REPORT OF A REVIEW OF A CRITICAL INCIDENT

by the

ACT INSPECTOR OF CORRECTIONAL SERVICES

Use of force to conduct a strip search at the Alexander Maconochie Centre on 11 January 2021

(CIR 01/21)

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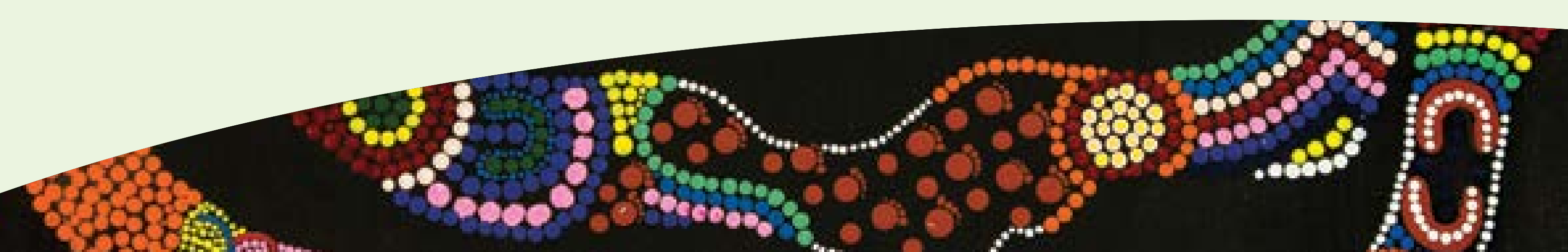

Rainbow Serpent (above and cover detail)
Marrilyn Kelly-Parkinson of the Yuin Tribe (2018)

'There are no bystanders – the standard you walk past is the standard you accept'

— Lieutenant General David Morrison, AO
Chief of Army (2014)

ABOUT THIS REPORT

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We acknowledge the traditional custodians of the ACT, the Ngunnawal people. We acknowledge and respect their continuing culture and the contribution they make to the life of this city and this region.

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(CIR 01/21)

Neil McAllister
ACT Inspector of Correctional Services
31 August 2021

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Note: Aboriginal and/or Torres Strait Islander readers are warned that this report refers to an Aboriginal and/or Torres Strait Islander person who has passed away.

GLOSSARY

Term	Meaning
ACTCS	ACT Corrective Services
AMC	Alexander Maconochie Centre (ACT adult prison)
CM Act	*Corrections Management Act 2007* (ACT)
CO	Corrections Officer ("prison officer")
CSU	Crisis Support Unit at AMC
FMH	Forensic Mental Health
HR Act	*Human Rights Act 2004* (ACT)
HRC	ACT Human Rights Commission
ICS Act	*Inspector of Correctional Services Act 2017* (ACT)
ILO	Indigenous Liaison Officer (AMC)
Inspector	ACT Inspector of Correctional Services
ISU	Indigenous Services Unit AMC
JH	Justice Health
OiC	Officer in Charge (as described in the *Use of Force and Restraint Policy*)
OICS	Office of the Inspector of Correctional Services
SCC	Special Care Centre (Women's accommodation unit at AMC)
TPPE	Tactical Personal Protective Equipment
Winnunga	Winnunga Nimmityjah Aboriginal Health Service

1. EXECUTIVE SUMMARY

On 26 January 2021 various media outlets published allegations made by a female Indigenous detainee on remand at the Alexander Maconochie Centre (AMC) (Detainee A)[1] that she was strip searched in view of a number of male detainees and staff in the Crisis Support Unit (CSU). The allegations were contained in a letter that had been provided to the media and the Minister for Corrections (the letter is reproduced at **Appendix A**). The Minister for Corrections declared the strip search to be a 'critical incident' under the *Inspector of Correctional Services Act 2017* (ACT) (ICS Act), and the Inspector decided to conduct a review of the critical incident.

This review concludes that the strip search did not occur in front of male staff or detainees but in a bathroom in front of two female Corrections Officers (COs). However, immediately preceding the strip search Detainee A was subjected to a planned use of force involving four COs in full Tactical Personal Protective Equipment[2] (TPPE) that was conducted with the intent of forcibly strip searching her. There was a prolonged struggle as COs attempted to restrain her, but ultimately, she yelled out that she would comply with the strip search and so was handcuffed and taken to a bathroom where the strip search was conducted in private by two female COs.

There is no doubt that the use of force would have been a highly traumatic incident for Detainee A, particularly given her recent history of sexual assault, her ongoing mental health condition, and the feelings of loss and grief experienced from the sudden death of her Grandmother. The latter was also intensified by her inability to participate in her Grandmother's funeral to show her deepest respects, fulfil her cultural responsibility and obligation, and to collectively attend to Sorry Business with her family and community. Furthermore, Detainee A had medical conditions relating to her heart and lung which were known to the COs, and it is highly likely that any risks to Detainee A's health posed by using force and restraining her were significantly increased due to these conditions. We note that the decision to conduct a forced strip search was not an approach that all staff were entirely comfortable with. This incident has been stressful for some staff involved.

Whilst the decision to use force to carry out the strip search was lawful under the *Corrections Management Act 2007* (ACT) (CM Act) in that staff had a reasonable suspicion Detainee A was concealing a 'seizable item' that could be used to harm herself or others, this report concludes that the decision to conduct a forced strip search did not comply with the *Human Rights Act 2004* (ACT) (HR Act). The HR Act requires human rights to be considered in all decision making by a public authority. However, ACT Corrective Services policies and procedures do not explicitly require staff to consider the impact of a forced strip search on the human rights of the detainee. The practice of a person being held down by officers in TPPE to have clothes removed or cut off is highly degrading and traumatising. Where there is time to plan a use of force to carry out a strip search, it is inexcusable that senior operational staff are not directed by policy and procedure and appropriately trained to consider the human rights impact of the practice when deciding whether or not to proceed. A human rights consistent approach would require considerations such as detainee's additional vulnerabilities and relevant medical conditions be considered when deciding whether to proceed with a forced strip search.

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1 Whilst the identity of Detainee A has been reported in the media, it has been OICS' practice not to name staff, detainees or other people mentioned in reports.

2 Tactical PPE includes helmets, vests, gloves, arm and knee pads.

In this case, staff were well aware of some of Detainee A's vulnerabilities. The decision to proceed with the use of force placed her poorer health at greater risk. Notwithstanding these conclusions, there is no suggestion that individual COs were wilfully negligent in the performance of their duties.

This report recommends that mandatory strip searching of detainees coming into the CSU immediately end to reduce the prevalence of this often degrading and traumatising practice. We note that ACTCS has been considering body scanning technology for some time and we recommend that ACTCS expedite the acquisition of body scanning technology that would obviate the need for strip searches in most cases. Body scanning technology has obvious benefits for detainees, and for staff, as it reduces the need for staff to be involved in a practice that they do not find pleasant.

Recommendation 1:	That ACT Corrective Services remove from policy, procedure and written direction any requirement for mandatory strip searches on entry into the Crisis Support Unit.

Recommendation 2:	That ACT Corrective Services expedite the procurement of body scanner technology to provide options for less restrictive ways than strip searching to search detainees on entry to the Crisis Support Unit.

We recognise that it may still be necessary to strip search detainees entering the CSU when there is a reasonable suspicion that a detainee has concealed a seizable item that could be used to cause harm to themselves or others. Even with scanning technology, if a scanner indicates a seizable item is concealed a strip search may still be necessary. However, if a detainee does not agree to a strip search, then it is imperative for human rights to be considered prior to proceeding with a planned use of force to carry out that strip search. To this end, the report recommends that human rights are explicitly considered before conducting planned forced strip searches. This means considering the impact the highly intrusive procedure would have on a detainee in light of any known medical conditions, history of trauma including sexual assault, mental health condition/s, and cognitive or other relevant disability.

Recommendation 3:	That ACT Corrective Services ensure that human rights are explicitly considered prior to conducting a planned use of force to carry out a strip search, and the reasons for a decision are documented. To support this, ACT Corrective Services should develop a practical decision making tool for operational staff, and incorporate it into relevant procedures.

Recommendation 4:	That ACT Corrective Services ensure that Operational Managers and Corrections Officers, level 3 and above have appropriate capability in considering human rights in decision making. Capacity building of staff should draw on expert input on human rights and decision making.

Finally, the report identifies a number of areas of sub-optimal operational practice that took place in relation to this incident and recommends a number of improvements.

Recommendation 5:	That ACT Corrective Services amend the *Corrections Management (Use of Force and Restraint) Policy* to require that non-essential staff leave the scene prior to a planned use of force.
Recommendation 6:	That all ACTCS Tactical Personal Protection Equipment helmets display a clearly visible number and that the number on a helmet be recorded when issued to a Corrections Officer.
Recommendation 7:	That the *Corrections Management (Duty Manager) Operating Procedure* be amended to require the Duty Manager to maintain a log of all conversations involving notifications to the Duty Manager and any advice or directions given by the Duty Manager.
Recommendation 8:	That staff are trained in the correct use of handheld video cameras to comply with relevant policy and procedure, for example, through recruit, refresher, or scenario training.
Recommendation 9:	That ACT Corrective Services develop terms of reference to guide the process of reviewing uses of force, that includes a requirement for reflective practice about whether the use of force complied with policy and procedure.

2. INTRODUCTION

On 11 January 2021 in a cell at the Crisis Support Unit (CSU) of the Alexander Maconochie Centre (AMC), a female Indigenous detainee (Detainee A) was subjected to a use of force by Corrections Officers (COs) who were attempting to strip search her. After a physical struggle lasting several minutes, Detainee A agreed to accompany COs to a bathroom in the unit where the closed-door strip search took place in front of two female COs.

Detainee A made a complaint about aspects of this incident to the ACT Human Rights Commission. The detainee also wrote an open letter outlining the incident (letter reproduced at **Appendix 1**). Extracts from this letter and some details of the incident were widely reported in the media. This letter was also received by the Minister for Corrections.

On 8 February 2021 the Minister for Corrections declared the strip search to be a 'critical incident' under the *Inspector of Correctional Services Act 2017* (ICS Act). Although the letter contains a number of other allegations, for example, about systemic racism, the scope of the 'critical incident' as declared by the Minister does not cover those matters and they are therefore not considered in this report.

2.1 Authority to conduct a review of a critical incident

Legal basis for conducting a review

The Inspector 'may review a critical incident on the inspector's own initiative or as requested by a relevant Minister or relevant director-general.'[3] The ICS Act specifies events that are critical incidents, and also provides that a relevant Minister or Director-General may identify any incident as a critical incident. As noted above, the Minister for Corrections wrote to the Inspector to declare 'the strip search of [Detainee A] in the Crisis Support Unit of the AMC' to be a critical incident. This was the first time since the establishment of the Office of the Inspector of Correctional Services (OICS) that a Minister or Director-General had declared an incident to be a critical incident. It was not an event that fit the other categories of 'critical incident' under the ICS Act and could not have been reviewed by the Inspector had the Minister not made the declaration.

Even so, the Inspector has discretion to review or not review a critical incident.[4] The Inspector decided in this case to review the incident given the seriousness of the allegations; the significant public interest in the matter, including either confirming or correcting allegations against ACTCS that are on the public record; and the potential that a review may identify areas for lessons learned or continual improvement to prevent future incidents. Given that the use of force was employed in this incident with the intention of carrying out the strip search, the Inspector's critical incident review covers the use of force prior to the strip search as well.

What must the Inspector report on?

Section 27 of the ICS Act requires that the Inspector include certain things in a report of an examination and review. This includes, for example, 'whether the rights under international and territory law of detainees at a correctional centre subject to review are protected' and 'whether law, policy and procedures applying to the correctional centre or service subject to review reflect best practice standards'.

3 *Inspector of Correctional Services Act 2017* (ACT)(ICS Act), s 18(1)(c).

4 ICS Act, s 18(1)(c).

In a previous report the Inspector noted that section 27 was directed towards the content of examinations and reviews of correctional centres and correctional services but was ambiguous about the content of reviews of critical incidents.[5] This report, like the previous critical incident reports has been structured to capture the spirit and intent of section 27 but without specific reference to some of the topics.

Public interest considerations

Section 28(1) of the Act provides that 'the inspector must consider whether any part of the report must be kept confidential because there are public interest considerations against disclosure, and those considerations outweigh the public interest in favour of disclosure.' Section 28(2) details grounds of public interest against disclosure and includes at part (d) 'identifying or allowing the identification of any person detained, working or otherwise at a correctional centre'. It is noted that this incident has received extensive media coverage which means that there may be more awareness about the identities of those involved than is usually the case with OICS' reports. Notwithstanding, in accordance with section 28(2)(d), certain information that might reveal the identities of detainees and staff involved in the incident has been withheld in this report.

Cooperation with ACT Human Rights Commission

At the time the OICS were conducting this review, the ACT Human Rights Commission was actively considering complaints relating to this issue in its discrimination and health services jurisdiction. The OICS and the ACT Human Rights Commission shared information relating to this matter as is permitted under section 35 of the ICS Act, to avoid unnecessary duplication of statutory functions. To avoid duplication, OICS did not consider the interface between ACTCS and Justice Health / Winnunga in relation to detainees with medical conditions who are subjected to planned uses of force.[6]

2.2 Methodology for the review

Evidence for this review was gathered through viewing CCTV and handheld camera footage, a site visit to the AMC, information requests made to ACTCS, and interviews with ACTCS staff.

OICS received an independent expert opinion on cultural and health considerations from Dr Elizabeth McEntyre who is a Worimi and Wonnarua First Nations Woman, and a Mental Health Social Worker in disability and criminal justice and is grateful for her input.[7] We also gratefully acknowledge the expert opinion provided on operational aspects of the use of force by Mr Mark Wilson PSM, General Manager, Governance and Continuous Improvement, Corrective Services NSW.

OICS offered Detainee A the opportunity to meet with the review team on a number of occasions but she did not take up the offers.

5 ACT Inspector of Correctional Services (2018), *Report of a review of an assault of a detainee at the Alexander Maconochie Centre on 23 May 2018*, OICS, Canberra, 6.

6 ICS Act, s 33(1)(b).

7 ICS Act, s 18(2) provides: '…the Inspector must, if appropriate and practicable, consult with people, or use staff, suitable to the cultural background or vulnerability of any detainee involved in a matter being examined or reviewed.'

3. FACTUAL BACKGROUND

3.1 Detainee A: Custodial history and current situation

Detainee A is an Indigenous woman in her late thirties. Detainee A was on remand at the time of this incident but was subsequently granted bail. Detainee A has been in the AMC numerous times and is well known to many AMC staff.

Detainee A has significant medical conditions, including a heart condition requiring a pacemaker. At the time of the incident, Detainee A also had a lung condition and was on anticoagulant medication which predisposed her to the risk of bleeding. Detainee A had also recently been a victim of sexual assault in the community.

3.2 Preceding events

3.2.1 Request to attend a funeral

On Wednesday 6 January 2021, an Indigenous Liaison Officer (ILO) attended the Special Care Centre (SCC) at the AMC where Detainee A was accommodated to inform her about the passing of her Grandmother. The ILO told Detainee A that she had some bad news to tell her. Detainee A became distressed and stated that someone had died, and that she did not want to know who. The ILO wrote the name of the family member who had passed on a piece of paper and left it with the COs in that unit, and later that day Detainee A agreed to look at the paper. Case notes from COs state Detainee A was provided with peer support at that time, and Forensic Mental Health (FMH) also visited her that day.

On Thursday 7 January 2021, the ILO attended the SCC and assisted Detainee A to fill out a leave application to attend her Grandmother's funeral but as the funeral details had not yet been confirmed, the application was left with the COs at SCC. The following day the ILO was on approved leave but did check emails during the day. The ILO received an email from a CO in SCC asking for confirmation of Detainee A's Grandmother's passing, and to confirm that the funeral was at 2pm the following Tuesday. The ILO was unaware of the funeral details, and as the ILO was not on duty, did not respond. There were no ILOs onsite at the AMC on Friday 8 January and ILOs do not work on weekends.

Late on the morning of Monday 11 January 2021 a different ILO visited Detainee A to seek further information and follow up on the leave request.

Consideration of the request on 11 January was described by ACTCS as follows:

> The Detainee Request Form, funeral notice and prisoner leave application [was] provided to the Deputy Commissioner Custodial Operations (DCCO). The Operations Area Manager and DCCO discussed the staffing struggles, that the rosters were significantly short and that areas of the [AMC] had recently been locked-in due to the inability to fill posts with overtime.
>
> The DCCO contacted the Commissioner, [ACTCS] to discuss the situation. It was noted that the applicant was Indigenous and ACTCS' desire to support attendance at funerals where possible. It was discussed that details and confirmation of the funeral had only been received that day and the only possible way to support the escort would be to lockdown portions of the detainee population in order to ensure that staff would be removed from a post and reassigned to the escort.
>
> It was agreed that the escort could not be accomplished due to the short notice and current staffing obligations.

By mid-afternoon on the Monday 11 January the Indigenous Services Unit (ISU) was advised that the escort had been declined 'on the basis of logistical issues associated with the short notice of the application with full funeral details including the date and time'.[8] An ILO visited Detainee A at about 4:20pm and informed her that she was not approved to attend her Grandmother's funeral and the reason for that decision.

3.2.2 Movement of Detainee A to CSU

A case note made by a CO describes Detainee A's response to being informed she could not attend the funeral:

> At this time detainee [A] immediately became agitated and threatening [sic] to self-harm. Detainee was asked to move back to her cell in which she complied. I spoke to this detainee at length following this and during this time this detainee continually stated she was going to self-harm by "ripping out her pacemaker".
>
> Detainee stated that once officers left her, she would "do it".
>
> I placed this detainee "At-Risk" and commenced constant observations and the At-Risk procedure.
>
> FMH [Forensic Mental Health] attended and deemed it necessary that [Detainee A] be placed in CSU.

Detainee A initially refused to be moved to the CSU. Staff thought that a use of force might be necessary to move Detainee A to CSU. At that time, the Operations CO3 contacted a doctor at Hume Health Centre[9] to discuss Detainee A's medical conditions, as per section 14.2 of the *Corrections Management (Use of Force and Restraint) Policy 2020*. This section states:

> 'Staff will take steps, as far as practicable, to verify whether a detainee has a medical condition that places them at greater risk of a medical emergency prior to a planned use of force.'

The CO3's recollection of the conversation was of advising the doctor 'that there may be a use of force in order to relocate the detainee' and the doctor 'agreed that a use of force would be appropriate to maintain safety and security'.[10]

The doctor's recollection of this conversation was that the CO3 asked if there were any medical reasons why Detainee A could not be transferred from SCC to CSU, to which the doctor responded that there was no medical reason to prevent her being transferred.

Ultimately, Detainee A willingly moved to CSU and so a use of force was not required for this move. However, on arrival at CSU, Detainee A refused to undergo a strip search. A number of staff OICS spoke to expressed the view that policy required mandatory strip searches on arrival to CSU because it is a 'sterile area'.[11] OICS review of data indicates that in practice, mandatory strip searching is not occurring (see Table 1 on page 17). Two COs who had a good rapport with Detainee A attempted to get her to willingly comply with the strip search.

8 The funeral was to be held at a location in NSW about four hours' drive from Canberra.

9 Health centre at the AMC, run by Justice Health.

10 Incident Report Form A2.F1 completed by the CO3 who was the Officer-in-Charge of the subsequent use of force.

11 An area devoid of things that a detainee night use to harm themselves or staff e.g. glass, pens, pencils, razors.

3.3 The use of force and strip search

3.3.1 Decision making and preparation

The Operations CO3 was the most senior officer in the AMC at the time Detainee A was moved to the CSU. This CO3 assumed the role of Officer-in-Charge (OiC) for the purposes of a planned use of force, under the *Use of Force and Restraint Policy*. When Detainee A refused to comply with a strip search, the CSU staff called the OiC who attended. The OiC spoke briefly to Detainee A but withdrew due to the hostile response received. The OiC did not want to escalate the situation further and left it to the COs already engaging with Detainee A to continue to do so.

Information provided by the OiC, both through the incident reports completed after the event and in an interview with the review team, noted that:

- Detainee A had threatened to remove her pacemaker, and the OiC had been previously advised by the Justice Health doctor the only way that would be possible is if she cut it out;
- a CO [who had been responsible for constant observation of Detainee A immediately prior to the move to CSU] had advised the OiC that he saw Detainee A with 'her hands in her crutch [sic] area' and that CO was 'of the belief she may have been attempting to secrete a razor or something to harm herself with';
- the OiC understood the *Corrections Management (Management of At-Risk Detainees) Policy 2019* to require that detainees are strip searched on admission to CSU because it was a 'sterile area';[12]
- the OiC had asked two COs to continue to try to convince Detainee A to comply with the strip search but after repeated attempts the OiC decided that further attempts to convince Detainee A to voluntarily participate in a strip search would not be successful;
- it was early evening when Detainee A had been transferred to the CSU. It was soon to be night shift with skeleton staff and in the OiC's view, the CSU night shift staff would have very limited capacity to respond to an incident if one occurred that evening; and
- it was a potential risk both to Detainee A and CSU night shift staff if Detainee A did have a razor.

The OiC noted that in her view even if an extra staff member was called in and was standing at the cell door doing constant observations, this did not sufficiently negate the risk to the safety of Detainee A or to responding staff if Detainee A did have a blade concealed and used it. We note that the OiC did not make inquiries into staffing availability.

The OiC stated that the most appropriate course of action in her view was to proceed with a planned use of force to carry out the strip search on Detainee A. The OiC was confident this approach was 'covered by [i.e., consistent with] policy'. The OiC did not contact an on-call doctor at this time to verify whether Detainee A had a medical condition that placed her at greater risk of a medical emergency from a planned forced strip search, as per section 14.2 of the *Use of Force and Restraint Policy*. Although an on-call doctor had been contacted by the OiC prior to moving Detainee A from SCC to CSU when it appeared as though a planned use of force may be necessary for that purpose, in OICS view this should have been done as a forced strip search was a separate incident that may pose different risks to Detainee A.

12 Note: data from ACTCS reveals that this is not the case in practice that all detainees are strip searched on admission to the CSU, as discussed later.

The OiC then contacted the on-call Duty Manager. The *Use of Force and Restraint Policy* requires that the OiC inform the Duty Manager prior to commencing a planned use of force. The Duty Manager can override the OiC's decision. The OiC explained to the Duty Manager over the phone the situation and the preferred course of action to conduct a use of force to carry out a strip search. The Duty Manager told the review team that the Duty Manager asked the OiC whether there was provision for the search to be left until the next day. The OiC's response was that there was not. The Duty Manager agreed with the OiC's decision to use force. The Duty Manager did not make any notes of the call, and there is currently no requirement that the Duty Manager keep a logbook or diary.

The OiC then assembled a team of four female COs who attended the security building. The team were briefed, including a short walk through of the procedure for conducting the strip search. The team donned TPPE. All the officer reports lack detail about specific issues covered in this briefing. A number of the reports note that they were briefed on formations and positions for when they entered the cell and 'on Detainee [A's] current medical conditions.' The reports do not state what these medical conditions were and what impact that would have on their technique. This briefing was not recorded on the handheld camera, contrary to the *Use of Force and Restraint Policy*.

The team then attended CSU to commence the use of force.

3.3.2 How the incident occurred

The chronology in **Appendix 2** outlines an approximate timeframe for the use of force based on the cell CCTV footage and the handheld camera.

The *initial* purpose of the use of force was that the use of force team restrain Detainee A and remove or cut her clothes off.

At the point the handheld camera footage commences, Detainee A is lying on the cell bed in a passive position with her back to the door. The OiC made the necessary warning announcements required by policy and then the three COs in TPPE enter her cell with the OiC as Team Leader (also in TPPE) entering the cell later. There is a protracted struggle of some minutes where the COs attempt to gain control of Detainee A.

During the use of force there is shouting from the OiC and Detainee A, and other detainees in CSU start calling out. From the handheld camera footage, it sounds as if other detainees are becoming more heightened. It is difficult to discern what is being said but at one point a comment sounds like "Just do it [Detainee A]". Although no other detainees in the CSU at the time were able to view the use of force, it is likely that some understood what was happening.

At various times throughout Detainee A shouts that she cannot breathe and has chest pains. A 'Code Pink (Medical Emergency)' is called, and nursing staff attend. At one point Detainee A bites a CO on their forearm. Then Detainee A starts shouting that she will comply with the strip search if a specific CO does it. At this point, the objective of the use of force changes from conducting a strip search to restraining Detainee A so she can be escorted to the bathroom for the strip search.

During the use of force there are up to 12 staff in the immediate vicinity, some at times enter the cell, and others stay by the door or in the corridor outside the cell. At least two of these staff are male. The use of force could also potentially be viewed live on CCTV by staff at the CSU duty point, in the Operations building and in the Master Control Room.

Finding 1:

That Detainee A was subject to a planned use of force that had the initial objective of forcibly removing her clothing for the purposes of conducting a strip search.

Finding 2:

That Detainee A was calm and in a safe location at the time the use of force commenced and constant observations would have been an appropriate alternative to a forced strip search.

Finding 3:

That while Detainee A was subject to a use of force to remove her clothes there were at times up to 12 staff in the immediate vicinity including at least two male staff.

Finding 4:

That other male detainees in the CSU could not view the use of force or strip search but it is likely that it was clear to some of them what was going on because they could hear the incident and some engaged verbally in the incident from their own cells.

Finding 5:

That Detainee A was strip searched by two female officers out of sight of other staff and detainees.

Finding 6:

That Justice Health staff were not present at the commencement of the use of force or for the strip search.

3.4 Post incident

Immediately after the strip search, Detainee A was taken to the Hume Health Centre for assessment, and then sent to The Canberra Hospital for further review. She returned to the AMC at around 1am the next day.

Meanwhile, the OiC provided support and assistance to the CO1 who had been bitten by Detainee A during the incident. This bite caused significant swelling and subsequent bruising but no broken skin, or bone or tissue damage. At 7pm, a hot debrief was conducted. This was chaired by the OiC and attended by the three CO1s involved in the use of force, the CO1 who operated the handheld camera, and the CO2 Security that had been present at the briefing and incident. The CO2 CSU was not present as she was on the hospital escort with Detainee A.

The hot debrief identified three issues of immediate concern:[13]

1. 'non-involved staff interfering in operation'
2. 'staff not being able to hear instructions due to other staff input', and
3. 'staff could not get traction on CSU floor to maintain control of detainee'.

The hot debrief report also lists for consideration in a formal debrief:

> …staff again identified that they had doubts about applying extra force during the incident for the concern that they would be questioned about excessive force particularly because the detainee claimed to be suffering a medical episode. Staff believe that had they have [sic] been more confident they would have had more control of the detainee in a more timely manner.

At this debrief, welfare checks were conducted on staff involved, and the peer support officers subsequently followed up with staff. Later when the incident was being reported in the media, the (then) Commissioner ACTCS also personally telephoned the staff involved.

There was no formal debrief held in this matter. However, the use of force was considered by the Use of Force Review Committee (discussed below at 4.2.2: Opportunities for internal review).

Detainee A's actions of biting the CO1 were referred to ACT Policing, but OICS understands that no charges have been laid. On 12 January, an ILO visited Detainee A and advised her of the supports available, including engagement with an Elder, access to the funeral service program for her Grandmother, access to art supplies and access to chaplaincy. An ILO continued to visit Detainee A regularly to offer support. On 20 January 2021, a video of the funeral service was uploaded to Detainee A's PrisonPC for her to view.

13 As identified in the hot debrief report.

4. ISSUES ARISING FROM THE INCIDENT

4.1 Legal basis for the actions, and human rights considerations

In summary, the review finds that one of the grounds cited by the OiC for conducting the search (that there was a reasonable suspicion of concealing a seizable item) was a lawful ground for a strip search under the CM Act. One ground was a sufficient basis to proceed under the CM Act but we note that the second ground cited by the OiC to the review team (strip searching is mandatory on entry to CSU), which is reflected in policy, was not a lawful ground. We find that when it came to making a decision to use force to conduct a strip search, there was a significant failure in policy and practice to consider Detainee A's human rights. We find that although the decision and action to use force to carry out a strip search was consistent with the CM Act, it was not compatible with the *Human Rights Act 2004* (ACT) (HR Act).

There are two legal grounds for conducting a strip search under the CM Act. These are:

1. If a CO suspects on reasonable grounds that the detainee has a seizable item concealed they may conduct a strip search (s 113B).
2. Where the detainee has been outside the immediate supervision or control of a CO (described in the legislation as 'where prudent') (s 113C). Under this section, ACTCS can make policies for situations where detainees will be strip searched, such as after returning from an external escort.

The OiC was the officer who made the decision to conduct a planned use of force to carry out a strip search. In the written reports and in interview with OICS, the OiC referred to both the 'reasonable suspicion' that Detainee A had something concealed in her pants, and that strip searches were mandatory on entry to CSU because it is a 'sterile zone' (the relevant policy being the *Corrections Management (Management of At-Risk Detainees) Policy 2019*). We will first consider the 'reasonable suspicion' ground for justifying the strip search, before examining the legality of mandatory strip searches on entry to CSU. Finally, we will discuss the relevance of the HR Act in the decision to *use force* to carry out a strip search.

4.1.1 Reasonable suspicion

Under section 113B of the CM Act, a strip search may be conducted if a CO 'suspects on reasonable grounds that the detainee has a seizeable item concealed on the detainee.' The post incident documentation prepared by the OiC noted that a CO advised the OiC that he had observed Detainee A with her hands in her pants and was of the belief Detainee A may have been attempting to secrete something to harm herself.

It appears that no one asked Detainee A if she had put something down her pants and if so, what it was. Communicating with Detainee A may have been a good course to take. Detainee A had her period at the time and so the explanation from Detainee A may have been that she was placing a pad or toilet paper in her pants. However, this response still may not have negated the reasonable suspicion held by the CO because a detainee intent on harming themselves may not voluntarily give up an instrument they have concealed and may give an alternate explanation, if questioned.

Therefore, OICS is of the opinion that there were sufficient grounds for a reasonable suspicion that Detainee A had a seizable item. This means that there was a lawful basis under section 113B of the CM Act for Detainee A to be strip searched.

However, there is discretion whether to conduct the strip search under this section and so the decision to use force to conduct the strip search and human rights considerations also need to be examined. This is discussed below [4.1.3].

OICS notes, as an aside, that if a detainee has concealed an item within their body, a strip search is unlikely to be effective in discovering the item. The risk mitigation potential of strip searches is therefore limited to occasions where detainees have items concealed in their clothes and underwear.

Finding 7:

That the decision to strip search Detainee A had a lawful basis under section 113B of the *Corrections Management Act 2007.*

4.1.2 Mandatory strip searching on admission to CSU

The legal basis for mandatory strip searching

The *Management of At-Risk Detainees policy* states 'all detainees will be searched on arrival to the CSU in accordance with the ***Searching Strategy***.' The Searching Strategy is not notified on the ACT Legislation Register, and the *Corrections Management (Searching) Policy 2020* does not state what searching is to be conducted on entry to CSU. However, a draft Searching Strategy from January 2021 that OICS has examined states that all detainees will be strip searched on arrival to CSU. The OiC stated that even though there were grounds for strip searching Detainee A based on a reasonable suspicion she was concealing a seizable item, that in the alternative, the OiC was covered by policy to strip search her on entry to the CSU as it was a 'sterile area'. We have therefore considered the legality of mandatory strip searching on entry to CSU.

Section 113C of the CM Act provides that a strip search may be conducted on a detainee where it is prudent. There are four criteria that must all be satisfied to be able to use this power:

1. the detainee has recently not been under the control or immediate supervision of a corrections officer for a period; and
2. during the period, may have had an opportunity to obtain a seizable item; and
3. a scanning search is either unavailable or if available is unlikely to detect more than a limited range of items or would have to be carried out using force that would make it ineffectual; and
4. a frisk or ordinary search must be unlikely to detect more than a limited range of seizable items.[14]

OICS is of the opinion that detainees who enter the CSU from other areas of the AMC have recently been 'under the control … of a corrections officer'.[15] Therefore, in OICS' opinion, as this criterion is not satisfied section 113C cannot be used as a lawful basis for routine strip searching at entry to CSU.

Human rights and mandatory strip searching on entry to the CSU

The practice of mandatory strip searching is also inconsistent with the HR Act. Strip searching engages and limits the right to humane treatment when deprived of liberty (s 19), protection from cruel, inhuman or degrading treatment (s 10), and the right to privacy (s 12). These rights can be limited but only where they are 'reasonable limits *set by laws* that can be demonstrably justified in a free and democratic society' (emphasis added) (s 28). Routine strip searching at entry to CSU is not provided for in the CM Act (or any other law).

14 *Corrections Management Act 2007* (ACT), s 113C(1)(a)-(c).

15 The examples of where section 113C would apply provided in the Explanatory Statement are where a detainee has returned from outside the AMC (for example, returning from the court cells), or has had an unsupervised contact visit. They are not where a detainee has remained in the AMC without unsupervised contact with external visitors. Explanatory Statement to the *Corrections Management Amendment Bill 2008*, 6.

An argument for strip searching on entry to CSU is to remove items with which detainees could harm themselves, which engages the right to life (s 9). We note that of the 44 strip searches conducted on admission to CSU in 2020, only two resulted in the discovery of seizable items.[16] OICS notes (but does not endorse) the argument that strip searches deter detainees from concealing seizable items and the possible perception that not being able to lawfully conduct a mandatory strip search on entry to CSU places detainees at risk of self-harm. However, it is important to consider that the practice of strip searching may cause further mental harm, particularly if done regularly. Research on the harm caused by strip searching is summarised in **Appendix 3**. In OICS view, mandatory strip searching on entry to the CSU is not a reasonable limitation on rights because there is not a clear rational connection between searching and detainees being safer, and there are less restrictive means to keep detainees safe.

Although required by current policy, mandatory strip searching of at-risk detainees on admission to the Crisis Support Unit is not occurring in practice

Despite the policy framework requiring mandatory strip searching on admission to CSU, and some officers telling OICS that it was required, ACTCS data indicates it is not occurring in practice.

OICS obtained data from ACTCS on the number of detainees admitted to CSU and the number of that were strip searched on admission. Data indicate that fewer than one in thirteen detainees admitted to CSU in 2020 were strip searched on admission.

About one third of detainees admitted to CSU in 2020 were marked 'at risk', which means that the *Management of At-Risk Detainees* policy should be applicable to them. Of this group, approximately one in seven were strip searched on admission.

Table 1: Strip searching in the Crisis Support Unit in 2020 [17]

	Admissions to CSU	Number of strip searches conducted on admission to CSU[17]	Percent
Total	**595**	**44**	**7.4 % of all detainees admitted to CSU are strip searched**
Total male admissions	498	32	6.4 % of males admitted to CSU are strip searched
Total female admissions	97	12	12.4 % of females admitted to CSU are strip searched
Total Indigenous admissions	226	15	6.6 % of Aboriginal and Torres Strait Islander detainees admitted to CSU are strip searched
Total at-risk admissions	216	31	14.5 % of detainees classified as at-risk admitted to CSU are strip searched

Source: ACTCS 2021

16 ACTCS data.

17 This figure includes strip searches of detainees newly admitted to AMC and placed in CSU, as all new admissions to AMC are strip searched regardless of placement.

Those who come into the CSU for being in an at-risk state are also in a situation of vulnerability and so the harmful effect of strip searching can be even greater. Therefore, the solution should not be to amend the CM Act, as it the practice would still be inconsistent with the HR Act. Instead, ACTCS should expedite the procurement of body scanning technology[18] so that the latest means to search detainees on entry to CSU are less restrictive on their rights. Strip searches will then be necessary if the body scanner detects something that the detainee refuses to surrender. This would be lawful because staff would have a reasonable suspicion that a detainee is concealing a seizable item.

We note ACTCS comments on a draft copy of this report that 'ACTCS is proactively progressing the procurement of body scanners'.

Finding 8:

That routine strip searching on admission to the Crisis Support Unit does not have a lawful basis under the *Corrections Management Act 2007*.

Finding 9:

That routine strip searching on admission to the Crisis Support Unit appears to be an unreasonable limitation of the right to privacy and the right to humane treatment when deprived of liberty under the *Human Rights Act 2004*.

Recommendation 1:

That ACT Corrective Services remove from policy, procedure and written direction any requirement for mandatory strip searches on entry into the Crisis Support Unit.

Finding 10:

That ACT Corrective Services does not currently have body scanning technology that could replace routine strip searching on admission to the Crisis Support Unit.

Recommendation 2:

That ACT Corrective Services expedite the procurement of body scanner technology to provide options for less restrictive ways than strip searching to search detainees on entry to the Crisis Support Unit.

18 OICS understands that ACTCS has had body scanners under consideration for some time.

4.1.3 Decision to use force to strip search: legal and human rights considerations

Legal basis

Corrections Officers may use force to carry out a strip search.[19] The CM Act states that use of force must be a last resort as far as practicable and the force used must only be what is reasonable and necessary.[20] There are two types of use of force: planned, and unplanned. A planned use of force is one where there is time to assess the situation, exhaust the alternatives to using force and plan the type and level of force to be used if it is unavoidable. An unplanned use of force requires an immediate response. This was clearly a planned use of force.

OICS is of the opinion that on this occasion there was another option that was not explored before the decision to use force to strip search Detainee A was made. A CO could have been called in to the CSU to conduct constant observations on Detainee A. COs could have tried again later that evening or the next morning to convince Detainee A to undergo the strip search, and if she did not comply, assessed at that point whether the use of force to carry out a strip search was necessary. As noted above, strip searches do not remove the risk that detainees could harm themselves with concealed items. The risk mitigation potential of strip searches is limited to occasions where detainees have items concealed in their clothes and underwear, and not internally.

In this case, the OiC had a contrary view, that calling in another officer to CSU to conduct constant observations would not have sufficiently mitigated the risk to either Detainee A or responding officers if Detainee A did have a blade concealed and used it to cause harm.

The CSU is designed as a safer environment for detainees at risk of harming themselves or others. It is close to the Hume Health Centre for rapid access from the health team if required,[21] the layout facilitates close observation by staff and there are minimal items in detainee cells and no ligature points. If Detainee A did have a seizable item concealed and attempted to use it to harm herself or COs, officers would be able to respond in a timelier manner compared to other accommodation options in the AMC. OICS does not seek to downplay the risk that Detainee A may have posed to herself or COs but notes that this risk was best managed in CSU and she was calm at the time the use of force to carry out the strip search commenced.

To satisfy the requirement that the use of force be a last resort, OICS is of the view that the option of calling an additional staff member should have been explored to see if it was feasible, and if it was feasible it should have been done in order to avoid the forced strip search that evening.

Finding 11:

That the use of force to carry out the strip search on Detainee A was not a last resort as required by the *Corrections Management Act 2007.*

19 CM Act, s 126.

20 CM Act, ss 137-138.

21 ACT Corrective Services comment on a draft of this report noted that the Hume Health Centre is not staffed after hours and so an ambulance may need to be called if medical assistance is required after hours.

Compliance with the Human Rights Act

The ACTCS has obligations under the HR Act as a public authority. These obligations include making decisions that properly consider human rights (procedural requirement), and that the outcome of decisions must be compatible with those rights (substantive requirement).[22]

1. *Proper consideration of rights in deciding to conduct a forced strip search*

Detainee A's human rights were not properly considered in the decision to conduct a planned forced strip search. Neither the *Use of Force and Restraint Policy* or the *Corrections Management (Searching) Policy 2010* (Restricted) provide staff with guidance on how to properly consider human rights and document their consideration. Staff also need to have the appropriate skills to do this.

There is time in a planned use of force to consider human rights at the decision-making stage. How this can occur is set out in Table 2 on page 22. If the decision is to proceed with the forced strip search, then at least there should have been consideration of any way to reduce the impact on a detainee's human rights (for example, limiting the number of people present to reduce the impact on privacy).

Considering human rights in decision making need not be a complex exercise, and a framework or check list to guide staff could assist. Importantly, it would ensure decision makers have turned their mind to the impact that a forced strip search would have on the specific individual detainee. It would also require that the decision making is documented.

For example, the search and seizure policy for Bimberi Youth Justice Centre requires decision makers to consider individual factors unique to each young detainee prior to deciding to strip search them. The *Children and Young People (Search and Seizure) Policy and Procedures 2018 (No. 1)* provides at 6.6:

> In making a decision to undertake a strip or body search of a young person, and in deciding how to conduct a personal search of a young person, the decision-maker must consider information known about the young person's individual characteristics such as age and maturity, impairment and known history such as any experience of abuse so as to minimise adverse psychological impact on the young person.

Finding 12:

That ACT Corrective Services policies and procedures relevant to planned uses of force to conduct a strip search do not refer to the requirement in the *Human Rights Act 2004* for decision makers to properly consider human rights in decision making.

Recommendation 3:

That ACT Corrective Services ensure that human rights are explicitly considered prior to conducting a planned use of force to carry out a strip search, and the reasons for a decision are documented. To support this, ACT Corrective Services should develop a practical decision making tool for operational staff, and incorporate it into relevant procedures.

22 HR Act s 40B(1).

Recommendation 4:

That ACT Corrective Services ensure that Operational Managers and Corrections Officers, level 3 and above have appropriate capability in considering human rights in decision making. Capacity building of staff should draw on expert input on human rights and decision making.

2. *Was the forced strip search compatible with Detainee A's human rights?*

As noted above there are two aspects of human rights considerations in decision making. The first obligation as discussed above is considering human rights in decision making. The second aspect is ensuring that the outcome of that decision is consistent with human rights.

Human rights can be limited, but only where the limit is lawful, justified and reasonable. The factors that must be considered in determining whether a limit is reasonable are set out in Table 3.

On balance, OICS is of the opinion that the decision to conduct a forced strip search and the events that followed (use of force, then strip search) was an unreasonable limitation on Detainee A's human rights. This conclusion is reached because of Detainee A's additional vulnerabilities including her mental and physical health condition caused what is an already inherently degrading practice to have even more of an impact on her rights, and because there was a less restrictive means that was not explored.

Finding 13:

ACT Corrective Services did not properly consider Detainee A's human rights in making the decision to conduct a forced strip search, and the forced strip search on Detainee A was incompatible with her human rights. Therefore, ACT Corrective Services has acted inconsistently with its public authority obligations under section 40B of the *Human Rights Act 2004*.

Table 2: Example of the proper consideration of human rights when making a decision to conduct a forced strip search[23]

Step	Consideration
1. Understand which rights may be affected and how	A forced strip search significantly affects rights including: • protection from cruel, inhuman or degrading treatment or punishment • humane treatment when deprived of liberty • right to privacy • right to security of person • right to life
2. Seriously consider the possible impact for the affected person	• there is a real risk that the physical nature of a use of force could exacerbate certain medical conditions and cause significant risk of injury or death. • being held down by COs in TPPE and having clothes cut off is likely to be traumatic. • for detainees at risk of self-harm, the practice of a forced strip search may in fact exacerbate the risk due to the trauma it could cause. • the detainee may feel humiliation or shame and find it highly degrading to be viewed naked in front of people who control their daily environment. • the impact of a forced strip search may be particularly severe for someone who has been a victim of sexual assault previously (a high proportion of female detainees). • the impact of a forced strip search may be particularly severe for Indigenous women who can experience intergenerational traumas from ongoing colonisation and features of patriarchy, racism and sexism.[24] • the impact of a forced strip search may be particularly severe for someone with a disability depending on the disability and their circumstances.
3. Identify countervailing interests or obligations	Preventing the entry of 'seizable items' into the CSU, including items that detainees could use to harm themselves, other detainees or staff is an important interest, and supports the right to life.
4. Balance competing interests as part of justification	This involves assessing whether the forced strip search is proportionate to the end it is seeking to achieve. What other options are available to limit the impact on human rights? For example: • asking the person whether they wish to declare any 'seizable item' before they are searched; • ensuring the strip search is the least restrictive means for achieving the purpose of keeping the detainee and staff safe, including by considering other forms of searching available, such as body scanning technology; • ensuring the detainee understands why the search is required and how it will proceed; • ensuring the search takes place in a private location wherever possible; • limiting the number of staff present and ensuring only staff of the same gender as the detainee are present.

23 This four-step test is set out in *Castles v Secretary of the Department of Justice* (2020) 28 VR 141.

24 Baldry and Cuneen argue that 'to understand contemporary penal culture and in particular its severity and excess in relation to Indigenous people and women, we need to draw upon an understanding of the dynamics of colonial patriarchy', Eileen Baldry and Chris Cuneen (2014), 'Imprisoned Indigenous women and the shadow of colonial patriarchy', *Australian & New Zealand Journal of Criminology* 0(0). McEntyre explains that Aboriginal girls and women endured some of the most pervasive terror and trauma-related abuses from the colonisers and that the hardships and injustices brutally inflicted were the result of gendered policies and practices. Elizabeth McEntyre (2019) *But-ton Kidn Doon-ga: Black Women Know – Re-presenting the lived realities of Australian Aboriginal women with mental and cognitive disabilities in criminal justice systems*, PhD Thesis, University of New South Wales.

Table 3: Was the forced strip search of Detainee A a reasonable limitation of her human rights?[25]

Factors	OICS analysis
a) The nature of the right affected	The rights affected by a forced strip search are set out in Table 2 (row 1). Regarding the nature of those rights, in a recent Victorian court case, it was noted that the 'rights that are limited by strip searching are important human rights. In a prison context, the dignity right in [s 19(1) of the HR Act] assumes particular importance.'
b) The importance of the purpose of the limitation	In this case, the purpose is to protect Detainee A from the risk of self-harm by recovering items that could be used to self-harm and also to protect the staff managing her. This is undoubtedly important.
c) The nature and extent of the limitation	Strip searching is a generally dehumanising procedure. In this case, Detainee A had a number of additional vulnerabilities that made the forced strip search an even greater limitation on her human rights. This includes: • Currently being in a period of mental, emotional, spiritual and cultural vulnerability due to having suddenly lost her Grandmother and being unable to attend the funeral with family and Community. • Having serious medical conditions that make a use of force dangerous, and potentially life threatening. The COs were generally aware of these serious conditions. They may not have known of the specific risk that these conditions posed and the OiC did not seek nor receive any specific medical information from Justice Health relating to risks posed by a forced strip search to Detainee A's health. However, COs were aware of Detainee A's pacemaker for a heart condition, and lung condition and in fact, these conditions are specified Section 14.3 of the *Use of Force and Restraint Policy* as conditions of particular relevance when proceeding with a use of force. • That force was going to be used which would mean more staff would be present than usual for a strip search. • That the forced strip search was to take place where it could be heard by other detainees potentially causing embarrassment or shame. • Being a victim of a recent sexual assault means that a forced strip search may be triggering and cause further trauma (although the decision maker must have known that or ought to reasonably have known that at the time of making the decision). The OiC told the review team that she was not aware of Detainee A's recent history of sexual assault
d) The relationship between the limitation and its purpose	A strip search may have uncovered items if Detainee A was hiding them in her clothes. However, a strip search will not uncover any item secreted internally, which was possible considering the basis of the reasonable suspicion was Detainee A touching her groin area. Therefore whilst there is a relationship between the limitation (the strip search) and its purpose (preventing harm), the strip search would only reduce the risk of harm somewhat and not eliminate it.
e) Any less restrictive means reasonably available to achieve the purpose the limitation seeks to achieve	As discussed above, there is the potential that an additional CO could have been called in to conduct constant observations on Detainee A to reduce the risk of self-harm.

25 Factors a) to e) are required considerations under the HR Act, s 28(2).

4.2 The use of force: good practice and lessons learned[26]

4.2.1 Good practice

For a planned use of force, a clear verbal warning of the intended use of force must be given and there must be enough time allowed for the warning to be observed.[27] In this incident, the COs provided the required verbal warning before entering the cell and provided Detainee A with time to respond.

The techniques and amount of force used by the officers appears to be consistent with the intended purpose of restraining the detainee to conduct a strip search. The use of force part of this incident went for approximately six minutes, which can be considered prolonged. One CO involved told OICS that in the briefing they were told 'not to go in full force, not to go 100% because of her medical conditions'. This may have contributed to the length of the incident as the use of force team were unable to restrain her initially.

Keeping to one side the decision to use force to conduct the strip search, OICS' conclusion is that the type and amount of force used was reasonable in the circumstances.

Finding 14:

That the type and amount of force used was reasonable in the circumstances.

A use of force must be a last resort under the CM Act. In a situation where the use of force is a planned one, there is time to prepare, including ensuring that every effort to de-escalate or in this case, every attempt to convince Detainee A to voluntarily submit to the strip search has been made. We are satisfied that COs made significant efforts in the hour prior to the use of force to attempt to convince Detainee A to submit to the strip search.

Finding 15:

That significant efforts had been made by a number of COs in the hours preceding the use of force to try to convince Detainee A to comply with the strip search.

We do note that one final opportunity could have been explored further. When the team entered the cell, Detainee A was in a passive position and not presenting any physical threat. Even though they were already in TPPE, COs could have used this opportunity to speak to Detainee A to try to convince her to comply with the strip search.

It is good practice that when Detainee A started to shout that she would comply with a strip search if a certain CO2 did it, the objective of the use of force changed to a less restrictive one of restraining her by cuffing her rather than cutting her clothes off. This is consistent with the *Use of Force and Restraint Policy* which requires that staff must continue attempts to de-escalate the situation in order to minimise continued use of force.

26 We note that footage of a use of force can be confronting and appear excessive to those unfamiliar with the technical aspects of use of force in closed environments. Therefore, in addition to viewing the CCTV and handheld camera footage of the use of force ourselves, we also engaged an external expert in use of force to view the footage and provide an opinion.

27 *CM Act, s 139.*

Finding 16:

That when, some five minutes after the use of force had commenced and Detainee A stated she would comply with the strip search if a certain CO did it, the objective of the use of force changed to the less restrictive objective of cuffing her rather than removing her clothes.

4.2.2 Lessons from this incident

Medical considerations

OICS is concerned that on this occasion, the policy framework for sharing relevant health information between ACTCS and Justice Health as it relates to a planned use of force was not adhered to.

The *Use of Force and Restraint Policy* contemplates ACTCS actively seeking information from Justice Health to 'verify whether a detainee has a medical condition that places them at greater risk of a medical emergency prior to a planned use of force' (section 14.2). The policy also requires (as far as practicable) a Justice Health Doctor or Registered Nurse to 'attend a planned use of force to provide clinical advice to the Officer-in-Charge' (section 9.4). These requirements seek to mitigate risks to detainee health associated with uses of force. Both these things did not occur in this incident.

OICS notes the *Use of Force and Restraint Policy* may raise issues of medical ethics and professional obligations for Justice Health staff. This is because it could be argued that health staff providing information and advice to Corrections Officers relating to a use of force or attending a use of force prior to it commencing are non-therapeutic functions, and therefore outside the role of a medical professional working in a correctional environment.

OICS understand that as part of their review of this incident, the ACT Health Services Commissioner is considering the role of Justice Health in relation to uses of force, and how information is shared between ACTCS and Justice Health/Winnunga to mitigate health risks associated with planned uses of force. To avoid duplication of functions as required by the ICS Act, OICS will not comment on this issue in this report.

Clearing the area of non-essential staff

A use of force to carry out a strip search is an extremely sensitive matter involving a significant limitation of the detainee's right to privacy. When the use of force occurred, Detainee A was in her cell in the CSU, which afforded visual privacy from other detainees but was constantly monitored by CCTV cameras which were viewed in the nearby officer station and can be viewed in the Operations building and Master Control Room. There was also the presence of at least three staff standing outside the cell that were not actively involved in the use of force. This is in addition to four nursing staff who arrived later as the result of a Code Pink (medical emergency) being called during the incident. One of the COs and at least one of the Nurses were male. The *Use of Force and Restraint Policy* does not require uninvolved staff to leave the scene unlike (for example) the NSW Corrective Services *Use of Force Policy* which states 'the area must be cleared of all uninvolved inmates and staff'.[28]

The presence of staff not directly involved in the incident meant that the impact on Detainee A was not the 'least restrictive' possible in the circumstances. Furthermore, additional staff caused complications in the command-and-control structure when they sought to intervene without the direction of the OiC (discussed further below).

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28 New South Wales Corrective Services *Custodial Operations Policy and Procedure 'Use of Force'* at 4.2, 17.

Finding 17:

That there were non-essential staff, including male staff, present throughout the use of force.

Recommendation 5:

That ACT Corrective Services amend the *Corrections Management (Use of Force and Restraint) Policy 2020* to require that non-essential staff leave the scene prior to a planned use of force.

Command and control of the use of force

Under the *Use of Force and Restraint Policy*, the OiC 'must remove themselves from the location of the planned use of force prior to its commencement and until the situation has concluded.'[29] In this case, the OiC was directly involved in the use of force. This decision was made during the incident when the CO1s could not gain control of Detainee A and the OiC felt the CO1s' safety was at risk. Whether available staff are appropriately skilled or experienced to proceed safely with a planned use of force is a factor to be taken into account at the point of determining whether to proceed with the use of force.

There was also a CO2 from the Security team present at the door to the cell. At a number of points, when Detainee A is calling out 'I'll comply for CO [name]' the CO2 Security instructs CO2 CSU to intervene. The CO2 CSU does seek to intervene but is ordered away by the OiC. This caused confusion as to who was in charge of the situation (the OiC or the CO2 Security) and made it difficult for clear directions to be given to, and received by, the staff members involved. This issue was identified by COs involved and by the Use of Force Committee.

Finding 18:

That there was a lack of command and control of the use of force because the Officer-in-Charge was directly involved in the use of force and there was more than one Corrections Officer giving directions.

Identification of staff wearing helmets

Although it was not a particular issue in this incident, it is extremely difficult to identify individual officers when they are wearing helmets:

In a major incident involving many 'kitted-up' officers such identification could be vital in determining where individuals were at a particular time and what they did or did not do.

29 At [9.6].

It would be simple and inexpensive to add a number to the rear and/or front of all ACTCS helmets. These numbers could then be recorded when issued to individual officers where TPPE is required for an incident response.

Recommendation 6:

That all ACTCS Tactical Personal Protection Equipment helmets display a clearly visible number and that the number on a helmet be recorded when issued to a Corrections Officer.

Documentation

Under the *Corrections Management (Incident Reporting, Notifications and Debriefs) Policy 2020* 'all staff … who were involved in, or witnessed, an incident must complete an A2.F1: Incident Report Form.' The CO2 Security did not complete an Incident Report Form despite witnessing the whole use of force.

All staff who applied force to a detainee must complete a Use of Force Report under the *Use of Force and Restraint Policy*. These reports 'must be factual and contain as much detail as possible on the circumstances and justifications for the use of force.' The reports written by the CO1s involved in this use of force lack specificity in relation to the briefing. Two of the reports state that they were briefed on Detainee A's 'current medical condition/s' but did not specify what medical conditions or how they were to ensure they did not aggravate them during the use of force.

The *Use of Force and Restraint Policy* also states, 'all reports under this policy must be completed individually and independently of any other staff member.' Two of the reports completed by CO1s are nearly identical. This suggests that they may have completed their reports together which is concerning.

Finding 19:

That the practices around completion of Use of Force reports was not consistent with relevant policy.

The *Corrections Management (Duty Manager) Operating Procedure* states 'The Duty Manager must record details of areas visited, actions taken, incidents and issues that have been dealt with or are on-going in the Duty Manager Summary Record'. However, there is no requirement for Duty Managers to keep a running log, nor record relevant calls they received out of hours when they are 'on call'. The *Duty Manager Operating Procedure* states 'in the event of a planned use of force, the Duty Manager must review the specific circumstances, taking account of available intelligence and other information from staff before authorising the use of force.' The *Duty Manager Operating Procedure* should require the Duty Manager to keep a written record of any authorisation given, including the information considered and the justification for authorisation.

Recommendation 7:

That the *Corrections Management (Duty Manager) Operating Procedure* be amended to require the Duty Manager to maintain a log of all conversations involving notifications to the Duty Manager and any advice or directions given by the Duty Manager.

Video footage (recording, preservation)

The briefing prior to the commencement of the use of force is required by the *Use of Force and Restraint Policy*[30] to be captured on handheld camera. This did not occur. This means there is no firsthand record of what staff were told about Detainee A's medical conditions, the use of force techniques to employ and other relevant considerations. This is unfortunate, particularly given the descriptions of the briefings in the officer reports lacked detail.

In this incident, the date and time was not included on the footage from the handheld camera, contrary to the *Corrections Management (Hand Held Video Cameras) Operating Procedure 2020*.

Contrary to the *Use of Force and Restraint Policy*,[31] the CCTV footage of Detainee A's cell and surrounding area in the period prior to the commencement of the use of force was not preserved. This would have provided evidence of efforts to de-escalate the situation. Footage from cameras capturing the area outside Detainee A's cell would have also assisted in understanding who was present.

Finding 20:

That all relevant CCTV and handheld camera footage relating to the Use of Force was either not captured or preserved contrary to the *Corrections Management (Use of Force and Restraint) Policy 2020*.

Finding 21:

That contrary to the *Corrections Management (Use of Force and Restraint) Policy 2020*, the preliminary briefing by the Officer-in-Charge was not recorded on a handheld video camera.

Recommendation 8:

That staff are trained in the correct use of handheld video cameras to comply with relevant policy and procedure, for example, through recruit, refresher, or scenario training.

Opportunities for internal review

Under the *Use of Force and Restraint Operating Procedure*, the General Manager must chair a weekly Use of Force Review Committee where the CCTV footage and use of force incident package are reviewed. The Committee completes a Use of Force and Restraint Review Form and the use of force and the review are to be entered in the General Manager's Monthly Report. Any incidents of concern are referred to the Commissioner. The Commissioner can then provide the footage of the incident to an 'assigned investigator'.

30 'The Officer-in-Charge is responsible for ensuring that all CCTV camera footage of a use of force is downloaded and logged … The downloaded footage must also include both the lead-up and aftermath of the incident' (section 10.1).

31 'The Officer-in-Charge is responsible for ensuring that all CCTV camera footage of a use of force is downloaded and logged … The downloaded footage must also include both the lead-up and aftermath of the incident' (section 10.1).

This matter was reviewed by the Use of Force Committee. The attendees were the General Manager, Senior Director Operations and Senior Director Accommodation. Under the heading 'Issues and Concerns' the report states:

> The committee agreed that there was a lack of command and control due to movement in and out of the cell. No concerns with use of force. De-Escalation appropriate.

Thorough reviews of uses of force are an essential mechanism for ensuring excessive use of force is identified and it can also encourage a culture of reflective practice and continuous learning. OICS notes that there is no written guidance about the purpose of the use of force review and the criteria to be applied when deciding if there are any 'issues and concerns' about the use of force.

Transparency would be enhanced by providing clear written guidance including about the objective of the review. For example, the purpose could be to only identify uses of force so problematic they require review by the Commissioner, or more broadly to identify failures to comply with policy and procedure which could then formulate feedback to staff on areas for improvement. In the review of this incident, no inconsistencies with policy or procedure were noted, such as the failure to video record the staff briefing. The review also did not record any consideration of whether the decision to use force was appropriate in these circumstances.

Finding 22:

There is no written guidance for ACTCS staff that sets out the criteria for a use of force review.

Recommendation 9:

That ACT Corrective Services develop terms of reference to guide the process of reviewing uses of force, that includes a requirement for reflective practice about whether the use of force complied with policy and procedure.

Staff training on non compliant strip searches

None of the COs involved in this use of force had been trained in a use of force to conduct a strip search. Members of the security team were aware that the COs that were in the use of force team were relatively junior COs and none had previously conducted a use of force to carry out a strip search. This was unavoidable as the use of force team had to be all female in this case and so the choice of team members was limited to female COs currently on shift. During the briefing, members of the Security team gave an example of how a non-compliant strip search is conducted.

Given the infrequency of the occurrence of uses of force to ensure compliance with a strip search[32] we do not think it reasonable for staff to be trained in specific techniques for use of force to carry out a strip search.

32 Data from ACTCS showed that there were five planned uses of force to conduct a strip search between September 2020 and March 2021. Of these, three were conducted on males including one Indigenous male, and two were conducted on females including one Indigenous female. Data on planned uses of force to conduct a strip search has only been collected by ACTCS since September 2020.

4.3 Placement in the Crisis Support Unit

The CSU is located at the back of the Health building and has ten beds in cells with CCTV coverage. The *Alexander Maconochie Centre: Functional Brief* (March 2005) described the purpose and structure of the CSU as providing 'a safe environment for prisoners undergoing acute episodes to be managed and stabilised out of the mainstream environment.' The *Management of At-Risk Detainees Policy* states:

> The CSU is the primary accommodation location for detainees clinically assessed as being at risk of self-harm and/or demonstrating a significant psychiatric condition requiring mental health treatment. CSU also accommodates detainees who require more intensive medical supervision.

There is currently no ACTCS policy or procedure that outlines the operation of the CSU. The *Corrections Management (Management of Detainees in the Crisis Support Unit) Policy 2016* was repealed in October 2019. ACTCS advised that the *Management of At-Risk Detainees Policy* has replaced it. However, this policy does not contain specific information on the operation of the CSU.

The CSU is an extremely austere environment, and it places further restrictions on detainees from what they experience in the main accommodation areas of the AMC. Cells are very basic and personal property is significantly limited due to the risk that items can be used as instruments to self-harm or as weapons. There are also very limited opportunities for contact with other detainees, and the exercise area is small and enclosed. These conditions engage detainees' right to humane treatment when deprived of liberty and right to privacy. Therefore, to ensure that limits being placed on these rights are reasonable the criteria for placement needs to be clear.

In this case, there were appropriate grounds for and oversight of Detainee A's placement in CSU. On 11 January 2021, FMH completed an Interim Risk Management Plan for Detainee A that recommended she be moved to CSU and placed on 15-minute observations. Under the *Management of At-Risk Detainees Policy*, the High Risk Assessment Team (HRAT)[33] must review an Interim Risk Management Plan on the next business day. The HRAT is responsible for determining ongoing admission to, and exit from, the CSU. The *Management of At-Risk Detainees Policy* states that the HRAT 'will review the placement of all detainees in the CSU on an ongoing basis'. Data from ACTCS indicated that approximately one in three of detainees admitted to CSU in 2020 were marked 'at risk'. OICS is concerned that there is no applicable policy in cases where detainees are placed in CSU for reasons other than being at-risk. This issue will be examined in the next Healthy Prison Review of the AMC.

4.4 Cultural support for Indigenous detainees who have experienced loss

4.4.1 Support to attend funerals

In recognition of the special significance of funerals to First Nations Peoples, the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) recommended that Corrective Services 'give favourable consideration to requests for permission to attend funeral services and burials'.[34] ACTCS has stated that they are committed to implementing the recommendations of RCIADIC,[35] and a 2015 internal review of ACTCS implementation of RCIADIC recommendations marked this as 'complete'.[36]

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33 This is a multi-agency decision and intervention planning team by ACTCS and Justice Health Services to coordinate the management of at-risk detainees.

34 Elliot Johnston QC, *Royal Commission into Aboriginal Deaths in Custody: National Report* (1991), vol 3, recommendation 171.

35 https://correctiveservices.act.gov.au/sites/default/files/2020-11/ACTCS%20Aboriginal%20and%20Torres%20Strait%20Islander%20Policy%20Statement%202020.pdf

36 https://www.justice.act.gov.au/sites/default/files/resources/uploads/JACS/PDF/ACTCS_2014-15_Internal_Review_of_Relevant_Recommendations_of_RCIADIC_JUNE2016.pdf

To attend a funeral a detainee at the AMC must be granted a leave permit under s 205 (local leave) or s 208 (interstate leave) of the CM Act. The process for applying for leave and the matters that are considered in assessing the application are not set out in any current AMC policies or procedures.[37] The *Corrections Management (Escorts) Policy and Procedure 2017 (No 2)* does state that for an interstate funeral, approval is required from the Commissioner.

From our discussion with AMC staff, we understand that the process for applying for a funeral is that a detainee submits a Detainee Request Form ('bluey') which is given to the Security CO3 who then assesses the application. For Aboriginal and/or Torres Strait Islander detainees, the ISU can provide support by assisting the detainee to fill out the leave request, contacting family members to get the funeral details, confirming the funeral details with the funeral director (or another third party) and then taking the completed paperwork to the Security CO3.

In Detainee A's case, an ILO attended SCC on Thursday 7 January to assist with filling out the paperwork for the leave request. However, as the funeral details could not be confirmed at the time, the paperwork could not be completed. What then seems to have occurred is a misunderstanding about who was responsible for progressing the leave application - the CO2 who was told the funeral details by Detainee A on Friday 8 January 2021 assumed the ILOs would confirm the funeral details and the ILOs assumed the COs would do it as the ILOs do not work on weekends. What this meant is that the funeral details were not confirmed until Monday when another ILO contacted the funeral directors. The request to attend the funeral was then denied because of the short notice given and current staffing obligations.

Finding 23:

That there was confusion or misunderstanding around the role of Corrections Officers and Indigenous Liaison Officers in relation to following up on Detainee A's funeral request.

It cannot be said that the request would have been granted if it was processed over the weekend because there were still significant logistics involved in the interstate escort and staffing implications. However, what this incident does identify is ambiguity about who is responsible for assisting Aboriginal and/or Torres Strait Islander detainees to submit leave requests, especially over the weekends. This must be rectified by ACTCS to ensure that detainee leave requests are processed as soon as the funeral details are known so that their opportunity to have leave approved is maximised. If the best solution is that ILOs are responsible for handling funeral requests for Indigenous detainees and after-hours work is required, they must be provided with appropriate compensation such as time in lieu.

37 The *Corrections Management (Escorts) Policy and Operating Procedure 2017 (No 2)* states that a 'Security Risk Assessment and Removal Authority' is to be completed for detainee escorts to funerals. However, this appears to be instructions for staff conducting the escort, not an assessment of whether the leave should be granted.

APPENDICES

Appendix 1: Letter from Detainee A outlining allegations

I am a female indigenous detainee currently being housed at the AMC here in Canberra. I am on Remand and have not been found guilty of an offence. I am also the very recent victim of a sexual assault and revenge porn that is being investigated by the AFP at this time. I am writing this letter to inform the media and the whole of the wider community about the conduct that is being displayed by the AMC staff and the ILOs. There is a very large degree of racism, disorderly conduct and a wide range of breaches of Human Rights. Most importantly, the outrageous, institutional abuse of Indigenous detainees. And lack of support from the ILOs out of fear of retribution.

I am a 37 year old woman with a heart condition, Pulmonary Embolism on my right lung and a collapsed lung. I also have a Borderline Personality Disorder. I have been in custody for almost 6 months on remand.

On the 6th of Jan 2021 I was informed that my grandmother had passed away. With her funeral being the 13th Jan 21. I completed the paperwork to be escorted. However, the ILOs failed to do what was required. For the ILOs to return on the 12th Jan to tell me I wasn't allowed to attend due to logistics. And because the paperwork was left on a desk it was too late. Upon telling me this I became very upset and was then made to move to the Crisis Support Unit. Because they fear for my safety and mental health. On arriving to CSU, I was placed in a cell where everything can be seen. There are also 5 to 7 men housed in the same unit, who can also see everything that occurs. Whilst laying on the bed a total of 4 female officers, 2 male officers, 2 male nurses and 5 male detainees with full view. Male detainees in their cells but still with full view. All officers and nurses enter my cell to strip me naked to check I had nothing on me for my safety I'm told. The female officers were in full squad gear, while the rest were there to watch. There [sic] intention was to forcefully remove all of my clothing by cutting my clothes clean off. At this time I was menstruating heavily due to all the blood thinning medication I take on a daily basis. Here I ask you to remember that I am a rape victim. So you can only imagine the horror, the screams, the degrading feeling, the absolute fear and shame [I] was experiencing.

And that's only a few of the things I was experiencing as well as greif [sic] and despair, disappointment of not being able to attend my grandmothers funeral.

I'd also like to point out that during this time, a little before on the 1st Jan 21, I was placed on segrogation [sic] for 23 hours a day with no contact with anyone, not even during the hour out. For an alleged assault that is being investigated by the AFP. Policy and procedure states that if the AFP are involved there can't be any discipline whilst in custody, Double Jepodary [sic]. However, this has still occurred. Is still occurring today. ILOs have done nothing to support me during this time. Corrective Services are continuing to segrogate [sic] me and treat me unfairly and against the rules, policy and procedure of the Alexander Moconochie [sic] Centre. The Human Rights Prison to which he has his name attached too [sic].

My mental health has deteriorated to a large degree without the support needed from my other peers in here. As I have completed applications to have welfare visits to support me during this very hard time. But I am constantly denied any human contact with anyone I have a rapport with or family member. I am isolated on my own for 23 hours a day and on the hour out I'm made to exercise in a wing filled with men. No female contact.

I also had my phone cut off for 2 to 3 days at a time, so I can not call family. I have lost all contact via email.

The only positive in this that I can see is, someone tipped off the Indigenous Official Visitor Vickie Quinn about the recent incident. She was not due back at work until the second week of February. But came in just to see me and lodge an official complaint. She also invited Karen Toohey from the Human Rights Commission who has also lodged a complaint on my behalf with the Ombudsman, regarding the large degree of misconduct that is being displayed. The racism is also very evident. Whilst being served with my segro paperwork in the begining [sic] it was stated to me "It's always about you blokes" "WE always have to look out for youse". I replied "who's you blokes"? being female I questioned this. The reply I received was "YOU ABORIGINALS" "ITS ALWAYS ABOUT YOUSE" "No one looks out for us" "All the services that just walk in and out of here for just you lot".

I approached the CO3 and CO4 via Blue Request Form regarding these statements. Only to have the letter attached returned on its own and the Bluey lost. I also bought this to the attention of the ILOs with the response to " just leave it". The only person to raise the issue was the indigenous official Vickie Quinn because she doesn't have to answer to Corrective Services. She's employed by Human Rights. There is no fear of retribution for her from Corrective Services. She is the only one solid thing we have has a voice when it comes to the injustices we receive in here. The other solid thing we have is Winnunga Medical Services. When Julie Tongs heard of the conduct she sent someone from the social health team to check on my welfare. If it wasn't for Julie, Vickie and Karen I would be purely alone and well and truly on a path of self destruction and self harm to the point of death.

These 3 indigenous women who work outside the prison are the only reason I am still alive today. And the little bit of hope I have left that maybe this letter falls into the right hands and something changes. So that what [sic] is happening to me on a daily basis doesn't happen or continue to happen as if no one cares. Be it, men or women.

As I write this and think about things I have heard many stories about the worst boys homes and Cootamundra Girls home. The level of abuse that was suffered in those places. And I used to think those things don't happen in places like this anymore. Not in this day & age. But on Monday 12 January that changed for me. When I felt like I was about to be raped all over again in front of men, women, nurses and 5 male detainees after being punished for something I've been charged with by Police, then further punished by not being able to attend the funeral, then again to be abused and have my clothes cut off me by force and further degraded whilst mensturating [sic] with 13 people watching all whilst being video taped by cameras on walls. For my safety, I don't think so. All without the support of the ILOs.

This isn't just happening for me. This is happening to men also Indigenous mates. My male cousin was bought [sic] to CSU and stripped whilst I was walking in the wing with female officers present. I chose to turn and walk away. Cause I knew that if he seen that I seen just a little bit of what was happening he would have been shame. No one should be made to experience what I have had to. If this can change even the smallest thing then something good has come out of my misery.

Thank you for reading this. Thank you if you think you can do something about it.

I had to go to great lengths to get this out of the prison as if it was seen it would have been confiscated and destroyed. Because no one wants people to know what really goes on at the Alexander Maconochie Centre. Because it goes against everything the Man stood for, HUMAN RIGHTS.

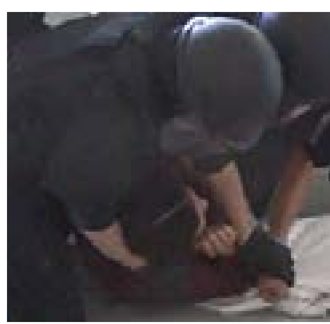
[signed]

PS I THINK THIS IS INSTITUTIONAL ABUSE IN ITS FINEST FORM. THERES MORE TO THIS IF YOU WANT TO KNOW

Appendix 2: Chronology of use of force on Detainee A on 11 January 2021

Note: This chronology is based on the cell CCTV camera and handheld camera footage. The timing is based on the CCTV footage which has a timestamp. The audio is based on what can be discerned from the handheld camera recording.

Time	
18:48	OiC gives Detainee A a warning from outside the cell, stating "I am giving you a direction to undergo a strip search, if you don't force may be used". This is followed by a second warning. Detainee A is lying on the bed with back to door and replies "get fucked".
18:49	Three CO1s enter cell in TPPE with the CO in front holding a shield. Detainee A is laying on the bed. OiC, CO2 CSU, CO2 Security, CO1 holding camera and another CO are outside the cell door.
	The COs lean on Detainee A with the shield attempting to pin her to the bed so they can get control of her arms. Detainee A resists by kicking at COs.
	OiC (in TPPE) enters the cell to assist.
	Struggle between COs and Detainee A. Detainee A yelling "fuck off" and "get off me now". Detainee A is held against the wall by COs.
	CO2 (not in TPPE) enters the cell to attempt to de-escalate Detainee A. CO2 is sent out of the cell. Another CO can also be seen next to the door just outside the frame – currently 9 COs on the scene.

Time	
18:50	COs lower Detainee A to the floor. Detainee A continues to struggle. COs attempt to place Detainee A on her side. Detainee A states "I've got pains in me chest" multiple times and "Real fuckin smart" COs attempt to turn Detainee A onto her side. "I hope I have a heart attack on you dogs" x2 "I've got pains in me chest you dumb cunts" "you dumb bastards, you dumb fucking bastards" 
18:51	OiC tells Detainee A to "just breathe" Detainee A: "I can't breathe, I've got a collapsed lung you dumb dog" OiC: "Just comply?" Detainee A: "No. I've got pains in me chest you dumb slut." "I'm telling you now, you fucking need to get off me." OiC: "Call a Code Pink" Detainee A: "you dumb cunts" "(panting) you dumb fucking dogs, you dumb dumb dogs, fuck off, fuck off" Detainee A rolls into wall and held on her side. Detainee A: "you don't believe me do ya, I've got mad pains in my chest you dumb cunts, you dumb dumb cunts." "yeah mad, induce a heart attack you fucking idiots, induce a heart attack you fucking idiots" "you need to get off my chest you fucking idiots" CO: "No one's on your chest, no one's on your chest" Detainee A: "You're on my fucking lung, you're on my fucking collapsed lung you fuckwit" OiC: "no one's on your chest" Detainee A: "why are you telling me I can't feel pressure on my lung you dumb dog" OiC: "just breathe" Detainee A: "I can't even fucking breathe properly" "get off, get off, get the fuck off me" OiC: "No… [inaudible]"

Time	
18:52	Detainee A: “fucking get off me” OiC: “Roll over and … [inaudible]” Detainee A: “No, I’ve got pains in my chest, get the fuck off me” OiC: “No” Detainee A: “Get the fuck off me” OiC: “We need to get this search done and then we’ll get you assessed” Detainee A: “No, no” OiC: “You need to just comply” Detainee A: “No” OiC: “You need to comply” Detainee A: “No” OiC: “Yeah you need to” Detainee A: “No” Four nurses and another person (possibly a CO) arrive as a result of the Code Pink that was called. One of the four nurses goes past door (out of frame).
	Detainee A bites a CO’s forearm. Detainee A: “fuck off, fuck off” CO2 Security enters cell and then steps back out. OiC: “get those legs in a lock”
	OiC asks “who’s got the knife?” one of the CO1’s responds “I do”
18:53	Another CO arrives (there are now 11, possibly 12, people on the scene). OiC: “[Detainee A], if you comply I’ll get them off you and we’ll get this over and done with” Detainee A: “get the fuck off me” Detainee A: says “if you get off, I’ll go with [CO2 CSU]”. “I’ve got pains in my chest, if you get off me I’ll go with [CO2 CSU]”. Detainee A then begins screaming for the CO2 CSU. CO2 CSU enters the cell but is pushed away and waits at door. CO2 CSU talks to Detainee A telling her to take a deep breath. The CO2 CSU appears distressed. Detainee A: “let me go with her” OiC: “I will when you calm down” Detainee A: “let me up, let me up and I won’t fuckin touch her” “let me up, I’ve got pains in me chest” OiC: “roll onto your side first” Detainee A: “you’re not listening” OiC: “No I am listening”

Time	
18:54	CO2 CSU, CO2 Security and nurse enter cell. Detainee A screaming "you're not fucking listening" Nurse motions with hand for COs to get off her. CO2 CSU: "I'm here [Detainee A]" repeatedly. Nurse exits cell. CO2 kneels down next to Detainee A and keeps talking to her. CO2 Security reaches into pocket and hand something to OiC (looks like safety scissors). OiC passes it to one of the CO1s. Different CO1 then passes it back to OiC. Detainee A is in a sitting position. CO2 CSU: "guys guys let me in" Someone: "she has to have the cuffs on" CO2 CSU: "[Detainee A] c'mon, please I tried [Detainee A]. C'mon deep breath. Me, you and Miss [CO name] will get the gear off and quickly go and do it. Please c'mon. Ok [Detainee A] you asked me to help, c'mon please" "it's ok, it'll be over soon, just let me get this arm, take a deep breath, take a deep breath for me" "how are we going, are we alright. Ok everyone step out for me, just give her a bit of space for me please"
18:55	All CO1s and OiC leave the cell. CO2 CSU remains sitting with Detainee A and talking to her.
18:56	Detainee A is given a cup of water and toilet paper.
18:58	Detainee A stands, goes to the sink and washes her hands.
18:59	Detainee A is walked from the cell to the bathroom where a strip search was conducted by two female officers.

Appendix 3: The effectiveness of routine strip searching- research summary

International standards recognise the harm caused by strip searching, particularly for people with a history of trauma. The United Nations Rules for the Treatment of Women Prisoners and Non-Custodial Measures for Women Offenders (the Bangkok Rules) recommend alternative screening methods replace strip searches and invasive body searches.[38] The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) recommend intrusive searches, like strip and body cavity searches, only be undertaken if absolutely necessary.[39] The United Kingdom now has a targeted, intelligence-based approach to strip searching of women after a report in 2007 highlighted that routine strip searching is humiliating, degrading and undignified.[40]

Research conducted in Australia has also highlighted the harm caused by strip searching. The Human Rights Law Centre noted that 'accounts from incarcerated women who have undergone strip searches describe feelings of humiliation, violation, powerlessness, fear and of having been abused, similar to that experienced as a result of sexual violence and abuse.'[41] The WA Inspector of Correctional Services surveyed prison staff and found that 'almost half of the 523 respondents reported seeing a person having a negative psychological or emotional reaction to being strip searched (48%).'[42]

Despite this harm, strip searching is justified in the basis of it being an effective way to detect contraband that risks the security and good order of a correctional centre. However, research has shown that strip searching is ineffective at detecting contraband. The WA Inspector of Custodial Services found that 900,000 strip searches were conducted in WA prisons over 5 years and only 571 contraband items were found. That is, only one in 1,500 searches uncovered contraband.[43] In addition, most of the 571 detected items were not drug or weapon related.[44] The Human Rights Law Centre reviewed six months of strip search register entries in two women's prisons in Victoria and found that in over 6,200 strip searches, only six items were discovered. Four of these were tobacco or nicotine products, one was a 'small quantity of gum' and one was an 'unidentified object'.[45]

38 *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders* (the Bangkok Rules), resolution adopted by the General Assembly, 6 October 2010, A/C.3/65/L.5, Rule 20.

39 *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the Nelson Mandela Rules), resolution adopted by the General Assembly, 8 January 2016, A/RES/70/175, Rule 52.

40 Home Office (United Kingdom), *The Corston Report: A report by Baroness Jean Corston of a Review of Women with Particular Vulnerabilities in the Criminal Justice System* (2007) 31, cited in Victorian Ombudsman, *Implementing OPCAT in Victoria: Report and inspection of Dame Phyllis Frost Centre* (November 2017), 59.

41 Human Rights Law Centre, *Total Control: Ending the routine strip searching of women in Victoria's prisons* (2017), 14.

42 Western Australian Office of the Inspector of Custodial Services, *Strip searching practices in Western Australian prisons* (March 2019), 2.

43 Ibid, iii.

44 Ibid.

45 Human Rights Law Centre, op cit n 38, 11.

Another argument for routine strip searching often made by prison authorities is that it deters detainees from hiding contraband. However, evidence suggests that this is not true. Three facilities in WA significantly reduced or eliminated strip searching and there was no increase in positive drug tests or detection of contraband through other searching methods.[46] In addition, there was a positive impact on the relationships between detainees and staff, which improved the safety of the facility.[47] Similar results came out of a pilot program commenced in Victoria in 2003 that reduced routine strip searching of female prisoners and increased random and targeted searches. Over two years, strip searches dropped from 21,000 to 14,000 and there was a 50% reduction in contraband finds and a 40% reduction in positive urine tests in the 12 months following the program's commencement. Other improvements included a positive effect on women's wellbeing and better relationships with staff.[48]

46 Western Australian Office of the Inspector of Custodial Services, op cit n 39, v.

47 Ibid, x.

48 Western Australian Office of the Inspector of Custodial Services, ibid n 38, 24.