Opening Statement by Ms Fiona Rafter, Inspector of Custodial Services

Inquiry into High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody

Tuesday 8 December 2020

Thank you for the opportunity to appear before you today. Firstly, I would like to acknowledge the traditional owners, the Gadigal people of the Eora nation. To assist the Inquiry with its work, I would like to provide some background about my role and functions as the Inspector of Custodial Services (**Inspector**) as well as the activities of my office (**Office**).

The Inspector is an independent statutory office created in October 2013 pursuant to the *Inspector of Custodial Services Act 2012* (NSW) (**Act**). The position of Inspector is appointed by the Governor of NSW. It is independent of Corrective Services NSW (**Corrective Services**), Youth Justice NSW (**Youth Justice**) and Justice Health and Forensic Mental Health Network (**Justice Health**) and reports directly to Parliament. The independence of the role of the Inspector is reinforced by section 19 of the Act which makes it an offence to obstruct, hinder, resist or threaten an Inspector, or their staff, in the exercise of functions under the Act.

The Inspector is one of a number of independent statutory agencies that play an important role in providing oversight of the custodial system in NSW. Each agency has separate and specific functions to provide the necessary oversight to the closed environment of custodial facilities. Resources are valuable and it is important that we do not duplicate our functions.

The NSW State Coroner (**Coroner**) is responsible for investigating and inquiring into deaths in custody (Recommendations 7 to 40 of the Royal Commission into Aboriginal Deaths in Custody), the NSW Ombudsman (**Ombudsman**) has a broad remit across Government but has a small custodial team that focuses on receiving and resolving inmate complaints (Recommendation 176 of the Royal Commission into Aboriginal Deaths in Custody (2012)), the Independent Commission Against Corruption (**ICAC**) also has a broad remit that includes alleged misconduct and corruption by Corrective Services staff and the Law Enforcement Conduct Commission (**LECC**) performs a specific role relating to police conduct and the review of police critical incidents.

My role does not duplicate their roles and the *Inspector of Custodial Services Act* guides my relationship with other independent statutory agencies, except the Coroner. I am able to refer individual complaints to the Ombudsman and I am obliged to refer alleged misconduct or corruption to ICAC or LECC.

The creation of an independent Inspector responds to Recommendation 328 of the Royal Commission and is distinct from the other oversight agencies that are primarily reactive in nature, given the focus of inspection is prevention and system improvement. Recommendation 333 of the Royal Commission is about the ratification of the Operational Protocol to the Convention Against Torture (**OPCAT**). The OPCAT aims to prevent the mistreatment of people in places of closed detention through a regime of regular independent inspections.

I note that in the Second Reading of the Inspector of Custodial Services Bill in May 2012 it was foreshadowed that the Inspector could be deemed to be part of the national preventive mechanism to assist the State in meeting its OPCAT obligations. The Commonwealth Ombudsman completed a baseline assessment of Australia's OPCAT readiness last year. They found that the Inspector has the necessary statutory powers and independence and that the Inspector meets the requirements of a National Preventive Mechanism (**NPM**). The Inspector is therefore OPCAT compliant and, in my view, any structural reform of the Office of the Inspector of Custodial Services could impact the requirements of an NPM. The WA Inspector of Custodial Services, on which the NSW Inspector is modelled, has already been announced as one of the NPMs for Western Australia.

A focus of my Office in 2020 has been preparing for the implementation of the OPCAT. We have reviewed our inspection methodology and implemented a new visitation methodology to increase regular visitation. We have reviewed our Inspection standards and entered into a collaboration with the University

of Sydney to develop a survey tool for use during inspections.[1] We continue to strive towards increasing diversity across our staff and expert consultants. To date, we have had three Aboriginal staff. We currently have 1 Aboriginal employee and we are recruiting for an Aboriginal inspection and liaison officer. This is a similar position to that which exists within the WA Office of Inspector of Custodial Services.

Section 17 of the Act provides that the Parliamentary Joint Committee on the Ombudsman, the Law Enforcement Conduct Commission and the Crime Commission has oversight to monitor and review the exercise of the Inspector's functions.

The activities of the Inspector relate to the inspection of custodial facilities and services as required by the Act. These functions are not triggered by the receipt of a particular complaint (as is primarily the case for the Ombudsman, nor in respect of a particular death in custody as is the case for the Coroner) Rather, the purpose of the Inspector is to proactively provide independent scrutiny of the conditions, treatment and outcomes for adults and young people in custody and to promote excellence in staff professional practice. The Inspector also monitors broader thematic and systemic issues arising from the inspection of adult and juvenile correctional facilities and services.

Section 6 of the Act sets out the functions of the Inspector. The principal function of the Inspector is to inspect each custodial centre at least once every 5 years and inspect each juvenile justice centre at least once every 3 years and report to Parliament on each such inspection. Section 6 also empowers the Inspector to examine and review any custodial service *at any time* and report to Parliament on each examination, inspection or review. The Inspector may report to Parliament on any particular issue or matter relating to its functions where it is, in the Inspector's opinion, in the interests of any person or in the public interest to do so. The Inspector is also required to report to Parliament on any particular issue or matter upon request by the Minister. For example, the reports on: "Use of Force, Separation, Segregation and Confinement in NSW Juvenile Justice Centres (2018)" and "Management of Radicalised Inmates (2018)" were prepared as a result of Ministerial requests. The Inspector may include advice or recommendations in its reports (including in relation to custodial centres and custodial services). The Inspector may exercise their functions on their own initiative, at the request of the Minister or in response to a reference by the Joint Committee or any public authority or public official. The Act also requires that progress on implementation of recommendations is publicly reported through my Annual Report.

As of December 2020, according to the fortnightly population report provided by Corrective Services, there were 36 correctional centres, 6 residential facilities, 12 24-hour court cells. There are also 6 juvenile justice centres. That is, 60 custodial facilities. The Inspector also has jurisdiction for 42 court cell locations, a fleet of 182 inmate transport vehicles and a detainee transport fleet of 23 vehicles. This represents a substantial body of work. The schedule for inspections is determined specifically in section 6 of the Act.

The inaugural Inspector, Dr John Paget, was appointed on 1 October 2013 and worked as the Inspector until October 2015. Since my appointment by the Governor in March 2016, and commencement in the role in April 2016, my primary focus has been to complete the inspections required by the Act and complete reviews of particular custodial services such as Rehabilitation services, Health and Transport. I have also completed two ministerial referrals.

In addition to inspections, we conduct liaison and monitoring visits to custodial centres to inform our inspection activities, and monitor the implementation of recommendations.

Since my appointment, the resources have grown from 4 to 14.2 full time equivalent staff in addition to myself. Expert consultants are also engaged for the purposes of assisting with the conduct of inspections, the preparation of various reports and to enhance my capacity to examine specialised operational areas requiring particular expertise. For example, I engage health practitioners, Aboriginal elders, operational and security experts, Inspectors from other jurisdictions and academics to assist me with my inspections and reports.

The Inspector is also charged with the oversight of the Official Visitor program conducted under the *Crimes (Administration of Sentences) Act 1999* (NSW) and the *Children (Detention Centres) Act 1987* (NSW) including advising, training and assisting Official Visitors to perform their functions. We have 94 Official Visitor positions (82 for adult corrections and 12 for juvenile justice). Amongst other functions, the

[1] Inspector of Custodial Services, *Annual Report 2019-2020,* page 32.

Official Visitors provide me with a 6 monthly report on conditions. When I commenced as Inspector, there were no Aboriginal Official Visitors appointed to juvenile justice facilities and there were 3 Aboriginal Official Visitors for the entire adult correctional system. This was a significant concern for me. There are now 5 juvenile justice Aboriginal Official Visitors. We currently have 11 Aboriginal Official Visitors appointed to 20 centres and have recommended the appointment of a further 3 Aboriginal Official Visitors to 5 custodial facilities. Two Aboriginal Statewide Official Visitors attend centres that do not have an Aboriginal Official Visitor appointed.

Section 6(1) (d) of the Act requires that I report to Parliament on the results of each inspection, examination or review. This complies with the requirements of the OPCAT and differentiates the role of the Inspector from, for example, the Ombudsman's investigations.

Since my appointment in March 2016, my staff and I have undertaken approximately 200 liaison/monitoring visits to custodial centres and 66 custodial centre inspections across NSW. This translates, on average, to approximately 3 liaison visits and between 1 and 2 centre inspections each month. During this period, we have tabled 13 significant reports in Parliament which relate to 60 custodial facilities and include 395 recommendations directed towards Corrective Services, Youth Justice, Justice Health or the relevant private provider where a custodial centre is operated under this model.

Over the 2019-20 financial year, despite COVID-19, my staff and I undertook 11 inspections and 54 liaison visits and met its mandate to inspect youth justice centres every 3 years. In this period, 4 reports were tabled in Parliament relating to the inspection of 23 custodial facilities in NSW which were titled:

1. "Women on Remand";

2."Inspection of Five Minimum Security Correctional Centres in Non-Metropolitan NSW";

3."Programs, Employment and Education Inspection"; and

4."Inspection of the Residential Facilities and the Compulsory Drug Treatment Correctional Centre".[2]

We also implemented an inspection methodology for individual custodial facilities having regard to our "Inspection Standards" and moved away from only theme based or multi centre inspections.

More recently, in the 2020-2021 financial year to date, we have tabled five reports, continued a regime of COVID-19 monitoring, conducted 41 liaison visits and conducted one significant Inspection. The reports are:

1. Inspection of Mary Wade Correctional Centre;
2. Inspection of Kariong and Kirkconnell Correctional Centres and the Integration Support Centre;
3. Inspection of Macquarie Correctional Centre and Hunter Correctional Centre;
4. Inspection of Cooma Correctional Centre; and
5. Inspection of Oberon Correctional Centre.

The *investigation* of individual complaints, suspected criminal conduct, misconduct and corruption and deaths in custody are not within the remit of the Inspector. They are instead within the remit of other agencies such as the Ombudsman, ICAC and the Coroner.[3] Division 3 of the Act sets out the relationship of the Inspector with other agencies, including the Ombudsman and ICAC, and provides for the Inspector to enter into arrangements with them on certain matters. Such arrangements have become embodied in Memorandums of Understanding (**MOUs**) between the Inspector and the Ombudsman and ICAC respectively. For example, the MOU currently in place between the Inspector and the Ombudsman (signed December 2014) defines the distinct and unique roles of each agency and sets out the arrangements for which the Inspector and the Ombudsman are empowered and required to exercise their functions including, for example, in relation to liaising and information exchange.

Unlike the Ombudsman, the Inspector is not specifically a body with an investigative function, nor does it have a complaints-handling role. Rather, it is an inspectorate and provides external scrutiny of the operational practices of custodial facilities and services provided on a proactive, rather than reactive

[2] Inspector of Custodial Services, *Annual Report 2019-2020,* pages 7, 8 and 30.
[3] Inspector of Custodial Services, *Annual Report 2019-2020,* page 5.

basis. The Inspector also monitors broader thematic and systemic issues arising out of that external scrutiny and maintains ongoing communication and consultation with the Ombudsman, amongst other stakeholders, regarding complaint trends and areas of interest for inspection.[4] It is not the remit of the Inspector to investigate individual deaths in custody. However, to the extent that such deaths raise systemic or thematic issues of concern, it can fall within my jurisdiction and I can make them a focus of my inspections or I could conduct a thematic review and report to Parliament in relation to them.

Any unnatural death of an Aboriginal person is a tragedy. I am mindful that under the *Coroner's Act 2009* (NSW) the Coroner is charged with the responsibility of investigating individual deaths in custody (whether amongst the Aboriginal prisoners or non-Aboriginal prisoners). I am respectful of the Coroner's primacy in investigating such deaths (with the assistance of NSW Police) and do not interfere with these inquiries.

The Inspector's role is distinct from that of the Coroner's: it is to proactively look to systemic issues. I maintain my own records about the cause of death (for example, natural or unnatural causes). My records in relation to deaths in custody also include information about whether a person is Aboriginal. Although it is not a formal requirement, I receive notifications of any death in custody from Corrective Services. I also monitor the Coroner's findings and recommendations surrounding deaths in correctional facilities in NSW.

If it was determined that I should have an investigative function for critical incidents including deaths in custody or escapes, such as the ACT Inspector, it would require a legislative amendment to the functions of my role. Additional resources would also be required.

Having said that, I am not convinced that this is the right course of action, nor is setting up a new investigative body. I favour providing the Coroner and the Aboriginal Legal Service with additional resources that increases the timeliness of Coronial Inquests, enhances trust in the process, and is culturally competent, informed by the views of the many Aboriginal people who have been prepared to either make submissions or come before this Committee and share their views on this important issue.

The Committee may wish to consider recommending the Inspector be given a specific function to monitor the implementation of Coronial recommendations and report that publicly in our Annual Report. This would be consistent with our existing prevention, monitoring and reporting functions.

In preparation for all inspections of a facility, I request key information. This information allows me to target particular issues that may arise in a facility and enables me to select the most appropriate team to assist me in my inspection. For example, and relevantly to this Inquiry, I request information about the percentage of Aboriginal people at the facility. Since 2017, where the data indicates that it would be warranted, I have engaged the assistance of an Aboriginal elder as a consultant. I have noticed that the presence of an Aboriginal elder on my team has had a significantly positive impact on engagement with Aboriginal prisoners and staff within a facility. As a result of this experience, I have advertised for an Aboriginal Inspection and Liaison Officer. I anticipate this role will be filled by early 2021 to assist with our schedule of Inspections next year.

My staff and I are currently finalising a Health Services Report which will address some issues in relation to the health of Aboriginal people in custody It is a complex thematic report. It has involved the inspection of 6 facilities and required visits to other facilities. There have been substantial data requests. I am using a consultant who is a qualified health practitioner and an Aboriginal elder with health qualifications. The "Women on Remand" report discusses health services for women in custody. There is a high prevalence of mental disorder and poor self-reported psychological well-being amongst incarcerated women. I have observed that Aboriginal women have an elevated risk of mental health issues and consider that Aboriginal specific options for mental health care are required, that are culturally safe and responsive to individual needs.[5]

The issues facing Aboriginal people in custody are pivotal concerns to me in my inspections and form the focus of many of my reports and the recommendations. . For example, my reports titled "Women on Remand", "Mary Wade Correctional Centre", "Residential Facilities and the Compulsory Drug Treatment Correctional Centre", as well as others have made a number of recommendations relating to the over-representation of Aboriginal women in custody.

[4] Inspector of Custodial Services, *Annual Report 2019-2020,* page 23.
[5] Inspector of Custodial Services, *Women on Remand* (February 2020), page 14.