Submission No 102

INQUIRY INTO HIGH LEVEL OF FIRST NATIONS PEOPLE IN CUSTODY AND OVERSIGHT AND REVIEW OF DEATHS IN CUSTODY

Organisation: National Justice Project

Date Received: 31 August 2020

National Justice Project

Submission to the Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody

August 2020

WARNING: *First Nations readers should note that this submission uses the name of the deceased with the permission of his family.*

"There's evidence of all the ancestors of what's happened in the past with deaths in custody. I'm the only one standing up for their rights. They've got to stop killing us."

– Leetona Dungay (Mother of David Dungay Jr, a young and proud Dunghutti man who died in custody while being held face down by 6 prison officers until he lost consciousness and his heart stopped)

FAMILY STATEMENT

LEETONA DUNGAY

30 August 2020

My name is Leetona Dungay. I am the mother of David Joseph Dungay.

I want to start by thanking the Legislative Council committee for allowing me to make submissions to your inquiry.

I address you on behalf of myself and also my three other children – Christine, Ernie and Cynthia and also for our whole mob – a whole family based mostly in Kempsey.

The first thing I want to do is to thank the traditional owners of the land where you meet – the Gadigal people.

I acknowledge Eora Elders past and present too.

Let me explain where we come from. The people around Kempsey are called the Dunghutti people. My son David Junior was a proud Dunghutti man.

David was born in Kempsey, at the old Burnt Bridge Mission on Pipers Creek Road in 1989. He was my youngest son.

He was dearly loved by his two older siblings Ernie and Christine and also his younger sister Cynthia.

As he got older Junior learned as he grew up how to take responsibility for his diabetes condition. He carried jelly beans and Jatz crackers around in case of his blood sugar becoming low. This condition was a constant burden, but Junior was also very knowledgeable about diabetes and proud of his ability to manage it independently.

He impressed his high school teachers who always gave him praise and encouragement. He completed the year 10 certificate successfully - something we were very proud of.

After David left school he got a job with CDEP. It is a Government funded program for Aboriginal youth. He used to mow lawns and collect rubbish. He worked a couple of days a week and got paid. It is very hard for young adults, who have just left school, in Kempsey to find employment. But David was keen to do it – he was growing into a lovely young man.

Later David made some bad mistakes and was locked up for this. He did his time, and he paid his debt to society. He was determined to come out and start a new life. He was so close to being free and being with us all again.

Next I want to share with you all some stories about my son David and what he meant to our family.

We all heard his voice on the phone call he made to his sister just an hour or two before he died. He was kind, loving, caring and beautiful.

This is the son, the brother, the uncle that we all knew and loved.

When we learned of my son's death we were all in shock. No mother should ever have to feel the pain of burying a son and then watching how he died begging to breathe. The world has seen the footage of David begging for his life, screaming "*I can't breathe*" to his last gasp.

One minute my beautiful son was alive and healthy. The next he was dead.

A few days later I viewed my son's body.

At the inquest, we heard experts say there was never any serious or immediate risk posed by David eating the biscuits and he posed no security risk in his cell – why then, did the prison officers have to raid his cell then and assault David?

The pain has stayed with us all for nearly five years now.

My family is extremely disappointed that just after David died a NSW Corrective Services Assistant Commissioner told the media that police were not treating the death as suspicious.

Imagine if that was your son.

My son was held face down by 6 prison officers until he lost consciousness and his heart stopped.

Those are the simple facts.

We have listened to the apologies that have been made for what happened to David.

We know that some changes have been made but they are not enough and that they are not systemic.

Some recommendations came out of the inquest to improve the way the gaol operates but there has been no justice for me, my family and my people from the NSW State after the death of my son.

Safework NSW won't investigate my son's death and the DPP says he can't investigate my son's death even though one of Sydney's leading criminal barristers says that there is sufficient evidence for charges to be considered by the DPP.

That's why my people are crying out that "*Black Lives Matter*"! When will you take our deaths seriously?

When someone cuts off a finger at work, Safework NSW are all over their employer like a rash – but if you're black – Safework NSW won't lift a finger to investigate and prosecute your death in custody.

When a Barrister like Phillip Boulton SC says that there is evidence to prosecute, the DPP says they can't investigate my son's death. That response is a slap in my face. I attach a copy of Mr Boulton's advice for you to read for yourself.

Black lives do matter and me and my family are not going to stop until someone is held accountable.

The system is broken and this parliament has the power to fix it.

You should be able to change the law so there is a pathway for the DPP to investigate my son's death.

You should be able to change the law to make Safework NSW investigate my son's death when there have been public apologies by those responsible for the care of my son for what happened to him.

We don't want another family to have to suffer what we are going through. We want Black lives to matter.

There is one strong, burning desire that I have and that my whole family has – it is something that is keeping us going through the ongoing trauma – we want to see justice for David's death.

Changes and improvements are one thing, but we believe someone or some organisation must be held accountable.

Thank you.

ABOUT THE AUTHORS

This submission has been co-authored by the National Justice Project (NJP) together with students of the Monash University Law Clinic and Macquarie University Social Justice Clinic. The submission was initiated by Adjunct Professor George Newhouse, CEO of the NJP and supervised by Steven Castan, Chair of the NJP, alongside Christina Athanasopoulos, MQ Social Justice Clinic Coordinator at the NJP.

Ms Leetona Dungay (David's mother) and Ms Christine Dungay (David's sister) were interviewed by the NJP on 21 August 2020 and this submission is in-part based their direct testimonies. We emphasise the critical importance of hearing the voices of this First Nations Dunghutti family who have lived through the trauma of losing a loved one in custody and who are still awaiting justice.

The National Justice Project

The NJP is a not-for-profit human rights legal service that works to eradicate institutional discrimination through advocacy, education and legal action. We apply our expertise to advancing human rights by representing First Nations clients who would otherwise be unable to find legal representation.

We acknowledge and celebrate the unique lore, knowledges, cultures, histories, perspectives and languages that Australia's First Nations Peoples hold. The NJP recognises that throughout history the Australian legal system has been an instrument of oppression against First Nations Peoples. The NJP seeks to strengthen and promote dialogue between the Australian legal system and First Nations laws, governance structures and protocols. We are committed to achieving social justice and to bring change to systemic problems of abuse and discrimination.

We have represented, and continue to represent, many clients who have been directly impacted by the NSW Coroner's policies and procedures surrounding First Nations deaths in custody. The traumatic effects of First Nations deaths in custody are felt across every community and every generation. These deaths are shattering First Nation families and communities who are left to deal with legal process which only re-traumatise them. It is from this perspective that we make the following submissions.

Acknowledgement of Country

The NJP pays its respects to First Nations Traditional Owners and Elders, past and present, and extends that respect to all First Nations Peoples. The NJP acknowledges the diversity of First Nations cultures and communities and recognises First Nations Peoples as the traditional owners and ongoing custodians of the land on which this report was written.

A. TERMS OF REFERENCE

The Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody was established on 17 June 2020 to inquire into and report on:

1. The unacceptably high level of First Nations people in custody in New South Wales,
2. The suitability of the oversight bodies tasked with inquiries into deaths in custody in New South Wales, with reference to the Inspector of Custodial Services, the NSW Ombudsman, the Independent Commission Against Corruption, Corrective Services Professional Standards, the NSW Coroner and any other oversight body that could undertake such oversight,
3. The oversight functions performed by various State bodies in relation to reviewing all deaths in custody, any overlaps in the functions and the funding of those bodies,
4. How those functions should be undertaken and what structures are appropriate, and
5. Any other related matter.

B. EXECUTIVE SUMMARY

SUBMISSIONS

We have read, acknowledge and endorse the recommendations made by the Jumbunna Institute for Indigenous Education and Research in their submissions to this Select Committee.

Additional to those submissions, and in addressing the terms of reference, we make the following submissions:

a) The disproportionate contact of First Nations Peoples with the criminal justice system is caused by systemic prejudice or bias in the manner in which our laws are enforced by police. This is reflected by: the criminalisation of minor offences, addiction and mental illness; over-policing; abuse of police power, and; the abuse of custodial sentencing.

b) First Nations Peoples are put at an unacceptable risk of death or harm in custody due to a lack of cultural safety, inadequate supervision and inadequate healthcare.

c) Existing oversight bodies tasked with investigating the First Nations deaths in custody such as the Coroner's Court, police investigators and the Law Enforcement Conduct Commission (LECC) are not implementing the recommendations of the *Royal Commission into Aboriginal Deaths in Custody* (RCIADIC)[1] or meeting the needs of First Nations people, particularly given the lack of First Nations involvement in these systems and the lack of oversight. First Nations Peoples do not feel safe knowing that it is police investigating police or prison guard actions.

d) There is a lack of proper notification to First Nations families in relation to the death of a relative in custody, re-traumatising the families, and there is a lack of support and legal services offered to those families.

e) There is a lack of accountability for the First Nations deaths that occur in custody.

f) The family of Dunghutti man, David Dungay Jr, feel that they have been unheard and denied justice. The family demand that Safework NSW and the NSW Director of Public Prosecutions (DPP) review their decisions not to investigate David's death.

[1] *Royal Commission into Aboriginal Deaths in Custody* (Final Report and Recommendations 1991) (To be referred to hereon as

RECOMMENDATIONS

1. Reduce overincarceration of First Nations Peoples

a) Support and invest in community-based and led diversion programs, healing and leadership to promote self-determination and cultural safety;
b) Close youth prisons and increase the age of criminal responsibility;
c) Reform outdated laws to reduce incarceration and pathways into the criminal justice system, decriminalise minor offences, mental illness and addiction and provide rehabilitative support;
d) Reform the *Police Act 1990* (NSW) to change the language of 'Police Force' to 'Police Service'. This language would reflect a change in objectives to focus on diversion from the criminal justice system, community policing and policing by consent.

2. Properly fund and provide appropriate and culturally safe care in detention delivered by culturally appropriate services with such care to include wholistic health care, mental health care, disability care and rehabilitation. *Fund First Nations-led education and rehabilitative programmes inside prison and youth detention and provide multi-disciplinary services, support and housing to individuals when they leave prison or detention*

3. Properly fund and establish a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability and reform of the justice system. *The investigative body should have the power to examine the death of a First Nations person in prisons, corrective services, transport, health and police. Such a body needs to have real powers to make recommendations, including to refer for prosecution and to undertake regular prison and youth detention inspections.*

3.1 In the interim and at the very least, the Coronial System needs to be overhauled with the appointment of First Nations Coroners to investigate and make recommendations about deaths in custody and expand their jurisdiction to consider broader issues and make recommendations about those issues.

4. Implement and provide resources for the implementation of the recommendations made in previous inquiries*, including RCIADIC, Pathways to Justice Report,*[2] *Jumbunna Institute BLM Call Out, Universal Periodic Reviews,*[3] *Special Rapporteur Country Visit Report.*[4] *Viable solutions have been provided time and time again – all that is lacking is political will.*

5. Self-Determination and Accountability*. First Nations communities need to be leading the abovementioned reforms and the overhaul of the existing criminal justice system to ensure that changes made are meaningful and proportionate to the deeply disturbing entrenched racial bias within existing systems, and they need to be funded to do so.*

[2] Australian Law Reform Commission, *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Report No. 133, December 2017) ('*Pathways to Justice Report*').
[3] *Human Rights Council, Universal Periodic Review Report of the Working Group on the Universal Periodic Review: Australia,* UN Doc A/HRC/WG.6/23/AUS/1 (7 August 2015).
[4] Human Rights Council, *Report of the Special Rapporteur on the rights of indigenous peoples on her visit to Australia*, UN Doc A/HRC/36/46/Add.2 (8 August 2017).

C. BACKGROUND

Royal Commission

Almost thirty years have passed since the RCIADIC.[5] Despite this, First Nations Peoples continue to be grossly over-represented in Australia's prison system, with deleterious social and health outcomes. First Nations people continue to die in custody without accountability, without answers, and without justice. Notwithstanding a Royal Commission and numerous other human rights enquiries, the majority of the recommendations have not been implemented.

As at March 2020, First Nations Peoples account for 28% of the national prison population despite only being 3% of the Australian population.[6] In parts of NSW, First Nations people are twice as likely to go to jail than non-Indigenous people for the same offence.[7] According to the Australian Institute of Criminology, there were 247 Indigenous deaths in prison custody in the period from 1991-92 to 2015-16. In that period, NSW recorded the highest number of Indigenous deaths in custody, with 67 fatalities.

Additional to the RCIADIC Recommendations, there have been numerous reports and inquiries by human rights bodies, First Nations organisations and successive governments relating to the over-incarceration of First Nations people,[8] yet this has not resulted in meaningful action or improvement of circumstances. The NJP submits that this tragedy is not due to a lack of practical solutions but because of an absence of political will. The Select Committee must not allow yet another opportunity for reform presented by this Inquiry to lapse without consequence. We call on the NSW Parliament to take immediate, specific and meaningful steps to reduce the over-incarceration and deaths in custody of First Nations people.

David Dungay Jr

On 29 December 2015, David Dungay Jr died in Long Bay Prison of cardiac arrhythmia whilst being restrained by the prison's Immediate Action Team (IAT). On the date of his death, David was eating rice crackers and biscuits in his cell within the Mental Health Unit at Long Bay Prison. Requests were made of David to stop eating the crackers, which he refused to do. The response was for six IAT to move David into another cell, which they did using extreme force. The six IAT officers restrained David, with a knee in his back, while he pleaded for the officers to get off him. David cried that he could not breathe more than ten times. David became unresponsive during this event. He was later pronounced deceased. The harrowing footage of these events can be found on the internet.[9]

From the time of Mr Dungay's death in 2015 to the release of the Coronial Inquest Report in November 2019, his family have been left in the dark about what happened to their loved one. The process was legalistic and alienating and at the end of the process his family have seen no justice. The Dungay family have drawn comparisons between David's death and the death of George Floyd in the USA. They emphasise that riots and protests ensued overseas due to the startlingly similar events. The Dungay family have expressed that they are not violent people, but they ask Australia – What will it take to cause that same outrage for First Nations victims? What will it take to get them justice?

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[5] Above n 1, vol 5.
[6] Australian Bureau of Statistics, *Persons in Custody, Australia, March Quarter 2020* (Catalogue No 4512.0, 4 April 2020); Australian Bureau of Statistics, *Estimates of Aboriginal and Torres Strait Islander Australians, June 2016* (Catalogue No 3238.0.55.001, 31 August 2018).
[7] Ella Archibald-Binge, Nigel Gladstone & Rhett Wyman, 'Aboriginal people twice as likely to get a jail sentence, data shows', *The Sydney Morning Herald* (17 August 2020).
[8] Above n 2, 3, 4.
[9] Lorena Allam, 'David Dungay inquest: guards who restrained Indigenous man before his death won't be disciplined', *The Guardian* (22 November 2019) <https://www.theguardian.com/australia-news/2019/nov/22/david-dungay-inquest-guards-who-restrained-indigenous-man-before-he-died-wont-be-disciplined>.

D. SUBMISSIONS

a) *DISPROPORTIONATE CONTACT WITH THE CRIMINAL JUSTICE SYSTEM*

TERMS OF REFERENCE 1

We submit that the disproportionate contact of First Nations peoples with the criminal justice system is caused by systemic prejudice or bias in the manner in which our laws are enforced by police. This is manifested by:

a) the criminalisation of minor offences, addiction and mental illness;
b) over-policing; abuse of police power, and;
c) the abuse of custodial sentencing.

Many of these issues were considered extensively by the Australian Law Reform Commission (ALRC) *Pathways to Justice Report*. We are disappointed that so few of the recommendations proposed by the ALRC to address these issues have been implemented in NSW.

i. Criminalisation and Custodial Sentencing

Australia's response to criminal behaviour has been through increasingly punitive measures. Australia saw a 100% increase in incarceration between 1984 and 2012, despite continually declining crime rates.[10] This has disproportionately affected First Nations people who are overly represented in our prison system.[11]

As part of its *Pathways to Justice* inquiry, the ALRC commissioned a detailed statistical review of the incarceration rates of First Nations peoples. This research established that, on a national level, First Nations people are:

- 7 times more likely than non-Indigenous people to be charged with a criminal offence and appear before the courts;
- 12.5 times more likely to receive a sentence of imprisonment than non-Indigenous people;
- more likely to have a prior record of imprisonment, with 76% of First Nations prisoners having been in prison previously.[12]

The ALRC research data also indicated that 45% of First Nations offenders received a sentence of less than six months, compared with 27% of non-Indigenous offenders.[13] The most common offences for which these short sentences were imposed were public order offences, justice-related offences, property damage and 'miscellaneous' offences.[14]

Currently, young First Nations people are around 13 times as likely to be under youth justice supervision as non-Indigenous young people.[15] The *Pathways to Justice* report cited research indicating that young

[10] William R. Wood, 'Justice Reinvestment in Australia' (2014) 9(1) *Victims & Offenders*, 100, 100.
[11] Above n 6.
[12] Above n 2, 3.2.
[13] Ibid.
[14] Ibid 3.68.
[15] Australian Institute of Health and Welfare, 'Youth justice in Australia 2018–19' (15 May 2020) <https://www.aihw.gov.au/reports/juv/132/youth-justice-in-australia-2018-19/contents/state-and-territory-factsheets/new-south-wales>.

First Nations persons were less likely to be diverted away from the criminal justice system by police.[16] This is despite the *Young Offenders Act 1997* (NSW) specifically providing for the use of warnings, cautions and conferences to address the over representation of First Nations children in the criminal justice system.

ii. Abuse of Police Powers

'*The first step in almost every Aboriginal custody is a police action*.'[17] The excessive and discretionary powers afforded to police are too often exercised in a way that is discriminatory against First Nations people.[18] For example, data from the NSW Bureau of Crime Statistics and Research (BOCSAR) illustrated that in 2017, NSW Police took 86% of First Nations people found with a non-indictable quantity of cannabis to court, compared to 54% of non-Indigenous people. While police have a discretion to issue a caution for this offence, only 9% of First Nations Australians were issued with a caution, compared to 39% of non-Indigenous people. These cautions are designed to reduce contact with the criminal justice system for minor offences and yet the discriminatory use of police discretion triggers a process of criminalisation.[19]

Recent reports have highlighted the disproportionate use of invasive police search powers in relation to First Nations people. NSW Police data showed that in 2017-18, First Nations people represented 9.8% of all strip searches in the field.[20] One case study included a strip search of a 12-year-old boy by police outside a supermarket.[21] In 2018-19, First Nations people represented 23.1% of all strip searches in police stations. Also of concern is the discriminatory use of drug detection dog operations in localities known to have a sizeable First Nations community, despite low levels of success in identifying drugs.[22] When these powers are applied in a discriminatory manner, it gives rise to a concern that Police are seeking to control, intimidate and humiliate First Nations people.[23]

iii. Cultural Safety

An individual experiences cultural safety as an environment: where there is no assault on, challenge to or denial of their identity, their way of being and their needs. Cultural safety is borne of shared respect, shared meaning, shared knowledge and experience, and involves learning, living and working together with dignity, and truly listening.[24] It encompasses self-reflection by officials on individual cultural identity and a recognition of the impact of another individual's culture on their professional practices.[25]

A lack of cultural safety policy and training in the police force – involving a lack of protective policies and strategies, a lack of understanding and education about First Nations communities and cultures, and ingrained prejudices against First Nations Peoples – has contributed to the strained relationship between First Nations people and the police.[26]

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[16] Above n 2, 453 [14.24].
[17] Above n 1, vol 2 [13.1.1].
[18] Above n 2, 448 [14.6].
[19] Michael McGowa and Christopher Knaus, ''Essentially a cover-up': why it's so hard to measure the over-policing of Indigenous Australians,' *The Guardian* (13 June 2020) <https://www.theguardian.com/australia-news/2020/jun/13/essentially-a-cover-up-why-its-so-hard-to-measure-the-over-policing-of-indigenous-australians>.
[20] Dr Michael Grewcock and Dr Vicki Sentas, *Rethinking Strip Searches by NSW Police,* < https://rlc.org.au/sites/default/files/attachments/Rethinking-strip-searches-by-NSW-Police-web.pdf> 31.
[21] Ibid.
[22] Ibid.
[23] Ibid.
[24] Robyn Williams, 'Cultural safety — what does it mean for our work practice?' (1999) 23(2) *Australian and New Zealand Journal of Public Health* 213-214.
[25] Maryann Bin-Sallik, 'Cultural Safety: Let's Name It' (2003) 32 *The Australian Journal of Indigenous Education*, 21-28.
[26] Aboriginal Legal Service NSW/ACT - Supplementary Submission, Submission No 112 to Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (10 October 2017).

Cultural safety starts with a First Nations designed policing policy and strategy rolled out throughout NSW and includes:

- Education about the social and historical factors that have contributed to the disadvantaged position of many First Nations people in society, as recommended in the RCIADIC;[27]
- Education about the history of relations between the police and First Nations communities, as recommended in the RCIADIC;[28]
- Learning how to respectfully and effectively communicate with people of low literacy, people with English as a second language or who speak different forms of English, such as Aboriginal English;[29]
- Education about the community, its history, its key figures and the dynamics within the First Nations community, within which the police officer is going to serve; and
- On-country type experiences as opposed to teacher-centred learning.[30]

Training should be ongoing and be more than a short session at the Police training academy. First Nations designed policing policy and strategy and police cultural safety practices and training curricula should be regularly reviewed and refreshed in conjunction with First Nations people.[31]

iv. Justice Reinvestment

Justice reinvestment is an emerging approach to tackle high incarceration rates of First Nations people by diverting funds currently being spent on policing and prisons and reinvesting in community programs.[32] The recent 'Black Lives Matter' protests internationally in the wake of the death of George Floyd, and similar protests here in Australia following the death of Mr David Dungay Jr, have drawn increased attention to 'defunding the police' and justice reinvestment as an alternative to police orientated justice.[33]

The Maranguka Justice Reinvestment Project in Bourke NSW exemplifies the effectiveness of justice reinvestment. The project effectively reduced the overall crime rates in the Bourke area as well as providing substantial economic saving by diversion from custodial and criminal justice settings.[34] The project saw a clear increase in the number of people gaining licences, while the number of driving offences decreased.[35] Its effectiveness can be attributed to its focus on targeting the underlying factors which may cause driving offences, such as lack of access to vehicles and supervisors, identification documents, and language and literacy issues which may be obstacles for written tests.[36]

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[27] Above n 1, vol 5, 228.
[28] Ibid.
[29] James Pilkington, North Australian Aboriginal Justice Agency, *Aboriginal Communities and the Police's Taskforce Themis: Case studies in remote Aboriginal community policing in the Northern Territory* (October 2009), 10.
[30] Juli Coffin, Gillian Kennedy and Julie Owen, 'Cultural Security Audit for WA Police' (Audit Report, March, 2018) 4.
[31] Ibid.
[32] Justice Reinvestment NSW, 'What is Justice Reinvestment?', *Justice Reinvestment NSW* (Web page, no date) <http://www.justreinvest.org.au/what-is-justice-reinvestment/>.
[33] Manni Truu, 'Some US cities are moving to defund the police. Could a different system work in Australia too?', *SBS News* (online, 10 October 2020) <https://www.sbs.com.au/news/some-us-cities-are-moving-to-defund-the-police-could-a-different-system-work-in-australia-too>.
[34] Key findings of the 2018 KPMG Impact Assessment the project included, 23% reduction in police recorded incidence in domestic violence and comparable drops in rates of reoffending, 31% increase in year 12 retention rates and 38% reduction in charges across the top five juvenile offence categories and 14% reduction in bail breaches and 42% reduction in days spent in custody: Justice Reinvestment NSW, 'Impact of Maranguka Justice Reinvestment: KPMG Assessment', *Justice Reinvestment NSW* (web page, no date) <http://www.justreinvest.org.au/impact-of-maranguka-justice-reinvestment/>.
[35] Simon Leo Brown, Chris Bullock and Ann Arnold, 'Three projects linking Aboriginal communities and police that are helping to stop more indigenous people going to jail,' *ABC News* (Online, 10 July 2020) <https://www.abc.net.au/news/2020-07-10/indigenous-incarceration-rates-programs-community-police/12433372>.
[36] Above n 2, 413-414, [12.131].

As the first major justice reinvestment project in Australia, the Maranguka Justice Reinvestment Project works in coordination with government and non-government agencies to create targeted methods of crime prevention, diversion and community development.[37] The Maranguka program effectively implemented the RCIADIC recommendation to identify and address the relevant factors leading to motor vehicle offences and to design community programs to address those factors.[38]

Justice reinvestment is the leading recommendation in the *Pathways to Justice Report*.[39] Consequently, what is now required is government commitment to implement these programs. However, the onus cannot simply be on First Nations communities to reduce contact with the criminal justice system. The NJP submits that police bias, discrimination and over-policing must also be addressed in tandem with community-led programs. We submit that where there is political will to incorporate existing viable solutions, for instance those recommended within RCIADIC, meaningful change will follow.

RECOMMENDATIONS

1. Reduce overincarceration of First Nations Peoples

a) Support and invest in community-based and led diversion programs, healing and leadership to promote self-determination and cultural safety;
b) Close youth prisons and increase the age of criminal responsibility;
c) Reform outdated laws to reduce incarceration and pathways into the criminal justice system, decriminalise minor offences, mental illness and addiction and provide rehabilitative support;
d) Reform the *Police Act 1990* (NSW) to change the language of 'Police Force' to 'Police Service'. This language would reflect a change in objectives to focus on diversion from the criminal justice system, community policing and policing by consent.

b) *UNACCEPTABLE RISK OF DEATH IN CUSTODY*

TERMS OF REFERENCE 5

We submit that First Nations Peoples are put at an unacceptable risk of death or harm in custody due to a lack of cultural safety, inadequate supervision and inadequate healthcare.

The RCIADIC found that Aboriginal people in custody do not die at a greater rate than non-Indigenous people in custody. However, statistics from BOSCAR revealed that First Nations people were 14.7 times more likely to die in police custody and 17.4 times more likely to die in prison than the general population between 1990 and 1995.[40] We submit to you the Dungay family testimony to humanise these statistics and to demonstrate the lethal impact that a lack of adequate, culturally sensitive medical care can have.

i. Dungay Family Testimony

Ms Leetona Dungay and Ms Christine Dungay expressed concerns about David's health care around the time of his death. David was suffering from chronic schizophrenia and had a lengthy history of Type I

[37] KPMG, *Unlocking the Future: Maranguka Bourke* (Preliminary Assessment, 2016) 71.
[38] Above n 1, vol 5, rec 95.
[39] Above n 2, ch 4.
[40] See table 3.1 at Australian Human Rights Commission, 'Indigenous Deaths in Custody 1989-1996' *Indigenous Deaths in Custody: Chapter 3 Comparison: Indigenous and Non-Indigenous Deaths, Part B – Statistical Analysis* < https://humanrights.gov.au/our-work/indigenous-deaths-custody-chapter-3-comparison-indigenous-and-non-indigenous-deaths>.

diabetes, first diagnosed at age five or six. From 2010 whilst David was in custody, he was known to experience periodic seizures related to episodes of hypoglycaemia. Leetona and Christine noted that David's blood sugar was high on the day of and in the weeks leading up to and his death. The family contend that the disregard for David's health needs, along with the lack of cultural understanding on the part of the prison staff, contributed to the decline of David's health in custody.

Ms Leetona Dungay emphasised that although David's health was of known concern leading up to his death, appropriate action was not taken for David to get the specialised care he required. While in custody, a nurse referred David to Prince of Wales Hospital for a diabetes assessment by a specialist. This assessment was supposed to occur in the weeks prior to David's death, but never eventuated.

> **"*The nurse knew two weeks prior to my son's death, that she had to get him out into a … hospital… [for a diabetes review]. My son would be still alive if she had sent him to a hospital to get checked over for what sickness he had.*" – Leetona Dungay**

Ms Christine Dungay framed the events on the date of David's death by providing context about how David learned to manage his diabetes from a young age. From the approximate age of ten years, David would carry a small bag of jelly beans and Jatz crackers. When David felt his blood sugar levels were low, he would eat some jelly beans. When he felt his blood sugar was high, he would eat the salty crackers. This was to stabilise his sugar levels to avoid a diabetic coma or fit. David was eating crackers in his cell at Long Bay Prison before being ordered to give them up. David was known to have had high blood sugar levels at the time and Christine believes that he was managing his diabetes himself. David understood his body better than anyone else, and he had eaten crackers in response to the symptoms of high blood sugar for a decade.

Although the IAT claimed they wanted David to stop eating the crackers for his own health, they approached this in a completely absurd manner. The IAT team are not medically trained professionals and prison guards should not be making medical decisions. Christine emphasised the impropriety of the IAT's approach. The guards should not have spoken to Mr Dungay and threatened him about a health issue. This is a disrespectful and ineffective way to convince David, or anyone else, to follow requests. It is culturally insensitive practice.

> **"*My brother had no chance. They [IAT] stormed his cell within minutes. Instead of doing that, they could have called an Aboriginal welfare officer to try and speak to David before they did what they did. With his conditions, schizophrenia and diabetes, it would have been good to have a doctor there. Just someone he knew.*" – Christine Dungay**

Christine elaborated that an Aboriginal Welfare Officer would have:

> ***"more of a cultural bond with these guys [Aboriginal inmates]. They'd be able to speak to them in the way they understand, and we [Aboriginal people] speak."***

Clearly, using a lethal level of force to move David into another cell was a disproportionate method to get him to comply with demands to stop eating crackers. It is unacceptable that David was restrained by six members of the IAT, with a knee in his back, in a contraindicated position, while he struggled to breathe and the video evidence made that fact very clear. David's last words were: "*I can't breathe*", which he cried out 12 times before he became unconscious and died.

At the *Inquest into the death of David Dungay*, the Coroner recommended that:

> *'all necessary steps be taken to make an Aboriginal Welfare Officer or Aboriginal Inmate Delegate available within Long Bay Hospital to assist where required, in interactions with Aboriginal or Torres Strait Islander inmates in the Mental Health Unit and that Corrective Services New South Wales inform and train officers working in the Mental Health Unit to utilise this process where appropriate.'*[41]

Christine Dungay agrees with this recommendation and acknowledges that the employment and participation of First Nations Peoples within the prison system would benefit inmates, who would feel better understood by individuals with similar lived experience and cultural connection.

RECOMMENDATIONS

2. Properly fund and provide appropriate and culturally safe care in detention delivered by culturally appropriate services with such care to include wholistic health care, mental health care, disability care and rehabilitation. *Fund First Nations-led education and rehabilitative programmes inside prison and youth detention and provide multi-disciplinary services, support and housing to individuals when they leave prison or detention*

An hour before his death, David spoke on the phone to his mother, Leetona, about an Aboriginal Liaison Officer who had helped him with his mental health issues by performing a traditional smoking ceremony. This is just one example of how recognising and implementing Indigenous health practices and customs can benefit Indigenous prisoners. These measures need to be meaningfully incorporated in a way that is not disjointed; this occurs by providing cultural safety training to all prison staff.

The only way to achieve culturally safe care is to increase the involvement of First Nations Health staff members in the design and implementation of prison policies and practices. Only then will it be possible for Indigenous prisoners to be treated with respect, dignity and understanding. Where First Nations health professionals are not available, all staff of Custodial Medical services (and any guards in such settings) must receive training to equip them with an understanding and appreciation of issues specifically affecting the health of First Nations Peoples, including history, culture and communication.

c) *INADEQUACY OF EXISTING OVERSIGHT BODIES*

TERMS OF REFERENCE 2, 3 & 4

We submit that existing oversight bodies tasked with investigating the First Nations deaths in custody such as the Coroner's Court, police investigators and the LECC are not implementing the recommendations of the RCIADIC or meeting the needs of First Nations people, particularly given the lack of First Nations involvement in these systems and the lack of oversight. First Nations people do not feel safe knowing that it is police investigating police or prison guard actions.

i. The Coronial System

Currently, in NSW, all deaths in police or corrective services custody must be reported to the Coroner.[42] NSW Police then conduct an internal investigation on behalf of the Coroner in accordance with the

[41] *Inquest into the death of David Dungay*, 22 November 2019, 2015/381722, 14.24.
[42] *Coroners Act 2009* (NSW) s 35.

internal Critical Incident Guidelines and prepare a brief of evidence.[43] Once the Coroner is satisfied with the brief, an inquest will be conducted.

Genuine accountability for wrongdoing is critical for deterring future misconduct and in providing justice for families of First Nations people who have died at the hands of police and in custodial environments. While Coroners have the power to refer individuals to prosecutors or disciplinary bodies, this rarely occurs.[44] Police retain a significant role in coronial inquests and are generally responsible for the initial fact-finding investigation.[45] No Australian jurisdiction has established a system for a completely independent investigation into deaths in police custody.[46] This lack of independence has led to mistrust in the system by First Nations families seeking justice in relation to deaths in custody.[47]

ii. Lack of Independent Body

The existing investigative procedure is critically lacking in fairness and independence. An independent investigation requires that those conducting it have no interest in the outcome to ensure unconscious bias does not influence the investigation. First Nations people can have no faith in a coronial inquest process that appears from the outset to be biased against the interests of the victim and in favour of the State.

A process in which 'police investigate police' or corrective services guards is far too vulnerable to both deliberate and unintentional perversion by investigators. A review by the Office of Police Integrity in Victoria identified the way that police may have a strong interest in 'protecting the reputation of… Police and safeguarding legal or financial liability that may arise if a person is wronged by the actions of police.'[48]The review also pointed to the 'culture of loyalty and empathy within police services' which may encourage officers to 'protect' each other, and prevent them from bringing an impartial mind to the investigation.[49] This 'culture of loyalty' places the interests of police officers in preserving their reputations over those of the civilians they are meant to serve and protect, including the First Nations people who are most vulnerable to discrimination, abuse and violence by police officers.

Many foreign jurisdictions have managed to establish coronial inquest processes with investigations that are independently conducted.[50] In New Zealand, the Independent Police Conduct Authority (a statutory body) provides truly independent oversight of police conduct, including monitoring places where police detention occurs. The Authority is itself empowered to investigate complaints and has a statutory mandate to operate with complete independence from both the police force and other parts of the State.[51] A similar degree of independence in oversight of NSW police conduct is crucial to creating a system of accountability which First Nations people can trust to operate impartially and in the interests of justice.

[43] NSW Police Force, Critical Incident Guidelines (December 2019), <https://www.police.nsw.gov.au/__data/assets/pdf_file/0020/420392/Critical_Incident_Guidelines_External_Version_updated_23_Dec_2019.pdf>.
[44] Lorena Allam, 'David Dungay inquest: guards who restrained Indigenous man before his death won't be disciplined', *The Guardian* (22 November 2019) <https://www.theguardian.com/australia-news/2019/nov/22/david-dungay-inquest-guards-who-restrained-indigenous-man-before-he-died-wont-be-disciplined>.
[45] Australian Law Reform Commission, *Pathways to Justice - Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (Final Report 133, 2018), [14.68].
[46] Human Rights Law Centre, Submission No 68, Australian Law Reform Commission, *Pathways to Justice - Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (4 September 2017).
[47] Ibid.
[48] Above n 2; Office of Police Integrity, *Review of the Investigative Process Following a Death Associated with Police Contact* (2011) 8.
[49] Above n 2, 466.
[50] *Independent Police Conduct Authority Act 1988* (NZ).
[51] Ibid s 4AB; *Crown Entities Act 2004* (NZ).

It is crucial that the primary investigation of the death itself be independently conducted. Although NSW police investigations may be subject to oversight by professional standards and disciplinary boards, this is no substitute for ensuring that initial investigations are properly conducted. It is crucial that critical and specific evidence, including at the location where the death took place, be properly collected and preserved for use in the coronial proceedings.[52] When protocols are not being adhered to, and the investigation is conducted by a party with a vested interest, the integrity of the investigation is automatically questionable. The use of First Nations investigators as senior members of investigatory teams should be encouraged in all cases where there is a First Nations death.

Beyond the prospect of actual bias in the police force, non-independent investigations seriously threaten the *appearance* of justice and integrity in the coronial inquest process. The experience of many First Nations people, including many of our clients, is that the Australian criminal justice system is fundamentally structured against their interests. It is perceived as a tool for perpetuating the suffering, impoverishment and punishment of their families, while police, under the sanction of the State, operate with impunity for the violence and suffering they inflict.

As the current coronial system stands, First Nations cultural practices and values are not accommodated for at all. Our First Nations clients have repeatedly reported to us that they feel their voices are not heard, they are discouraged from speaking up, or are cross-examined as if they are to blame for their loved one's death. A particular issue is the failure to accommodate cultural and religious concerns about the treatment of bodies of the deceased or other expressions of culture throughout the inquest. Without the appearance of independence and integrity, the coronial inquest process will only serve to further validate this perception, alienating First Nations people from institutions which are meant to protect all Australians in a just and equitable way. The process may also re-traumatise First Nations people who have spent lifetimes contending with institutions and officials who systematically fail to protect their most basic interests.

iii. Dungay Family Testimony

Investigation Process and Evidence

The Dungay family testified that the investigation into David's death, mismanagement of evidence and lack of First Nations involvement throughout the coronial process reinforced their existing distrust in the criminal justice system and re-traumatised their family.

Firstly, Ms Leetona Dungay was extremely upset to read in the media that the NSW Corrective Services Assistant Commissioner made a statement that David's death was not suspicious. Leetona, with the help of her solicitor Mr George Newhouse, wrote to the Department and asked for an apology because there was no basis for making such claims as there had not yet been a proper inquiry.

Following this incident, Ms Leetona and Ms Christine Dungay raised the issue of mismanagement of evidence. They were disturbed to find that a crime scene was not declared in relation to David's cell and that protocols to secure evidence were not adhered to and Mr Dungay's cell was cleaned against protocol. Although the destruction of evidence and government records may be a criminal offence, no one was held responsible for the breaches of protocols and the law. Rather, an internal corrective

[52] An example is the investigation on Palm Island of the conduct of Senior Sergeant Christopher Hurley, discussed in Craig Longman, "Police investigators too in-house to probe deaths in custody," *The Conversation* (April 2011), <https://theconversation.com/police-investigators-too-in-house-to-probe-deaths-in-custody-838>.

services investigation found that there was no criminal negligence,[53] and initial Police investigations found that Mr Dungay's death was not suspicious. Christine noted her frustration and heartbreak that a forensic and criminal investigation was not possible following David's death, as all the physical evidence was cleaned up. Mr Dungay's clothes and some of his belongings were never returned to his family. Further, there is CCTV footage of David on the date of his death that is missing or has been recorded over. The mismanagement of this evidence, which may be a crime under NSW law, has re-traumatised the family and has left them without closure.

> **"*What happened to his [David's] clothes? None of his clothes have been returned*."**
> **– Leetona Dungay**

In Ms Leetona Dungay's brave and painful testimony about her son's death provided to the NJP, she described the state of her son David's body after his death. Leetona recounted that she, and her eldest son Ernest, visited the morgue and took pictures of David's body. Leetona and her son Ernest felt compelled to take this action because they believed that the circumstances of David's death were suspicious and they did not trust the investigation that was being undertaken, in light of the aforementioned representations that were made to the media. It is that evidence, which shows the bruising on David's body, his broken nose, broken teeth and "***flattened face",*** that leads Leetona and her family to believe that David's death requires further investigation.

> ***"I've got a USB – which me and my children had to shockingly do again, to make sure this evidence comes out clearly – on the USB, of my son in the morgue, of every mark on that body... took evidence of every assault they done on my son's body… My oldest son Ernest is very affected about that now*."** **– Leetona Dungay**

The Dungay family's testimony demonstrates the lack of cultural sensitivity and due investigative process afforded to First Nations families who lose a relative in custody. Public claims relating to the nature and circumstances of Mr David Dungay's death were made before an inquiry was undertaken. From the first step in the process – investigation – missing evidence and a lack of due diligence meant that David's place of death was not treated as a crime scene. The family was re-traumatised by the prospect that they may never receive closure about their loved one's death, and felt it was their responsibility to collate evidence so that they could get justice. No family should ever have to go through this trauma.

<u>Coronial Inquest</u>

The cultural insensitivity and lack of justice provided by the coronial process was raised by Leetona and Christine at length in our conversations with them.

When asked about the extent of her, and her family's, involvement in the coronial inquest **Ms Leetona Dungay said, "*We never hardly had no involvement in that*."**

When asked about how that made her feel, she said**: "*No good, actually. Very no good. We're gonna fight for justice, that's it. Whether the government likes it or not. Whether any one likes it or not*."**

On the Dungay Family's involvement in the coronial inquest process, **Ms Christine Dungay** described her feelings as follows:

[53] Helen Davidson, 'The story of David Dungay and an Indigenous death in custody', *The Guardian* (11 June 2020) <https://www.theguardian.com/australia-news/2020/jun/11/the-story-of-david-dungay-and-an-indigenous-death-in-custody>.

"We went there to get answers and we got nothing really…"
"We still don't know why they [the IAT] did it. It's horrible. It's so horrible knowing they have the answers and are just worried about covering [themselves]."

The Dungay family made submissions to the *Inquest into the death of David Dungay* that there was a need to examine failures in relation to the treatment of his diabetes and mental health. In particular, the Dungay family believed, and still believe, that David's mental health should have been managed in a hospital rather than a custodial setting. This was considered important as trained medical staff would not have been permitted to use force upon David. The Coroner, however, determined that these '*broader issues relating to the management of David's mental health fall outside the parameters of the inquest*.' Ms Leetona Dungay and Ms Christine Dungay feel that this central issue was not meaningfully or adequately addressed, which highlights the limitations of the Coronial process and the failure of the NSW Government to implement the recommendations of RCIADIC.

Ms Leetona Dungay was appalled that her son, Mr David Dungay Jr, was physically restrained by six IAT officers, given that he was known to have serious health issues that needed to be addressed with care by medical professionals, including both Type I diabetes and schizophrenia. She does not feel this issue was adequately addressed at the coronial inquest.

"In a mental health institution, you aren't allowed to […] touch a mental health patient."

Coronial inquests in NSW are also often plagued with lengthy delays, which only serve to re-traumatise families of victims. Long delays disrupt the own emotional grieving of families and hinders their ability to achieve closure after the death of a loved one. The family of David Dungay Jr had to wait almost four years to receive answers concerning his death. The answers they did receive left them asking more questions about David's medical care and treatment in custody.

"If there's any inquiry into an Aboriginal death in custody, witnesses will take all the time in the world to fix up their statements…" **– Ms Leetona Dungay**

The Dungay family felt disempowered by the adversarial nature of the coronial inquest, which provided no real opportunity for open discussion about what happened, nor did it accommodate the participation of the family. Ms Christine Dungay expressed that the lack of First Nations representation in the Coronial system, compounded by the amount of legal representation resourced for the IAT guards, portrayed the image that the guards were victims, rather than her brother David, who lost his life.

"We've got no law to help us Aboriginal people because it's a white man's law." **– Ms Leetona Dungay**

Ms Leetona Dungay and Ms Christine Dungay each state that there needs to be an Aboriginal Coroner and Investigators in NSW, alongside better First Nations representation in employment throughout the entire criminal justice system. The Dungay family acknowledge that this would have improved their own experience in the Coroner's Court and would help them to build some level of trust in the system, which is exceptionally low.

RECOMMENDATIONS

3. Properly fund and establish a culturally appropriate, First Nations staffed, independent oversight and investigative body into deaths in custody with a statutory focus on accountability

and reform of the justice system. *The investigative body should have the power to examine the death of a First Nations person while under the control of state officials, whether those officials are working in prisons, corrective services, transport, health or police. Such a body needs to have real powers to make recommendations, including to refer for prosecution and to undertake regular prison and youth detention inspections.*

This should include jurisdiction to oversee and inquire into the variety of custodial environments where First Nations people are held in custody, such as prisons, police cells, healthcare, as well as inquiring into the interrelated decisions made by these various bodies. This reform should also apply to any circumstances where custody is unclear, such as in transportation from one facility to another by Ambulance or Police vehicle, or hospitals within prisons such as Long Bay Correctional Complex where Mr David Dungay Jr died.

3.1 In the interim and at the very least, the Coronial System needs to be overhauled with the appointment of First Nations Coroners to investigate and make recommendations about deaths in custody and an expanded jurisdiction.

The appointment of First Nations coroners in every state and territory would significantly improve the cultural appropriateness of the Coronial system. These First Nations led inquests could be held on-country, and the court processes adapted to be more culturally appropriate in consultation with Elders from the community, similar to the Koori Court system in Victoria. The Coroner would sit at a table with community Elders, and legalese would be strongly limited. Members of the family would also be at the table, participating in the proceedings. Counsel Assisting would work with the family and Elders to both guide and take guidance from them on appropriate practices.

There needs to be an Aboriginal Liaison Officer (ALO) within the Coroner's Court. An ALO would be able to assist and help Aboriginal families navigate through the process after the death of their loved one and facilitate their engagement in the process. In the scope of the Coroner's inquiry the RCIADIC recommended that: '*a Coroner inquiring into a death in custody be required by law to investigate not only the cause and circumstances of the death but also the quality of the care, treatment and supervision of the deceased prior to death*.' Unfortunately, like many of the recommendations from previous inquiries, this recommendation has not been incorporated into the *Coroners Act 2009* (NSW). This Act confers significant discretion to the Coroner in relation to the scope of the inquiry, providing that they: may make such recommendations as the coroner or jury considers necessary or desirable to make in relation to any matter connected with the death.

The jurisdiction of coronial courts should be extended to include deaths 'close to' custody. An example of such a case is the tragic death of Tamica Mullaley's baby in Western Australia, another client of the NJP. The police failed to take the child into care as a priority to ensure the child's protection from Ms Mullaley's abusive partner. The Western Australian Coroner has refused to investigate this inaction by the police and the Supreme Court has refused to order an inquest be held stating declaring that, '*The function of an inquest is to inquire into the death and make findings. Any comments or recommendations made … are ancillary to that function*.'[54] NSW Coroners need to be mandated by legislation to make comments and recommendations relating to care and custody in these situations, so that any person in the chain of events leading to a death can be held responsible.

[54] *Mullaley v State Coroner of Western Australia* [2020] WASC 264.

d) *NOTIFICATION OF DEATH IN CUSTODY*

TERMS OF REFERENCE 5

We submit that there is a lack of proper notification to First Nations families in relation to the death of a relative in custody, re-traumatising the families, and there is a lack of support and legal services offered to those families.

The RCIADIC recognised that notifying the family of a death of their loved one requires '*skill and sensitivity*.'[55] It made clear that such notifications to families should be delivered in a sensitive manner which respects the culture and interests of the families being notified. It reinforced the entitlement of such families to full and frank reporting of the circumstances of the death which are known at that time.[56] The family of David Dungay Jr failed to receive a proper or culturally sensitive notification of David's death by NSW Police and below we submit to you their lived experience.

i. Dungay Family Testimony

Ms Leetona Dungay and Ms Christine Dungay have each expressed their disappointment at the lack of appropriate notification of Mr Dungay's death by NSW police. Mr Dungay's mother was not the first person to be notified of her son's death. Leetona's eldest son, Ernest, was the person to inform her of David's death. The police later contacted Leetona to let her know over the phone.

> **"*That wasn't very nice. They should have come to where I was directly. I'm his mum, I should have been told first.*" – Leetona Dungay**

Mr David Dungay's sister, Ms Christine Dungay, was notified of David's death by the police coming to her house. Christine was not home when they attended at the first instance. Christine called the police when she returned home. Christine met the police officer at the fence of her yard, noting that whenever the police had attended her residence prior to this occasion, she felt the interactions to be unproductive and disrespectful. In this context of distrust, it is clear that the NSW Police were not the best means by which to notify the Dungay family of their tragic loss. Ms Christine Dungay was asked by the officer whether she was Mr David Dungay Jr's sister.

> **"*I automatically knew that there was something wrong… I felt in my heart straight away that something bad had happened to him [David]… he only had three weeks to go… he wouldn't do anything to muck that up, to get out and see his family."* – Christine Dungay**

The notification of Mr David Dungay Jr's death by NSW police was not given in a sensitive manner which respected the culture and interests of the Dungay family. Their communications with the Dungay family only functioned to cause confusion, distress and anger for a family that was newly grieving. The fact that David's mother was not first to be notified, and that her children were sought first, was not a sensitive way to approach the matter. It is a clear example of the lack culturally appropriate care exercised by the NSW Police in the performance of their duties.

The nature of the Dungay family's experience is far from the openness, frankness and sensitivity recommended in the RCIADIC regarding the notification of families of those who have died in custody. The inherent feeling of distrust in the system was only aggravated by these encounters.

[55] Above n 1 [4.6.5].
[56] Ibid rec 19.

RECOMMENDATIONS

4. Implement and provide resources for the implementation of the recommendations made in previous inquiries, *including RCIADIC, Pathways to Justice Report, Jumbunna Institute BLM Call Out, Universal Periodic Reviews, Special Rapporteur Country Visit Report. Viable solutions have been provided time and time again – all that is lacking is political will.*

It has been recommended time and time again that following the death of a First Nations person in custody, the family and the nominated emergency contact of the deceased need to be notified immediately. This notification should occur wherever possible, in person, and preferably by a First Nations person known by those being notified. The notification should always be given in a sensitive manner which respects the culture and interests of the persons being notified.

This recommendation applies not only to the notification of deaths in custody, but extends to the entire subject matter of these submissions. We implore that the Select Committee acknowledge and access the existing workable solutions to the high rate of First Nations incarceration rates, oversight and review of deaths in custody, and matters relating to those deaths.

e) *ACCOUNTABILITY*

TERMS OF REFERENCE 5

We submit that there is a lack of accountability for the deaths that occur in custody. More than 400 First Nations people have died in police custody since the RCIADIC in 1991.[57] Unfortunately in recent weeks, the number of deaths in custody has continued to grow yet no police officer or prison officer has been held responsible.

Following the death of a loved one in custody, many families experience not only strong emotional trauma but a profound desire for justice and accountability. The outcomes of coronial inquests often fail to deliver justice or provide answers for families of victims who have died in custody. It is no wonder that First Nations families feel completely disengaged and excluded from the NSW criminal justice system. Mr David Dungay Jr lost his life due to the abovementioned issues and failures, and his family has been let down every step of the way. From the notification of David's death, to the investigation and evidence gathering process, to the coronial inquest process, to the denial of their access to criminal proceedings – there has been no accountability.

i. Dungay Family Testimony

The family of Mr David Dungay Jr had to wait almost four years after lengthy delays to receive answers concerning his death. The Coroner found that none of the five guards involved in David's death should face any disciplinary action.[58] The Coroner found that the conduct of the guards was *'limited by systemic efficiencies in training*' and not motivated by *'malicious intent*.'[59] The Coroner is empowered to refer the conduct of police and corrective service officers to the DPP for investigation, but there has been a general reluctance on the part of Coroners to do so, as seen in the matter of Mr Dungay Jr.

[57] Alexandra Gannoni and Samanthan Bricknell, "Indigenous deaths in custody: 25 years since the Royal Commission into Aboriginal Deaths in Custody," Australian Institute of Criminality (February 2019), https://www.aic.gov.au/sites/default/files/2020-05/sb17_indigenous_deaths_in_custody_-_25_years_since_the_rciadic_210219.pdf.
[58] *Inquest into the death of David Dungay*, 22 November 2019, 2015/381722.
[59] Ibid 60.

"*We want an investigation and if evidence is available, then prosecutions… I am going to fight until I live in a country where black lives matter*." – Leetona Dungay

f) *JUSTICE FOR DAVID DUNGAY JR*

The family of David Dungay Jr feel that they have been unheard and denied justice. The family continue to organise protests and mount public pressure campaigns to persuade the government to take long overdue action and hold the officers who stormed David's cell accountable for their actions.

The Dungay family have an opinion from one of Sydney's most eminent criminal barristers that confirms there is sufficient evidence for charges to be laid and they demand that Safework NSW and the NSW DPP review their decisions not to investigate David's death. They see trivial matters subject to investigation by Safework NSW and the NSW DPP, and they cannot understand why David's death is not worthy of their consideration. If they cannot even find a pathway to an investigation, then the system is truly broken and requires urgent reform.

We urge Safework NSW and the NSW DPP review their decisions not to investigate David's death.

The experience of Mr David Dungay's family reflects the failure of the existing coronial inquest process to provide justice for families who suffer the loss of a loved one in custody. These failures highlight the need for better First Nations representation and participation within the NSW criminal justice system at large; from systems that would prevent the incarceration of First Nations Peoples in the first place, right through to an appropriate oversight system. Accountability needs to be legally mandated and reinforced by our system – so that police can no longer investigate police. Organised and systemic change needs to happen now.

RECOMMENDATIONS

5. Self-Determination and Accountability. *First Nations communities need to be leading the abovementioned reforms and the overhaul of the existing criminal justice system, to ensure that changes made are meaningful and proportionate to the deeply disturbing entrenched racial bias within existing systems and they need to be funded to do so.*

CONCLUSION

The NJP thanks the Legislative Council for this inquiry but trusts that is not the final step taken by NSW Parliament to address the inadequacies of our criminal justice system and its grossly disproportionate impact upon First Nations communities. Inquiries, Royal Commissions and law reform reports are important to understand community grievances and avenues for change. However, the RCIADIC and the ALRC's *Pathways to Justice Report* outlined many of the same issues which we have identified in this submission. Inquiries to date have not reduced First Nations incarceration rates and deaths in custody, it is a lack of genuine and lasting political commitment to implementing the recommended changes that is at the heart of the problem and we encourage this committee to recommend real action.