evidence or damage property[59]

Once a person is taken into custody, and placed in a police vehicle, members should not unduly delay in conveying them to the appropriate facility. They should not be locked inside police vans without access to water and toilets for other than a reasonable period of time.

Drivers of police vans should drive extra carefully, particularly when they are transporting alcohol or other drug affected persons who may not be restrained in seat belts.

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56 From Special Order 88, No. 24 July 1988, Metropolitan Police Department, Washington, District of Columbia.

57 Victoria Police Manual, Operating Procedures 1.3.6 at p 1-46, see also New Zealand General Instructions Ten One 6/14 P109 at para 2.

58 Based on Special Order 88, No. 24 July 1988, Metropolitan Police Department, Washington, District of Columbia.

59 NSW Police Service *Safe Custody Manual* at p 16.

Where an intoxicated person is being transported to the police station or lock-up in a sedan, he or she should be seated in the left rear seat and the other officer should be seated beside him or her.[60]

Where practicable, the practice of placing intoxicated persons in a prone position in the rear of vans and utilities should be phased out as injuries may be caused as a result of an incapacity of the person to maintain balance while the vehicle is in motion.[61]

Commentary

A common practice amongst police is to transport intoxicated persons in the rear of police utilities. It must be recognised that intoxicated persons are seldom in an appropriate condition to maintain balance, and there is always the risk of the police vehicle stopping suddenly or being involved in an accident. Unrestrained persons in the back of these vehicles are at significant risk of sustaining injuries. In those jurisdictions which have a particularly high level of intoxicated persons who are transported by police, consideration should be given to acquiring special purpose vehicles or vans with proper seating which will permit transporting such persons with a greater degree of safety.

Blame cannot always be apportioned to the conduct of police when an intoxicated person dies. Certainly, transport of an unconscious or heavily drug affected person can be dangerous or fatal. In the inquest into the death of George Lazarou in Melbourne, for example, the Coroner found that medical personnel failed to insist the heavily sedated and unconscious Lazarou be transported by ambulance to the hospital. Lazarou died of a heart attack in the back of a police van where he was placed face down and unconscious.[62]

In a recent New South Wales case, a detainee en route to a police station in a police vehicle complained of being hot and feeling faint. The police vehicle was stopped and the detainee inspected. Because the detainee did indeed feel hot and because he complained of head pain, the officers took the correct action and summoned an ambulance. The ambulance found nothing unusual except for sluggish eye movements but nevertheless conveyed the person to the hospital. At the hospital, it was discovered that he had a sore jaw and an infected tooth. The doctor treating the detainee pronounced him fit to travel and he was then conveyed to the watch-house without incident. This is an example of correct police procedure and although in this particular case, the detainee's medical problem was not severe, had it been so, the officers involved could have saved his life.

While the Port Adelaide lock-ups were being visited, an Aboriginal woman, claiming mental illness and an urgent need for medication was brought to the watch-house under arrest. On the basis of her claim the apprehending member had

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60 Tasmania police, Standing Orders at 412.10.

61 Based on the ACT Regional Instructions 26/91.

62 Harding, Allison, "The Life not Worth $100" *Herald Sun (Melbourne)*, Wednesday, 5 Jan. 1994 pp 1-2.

taken her to the hospital for a medical examination to ascertain her fitness for admission to the cells. The woman was found fit to be admitted. The mental hospital at which the woman claimed to have been and in-patient had been contacted but no record of her was found. Finally, the custodial officer sought help through the Aboriginal visitors scheme in relation to her claim for medication. A common concern is the delay involved in transporting apprehended persons[63].

63 For example, according to the Aboriginal Legal Service in an outer suburb of one capital city jurisdiction visited, there is often a long delay between the time of apprehension of a person and their delivery to the lock-up where medical treatment is available. As in this jurisdiction, adults are often alcohol affected and juveniles affected by glue, there is generally an urgent need for treatment. Hence such delays are not conducive to safe handling.

SEARCHES

Policy

The objective of a search is to provide safe keeping of the detainee's property and to take from the detainee anything which may:

- **cause harm to himself/herself or others**
- **facilitate escape**
- **damage property**
- **provide evidence material to a charge.**[64]

Procedure

When confronted by violent persons, members should use only as much force as is reasonably necessary in the circumstances.

Restraint techniques which could cause injury to the person should be avoided.[65]

Members should apply approved techniques that they have acquired in training for restraining violent persons.

Where practicable, when dealing with violent detainees, a member other than the arresting member, should carry out the search of the detainee.[66]

Commentary

Violent detainees are subject to the use of a reasonable amount of force, as stated above, but only as a last resort. Many violent people are such because they are intoxicated and the use of certain restraint methods may cause unnecessary harm. According to the RCIADIC report, two deaths occurred after restraint was used, and in one, the prisoner died of asphyxia.[67] These did not occur in the course of a search, but nonetheless demonstrate the possible effects of restraint techniques.

Policy

Where practicable, searches should be carried out at the time of arrest, before and after a person is placed in a police car, and before and after the person is put into a police cell.

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64 South Australia Police, General Order, Issue 25, May 1993 at 1.
65 NSW Police Service *Safe Custody Manual* at p 19.
66 Based on NT General Order P12, October, 1992 at para 38.
67 RCIADIC, vol. 3 at p 287.

Procedure

It is the responsibility of the member placing a detainee in a holding cell to ensure the person is thoroughly searched. No member shall, unless it is unavoidable, search a prisoner or detainee without another member being present.[68]

A custodial officer will ensure that detainees are thoroughly searched before being placed in the cells, that all necessary property is taken into possession and recorded, and detainees are not permitted to retain possession of any article or matter by which they may inflict injury upon themselves, or any other person. This aspect will be given particularly close attention where the detainee is violent, depressed, or otherwise upset emotionally.[69]

Where practicable, procedures for searching should be followed as set out in these guidelines.

Commentary

One example of the importance of searching a detainee prior to placing them in a police car is exemplified in the following reference contained in the Western Australia Police Academy *Custodial Care Manual* as amended 10/11/92:

> Attention is also drawn to search techniques of arrested persons prior to placing them in vehicles for conveyance to a lockup. In the first six months of 1991, Occupational Health Safety and Welfare have had reports of at least three incidents where syringes have been located behind seats of sedans at the Maylands Workshop.

Findings such as these are not uncommon in other jurisdictions and accordingly highlight the care that must be used when searching or cleaning out vihicles that have been used for transporting witnesses, offenders, or other detainees.

Policy

Searches should be conducted so as to minimise embarrassment to detainees and should not unnecessarily violate the individual dignity and privacy of the person.[70]

Procedure

The searching of a detainee, except in cases of extreme urgency or danger, shall be carried out by a member of the same sex as the detainee. This is especially true of strip searches.[71] *A body cavity search, if requested, shall be carried out by medical personnel only.*

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68 ACT Regional Instructions 1/92 at para. 5.
69 NT General Order P12 at para 36.
70 NSW Police Service, *Safe Custody Manual* at p 14.
71 Queensland Police Service *Custody Manual,* July, 1993 at p 25. see also WA Police Lockup Manual, Orders and Procedures C1020391.

Policy

Searching procedures should be used that minimise the chance of harm to the police. In general, police should not put their hands in places they cannot see.

Procedure

The following are some techniques which the police may adopt:

(a) Latex or other suitable gloves should be worn where practicable

(b) Situations in which sharp objects, such as knifes, needles, or syringes may be concealed should be anticipated whenever possible.

(c) When searching a person, special care should be taken to avoid injuries from concealed sharp objects. The person being searched could be asked:

i. to empty out their own pockets,
ii. to remove and tip out their shoes,
iii. to run their hands through their hair
iv to turn down their collar, cuffs, sleeves or other parts of their clothing where sharp objects may be concealed, or
v. if they have any dangerous objects on them that the officer should know about.

(d) When searching bags, drawers, etc., the contents should be tipped out onto a flat surface for examination.

(e) Sharp objects which may be used as evidence should be placed in a rigid, puncture resistant sharps container. A clear sharps container is ideal. Other items contaminated with blood or body substances should be placed in a plastic bag and sealed with tape, not stapled. All samples should be clearly labelled.

(f) Needles should not be recapped, bent or broken. Where possible, forceps, tongs or another hands-free method should be used to pick up the sharp object. Sharp objects found in the search should be placed in a sharps container.

(g) Sharps containers should be carried to the area rather than carrying the object to the sharps container.

(h) Gloves should be removed, put into a sealable plastic bag and disposed of appropriately when searching is completed.

(i) Hands should be washed when searching is completed.[72]

Commentary

In some jurisdictions, it is up to the officer's discretion as to whether to allow detainees to empty out their own pockets. An officer may choose not to allow the detainee to do this in the interest of safety because the detainee may have a weapon which may suddenly be used against the officer.

In the June, 1991 issue of *Police Life* from the Victoria Police, an incident was recalled in which, during a search, an officer received multiple needle stick injuries. The officer shoved his hand under a mattress and received the injuries. Police were looking for stolen videos, and did not expect that there would be over 200 used syringes under the mattress. This is a prime example to show that police officers should not put their hands in places where they cannot see.[73]

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[72] Draft National Code of NOHSC.

[73] *Police Life*, VIC Police, June 1991, at pp 10-11.

CELL ACCOMMODATION

Policy

Detainees should be accommodated in police cells in a way that will minimise the potential for occasioning harm to: themselves, to other detainees and to any other persons, including members who are required to handle them.

Procedure

When considering the detention of a detainee in a police cell, the custodial officer shall exercise skill and judgment in deciding whether that detainee should be required to share a cell with other detainees or be segregated from the general population of detainees.

Unless there are strong countervailing reasons for not doing so, the following category of detainees should not be placed into a police cell by themselves:

1) *persons assessed as potentially suicidal*
2) *Aborigines and Torres Strait Islanders*

As a general rule, persons of the same ethnic background and sex should be permitted to share cells.

Unless there are exceptional circumstances, the following categories of detainees should be segregated from the general population of detainees:

(1) *Juveniles (to be separated from adult detainees)*
(2) *Females (to be separated from male detainees)*
(3) *Alcohol or other drug affected persons*
(4) *Violent detainees*
(5) *Mentally ill or emotionally disturbed detainees OR*
(6) *Any other group or individual person for whom sharing accommodation could fairly be regarded as inappropriate having regard to the particular circumstances of the case*

So far as practicable, separation of detainees should include, for children and women, the use of separate toilets, wash, shower, exercise and other facilities.[74]

Detainees who manifest violent behaviour towards others should be detained in a separate cell and monitored more intensively than most other category of detainees.

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[74] VIC Police Recruit Item 44, Nov. 1993 at p 10.

When it is not possible or it is otherwise impractical to apply any one or more of the above procedures, the custodial officer shall exercise discretion as to how best to accommodate the detainee, having regard always to the principle of harm minimisation.

Violent alcohol or other drug affected detainees should be escorted to or from a cell by more than one member.

No person should be detained in a police cell, unless a member is in attendance at the watch-house and is able to perform duties of care and supervision.[75]

Commentary

There are many possible combinations of cell accommodation arrangements, and clearly there will be times when it is not possible to segregate detainees along the lines set out above. Exceptions to the guidelines above may occur. For example, there may simply be insufficient cell accommodation or an Aboriginal youth and an Aboriginal adult might be a better placement than keeping them isolated. Similarly, Aboriginal detainees from different communities may express a desire not to be placed together. The custodial officer needs to use his/her discretion when situations like these arise, inquire into any concerns the detainee may have with respect to sharing a cell and make decisions which will help to reduce the incidence of conflict or the opportunities for undetected self inflicted harm.

Placing detainees in cells alone may increase loneliness, depression, and other factors which may lead someone to suicide. Being isolated from friends and family can be devastating and to have the company of other detainees may make a difference between life and death. "Human interaction is one of the most useful tools in suicide prevention."[76] In all but two cases of hanging investigated by the Royal Commission, the deceased was placed into a cell alone. In one of these two cases, the deceased was placed into a cell with someone who was unconscious.[77] By placing detainees with other detainees, a custody officer may also help facilitate getting aid to a detainee if one of his/her cellmates calls attention to the predicament. However, placing detainees together does not mean that the responsibility for conducting regular cell checks is lessened.[78]

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75 RCIADIC vol. 3 at p. 141.
76 RCIADIC vol. 3 at p 228.
77 RCIADIC vol. 3 at p 227.
78 RCIADIC vol. 3 at p 228.

COMMUNICATION AND RECORD KEEPING

Policy

Officers should communicate with each other and with detainees in order to exchange information about the health and well-being of detainees.

Procedure

The transporting officer will inform the person receiving the detainee of injury, threats of violence, attempted self harm, and any information that will assist in providing appropriate treatment for the detainee.[79]

When changes of shift occur, information including health and safety information should be communicated to the next shift, including having the officer on the outgoing shift conduct a check with the officers on the incoming shift.[80]

If detainees are suicidal, talk to them while waiting for medical assistance, acknowledge their cry for help and make suggestions firmly but gently. Build rapport. Talking with a detainee will make it harder for them to make a final decision on suicide.[81]

Policy

Police should interact with detainees in a humane and courteous manner.[82]

Procedure

In selecting a cell, preference should be given to those which allow detainees to communicate with members should they wish to do so. This is particularly important in the event of an emergency. For cells which are remote from the main office, an intercom system or buzzer should be employed.

Complaints or requests made by a detainee should be investigated.

In many cases video surveillance will be appropriate but the element of human contact and interaction, however, should continue to be used as the main form of communication and should not be regarded as unnecessary by reason of the availability of electronic equipment.

In order to prevent disruptive behaviour of detainees, custodial officers should avoid taking an authoritarian attitude and, where possible, should attempt to establish a rapport with the person. To establish rapport:

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79 QLD Police Service, *Custody Manual* July 1993 at p 13. (see also section on communication.
80 Eg see Northern Territory Police General Order P12 October, 1992 at para 4.
81 NSW Police Service, *Safe Custody Manual* at p 4, 6. See also NT General Order P12 at para 4.
82 RCIADIC vol 3 p. 136.

a) *Introduce yourself and attempt to put the detainee at ease by explaining each step of the process. Give clear, concrete directions and if necessary, escort them to and from their destination. Be polite.*

b) *Obtain information in relation to any illness or injury with a view to demonstrating your concern for the detainee's welfare.*

c) *When talking to detainees, use their name. Where appropriate, use slow, distinct speech and simple sentences, and repeat information or questions if necessary.*

d) *Maintain eye contact. Note, however, to be aware of cultural differences. For example, eye contact may not be appropriate for some Aboriginal and Torres Strait Islanders. Observe the detainee's reactions and adjust your behaviour accordingly.*

e) *Avoid emotional topics and involved discussions.*[83]

The custodial officer should allow the detainee to communicate with a relative or friend or someone else who has an interest in that person's health or welfare. This includes permitting telephone calls to solicitors, friends, relatives, consular officers, parents or guardians of a juvenile, or a private medical practitioner.[84]

Commentary

Communication between the officer and the detainee is also of great importance. Although electronic surveillance techniques are available and important, human interaction is of the utmost importance. This was stressed throughout the RCIADIC. There were some locations studied that the detainees could not have their calls for help heard. When speaking with detainees, biases must be put aside (indeed, agencies should work to eliminate them) and detainees should be treated humanely. Failure to do this may lead to aggression, depression, or feelings of worthlessness, which in turn may lead to suicidal tendencies. By building rapport with the detainee, a member may be able to prevent a death.

Electronic surveillance monitors ideally should be in colour as this provides for easier monitoring and more accurate visual impact of the scene.

Policy

Where members in charge of detainees acquire information relating to the medical condition of a detainee, such information should be recorded where

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83 Curtis, I., 'Medical Aspects of Police Custody', QLD Police Service, *Custody Manual* at p. XXXI.
84 Ibid at p 66.

it may be accessed by any other member who is authorised to view it. The information should be added to the screening form or filed with it.[85]

Police should develop and/or improve upon computerised information systems for recording details of apprehended or arrested persons in order to more efficiently consider and communicate information relating to health and other risk factors pertaining to detainees.

Procedure

A check-list should be used so that when a shift change occurs, the oncoming officers may have access to that information.[86]

The Detainee Medical Checklist and station instructions relative to detainees must be displayed in the detainee reception area and instructions followed by members.[87]

In order to protect police from unfair criticism and provide a permanent record for the police officer dealing with the investigation, a Register of Detainee Admission and Management Forms should be maintained.[88]

When a detainee:

- *has received surgical or medical treatment*
- *has injured himself or herself, or attempted suicide*
- *demonstrates a tendency toward suicide or self injury*
- *requires protection or separation due to the nature of the charges, or for other reasons,*

a report detailing one or more of these matters should be attached to the remand or commitment warrant for the information of gaol authorities.[89]

Notwithstanding the above procedures, members should respect the confidential nature of the information acquired about a detainee in the course of their employment and must not communicate medical or other private information about the detainee to any other person except on a 'needs to know' basis.

Commentary

Communication is of utmost importance because it enables officers to know more about the condition of the detainees. A written record of checks and screening processes can be important because a new officer can look at the written record to obtain a starting point on how to handle the detainee. The RCIADIC found deficiencies in this area.

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85 RCIADIC vol. 3 at p 131.
86 Ibid at p 132.
87 Vic Police Force, Circular Memo No. 92-7, June 1992 at pp 2, 23 .
88 NSW Police Service, *Safe Custody Manual*, at p 2.
89 Victoria Police Manual 91-9-18 at p 22.

> In many cases it was clear that relevant information was not passed from one shift to the next; in others there was a dispute between outgoing and incoming officers as to whether it was exchanged. These inconsistencies clearly make the case for recording such information.[90]

The custody officer is responsible for the accuracy and completeness of the detainee's record, and is also responsible for making sure that the form goes with the detainee, should he/she be transferred.[91]

The development of computerised information systems is gradually replacing the use of paper forms. In the Northern Territory, for example, the Integrated Justice Information System (IJIS) allows information to flow from police to courts and corrections such that it is possible to have a very good description of the offender's personal details including prior risk factors such as past suicide attempts, mental illness, and the like. This is very useful as it flags potential risk factors for persons who have been detained on a prior occasion and therefore allows the custodial officer to question the detainee in relation to them. In this there are issues of privacy and confidentiality, and accordingly considerable care is required in how this information is treated.

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90 RCIADIC vol. 1 at p 84.

91 *Police and Criminal Evidence Act, s.66*, April 1991, at p 40.

INSPECTING PEOPLE IN CUSTODY

The RCIADIC has shown that the first twenty-four hours and especially the first few hours in custody are the most critical periods for suicides in custody. Accordingly, particular care has to be taken in the initial stages of police custody. This is especially true when dealing with intoxicated persons.

Policy

All intoxicated persons who are detained in police cells should be checked regularly to ensure that they are safe and well.

Procedure

Unless impracticable, for alcohol or other drug affected persons in custody in a police cell, checks should be carried out at least once in every 15 minutes for the first hour [92] *and once in every 20 minutes for the second hour.*

Thereafter , checks should be undertaken at least once per hour.

Detainees identified as, or suspected of being at risk of harm or injury should be inspected more frequently. In some cases, constant observation may be required, in other cases medical advice, treatment or hospitalisation should be sought.

Checks should involve human contact, not just video or audio surveillance.[93] *If time permits, members should converse with detainees.*

Generally, detainees should be permitted to sleep uninterrupted only if they are breathing comfortably and appear to be in good health. However, if the inspecting member has any reason to be concerned about the mental or physical well-being of detainees, they must be woken and a verbal response obtained.[94]

If detainees sleep for an excessive amount of time, are snoring with breathing difficulties, or there is evidence of vomit, they should be woken up and asked about their condition. If they have vomited previously, medical advice should be sought.

Where detainees are severely intoxicated they should be placed to lie in the coma position. This will reduce the risk of the person drowning should he/she vomit.

When placing persons in the coma position, place them on their side with their back against a wall so that they cannot roll onto their backs. Alternatively, place

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92 Follows RCIADIC recommendations, see also NT General Order P12 October 1992, at para 15.1.
93 RCIADIC vol. 3 at p 139.
94 Northern Territory General Order P12, October 1992 at para 15.1.

them face down on the floor or bed so that should they vomit, they will not inhale it.[95]

Where detainees appear angry, withdrawn, or depressed, very close surveillance should be maintained. Surveillance must proceed on the basis that the person is at risk of serious injury or may attempt suicide, notwithstanding assertions to the contrary made by that person.[96]

All checks should be recorded, indicating the time that the inspection took place and include comments about the detainee's well-being. The officer should note any changes in behaviour or condition from one check to the next.

Commentary

Perhaps one of the most important practices carried out in detention facilities is that of inspecting detainees. These checks, if carried out properly, may prove invaluable in aiding members to discover problems that could help prevent the death of detainees. For example, changes in behaviour, seizures, depression or other warning signs may manifest themselves at any time. These may not have been present, or present in a much milder form when the detainee was first admitted into custody.

In one case described in the RCIADIC, detainees tried to tell the officers that a person was dead at 1 am in the morning, but the officers did not even investigate or carry out a check until 5:25 am[97] In many other cases, the deceased died within a short time of being taken into custody, but no checks were made until they were found dead.

In order to ensure that adequate surveillance is conducted and that an adequate system of accountability is in place, a running log should be kept of all inspections, and any indication of a change in condition of the detainee should be reported and acted upon.

In some remote areas where there are only two or three members for the whole location surveillance checks may be less than that which is recommended above. Nevertheless, if the person detained in custody is regarded as an at risk detainee, then every effort should be made to ensure that adequate inspections are carried out.

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95 Based on New Zealand Police, General Instructions: Ten One 6/14, susbection P109.
96 ACT, Regional Instructions 26/91, at para. 9.
97 RCIADIC vol. 1 at p 88.

TRAINING

Policy

All members should receive training at the recruit and in-service level to enable them to identify persons in distress or at risk of death or injury through illness, injury or self-harm. Members working substantially in cell guard duties should have more intensive training.[98]

Procedure

Members should apply their knowledge acquired through training, and in particular consider:

(1) Information as to the general health status and other issues affecting the Aboriginal and Torres Strait Islander populations,

(2) The dangers associated with detaining unconscious or semi-conscious persons and the action to be taken in regard to those matters,

(3) the benefits of CPR and CPR refresher courses,

4) Information about drug cultures and alcohol and its effects, especially with regard to alcohol withdrawal.

While members cannot be expected to make diagnoses of the medical condition of suspected alcohol or other drug affected persons they should be trained to recognise or at least be aware that there are some conditions that mimic the symptoms of intoxication. These include:

- *Head Injury (clot or stroke)*
- *Hypoglycaemia (low blood sugar)*
- *Hyperglycaemia (uncontrolled diabetes)*
- *Mixed alcohol/drug overdose*
- *Low blood pressure from excess treatment of high blood pressure*
- *Hypoxia from asthma or respiratory blockage or infection*
- *Schizophrenia and manic depression psychosis*
- *Abuse of volatile glues, coolants and wood alcohols*[99]

Members should apply principles and procedures they have acquired in training and education programs on AIDS and other infectious diseases. The topics covered by such training should include an appreciation of:

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98 RCIADIC vol 3 at p 133.

99 Curits, I., "Medical Aspects of Police Custody"; in the QLD Police Service *Custody Manual,* at p.XXXIX.

- *the means of transmission of HIV (or other) infection*
- *methods of preventing the disease*
- *CPR/First Aid procedures*
- *search procedures*
- *arrest procedures*
- *transportation of prisoners*
- *crime scene processing*
- *evidence handling and laboratory procedures*
- *disposal of contaminated materials*
- *custody issues*
- *body removal procedures*
- *legal liability and duty of care*
- *HIV antibody testing procedures*[100]

Note: Reference should also be made to the procedures set out under the chapter headed 'Officer Safety (Emphasis on HIV/AIDS and Infectious Diseases)'.

Commentary

There are several areas in which training has improved. For example, the Northern Territory has involved an anthropologist in their Aboriginal culture courses and in Queensland, first-year constables may live in an Aboriginal community for four weeks on a social level to provide a better understanding of the Aboriginal culture and customs.[101] Also in Queensland, the use of training videos is to be applauded. The videos emphasise the police officers' duty of care for the detainee as well as help members to recognise symptoms of various dangerous conditions and how to handle intoxicated persons in such circumstances.

Officers are not expected to become medical experts with diagnostic prowess, but are expected to act as a reasonable person would and with the knowledge of an informed lay person.[102]

In the case of Faith Barnes, reviewed by the RCIADIC, no evidence of the presence of drug or alcohol was detected when tests were conducted. Yet she was detained for drunkenness. When officers encountered Barnes, she was either unconscious or semiconscious, and was still taken into police custody. During cell checks, her condition was the same and yet she was not taken to the hospital for a long time. When she was finally taken to the hospital, she died of blood clots in her head. Commissioner O'Dea stated in his Inquiry into the Death of Faith Barnes that, "as a result of breach of duty, Barnes was likely injured in police custody and died from those injuries".[103]

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[100] Hammett, T M, 'Aids and the Law Enforcement Officer: Concerns and Policy Responses', Office of Communication and Research Utilization, U S Department of Justice, June 1987

[101] *Implementation of Commonwealth Government Responses to the Recommendations of the Royal Commission Into Aboriginal Deaths in Custody,* First Annual Report 1992-1993, volume 1,. at p 54.

[102] RCIADIC vol. 3 at p 195.

[103] O'Dea, D.J., *RCIADIC Report of the Inquiry into the Death of Faith Barnes,* at p 28.

Training plays an important role in all police functions. The treatment of persons in custody is no different. Officers should receive appropriate training to monitor the conditions of person in their custody. Not only *should* they do this, but it is a part of their duty of care to do so. However, if police are to behave responsibly in this area, they must be skilled and equipped to do so.

As indicated above, training may be facilitated by the use of videos such as currently used by Queensland police. The advantage of using such training material is that conditions requiring medical attention can be simulated and provide a very efficient means of communicating symptoms that can be recognised by police.

VISITORS AND NOTIFICATIONS

Policy

Visits by relatives or friends of indigenous Australians in police custody are to be encouraged as Aboriginal and Torres Strait Islander persons may have problems coping with the isolation of a cell.

Visits by certain other persons may also be permitted and appropriate notifications made where this will contribute to the reduction of stress and the smooth management of the watch-house.

Procedure

Where there is concern that the person detained may have problems in coping with the isolation of a cell, the custody officer in the exercise of his or her discretion, may arrange visits by relatives, friends, community liaison officers or members of community groups.[104] *This applies particularly to indigenous Australians.*[105]

Similarly, persons in custody should be allowed, within reason, to communicate with potential witnesses or relatives or friends who may wish to arrange bail.[106]

A minister of religion or a legal representative should be permitted to visit a detainee at the request of:

- *the detainee*
- *the family of the detainee*
- *a friend of the detainee.*

Where practicable, the custody officer should endeavour to notify a relative when a detainee is regarded as "at risk," or where the detainee has been transferred to a hospital.[107]

Generally, visits from legal representatives should be allowed at the request of the detainee and the guard shall keep them in view but be out of hearing distance.[108]

All visits should be recorded in the Register of Prisoners book and a separate Visitors Book. The details of the visit are also to be recorded.

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104 NSW Police Service, *Safe Custody Manual*, at p 48.
105 ACT Regional Instructions 1/92 at para 11.
106 SA Police, General Orders, Issue 24, Dec. 1992.
107 NT General Oder P12 October 1992 at para 5.1.
108 VIC Police Recruit Item 44, Nov. 1993 at p 8.

Aboriginal and Torres Strait Islander participants in visitor schemes should be those nominated or approved by appropriate Aboriginal and Torres Strait Islander communities and/or organisations as well as by any other person whose approval is required by local practice.[109]

Commentary

Early reports indicate that visitor schemes which commenced after the Royal Commission reported are successful. In Western Australia, an Aboriginal visitors scheme has had, "a profound effect upon both lock-up staff and Aboriginal detainees."[110] The visitors are able to diffuse situations quickly and calm down the detainee. Most of the lock-ups receive daily visits and rural areas may have visitors on call.[111]

It is important to recognise the value of such schemes as they assist in reducing stress in detainees and the risk of violent behaviour from occurring . This also reduces stress on custodial staff and therefore contributes to the smooth management of the police lock-up.

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109 RCIADIC vol. 3 at p 145.

110 *Implementation of Commonwealth Government Responses to the Recommendations of the Royal Commission into Aboriginal Deaths in Custody*, First Annual Report 1992-1993, volume 1, at p. 60.

111 *Ibid* p. 60-61.

NECESSITIES WHILE IN CUSTODY

Policy

Necessities of life, including meals, blankets, access to facilities and hygiene materials are to be provided.

Procedure

Members will closely supervise meals and make sure that all utensils are removed after the detainee has finished eating.

Officers in charge shall make sure that each detainee is supplied with adequate blankets and make sure that the cells are kept in a clean condition. Detainees will be allowed to maintain personal hygiene where practicable.[112]

Where practicable, and in order to reduce the risk of spreading disease or infection, all blankets should be washed after being used by a person. Where blankets have been used by any person suspected of having a contagious disease, such blankets should be either fumigated immediately or destroyed.[113]

Access to tobacco/cigarettes should be left at the discretion of the custody officer. However, denial of cigarettes may cause stress, which in turn may increase the effects of alcohol or other drug withdrawal.[114]

Note: Signs of alcohol or other drug withdrawal should not be ignored as these may present a threat to the person's health, safety or life. If in doubt medical advice or attention should be sought without delay.

Policy

If a detainee is taking medication, the custodial officer should ensure that the detainee is given the opportunity to take the medication in accordance with the directions given.[115]

Procedure

When a detainee has medication with them, they are to be allowed to take that medication provided that it

1) has been prescribed by a medical practitioner

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112 SA Police, Gen. Orders, Issue 24, Dec. 1992.
113 New Zealand Police, General Instruction Ten One 6/14, subsection P 110 at para 3 & 4.
114 NSW Police Service, *Safe Custody Manual* at p 44.
115 Adopted from ACT Regional Instruction 1/92 at p 16.

2) *the medicine in the package is indeed what the detainee says he/she should be taking, and*

3) *is administered according to the label.*

An asthmatic, where practicable, should be allowed to keep his/her inhaler as the removal of this item may cause anxiety.[116]

If a detainee is given medication, the date, time, and dosage given is to be recorded.[117]

If a detainee needs to self-inject:

- *the detainee should not to be left alone with the syringe,*
- *if there is a concern that the detainee will misuse the syringe, then a Forensic Nurse or a doctor should be called to administer the injection,*
- *a Forensic Medical Officer or the Forensic Nurse may be contacted with any questions.*

Methadone should not be administered by members. A Medical Practitioner, Pharmacist, or other authorised person must do this.[118]

Note: As for concerns or disputes arising from the taking of medication, see also procedures included in the section headed 'The Exercise of Discretion'.

Commentary

The dispensing of medication is not a police function and should only be handled by medically trained persons. The Police Association of Victoria suggest adopting a policy in relation to the issue of drugs to detainees along the lines that no Police Association member should issue, dispense, or handle prescription drugs for persons in their custody. At the present time in Victoria there is a trialing of a Forensic Nursing service whereby dosette boxes and qualified nurses are used to administer prescription drugs to persons in police custody.[119] The Victorian approach would appear to be a very sensible solution to the problems faced by police and should be considered elsewhere.

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116 NSW Police Service, *Safe Custody Manual,* at p 28. See also WA Police Lockup Manual, March 1991at F1030391

117 VIC Police Manual at p 10-13.

118 VIC Police Manual at p 10-13.

119 Based on information from a letter from Police Federation of Australia and New Zealand, 25 March, 1994.

RELEASE PROCEDURES

Policy

Release of an intoxicated person who is not otherwise detained for a serious offence, should take place as soon as the need for protection has passed.

Procedure

An intoxicated person who is not otherwise detained for a serious offence should be released when the custodial officer has determined that the person may be released into the care of a responsible person, or the detainee is not behaving disruptively, or is not likely to injure themselves or others.

When an intoxicated person, who has not committed an offence, is detained, the intoxicated person should be informed that a responsible person who is willing to take care of the detainee may secure that person's release and the detainee shall be given a reasonable opportunity to contact such a person.[120]

Commentary

In jurisdictions where drunkenness continues to be an offence, (Victoria, Queensland and Tasmania), detainees are generally released on police bail. In the other jurisdictions, power to detain such persons is strictly limited. For example, in New South Wales under the Intoxicated Persons Act of 1979 s 5 (2) (b), intoxicated persons are to be released after eight hours, after they have ceased to be intoxicated, or when a responsible person has agreed to take care of them. In other states the following times apply: South Australia, 10 hours or transfer to a sobering-up unit for an additional 8 hours, Public Intoxication Act 1984 section 7(4); Northern Territory, 6 hours, but can be extended by application to a Justice, Police Administration Act 1990 s 132 (1); Western Australia, 8 hours, can be extended by application to a Justice, Police Act 1892 s 53 I(c).

120 NSW Intoxicated Persons Act 1979.

SECURITY

Policy

Security of the watch-house is the responsibility of the custody officer.

Procedure

The custodial officer shall make sure that the detainees are safe and that no item that could aid in an escape or harm someone is left in the possession of detainees.

When entering a cell, make sure that there are sufficient members on hand to deal with an attempted escape or an assault upon members.

Do not allow detainees to make physical contact with visitors. If a detainee is given additional clothing or food, check it thoroughly before giving it to the detainee.

Do not permit detainees to take matches or dangerous materials into the cell with them.[121]

So far as is possible, there should be an attempt to provide tear-proof or near tear-proof blankets eg, the Onkaparinga brand of blanket is one such brand that is nearly tear-proof.

Commentary

The key to an effective lockup is careful supervision. The death of Karen O'Rourke was an example in which custody officers didn't make sure that persons in their custody were not in possession of harmful objects. Karen O'Rourke wasn't searched properly and carried matches with her into a detention room. She died as a result of burns to 100% of her body when she started a fire in her room. Prior to her death at the hospital, when asked if she was trying to kill herself she replied, "No, I was only trying to get out of the place."[122]

It is common practice in many watch-houses to find a "drunk tank" where a number of intoxicated persons are kept. Some such cells are very large and can accommodate scores of people. The watch-house at Alice Springs, for example, contains a very large drunk tank which, because of its design and size, does not allow police to inspect detainees from the doorway . Instead if the condition of detainees are to be checked properly, members must enter the cell. This is often done by a single police officer, and can therefore present a very dangerous situation should one or more of the detainees decide to assault the member. Smaller cells, fewer detainees, and more police officers would reduce the risk of such an

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121 VIC Police Recruit Item 44, Nov. 1993 at pp. 6-7.

122 Wyvil, L.F., *RCIADIC Report on the Inquiry into the Death of Karen O'Rourke*, at p 2.

occurrence. Ultimately, of course, it is recognised that police cells are not ideal places to detain intoxicated persons who are in need of protective custody and facilities such as sobering-up shelters with specialised staff are more appropriate.

CELL CONDITIONS

Policy

The cleanliness of police cells is the responsibility of the custody officer.

Procedure

The custody officer will ensure that blankets are cleaned and cells do not become vermin infested.

Blankets should be washed after use by each detainee in order to reduce the risk of the spread of infection or disease. Soiled mattresses should be cleaned or destroyed.

The custody officer should ensure that contract cleaners perform their tasks adequately and that the cells are clean and habitable before anyone is permitted to be detained in them.

Policy

The cell environment should contain features which help reduce stress on detainees.

Visual access to the outside environment, ie. through the use of exercise yards, windows etc., may help to reduce stress.[123]

Piped music should be permitted on the basis that this may reduce stress and anxiety on the part of detainees. [124]

Intoxicated persons should receive meals of an appropriate standard provided they are sufficiently sober to eat.

Policy

The use of padded cells should be phased out.

Procedure

Padded cells, where they exist, eg for violent persons who are self-inflicting, should be used as an absolute last resort and for as short a time as possible.

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[123] Ibid. at pp 176-177.

[124] See similar in RCIADIC vol. 3 at p 235.

If a padded cell is used, the reasons for its use should be noted, and the duration of its use, indicating the time when the person was first placed in the cell and the time when the person was removed from the cell, should also be noted.

Persons who are detained in padded cells should be regarded as high risk detainees and should be monitored continuously.

If, in the judgment of the custodial officer, the detainee is sufficiently disturbed as to warrant placement into a padded cell, it may be an indication that the person should not be detained in police custody but should be transferred for psychological or psychiatric care and assessment. In these circumstances, the custodial officer should obtain medical advice or attention for the person and/or seek to transfer the person to a more appropriate facility with as little delay as possible.

Note: If the alcohol or other drug affected person has to be transported, reference should also be made to the procedures set out in the section headed 'Transportation'.

Commentary

The Royal Commission recommended[125] that the installation and/or use of padded cells in police watch-houses for punitive purposes or for the management of those at risk should be discontinued immediately.[126]

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125 Recommendation 142 in RCIADIC vol. 3 at p 248.

126 Some jurisdictions continue to use padded cells. For example, at the time of writing there are three padded cells in each of the Adelaide and Port Adelaide watch-houses. Persons are held in these cells and are often left in darkness and monitored with infra-red equipment. At East Perth, the light is left on and the person is monitored visually as well as with cameras. The metal surround of the observation window is a place where detainees can injure themselves. In the more modern South Australian cells, there is only a small peephole and the likelihood of injuries from this is minimal. There is room for concern that police may be using padded cells for non-medical reasons and decisions for their use are made on a non medical basis by non medically qualified people. The Sydney city watch-house, which is the largest in the New South Wales, if not in Australia, does not have a padded cell and accordingly, there is some evidence that padded cells are not a necessary or desirable feature of police lock-ups.

Reference has already been made to the archaic condition of many capital city watch-houses. Smaller facilities are often not any better. For example, Reser describes appalling conditions at certain lock-ups. Testimony given at Wujal Wujal, indicated that there was no running water and no sanitation except for a bucket. At Hall's Creek in Western Australia, on a hot day, the iron roof and wall of the cells may reach temperatures of 50 degrees (Reser, at p 157). Cell conditions such as these, added to the stress of being detained and held in custody, can have adverse effects on the detainee. In cases of suicide, Reser noted that where, "a well designed police cell can substantially reduce stress and physical opportunity; it cannot wholly prevent particular behaviours." (Ibid. at p 149) Clearly, there is much more to be done in the provision of adequate facilities for police and the phasing out of the older cells.

OFFICER SAFETY (EMPHASIS ON HIV/AIDS AND INFECTIOUS DISEASES)

In recent years, occupational health and safety concerns have risen to the forefront. The employer's duty of care is even more important with the increase in the incidence of diseases such as AIDS and Hepatitis. Police Departments must ensure as much as possible that their members use safe procedures and equipment in carrying out their duties. This may include such things as the provision of personal protection kits and training in the use of those kits. Regular and up to date training must be provided by Departments in order to bring home to members the risks associated with the transmission of HIV and other infectious diseases and in the procedures to be applied in order to reduce those risks.

Policy

Police departments (in line with their duty of care) should provide any equipment required that ensures policing duties can be carried out in a safe manner.[127]

Procedure

Police departments should provide Personal Protection Kits which may include:

a) *Sodium Chloride Irrigation- to be used as an eye wash, applying to the outer lower area of the eye. Disposal: once opened discard into a bin as sterility is lost.*

b) *Sealed Plastic Bags- for the collection of contaminated articles for transport to either disposal facility or station as evidence. NOT for the collection of syringes or other sharps.*

c) *Resusci Face Shield- for protection during mouth to mouth resuscitation. Has a one way valve so that infective organisms cannot travel from recipient to resuscitation giver.*

d) *Sodium Chloride Sterile Irrigation Sachet- to be used for cleansing wounds or as extra eye wash where water is not available.*

e) *Disposable Overalls- liquid resistant overalls for the use of protection of uniform where required.*

f) *Shoe Covers- To protect shoes from being soiled. Not required to protect against HIV infection.*

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127 Tomnay, Jane, VIC Police HIV/AIDS Education Project at p 23.

g) *Disposable Dust Mist Mask- insulated with charcoal to minimise nauseous smells. NOT used to protect against harmful fumes of gases.*

h) *Disposable Rubber Gloves- used for handling contaminated articles and persons. Protective against infective organisms carried in blood and body tissue.*

i) *Disposable Towels- used for wiping hands after washing, also used with disposable gloves to wipe up body fluid spillages. Contaminated towels to be resealed inside plastic bag.*

j) *Propax Combine Pads, Propax Gauze, Smith and Nephew Standard Dressing- all used to apply to wounds to arrest bleeding or cover surface of would.*

k) *Elastocrepe and Tensofix Bandages- used to prevent swelling or to keep dressings in place.*

l) *Elastoplast Band-aids- apply as a dressing to cover small, minor wounds.*

n) *Sharps Container- for the disposal of all sharps including syringes. Dispose of at nearest public hospital when three quarters full.*[128]

Policy

Mouth to mouth resuscitation should not be withheld for the sole reason of any of the precautionary items being unavailable.[129]

Procedure

Senior members must make sure that their staff have sufficient equipment and report any deficiencies.[130]

Commentary

Equipment should be available and checked before the commencement of every shift so that incidents like the death of Anthony Cain are avoided. Cain, a known drug user died in the back of a police van while police officers searched for a mask in order to do mouth to mouth resuscitation. When a mask was finally produced ten minutes later, it was found to be defective. [131]

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128 Taken directly from the Victoria Police HIV/AIDS Education Project, 25/2/1991 to 25/3/1992.

129 NSW Police Service, *Trainers Manual, CPR and Basic First Aid for Police Officers*, July 1993, at p 46.

130 Ibid.at p 49.

131 Diaz, Tina, "Aborigine Died in Van, Inquest Told," *Sydney Morning Herald* 25 Jan, 1994.

Policy

There is increasing concern for the prevention of occupational risks associated with HIV/AIDS and other infectious diseases. In this regard the handling of any of the following matters require special attention:

- **Needle stick injuries**
- **Loss of skin integrity**
- **Blood into eyes, nose, and mouth**
- **Deceased Persons**
- **Clothing**

Procedure

For needle stick injuries:

a) *Gently massage area to encourage blood flow out of wound for approximately 20-30 seconds.*

b) *Allow wound to bleed.*

c) *Wash area immediately under cold water using soap or antiseptic wash, where available.*

d) *Cover wound with antiseptic and a clean dry band-aid.*

e) *Contact the appropriate medical facility immediately to gain next available appointment.*[132]

For Blood Contamination:

a) *Wash area immediately with cold water and soap or antiseptic wash, where available*

b) *If skin integrity is lost as in a bite, cover area with antiseptic and a clean dry band-aid or dressing*

c) *Contact the proper health authority immediately*

d) *Launder clothes that are blood contaminated in usual manner using detergents and normal machine wash. Handle all soiled clothes while gloved, at any scene.*[133]

For blood spillage or contaminated surfaces:

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[132] Commonwealth Health Department, June 1990 as found in Victoria Police HIV/AIDS Education Project.
[133] Ibid.

a) *For general disinfection of blood or body fluid soiled surfaces use liquid household bleach in the ratio of 1ml. to every 100 mls. of water.*

b) *When area cannot be adequately disinfected as above, for example porous surfaces, a dilution of household bleach 1ml. to every 10 mls. of water should be used. This solution should be left to sit in contact with the surface for ten minutes. Any bleach used must contain chlorine.*[134]

Policy

When a needle stick; splash of blood or body fluid to the eyes, nose, or mouth; human bite with broken skin; or other potentially infectious disease exposure occurs, members shall immediately contact their supervisor. The supervisor shall ensure that the member goes to an appropriate medical centre for treatment and evaluation and counselling.[135]

Procedure

Depending on the circumstances the following procedure should be adopted:

(1) *Where a member has been splashed or smeared with body fluids on any unbroken skin, wash and disinfect that area as soon as possible. NO OTHER TREATMENT IS NECESSARY*

(2) *When a member receives an injury,(eg. a minor skin abrasion with exposure to the suspect's blood or secretions), that does not necessitate treatment by a medical officer. The member will:*

- *clean and disinfect the injury*
- *cover the injury (ie. band aid)*
- *NO OTHER TREATMENT IS NECESSARY. However, due to the very nature of the incident, the police medical officer may be contacted as soon as practical to reassure the member concerned.*

(3) *Where a member has received an open wound that requires immediate treatment by a medical officer, and as a result, a possible blood to blood stream exposure occurs with a suspected carrier, the member will:*

- *clean and disinfect the wound as soon as possible*
- *cover the wound*
- *attend at the nearest government hospital or medical treatment centre in the member's specific area.*[136]

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134 Ibid..

135 From the San Francisco Police Department's General Order NO. D-19, p. 1.

136 South Australia P.C.O. Circular No. 465 Addendum B *AIDS* at p 6.

If there is an incident where there is a reasonable risk of contracting a communicable disease:

a) a history of the event will be recorded

b) the degree of risk will be assessed by the appropriate medical personnel and discussed with the member

c) a blood sample may be taken with the consent of the member for a baseline reading. This will indicate the member's HIV status PRIOR to the incident. This may assist with Workcare claims

d) If the offender is known, he/she may be asked to consent to a blood test

e) Counselling for the member and family regarding exposure can be done at this first appointment

f) Follow-up blood test three months later after the window period, to assess if infection has actually occurred

g) Welfare, Social Work, Psychology Office and the Police Chaplain are available for further counselling and support of the affected member, partner, family and friends.

h) The role of supervisors is to encourage and ensure safe working practices are carried out by all member under his/her supervision.[137]

Results of an HIV test for a member shall remain confidential.

Commentary

The severely intoxicated person is often found to belong to the category of substance abusers who, because of their lifestyles, often belong to the high risk category. Despite this, it should be recognised that it is impossible to identify all persons who may be infected with a contagious disease, and in the case of HIV it is necessary to wait for three months for test results showing that the person is free of the disease.

The provision and maintenance of a healthy and safe working environment is an important goal for police as it is for other occupations. Clearly much of police work takes place in the field (ie. often in hostile or dangerous environments where risk of injury to themselves and to others may be quite high). It is not always possible to render such environments safe and the degree to which they present a danger will often depend on the actions taken by police themselves. In many cases, problems can be defused or avoided by the adoption of sensible procedures (eg. ignoring annoying provocation, calling for back-up rather than risking serious injury, waiting for the right moment to act, avoiding steps which may be calculated

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137 Adopted from the Victoria Police HIV/AIDS Education Project 25/02/1991 to 25/03/1992.

to lead to an escalation of violence, not pursuing vehicles at high speed through populated areas).

In aiming to provide a safe environment, the Department, the unions, and staff should consult with a view to identifying risks in the workplace and how these can be minimised. Sometimes the answers will lie in the provision of material resources, at other times it may require a review of procedures. Adequate and appropriate resources should be provided to ensure that necessary occupational health and safety programs and activities are established and maintained.

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