Submission No 116

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

Organisation: Australian Lawyers for Human Rights

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AUSTRALIAN LAWYERS FOR HUMAN RIGHTS

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PO Box A147
Sydney South
NSW 1235
DX 585 Sydney

www.alhr.org.au

Mr Adam Searle MLC
Committee Chair
Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Death in Custody
New South Wales Parliament House
Macquarie Street
Sydney NSW 2000

By email: First.Nations@parliament.nsw.gov.au

Dear Committee Chair

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

Australian Lawyers for Human Rights (**ALHR**) is grateful for the opportunity to provide this submission in relation to the Inquiry into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody (**Inquiry**).

About ALHR

ALHR was established in 1993 and is a national network of Australian solicitors, barristers, academics, judicial officers and law students who practise and promote international human rights law in Australia. ALHR has active and engaged national, state and territory committees as well as specialist national thematic committees. Through the provision of training, education, publications, CLE courses, conferences, seminars and mentoring, ALHR assists members to continue to develop their knowledge of human rights law and incorporate human rights principles into their areas of legal practice in Australia.

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1. Summary

1.1. **ALHR submits that the current framework in NSW for investigating deaths in custody lacks independence and meets neither community expectations nor relevant international human rights law standards.**

1.2. **ALHR recommends that an independent body be tasked with investigating deaths in custody and be given powers to obtain evidence and actively manage and oversee all aspects of the investigation.**

1.3. **ALHR recommends changes to the functions and funding of the Law Enforcement Conduct Commission (LECC) to ensure it is adequately resourced to carry out effective and independent investigations into deaths in custody, and police conduct, more broadly.**

2. The high level of First Nations people in custody in NSW

2.1. In 1991, the Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**) found that Indigenous Australians (or First Nations peoples) were grossly overrepresented in custody. The RCIADIC delivered 339 recommendations to the Australian Government across a wide range of policy areas. The largest number of recommendations relate to policing, criminal justice, incarceration and deaths in custody. The RCIADIC also made recommendations relating to health, education and self-determination in recognition of the breadth of factors leading to the high rates of incarceration of Aboriginal and Torres Strait Islander people, particularly for young people.[1]

2.2. Importantly, the RCIADIC concluded that "Aboriginal people in custody do not die at a greater rate than non-Aboriginal people in custody … what is overwhelmingly different is the rate at which Aboriginal people come into custody, compared with the rate of the general community".[2]

[1] Department of Prime Minister and Cabinet, *Review of the Implementation of the Recommendations of the Royal Commission into Aboriginal Deaths in Custody*, August 2018, <https://www.niaa.gov.au/sites/default/files/publications/rciadic-review-report.pdf>.
[2] RCIADIC, Volume 1, paragraphs 1.3.1-1.3.2.

2.3. Despite this key finding, in the 29 years since the RCIADIC, the Aboriginal and Torres Strait Islander share of the prison population has doubled.

2.4. Although Indigenous Australians make up approximately 2% of the total Australian population aged 18 years and over, they accounted for 28% of the total Australian prisoner population in 2019.[3] In NSW, they constituted 23% of the prisoner population.[4]

2.5. As of March 2020, according to the Australian Bureau of Statistics, Indigenous people are still incarcerated in NSW at a rate of 2,434.9 people per 100,000, compared to the general population rate of 220.4 per 100,000.[5]

2.6. In the last six years, the number of Indigenous women incarcerated in NSW grew faster than any other demographic. Recent research shows that incarceration rates of women climbed 33% between March 2013 and June 2019, with almost a third of them being Aboriginal or Torres Strait Islander.[6] Indigenous women make up 2% of Australia's population yet constitute 34% of the women behind bars.[7]

2.7. It is clear that with Indigenous men approximately 12 times more likely than non-Indigenous men to be imprisoned, and Indigenous women being 21 times more likely to be imprisoned than non-Indigenous women, State and Federal governments need to do more to address, not only the conditions for Indigenous incarceration, but also the root causes of the overrepresentation of Indigenous people in Australia's prisons.

2.8. Australia is a signatory to a number of core international human rights law treaties which impose obligations relevant to the incarceration of Aboriginal and Torres Strait Islander peoples, including:

a) the *International Covenant on Civil and Political Rights*;

b) the *Convention on the Rights of the Child;*

c) the *International Convention on the Elimination of all forms of Racial Discrimination;*

d) the *International Covenant on Economic, Social and Cultural Rights;* and

e) the *Convention on the Rights of Persons with Disabilities*.

[3] Australian Bureau of Statistics, *Prisoners in Australia*, 5 December 2019 <https://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0>.
[4] Ibid.
[5] Australian Bureau of Statistics, *Prisoners in Australia*, 4 June 2020 <https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4512.0Main+Features1March%20Quarter%202020?OpenDocument>.
[6] Keeping Women Out of Prison Coalition, <https://www.sydneycommunityfoundation.org.au/find_a_fund/kwoop-keeping-women-out-of-prison/>.
[7] Australian Human Rights Commission, *Imprisonment Rates of Indigenous Women a National Shame*, 2 May 2018, <https://humanrights.gov.au/about/news/imprisonment-rates-indigenous-women-national-shame>.

2.9. Under international law, these treaties are regarded as imposing binding obligations regardless of the extent to which Australia has incorporated their provisions into domestic law or practice.

2.10. In addition, the Australian Government has endorsed the *United Nations Declaration on the Rights of Indigenous Peoples* (**UNDRIP**) which affirms the minimum standards for the survival, dignity, security and wellbeing of Indigenous peoples.

2.11. As acknowledged in the UNDRIP, Indigenous peoples are entitled to the full enjoyment of all the human rights standards contained in international law.[8]

2.12. ALHR is of the view that the UNDRIP should be considered as an authoritative interpretation of human rights obligations Australia bears under international law, in relation to the interactions between Aboriginal and Torres Strait Islander peoples and the criminal justice system. Such an approach has been endorsed by the Parliamentary Joint Committee on Human Rights, which expects the Commonwealth Parliament to draw on the UNDRIP as an influential source of guidance for policy-making and legislative drafting.[9]

2.13. Suitability of oversight bodies

2.14. In ALHR's view, a suitable oversight body tasked with conducting inquiries into deaths in custody should have the following features:

a) the purpose and jurisdiction of the body should be directly related to conducting inquiries into all deaths in custody;

b) the body must be well-resourced and sufficiently funded to conduct inquiries; and

c) the body must be independent and accountable to parliament.

2.15. ALHR is of the view that neither the Inspector of Custodial Services, the Independent Commission Against Corruption nor any professional standards department within Justice NSW meets such criteria and that they are not suitable bodies to be tasked with conducting inquiries into deaths in custody.

2.16. It is ALHR's opinion that, in addition to the possibility of the LECC being given new powers in respect of deaths in custody, the NSW Ombudsman and the NSW Coroner may also be suitable bodies to oversee investigations into deaths in custody, under specific statutory or delegated powers, and with dedicated funding and resources.

2.17. **The Inspector of Custodial Services**

[8] United Nations Declaration on the Rights of Indigenous Peoples, GA Res 61/295, A/RES/61/295 (2007) art. 1.

[9] Parliamentary Joint Committee on Human Rights, *Examination of Legislation in Accordance with the Human Rights (Parliamentary Scrutiny) Act 2011: Stronger Futures in the Northern Territory Act 2012 and Related Legislation* (2013) 15-16.

2.17.1. In ALHR's view, the Inspector of Custodial Services is an unsuitable body to provide the standard of oversight necessary to conduct inquiries into deaths in custody. Despite the Inspector's independence and accountability to NSW Parliament, ALHR does not think that conducting inquiries aligns with the purpose and focus of the Inspector of Custodial Services.

2.17.2. Purpose and jurisdiction: First, the narrow purpose of the Inspector of Custodial Services on conducting inspections to monitor standards, rather than conducting investigations into matters relating to individuals means that it is an unsuitable body to be tasked with conducting inquiries into deaths in custody. Deaths in custody are not directly related to the Inspector's focus on conditions, treatment and outcomes. This is evidenced in the fact that none of the inspection reports or the past Annual Reports for the period of 2014-15, 2015-16, 2016-17, 2017-18 or 2018-19 publicly available address deaths in custody.

2.17.3. Instead, the stated purpose of the Inspector is to "provide independent scrutiny of the conditions, treatment and outcomes for adults and young people in custody and to promote excellence in staff professional practice".[10]

2.17.4. The unsuitability of the purpose and focus of the Inspector is evidenced by the fact that there is no reference to deaths in custody in the 2017-2018 or 2018-2019 Annual Reports. Further, the Inspector of Custodial Services, Ms Fiona Rafter, emphasised that the role is one of inspection, rather than investigation. She stated in evidence to the Portfolio Committee in September 2018:

> "The Inspector's role is not specifically an investigative function. Those functions are performed by a number of other agencies. We are an inspectorate. We have standards that we inspect to. Our role is to inspect those centres once every five years. We do that in accordance with our standards… We are not resourced and we do not have the remit to investigate every incident that happens within Corrective Services; there are others that have that jurisdiction…**The focus of the inspectorate is around system improvements and not investigation of individual matters" (emphasis added).**[11]

2.17.5. ALHR recognises that the Inspector is empowered in the exercise of its functions to full access to the records of any custodial centre, and to visit and examine any custodial centre at any time the Inspector considers fit.[12] These statutory powers are valuable in supporting the capacity of the Inspector to comprehensively review deaths in custody. However, in light of the fact that these powers are not used in an investigatory sense, they are limited in their relevance.

[10] Inspector of Custodial Services, *Annual Report 2017-18* (October 2018) [1.2] <http://www.custodialinspector.justice.nsw.gov.au/Documents/Annual%20Report%202017-18.pdf>.
[11] Evidence, Ms Fiona Rafter, Inspector of Custodial Services, Proceedings before Portfolio Committee No 4 - Legal Affairs, Parklea Correctional Centre and Other Operational Issues, 28 September 2018 at 4.
[12] *Inspector of Custodial Services Act 2012* (NSW) s 7.

2.17.6. A further issue is that the Inspector may lack jurisdiction over some places of detention. Ms Rafter has identified that she does not currently have jurisdiction over some places of detention, for example police cells that are not managed by Corrective Services.[13]

2.17.7. Resourcing and funding: Second, the suitability of the Inspector of Custodial Services is also compromised by the lack of resources and funding to meet its statutory obligations. The Inspector of Custodial Services has the capacity to initiate investigations under section 6(1)(e) of the *Inspector of Custodial Services 2012* (NSW) whereby the Inspector may "report to Parliament on any particular issue or general matter relating to the functions of the Inspector if, in the Inspector's Opinion, it is in the interests of any person or in the public interest to do so". As far as we are aware, the Inspector has not exercised this statutory power. Ms Rafter gave evidence in February 2020 that the current resourcing for the Inspector of Custodial Services is insufficient to fulfil "discretionary functions" such as "public interest reports" and to fulfil the obligations of NSW under the *Optional Protocol to the Convention Against Torture*.[14]

2.17.8. Furthermore, issues have been raised regarding deficiencies in the ability of Official Visitors being able to receive and respond to complaints by inmates.[15]

2.17.9. Independence and accountability: In the opinion of ALHR, the independence and accountability of the body tasked with reviewing deaths in custody is an important feature. ALHR notes that the independence of the Inspector and its accountability to Parliament is favourable towards its suitability as a body to review deaths in custody.

2.18. **The NSW Ombudsman**

2.18.1. In ALHR's opinion, the NSW Ombudsman is a suitable body to be tasked with inquiries into deaths in custody due to its experience in conducting investigations in custodial settings and reviewing the deaths of children in juvenile justice facilities. ALHR also thinks that the pre-existing resources, independence and accountability of the NSW Ombudsman further supports its suitability.

2.18.2. Purpose and jurisdiction: Whilst the NSW Ombudsman does not have a specific statutory mandate to review the deaths of adults in custody, it has jurisdiction to receive complaints relating to corrective service facilities and youth justice facilities and has previously conducted investigations into corrective service facilities and undertaken review of deaths of children in youth justice facilities.

2.18.3. The NSW Ombudsman receives complaints about the conduct of public authorities, including corrective service facilities and youth justice facilities.[16] The NSW Ombudsman

[13] Evidence, Ms Fiona Rafter, Inspector of Custodial Services, Proceedings before Committee on the Ombudsman, the Law Enforcement Conduct Commission and the Crime Commission, 2020 Review of the Annual and Other Reports of Oversighted Bodies 18 February 2020.
[14] Ibid.
[15] See Report No 38 of Portfolio Committee No 4, *'Legal Affairs entitled 'Parklea Correctional Centre and other operational issues'* (December 2018) [6.21] available at <https://www.parliament.nsw.gov.au/tp/files/75278/Parklea%20correctional%20centre.pdf>.
[16] *Ombudsman Act 1937* (NSW), Pt 3.

is also empowered to handle complaints about private correctional centres such as at Junee, Parklea and Grafton.

2.18.4. ALHR notes that the NSW Ombudsman has a significant investigatory role in custodial settings which strengthens its suitability as a body. As specified in the NSW Ombudsman's Inquiry into Parklea Correctional Centre and other operational issues, as at 30 June 2018, the NSW Ombudsman was undertaking 37 preliminary or informal investigations into correctional centres and Justice Health.[17]

2.18.5. Furthermore, the NSW Ombudsman is required under Part 6 of the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) to monitor and review the deaths of certain children and persons with disabilities in care, formulate recommendations as to policies and practices to be implemented, and undertake research or other projects for the purpose of reducing or removing risk factors associated with preventable deaths.[18] Reviewable deaths include the deaths of children, who at the time of death, are an inmate of a children's correctional centre or lock-up.[19]

2.18.6. Resources and funding: In ALHR's view, the suitability of the Ombudsman as a body to review deaths in custody is strengthened by the Ombudsman's existing Custodial Services Unit which is responsible for handling complaints in respect of both public and private correctional services and contains "specialist custodial services and staff".[20] In addition, since 2011, the Ombudsman is the Convenor of the NSW Child Death Review Team. The ALHR could not identify any known funding or resource issues that may compromise its suitability.

2.18.7. Independence and accountability: The independence and accountability of the NSW Ombudsman supports its suitability as a body tasked with reviewing deaths in custody. The Ombudsman is an independent integrity agency that holds NSW government agencies, including Corrective Services NSW to account. Furthermore, the Ombudsman reports directly to Parliament through its annual reports and is subject to the scrutiny of the Parliamentary Oversight Committee.

2.19. **The Independent Commission Against Corruption (ICAC)**

2.19.1. ICAC is not a suitable body due to its narrow focus and jurisdiction in investigating, exposing or preventing corruption. It is also not an appropriate body because of its vulnerability to political attacks and defunding.

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[17] New South Wales Ombudsman, *'Responses from NSW Ombudsman to questions on notice from Portfolio Committee No 4 - Legal Affairs*', Inquiry into Parklea Correctional Centre and other operational issues (October 2018) at 83, available at <https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0006/62817/Responses-to-inquiry-into-Parklea-Correctional-Centre-and-other-operational-issues-Oct-2018.pdf>.

[18] New South Wales Ombudsman, '*Report of Reviewable Deaths in 2012 and 2013*', vol 1 (June 2015) 12, available at <https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0011/25013/Reviewable-Deaths-in-2012-2013_Volume-1-Child.pdf>.

[19] *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW) s 35(1)(e).

[20] See New South Wales Ombudsman, '*Custodial Services*', available at <https://www.ombo.nsw.gov.au/what-we-do/our-work/custodial-services>.

2.19.2. Purpose and jurisdiction: Section 2A of the *Independent Commission Against Corruption Act 1988* (NSW) identifies the principal purposes of ICAC as "an independent and accountable body" is "to investigate, expose and prevent corruption involving or affecting public authorities and public officials, and to educate public authorities, public officials and members of the public about corruption and its detrimental effects on public administration and on the community". ICAC is only empowered to investigate matters within its jurisdiction, relating to corruption involving or affecting the NSW public sector. ALHR thinks that the narrow focus of ICAC means that it is an unsuitable body to undertake inquiries into deaths in custody as only certain deaths in custody related to corruption may fall within its jurisdiction.

2.19.3. Resources and funding and independence: ALHR is very concerned that ICAC has suffered repeated cuts to its funding and is now one of the smallest commissions of its kind in Australia.[21]

2.19.4. Independence and accountability: ALHR did not identify any particular concerns relating to the independence and accountability of ICAC. In June 2019, ICAC investigated the conduct of NSW Corrective Service officers at Lithgow Correctional Centre and subsequently published a Report to the Legislative Council and Legislative Assembly on the corrupt conduct of NSW Corrective Services officers.[22]

2.20. **Corrective Services Professional Standards**

2.20.1. ALHR does not think that the use of Corrective Services professional standards is a suitable means to conduct inquiries into deaths in custody.

2.20.2. It is difficult to give feedback on the suitability of Corrective Services professional standards given the lack of information publicly available about the nature and implementation of standards. The Department of Justice's Custodial Operations Policy and Procedures on deaths in custody is stated as being currently under review and will be published in 2018. This has not been updated. The document that is available is highly redacted.

2.20.3. ALHR notes that Corrective Services remains an opaque department within the NSW Justice system.

2.20.4. Further, the use of Corrective Services professional standards to investigate deaths in custody may give rise to the perception of (or an actual) conflict of interest in favour of Corrective Services staff.

2.21. **NSW Coroner**

[21] ICAC, *The Need for a New Independent Funding Model for the ICAC* (May 2020) available at <https://www.icac.nsw.gov.au/ArticleDocuments/933/Section%2075%20Report%20-%20May20%20_Final.pdf.aspx>.

[22] See Independent Commission Against Corruption, *'Investigation into the Conduct of NSW Corrective Services Officers at Lithgow Correctional Centre*' (June 2019).

2.21.1. ALHR thinks that the NSW Coroner is a suitable body to be tasked with undertaking inquiries into deaths in custody due to its purpose and jurisdiction being closely tied with reviewing certain deaths, including those in custody. The suitability of the NSW Coroner is further supported by its strong accountability mechanisms.

2.21.2. Purpose and jurisdiction: The purpose and jurisdiction of the NSW Coroner is suited to undertaking reviews into deaths in custody. The NSW Coroner is required to hold an inquest concerning the death of a person if it appears to the Coroner that the person has died while in a correctional centre.[23] The Coroner is also required to investigate not only the cause and circumstances of the death but also the quality of care, treatment and supervision of the deceased prior to death, and whether custodial officers observed all relevant policies and instructions. Furthermore, the NSW Coroner must make a written report to the Minister containing a summary of the details of all deaths in custody on an annual basis. This report is to be tabled in each House of Parliament and also published on the NSW Coroner's website.

2.21.3. Resources and funding: ALHR did not identify any concerns regarding resources or funding that may compromise the suitability of the NSW Coroner.

2.21.4. Independence and accountability: In ALHR's view, the independence and accountability of the NSW Coroner further supports its suitability. Formal written findings must be handed down by the Coroner outlining the circumstances, reasons, and findings related to the death in custody. Findings are published on the NSW Coroner's website and in the State Coroner Annual Report on Deaths in Custody. Furthermore, the NSW Coroner is required pursuant to s 37(1) of the *Coroners Act 2009* to provide to the Attorney General an annual summary of deaths in custody and deaths in police operations that were reported to a coroner in the previous year which is to be tabled in each House. The oversight that the NSW Coroner is subject to by NSW Parliament strengthens its suitability as a body.

3. Oversight functions performed by State bodies, any overlaps in the functions and the funding of those bodies

3.1. Law Enforcement Conduct Commission (LECC)

3.1.1. The LECC, established in 2017 to replace the Police Integrity Commission and the Police Compliance Branch of the NSW Ombudsman, monitors the NSW Police Force's investigation of critical incidents. "Critical incident" is defined as an incident involving a police officer or other member of the NSW Police Force that results in death or serious injury to a person. If the LECC determines that the investigation is not being conducted appropriately, it can advise the NSW Police Force and/or the NSW Coroner of those concerns and make recommendations. On funding, ALHR understands the LECC is funded as a government body with a budget of $22,300,000 as reported in the 2018-19 annual report.

[23] *Coroners Act 2009* (NSW), ss 23(1)(b) and 27(1)(d)(ii).

3.1.2. In ALHR's view, there are several shortcomings with the LECC's functions that impair its ability to independently, transparently and robustly review deaths in custody. Our key concerns are:

a) that while the NSW Police Force are required to respond to recommendations, the recommendations are not binding, and are not referred to any accountability body. This means they have no 'teeth' and may not result in full accountability or systemic change to prevent further deaths;

b) although findings may be publicly released, as this is not mandatory it impairs full accountability and transparency;

c) that the LECC only monitors the NSW Police Force's investigation and does not conduct its own separate investigation and is therefore dependent on information held by the NSW Police Force (whose members are the potential perpetrators).

3.1.3. Several existing NSW bodies could cooperate with the LECC to strengthen its oversight function. ALHR is not aware of any existing, mandatory cooperation between these bodies.

3.1.4. For example, the Inspector Custodial Services states that it provides independent scrutiny of the conditions, treatment and outcomes for adults and young people in custody. The NSW Ombudsman states that it reviews and monitors the deaths specifically of children who die while in detention but does not investigate deaths. NSW Corrective Services has established a policy on procedures to follow (for example notifying next of kin and Aboriginal Legal Services) when there is a death of an Aboriginal inmate in its custody. This information may be valuable in informing LECC's oversight capacity and shaping policy responses by relevant NSW bodies.

3.1.5. ALHR recommends bolstering the LECC's oversight capacity by:

a) conducting independent inquiries into deaths in custody;

b) issuing public, binding recommendations including referrals to criminal justice systems; and

c) ensuring greater cooperation including through information sharing between the relevant NSW bodies particularly the NSW Ombudsman and NSW Coroner.

4. How those functions should be undertaken and what structures are appropriate, and any other related matter

4.1. The need for an independent authority to investigate NSW deaths in custody

4.1.1. Current arrangements for the investigations of deaths in custody fall short of community expectations,[24] and international human rights standards.

[24] NITV, 'We have been stuck': Family seeks answers over death of Tane Chatfield', 22 July 2020 <https://www.sbs.com.au/nitv/article/2020/07/22/we-have-been-stuck-family-seeks-answers-over-death-

4.1.2. Under human rights law, the prohibition against the arbitrary deprivation of life has been interpreted as imposing an obligation to investigate alleged violations of the right to life.

4.1.3. The European Court of Human Rights has outlined the following criteria which must be met in order to ensure the integrity of the investigation:

a) Independence;

b) Effectiveness;

c) Promptness (timeliness);

d) Next of kin involvement; and

e) Sufficient public scrutiny (transparency).[25]

4.1.4. Section 23 of the *Coroners Act 2009* (NSW) mandates that a coronial inquest must be conducted where the death of an individual occurred in full-time custody within the NSW correctional system.

4.1.5. Upon a death in custody occurring, the Corrective Services NSW Investigations Branch and NSW Police Force conduct their own investigations into the death in custody which is tendered as evidence at a coronial inquest.

4.1.6. As the Australian Law Reform Commission (**ALRC**) explained, 'police retain an important role and generally have primary carriage of the initial fact finding investigation when there is a death in police custody.'[26]

4.1.7. The RCIADIC was critical of the process of members of the NSW Police Force investigating the conduct of other police officers. It emphasised that full and proper investigations into deaths in custody are critical, both to alleviate public suspicion, and serve the public interest.[27] It made a total of 35 recommendations for the reform of custody investigations and coronial inquiries in the event of an Aboriginal and Torres Strait Islander person dying in custody,[28] which have been implemented to varying degrees by states and territories.

4.1.8. ALHR supports the recommendation of the Human Rights Law Centre that:

> Each state and territory should establish an independent body for investigating deaths in police custody and complaints against police. Such a body should be hierarchically,

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tane-chatfield>; NITV, 'Family demand justice for death in custody of David Dungay Jnr', 8 November 2017, <https://www.sbs.com.au/nitv/family/nitv-news/article/2016/12/22/family-demand-justice-death-custody-david-dungay-jnr>.

[25] Council of Europe Commissioner for Human Rights, *Opinion Concerning Independent and Effective Determination of Complaints Against the Police*, 2009, available at: <https://wcd.coe.int/ViewDoc.jsp?id=1417857&Site=CommDH)>.

[26] Australian Law Reform Commission, *Pathways to Justice–Inquiry into The Incarceration Rate Of Aboriginal And Torres Strait Islander Peoples,* Report No 133 (2018) 467.

[27] Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) vol. 1, 4.5.56.

[28] Ibid, vol. 5.

> institutionally and practically independent of the police and have features to ensure that investigations are comprehensive, prompt, subject to public scrutiny and, in the case of deaths in custody, involve the family of the deceased.[29]

4.1.9. In its *Pathways to Justice* report, the ALRC pointed to a number of independent models for investigating deaths in custody from international jurisdictions, including the Independent Police Conduct Authority in New Zealand, Garda Síochána Ombudsman in the Republic of Ireland and the Special Investigations Unit in Ontario, Canada.[30] In these jurisdictions, an agency separate to the police are vested with powers to carry out investigations into deaths in custody.

4.1.10. As recommended by the ALRC, the strengths and challenges of these models should be considered as part of reforms to the current framework for investigating NSW deaths in custody, and complaints against police, more broadly.

4.1.11. Craig Longman, barrister and senior researcher at the Jumbunna Indigenous House of Learning, has proposed the following criteria for ensuring independence:

a) Investigators should be trained civilians, not any active duty, seconded, or ex-police officers.

b) Where investigators and the NSW Police Force are investigating related events, the most severe allegation should take preference and evidence should be collected by the agency with responsibility for investigating that offence.

c) Investigators should use their own medical and forensic experts.

d) Investigators should not uncritically rely on police versions of an event.

e) The investigatory body should have real powers to investigate and adjudicate.[31]

4.1.12. ALHR recommends that an independent oversight body be tasked with investigating deaths in custody, with civilian investigators who have a range of investigative powers similar to those of the NSW Police Force.

4.1.13. ALHR supports reforms to the powers and functions of LECC to fulfil this role, as discussed in further detail below.

4.2. How functions with respect of misconduct matters by the LECC should be undertaken

4.2.1. Currently, the LECC's functions are to detect, investigate and expose serious misconduct and maladministration in the NSW Police Force and the NSW Crime Commission, and to

[29] Human Rights Law Centre, Submission No 68 to the Australian Law Reform Commission, *Inquiry into The Incarceration Rate of Aboriginal and Torres Strait Islander Peoples,*
[30] Australian Law Reform Commission, above n 26, 467.
[31] Craig Longman, *The Conversation,* 'Scales of Justice Still Tipped Towards Police Who Harm People in Their Custody', 15 April 2016, available at: <https://theconversation.com/scales-of-justice-still-tipped-towards-police-who-harm-people-in-their-custody-57125>.

monitor the NSW Police Force's investigation of critical incidents and complaints against police.

4.2.2. ALHR recommends amendments to the *Law Enforcement Conduct Commission Act 2016* (NSW) (**LECC Act**) to strengthen the role of the LECC. The LECC should not merely be a monitoring body overseeing critical incidents, but a body that conducts independent inquiries and investigations into all aspects of alleged police misconduct and deaths in custody as a result of police actions or inactions. The LECC should also be empowered to make binding recommendations to the Commissioner of Police in respect of its findings.

4.2.3. The functions of the LECC in respect of police conduct is contained in s 26 of the LECC Act, which states that the LECC is: "to detect, investigate (including by carrying out examinations in appropriate cases) and expose conduct that is (or could be) **serious misconduct** or **serious maladministration**" (also provided for in section 51 of the LECC Act).

4.2.4. The LECC is not tasked with investigating police misconduct that does not fall into the definition of "serious misconduct" "or "serious maladministration, although that conduct may still be criminal conduct. The limited scope of the matters that the LECC may investigate reduces the effectiveness of the LECC as an overall oversight body for the NSW Police Force and NSW Crime Commission. This was raised by acting NSW Ombudsman, John McMillian, in his letter of 14 September 2016, to Mr Lee Evans MP, Chair Committee on the Office of the Ombudsman, the Police Integrity Commission and the Crime Commission. Mr McMillian (**emphasis added**):

> Mr Tink made it clear in his report (p 92) that he expected that the creation of a single oversight agency would increase the number of external investigations into what he described as **'everyday policing'**. He envisaged that these would be conducted by the Oversight Division. **However, in our view, the LECC's inability to investigate complaints about officer conduct that does not meet the threshold of 'serious misconduct' or 'serious officer maladministration' will make this outcome less likely**.[32]

4.2.5. The importance of an independent body having oversight of "everyday policing", particularly in respect of police conduct affecting First Nations people, was highlighted by the Redfern Legal Centre in its 2017 submissions to the ALRC, which stated (**emphasis added**):

> The LECC's investigative powers are limited to 'serious misconduct' meaning conduct that could result in prosecution for an offence or serious disciplinary action, a pattern of

[32] Professor John McMillian, Acting Ombudsman of the NSW Ombudsman, Letter to Mr Lee Evans MP, Chair Committee on the Office of the Ombudsman, the Police Integrity Commission and the Crime Commission regarding the Law Enforcement Conduct Commission Bill, 14 September 2016, 4, available at: <https://www.parliament.nsw.gov.au/committees/DBAssets/InquiryOther/Transcript/10311/Letter%20from%20NSW%20Ombudsman%20regarding%20LECC%20Bill.PDF>.

> misconduct involving more than one occasion or more than one participant that is indicative of a systemic issue or corrupt conduct. **Many complaints made by our clients would not necessarily meet the threshold of 'serious misconduct' as defined in the LECC Act, despite the fact that the conduct complained of may involve an abuse of power that routinely impacts Aboriginal and Torres Strait Islander clients**. This means that there may be limited oversight of non-serious misconduct, making the role of police in detecting and deterring misconduct more critical. In this regard, we suggest that the LECC interprets s10(1)(b) to include a pattern of conduct that disproportionately impacts Aboriginal and Torres Strait Islander people, whether or not the specific incident involves more than one participant.[33]

4.2.6. ALHR is of the view that there needs to be a broadening of the types of conduct that the LECC is empowered to investigate to ensure that there is accountability in respect to all aspects of policing as recommended by Mr Tink AM.[34] Changes in police attitudes and actions in everyday policing, in the circumstances where there is an independent body overseeing those actions, may lead to the systemic change required to reduce the number of First Nations people in custody.

4.3. How functions with respect of critical incident matters by the LECC should be undertaken

4.3.1. The LECC investigates serious police misconduct or excessive force that does not lead to serious injury or death, however, critical incidents that have resulted in death or serious injury will be self-investigated by the police.

4.3.2. The LECC's functions in respect of critical incidents is limited. The LECC Act provides that critical incidents are to be investigated by the NSW Police Force", while the LECC (**emphasis added**) "may **monitor** the conduct of a critical incident investigation if the Commission decides that it is in the public interest to do so": sections 113 and 114 of the LECC Act, respectively.

4.3.3. For there to be public confidence in the NSW Police Force, and accountability of police conduct, the NSW Police Force cannot be investigating itself. ALHR submits that investigation of critical incidents should be undertaken by the LECC. If this is not accepted, then at the very least, the LECC's monitoring role in a critical incident should be mandatory.

4.3.4. The features of a critical incident are provided in s 110 of the LECC Act. ALHR calls for a more inclusive definition of the term "critical incident" to cover police omissions or inactions, for example to include situations where the NSW Police Force have been called to an incident but have either not attended or refused to assist.

4.3.5. Section 111 of the LECC Act states that (**emphasis added**): "[t]he Commissioner of Police **may** (verbally or in writing) declare an incident to be a critical incident …" if the

[33] Redfern Legal Centre, Submission No 79 to the Australian Law Reform Commission, *Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander Peoples*, 12 September 2017, 19.
[34] Andrew Tink AM, *Review of Police Oversight: A Report to the New South Wales Government on Options for a Single Civilian Oversight Model for Police*, August 2015, 74-79.

conditions in subsections 111(1)(a) and (b) are fulfilled. ALHR is of the view that the discretion provided by the word "may" should be substituted for "must".

4.3.6. Section 117(6) of the LECC Act, if the LECC:

> ...makes a recommendation to the Commissioner of Police, the Commission may require the Commissioner of Police to provide to the Commission, within a reasonable time specified by the Commission, advice as to whether the Commissioner of Police intends to implement the recommendation and, if not, the reasons for not doing so.

4.3.7. ALHR recommends that the LECC Act should be amended to ensure that the LECC's recommendations to the Commissioner of Police are binding. In order to ensure full accountability for police actions and lasting cultural and systemic change within the NSW Police Force, the Commissioner of Police should not be in a position to pick and choose which recommendations, if any, it will implement.

4.3.8. It is ALHR's view that if these recommended amendments to the LECC Act are implemented, they will strengthen and broaden the LECC's function, thereby resulting in greater transparency, police accountability, and effective redress for the victims of police misconduct.

4.3.9. That said, for the LECC to effectively and efficiently undertake its functions, it must be adequately resourced to do so. In March 2020, the NSW Legislative Council Public Accountability Committee published its report titled *Budget Process for Independent Oversight Bodies and the Parliament of New South Wales - First Report*.[35] Paragraphs 3.20 to 3.24 of that report referred to submissions made by the LECC, in which the LECC raised serious concerns respect of its current funding, including:

a) that its initial budget was not capable of funding the structure of its inherited work and its new function of critical investigation monitoring;

b) that its funding model was inconsistent with the view in the Tink review;

c) due to its underfunding, there had been significant delays in investigations and focus on simple and straightforward matters for investigation; and

d) that the increase in the size of the NSW Police Force was not matched with the provision of additional resources to the LECC.

4.3.10. These funding matters need to be addressed to allow the LECC to effectively and efficiently undertake its functions.

[35] NSW Legislative Council Public Accountability Committee, *Budget Process for Independent Oversight Bodies and the Parliament of New South Wales - First Report*, March 2020, available at: <https://www.parliament.nsw.gov.au/lc/tabledpapers/Pages/tabled-paper-details.aspx?pk=77404&houseCode=lc>.

5. Conclusion

5.1. There is currently no framework in place in NSW for conducting independent investigations of deaths in custody.

5.2. As the NSW Police Force and Corrective Services play key roles in investigating deaths in custody, the independence of such investigations is impaired.

5.3. Urgent reform of the current framework for investigating deaths in custody is required to bring justice for the deceased, families and the wider community; to improve standards of custodial care; and to prevent further deaths.

5.4. ALHR recommends that an independent oversight body be tasked with investigating deaths in custody, with civilian investigators who are given a range of investigative powers similar to those of the NSW Police Force.

5.5. ALHR supports increasing the powers and functions of LECC to fulfil this role, including a broadening of the types of conduct that the LECC is empowered to investigate and increasing funding to ensure that the LECC is properly resource to undertake its increased functions.

ALHR is happy to provide any further information or clarification in relation to the above if the Council so requires.

If you would like to discuss any aspect of this submission, please email me at:

Yours faithfully

Kerry Weste
President
Australian Lawyers for Human Rights
ALHR

Any information provided in this submission is not intended to constitute legal advice, to be a comprehensive review of all developments in the law and practice, or to cover all aspects of the matters referred to. Readers should take their own legal advice before applying any information provided in this document to specific issues or situations.

Contributors:
Johanna Byrne
Nameeta Chandra
Christina Hey-Nguyen
Jessica Elliot
Sonali Seneviratne
Nicholas Stewart
Kerry Weste
Manny Zhang