

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

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Parliamentary inquiry into
the high level of First Nations
people in custody and
oversight and review of
deaths in custody

Legal Aid NSW submission to
the Select Committee Inquiry
into the High Level of First
Nations People in Custody and
Oversight and Review of Deaths
in Custody

September 2020

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About Legal Aid NSW

The Legal Aid Commission of New South Wales (**Legal Aid NSW**) is an independent statutory body established under the *Legal Aid Commission Act 1979* (NSW). We provide legal services across New South Wales through a state-wide network of 24 offices and 221 regular outreach locations, with a particular focus on the needs of people who are socially and economically disadvantaged.

We assist with legal problems through a comprehensive suite of services across criminal, family and civil law. Our services range from legal information, education, advice, minor assistance, dispute resolution and duty services, through to an extensive litigation practice. We work in partnership with private lawyers who receive funding from Legal Aid NSW to represent legally aided clients.

We also work in close partnership with community legal centres, the Aboriginal Legal Service (NSW/ACT) Limited and pro bono legal services. Our community partnerships include 27 Women's Domestic Violence Court Advocacy Services, and health services with a range of Health Justice Partnerships.

The Criminal Law Division assists people charged with criminal offences appearing before the Local Court, Children's Court, District Court, Supreme Court, Court of Criminal Appeal and the High Court. The Criminal Law Division also provides advice and representation in specialist jurisdictions including the State Parole Authority and Drug Court.

The Children's Legal Service (**CLS**) advises and represents children and young people involved in criminal cases in the Children's Court, including young people appearing before the Children's

Court for parole matters. CLS lawyers also visit Youth Justice centres and give free advice and assistance to young people in custody.

The Civil Law Division provides advice, minor assistance, duty and casework services from the Central Sydney office and 20 regional offices. It focuses on legal problems that impact on the everyday lives of disadvantaged clients and communities in areas such as housing, human rights, social security, financial hardship, consumer protection, employment, immigration and fines. The Civil Law practice includes dedicated services for Aboriginal communities, children, refugees, prisoners and older people experiencing elder abuse.

Legal Aid NSW has specialist legal services to assist people who are particularly vulnerable or require additional support. These include the Mental Health Advocacy Service; Coronial Inquest Unit; the Sexual Assault Communications Privilege Service; Work and Development Order Service and the Prisoners Legal Service.

Legal Aid NSW welcomes the opportunity to make a submission to the Select Committee inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody. Should you require any further information, please contact:

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Executive summary

Legal Aid NSW welcomes the opportunity to provide a submission to the Select Committee inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody (**Inquiry**).

In our view, the key factors that lead to a significant number of Aboriginal and Torres Strait Islander deaths in custody are the overrepresentation of Aboriginal and Torres Strait Islander people in custody, and poor access to health care and health treatment in custody, particularly mental health care.

In NSW, Aboriginal and Torres Strait Islander adults are imprisoned at a rate that is 12 times higher than non-Indigenous adults. Even more concerning is that Aboriginal and Torres Strait Islander juveniles are imprisoned at a rate that is 16 times higher than non-Indigenous juveniles.¹ Aboriginal and Torres Strait Islander women are vastly over-represented in the remand population, often because of insecure housing or employment, or previous convictions (commonly for low-level offending behaviour).²

Previous reviews

There have been significant and numerous reviews into the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system, which have unequivocally made the case for reform, and which should guide the Select Committee's inquiry. The Australian Law Reform Commission's *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples (ALRC Inquiry)*³ is the most recent review of the drivers of overrepresentation of Aboriginal and Torres Strait Islander people in detention. The 2018 report contains 35 recommendations designed to reduce the disproportionate rate of incarceration of Aboriginal and Torres Strait Islander people and improve community safety. The lack of a Federal Government response to the report should not prevent action at a State level to implement its recommendations.

In NSW, there have also been numerous relevant reviews that have identified legislative, policy and procedural changes to address the overrepresentation of Aboriginal and Torres Strait Islander people in the criminal justice system, including:

- the 2017 statutory review of the Bail Act,⁴ and the NSW Government's current review

¹ 'Young People are not *Overrepresented* in the Criminal Justice System: Baseline Data', *Closing the Gap* (Web Page) <<https://www.closingthegap.gov.au/young-people-are-not-overrepresented-criminal-justice-system>>.

² Australia's National Research Organisation for Women's Safety, *Women's Imprisonment and Domestic, Family and Sexual Violence* (Report, 2020) 4.

³ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018).

⁴ Department of Justice, *Statutory Review: Bail Act 2013* (Report, June 2018).

of the *Bail Act 2013* (NSW) (**Bail Act**)⁵

- the 2019 Special Commission of Inquiry into the Drug 'Ice' (**Ice Inquiry**)⁶
- the 2018 NSW Parliament Inquiry into the adequacy of youth diversionary programs in NSW (**Youth Diversion Inquiry**),⁷ and
- the 2018 NSW Parliament Inquiry into the provision of drug rehabilitation services in regional, rural and remote NSW.

The report of the Royal Commission into Aboriginal Deaths in Custody (1991) (**RCADIC**) highlighted the problematic treatment of Aboriginal and Torres Strait Islander people within the justice system and from police. Legal Aid NSW considers that the recommendations of the RCADIC remain vital in considering how to reduce incarceration rates for Aboriginal and Torres Strait Islander peoples. Some of these recommendations are highlighted in this submission.

Legal Aid NSW is concerned that many of the recommendations of our previous submissions and the previous inquiries and reviews have not been implemented or remain unanswered. A key plank of any response to the issue of Aboriginal and Torres Strait Islander deaths in custody should involve oversight and ongoing monitoring of Government response(s) to such recommendations.

The case for change

We consider that there must be a move away from punitive approaches to offending by Aboriginal and Torres Strait Islander people that emphasise incarceration, monitoring and control, towards healing and trauma-informed approaches that focus on rehabilitation, reintegration and reconciliation. Criminal justice reforms should be undertaken within a broader legal framework which emphasises early intervention, access to justice, and the diversion of resources from imprisonment to investment in social supports that can help reduce crime and the number of Aboriginal and Torres Strait Islander people entering the prison system. Aboriginal and Torres Strait Islander communities and agencies should be resourced to effectively participate in all stages of the criminal justice process, consistent with their rights to access to justice and non-discriminatory treatment before the law.⁸

⁵ 'Administrative Review of the Bail Act 2013', Department of Communities and Justice (Web Page, 8 July 2020)

<https://www.justice.nsw.gov.au/justicepolicy/Pages/lpcldr/lpcldr_consultation/administrative-review-of-the-bail-act-2013.aspx>.

⁶ Department of Premier and Cabinet, *The Special Commission of Inquiry into the Drug 'Ice'* (Report, January 2020).

⁷ Law and Safety Committee, Parliament of NSW, *The Adequacy of Youth Diversionary Programs in NSW* (Report 2/56, September 2018).

⁸ Indigenous peoples have the right to access to and prompt decision through just and fair procedures for the resolution of conflicts and disputes with States or other parties, as well as to effective remedies for all infringements of their individual and collective rights: *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UN Doc A/RES/61/295 (2 October 2007, adopted 13 September 2007) Art 40.

Key intervention points

There are several points at which the overrepresentation of Aboriginal and Torres Strait Islander people in custody can be addressed. Part A of this submission outlines what Legal Aid NSW considers to be these key intervention points, which necessarily begin with children and young people. It also discusses the contributing factors to the overrepresentation of Aboriginal and Torres Strait Islander people in custody, and ways to address these issues.

The common underlying theme of these factors is the absence of support services and therapeutic interventions to appropriately divert Aboriginal and Torres Strait Islander people from the criminal justice system. Legal Aid NSW strongly supports a community-led and government-supported justice reinvestment approach. We consider that a justice reinvestment approach at every stage, with investment in police and prisons being redirected to health and other support services, has significant potential for reducing rates of Aboriginal and Torres Strait Islander incarceration.

We also support calls from other stakeholders in the legal assistance sector for the NSW Government to take the lead in adopting ambitious jurisdictional-based justice targets, as part of the Closing the Gap Agreement, to reduce the imprisonment of Aboriginal and Torres Strait Islander people in NSW.⁹

In this submission, we largely draw on our previous submissions made to the above relevant inquiries – in particular, our previous submission to the ALRC Inquiry (**2017 ALRC submission**)¹⁰ – and link to these previous submissions without repeating their content in detail.

Preventing Aboriginal and Torres Strait Islander deaths in custody

Part B of this submission considers Aboriginal and Torres Strait Islander deaths in custody.

In Legal Aid NSW's view, the key issues that lead to a significant number of Aboriginal and Torres Strait Islander deaths in custody are:

1. the overrepresentation of Aboriginal and Torres Strait Islander people in custody, and
2. poor access to health care and health treatment in custody, particularly mental health care.

⁹ Aboriginal Legal Service NSW/ACT Ltd, 'ALS Urges NSW and ACT Governments to Lead, Adopting 10 Year Justice Targets to End Imprisonment' (Media Release, 7 August 2020).

¹⁰ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

Part B outlines the particular barriers to health care and treatment faced by Aboriginal and Torres Strait Islander people in custody, and discusses how access to health care, particularly mental health care, for this cohort can be improved.

Oversight and review of deaths in custody in NSW

Part C of this submission discusses the system of oversight and review of deaths in custody in NSW.

In Legal Aid NSW's view, there are aspects of the NSW coronial system that are operating well. However, there are a number of fundamental issues which continue to impact on the coronial system, and particularly the experience of family members of the deceased person. Some are evident across the coronial system as a whole. Others are relevant only to death in custody matters. Other matters relate particularly to the experience of Aboriginal and Torres Strait Islander people.

We are concerned that the coronial system is under-resourced, hampered by delay at various stages of the process, and not adapted to accommodating the needs of Aboriginal and Torres Strait Islander people, particularly families of deceased. There is also a need to improve the transparency and accountability of the coronial process, and adopt mechanisms to ensure that the coronial system has a greater focus on preventing deaths.

Key priority areas for reform

The following are what we consider to be the key priority areas for reform to address the overrepresentation of Aboriginal and Torres Strait Islander people in custody, improve the coronial process and improve prisoner health care. We provide further detail and expand on these recommendations in the body of the submission.

Children and young people

1. We strongly support raising the minimum age of criminal responsibility to 14 years old. Alternative, therapeutic approaches to dealing with children of any age in the criminal justice system should be implemented.
2. We recommend that the outstanding recommendations made by the NSW Legislative Assembly Law and Safety Committee's Youth Diversion Inquiry be implemented, including targeted amendments to the *Young Offenders Act 1997* (NSW) (**YOA**) and the *Bail Act 2013* (NSW) (**Bail Act**).
3. We recommend greater investment in diversionary approaches and diversionary programs for Aboriginal and Torres Strait Islander children and young people, in particular:
 - expansion of the Youth Koori Court to regional areas, as recommended by the Ice Inquiry. This should be accompanied by a commitment to therapeutic services for young people, including outpatient and residential drug and alcohol detoxification and rehabilitation facilities that are accessible and culturally appropriate

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- establishment of a fully funded Youth Drug and Alcohol Court, with a legislative basis
 - a system of Magistrates Early Referral Into Treatment (**MERIT**) type diversion in the Children's Court, consistent with the recommendation of the Ice Inquiry, and
 - expansion of Youth on Track, as recommended by the Youth Diversion Inquiry and supported by the Ice Inquiry.

Domestic and family violence and policing

4. We recommend that the NSW Police Force examine Operation Solidarity in Bourke as a best practice policing model for Aboriginal and Torres Strait Islander communities, with a view to expanding this approach state-wide.
5. We recommend more broadly that the NSW Police Force and Aboriginal and Torres Strait Islander communities form formal partnerships that facilitate shared decision-making. These partnerships should focus on how communities are policed with the aim of reducing crime and making communities safer.

Bail and the remand population

6. We encourage the NSW Government to take steps to implement the recommendations of the ALRC Inquiry for bail reform, to address the rate of incarceration of Aboriginal and Torres Strait Islander people. In particular, we support:
 - collaboration between the NSW Government and relevant Aboriginal and Torres Strait Islander organisations and peak legal bodies, to develop guidelines on requirements for bail authorities to consider any issues that arise due to a person's Aboriginality,
 - funding for culturally appropriate bail support programs and diversion options, to facilitate the granting of bail and to support compliance with it, and
 - measures being adopted to achieve better police bail decisions, more appropriately tailored bail conditions and legislative amendment to ensure that bail conditions made by courts and police address the objectively identified risks, and improved police approaches to enforcement and breaches of bail. This includes targeted amendments to the Bail Act to:
 - require the bail authority, when making a decision to impose a bail condition, to record reasons in writing to identify what risk each of the bail conditions is addressing, and how the imposition of that condition will mitigate that risk
 - require that a police officer who takes action to enforce bail conditions provide reasons for doing so in writing to the court, which is consistent with the requirement to provide for reasons for bail decisions,¹¹ and

¹¹ *Bail Act 2013* (NSW) s 38.

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- repeal section 74 to remove the prohibition on repeat bail applications.

Diversions options and specialist sentencing courts

7. We recommend that the NSW Government expand diversionary approaches and diversionary programs for Aboriginal and Torres Strait Islander people, in particular:
 - expansion of drug courts to regional, rural and remote areas. Access to the Drug Court could be improved by reviewing its cultural appropriateness and eligibility criteria, including expanding eligibility to violent offenders
 - expansion of associated drug rehabilitation services (including the MERIT program and the Compulsory Drug Treatment Program) to regional, rural and remote areas, and
 - expansion of MERIT to include people suffering from alcohol abuse problems in all locations, people in custody, and people charged with strictly indictable and/or violent offences.

These initiatives require concurrent commitments to appropriate services and programs, including residential drug and alcohol detoxification and rehabilitation facilities.

8. We recommend that the NSW Government expand specialist courts for Aboriginal and Torres Strait Islander people. In particular, we support the establishment of the proposed District Court of NSW Koori Court (the Walama Court), as recommended by the ALRC Inquiry.
9. We recommend that Circle Sentencing be made available in every Magistrates Court in NSW, and to every defendant who qualifies.

Sentencing

10. We consider that the NSW Government should implement the recommendations of the ALRC and the NSW Law Reform Commission, that sentencing legislation should be reformed to provide that, when sentencing Aboriginal and Torres Strait Islander offenders, courts should be expressly required to pay particular attention to the offender's circumstances, including the unique systemic and background factors affecting Aboriginal and Torres Strait Islander peoples.

Prison programs, services and supports for Aboriginal and Torres Strait Islander people in custody

11. We recommend that the NSW Government increase services and supports for Aboriginal and Torres Strait Islander people in custody, particularly in relation to drug and alcohol-related issues, mental health care, throughcare and transitional support, including access to housing prior to release. Specifically, there should be a greater focus on reintegration planning for Aboriginal and Torres Strait Islander people leaving custody and the establishment of partnerships with local Aboriginal and Torres Strait

Islander communities to reduce the risk of Aboriginal and Torres Strait Islander people reoffending in the first 12 months of release from custody.

12. We recommend that, consistent with the recommendation of the ALRC Inquiry, the NSW Government develop prison programs with relevant Aboriginal and Torres Strait Islander organisations that address offending behaviours – particularly in relation to alcohol and other drugs, domestic violence and anger management – and prepare Aboriginal and Torres Strait Islander people for release. The availability of such prison programs should be expanded and made available to people held on remand, prisoners serving short sentences, those at high risk of reoffending and Aboriginal and Torres Strait Islander women in custody.
13. We recommend that the NSW Government develop trauma-informed, culturally appropriate programs and services for Aboriginal and Torres Strait Islander women that are available before, during and post incarceration. We support the recommendation of the ALRC inquiry that programs and services delivered to Aboriginal and Torres Strait Islander women in custody should be developed and delivered by Aboriginal and Torres Strait Islander women, and take into account their particular needs so as to improve their chances of rehabilitation, reduce their likelihood of reoffending and decrease their involvement with the criminal justice system.
14. We consider that further diversionary options are needed for Aboriginal and Torres Strait Islander women who are defendants and offenders, which take into account care giving responsibilities and incorporate assistance with civil law problems and living skills, such as dealing with Centrelink, banks, housing and consumer issues.

Drugs and alcohol

15. We support the recommendation by the Ice Inquiry that the NSW Government partner with Aboriginal communities and Aboriginal community-controlled health services to develop and increase the availability of local, specialist, culturally safe drug treatment services.
16. We support the provision of alcohol addiction treatment services at all stages of the criminal justice system, and demand and supply reduction measures where they are evidence-based and supported by communities. We support recommendations by the ALRC Inquiry that all initiatives to reduce the harmful effects of alcohol in Aboriginal and Torres Strait Islander communities should be developed with, and led by, these communities to meet their particular needs.

Forensic patients

17. We suggest that options be considered to ensure that step-down facilities and services are more readily available within the forensic mental health system, so that forensic patients can progress through the various stages of detention in a timely way and transition successfully back into the community.

Post sentence detention and supervision

18. We recommend that the NSW Attorney General refer the *Crimes (High Risk Offenders) Act 2006* (NSW) and the *Terrorism (High Risk Offenders) Act 2017* (NSW) to the NSW Law Reform Commission for comprehensive review, including in respect of the impact of the legislation on Aboriginal and Torres Strait Islander people.

Cultural competence and leadership

19. We recommend that the NSW Government ensure that those who work with Aboriginal and Torres Strait Islander people and communities, including police, the judiciary and CSNSW staff, receive training on cultural competence and trauma-informed practice. This should include training about the local area in which they work, contemporary Aboriginal society, customs and traditions, and historical and social factors which contribute to the position of Aboriginal and Torres Strait Islander people today. For CSNSW staff and police, it should also include training about how to respond to trauma within the custodial setting.

Fines, driver licences and offensive language

20. We support the recommendation of the ALRC Inquiry that options be developed with Aboriginal and Torres Strait Islander organisations, to reduce the imposition of fines and infringement notices, limit the penalty amounts of infringement notices, avoid suspension of driver licences for fine default, and provide alternative ways of paying fines and infringement notices.
21. We support the increased use of warnings and cautions by police instead of issuing a fine, particularly for low level offences (e.g. riding a bicycle without a helmet).
22. We support the repeal of Division 6 of the *Fines Act 1996* (NSW) (**Fines Act**), which provides for imprisonment where a community service order is breached for non-payment of a fine.
23. We consider that driver licence sanctions should not be an enforcement mechanism for non-driving related fines.
24. We consider that, consistent with the recommendation of the ALRC Inquiry, offensive language should not be a criminal offence.

Monitoring and accountability

25. We suggest that when a new or amended law or policy is introduced that may increase rates of criminalisation and/or incarceration of Aboriginal and Torres Strait Islander people, an Aboriginal and Torres Strait Islander Incarceration Impact Assessment should be published and tabled in the NSW Parliament.
26. We suggest that funding be provided to an Aboriginal and Torres Strait Islander-led agency to monitor NSW Government responses to recommendations of this inquiry and other inquiries and reviews.

Prison health care

27. We recommend that the availability of culturally appropriate and culturally safe health care for Aboriginal and Torres Strait Islander prisoners be reviewed and enhanced by improving the number, capacity and retention of Aboriginal Health Workers, improving health programs and services tailored to Aboriginal and Torres Strait Islander prisoners and partnering with Aboriginal Health Justice organisations in the community.
28. We support the Productivity Commission's draft recommendation that the NSW Government ensure that Aboriginal and Torres Strait Islander people in custody have access to mental health supports and services that are culturally appropriate; trauma-informed; designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible; and focused on practical application. We also support its draft recommendation that the NSW Government work with Aboriginal and Torres Strait Islander organisations to ensure that Aboriginal and Torres Strait Islander people with mental illness are connected to culturally appropriate mental healthcare in the community upon release from prison.
29. We recommend that consideration be given to a pilot in various NSW prisons for a local Aboriginal Medical Service to provide medical services to Aboriginal and Torres Strait Islander prisoners in custody.

Coronial system

30. We support legislative reform and improved coronial processes to better support Aboriginal and Torres Strait Islander families of deceased persons, both in general and following a death in custody. Specifically, there is an opportunity to provide better information and support for families, more timely and better legal representation, and culturally appropriate services. Legal Aid NSW supports:
- the creation of a culturally specific unit in the Coroners Court and Aboriginal-identified positions in counselling and support roles at the Coroners Court, the Department of Forensic Medicine and the Coronial Information and Support Program
 - increased funding for legal services that assist families, and
 - the development of a Coroners Practice Note to cover Aboriginal and Torres Strait Islander deaths in custody.
31. The NSW Police Force should review the cultural sensitivity and quality of investigations by NSW Police into Aboriginal and Torres Strait Islander deaths in custody. We recommend that consideration be given to:
- ensuring that police investigating any Aboriginal or Torres Strait Islander death in custody or as a result of a police operation have received Aboriginal cultural training

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- the mandatory involvement of Aboriginal Community Liaison Officers in the investigation of any Aboriginal or Torres Strait Islander death in custody or as a result of a police operation, and
 - returning the investigative function for deaths in custody to the Corrective Services Investigation Unit.
32. We reiterate our recommendation that there be a legislative requirement for the provision and publication of a government agency response to coronial findings and recommendations. The written response should include a report as to whether any action has been taken, is being taken, or is proposed to be taken in response to the findings and recommendations, and should be provided within either three or six months of receipt of the Coroner's findings.
33. We strongly support the establishment of a unit similar to the Coronial Prevention Unit in Victoria, to assist coroners in the development of prevention-focused coronial recommendations. We also support the establishment of a specialist death review team with a statutory basis, based on the purpose and functions of the NSW DVDRT, to monitor and inform policy and systemic change in relation to all deaths in custody, with a particular focus on Aboriginal and Torres Strait Islander deaths in custody.
34. We consider that there is a need for a broader independent review or audit of how the coronial inquest system operates in NSW, with the aim of ensuring that the NSW model has a greater focus on preventing deaths. The review should consider the adequacy of funding of the coronial system, including legal services for families, delays and other inadequacies in relation to the provision of information and support to families.

Conclusion

Legal Aid NSW has extensive experience providing legal assistance to Aboriginal and Torres Strait Islander clients across each of our practice areas—Family, Civil and Crime. Our model of service delivery is holistic, timely and trauma-informed. We are committed to a holistic approach to a client's legal problems by providing early legal assistance, identifying systemic legal issues and referring clients to appropriate services, and providing community legal education (**CLE**). Our lawyers have significant expertise and experience working with clients and communities in metropolitan, as well as rural, regional and remote areas across NSW, which gives us a unique insight into the way in which laws, policies and service delivery affects Aboriginal and Torres Strait Islander people. We would welcome the opportunity for Legal Aid NSW solicitors across each of our practice areas to give evidence to this Inquiry.

Part A: Overrepresentation of Aboriginal and Torres Strait Islander people in custody in NSW

In NSW, Aboriginal and Torres Strait Islander adults are imprisoned at a rate that is 12 times higher than non-Indigenous adults.¹² Even more concerning is that Aboriginal and Torres Strait Islander children are imprisoned at a rate that is 16 times higher than non-Indigenous children.¹³

It is estimated that Aboriginal and Torres Strait Islander people represent 3.4% of the total NSW population.¹⁴ However, as at June 2020:

- Aboriginal and Torres Strait Islander children represented 40% of those in juvenile custody
- Aboriginal and Torres Strait Islander people represented 25% of those in adult custody
- Of the women in custody, 32% were Aboriginal or Torres Strait Islander
- Aboriginal and Torres Strait Islander adults represented 26.1% of the total remand population - Aboriginal and Torres Strait Islander women represented 30.7% of the overall women on remand, and Aboriginal and Torres Strait Islander men represented 25.7% of the total men on remand.¹⁵

We note that there was a 11.3% decrease in the number of Aboriginal and Torres Strait Islander people in prison over the last quarter. The majority of this decline was due to a reduction in the number of people being held in custody on remand. The COVID-19 pandemic has resulted in police issuing fewer court attendance notices, and more people being granted bail by both police and courts.¹⁶ This demonstrates that we can reduce prison numbers when there is political will to undertake systems change to ensure people's wellbeing is the priority.

Legal Aid NSW has extensive experience providing legal assistance to Aboriginal and Torres Strait Islander clients. Over the past five years, there has been an increase in our criminal law services provided to Aboriginal clients. Over the period from 1 January 2015 to 31 December 2019, our criminal law services to Aboriginal clients as a proportion of our total criminal law services increased from 10.6% to 14.3%. Notably, our in-house duty

¹² 'Adults are not Overrepresented in the Criminal Justice System', *Closing the Gap* (Web Page) <<https://www.closingthegap.gov.au/adults-are-not-overrepresented-criminal-justice-system>>.

¹³ 'Young People are not Overrepresented in the Criminal Justice System', *Closing the Gap* (Web Page) <<https://www.closingthegap.gov.au/young-people-are-not-overrepresented-criminal-justice-system>>.

¹⁴ 'Key Data – NSW Aboriginal People', *Aboriginal Affairs* (Web Page) <<https://www.aboriginalaffairs.nsw.gov.au/pdfs/new-knowledge/KEY-DATA-ABORIGINAL-PEOPLE-OCTOBER-2019.pdf>>.

¹⁵ NSW Bureau of Crime Statistics and Research, *New South Wales Custody Statistics* (Report, June 2019).

¹⁶ Aboriginal Legal Service NSW/ACT Ltd, 'ALS Urges NSW and ACT Governments to Lead, Adopting 10 Year Justice Targets to End Imprisonment' (Media Release, 7 August 2020).

lawyer services to Aboriginal clients as a proportion of total in-house duty lawyer services increased from 11.5% to 15.6%, and grants of legal aid to Aboriginal clients as a proportion of total grants increased from 11.3% to 18.2%.

We recognise that the legal needs of Aboriginal and Torres Strait Islander people are often complex, encompassing not only criminal law, but also civil and family law and a range of social and cultural issues. In 2018–19, Aboriginal and Torres Strait Islander people made up approximately 16.2% of the clients in Legal Aid NSW’s criminal law practice, compared with 15% of clients in the civil law practice, and 13.2% in the family law practice. We work in close partnership with the Aboriginal Legal Service (NSW/ACT) (**ALS**), in accordance with the organisations’ joint Statement of Commitment.

There are several points at which the overrepresentation of Aboriginal and Torres Strait Islander people in custody can be addressed. This part of the submission outlines what Legal Aid NSW considers to be key points of intervention, beginning with children and young people. It also discusses the contributing factors to the overrepresentation of Aboriginal and Torres Strait Islander people in custody, and ways to address these issues.

Children and young people

Minimum age of criminal responsibility

Legal Aid NSW strongly supports raising the minimum age of criminal responsibility to 14 years old. One of the compelling reasons for this is the overrepresentation of Aboriginal and Torres Strait Islander children under 14 years old in the criminal justice system.

The Australian Institute of Health and Welfare report on youth justice in Australia in 2018–19 found that, on average, Aboriginal and Torres Strait Islander young people entered youth justice supervision at a younger age than non-Indigenous young people. About two in five (38%) Aboriginal and Torres Strait Islander young people under supervision in 2018–19 were first supervised when aged 10 to 13 years, compared with about one in seven (15%) non-Indigenous young people.¹⁷

For further information, see section 5 of the National Legal Aid submission to the Council of Attorneys-General on the Age of Criminal Responsibility Working Group review, dated 28 February 2020.¹⁸

We note that the Council of Attorneys-General considered the issue of raising the minimum age of criminal responsibility at its meeting in July 2020. In its communique dated 27 July 2020, the Council of Attorneys-General noted that the Age of Criminal Responsibility Working Group identified the need for further work to occur regarding the

¹⁷ Australian Institute of Health and Welfare, *Youth Justice in Australia 2018-19* (Report, 15 May 2020) vi.

¹⁸ Legal Aid NSW, Submission to the Council of Attorneys-General Age of Criminal Responsibility Working Group, *Review of the Minimum Age of Criminal Responsibility* (28 February 2020) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0009/39267/NLA-sub-CAG-age-of-criminal-responsibility-28-02-20.pdf>.

need for adequate processes and services for children who exhibit offending behaviour.

Legal Aid NSW will continue to work with our state and territory colleagues through National Legal Aid to inform the review of the age of criminal responsibility by the Council of Attorneys-General.

Arrest as a last resort

In our view, unnecessary arrest, combined with inappropriate bail conditions, account for the majority of the unnecessary detention of children in NSW.

The use of arrest as a last resort for children is the existing NSW Police Force position. However, Legal Aid NSW's casework experience suggests that children are very frequently arrested unnecessarily. In practice, police officers do not turn their mind to alternatives to arrest during contact with children, and frequently fail to exercise their discretion to arrest under either section 99 of the *Law Enforcement (Power and Responsibilities) Act 2002* (NSW) (**LEPRA**) or section 77 of the Bail Act.

Legal Aid NSW considers that explicit legislative amendments to the YOA are required to confirm that arrest be a measure of last resort for a child, and that a child should not be arrested to administer the YOA. Legislating arrest as a last resort may reduce not only the number of children arrested but also those subsequently arrested for breaching bail in circumstances where the arrest giving rise to bail was unnecessary.

It is imperative that any proposed amendment to legislation in relation to arrest as a last resort for children does not have the unintended consequence of displacing the common law principle that arrest be used only as a last resort as it applies to people of all ages.

We also suggest that consideration be given to amending both section 99 of LEPRA and section 77 of the Bail Act to reflect a consistent approach to arrest as a last resort for children.

Bail

Legal Aid NSW is concerned about onerous, inappropriate and unnecessary bail conditions for children. These conditions, together with a lack of understanding of the condition(s) by the child, often result in children being taken into custody and spending several short periods on remand for a breach of bail conditions rather than the commission of a new offence. We are also concerned that some children charged with criminal offences are remanded in custody because of a lack of suitable accommodation.

We recommend that the outstanding recommendations for bail reform made by the Youth Diversion Inquiry be implemented. We note that the NSW Government has committed to consider these recommendations, as part of the current review of the Bail Act.¹⁹ These

¹⁹ NSW Government, *Report of the Legislative Assembly Committee on Law and Safety - Inquiry into the Adequacy of Youth Diversionary Programs in NSW: NSW Government Response* (28 August 2019) 6.

include targeted amendments to the Bail Act to ensure that decision-makers have particular regard to a person's age in determining what action to take for a breach of bail, as well as non-legislative changes, including promoting greater diversion of young people wherever possible, and increasing bail support services available to young people in regional and rural, as well as metro areas.

For further information and Legal Aid NSW's recommendations for bail reform, see the section on 'Bail issues concerning children and young people' in our 2020 submission to the Bail Act review.²⁰

Diversion under the Young Offenders Act 1997 (NSW)

Legal Aid NSW considers that the YOA provides a good legislative framework for the diversion of young offenders in NSW. However, we are concerned that the Act's scope and implementation have hampered the full realisation of its objectives, particularly with respect to Aboriginal and Torres Strait Islander children.

One of the express objects of the YOA is to address the overrepresentation of Aboriginal and Torres Strait Islander children in the criminal justice system through the use of youth justice conferences, cautions and warnings.²¹ However, Legal Aid NSW is concerned that the YOA is failing to meet this objective. Research by the NSW Bureau of Crime Statistics and Research (**BOCSAR**) has found that Aboriginal and Torres Strait Islander children do not enjoy equal access to diversion under the YOA.²² After examining data for almost 20,000 records of cautions, conferences and Children's Court matters between 2010-2011, BOCSAR found that Aboriginal and Torres Strait Islander children were less likely to receive a caution or a conference than non-Indigenous children, even after adjusting for factors such as prior cautions, conferences and court appearances.²³

We recommend that the outstanding recommendations made by the Youth Diversion Inquiry be implemented, including targeted amendments to the YOA.

We submit that any offence able to be dealt with in the Children's Court, or any person who can fall within the Children's Court jurisdiction, should be eligible to be dealt with under the YOA. This includes strictly indictable offences (except serious children's indictable offences), traffic offences, sexual offence matters, drug matters and graffiti offences. Many of the exclusions of offences from the YOA are unwarranted and prevent the diversion of children in appropriate cases (e.g. offences under the *Crimes (Domestic and Personal Violence) Act 2007* (NSW)). Police, the Director of Public Prosecutions and courts should have as much discretion as possible, to determine the appropriateness of

²⁰ Legal Aid NSW, Submission to the NSW Department of Communities and Justice, *Review of the Bail Act 2013* (NSW) (17 August 2020) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0019/41266/200817-LANSW-submission-to-DCJ-review-of-the-Bail-Act-2013.pdf>.

²¹ *Young Offenders Act 1997* (NSW) s 3.

²² Clare Ringland and Nadine Smith, NSW Bureau of Crime Statistics and Research, *Police Use of Court Alternatives for Young Persons in NSW* (Crime and Justice Bulletin No 167, January 2013) 10.

²³ *Ibid.*

diversion under the YOA.

We strongly support removal of the restriction in the YOA on the number of cautions that a child can receive,²⁴ particularly given the vast overrepresentation of Aboriginal and Torres Strait Islander children in the criminal justice system. Legal Aid NSW solicitors have, in recent years, observed an increase in the number of cautions given to younger children, particularly Aboriginal and Torres Strait Islander children and children living in remote areas. This increases the impact of the cap on cautions, as children will reach their limit of three cautions much earlier, and therefore have more limited opportunity for diversion.

Diversionary programs and alternative, therapeutic approaches to youth justice

Legal Aid NSW considers that there is a need to develop and implement alternative, therapeutic approaches to dealing with children in the criminal justice system, which better recognise their vulnerability and support their rehabilitation and reintegration into the community. In the context of diversionary programs for children to avoid long-term involvement in the criminal justice system, we reiterate that more attention should be paid to the drug rehabilitation needs of young offenders. We are concerned about the lack of culturally appropriate and trauma-informed services for Aboriginal and Torres Strait Islander children and young people.

We recommend greater investment in diversionary approaches and diversionary programs for Aboriginal and Torres Strait Islander children and young people which could be effective in addressing Aboriginal and Torres Strait Islander offending and incarceration rates. In particular, we recommend:

- expansion of the Youth Koori Court to regional areas, as recommended by the Ice Inquiry.²⁵ This should be accompanied by a commitment to therapeutic services for young people, including outpatient and residential drug and alcohol detoxification and rehabilitation facilities that are accessible and culturally appropriate
- establishment of a fully funded Youth Drug and Alcohol Court, with a legislative basis
- a system of MERIT type diversion in the Children's Court, noting the effectiveness of MERIT in the adult courts. This is consistent with the recommendation of the Ice Inquiry,²⁶ and
- expansion of Youth on Track, which has achieved impressive results for very at-risk young people. This was recommended by the Youth Diversion Inquiry²⁷ and supported

²⁴ *Young Offenders Act 1997* (NSW) s 20(7).

²⁵ Department of Premier and Cabinet, *The Special Commission of Inquiry into the Drug 'Ice'* (Report, January 2020) Recommendation 60.

²⁶ *Ibid* Recommendation 16.

²⁷ Law and Safety Committee, Parliament of NSW, *The Adequacy of Youth Diversionary Programs in NSW* (Report 2/56, September 2018) Finding 7.

by the Ice Inquiry.²⁸ We note that the program is currently being evaluated by BOCSAR, which is due to report in 2020.

For further information, see the section on 'Diversionary programs and therapeutic approaches to youth justice' in Legal Aid NSW's 2019 submission to the Ice Inquiry.²⁹

Experiences of Legal Aid NSW staff from the Broken Hill office – services and approaches for Aboriginal children

The following issues for Aboriginal children in the Far West region demonstrate the ongoing need for improved resourcing for child-specific services and therapeutic approaches for Aboriginal and Torres Strait Islander children in regional, rural and remote areas:

- Processes that apply to adults in custody continue to be inappropriately applied to children in custody: For example, in smaller regional areas, children are held in police custody with adults often overnight. Recently in Wilcannia, our solicitors were informed that two children on separate occasions witnessed violent assaults in custody, and one was unable to lie down due to the large amount of blood in the cell. The lack of facilities means that children are sharing facilities with adults, often without a support person or support from Youth Justice NSW. We consider that there is a need for greater investment in child-specific facilities in police stations and areas of detention.
- Lack of audio visual link (AVL) facilities: For example, children arrested in Wilcannia have a three-hour drive in a police truck to face court, then often bail is granted and they are forced to travel back. AVL facilities are available in some metropolitan and larger regional centres for individuals who are police bail refused, yet there is no police station or court equipped with these facilities between Dubbo and Broken Hill, a distance of around 750 kilometres. This means that children who are refused police bail are transported long distances alone in police trucks. If children are bail refused in Broken Hill, they are transported by Youth Justice NSW to Dubbo by plane at a cost of around \$4,000.

We reiterate our concern about the unjustifiably high rates of police breach of bail and bail refusal in relation to children. In addition, we consider that any expansion of AVL facilities and associated police training across NSW would logically prioritise those locations furthest from Youth Justice centres and/or court. This would include locations such as Wilcannia, Tibooburra, Cobar and Nyngani. Additional safeguards

²⁸ Department of Premier and Cabinet, *The Special Commission of Inquiry into the Drug 'Ice'* (Report, January 2020) Recommendation 17.

²⁹ Legal Aid NSW, Submission to the Special Commission of Inquiry into the Drug 'Ice', *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-type Stimulants* (May 2019) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0003/31476/Legal-Aid-NSW-submission-to-Special-Commission-of-Inquiry-into-Ice-Issues-Paper-2.pdf>.

of the rights and welfare of the child (such as access to Youth Justice, support persons and appropriate bail support services) would need to be included if expanded use of AVL for children in remand were to be progressed.

- Lack of services for mental health and associated issues: There is no access to mental health services within a 1000 kilometre radius of Broken Hill, and no ability for psychologists to perform the required assessments for section 32 mental health applications or treatment plans.³⁰ We note that provision is made for prisoners to receive diagnosis and care via AVL whilst in custody. We consider that a mental health AVL service could extend mental health care and treatment to Aboriginal and Torres Strait Islander children and others in remote areas, whose interaction with the criminal justice system is often underpinned by mental health issues.

Overpolicing and STMPs

In the experience of our solicitors, the NSW Police Suspect Targeting Management Plan (STMP) conflicts with the objective of diverting Aboriginal and Torres Strait Islander children and avoiding their ongoing involvement with the criminal justice system.

Legal Aid NSW notes the disproportionate impact of the STMP regime on Aboriginal children.³¹ According to a recent report by the Law Enforcement Conduct Commission, during the period from 1 August 2016 to 1 August 2018, 72% of the young people selected by NSW Police for STMP targeting were recorded as being possibly Aboriginal or Torres Strait Islander.³² Of that cohort, more than half (65%) were located across the three NSW Police Force Regions covering rural and remote areas.³³

The youngest children in the total cohort of 429 (aged nine and 12 years old) were Aboriginal and did not have a charge history before they were nominated, which the Commission noted was cause for concern. The Commission was particularly concerned that police did not apply any positive STMP policing strategies to manage them.³⁴

The Commission expressed concern that “the identification of targets appears to occur in

³⁰ Section 32 of the *Mental Health (Forensic Provisions) Act 1990* (NSW) provides that a Magistrate may divert a defendant into the care and treatment of a mental health professional, generally for a period of six months, rather than dealing with them according to the criminal law. Section 32 mental health applications require a report from a psychologist or psychiatrist which (1) provides that at the time of the alleged offence, the defendant was cognitively impaired, suffering from mental illness, or suffering from a mental condition for which treatment is available in a mental health facility; (2) shows how the mental illness contributed to the alleged offending behaviour; and (3) includes a treatment plan.

³¹ Youth Justice Coalition, *Policing Young People in NSW: A Study of the Suspect Targeting Management Plan* (Report, 2017).

³² The NSW Police Force estimates that the proportion of the cohort that is Aboriginal is actually 42%, and uses a different method for calculating this figure: Law Enforcement Conduct Commission, *An Investigation into the Formulation and Use of the NSW Police Force Suspect Targeting Management Plan on Children and Young People* (Interim Report, January 2020) 11, 17, 24.

³³ *Ibid* 17.

³⁴ *Ibid* 19.

an unstructured and ad hoc manner which gives rise to the risk of real or perceived bias in the selection of STMP targets”.³⁵ Its report states:

The Commission acknowledges the representation of Aboriginal people in the cohort is reflective of a problem that has been identified generally in the Australian community about how the criminal justice system interacts with Aboriginal people and is not solely derived from interactions with police. However, the Commission has concerns that the local target identification process does not demonstrate sufficient rigour to prevent the unfair targeting of certain types of young offenders and ameliorate officer bias in who gets selected...

The *Young Offenders Act 1997* (NSW) emphasises as one of its principles the need to address the over representation of Aboriginal and Torres Strait Islander children and young people in the criminal justice system. It is important that the NSW Police Force carefully scrutinises the reasons for the high representation of young Indigenous STMP targets, to ensure it is consistent with the intention of Parliament to address the over representation of Aboriginal and Torres Strait Islander children and young people in the criminal justice system.³⁶

The report notes that the Aboriginal Community Liaison Officer was only listed in nine Target Action Plans (**TAPs**).³⁷ These plans list the strategies police will apply to actively monitor and target an individual.³⁸ The Commission recommended that NSW Police increase the engagement of Aboriginal Community Liaison Officers in the development and application of TAPs for Aboriginal children and young people.³⁹

The Commission found evidence that targeting under the STMP was focused on coercive targeting strategies involving increased overt monitoring of the targets in their home and in public, which could result in charges and unnecessary contact with the court.⁴⁰ It recommended that NSW Police increase the use of positive targeting strategies for young STMP targets.⁴¹ These include referrals to the Police Citizens Youth Club (**PCYC**), utilising diversion programs, and engaging with external agencies for support, as well as parents or guardians to assist in developing strategies to reduce the young person’s involvement in crime.⁴²

The Commission also recommended that NSW Police undertake an evidence-based review and evaluation of the efficacy of the STMP on children and young people, which should consider the broader legislative and policy framework as it relates to children and young people, including against aims such as reducing the numbers of Aboriginal and Torres Strait Islander people involved in the criminal justice system and in custody.⁴³

The report notes that many of the concerns raised by the Commission have been considered and addressed by NSW Police in the new draft STMP III policy, however it is

³⁵ Ibid.

³⁶ Ibid 18.

³⁷ Ibid 31.

³⁸ Ibid 29.

³⁹ Ibid 32.

⁴⁰ Ibid 40.

⁴¹ Ibid 55.

⁴² Ibid 52.

⁴³ Ibid 37-38.

too early to assess whether all issues identified have been resolved.⁴⁴

Legal Aid NSW considers that STMPs should not be used against children (persons under 18 years of age). We agree with submissions from other stakeholders made to the Youth Diversion Inquiry, that the use of the STMP on children runs counter to current policy settings for youth justice in NSW that emphasise therapeutic interventions designed to address the causes of offending, divert young people from the criminal justice system and rehabilitate them.⁴⁵

However, if the STMP is retained as a policing tool for persons under 18, we support the recommendations of the Youth Diversion Inquiry and the LECC Inquiry that STMP nominations for a child under 14 years of age must be approved at Assistant Commissioner level. We welcome the NSW Police Force's confirmation that this is now occurring.⁴⁶ However, we would also welcome consideration by the NSW Police Force of applying this approval process retrospectively, to ensure that the Assistant Commissioner also reviews the application of the STMP on any children who were under 14 years of age at the time that it was applied.

We also support the NSW Police Force's ongoing implementation of the remainder of the LECC Inquiry recommendations, and the LECC's ongoing monitoring of the use of the STMP on children, to ensure that these policing approaches do not have a disproportionate impact on Aboriginal and Torres Strait Islander children.

Custody Notification Service

Police will call the ALS Custody Notification Service (**CNS**) where they are dealing with an Aboriginal and Torres Strait Islander child who they are considering for a YOA outcome, or arrest or charge. To date, police have used the CNS (and the Youth Hotline) not only when they have a child at a police station, but also when they have visited the child's home, or when dealing with the child in a public place.

However, the ALS has recently advised that the CNS will no longer be available in situations where a child (or adult) is not in police custody. It is uncertain whether police will make a call to the Legal Aid NSW Youth Hotline in these circumstances. This is likely to impact on the already concerning low rates of diversion of Aboriginal and Torres Strait Islander children under the YOA. We consider that increased funding to expand the CNS

⁴⁴ Ibid 14, 62.

⁴⁵ Law and Safety Committee, Parliament of NSW, *The Adequacy of Youth Diversionary Programs in NSW* (Report 2/56, September 2018) 40-41.

⁴⁶ The NSW Police Force estimates that the proportion of the cohort that is Aboriginal is actually 42%, and uses a different method for calculating this figure: Law Enforcement Conduct Commission, *An Investigation into the Formulation and Use of the NSW Police Force Suspect Targeting Management Plan on Children and Young People* (Interim Report, January 2020) 15.

is needed to cover this gap.

Domestic and family violence and policing

A significant driver of the increase in Aboriginal and Torres Strait Islander adult incarceration is domestic and family violence and the subsequent policing of conditional liberty that flows from police attending a domestic violence incident – specifically, the enforcement of bail conditions and conditions of Apprehended Domestic Violence Orders (**ADVOs**). While Legal Aid NSW strongly supports the increased focus on domestic and family violence as a serious crime, which is making Aboriginal and Torres Strait Islander women and children safer, we acknowledge that this also contributes to the high rate of Aboriginal and Torres Strait Islander men in custody.

We support the need to examine strategies that move the focus away from a simple criminal justice model towards collective processes of community healing grounded in Aboriginal and Torres Strait Islander knowledge. Drawing on recent research from ANROWS, which examined responses to family violence in a number of remote Aboriginal and Torres Strait Islander communities, we encourage the NSW Government to develop family violence strategies that are owned and managed by Aboriginal and Torres Strait Islander people and that acknowledge and incorporate measures to address alcohol reduction, inter-generational trauma, social and emotional wellbeing, and alternatives to custody. The development of initiatives that are alternative to custody would be based on the particular needs of the Aboriginal and Torres Strait Islander communities, but would still ensure that responses to family violence reflect the needs of local women and children.⁴⁷

For example, the NSW Police Force recently implemented an activity called Operation Solidarity in the Bourke Local Area Command, as part of the larger Maranguka Justice Reinvestment Project. The operation was led by the Local Area Commander, and involved heavy engagement with local Aboriginal people. The model involved a morning meeting with local Aboriginal leaders to discuss matters including the past day's breach and enforcement activities and how to follow up those activities, engagement of people in helping to police themselves, and the development of reasonable conditions on orders. We understand that as a result, that community saw a significant reduction in the rates of arrest and detention of people and a corresponding reduction in reported crime, including domestic and family violence offences.

We recommend that the NSW Police Force examine Operation Solidarity in Bourke as a best practice policing model for Aboriginal and Torres Strait Islander communities, with a view to expanding this approach state-wide.

More broadly, we also recommend that the NSW Police Force and Aboriginal and Torres Strait Islander communities form formal partnerships that facilitate shared decision-making and meaningful engagement with those communities to discuss policing

⁴⁷ See for example Prof Harry Blagg et al, 'Innovative Models in Addressing Violence Against Indigenous Women: Final Report' (2018) *ANROWS Horizons*.

strategies. These partnerships should focus on how communities are policed with the aim of reducing crime and making communities safer. These partnerships should be supported by a proper operational decision-making structure (such as the morning meetings in Bourke as part of Operation Solidarity), active discussion on upcoming breach and enforcement activities, and community engagement to assist in designing conditions on liberty and helping defendants meet those conditions.

Bail and the remand population

In NSW criminal courts, Aboriginal defendants are refused bail at almost double the rate when compared to all defendants in NSW.⁴⁸

Legal Aid NSW is concerned that some aspects of the Bail Act and its implementation do not strike an appropriate balance between the right of a defendant to liberty and the presumption of innocence, and the need to ensure that a defendant does not abscond, interfere with witnesses, or commit other offences. We are particularly concerned about the impact of the operation of the Bail Act and its role in the unnecessary criminalisation of Aboriginal and Torres Strait Islander people.

Legal Aid NSW remains concerned about the imposition of inappropriate bail conditions, and the NSW Police Force's approach to enforcing those conditions. Legal Aid NSW solicitors have identified that bail conditions are regularly imposed without being linked to mitigation of a bail concern. We regularly see a large number of conditions being imposed on our clients, which often leads to a greater volume of minor or technical breaches. Our clients are frequently arrested for such breaches of bail (with no new offence committed), which in turn leads to significant and in our view unnecessary increase in the remand population. This reflects the BOCSAR findings that in 35% of orders, defendants had only breached their bail conditions through technical breaches rather than through reoffending. BOCSAR further reported that the predominant court response to defendants who breached their bail orders was to continue bail (61.3%).⁴⁹

Our solicitors have observed that police often impose bail conditions that are excessively onerous and not necessary to address risk, despite the clear provisions of s20A(2) of the *Bail Act 2013*. Such conditions can have a particularly harsh effect as they may be inadvertently breached, exposing the defendant to breach proceedings and the risk of detention even where the alleged offence is minor and does not warrant a custodial penalty. Data provided by BOCSAR highlighted that in 2018 over 35% of female and 25% of male Aboriginal and Torres Strait Islander defendants who were on remand at the time of finalisation received a non-custodial penalty.⁵⁰ A history of non-compliance with bail conditions also decreases the likelihood of a person being granted bail in the future.⁵¹

⁴⁸ NSW Bureau of Crime Statistics and Research, *NSW Criminal Courts Statistics January 2015 to December 2019* (December 2019).

⁴⁹ Neil Donnelly and Lily Trimboli, NSW Bureau of Crime Statistics and Research, *The Nature of Bail Breaches in NSW* (Bureau Brief No 133, 2018).

⁵⁰ NSW Legal Assistance Forum, *Aboriginal Incarceration Working Group Report* (Report, May 2019).

⁵¹ *Bail Act 2013* (NSW) s 18(f)(ii).

Legal Aid NSW is concerned about enforcement of bail conditions. We have observed that police often arrest people for minor or technical⁵² breaches of bail, and in circumstances where there are other appropriate options besides arrest. This generally results in people spending time in custody, such as overnight, before being taken before the court. This often occurs in circumstances where the defendant has been charged with a relatively minor offence and is unlikely to be sentenced to imprisonment if convicted. Arrest for technical breach of bail is also contributing to the overrepresentation of Aboriginal and Torres Strait Islander people in custody. In 2018, 40% of people arrested for a technical breach of bail were Aboriginal or Torres Strait Islander.⁵³

We consider that police should exercise greater discretion in determining how to respond to a breach of bail and exercise the least restrictive option available, in reference to the bail risks and considerations in sections 17 and 18 of the *Bail Act*.

Legal Aid NSW is also concerned that the prohibition on repeat bail applications in section 74 of the *Bail Act* is contributing to people spending longer times on remand, including in circumstances where they are unlikely to be sentenced to a term of imprisonment if convicted. In particular, we are concerned that the prohibition is unfairly limiting a person's access to the court. It acts as a deterrent to solicitors making bail applications quickly, which in turn is contributing to the increase in the short-term remand population in adult and juvenile correctional centres.

In our experience, the prohibition on repeat applications for bail has resulted in bail applications becoming longer and more complex. Lawyers are aware that this may be their client's only opportunity to seek bail in the Local Court, so feel obliged to address every bail consideration in detail, including the strength of the Crown case. The courts already have discretion to refuse to hear frivolous or vexatious applications, and those that are 'without substance or have no reasonable prospect of success' and this safeguard is sufficient.⁵⁴

We encourage the NSW Government to take steps to implement the recommendations of the ALRC Inquiry for bail reform, to address the rate of incarceration of Aboriginal and Torres Strait Islander people,⁵⁵ as well as targeted legislative amendments that we have identified in our recent submission to the NSW Government's statutory review of the *Bail Act*. In particular, we support:

- collaboration between the NSW Government and relevant Aboriginal and Torres Strait Islander organisations and peak legal bodies, to develop guidelines on requirements for bail authorities to consider any issues that arise due to a person's Aboriginality. Greater collaboration with Aboriginal and Torres Strait Islander organisations and peak legal bodies is also critical to identify gaps in the provision of culturally appropriate bail

⁵² A technical breach is where the defendant did not commit another offence.

⁵³ Parliament of NSW, *Budget Estimates 2019-2020 Supplementary Questions*, Portfolio Committee No. 5 – Legal Affairs, Attorney General and Prevention of Domestic Violence (13 March 2020) 9.

⁵⁴ *Bail Act 2013* (NSW) s 73.

⁵⁵ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) Recommendations 5-1 and 5-2.

support programs and diversion options, and to develop and implement relevant bail support and diversion options

- the introduction of a standalone provision that requires bail authorities to consider any issues that arise due to a person's Aboriginality, including cultural background, ties to family and place, and cultural obligations,
- measures being adopted to achieve better police bail decisions, more appropriately tailored bail conditions and legislative amendment to ensure that bail conditions made by courts and police address the objectively identified risks, community-based supports to help people comply with their bail conditions, and improved police approaches to enforcement and breaches of bail. This includes targeted amendments to the Bail Act to:
 - require the bail authority, when making a decision to impose a bail condition, to record reasons in writing to identify what risk each of the bail conditions is addressing, and how the imposition of that condition will mitigate that risk. We consider that such a legislative requirement may help to ensure that conditions are appropriately tailored to address the identified risks. This amendment would also contribute to reducing the overall high number of bail conditions that are currently being imposed on adults and juveniles, reduce unnecessary bail breaches, and leading to an overall reduction in the remand population
 - require that a police officer who takes action to enforce bail conditions provide reasons for doing so in writing to the court. This is consistent with the requirement to provide for reasons for bail decisions,⁵⁶ and
 - repeal s 74 to remove the prohibition on repeat bail applications.

The recommendations from the numerous recent comprehensive inquiries present a clear pathway for reform – an opportunity to holistically examine the NSW justice system's approach to bail decisions and breaches and the availability of necessary services and supports, and to address the overrepresentation of Aboriginal and Torres Strait Islander people in the NSW criminal justice system.

For further information, see Legal Aid NSW's submission to the Bail Act review,⁵⁷ which identifies targeted amendments to the Bail Act to address some of these concerns, as well as non-legislative measures to achieve more appropriately tailored bail conditions and improved police approaches to breaches of bail.

See also Legal Aid NSW's concerns and recommendations about bail and the Aboriginal

⁵⁶ *Bail Act 2013* (NSW) s 38.

⁵⁷ Legal Aid NSW, Submission to the NSW Department of Communities and Justice, *Review of the Bail Act 2013* (NSW) (17 August 2020) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0019/41266/200817-LANSW-submission-to-DCJ-review-of-the-Bail-Act-2013.pdf>.

Torres Strait Islander remand population in chapter 2 of our 2017 ALRC submission.⁵⁸

Community-based bail intervention

Consideration should be given to a community-based bail intervention program, akin to a hybrid between a Koori Court and MERIT program, for Aboriginal and Torres Strait Islander people charged with offences. Such a program could help to acknowledge cultural and economic dispossession, and provide targeted and tangible supports to Aboriginal and Torres Strait Islander people involved in the criminal justice system, but in a community setting. We also consider that having a dedicated field officer or social worker could potentially increase compliance with bail conditions and increase future grants of bail. We suggest that funding for a pilot program, developed in consultation with organisations in the community and on Country, should be explored by the NSW Government.

Diversiónary options and specialist sentencing courts

Legal Aid NSW is concerned about the lack of alternative options to entering the criminal justice system early.

We recommend that the NSW Government expand diversionary approaches and diversionary programs for Aboriginal and Torres Strait Islander people, including drug courts and drug rehabilitation services. The following initiatives should be considered to reduce Aboriginal offending and incarceration rates:

- expansion of drug courts⁵⁹ to regional, rural and remote areas. Access to the Drug Court could be improved by reviewing its cultural appropriateness and eligibility criteria, including expanding eligibility to violent offenders
- expansion of associated drug rehabilitation services (including the Magistrates Early Referral Into Treatment (**MERIT**) program and the Compulsory Drug Treatment Program) to regional, rural and remote areas, and
- expansion of MERIT to include people suffering from alcohol abuse problems in all locations, people in custody, and people charged with strictly indictable and/or violent offences.

These initiatives require concurrent commitments to appropriate services and programs, including residential drug and alcohol detoxification and rehabilitation facilities. We note

⁵⁸ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

⁵⁹ Evaluations have found that participants in the NSW Drug Court are less likely to be reconvicted than offenders given conventional sanctions (mostly imprisonment), and the Drug Court costs less than conventional sanctions: Don Weatherburn et al, NSW Bureau of Crime Statistics and Research, *The NSW Drug Court: A Re-evaluation of its Effectiveness* (Crime and Justice Bulletin No 121, September 2008) 1; Stephen Goodall, Richard Norman and Marion Haas, NSW Bureau of Crime Statistics and Research, *The Costs of NSW Drug Court* (Crime and Justice Bulletin No 122, September 2008).

that if the Drug Court is expanded to violent offenders, alcohol and other drug services also need to be made available to violent offenders. Our solicitors previously had difficulties gaining access to rehabilitation services for some clients who were violent offenders, due to the risks they posed to other residents.

We also recommend that the NSW Government expand specialist courts for Aboriginal and Torres Strait Islander people. In particular, we support the establishment of the proposed District Court of NSW Koori Court (the Walama Court),⁶⁰ as recommended by the ALRC Inquiry.

For further information, see Chapter 11 of our 2017 ALRC submission.⁶¹

Circle Sentencing

Circle Sentencing is an alternative sentencing option for Aboriginal and Torres Strait Islander offenders which involves members of the offender's local community and Elders in the sentencing process. Circle Sentencing has the full sentencing power of a traditional court, for Aboriginal offenders who meet a specific set of conditions.⁶² It is currently available in 12 NSW Local Courts.⁶³

A recent study by BOCSAR has found that Aboriginal and Torres Strait Islander people who participate in Circle Sentencing have lower rates of imprisonment and recidivism than those who are sentenced in the conventional way.⁶⁴

In our experience, Circle Sentencing can provide for a culturally appropriate setting and framework for developing a sentence. Circle Sentencing gives Elders in the community a respected role in the justice system and the authority to hand down a sentence. It also gives Local Court Magistrates the opportunity to see how Elders function and what their expectations are of the participating offenders. The benefits of Circle Sentencing for the community as a whole are extensive.

Experiences of Legal Aid NSW staff from the Nowra office – Circle Sentencing

The Local Court Magistrate participated in Circle Sentencing proceedings in the region. At the start of a Circle Sentencing, the Magistrate would provide an introduction, then take a back seat as the Elders led proceedings. Over time, Circle Sentencing helped to build mutual respect and trust between the local Aboriginal community and the Magistrate. Through his involvement in Circle Sentencing, the Magistrate developed a

⁶⁰ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) 332.

⁶¹ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/_data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

⁶² Steve Yeong and Elizabeth Moore, NSW Bureau of Crime Statistics and Research, *Circle Sentencing, Incarceration and Recidivism* (Crime and Justice Bulletin No 226, April 2020) 2.

⁶³ *Ibid* 3.

⁶⁴ *Ibid* 1.

better understanding of the local Aboriginal community. In our view, a lot of Aboriginal people going through the court system benefited from his understanding of the community.

We are concerned that Circle Sentencing is currently limited to a few locations, and can also be limited by the court's time. We note that the effectiveness of Circle Sentencing may be limited by the resources available to implement the outcome determined by the circle, particularly with aftercare and support. It is expected that Elders and the community will monitor and support the offender, however this is not always viable. For example, an Elder may not be able to monitor the offender's attendance at a rehabilitation program due to a lack of available transport.

One difficulty raised by a Legal Aid NSW regional solicitor is that many people referred to Circle Sentencing are not necessarily from the area. Another regional solicitor reports that, in one case, Elders did not want to proceed with Circle Sentencing with an offender as the person was not from their community, and they felt they had no authority over the person. Aside from this incident, referrals from outside an area may still be a valid compromise in order to sustain the program.

Another potential barrier is client participation. One regional solicitor reports referring a few clients to Circle Sentencing, however none of them ultimately participated in the process. By the time our clients are on the cusp of entering custody (the stage that Circle Sentencing is designed for), many of them are already quite vulnerable, experiencing homelessness and substance abuse issues, and so their capacity to participate is limited. These are barriers to participation in the justice system and, as a corollary, Circle Sentencing. Circle Sentencing could have a greater impact on people at risk of lengthy involvement in the criminal justice system.

Despite the potential limitations outlined above, we acknowledge the effectiveness of Circle Sentencing in reducing reoffending by Aboriginal and Torres Strait Islander people. We recommend that Circle Sentencing be made available in every Magistrates Court in NSW, and to every defendant who qualifies.

Diversionary programs

Diversionary programs offer an opportunity to break pathways into the criminal justice system. Legal Aid NSW has delivered advice clinics aimed at diverting individuals from the prison system – for example, at Balund-a and at Maayu Mali Rehabilitation Centre (**Maayu Mali**). Legal advice clinics at these locations offer an opportunity to tackle unaddressed legal needs to enable reintegration into the community. Unfortunately, the availability of such programs, particularly ones that are culturally appropriate and which enable Aboriginal and Torres Strait Islander women to remain on Country, is limited.

*Destiny's story*⁶⁵

Legal Aid NSW's Civil Law Service for Aboriginal Communities provides a civil law service at Maayu Mali in Moree. We saw a young Aboriginal woman in the program who was originally from Albury-Wodonga where she had lived for most of her life. Moree to Albury is 890 kilometres. Legal Aid NSW agreed to look into her housing and discovered that she had a negative housing classification arising from domestic violence. Destiny ultimately breached her bail conditions and was incarcerated at Silverwater Correctional Centre. If rehabilitation options were provided closer to her home town, Destiny may have had greater success due to the ability to access family and other social support.

Balund-a Program

Balund-a Program is a diversionary program run by Corrective Services NSW (CSNSW) in a rural area 23 kilometres from Tabulam NSW. It is only available for men who have pleaded or been found guilty of charges, who can apply to attend the Program prior to being sentenced.⁶⁶ If residents leave the Program, they must go back to Court where they may be sentenced immediately.

Balund-a was opened to support Aboriginal and Torres Strait Islander defendants,⁶⁷ however men from any cultural background can attend.

Culture is central to the Program. Run within the Bundjalung nation, local Elders are employed at Balund-a, and support residents to recognise, restore and value cultural links with their land and history. This happens through cultural programs, and through care and support in personal relationships built over the course of the Program. This cultural framework is core to the Program's life-changing success for so many men.

The Balund-a Program offers counselling and mental health support directly tailored to residents' individual needs. The counselling service works closely with Community Corrections Psychology, arranging referrals to a GP, Mental Health Nurse and psychiatric support. The service also supports residents after they complete the Program and return to community, with access to the National Disability Insurance Scheme (NDIS), ongoing counselling, GP support and access to Narcotics Anonymous and Alcoholics Anonymous programs. Residents also attend EQUIPS⁶⁸ groups on subjects such as addiction, aggression, domestic violence and parenting, and are supported to arrange appropriate housing for after Balund-a if necessary.

⁶⁵ All case studies marked with an asterisk in this submission have been de-identified.

⁶⁶ Under this program, participants will live and work at this program for six months and two weeks. Each day spent at Balund-a can be deducted as half a day already spent in custody from the final sentence.

⁶⁷ To implement recommendations of the RCADIC.

⁶⁸ The EQUIPS (Explore, Question, Understand, Investigate, Practice, Succeed) suite of programs address the criminogenic needs of offenders across NSW. There are four programs in the suite, addressing General Offending, Addictions, Aggression, and Domestic Abuse.

Legal Aid NSW supports the calls for programs such as Balund-a to be made available across the state. There is a particularly high need for programs for women, and programs that are family-based, where female residents can attend with their partners and children, and where programs are flexible for family needs within an Aboriginal or Torres Strait Islander cultural framework.

Warrant amnesty

Consideration should be given to developing a warrants amnesty or warrants hotline for people with less serious offences. In our experience, sometimes the reason a person fails to attend court is that they are not ready to face the inevitable consequences. Other times, it is a lack of knowledge that they could be released if they attended. This results in the person ceasing to access services or engage with work or education, which can lead to homelessness and further offending. The Maranguka Justice Reinvestment Project implemented a warrant clinic in Bourke to address the issue of people with outstanding warrants 'going underground'. The clinic brought participants together with a support team to develop a plan to submit to the court on sentence or in relation to bail, thereby assisting young people who had committed less serious offences to stay out of remand.⁶⁹ This and other warrants amnesty initiatives should be further explored in NSW.

Sentencing

Legal Aid NSW considers that the NSW Government should implement the recommendations of the ALRC and the NSW Law Reform Commission (**NSWLRC**) that sentencing legislation should be reformed to provide that, when sentencing Aboriginal and Torres Strait Islander offenders, courts should be expressly required to pay particular attention to the offender's circumstances, including the unique systemic and background factors affecting Aboriginal and Torres Strait Islander peoples.⁷⁰

For further information, see chapter 3 of our 2017 ALRC submission.⁷¹

Experiences of Legal Aid NSW staff from the Broken Hill office – sentencing

A lack of sentencing options available in regional, rural and remote areas creates a "postcode justice" approach to sentencing. For example, many people living in the Far West region are often precluded from participating in community service work as it is unavailable. For many smaller towns, participants would be required to travel for up to three hours each way, often without their own means of transport. Often home detention

⁶⁹ Just Reinvest NSW, Submission No 21 to the Legislative Assembly Committee on Law and Safety, *Inquiry into the Adequacy of Youth Diversionary Programs in NSW* (13 February 2018) 11-12.

⁷⁰ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) Recommendation 6-1.

⁷¹ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017)

<https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

is ruled out due to the lack of a 4G network and therefore the inability of CSNSW to provide monitoring. We submit that more regionally appropriate sentencing options should be available that consider the culture and heritage of the particular area, as well as logistical constraints. Considering and implementing local alternatives would help to alleviate and reduce the high level of incarceration of Aboriginal and Torres Strait Islander people.

Cross border communities and sentencing

Since June 2018, NSW courts have been prohibited from imposing an Intensive Correction Order (ICO) in respect of an offender who resides, or intends to reside, in another state or territory unless that jurisdiction has been declared by regulation to be an approved jurisdiction.⁷²

Section 69(3) of the *Crimes (Sentencing Procedure) Act 1999* (NSW) (CSPA) contemplates arrangements with interstate jurisdictions to support remote supervision of ICOs. To date, however, there has been no declaration of an interstate jurisdiction pursuant to section 69(3). As a result, a NSW sentencing court is currently prevented from making appropriately tailored ICOs for offenders who would, but for their residence close to the border, be suitable candidates for a community-based order. The sentencing court may consequently be limited to imposing a sentence of full-time custody.

These issues are particularly acute in cross-border Aboriginal communities in the Riverina/Murray and Far West areas, as illustrated in the case of Clinton below.

*Clinton's story**

Clinton is a young Aboriginal man living in a town close to the NSW/Victoria border. He has complex needs including severe mental health issues. He is at high risk of self-harm in jail. Clinton has offended and is facing sentence in NSW. He is assessed as suitable for an ICO with appropriate conditions to address the underlying causes of his offending, including treatment. Clinton would like to live with his mother on the Victorian side of the border. She has organised multiple appointments for him with local mental health and drug services. Living with her would also enable Clinton to get away from negative peer groups that have been associated with his offending. However, the NSW court is unable to impose an ICO because Clinton proposes to live in Victoria.

We consider that better coordination between NSW and other states and territories to address these issues is needed. A necessary first step in enabling ICOs to be made in respect of offenders such as Clinton would be prescribing Victoria, South Australia, Queensland and the ACT as approved jurisdictions under section 69(3) of the CSPA.

⁷² *Crimes (Sentencing Procedure) Act 1999* (NSW) s 69(3).

Prison programs, services and supports, including post-release supports, for Aboriginal and Torres Strait Islander people in custody

Legal Aid NSW has concerns about the services and supports available for Aboriginal and Torres Strait Islander people in custody. Around 54% of Aboriginal and Torres Strait Islander people released from custody in NSW reoffend within 12 months, compared with 35% for non-Indigenous offenders.⁷³ These reoffending rates indicate that more could be done to support Aboriginal and Torres Strait Islander people held in custody.

We recommend that the NSW Government increase services and supports for Aboriginal and Torres Strait Islander people in custody, particularly in relation to drug and alcohol-related issues, mental health care, throughcare and transitional support. We reiterate that significant reductions in reoffending and incarceration rates of Aboriginal and Torres Strait Islander prisoners in NSW could be achieved by establishing throughcare and transitional programs directed to both offending behaviour and underlying needs of offenders.

There should be a greater focus on reintegration planning for Aboriginal and Torres Strait Islander offenders and the establishment of partnerships with local Aboriginal and Torres Strait Islander communities, to ensure that Aboriginal and Torres Strait Islander people do not reoffend in the first 12 months of release. Furthermore, post-release housing needs should be prioritised.

Legal Aid NSW recommends that, consistent with the recommendation of the ALRC Inquiry,⁷⁴ the NSW Government develop prison programs with relevant Aboriginal and Torres Strait Islander organisations that address offending behaviours – particularly in relation to alcohol and other drugs, domestic and family violence and anger management – and prepare Aboriginal and Torres Strait Islander people for release. The availability of such prison programs should be expanded and made available to people held on remand, prisoners serving short sentences and Aboriginal and Torres Strait Islander women in custody.

Specifically, Legal Aid NSW considers that significant reductions in reoffending and incarceration rates of Aboriginal and Torres Strait Islander prisoners in NSW could be achieved by:

- additional resourcing of therapeutic programs throughout NSW prisons, including the expansion of EQUIPS to all prisons. Measures are urgently required to address the limited availability of specialised programs for Aboriginal and Torres Strait Islander prisoners, who suffer from significantly higher rates of mental and cognitive disability than non-Indigenous prisoners⁷⁵
- making evidence-based and culturally appropriate prison programs available to people

⁷³ NSW Bureau of Crime Statistics and Research, *NSW Reoffending Database January 2000 to March 2020: Table 2* (2020).

⁷⁴ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) Recommendation 9-1.

⁷⁵ Eileen Baldry et al, UNSW, *A Predictable and Preventable Path: Aboriginal People with Mental and*
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held on remand

- establishing targets for participation of Aboriginal and Torres Strait Islander offenders in both mainstream and specialist prison programs proportionate to Aboriginal and Torres Strait Islander imprisonment rates. More importantly, as Aboriginal and Torres Strait Islander people are overrepresented in the cohort who are at high risk of reoffending, such participation targets should reflect the percentage of Aboriginal and Torres Strait Islander people in this cohort and prioritise their participation, and
- expanding the Community Offender Support Program (**COSP**) to enable culturally suitable supported accommodation and programs to be established beyond the Sydney metropolitan area. In our experience, our clients from rural, regional and remote areas struggle when they are released from prison and forced to remain in the city, especially our Aboriginal and Torres Strait Islander clients. The noise, the social isolation and the difficulty in getting around makes reintegration particularly difficult for these clients.

For further information, see chapter 5 of our 2017 ALRC submission.⁷⁶

Services and programs for people held on remand

We remain concerned about the lack of access to services and programs for people held on remand. People held on remand do not have the ability to access many of the programs that would assist them to address underlying social and emotional problems before being released into the community. Programs that support wellbeing should be provided to people in custody regardless of sentencing status.

CSNSW has published policies for case management,⁷⁷ compendium program planning and scheduling,⁷⁸ however these documents outline the process once a prisoner has been sentenced.

There are some CSNSW programs for people held on remand. For example, CSNSW and Legal Aid NSW have developed the Remand Domestic Violence Intervention program, a voluntary intervention which focuses on assisting prisoners to understand their legal circumstances specific to domestic violence and to provide them with knowledge and skills for healthier relationships.⁷⁹ CSNSW has also developed the Remand Addiction Intervention, which is a modified version of the EQUIPS Addiction program,⁸⁰ and

Cognitive Disabilities in the Criminal Justice System (Report, October 2015).

⁷⁶ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

⁷⁷ Corrective Services NSW, *Policy for Case Management in Correctional Centres* (8 December 2017).

⁷⁸ Corrective Services NSW, *Policy for Compendium Program Planning and Scheduling* (28 July 2017).

⁷⁹ Corrective Services NSW, *Policy for Implementation and Recording Remand Interventions for State-wide Programs* (19 September 2018).

⁸⁰ *Ibid.*

available in a limited number of prisons. We submit that this program needs to be more widespread, and made available in all state and private prisons.

The lack of services and programs for people held on remand has unintended impacts. People on remand are unable to work off fines through a Work and Development Order (**WDO**) and are released with debt. They are unable to demonstrate that they have addressed offending behaviour for sentencing submissions or appeals to Department of Communities and Justice (**DCJ**) Housing. In our experience, early intervention programs, such as parenting from a distance or financial literacy, assist our clients upon release.

We are concerned by the high recidivism rate of people who receive short-term sentences.⁸¹ A 2018 report by the Audit Office of NSW found that in 2015–16, 75% of prisoners who needed a prison-based therapeutic program did not receive one before their earliest release date, resulting in prisoners being released without having access to programs which could have reduced the rate of recidivism.⁸² The report recommended that CSNSW ensure eligible prisoners receive timely programs to reduce the risk they will reoffend on release.⁸³

In our view, the provision of services and programs for people held on remand should be prioritised. Given the backlog of matters currently before the court due to COVID-19, it is anticipated that people will be on remand for longer periods of time if bail is refused. People in custody who have been refused Local Court and Supreme Court bail should be prioritised for case management and referral to appropriate programs.

Targeted programs and services for Aboriginal and Torres Strait Islander women in custody

Between 2011 and 2017, the number of Aboriginal and Torres Strait Islander women imprisoned in NSW rose by 74% (from 195 to 340), compared with a 40% growth in the number of non-Indigenous women in prison over the same time period.⁸⁴ Aboriginal and Torres Strait Islander women are vastly overrepresented in the remand population, often because of insecure housing or employment, or previous convictions (commonly for low-level offending behaviour).⁸⁵

Legal Aid NSW's Civil Law Service for Aboriginal Communities (**CLSAC**) provides holistic civil law services to Aboriginal women.⁸⁶ Legal Aid NSW assists Aboriginal and Torres Strait Islander women leaving custody through fortnightly advice clinics and monthly CLE sessions at Silverwater Women's Correctional Centre. Follow-up appointments are

⁸¹ See Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (Discussion Paper 84, 19 July 2017) Chapter 5.

⁸² Audit Office NSW, 'Therapeutic Programs in Prisons' (Media Release, 3 May 2017).

⁸³ *Ibid.*

⁸⁴ Evann J Ooi, NSW Bureau of Crime Statistics and Research, *Recent Trends in the NSW Female Prison Population* (Bureau Brief Issue Paper No 130, January 2018).

⁸⁵ Australia's National Research Organisation for Women's Safety, *Women's Imprisonment and Domestic, Family and Sexual Violence* (Report, 2020) 4.

⁸⁶ The service grew out of a 2013–14 project which identified a need for ongoing legal assistance and reform, as outlined in Legal Aid NSW's 2015 report entitled *Aboriginal Women Leaving Custody: Report into Barriers to Housing*.

arranged via AVL. We provide targeted legal assistance to address barriers to housing, as well as financial counselling support. In addition to advice, casework and representation services, CLSAC provides CLE to women in custody on issues such as housing, fines and social security law, in a manner that encourages interactive learning in a culturally safe way. We also work with community legal centres and community services to ensure that women in custody can access legal assistance outside of Legal Aid NSW's scope and pre- and post-release casework support.

Our solicitors frequently represent Aboriginal and Torres Strait Islander women who would benefit from diversionary options and support services, but for whom no services are provided or available. Women on remand are particularly disadvantaged by a service vacuum. SAPOs and welfare officers are focused on triage and do not have the capacity to prepare women on remand for release or address issues that impact on recidivism. This requires a reorientation for CSNSW towards rehabilitation objectives, as opposed to punishment.

A recent ANROWS Report found that the links between imprisonment and domestic and family violence and sexual violence are poorly understood, but are crucial in addressing cycles of violence/imprisonment, and providing support services to women who have experienced both violence and imprisonment. There is a high and growing proportion of Aboriginal and Torres Strait Islander women in prison who are on remand, including for breach of bail, and a large proportion of women on short sentences and incarcerated for parole violations. The research recognises the importance of continuity of services, case management, pre-release planning and throughcare for these women, and that it is particularly critical that these services are available to women on short sentences or on remand.⁸⁷

For women, increasing the availability of throughcare services focussing on their specific gender needs in custody and post-release is important, specifically in relation to housing and resumption of care or contact with their children. It is also crucial that women in custody have access to education, including literacy programs targeted towards women whose schooling has been disrupted, for example, children who have been in detention and/or care.

*Jane's story**

Jane is a young person who received legal assistance from the Legal Aid NSW Children's Civil Law Service (**CCLS**) for several years while she was in out-of-home care. She was also being supported by the CCLS social worker during this time.

At 18 years of age, Jane presented to the Legal Aid NSW Aboriginal Women Leaving Custody (**AWLC**) service at Dillwynia Correctional Centre, and again at a CLE session at Silverwater Women's Correctional Centre. Since then, the AWLC has been assisting

⁸⁷ Australia's National Research Organisation for Women's Safety, *Women's Imprisonment and Domestic, Family and Sexual Violence* (Report, 2020) 4.

Jane with housing, including to get her on the social housing waitlist. When not in custody, Jane often stays with extended family in overcrowded social housing. Jane's engagement with our service has been more complex as she struggles with reading and writing, which impacts on her comprehension of the legal issues she faces.

We recommend that the NSW Government develop trauma-informed, culturally appropriate programs and services for Aboriginal and Torres Strait Islander women that are available before, during and post incarceration. We support the recommendation of the ALRC inquiry that programs and services delivered to Aboriginal and Torres Strait Islander women in custody should be developed and delivered by Aboriginal and Torres Strait Islander women, and take into account their particular needs so as to improve their chances of rehabilitation, reduce their likelihood of reoffending and decrease their involvement with the criminal justice system.⁸⁸

Legal Aid NSW reiterates that further diversionary options are needed for Aboriginal and Torres Strait Islander women who are defendants and offenders, which take into account care giving responsibilities and incorporate assistance with civil law problems and living skills, such as dealing with Centrelink, banks, housing, managing fines and consumer issues (see chapter 9 of our 2017 ALRC submission).⁸⁹

High Intensity Program Units

The civil law needs of prisoners (much like in the community) are often unrecognised and therefore unmet. This is compounded for prisoners as they do not have access to the internet and limited access to resources or untimed telephone calls.

There are legal and non-legal factors that can increase the risk of a prisoner reoffending, usually within the first two years of release. It is not uncommon for a prisoner to be released into homelessness, without any form of identification, with large debts, insecure housing and disconnection from family. Without a permanent address, support services (such as Legal Aid NSW, Centrelink and the NDIS) will have difficulty following up with the individual to provide assistance or resolve their matters. All of these factors can greatly impede their ability to lead crime-free lives after imprisonment.⁹⁰

Many of these barriers could be addressed in custody with the right programs and supports. However, the shortage of services for prisoners and throughcare programs

⁸⁸ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) Recommendation 11-1.

⁸⁹ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/_data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

⁹⁰ Dr Garner Clancey, Brenda Lin and Cindy Wang, *Responding to Civil Legal Needs of Prisoners in High Intensity Program Units: A Preliminary Analysis* (Unpublished Report, 27 September 2019) 88.

means that our civil law solicitors are often required to do non-legal work to assist clients simply because there are no other suitable services available.

High Intensity Program Units (**HIPUs**) are for prisoners serving short sentences who are identified at high risk of reoffending. They address the vulnerability and complexity of prisoners and aim to assist with reintegration back into the community at the completion of the custodial sentence. HIPU participants have an individualised plan to address factors such as unemployment and homelessness, and participate in an intensive suite of programs over a four-month period. Each HIPU delivers rehabilitation services, programs, release planning, financial counselling services as well as civil law clinics provided by Legal Aid NSW.

Legal Aid NSW has committed to providing a civil law service at all 10 HIPUs.⁹¹ Service delivery models include group CLE followed by individual advice, and individual advice sessions only. A Prisoner Law Check-Up tool enables referrals from the Services and Programs Officers as early identification of legal problems can assist with early resolution.

The following case studies demonstrate the critical role of Legal Aid NSW's civil law service at HIPUs in helping Aboriginal clients to address their immediate civil law needs when leaving custody.

*Molly's story**

Molly was referred to Legal Aid NSW through our outreach advice clinic for HIPU inmates.

We first spoke to Molly about three months before she was due to be released from custody. At that time, she had a negative former tenant classification from DCJ Housing. This would have seen Molly barred from applying for, or receiving, social housing upon her release.

Legal Aid NSW lodged a first tier (internal) appeal with DCJ Housing against Molly's negative classification. The appeal was successful. Molly was able to apply for social housing and for High Priority Tenancy Reinstatement before her release from custody.

*Kathleen's story**

Kathleen was referred to Legal Aid NSW through our outreach service to one of the HIPUs. She presented with multiple legal problems.

⁹¹ HIPUs have been established across seven correctional centres in NSW – namely, in Bathurst, Cooma, Cessnock, Dillwynia (Windsor), Mid North Coast (Kempsey), South Coast (Nowra) and Wellington. The Wellington and Mid North Coast Correctional Centres have Aboriginal-specific HIPUs. The Legal Aid NSW Prisoners Legal Service provides assistance to Cooma; all other locations are serviced by their Legal Aid NSW office.

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- Kathleen wanted to bring a claim against a neighbour who she said had entered her home after she went into custody and stolen all her possessions. We drafted a letter of demand for her to send to the neighbour.
 - Kathleen disclosed that she had suffered sexual abuse as a child. We prepared and submitted a claim on her behalf to Victims Services for financial and other assistance.
 - Kathleen was concerned that her car had been used by somebody else while she was in custody, and that tolls or fines might have been incurred in her name. We were able to make inquiries for her with Revenue NSW and the various tollways operators about this.
 - Kathleen was a current social housing tenant. Because she had been sentenced to just under three years in custody, we helped her to relinquish her tenancy. We lodged a first tier internal appeal to DCJ Housing on her behalf against a 'less than satisfactory' former tenancy classification. The appeal was successful. Legal Aid NSW is currently advocating for Kathleen to be assessed for High Priority Tenancy Reinstatement prior to her release.

Findings from a preliminary analysis of HIPUs demonstrate the value of ensuring prisoners have their practical problems (many of which are civil legal needs) addressed and resolved, in order to give them the best possible chance of succeeding upon release from prison.⁹² Addressing prisoners' civil law problems can also assist to meet the objectives of the NSW Premier's Priorities of reducing reoffending and reducing homelessness.

Legal Aid NSW is in a strong position to provide these services as we have a presence across the state through the Prisoners Legal Service and through regional Legal Aid NSW offices.

To date, Legal Aid NSW has absorbed civil law outreach to HIPUs and continues to advocate for dedicated funding to ensure sustainability of the program. We also support greater funding to expand the HIPUs to additional locations, and to ensure that Legal Aid NSW can continue to have a presence in all of these locations. Consideration should be given to alternative forms of service delivery, as well as expanding eligibility, to enable a greater proportion of prisoners to be assisted.

Programs for sexual offenders and persons convicted of serious violence offences

We consider that programs for sexual offenders and persons convicted of serious violence offences need to be made available earlier in the sentence. These prisoners are often not able to access these programs until well into their parole periods, which means that any benefit or considerations at sentencing relating to their Aboriginality are lost. It also means

⁹² Dr Garner Clancey, Brenda Lin and Cindy Wang, *Responding to Civil Legal Needs of Prisoners in High Intensity Program Units: A Preliminary Analysis* (Unpublished Report, 27 September 2019) 88.

that, despite motivation to undertake programs, such offenders will be at increased risk of continued detention or supervision at the end of their sentence under the NSW high risk offender scheme. Those who deny their offending are at a particular disadvantage as the program for deniers of sexual offending is only delivered when there is a cohort ready to participate. In our experience, it can be years between this program being offered if there are not enough people ready to participate.

Welfare Officers in prisons

We consider that the previous Welfare Officer roles should be restored and made available at all prisons. In our experience, Welfare Officers provided a vital service to our clients in custody in relation to contact with family in emergencies, assistance with rehabilitation applications, contact with lawyers when the prisoner was unable to reach them on the prison phone or when the lawyer needed to get in contact with them urgently.

There are some Welfare Officer roles at certain prisons (e.g. Emu Plains Correctional Centre), but these roles have largely been replaced by Services and Programs Officers (**SAPOs**) and case managers. We are concerned that the welfare aspect has all but disappeared, as SAPOs may not have capacity to provide welfare support as well as case management. Having someone to help with rehabilitation applications within prison would also assist Aboriginal and Torres Strait Islander prisoners with lower levels of literacy and/or issues with access to information.

*Graeme's story**

Legal Aid NSW acted for Graeme, an Aboriginal man with long-term drug and alcohol dependence. He was charged with offences related to domestic violence in August 2016. He was bail refused and pleaded guilty to the charges at his first appearance in the Local Court. A court-ordered drug and alcohol assessment identified Graeme as suitable for a long-term residential rehabilitation program. He was accepted into a facility, but with an expected wait time of approximately six weeks. Graeme was told he must call the facility three times a week between 10am and 4pm to maintain his position on the waiting list.

By November 2016, Graeme had run out of jail money and was unable to keep calling the facility three times a week. During that time, his brother committed suicide, and Graeme was refused leave by CSNSW to go to the funeral. He only called the facility once a week, and so lost his place on the program. At his solicitor's request he was placed back on the waiting list, but at the bottom of the list and with an expected wait time of more than three months. A further bail application was refused. By December 2016, Graeme had progressed to the top half of the list. By the end of January 2017, however, he gave up trying to get into the program and proceeded to be sentenced. While the sentence he received was backdated, he had spent five months on remand with no access to a rehabilitation program.

Support to maintain family and community ties

It has long been recognised that connection to land plays a central role in Aboriginal cultures and communities. However, despite the recommendation from the RCADIC that, where possible, an Aboriginal prisoner should be placed in an institution as close as possible to the place of residence of their family,⁹³ Aboriginal and Torres Strait Islander people are still detained sometimes hundreds of kilometres from home. We consider that holding them closer to home would enable them to more easily maintain ties with family, community and Country, and assist with their reintegration on release.

During the current COVID-19 pandemic, CSNSW are using AVL/tablets on weekends for family visits. We would encourage the continued use of AVL/tablets post-COVID, particularly for Aboriginal and Torres Strait Islander prisoners who are not able to receive family visits due to distance or ill health of family members.

Support for Aboriginal and Torres Strait Islander people with disability

While there is no single population-based survey that authoritatively captures the prevalence and profile of Aboriginal and Torres Strait Islander people with disability, the Australian Bureau of Statistics (ABS) 2015 Survey of Disability, Ageing and Carers stated that 23% of Aboriginal and Torres Strait Islander people reported disability, while the ABS' National Aboriginal and Torres Strait Islander Social Survey estimated that 45% of Aboriginal and Torres Strait Islander people report a long term health condition of disability.⁹⁴

Coupled with the overrepresentation of Aboriginal and Torres Strait Islander people in the prison population, the elevated prevalence of disability among the Aboriginal and Torres Strait Islander population means that there is a high proportion of Aboriginal and Torres Strait Islander people with disability in custody. According to a 2015 report by the Australian Institute of Health and Welfare, 29% of Aboriginal and Torres Strait Islander prison entrants aged 35–54 years identified having an activity limitation or restriction in employment and education due to their disability.⁹⁵

Aboriginal and Torres Strait Islander people are significantly overrepresented amongst those in prison with complex disability support needs. Cognitive impairment has been identified as a factor contributing to the disproportionately high rate of imprisonment of

⁹³ *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 168.

⁹⁴ Scott Avery, First People's Disability Network, *Culture Is Inclusion: A Narrative of Aboriginal and Torres Strait Islander People with Disability* (Report, 2018).

⁹⁵ Australian Institute of Health and Welfare, *The Health of Australia's Prisoners 2015* (Report, 27 November 2015).

Aboriginal and Torres Strait Islander people, along with other forms of disability.⁹⁶

Implications for prisoners with disability can be varied and complicated. In our experience, the physical infrastructure of prisons can create restrictions, some of which impact access to justice. We have experienced clients in one NSW Correctional Centre who are unable to access AVL suites, and therefore legal advice, due to inadequate wheelchair access.

Similarly, access to health and disability services can create complications. In our experience, we have witnessed the acute harm arising from failures of the NDIS for our clients in detention. In the absence of proactive discharge and pre-release planning, discharge or release can be delayed. This means that people with disabilities are left in prisons and mental health facilities as a direct result of delays in accessing their NDIS plans.

Poor planning or subsequent market failure can mean that a person exits with inadequate supports and is more vulnerable to re-offending or readmission. People who remain in custody or mental health units because of a failure to secure disability services should be identified and prioritised by the National Disability Insurance Agency (**NDIA**) and the NSW Government as a matter of urgency. Clear processes for planning for a person's release before their sentence is complete or discharge is imminent should be systematically introduced so that supports are in place to facilitate successful discharge or release and reduce the risk of reoffending or readmission. This may also require the funding of supports for transition prior to release.

Access to housing and preventing exit from custody into homelessness

Access to housing is one of the biggest challenges for services providing support to people leaving prison in NSW.⁹⁷ Currently, the process for acquiring temporary accommodation in NSW is complex and lengthy, and people are allocated only 28 days per year (temporarily increased to 40 days during COVID-19), which is insufficient to enable someone to transition effectively into the community. Part of this allocation may have been used before incarceration, leaving less than 28 days upon release. Temporary accommodation is usually provided for short blocks of one or two days at a time, rather than as a consecutive block. This undermines the ability of clients to gain the stability needed to engage with other support services and DCJ Housing about their longer-term needs.

These difficulties contribute to the large number of people released into homelessness each year. Improving access to stable housing is critical, given that the lack of stable accommodation is a key contributor to reoffending.

Access to housing is a particularly critical issue for our Aboriginal and Torres Strait Islander female clients in custody, who frequently report being homeless or at risk of

⁹⁶ Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (Discussion Paper 84, 19 July 2017) [1.12].

⁹⁷ Melanie Schwartz et al, UNSW, *Obstacles to Effective Support of People Released from Prison: Wisdom from the Field* (Report, 2020).

homelessness before coming into, and on release from, custody. Legal Aid NSW's experience in delivering legal services to Aboriginal and Torres Strait Islander women in custody has shown the link between homelessness, an absence of support services and recidivism, which is reflected in the data on women released from custody in NSW.⁹⁸ The lack of affordable housing, declining public housing stock, long waitlists for social and community housing, social and community housing provider policies, and other barriers to housing undermine women's ability to achieve stability and independence once they leave custody.

*Ashley's story**

Ashley is a 28-year-old Aboriginal woman, who has been a continuous social housing tenant from 2012 until she was remanded in custody in December 2019. Ashley is a model tenant, never having owed money for rent or utilities or had a negative classification. Ashley never committed any prior serious offence, has held permanent employment, and this was her first time in custody. Ashley has bipolar disorder, and Family and Community Services placed her daughter in the maternal grandmother's care.

Ashley was granted an approved absence and rental abatement for six months (the maximum allowed under DCJ Housing policy) until July 2020. Although Ashley is scheduled to be released from custody in September 2020, DCJ Housing has asked Ashley to immediately relinquish the tenancy, and refused to extend the absence and abatement for a further three months. This will result in Ashley being released into homelessness.

Without stable long-term housing, Ashley will be unable to progress reunification with her daughter. She will be required to reapply for housing and await an allocation, with impacts on her wellbeing, stability and heightened risk of return to custody.

Following a recommendation made in the *Aboriginal Women Leaving Custody Report*,⁹⁹ DCJ Housing implemented a priority housing pilot. The aim of the pilot was to trial whether women in custody could be assessed for priority housing before being released, as current policy requires a person to be out of custody to be eligible to apply and be assessed for priority housing. The following two case studies demonstrate the differences in outcomes for those who had access to the pilot, and those who did not. The current status of the

⁹⁸ During 2019, of the 2760 women released from NSW prison, at least 900 were released into homelessness or unstable accommodation. There are, at most, only 9 dedicated beds available in NSW for women immediately after leaving prison. Five of these are short-term beds and 4 are negotiated transitional placements (beds in transitional community housing properties that providers agree to use for women leaving custody if they also have community support). At best, only 22% of women (615 individuals) receive any kind of service on release from prison: Keeping Women Out of Prison Coalition, *Profile of Women in Prison in NSW* (Report, December 2019).

⁹⁹ Legal Aid NSW, *Aboriginal Women Leaving Custody: Report into Barriers to Housing* (Report, 2015).

pilot is unclear. Legal Aid NSW strongly supports DCJ Housing being able to assess the housing needs of people in custody, in partnership with CSNSW, before their release.

*Anne's story**

Legal Aid NSW's CLSAC first saw Anne, an Aboriginal woman, at Silverwater Women's Correctional Centre in July 2014. She was then 29 and living on the streets of Redfern and Woolloomooloo. She talked about the connection between being in and out of custody over many years and her homelessness.

CLSAC helped Anne to apply for social housing. Housing NSW (as it was known then) accepted her application to the general waitlist, and suspended it for the remainder of her time in custody. At that time, Housing NSW was not making assessments for priority housing while people were in custody, and so our advice was that she needed to wait to be released before being able to apply for priority housing.

Anne was released in 2015 with no supports and no housing. She struggled to engage with Housing NSW and her application was eventually closed. Anne continues to experience drug dependency issues and has been a victim of serious domestic and personal violence while homeless.

In April 2020, CLSAC saw Anne at Silverwater Women's Correctional Centre again. They assisted her to re-apply for housing and reiterated advice that she cannot get her need for priority housing assessed while in custody, as the pilot project is not currently operating. Anne is likely to be released into homelessness in late 2020.

*Paula's story**

Paula is a 47-year-old Aboriginal woman who has been homeless for most of her adult life. She had gone through cervical cancer, was involved in a serious car accident that led to a brain injury and significant memory loss, and drug dependency.

CLSAC saw Paula in at the Dillwynia Correctional Centre in September 2018. At that time, Housing NSW was conducting its pilot priority housing project for women in custody. CLSAC referred Paula to the pilot. She was assessed for priority housing while in custody and her application for social housing was accepted in November 2018. Paula was released from custody at the end of 2018 and she was offered a priority property in Newcastle within several months. Paula moved in and was elated at renting her own home for the first time in her life.

CLSAC understands that Paula has not returned to custody since securing housing, which has also allowed her the stability to access medical and other support services.

There is a clear need to increase the availability and duration of transitional

accommodation and resources to enable support services to meet demand. Specifically, we recommend that transitional housing should be provided for a consecutive period of three to six months upon release, in order to increase the likelihood of successful transition to the community. This quota should be in addition to the ordinary 28-day allocation of temporary accommodation. There is also the need for greater coordination across agencies such as NSW Health, CSNSW and DCJ Housing to prioritise access to adequate housing to people in custody, prior to release.

For further information, see ‘Specific issues for Aboriginal and Torres Strait Islander women in custody’ in Legal Aid NSW’s 2020 submission to the inquiry into family, domestic and sexual violence,¹⁰⁰ and ‘Housing post release’ in chapter 9 of our 2017 ALRC submission.¹⁰¹

Drugs and alcohol

Legal Aid NSW notes that the Ice Inquiry found that the criminalisation of drug possession disproportionately affects Aboriginal and Torres Strait Islander people because of unequal access to diversionary schemes in NSW.¹⁰² We support the recommendation of the Ice Inquiry that, in conjunction with increased resourcing for specialist drug assessment and treatment services, the NSW Government implement a model for the decriminalisation of the use and possession for personal use of prohibited drugs.¹⁰³

Legal Aid NSW strongly supports harm reduction strategies, and supports substance testing as a powerful harm prevention strategy. We also support the expansion of Medically Supervised Injecting Centres. Such initiatives reduce public risk. The criminal prosecution of users of amphetamine-type stimulants for behaviour which does not put the public at risk (i.e. drug possession and drive with the presence of drug in system), does little to deter use or reduce demand. We reiterate our recommendation that drug law enforcement strategies be reviewed.

Work and Development Orders, which allow people experiencing disadvantage to clear fines through participation in unpaid work, courses, treatment programs and other approved activities, have therapeutic and harm reduction benefits for people with addiction to drugs or alcohol.

We are concerned about the lack of community-based support services for rehabilitation. An improvement in the availability of drug rehabilitation services in rural, regional and

¹⁰⁰ Legal Aid NSW, Submission to the Standing Committee on Social Policy and Legal Affairs, *Inquiry into Family, Domestic and Sexual Violence* (July 2020) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0020/41177/200622-Legal-Aid-NSW-submission-to-Inquiry-into-family,-domestic-and-sexual-violence.pdf>.

¹⁰¹ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

¹⁰² Department of Premier and Cabinet, *The Special Commission of Inquiry into the Drug ‘Ice’* (Report, January 2020) Vol 2, 298-300, [11.83], [11.91]-[11.92].

¹⁰³ Ibid Recommendation 11.

remote areas would be of significant benefit to vulnerable people with both unpaid fines and drug and alcohol addiction.

The following case study illustrates the harmful impact of Ice on Aboriginal communities on the north coast of NSW.

*Damian's story**

Damian's case is typical for many young Aboriginal men on the NSW north coast who end up at court and in prison. Damian has a mild intellectual disability and hearing issues, resulting in him leaving school at an early age. Damian's employment opportunities are limited.

Damian had a number of court appearances as a child and has been unable to engage with the services that he needs, in particular, vocation/education and drug and alcohol services – the type of support he would get from a program such as 'Rekindling the Spirit'¹⁰⁴ in Lismore. Rekindling the Spirit is an Aboriginal-owned and run program that provides a holistic healing service to Aboriginal families and individuals who have family violence and substance abuse issues, with an emphasis on behavioural change.¹⁰⁵ However, the program is more difficult to access from other areas due to transport issues.

Like many young Aboriginal people in Damian's area, Damian has had regular interaction with police. In the local government area where Damian resides, Aboriginal and Torres Strait Islander people make up only 7% of the population but represent 43% of alleged offenders proceeded against by NSW Police.¹⁰⁶

Legal Aid NSW acted for Damian in relation to an assault when he was on bail for a robbery. The robbery was dealt with initially in the District Court. After completing his six-month non-parole period, Damian went to Maayu Mali as a condition of his bail. He completed the three-month program and was released on bail to live with his parents. His parents are supportive and provide a safe environment. A condition of bail was that he does not leave the house unless in the company of his parents between 7pm and 7am. This is a typical bail condition imposed on many young Aboriginal people and, due to many factors, a condition that is rarely complied with.

The assault charge was to be dealt with in the District Court three months later, but Damian breached his bail curfew by being out at night. There were regular bail checks by the police (including when he was in custody), and after a warning from the court, he was bail refused for a second breach and in custody at sentence. His mother told Legal Aid NSW that she believed he was using Ice again. For a variety of reasons, after

¹⁰⁴ *Rekindling the Spirit* (2020) <<https://www.rekindlingthespirit.org.au/>>.

¹⁰⁵ 'Rekindling the Spirit', *Australian Indigenous Health InfoNet: Alcohol and Other Drugs Knowledge Centre* (27 May 2020) <<https://aodknowledgecentre.ecu.edu.au/key-resources/programs-and-projects/438/?title=Rekindling%20the%20Spirit>>.

¹⁰⁶ NSW Bureau of Crime Statistics and Research, *NSW Recorded Crime Statistics 2019* (2019). Note that these statistics are for incidents of selected offences only.

spending a week in custody with bail refused, he was placed on a 16-month ICO, with a condition that he return to Maayu Mali when a bed became available.

Despite a variety of conditions, he was out in the community for a very short time and is now back in custody on another charge.

In our experience, the rehabilitation program at Maayu Mali is excellent, and is one of very few programs available to people addicted to Ice. However, three months is insufficient time on a rehabilitation program for a young person with an Ice addiction, and, in our view, it should be up to 12 months.

There is a lack of available beds in residential rehabilitation facilities for women with drug and alcohol dependences, particularly when exiting custody. Clients of the AWLC service often seek referral to such facilities, however the options are very limited and few referrals are successful. We often see these clients return to custody within a very short time.

Legal Aid NSW reiterates that all rehabilitation services should undertake localised Aboriginal and Torres Strait Islander cultural awareness training to build their capacity to deliver services to Aboriginal and Torres Strait Islander people. There should also be more Aboriginal community controlled and culturally appropriate rehabilitation centres, particularly in regional, rural and remote communities. We support the recommendation by the Ice Inquiry that the NSW Government partner with Aboriginal communities and Aboriginal community-controlled health services to develop and increase the availability of local, specialist, culturally safe drug treatment services.¹⁰⁷

We reiterate our support for the provision of alcohol addiction treatment services at all stages of the criminal justice system, and demand and supply reduction measures where they are evidence-based and supported by communities. We support recommendations by the ALRC Inquiry that all initiatives to reduce the harmful effects of alcohol in Aboriginal and Torres Strait Islander communities should be developed with, and led by, these communities to meet their particular needs.¹⁰⁸

For further information, see Legal Aid NSW's 2019 submission to the Ice Inquiry¹⁰⁹ and

¹⁰⁷ Department of Premier and Cabinet, *The Special Commission of Inquiry into the Drug 'Ice'* (Report, January 2020) Recommendation 58.

¹⁰⁸ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) Recommendation 13-1.

¹⁰⁹ Legal Aid NSW, Submission to the Special Commission of Inquiry into the Drug 'Ice', *Special Commission of Inquiry into Crystal Methamphetamine and Other Amphetamine-type Stimulants* (May 2019) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0003/31476/Legal-Aid-NSW-submission-to-Special-Commission-of-Inquiry-into-Ice-Issues-Paper-2.pdf>.

chapter 8 of our 2017 ALRC submission.¹¹⁰

Forensic patients

Under the *Mental Health (Forensic Provisions) Act 1990* (NSW), a forensic patient is a person who has been found not guilty by reason of mental illness (**NGMI**) or a person who has been found unfit to be tried for an offence and subject to a limiting term. Legal Aid NSW's Mental Health Advocacy Service provides advice and representation to all forensic patients in NSW.¹¹¹

As at 30 June 2019, there were 477 forensic patients in NSW. Of these, approximately 17% were detained in a correctional centre.¹¹² Currently, approximately 7% of forensic patients identify as being Aboriginal or Torres Strait Islander.¹¹³ However, as at 1 October 2018, 17% of forensic patients *in the custody setting* identified as Aboriginal or Torres Strait Islander.¹¹⁴

Analysis from the NSW-based Forensic Patient Database project has found that NGMI patients have typically experienced trauma earlier in life and come from disadvantaged backgrounds.¹¹⁵ The rates of reoffending for forensic patients are notably lower compared to the rates for those released from prison in NSW.¹¹⁶

By definition, forensic patients found NGMI are not criminally responsible and, as such, punishment is not a relevant consideration when they are detained. Where detention is required for community safety, security requirements should be met through detention in a secure mental health facility, which will also address the health needs of the patient.

In our casework experience, forensic patients are typically detained in a correctional centre on remand for around two years while waiting for their court proceedings to be finalised. Even after a finding of NGMI or the imposition of a limiting term, many forensic patients continue to be detained in a correctional facility for approximately 18 months to two years while awaiting transfer to a hospital setting. During this time, they do not have

¹¹⁰ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

¹¹¹ Section 152 of the *Mental Health Act 2007* (NSW) requires all forensic patients having any matter before the Mental Health Review Tribunal to be represented by a legal practitioner unless the forensic patient refuses representation.

¹¹² Mental Health Review Tribunal, *2018/19 Annual Report* (Report, 2019). Approximately 39% of forensic patients were living in the community under a conditional release order from the Tribunal, while approximately 44% were detained in a mental health facility.

¹¹³ According to data provided to Legal Aid NSW by the Mental Health Review Tribunal.

¹¹⁴ Legislative Council Portfolio Committee No 4 – Legal Affairs, Parliament of NSW, *Parklea Correctional Centre and Other Operational Issues* (Report 38, December 2018).

¹¹⁵ NSW Health, *Mental Health Review Tribunal: A Review in Respect of Forensic Patients* (Report, December 2017).

¹¹⁶ Heather Hayes, Richard I Kemp, Matthew M Large and Olav B Nielssen, 'A 21-year Retrospective Outcome Study of NSW Forensic Patients Granted Conditional and Unconditional Release (2014) 48(3) *Australian & New Zealand Journal of Psychiatry* 259–282.

access to the appropriate care, treatment and rehabilitation programs they require. For example, inmates are regularly in their cells for more than 18 hours per day.

The Productivity Commission's draft Mental Health report, published in October 2019, has observed that there are serious shortages of inpatient forensic mental health facilities in all States and Territories, in particular for young people.¹¹⁷

At any one time there are approximately 30 forensic patients in NSW correctional centres who are waiting for a bed to become available at the Forensic Hospital, or some other mental health facility, following an order being made for their transfer by the Mental Health Review Tribunal. Unfortunately, the Forensic Hospital does not have sufficient beds to allow for timely admission of new patients. This is compounded by the lack of beds in medium-secure facilities, which prevents patients being transferred out of the Forensic Hospital at the earliest opportunity. The President of the Mental Health Review Tribunal has recently noted that "often, there are no or limited beds in a less secure mental health facility at the time the review is undertaken" even where such a placement is appropriate from a clinical and legal perspective.¹¹⁸

The inability to move patients from the correctional environment to a health care facility is also often the flow on effect of a lack of community-based accommodation and support for people. The release of a forensic patient is dependent on the availability of these types of supports. People often remain in detention until such supports can be secured.

Forensic patients serving limiting terms

In contrast, those who are found unfit to be tried and receive a limiting term are most often detained in a prison for the entirety of their limiting term. This is because this cohort of forensic patients most commonly have an intellectual disability or cognitive impairment for which there is not treatment available in a mental health facility.¹¹⁹ A limiting term is designed to reflect the sentence the person would have received in the event they were convicted of the offending.¹²⁰ However, unlike persons who receive a sentence, forensic patients who receive a limiting term do not receive a non-parole period. Instead, they can only be released to the community prior to the expiration of their limiting term by satisfying the Mental Health Review Tribunal that they have spent 'sufficient time in custody' and that their conditional release into the community will not seriously endanger the forensic patient or other members of the community.¹²¹ The difficulty with satisfying the Tribunal of the risk component of the test is that it is contingent on the person having adequate supports in the community, such as appropriate supported accommodation. It can be very difficult to find service providers with the required expertise, and willingness, to provide support to forensic patients due to the stigma that is attached to the label. There is also a

¹¹⁷ Productivity Commission, *Mental Health Draft Report: Volume 1* (Draft Report, 31 October 2019) 627.

¹¹⁸ Mental Health Review Tribunal, *2018/19 Annual Report* (Report, 2019) 2.

¹¹⁹ *Mental Health (Forensic Provisions) Act 1990* (NSW) s 24(2)(b).

¹²⁰ *Ibid* s 23(1).

¹²¹ *Ibid* ss 43 and 74(e).

lack of suitable accommodation in NSW, most of whom require supported accommodation.

Approximately 27% of forensic clients have an intellectual disability,¹²² but there is a noticeable lack of appropriate detention facilities and step down accommodation, which results in people spending their limiting terms in custody.

Furthermore, forensic patients on conditional release continue to be the subject of the jurisdiction of the Mental Health Review Tribunal. The implementation of the NDIS has created barriers for some forensic patients, as requirements imposed by the Mental Health Review Tribunal, such as supervision in the community are often deemed by the NDIA as being a justice rather than health/disability issue. However, forensic patients are also unable to obtain these supports through the justice system, as they are not justice clients. For example, they are not eligible for the supports and accommodation provided by CSNSW to those subject to parole. These supports include community-based supervision, and community-based rehabilitation and education programs. The outcome is that persons who are the subject of a limiting term are more likely to serve their entire limiting term in prison, compared to those who are convicted and receive a sentence with the availability of parole. These service gaps result in slower progression through the system, less community contact and delayed recovery.

Mental Health Review Tribunal data shows an increase in the number of forensic patients in NSW every year with no corresponding increase in funding to services or facilities within the forensic mental health system, or to the Legal Aid NSW Mental Health Advocacy Service. We suggest increased funding for more beds in specialist medium and low secure forensic mental health units as a matter of urgency.

We note that, in 2019, the NSW Government endorsed the National Statement of Principles Relating to Persons found Unfit to Plead or Found Not Guilty by Reasons of Cognitive or Mental Health Impairment.¹²³ To ensure that forensic patients are given best-practice supports in their rehabilitation and transition back to the community, we suggest urgent implementation of its principles including, but not limited to:

- forensic patients should have a personalised, recovery-oriented care plan which focuses on the least restrictive options
- detention should occur in facilities appropriate to the person's needs and in the least restrictive environment that is possible to protect against serious risk of significant harm, and
- step-down accommodation should be available to ensure that people can recover and transition to life in the community.

¹²² The 2016 Forensic Mental Health Patient Survey Report provides a comprehensive snapshot of the characteristics, health and wellbeing of forensic patients and others with similar secure mental health needs in NSW. It was conducted by the Justice Health and Forensic Mental Health Network.

¹²³ *National Statement of Principles Relating to Persons Unfit to Plead or Found Not Guilty by Reason of Cognitive or Mental Health Impairment* (9 August 2019).

Post sentence detention and supervision

Aboriginal and Torres Strait Islander offenders experience particularly negative outcomes under the NSW high risk offender (**HRO**) scheme. Its application may indeed conflict with recommendations of the RCADIC.¹²⁴

Legal Aid NSW solicitors in the High Risk Offender Unit appear in applications made by the State of NSW for post-sentence extended supervision or continuing detention under the *Crimes (High Risk Offenders) Act 2006* (NSW) and *Terrorism (High Risk Offenders) Act 2017* (NSW). Orders are very strict and usually include electronic monitoring, scheduling and restrictions on behaviour including where a person lives; place and contact restrictions, restrictions on specific behaviour such as consumption of drugs or alcohol, and access to the internet, and personal and property searches. Orders prohibit otherwise lawful activities, such as getting a job, choosing where to live, and freedom of movement. Breach of these orders, even for otherwise non-criminal conduct (like being home later than scheduled) carry criminal penalties of up to five years' imprisonment.

The legislation was introduced with the intention of supervising “the worst of the worst” and targeting offenders who were resistant to change. However, over time, the ambit of the legislation has been broadened to capture less serious offences.

There are approximately 120 people on one of these orders at any given time, with about 10 of those on detention orders. Approximately 50 (representing close to half of all people on a supervision order) are in custody for a breach of their order at any given time. A disproportionate number of people subject to the HRO scheme are Aboriginal and Torres Strait Islander people. Currently, 31% of all matters under the *Terrorism (High Risk Offenders) Act 2017* (NSW) involve Aboriginal or Torres Strait Islander persons.¹²⁵ We are concerned about the lack of data collection in relation to the *Crimes (High Risk Offenders) Act 2006* (NSW).¹²⁶ A high number of HROs were involved in the criminal justice system as children. Their time spent in custody did not help to rehabilitate them—rather, it institutionalised them and they are now being targeted by the HRO scheme. This also indicates the failures of the criminal justice system to deal with children and young people in custody.

Most of our HRO clients have complex needs, including psychosocial disability, intellectual disability, cognitive impairment, and/or mental health issues, which may be closely related to their risk of offending. Because of the nature of their disability, they are not amenable to normal rehabilitation and treatment. Some are likely to be regarded as “high risk” all of

¹²⁴ See *State of New South Wales v Bugmy* [2016] NSWSC 1128, [48]-[51].

¹²⁵ Five out of 16 matters.

¹²⁶ We note that the NSW Bureau of Crime Statistics and Research, Court Services and the NSW Civil and Administrative Tribunal have advised that they do not capture data on the number and percentage of people in the high risk offender scheme (i.e. people under an extended supervision order or continuing detention order under the *Crimes (High Risk Offenders) Act 2006* (NSW) or *Terrorism (High Risk Offenders) Act 2017* (NSW)) who identify as an Aboriginal or Torres Strait Islander person.

their lives. Many of our clients are themselves the victims of violence, abuse and neglect, which has contributed to or exacerbated their disabilities.

The law allows for continuing detention or extended supervision of up to five years at a time, but there is no limit on the number of consecutive applications that can be made. In some cases, the person has not committed a serious offence for 10 to 20 years. However, given their ongoing risk profile, the HRO jurisdiction has been employed as a means of maintaining high level supervision. In a number of cases, where there has been a pattern of repeat offending and detention over many years, there has been insufficient attention paid to whether the behaviour leading to this pattern is linked to underlying mental health issues or cognitive or other disabilities. These proceedings themselves may prompt such diagnostic testing or it may occur when court experts are appointed.

Often, despite years of notice about impending release, clients are released to supervision orders with no effort to secure appropriate accommodation, resulting in extended time in CSNSW transitional centres and a lack of opportunities for education and support services. The restrictiveness of orders may prevent clients from accessing family and supports (for example, for clients who are required to live in Sydney but who are not originally from Sydney). This is particularly harsh for Aboriginal and Torres Strait Islander clients wanting to return to family and Country.

Unlike examples in the criminal jurisdiction where clients may be charged with substantive offences like 'Damage property' or 'Assault', HROs can be prosecuted and imprisoned for what is otherwise non-criminal conduct. Conditions are applied for by the State in a largely standard way, with limited adaptation to individual circumstances. In our experience, conditions are administered by CSNSW by reference to standardised policies and procedures, with little emphasis on truly individualised or culturally sensitive case planning – including, for example, around the crucial importance of kinship contact and connection to Country. It is our experience, highlighted in the case of *Carr* below, that despite conditions vesting discretion for decision-making with CSNSW through a Departmental Supervising Officer, decision-making for breach action is being delegated by CSNSW to NSW Police who form part of the Extended Supervision Order (**ESO**) Investigation Team. It is very rare for discretion to be exercised not to charge where there is evidence of breach of a condition. For example, even where an offender has a complicated history of drug dependence and is positively engaging with treatment providers, a positive drug test is almost always prosecuted in HRO matters. This is contrary to a parole order, where warnings are readily utilised as a means of dealing with a breach as an alternative. It is commonplace for an ESO to have approximately 50 conditions that the defendant must follow – even where the person required a tutor for proceedings or is clearly very intellectually impaired.

The ESO focus is on community protection, which is the primary objective of the legislation, however Legal Aid NSW considers that there is insufficient funding to provide for the rehabilitation of offenders in the community (the second objective of the legislation).

This is problematic for clients with such high needs as a result of their disabilities.

The following case studies demonstrate the failure of early intervention, which has resulted in our clients being targeted by the HRO scheme.

Daryl's story

Legal Aid NSW represented Daryl Carr, an Aboriginal man with an intellectual disability. Daryl was imprisoned in 2001 for committing serious sexual offences at the age of 16. In 2009, Daryl was placed on a five-year ESO, which was only revoked in May 2020.

Daryl has spent most of his adult life in prison, not for any heinous crime he has committed, but because of “technical” breaches of his ESO. Some of these breaches involve using illegal drugs, others involve breaches of curfews, schedules of movements and accommodation conditions. Daryl’s cycle of reincarceration led to a risk of indefinite detention, and culturally inappropriate, punitive supervision practices which hampered his rehabilitation.

The 2014 Supreme Court decision of *State of New South Wales v Carr*¹²⁷ revealed a five-year history of repeated incarceration for breach offences. Justice Hamill found that the practical implementation and enforcement of the ESO had been ‘punitive’.¹²⁸ Of particular concern was the alacrity with which relatively minor breaches were dealt with by criminal punishment (that is, incarceration), a lack of engagement with culturally appropriate programs, and the isolation of Daryl from his family. His Honour also expressed concern about evidence that supervision had failed adequately to take into account the “real and significant difficulties” experienced by Daryl as an intellectually disabled Aboriginal man.¹²⁹

His Honour expressed reservations as to whether Daryl could, at the age of 29, still be described as a “serious sex offender”,¹³⁰ noting that Daryl had committed no offences other than breaches of the ESO, and there was no evidence that Daryl’s use of drugs had led him into the commission of any other criminal offences.¹³¹ The risk Daryl posed was one of reoffending generally as opposed to sexual reoffending, arising as a result of the lifestyle associated with “heavier” drug use.¹³² Daryl’s addiction to “heavier drugs” appeared to have developed during a period of incarceration for a breach offence.¹³³ His Honour refused to reintroduce electronic monitoring, and instead insisted upon the parties fashioning different and more simple conditions that may be easier for Daryl to understand and comply with.

The matter of Daryl’s ESO returned to the Court in May 2020. Five years on, Justice

¹²⁷ *State of New South Wales v Carr* [2014] NSWSC 1348.

¹²⁸ *Ibid* [8].

¹²⁹ *Ibid* [26]-[27].

¹³⁰ *Ibid* [37].

¹³¹ *Ibid* [36].

¹³² *Ibid* [32].

¹³³ *Ibid* [9] and [20].

Hamill concluded that “much, if not all, of what I said in 2014 fell on deaf ears”.¹³⁴ He found that the risk assessments no longer established or suggested that Daryl represented a high risk of offending, and that the impact of the order resulting in his repeated incarceration for relatively minor breaches and his consequent institutionalisation adversely impacted on his prospects of rehabilitation.¹³⁵ His Honour ordered that the ESO be revoked, 11 years after the order was imposed.

Daryl was released from prison in May 2020, after just turning 35.

We also refer to the case summaries of *GB* and *RC* (see **Annexure A**), which reveal both the systemic failures in early intervention approaches to offending by young Aboriginal people and the resulting vulnerability of such offenders to applications by the State for continued detention or supervision as high risk terrorist offenders.

We are concerned about the significantly high proportion of Aboriginal and Torres Strait Islander people against whom orders under the HRO scheme are routinely sought and granted. We recommend that the NSW Attorney General refer the *Crimes (High Risk Offenders) Act 2006* (NSW) and the *Terrorism (High Risk Offenders) Act 2017* (NSW) to the NSW Law Reform Commission for comprehensive review, including in respect of the impact of the legislation on Aboriginal and Torres Strait Islander people.

For further information, see ‘Post sentence detention and supervision’ under chapter 5 of our 2017 ALRC submission.¹³⁶

Cultural competence and leadership

Legal Aid NSW reiterates the need for a broader understanding of the complex cross-cultural issues that impact on Aboriginal and Torres Strait Islander people’s interactions with the criminal justice system. Those who work in the criminal justice system should be fully cognisant of Aboriginal modes of communication and the particular challenges faced by Aboriginal suspects and offenders when communicating with authority figures.

We recommend that the NSW Government should ensure that those who work with Aboriginal and Torres Strait Islander people and communities, including police, the judiciary and CSNSW staff, receive training on cultural competence and trauma-informed practice. This should include training about the local area in which they work, contemporary Aboriginal society, customs and traditions, and historical and social factors which contribute to the position of Aboriginal and Torres Strait Islander people today.

In our view, cultural awareness training and having Aboriginal and Torres Strait Islander

¹³⁴ *State of New South Wales v Carr* [2020] NSWSC 643 [5].

¹³⁵ *Ibid* [31]–[32].

¹³⁶ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

people in positions of leadership are two areas that would assist in changes from the police, the judiciary and CSNSW staff. We suggest that police, judicial officers and CSNSW staff would benefit from cultural awareness training specific to their regions. Legal Aid NSW's *Best Practice Standards for Representing Aboriginal Clients*¹³⁷ is a resource that could be adapted for all police, judicial officers and CSNSW staff.

Experiences of Legal Aid NSW staff from the Lismore office

- At Lismore police station, there are three Aboriginal Community Liaison Officers for Lismore, Ballina and Casino, but the Aboriginal Community Liaison Officer would not be based at Casino due to work, health and safety issues. That alone does not bode well for Aboriginal people in Casino.
- Our solicitors have appeared before judges who have an excellent grasp of Bugmy issues,¹³⁸ but lack an understanding of Country and the trauma that is present in a lot of Aboriginal people's lives. For example, we called a client's mother to give evidence in District Court sentence proceedings. The family came from Tabulam, an isolated community an hour west of Casino. The tone used by the judge was aggressive, and the judge continued to cross-examine the mother about "there being nothing to do at Tabulam". This demonstrated a lack of understanding about the meaning of Country. There was also a lack of patience on the part of the judge whenever the mother took time to reflect on an answer before speaking.
- Cultural awareness training from the different Aboriginal communities in the regions has been helpful in changing the attitudes of Legal Aid NSW staff.

We also recommend that CSNSW staff and police receive training on how to respond to trauma within the custodial setting. We are concerned that a number of our clients who were sexually assaulted in prison were not dealt with appropriately by the prison.

*Ben's story**

Ben is a 20-year-old Aboriginal man. He recently reported being sexually assaulted in prison by a cell mate. Ben was taken by prison staff to Hospital A. They were told by the hospital staff that the hospital did not have the appropriate facilities to deal with sexual assaults, and to take Ben to Hospital B which has the required specialist unit. Rather than doing that, the prison staff returned Ben to the prison without any medical attention, counselling or support. It took multiple communications to the prison and to the health provider before Legal Aid NSW was assured that some form of health

¹³⁷ Legal Aid NSW, *Best Practice Standards for Representing Aboriginal Clients* (June 2020).

¹³⁸ In *Bugmy v The Queen* (2013) 249 CLR 571, the High Court held that the effects upon an offender of profound deprivation do not diminish over time and should be given full weight in every sentencing decision, and that the impact on an individual sentence of a person's history of social disadvantage can and should vary as the weight to be afforded social disadvantage requires individual assessment.

assessment and counselling would be provided to Ben. Ben has since been moved to another Correctional Centre.

In the experience of our solicitors, some CSNSW staff have displayed concerning behaviour or attitudes towards Aboriginal and Torres Strait Islander people in custody. We submit that there needs to be a re-orientation towards respectful and trauma-informed relationships with women and people in custody, particularly people in custody with mental illness or cognitive impairment or neurological diversity.

*Kate's story**

The Aboriginal Women Leaving Custody (**AWLC**) service runs fortnightly clinics at Silverwater Women's Correctional Centre. On one such clinic, the legal rooms were full and the AWLC had to set up in the open visitors' section. Prior to bringing up Kate for advice, one CSNSW officer approached the AWLC solicitor and project officer and said words to the effect of "be careful, this girl is a psycho". Later, the Correctives officer again approached the solicitor and made further comments about Kate's mental state, including that she was "crazy".

We also submit that CSNSW staff should work in close partnership with the relevant community in developing local initiatives that respond to local needs and capacity, including in respect of post-release employment and reintegration of Aboriginal and Torres Strait Islander offenders. This approach would be consistent with the recommendation of the RCADIC that there be greater involvement of Aboriginal organisations in correctional processes.¹³⁹

Fines, driver licences and offensive language

We remain concerned that Aboriginal and Torres Strait Islander people are more likely to accumulate large fine debt, and be subject to fine enforcement measures, such as driver licence sanctions and garnishee orders. Incarceration can then result from driving while subject to driver licence sanctions for fine default. In 2019, Aboriginal and Torres Strait Islander people made up 35% of all people imprisoned for driver licence offences in NSW.¹⁴⁰ We note that driver licence sanctions for fine default are not restricted to traffic-related offences. They are imposed for non-payment of all fines, ranging from fines for failing to vote to riding a bicycle without a helmet, for example. In our experience, this is a particular issue for people in remote communities. We reiterate that driver licence sanctions should not be an enforcement mechanism for non-driving related fines.

¹³⁹ *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 187.

¹⁴⁰ NSW Bureau of Crime Statistics and Research, *NSW Criminal Courts Statistics January 2015 to December 2019* (December 2019) Tables 5 and 14.

We support the recommendation of the ALRC Inquiry that options be developed with Aboriginal and Torres Strait Islander organisations, to reduce the imposition of fines and infringement notices, limit the penalty amounts of infringement notices, avoid suspension of driver licences for fine default, and provide alternative ways of paying fines and infringement notices.¹⁴¹ We also strongly support the increased use of warnings and cautions by police instead of issuing a fine, particularly for low level offences (e.g. riding a bicycle without a helmet).

We acknowledge the recent Fairer Fines reforms introduced by the NSW Government, which aim to make the fines system fairer for people experiencing hardship by:

- easing time restrictions to allow more time to choose to have a matter heard in court, request a review or nominate the responsible driver
- allowing customers to choose to receive fines digitally
- allowing customers to choose to pay their fines via a payment plan, and
- providing that people in acute financial hardship, who are in receipt of a Government benefit at the time of being fined, can apply to Revenue NSW to be considered for a 50% reduction for some fines before the fine becomes overdue.¹⁴²

We reiterate our support for the repeal of Division 6 of the Fines Act, which provides for imprisonment where a community service order is breached for non-payment of a fine. This is consistent with the ALRC recommendation that state and territory governments should abolish provisions in fine enforcement statutes that provide for imprisonment in lieu of, or as a result of, unpaid fines.¹⁴³

We also reiterate that, consistent with the recommendation of the ALRC Inquiry, offensive language should not be a criminal offence. In our view, the offence is now out of step with community standards regarding language, and, in practice, has very real net-widening effects for Aboriginal and Torres Strait Islander people. We note that the ALRC Inquiry recommended that state and territory governments review the effect on Aboriginal and Torres Strait Islander people of statutory provisions that criminalise offensive language, with a view to repealing the provisions or narrowing their application to language that is abusive or threatening.¹⁴⁴

For further information, see chapter 6 of our 2017 ALRC submission for our concerns and recommendations regarding fines and driver licences, including alternatives to

¹⁴¹ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) Recommendation 12-2.

¹⁴² *Fines Amendment Act 2019* (NSW), which commenced on 1 July 2020.

¹⁴³ Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) Recommendation 12-1.

¹⁴⁴ *Ibid* Recommendation 12-4.

infringement notices.¹⁴⁵

Monitoring and accountability

Given the disproportionately high level of Aboriginal and Torres Strait Islander people in custody, we consider that the NSW Government should consider adopting measures to evaluate the impact of laws or policies on rates of criminalisation and/or incarceration of Aboriginal and Torres Strait Islander people (e.g. new police powers or increased penalties).

We suggest that when a new or amended law or policy is introduced that may increase rates of criminalisation and/or incarceration of Aboriginal and Torres Strait Islander people, an Aboriginal and Torres Strait Islander Incarceration Impact Assessment should be published and tabled in the NSW Parliament. This proposal would be similar to the Criminal Justice Impact Assessment that is now required to assess the system-wide impacts and costs of proposed laws or policies for the Justice Cluster.

We also suggest that funding be provided to an Aboriginal and Torres Strait Islander-led agency to monitor NSW Government responses to recommendations of this inquiry and other inquiries and reviews.

¹⁴⁵ Legal Aid NSW, Submission to the Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (September 2017) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0007/27592/Legal-Aid-NSW-submission-to-the-Australian-Law-Reform-Commissions-Inquir....pdf>.

Part B: Preventing Aboriginal and Torres Strait Islander deaths in custody

Royal Commission into Aboriginal deaths in custody

The Royal Commission into Aboriginal Deaths in Custody (**RCADIC**) was established in response to a growing public concern that deaths in custody of Aboriginal people were too common and public explanations were too evasive to discount the possibility that foul play was a factor in many of them.¹⁴⁶

The findings of the RCADIC, however, did not show that Aboriginal detainees were dying due to the malicious acts of police or prison officers. The Report of the RCADIC stated that, while it could not point to a common thread of abuse, neglect or racism that is common to these deaths, “*an examination of the lives of the ninety-nine shows that facts associated in every case with their Aboriginality played a significant and in most cases dominant role in their being in custody and dying in custody*”.¹⁴⁷ The Report noted that:

1.2.3 ... generally, there appeared to be little appreciation of and less dedication to the duty of care owed by custodial authorities and their officers to persons in custody. We found many system defects in relation to care, many failures to exercise proper care and in general a poor standard of care. In some cases the defects and failures were causally related to the deaths, in some cases they were not and in others it was open to debate.¹⁴⁸

The RCADIC's review of 99 Aboriginal and Torres Strait Islander deaths occurring between 1980–89 showed that Aboriginal and Torres Strait Islander people did not die at a greater rate than non-Indigenous people in custody. Its principal finding was that the Aboriginal and Torres Strait Islander deaths were linked to the disproportional representation of Aboriginal and Torres Strait Islander people in custody. Its resulting recommendations included many recommendations targeted at reducing this overrepresentation in the criminal justice system. Almost 30 years on from these findings, it is clear that the problem of over-representation persists, and is in fact markedly worse. It remains a major issue if Aboriginal and Torres Strait Islander deaths in custody are to be reduced.

Deaths in custody in NSW in recent years

Over the past 20 years in NSW, there have been 53 Aboriginal or Torres Strait Islander deaths in custody (average 2.65 per year), representing 13% of the total 405 deaths in custody during that period. Although there was an increase in the average number of Aboriginal or Torres Strait Islander deaths in custody per year during the past five years (total 19 deaths, i.e. average 3.8 per year), Aboriginal and Torres Strait Islander deaths in custody still represented 13% of total deaths in custody in that period. This is despite

¹⁴⁶ *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) [1.1.2].

¹⁴⁷ *Ibid* [1.1.1].

¹⁴⁸ *Ibid* [1.2.3].

Aboriginal and Torres Strait Islander people now making up almost 30% of the NSW prison population over that period.

On the basis of publicly available records, Legal Aid NSW is only aware of one Aboriginal or Torres Strait Islander death in police custody in NSW since the introduction of the Custody Notification Service in 2000 – that of Rebecca Maher in 2016.

Rebecca's story

Rebecca Maher was first seen in 2015 by Legal Aid NSW's Civil Law Service for Aboriginal Communities at Silverwater Correctional Centre. Rebecca was an Aboriginal woman with a long history of drug addiction. At the age of 35, Rebecca had never had a social housing tenancy of her own and had spent most of her life homeless and in custody. She had applied for public housing assistance, but had been taken off the waiting list due to a failure to contact DCJ Housing.

In 2015, Legal Aid NSW assisted Rebecca to have her applications for public housing reactivated and backdated to 2007. This reactivation would have placed her very close to the top of the housing register. It is not clear what actions were taken by DJC Housing to progress her application or if she was housed.

In 2016, Rebecca died in police custody at Maitland Police cells. The NSW Police Force had detained her as an 'intoxicated person', after she had been witnessed in an intoxicated state. The Coroner found that Rebecca would have survived had an ambulance been called rather than holding her in a police cell.¹⁴⁹

Cause of death

There were 23 death in custody inquests finalised in both 2018 and 2019. Of these, 11 were deemed death by natural causes in 2019, and 18 were natural causes deaths in 2018. A large number of the inquest findings were brief, with no issues noted. In almost all cases, these were deaths by natural causes, most often from heart disease, lung disease and cancer. Many of these inmates were aged in their 70s to 90s.

A review of NSW coronial inquest findings contained in the 2019 and 2018 annual reports¹⁵⁰ from the NSW State Coroner identified the following recurring issues:

- access to mental health treatment¹⁵¹

¹⁴⁹ *Inquest into the Death of Rebecca Maher*, Acting State Coroner O'Sullivan (5 July 2019).

¹⁵⁰ NSW Office of the State Coroner and NSW Department of Communities and Justice, *Report by the NSW State Coroner into Deaths in Custody / Police Operations for the Year 2019* (Report, 2020).

¹⁵¹ *Inquest into the Deaths of RP and DJ*, Deputy State Coroner Grahame (4 July 2019); *Inquest into the Death of L*, Deputy State Coroner Ryan (30 April 2019); *Inquest into the Death of MC*, Deputy State Coroner Lee (31 August 2018); *Inquest into the Death of GR*, Deputy State Coroner Stone (12 June 2018); *Inquest into the Death of FJT*, Deputy State Coroner O'Sullivan (13 July 2018).

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- exchange of information between Justice Health and CSNSW and record-keeping¹⁵²
 - access to hanging points,¹⁵³ and
 - access to family during palliative care.¹⁵⁴

The cases demonstrate that one of the key issues in relation to deaths in custody is mental health treatment, together with the need for suicide prevention by way of eliminating hanging points and proper cell allocation.

Case examples from NSW do not demonstrate that there is deliberate violence or brutality on the part of prison guards causing deaths of Aboriginal and Torres Strait Islander people in custody. The death of David Dungay stands out as a possible exception. Likewise, recent cases of Aboriginal and Torres Strait Islander deaths in custody in NSW have not demonstrated overt racist treatment causing death.

However, given the prevalence of racism and discriminatory treatment towards Aboriginal and Torres Strait Islander people in the criminal justice system more broadly, the possibility of systemic or structural racism or mistreatment cannot be eliminated as a contributor to Aboriginal and Torres Strait Islander deaths in custody, and its existence ought to be considered and countered. Suggested measures to identify systemic issues are discussed in Part C—Oversight and review of deaths in custody, below.

Aboriginal and Torres Strait Islander deaths in custody

In Legal Aid NSW's view, the key issues that lead to a significant number of Aboriginal and Torres Strait Islander deaths in custody are:

1. the overrepresentation of Aboriginal and Torres Strait Islander people in custody, and
2. poor access to health care and health treatment in custody, particularly mental health care.

Part A of this submission outlined the ways in which the overrepresentation of Aboriginal and Torres Strait Islander people in custody should be addressed.

This Part of the submission outlines how access to health care, particularly mental health care, for Aboriginal and Torres Strait Islander people in custody should be improved.

Aboriginal and Torres Strait Islander prisoner health

Over a decade of research and data suggests that Aboriginal and Torres Strait Islander

¹⁵² *Inquest into the Death of Sony William Tran Bui*, Deputy State Coroner Lee (13 July 2018); *Inquest into the Death of MC*, Deputy State Coroner Lee (31 August 2018); *Inquest into the Death of GR*, Deputy State Coroner Stone (12 June 2018);

¹⁵³ NSW Office of the State Coroner and NSW Department of Communities and Justice, *Report by the NSW State Coroner into Deaths in Custody / Police Operations for the Year 2019* (Report, 2020); NSW Office of the State Coroner and NSW Department of Attorney General and Justice, *Report by the NSW State Coroner into Deaths in Custody / Police Operations for the Year 2018* (Report, 2019).

¹⁵⁴ *Inquest into the Death of Kenneth Hellyer*, Deputy State Coroner Truscott (3 April 2019); *Inquest into the Death of Clifford Deas*, Deputy State Coroner Russell (22 March 2018); *Inquest into the Death of Neville Betteridge*, State Coroner Mabbutt (18 July 2018).

prisoners exhibit greater levels of ill-health than non-Indigenous prisoners. Aboriginal and Torres Strait Islander people are significantly overrepresented in custody and leave prison with poorer health outcomes than other inmates. This has important implications for delivering health care to Aboriginal and Torres Strait Islander prisoners.

Aboriginal and Torres Strait Islander prisoner health

A 2009 inmate health survey indicated that Aboriginal and Torres Strait Islander prisoners had poorer health indicators in a range of areas, including asthma, liver disease, and blood borne viruses.¹⁵⁵ A 2010 Senate Inquiry found that approximately 98% of Aboriginal and Torres Strait Islander prisoners across all jurisdictions have a cognitive disability, commonly hearing loss.¹⁵⁶ Another review of Aboriginal and Torres Strait Islander offender health from 2013 noted:

Within the prison population, Indigenous offenders are at a further disadvantage, entering prison with poorer health than non-Indigenous offenders, and leaving prison to face poorer health outcomes and life expectancies than their non-Indigenous counterparts.¹⁵⁷

The most recent Aboriginal inmate health survey in 2015 reflected the same concerns,¹⁵⁸ suggesting that efforts to address Aboriginal and Torres Strait Islander health inequalities have done little to close the gap, despite the state-wide program of 'Closing the Gap' health promotion events undertaken in 2015.

Chronic health conditions are more prevalent among Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people are four times more likely to develop Type 2 diabetes than non-Indigenous people and typically onset occurs much earlier in their lifetime. The death rate is also four times that of non-Indigenous people when diabetes is an underlying or associated cause of death.

It is well-established that Aboriginal and Torres Strait Islander communities experience a trifecta of comorbidities which commonly include diabetes, cardiovascular disease and chronic kidney disease. According to the Australian Institute of Health and Welfare:

These diseases tend to appear earlier, progress faster, present alongside other chronic diseases and cause more premature death in Indigenous people than in non-Indigenous people (AIHW 2015a).

Aboriginal and Torres Strait Islander people are recognised as at risk populations for a range of mental illnesses. A critical example of this disparity is Aboriginal and Torres Strait Islander people are more likely to commit suicide than non-Indigenous people.

¹⁵⁵ Devon Indig et al, Justice Health, *2009 NSW Inmate Health Survey: Aboriginal Health Report* (Report, 2010).

¹⁵⁶ Senate Legal and Constitutional Affairs References Committee, Parliament of Australia, *Hear Us: Inquiry into Hearing Health in Australia* (2010) [8.103], cited in Law Council of Australia, *The Justice Project, Final Report – Part 1, 'Prisoners and Detainees'* (Final Report, August 2018).

¹⁵⁷ See Jocelyn Grace et al, 'Review of Indigenous Offender Health' (2013) 11(2) *Australian Indigenous Health Bulletin* 17.

¹⁵⁸ See Justice Health & Forensic Mental Health Network, *Network Patient Health Survey – Aboriginal People's Health Report 2015* (Report, November 2017).

According to the most recent Aboriginal inmate health survey in 2015, a higher proportion of Aboriginal and Torres Strait Islander participants reported receiving a mental health diagnosis while in custody.¹⁵⁹ Almost a quarter of Aboriginal and Torres Strait Islander men (23.3%) with a mental health diagnosis were diagnosed in custody compared to 17.2% of non-Indigenous men. A number of participants identified that they were diagnosed both in the community and in custody. A much higher proportion of Aboriginal and Torres Strait Islander women (19.4%) received a diagnosis in both places compared to non-Indigenous women (13.1%).¹⁶⁰

Deaths in custody and mental health care

Legal Aid NSW is uniquely placed to comment on the relationship between mental health care and deaths in custody because our solicitors represent clients in both the mental health and coronial jurisdictions. In our experience, poor mental health care arises repeatedly in coronial inquest matters. This occurs in relation to both Aboriginal and Torres Strait Islander deaths and non-Indigenous deaths in custody. We consider that deaths in custody are predominantly the result of mental health issues and a failure by CSNSW to properly house dangerous inmates, and/or a failure by Justice Health to properly monitor and manage an inmate's mental health, in circumstances where they are a risk of harm to others.

In our experience, there are lengthy delays for prisoners to access critical medical treatment, including medication and treatment that supports mental health. Many of our clients report that their mental health medication is interrupted when they enter custody, and they are unable to access medication again until they have been clinically assessed by Justice Health. There are often delays in the assessment process, which mean that patients not only suffer serious negative consequences of sudden medication withdrawal, but also that their mental health condition remains untreated for substantial periods of time.

Prisoner mental health care can be interrupted by movement between prisons. We note that CSNSW intends to significantly reduce prisoner movements, but currently movements interfere with adequate mental health treatment (e.g. medication may be interrupted or changed depending on availability at the new centre) and lead to deterioration in mental health. Health recommendations about movement holds are currently not mandatory, which means inmates can be moved even where health professionals consider this would be detrimental.

Many medications for mental ill health cause unpleasant side-effects. Our clients in custody report that they find it very difficult to obtain a review of their medication when they are suffering from side-effects. Often, they do not hear back in response to a request for review. Many times, they report having decisions about medication type and dose

¹⁵⁹ Ibid 28.

¹⁶⁰ Ibid.

made without any consultation.

Coronial findings have repeatedly highlighted the need for better resourcing of prison mental health care, and more timely mental health assessments and treatment. The coronial inquest into the death of Jonathon Hogan illustrates this.

Inquest into the death of Jonathon Hogan

Jonathon was a 23-year-old Wiradjuri, Ngiyampaa and Murrawarri man who killed himself at Junee Correctional Centre in February 2018. He had been in and out of correctional facilities since he was 14 and had a diagnosis of schizophrenia. We granted aid to his father Matt Hogan.

The Coroner delivered very strong findings on the failure of the State to provide adequate mental health care and apologised to Jonathon's family. Three of the six recommendations directly relate to mental health treatment in custody, including the need to:

- review intake procedures to ensure timely reviews of inmates with serious mental illnesses by mental health clinicians
- examine staffing ratios and resources to determine whether they are sufficient to ensure intake and ongoing reviews in a timely manner, and
- review notification process where inmate not compliant with anti-psychotic medication.¹⁶¹

Findings from recent coronial inquests also point to a deeper structural issue concerning the provision of mental health care to prisoners. As far as we are aware, NSW is the only state in Australia that has a mental health facility within a prison and therefore provides involuntary care and treatment inside a prison setting. This arguably creates the potential for conflict and confusion between correctional and health staff when it comes to decisions about care. Such problems were scrutinised at the inquest into the death of David Dungay,¹⁶² a correctional patient and client of Legal Aid NSW's Mental Health Advocacy Service at the time of his death. Legal aid had been granted to his mother, Leetona Dungay, for representation at the inquest.

Inquest into the death of David Dungay

David Dungay was a proud Dunghutti man from Kempsey. He had type 1 diabetes which required strict monitoring. He also had a history of psychiatric issues. As David was in lawful custody at the time of his death an inquest into his death was mandatory.

During the afternoon on 29 December 2015, David retrieved some rice crackers and biscuits from his belongings, returned to his cell, and began to eat them. Nursing and

¹⁶¹ *Inquest into the Death of Jonathon Hogan*, Deputy State Coroner Grahame (6 May 2020).

¹⁶² *Inquest into the Death of David Dungay*, Deputy State Coroner Lee (22 November 2019).

correctional staff in the ward where David was housed expressed concern about this, given David's elevated blood sugar levels (measured earlier that day). They asked him to return his biscuits and crackers but David refused to do so. Correctional staff then forcibly removed David from his cell to a different cell so that his condition could be observed. Less than 10 minutes after the cell move began David suddenly became unresponsive whilst being restrained in a prone position. Resuscitation efforts were commenced but were unsuccessful. David was pronounced deceased a short time later.

The inquest found that David died within the Mental Health Unit at Long Bay Hospital as a result of cardiac arrhythmia. In relation to the manner of death, the Coroner found that:

David died whilst being restrained in the prone position by Corrective Services New South Wales officers. David's long-standing poorly controlled type I diabetes, hyperglycaemia, prescription of antipsychotic medication with a propensity to prolong the QT interval, elevated body mass index, likely hypoxaemia caused by prone restraint, and extreme stress and agitation as a result of the use of force and restraint were all contributory factors to David's death.

More detail about the circumstances of David's death can be found in the published findings. Of particular note, however, was evidence of accountability and policy confusion. According to the published findings, there were at least four instances of uncertainty among Justice Health and CSNSW staff about who bore responsibility for certain decisions during the incident which led to David's cell transfer, restraint, sedation and subsequent death:

1. There was confusion about whether the cell transfer was effected on medical or non-medical grounds and by which agency staff. Officer F maintained that "the nurses" had requested the cell move; RN Xu gave evidence that he made no request on medical grounds to move David. The Coroner concluded that the absence of a completed medical certificate supported RN Xu's evidence.
2. Officer F maintained that the Immediate Action Team (**IAT**) was always called to respond to a volatile or irate inmate. Officer E stated that doctors and nurses "only inflame a situation more than help it" and CSNSW officers were better at de-escalating situations than Justice Health staff. The Coroner concluded that none of the criteria in the Operating Procedures Manual provided that the IAT had a general role to respond to medical issues. The evidence established that there was no proper basis for Officer F to request the attendance of the IAT.
3. There was confusion about who was responsible for monitoring David after administering the sedative. RN Xu asserted that he was told during training that CSNSW staff were responsible during a sedation/restraint scenario, and that he was directed by an officer to leave the cell. The Coroner concluded that although RN Xu was confronted by the situation and felt obliged to leave the cell at the implicit direction of one officer, his clinical duty to observe David after giving the first sedative was inappropriately overborne by these considerations.
4. The Coroner concluded that the responsibility for deciding whether additional

sedation was appropriate rested with Dr Ma. Instead, Officer G unreasonably allowed a perceived security issue to dictate management of a medical issue which did not fall within his remit. David was therefore subjected to additional prone restraint which was not warranted in the circumstances.¹⁶³

In our view, the kind of conflicts which came to light in the *Dungay* inquest are endemic to stressful incidents and reflect the inherent disharmony between delivering quality mental health care and operating a prison. The care which David received fell well short of the required human rights and professional standards in that:

- the care was not appropriate because the facility in which he was sedated was first and foremost a prison, not a hospital, in which correctional officers purported to have or were perceived as having ranking authority
- the care was not ultimately delivered by skilled medical personnel because Officer G was permitted to make a decision affecting David's health
- the care was not culturally appropriate and safe because no Aboriginal Health Worker was present to try to de-escalate the situation to avoid restraint, and
- the prison environment privileged security over health considerations in contravention of best practice as described in Principle 3 of the National Statement of Principles for Forensic Mental Health.

Lack of access to appropriate mental health care

In NSW, 'correctional patients'¹⁶⁴ can be transferred to a mental health facility when in need of mental health treatment and can be involuntarily transferred if they are 'mentally ill'.¹⁶⁵ In practice, however, correctional patients are transferred to the Mental Health Unit at Long Bay Hospital which has only 40 beds, as this is the only mental health facility within the NSW correctional system. It is likely that the demand for mental health treatment in hospital will be well in excess of 40 people at any given time. Involuntary treatment in this facility reduces the capacity of Long Bay Hospital to provide mental health treatment to other prisoners who need it, and is inconsistent with the position statement of the Royal Australian and New Zealand College of Psychiatrists that involuntary care within custodial settings should be eliminated.¹⁶⁶

In our view, demand for beds within the correctional mental health system could be eased by creating alternative treatment models through partnerships with community mental health facilities. Arrangements to enable transfer of correctional patients to community mental health facilities would ensure that they receive equivalence of care and would also

¹⁶³ Ibid 31, 33-35, 70-71 and 81.

¹⁶⁴ See *Mental Health (Forensic Provisions) Act 1990* (NSW) s 41.

¹⁶⁵ Ibid s 55.

¹⁶⁶ The Royal Australian & New Zealand College of Psychiatrists, *Involuntary Mental Health Treatment in Custody* (Position Statement 93).

result in reduced demand for beds in Long Bay Hospital, leaving that facility better able to manage less acute cases. In turn, this could reduce the number of mentally ill people in the general prison population.

There appears to be no legal barrier to prisoners being cared for in mental health facilities outside of prisons in NSW. When a prisoner is physically unwell and unable to receive sufficient care in an on-site health clinic, they are transferred to hospital for treatment. On such occasions, a correctional officer remains with the prisoner. It is both irrational and inhuman to categorise mental health care differently to other forms of health care, especially in circumstances where stresses in the prison environment are known to exacerbate mental health symptoms.

We recommend that:

- Involuntary (coercive) care within prison settings should be eliminated and the status of the Long Bay Hospital Mental Health Unit as a declared mental health facility should be repealed, and
- Justice Health should continue to provide care and treatment at Long Bay Hospital to those experiencing mental illness but only for voluntary patients.

Female prisoners

The majority of female prisoners in the Legal Aid NSW Aboriginal Women Leaving Custody service have clearly visible and self-reported mental health issues and diagnosis. The failure to provide mental health assistance and medical support to these women while in custody, including on remand, leads to overwhelming limitations on the women's ability to process and progress their legal and non-legal supports. It also places their health, welfare and wellbeing at a distinct disadvantage while in custody and upon release from custody.

Sarah's experience illustrates how challenging it is to meet the complex psychosocial needs of women who experience pregnancy loss in custody, in particular for Aboriginal and Torres Strait Islander women. Sarah suffered what is commonly called a 'missed miscarriage', in which the baby has died or failed to develop but has not physically miscarried.

Sarah's story*

Sarah was an Aboriginal woman in her late twenties with a history of substance addiction, homelessness and mental health issues. She had been incarcerated multiple times. On two occasions, she was pregnant when she entered custody.

Missed Miscarriage in 2013

In August 2013, Sarah suffered a missed miscarriage around the time she entered prison. She was not aware of the miscarriage until she attended hospital for an ultrasound which revealed a foetus with no heartbeat. At this time, hospital staff told

Sarah she needed a procedure to remove the dead fetus. Sarah wanted to have the procedure immediately, but CSNSW officers refused, claiming they lacked permission to stay at the hospital with her. Instead they escorted her back to prison.

Sarah carried the dead fetus for another 6 days until she had the procedure at another hospital. Just prior to attending, she saw a nurse at the Justice Health clinic who said to her: *"They're just going to suck it out of you and get rid of it"*.

Sarah found this comment very upsetting, insensitive and disrespectful.

After the procedure, Sarah said she woke up handcuffed to the bed. On her return to prison, it was 7 days before she saw a psychiatrist, who did not engage with her about the miscarriage or procedure. It was another 17 days before she saw a mental health practitioner.

Termination in 2016

In August 2016, Sarah was again pregnant and in custody. At her Reception Screening, she said she wanted to terminate the pregnancy. She confirmed this request to health staff on two more occasions. During this time, Sarah showed signs of distress and threatened self-harm, and she was placed in an assessment cell under the management of the Risk Intervention Team (RIT). She reported having dreams of a baby crying and sleeping poorly.

In the 17 days which passed between her initial request and the procedure, she received almost no counselling or support. The only exception was one mandatory session at the women's health clinic on the day of the termination. Sarah was given information to access a telephone counselling service, but on return to custody, she had no access to a telephone.

Sarah also raised complaints about infringements of her basic dignity:

- she was handcuffed by officers escorting her to and from the external clinic
- an officer was present while she was under anaesthetic
- officers received health information from doctors without her consent
- the women's health clinic gave her sanitary products because Justice Health failed to inform her to bring clean underwear or supply her with maternity pads
- on return to custody, Sarah was strip searched and asked by officers to "lift her feet" for security reasons, despite being under permanent observation by officers at the clinic
- she had no access to an Aboriginal Health Worker for culturally appropriate care.

Legal Aid NSW helped Sarah lodge a complaint with the NSW Health Care Complaints Commission and represented her at an Assisted Resolution meeting to discuss the above issues directly with Justice Health.

Some months after her release from custody in late 2018, Sarah died by suicide.

Increased resourcing for better access to health care in custody

There are numerous recommendations from a variety of inquests that would promote better access to health care in custody if implemented, many of which relate to resourcing issues. In the experience of our solicitors, there are good clinicians working in very challenging conditions, and inmates are simply not given adequate health services to reduce their risks, be it of self-harm or suicide, or other complications causing death.

For example, Legal Aid NSW has seen deficiencies in the way that diabetes is managed and treated in short-term custody, including the failure to promptly obtain the medical information necessary to provide appropriate and timely health care and the failure to act on information contained in medical records. This particularly impacts on Aboriginal and Torres Strait Islander people.

*Koa's story**

Koa, an Aboriginal man with Type 1 diabetes who was insulin dependent, was arrested and detained at a police station just after midnight. Three hours later he was transferred to custody at the Surry Hills Police Centre. After 14 hours in custody, he was released from custody on bail later that day at 4pm.

Despite his medical condition and insulin dependence being recorded on information and lodgement documents, being seen by a nurse, and asking different officers for insulin on multiple occasions, Koa was unable to access insulin and he did not receive sufficient blood glucose testing during his time in custody. He became unwell, had difficulty moving and talking, and struggled to participate in his court appearance by AVL.

On his release, he struggled to walk to his brother's home nearby where he always keeps a blood glucose testing kit and insulin. On arrival, he immediately self-administered an appropriate insulin dose.

Koa came to Legal Aid NSW for assistance to make a health care complaint. In response to his complaint, Justice Health apologised that he did not receive adequate care and acknowledged the potential for poor health consequences which he could have experienced as a result of not receiving insulin. Koa describes those consequences more bluntly: "I didn't want to become just another black death in custody."

Culturally appropriate services in custody

Some researchers have expressed concerns that the health care provided in prisons is not responsive to the specific needs of Aboriginal and Torres Strait Islander prisoners.¹⁶⁷ When recognising the high proportion of Aboriginal and Torres Strait Islander people in custody, it is critical to understand the influence of culture and spirituality on health and justice outcomes. It is concerning that in a 2015 NSW Network Patient Health Survey, only

¹⁶⁷ Jocelyn Grace et al, 'Review of Indigenous Offender Health' (2013) 11(2) *Australian Indigenous Health Bulletin* 17.

about half of men and about two thirds of women reported that there was an Aboriginal Health Worker at their current correctional centre, and only about a quarter reported having seen one in custody in the last 12 months.¹⁶⁸ This limits access to appropriate care and can reduce the likelihood of inmates engaging with needed health care and rehabilitation services.

Evidence was presented at the David Dungay inquest that, as at March 2019, Justice Health were in the process of recruiting an Aboriginal Health Worker for the Long Bay complex. In the Jonathon Hogan inquest, a recommendation was made by Deputy State Coroner Grahame to the CEO of the GEO Group (which operates the Junee Correctional Centre) that it “[c]onsider creating at least three full-time equivalent Aboriginal Health Worker positions based at the Junee [Correctional Centre], at least one of whom has responsibility for the provision of mental health care and treatment to Aboriginal inmates.”¹⁶⁹

Legal Aid NSW recommends that the availability of culturally appropriate and culturally safe health care for Aboriginal and Torres Strait Islander prisoners be reviewed and enhanced by improving the number, capacity and retention of Aboriginal Health Workers, improving health programs and services tailored to Aboriginal and Torres Strait Islander prisoners and partnering with Aboriginal Health Justice organisations in the community. We submit that the high level of Aboriginal and Torres Strait Islander people in custody, coupled with poor health outcomes of Aboriginal and Torres Strait Islander people generally and amongst Aboriginal and Torres Strait Islander prisoners, justifies the need for more culturally appropriate health care services for this cohort in prison.

Legal Aid NSW supports the Productivity Commission’s draft recommendation that the NSW Government ensure that Aboriginal and Torres Strait Islander people in custody have access to mental health supports and services that are culturally appropriate; trauma-informed; designed, developed and delivered by Aboriginal and Torres Strait Islander organisations where possible; and focused on practical application.¹⁷⁰ We also support its draft recommendation that the NSW Government work with Aboriginal and Torres Strait Islander organisations to ensure that Aboriginal and Torres Strait Islander people with mental illness are connected to culturally appropriate mental healthcare in the community upon release from prison.¹⁷¹

We also recommend that consideration be given to a pilot in various NSW prisons for a local Aboriginal Medical Service (**AMS**) to provide medical services to Aboriginal and

¹⁶⁸ Justice Health & Forensic Mental Health Network, *Network Patient Health Survey – Aboriginal People’s Health Report 2015* (Report, November 2017) 26.

¹⁶⁹ *Inquest into the Death of Jonathon Hogan*, Deputy State Coroner Grahame (6 May 2020) [306].

¹⁷⁰ Productivity Commission, *Mental Health* (Draft Report, 31 October 2019) 632. The ALRC recognised that a key element of best practice prison programs is that they are culturally appropriate, and that these features constituted a culturally appropriate program for Aboriginal and Torres Strait Islander prisoners on remand or serving short sentences, and for female Aboriginal and Torres Strait Islander prisoners: Australian Law Reform Commission, *Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples* (ALRC Report 133, 2018) [9.46]

¹⁷¹ *Ibid.*

Torres Strait Islander prisoners in custody. For example, the Winnunga Nimmityjah Aboriginal Health Service in Canberra provides a 24/7 nursing service to Aboriginal and Torres Strait Islander prisoners in Alexander Maconochie Correctional Centre in the ACT, together with clinical and psychological services.

We have also identified further opportunities to improve the oversight and complaints system for prison health care. These improvements would contribute to preventing Aboriginal and Torres Strait Islander deaths in custody. See **Annexure B**.

Part C: Oversight and review of deaths in custody

Legal Aid NSW's Coronial Inquest Unit

Legal Aid NSW's Coronial Inquest Unit is a state-wide specialist service that provides free legal advice and assistance in coronial matters and represents people at coronial inquests where legal aid has been granted. Legal Aid is available to family members in cases involving the death of an Aboriginal or Torres Strait Islander person in custody.

Oversight of deaths in custody, the investigation process and the NSW Coroners Court

The NSW Coroner's Court is the key oversight body tasked with conducting inquiries into deaths in custody in NSW. Under the *Coroners Act 2009* (NSW) (**Coroners Act**), all deaths in custody in NSW must be reported to the coroner.¹⁷² Only a senior coroner (i.e. the State Coroner or a Deputy State Coroner) has jurisdiction to hold an inquest concerning a death in custody.¹⁷³ The definition of a death in custody includes a situation where a person has died in the custody of a police officer or in other lawful custody, which will include CSNSW custody, or detention in a juvenile detention centre.¹⁷⁴ Inquests are mandatory in those circumstances, and are also mandatory in circumstances where a person has died as a result of police operations.¹⁷⁵ Investigation is undertaken by NSW Police under the direction of the allocated coroner.

In relation to the other oversight bodies referred to in the terms of reference:

- Inspector of Custodial Services: The principal functions of the Inspector do not include any role in relation to deaths in custody.¹⁷⁶
- NSW Ombudsman: The Ombudsman convenes the NSW Child Death Review Team, which reviews the deaths of children in NSW (which includes a child in detention), and as such the Coroners Act requires the State Coroner to inform the Ombudsman if this occurs.¹⁷⁷ The Ombudsman also has a function to investigate complaints in relation to custodial services from inmates and offenders. Otherwise, the Ombudsman has no role in relation to deaths in custody.
- Independent Commission Against Corruption: Investigates corruption in the public sector, and has no oversight function in relation to deaths in custody.¹⁷⁸
- CSNSW Professional Standards: It is understood that after a death in custody, an

¹⁷² *Coroners Act 2009* (NSW) s 35(1)(a).

¹⁷³ *Ibid* s 22.

¹⁷⁴ Deaths whilst escaping or attempting to escape custody are included, together with deaths while temporarily absent from a correctional centre, detention centre, or lock-up, or whilst proceeding to those locations for the purpose of being admitted as an inmate.

¹⁷⁵ *Coroners Act 2009* (NSW) s 23.

¹⁷⁶ *Inspector of Custodial Services Act 2012* (NSW) s 6.

¹⁷⁷ *Coroners Act 2009* (NSW) s 36(1).

¹⁷⁸ *Independent Commission Against Corruption Act 1988* (NSW) ss 2A and 8.

internal investigation is undertaken by CSNSW.

Where there is a death in police custody, the NSW Police Force investigation is undertaken pursuant to NSW Police Critical Incident Guidelines. The NSW Police Professional Standards Command supervises this investigation, and further oversight is provided by LECC. In all cases the investigation will be directed by the State Coroner or a Deputy State Coroner. The Department of Forensic Medicine provides pathology and post-mortem expertise.

The NSW Police Critical Incident Guidelines have been established to ensure the independence of the investigation, to the extent that is possible. Under the Guidelines, a critical incident includes a death which arises while a person is in custody or while escaping or attempting to escape from custody. They apply not only to deaths in police custody, but also to police shootings, police pursuits, and other deaths resulting from police operations.

Key guiding principles within the Guidelines include ensuring skilled and experienced investigators are utilised, and that independent monitoring by LECC is facilitated. The Guidelines include protocols to ensure no conflicts, and the NSW Police Professional Standards Command has an oversight role that sits above the Critical Incident Team, but below the oversight undertaken by LECC.

Where there is a death in prison custody, the NSW Police Force is the key investigator, aided by the internal investigations undertaken by CSNSW.

These investigations are normally directed by the State Coroner or a Deputy State Coroner. This will be the case unless criminal charges are likely, in which case the NSW Police Force investigates the matter as a homicide, rather than under the direction of the Coroner. Our recommendations regarding improvements to processes and oversight of deaths in police custody are detailed further below.

Positive aspects of the coronial system

In Legal Aid NSW's view, there are aspects of the NSW coronial system that are operating well. For example, in complex matters the State and Deputy State Coroners are normally assisted by solicitors from the Crown Solicitors office. In turn, these solicitors usually brief a barrister from the private bar as Counsel Assisting. In such cases, coronial matters are mostly well-prepared prior to inquest. Expert opinion is often obtained to assist with resolution of the issues at inquest. Hearings involve a detailed review of issues that are causally related to the manner and cause of death, and detailed findings are published.

In relation to judicial independence, the Coroner is a magistrate and presides in court as an independent statutory appointment. The Coroner is often assisted by government solicitors and independent barristers. Counsel Assisting the Coroner will often take a different view to police investigators, explore different avenues of inquiry, and consult with independent experts to better understand issues relating to the manner and cause of death. The independence of the Coroner is demonstrated through the making of coronial recommendations that are targeted to changes or improvements to government policy or

to government agencies.

In terms of family involvement in the inquest process, the Coroners Act provides that relatives of the deceased person can seek leave to appear in the proceedings themselves or be represented by a lawyer. Leave must be granted unless there are exceptional circumstances.¹⁷⁹ A family member or their lawyer can cross-examine witnesses. They can apply to the Coroner to have particular witnesses called.¹⁸⁰ Unrepresented relatives of the deceased person may request Counsel Assisting to ask specific questions on their behalf.¹⁸¹

Any family member or person with sufficient interest can seek representation through Legal Aid NSW's Coronial Inquest Unit. A grant of legal aid can be made where the public interest will be advanced through our representation. A means test will normally apply. However, where the matter relates to an Aboriginal or Torres Strait Islander death in custody, legal aid is available, and there is no requirement for the family of the deceased person to satisfy either a "public interest" test or a means test.¹⁸²

In well-run cases, where the family is represented or involved, they will be consulted about the issues they see as important in the inquest. These issues are often set out prior to an inquest in an issues list. Many of the procedural requirements for inquests are now set out in a Coroner's Court Practice Note.¹⁸³

A key therapeutic aspect of the coronial system is the family statement. Relatives of the deceased will often be offered the opportunity to say something personal about their loved one. This takes place during the inquest after the evidence is completed and before submissions. Often these occasions are particularly moving and bring into focus the personal attributes of the deceased, and the effect of their passing – often in stark contrast to the detailed examination of issues which has taken place during the evidence.

Recommendations to improve the coronial system in NSW

Despite these positive aspects of the coronial system, there are a number of fundamental issues which continue to impact on the coronial system, and particularly the experience of Aboriginal and Torres Strait Islander people. This includes the delays and the impact on families, inadequate provision of information to families of deceased persons throughout the process. These issues are outlined in greater detail below.

¹⁷⁹ *Coroners Act 2009* (NSW) s 57.

¹⁸⁰ *Ibid* s 60.

¹⁸¹ Local Court, *Coronial Practice Note No 1 of 2018* (19 November 2018) [8.5].

¹⁸² These variations to Legal Aid NSW's guidelines were introduced in May 2018 and August 2020 for Aboriginal or Torres Strait Islander death in custody matters. The rationale for the changes was partly based on ensuring compliance with Recommendation 23 of the RCADIC: "That the family of the deceased be entitled to legal representation at the inquest and that government pay the reasonable costs of such representation through legal aid schemes or otherwise."

¹⁸³ Local Court, *Coronial Practice Note No 1 of 2018* (19 November 2018).

Delay and its impact on families

Significant delays exist in having inquest matters heard before the NSW Coroners Court. In our experience, many inquests, including deaths in custody, do not run as inquests until two or three or more years after death. This delay impacts on the quality of the evidence, causes great distress to the family, and can diminish the utility of any recommendations.

The latest annual report from the NSW State Coroner demonstrates a significant number of outstanding death in custody matters.¹⁸⁴ By the end of 2019, there were 94 death in custody inquests that had not been completed, consisting of 91 deaths in prison custody, two deaths in detention centres, and one forensic matter.¹⁸⁵

Taking into account that only 23 death in custody inquests were finalised in both 2018 and 2019, Legal Aid NSW has significant concerns about the delays that will occur in finalising the 94 outstanding death in custody inquests that existed at the end of 2019. The NSW Coroners Court is under immense pressure not only to deal with the approximately 6,000 reportable deaths each year, and all outstanding mandatory section 23 inquests, but also the inquests and inquiries arising out of the 2019–20 bushfire season (including 25 deaths), which was unprecedented.

Furthermore, one of the consequences of the COVID-19 pandemic was that the hearing of inquests was suspended for a number of months, and many inquests were adjourned for periods of six to nine months or more. Taking account of the 47 death in custody matters reported to the NSW State Coroner in 2019, there is now a very large number of death in custody inquests to be conducted, without any additional resources to counter existing delays.

The State Coroner's latest annual report refers to "unavoidable delays in hearing inquests", but does not raise any issue with the impacts of these delays on the coronial process and family members of the deceased.¹⁸⁶ Our experience in representing family members is that these delays cause unacceptable levels of prolonged grief and suffering.

This observation is well-supported by the literature. Reviews conducted in Victoria and Western Australia demonstrated that "delays in coronial proceedings were a significant source of distress for families, particularly due to attrition in evidence, financial strain, and

¹⁸⁴ NSW Office of the State Coroner and NSW Department of Communities and Justice, *Report by the NSW State Coroner into Deaths in Custody / Police Operations for the Year 2019* (Report, 30 April 2020) 577.

¹⁸⁵ These included five outstanding matters from 2015, two matters from 2016, 16 matters from 2017, and 23 matters from 2018. These figures do not include the 35 outstanding inquests dating from 2014 onwards for deaths during or as a result of a police operation, at least 12 of which are over three years old (making a total of 129 outstanding mandatory section 23 inquests).

¹⁸⁶ NSW Office of the State Coroner and NSW Department of Communities and Justice, *Report by the NSW State Coroner into Deaths in Custody / Police Operations for the Year 2019* (Report, 30 April 2020) 14.

prolonged grieving for families recounting information many years after a death.”¹⁸⁷

Delay in the Coroners Court: The death of David Dungay

David Dungay, a proud Dunghutti man, died on 29 December 2015 while being restrained by prison guards at Long Bay Hospital. He was an involuntary mental health patient.

Because of the practice in NSW of keeping scheduled inmates in a prison hospital, he was housed at Long Bay Hospital.

His inquest did not commence until 16 July 2018. The first thing the Coroner did was acknowledge the delay:

Firstly, let me acknowledge the time it's taken to get here today. It is probably an unusual thing for anybody who is not a lawyer to experience the time that it has taken to get here today; that is, it's taken now two and a half years from an event until the Court proceeding. Anybody who is not a lawyer probably correctly thinks of that as being a long time. No doubt, in that period of time, your patience has been tested on many occasions and it's given rise to frustration on many occasions.

Family members of David Dungay had been adamantly protesting his death since it occurred. After two weeks of evidence in July 2018, the inquest was not finished. The matter was adjourned for nine months until 4 March 2019, as the Coroner had no available time.

Findings were delivered on 22 November 2019, almost four years after David's death.

A Coronial Practice Note was introduced by the Coroners Court in 2018 to specifically deal with delays to inquests resulting from deaths in police operations.¹⁸⁸ However, without additional resourcing it is unlikely that the Court itself will be able to achieve compliance with its own Practice Note. Legal Aid NSW represents many families of the deceased in circumstances where the family waits for years for any meaningful developments to occur prior to inquests.

In our view, inadequate resourcing significantly contributes to delay in the coronial system. NSW coroners deal with around 6,000 reportable deaths per year, and conduct about 80 to 90 coronial inquests each year. Only a very small portion of reportable deaths result in an inquest, and a large portion of inquests conducted each year are mandatory. Whilst the quality of individual inquiries is high, their efficacy and the benefits for families are

¹⁸⁷ Stephanie Dartnall, Jane Goodman-Delahunty and Judith Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice' (2019) 10 *Frontiers in Psychology* 2322, 2.

¹⁸⁸ Local Court, *Coronial Practice Note No 1 of 2018* (19 November 2018).

greatly compromised by the significant delays which characterise the coronial system in NSW.

In addition to inadequate resourcing of the Coroners Court, there are a number of discrete issues that contribute to the delay:

- Delay in the provision of autopsy reports: In our experience, these reports are routinely not provided until six to nine months after death, and often after far longer periods. This creates a hurdle in the investigation and the start of proceedings. A Coroner will often await provision of the report before taking further steps. It would be appropriate for pathologists from the Department of Forensic Medicine to issue a preliminary cause of death report within the short timeframe after death.
- Delay in obtaining statements from health professionals: Statements from doctors and nurses are generally not obtained by NSW Police. Rather, they are prepared with the assistance of the lawyer retained by doctors or nurses, normally well after the event (e.g. sometimes a number of years). This results in poor quality evidence with little detail. In contrast, in the experience of our solicitors, recorded interviews with police shortly after a death possess vastly greater evidential value. We suggest that NSW Police should obtain statements as part of their investigation, or alternatively, that the timely provision of statements by Department of Health employees and doctors be mandated.
- Delay in preparation and service of the brief of evidence: Often there are lengthy delays before a brief of evidence is prepared, and then further lengthy delays before it is ever served on the deceased's family. It can take years before a proper brief is compiled. In some cases, the family and/or its representatives do not receive a brief of evidence until four to six weeks before the inquest. This provides insufficient time to discuss the evidence with the family and properly prepare for the inquest.
- Delays due to procedural matters: Often there is material of a confidential nature which will be contained in the brief of evidence. Parties such as the NSW Police Force or Commissioner of Corrective Services will seek to obtain protective orders from the Coroner as to disclosure and non-publication. In Legal Aid NSW's experience, this can often create significant delays in having a matter listed or the family being provided with the brief of evidence.

We consider that a broad-based working group should be established to address ongoing operational issues, including delay and other processes within the coronial jurisdiction. Key stakeholders should include the NSW Coroners Court, NSW Police, CSNSW, Justice Health, the Department of Health, Crown Solicitors Office, the Inquests, Inquiries and Representation team from Legal branch of DCJ, Legal Aid NSW, the Aboriginal Legal Service, and others who can speak on behalf of bereaved family members or participate directly.

We understand that there is a Ministerial taskforce, with representatives from DCJ, NSW Health and NSW Police, looking at delays in the coronial jurisdiction, however information about its Terms of Reference or outcomes are not publicly available. We consider that

stakeholders who can speak on behalf of families (e.g. Legal Aid NSW and the ALS) should also be included as members on this taskforce, if its work is to continue.

Delays in the provision of information to family members

Families involved in the coronial process experience significant delays in getting information about the circumstances surrounding their loved one's death. The Court does not provide regular updates to families, who are often left to repeatedly make requests for information. Requests for documentation are often denied. In other cases, families will be told that no decision has been made to progress the matter. Delays of six to 12 months or more are not uncommon, including to decide whether there will be an inquest (given that in the vast majority of reportable deaths, the Coroner can dispense with an inquest).

The impact on families has been described in various studies:

These studies revealed that families were concerned and frustrated by infrequent updates, a poor understanding of their rights and whether an inquest would be held, and delays that prolonged stress and impaired witness memory.

Families valued inquests, and perceived a sense of justice or enhanced trust in the outcomes, when: (a) provided direct access to previously inaccessible evidence, (b) treated with greater respect than in other investigations, (c) permitted to raise opinions or questions in the inquest directly or through legal representation, or (d) the inquest revealed previously unidentified systemic failings that contributed to the death.¹⁸⁹

Limited representation of family members at inquest

Legal Aid NSW is the first organisation in Australia to establish a specialist coronial inquest unit providing legal representation in public interest coronial inquests. The Unit began in 2007 and has provided legal advice and assistance, together with representation at inquests, to many family members. Since its inception, the Unit has been staffed by two lawyers. Our lawyers have appeared or instructed in numerous high-profile inquests including the Lindt Café inquest, the Courtney Topic inquest, the David Dungay inquest, and the Rebecca Maher inquest.

Of the inquests completed in 2018 and 2019, families were represented in just a third of the deaths investigated. Of these families, about 40% were represented by the Coronial Inquest Unit or funded by Legal Aid NSW. There were similar levels of private representation. However, it appears that families were represented in just 74 of the 220 circumstances where a death was investigated at an inquest.

We consider that families having legal representation from an early stage of the coronial process is crucial to their experience of the process. In our experience, having a family representative involved in proceedings adds an extra layer of rigour and is vital to ensure that issues are properly reviewed. The level of inquiry that takes place where families are

¹⁸⁹ Stephanie Dartnall, Jane Goodman-Delahunty and Judith Gullifer, 'An Opportunity to Be Heard: Family Experiences of Coronial Investigations Into Missing People and Views on Best Practice' (2019) 10 *Frontiers in Psychology* 2322, 3.

properly represented is almost undoubtedly greater than if there was no such representative. Furthermore, the therapeutic impact on families of being able to voice their concerns through legal representation, and participate fully in the inquest process, are well-recognised.¹⁹⁰

We consider that Legal Aid NSW and the ALS have an important role to play in these matters. There is a need to review levels of funding to Legal Aid NSW so that adequate, culturally sensitive services can be provided to the many families seeking assistance in coronial matters and representation at inquest.

Specific issues for Aboriginal and Torres Strait Islander families

In our experience, great anguish and distress is experienced by Aboriginal families whose loved ones die in custody. There is an overwhelming distrust of the custodial system. Combined with being given limited or no information about what has taken place, for Aboriginal families this often leads to speculation about what happened, usually an intense suspicion, and often outrage. Numerous recent examples exist, including in relation to the deaths of David Dungay, Tane Chatfield and Patrick Fisher.

The NSW coronial system should address the widening gap that exists between the existing coronial processes and the expectations and needs of Aboriginal and Torres Strait Islander families coming into contact with this system. The recurring client experience we observe at Legal Aid NSW was described by the RCADIC Commissioner in his findings in relation to foul play:

The suspicion on the part of relatives and friends that there had been foul play was very strong indeed in some cases. One of the great weaknesses in those responsible for notifying relatives of deaths or for conducting investigations into deaths has often been the failure to realise that such suspicion was likely to occur and was not unreasonable in the minds of relatives. From the point of view of relatives a live brother, father, husband or son goes into custody and a dead body is returned. It must never be forgotten that a very important and legitimate part of the 'racial memory' or 'cultural heritage' of Aboriginals in this country is the deliberate hunting down and killing of their ancestors and the deliberate destruction of their families by the forcible movement of groups and individuals and the taking away of children. With these memories police are very strongly associated. Today police continue to arrest Aboriginals at many times the rate at which they arrest other people. One simply cannot expect many Aboriginals to share the benign view of the police function that is held by many non-Aboriginals.

Death often takes place under circumstances where the only witnesses of the immediately surrounding events are custodial officers, in whose interest it is that the deceased should be found to have died by his or her own hand, or by natural causes without fault on their part. Any investigation which is to convince outsiders must critically examine such hypotheses and investigate the alternative hypotheses of death by foul play or negligence.¹⁹¹

Legal Aid NSW supports legislative reform and improved coronial processes to better support Aboriginal and Torres Strait Islander families of deceased persons, both in general

¹⁹⁰ Ibid 5.

¹⁹¹ *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) 61-62.

and following a death in custody. Specifically, there is an opportunity to provide better information and support for families, more timely and better legal representation, and culturally appropriate services.

Culturally appropriate services

First, there is the need for culturally specific services to accommodate the large number of Aboriginal and Torres Strait Islander people who interact with the NSW coronial system. In particular:

- There are currently no Aboriginal or Torres Strait Islander-identified positions within the NSW Coroners Court for DCJ staff.
- The Coronial Information and Support Program (**CISP**) has never had any Aboriginal or Torres Strait Islander staff, and we are not aware of any Aboriginal or Torres Strait Islander staff ever filling any positions within the counselling services provided by DOFM. These are the two services that provide specialist support to families of the deceased, first at the initial stage where a body has been received (DOFM counsellors contact the family), and second, when a coronial matter is received by the Coroners Court and support is required (CISP counsellors have limited capacity to assist and refer families for further help).
- There are currently no Aboriginal or Torres Strait Islander staff working in the registry of the NSW Coroners Court. Registry staff answer requests from families for information and updates on coronial investigations and inquests.

In contrast, Victoria has a Koori Family Engagement Unit which provides guidance to the Coroners Court of Victoria, to ensure its service provision is and remains culturally informed and appropriate. Two Aboriginal-identified roles have been funded to appropriately resource the team to support both Men's Business and Women's Business. In March 2019, a Koori Family Engagement Coordinator was appointed to better serve Aboriginal and Torres Strait Islander families involved in coronial investigations. The role was developed in consultation with the Aboriginal Justice Caucus and Aboriginal and Torres Strait Islander community groups. It provides services to support families and ensure culturally safe practices are embedded within Court processes. It includes incorporating Sorry Business practices throughout coronial investigations and coordinating smoking ceremonies and Welcomes to Country during inquests. A second position of Koori Family Engagement Officer was advertised in 2020, again to provide culturally safe support to family, friends, and the community throughout the coronial process, while offering culturally focused advice and support to Coroners on aspects of their coronial investigations.

Legal Aid NSW supports the creation of similar positions and a culturally specific unit within the NSW Coroners Court. Such a unit would employ Aboriginal and Torres Strait Islander staff who would act as a point of contact for Aboriginal and Torres Strait Islander families, provide support to the families during the process, and help build trust and

informed participation in the system. This should be developed in consultation with Aboriginal and Torres Strait Islander community groups.

We also support the creation of Aboriginal-identified positions in counselling and support roles at the Coroners Court, DOFM and CISP. We believe that level of support would help build trust within Aboriginal and Torres Strait Islander community. Intergenerational trauma and a history of dispossession are likely barriers to Aboriginal and Torres Strait Islander families placing trust in the coronial process.

Legislative reform to reflect cultural considerations

Second, there is the need for the Coroners Act and coronial processes to specifically accommodate cultural needs and considerations. There are no specific provisions in the Coroners Act that make provision for cultural considerations, particularly in relation to Aboriginal and Torres Strait Islander people. NSW is the only Australian jurisdiction that has a Coroners Act which does not make specific provision for Aboriginal and Torres Strait Islander peoples, other than South Australia. Other jurisdictions make provisions in relation to the determination of senior next of kin and family members, thereby allowing consideration of the customs and traditions of the community or group to which the person belongs, in the case of an Aboriginal or Torres Strait Islander person. Other provisions encourage the coronial system to engage with families in ways that respect cultural diversity, whilst in Western Australia, the Act allows regulations to be made that would give effect to the recommendations of the RCADIC.

Provisions in the NSW Coroners Act dealing with investigation directions and exhumations, and objections to the exercise of post-mortem investigative functions, contain no requirement to take account of cultural considerations, particularly those of Aboriginal and Torres Strait Islander people.¹⁹² Likewise, the definition of ‘relative’ and ‘senior next of kin’ make no reference to cultural considerations, and no allowance for the potential departure of Aboriginal family relationships from those definitions.¹⁹³

Legal Aid NSW supports legislative reform of the Coroners Act to the effect that the definition of ‘relative’ and ‘senior next of kin’ be amended to recognise persons who are part of an extended familial or kinship structure in different cultures (including Aboriginal and Torres Strait Islander cultures). We would also support amendments to allow the appointment of persons other than the default senior next of kin, including where there are competing claims, but only in exceptional circumstances.¹⁹⁴

¹⁹² *Coroners Act 2009* (NSW) Pt 8.1 and 8.2.

¹⁹³ *Ibid* ss 5 and 6A.

¹⁹⁴ In the statutory review of the *Coroners Act 2009* (NSW), we proposed that if such an amendment occurred, the *Coroners Act 2009* (NSW) or its regulations should stipulate a set of inclusive factors to guide the coroner’s discretion on when the statutory hierarchy should be displaced. These factors should include “religious, cultural or spiritual factors”. Alternatively, a preferable and simpler approach, and one which does not try to find equivalence of Aboriginal and Torres Strait Islander concepts of family and kin with non-Indigenous meanings of “relative,” is found in the definition of “domestic relationship” contained in s 5(1)(h) of the *Crimes (Personal and Domestic Violence) Act 2007* (NSW). It provides “that a person has a domestic relationship with another person if the person, in the case of

Protocol for post-mortem investigations

We also support the development of protocols that will guide the State Coroner's Court in its dealings with Aboriginal families after a death has taken place. In our experience, many of the suspicions and grievances experienced by Aboriginal families have related to their contact with DOFM and the Coroners Court shortly after a death. In particular, the viewing of deceased relatives by family members has resulted in observations that continue to disproportionately and incorrectly inform their views as to what may have taken place.

It is noteworthy that almost 30 years ago, the RCADIC recommended that the State Coroner or their representative:

... should consult generally with Aboriginal Legal Services and Aboriginal Health Services to develop a protocol for the resolution of questions involving the conduct of inquiries and autopsies, the removal and burial of organs and the removal and return of the body of the deceased. It is highly desirable that as far as possible no obstacle be placed in the way of carrying out of traditional rights and that relatives of a deceased aboriginal person be spared further grief.¹⁹⁵

Legal Aid NSW is not aware of any relevant protocol being developed by the Coroners Court, especially to recognise cultural considerations around post-mortem investigations and the release of the deceased's body to family. Establishing a culturally specific unit at the NSW Coroners Court (similar to Victoria's Koori Family Engagement Unit) would provide the resources and expertise for such a protocol to be developed.

Protocol for the conduct of death in custody inquests

The RCADIC recommended that the State Coroner develop a protocol for the conduct of coronial inquiries into deaths in custody.¹⁹⁶ The annual report by the State Coroner to the NSW Parliament provides a brief 'coronial protocol for deaths in custody / police operations',¹⁹⁷ but no protocol is published on the Coroners Court website. Given the lengthy delays that occur with death in custody inquests, and the often inadequate provision of information and support to Aboriginal and Torres Strait Islander families, Legal Aid NSW considers there is an immediate need for development of such a protocol, including by way of a Coroners Court Practice Note in relation to Aboriginal and Torres Strait Islander deaths in custody.¹⁹⁸

an Aboriginal person or a Torres Strait Islander, is or has been part of the extended family or kin of the other person according to the Indigenous kinship system of the person's culture." In any event, we suggest this provision be referred to relevant Aboriginal and Torres Strait Islander stakeholders for comment, including the ALS.

¹⁹⁵ *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 38.

¹⁹⁶ *Ibid* Recommendation 8.

¹⁹⁷ NSW Office of the State Coroner and NSW Department of Communities and Justice, *Report by the NSW State Coroner into Deaths in Custody / Police Operations for the Year 2019* (Report, 30 April 2020) 10.

¹⁹⁸ Amongst other things, this Practice Note could establish a timetable for provision of the brief of evidence, a process for the immediate briefing of Crown Solicitors Office, and provision for an early directions hearing to engage the family.

We have been developing a Practice Note with the NSW Coroners Court to cover Aboriginal and Torres Strait Islander deaths in custody. In our view, key features of such a Practice Note would include briefing of the Crown Solicitors Office within 48 hours of a death notification, timetables for the provision of the brief of evidence by NSW Police and Corrective Services, an early directions hearing at a fixed time after death, and a timetable for the provision of witness and issues lists. One purpose of the early directions hearing would be to engage the family at an early stage in the court process. Guidelines would also be established in the Practice Note for provision of the brief to the family of the deceased, and the allocation of inquest dates at an early stage of the proceedings.

Issues with the investigation into deaths in custody

One of the key findings of the RCADIC was its concern over the quality of investigation into deaths in custody. In the overall findings of the National Report, the RCADIC stated:

It is not surprising that there was much cynicism about official explanations for the deaths. It is quite clear that this Royal Commission would not have been necessary or at least its Terms of Reference would have been very different--had there been adequate, objective and independent investigations conducted into each of the deaths after they occurred and had those investigations examined not only the cause of death--in the medical sense--and whether there had been foul play but also questions of custodial care and the issue of responsibility in the wider sense.

In very few cases prior to the establishment of the Commission was the investigation into the death other than perfunctory and from a narrow focus and the coronial inquest mirrored the faults in the investigations.

... it is plain that much harm was done to relations between Aboriginal people and the broader community, and great hardship was imposed on the relatives of the deceased persons as a result of the inadequacies of most post-death investigations. It must never again be the case that a death in custody, of Aboriginal or non-Aboriginal persons, will not lead to rigorous and accountable investigations and a comprehensive coronial inquiry.¹⁹⁹

Despite the 35 comprehensive recommendations made by the RCADIC in 1991 in relation to post-death investigations, successive NSW governments have failed to fully implement those recommendations. The following important issues arise in relation to the existing NSW system for the investigation of deaths in custody.

Culturally sensitive investigations by NSW Police

We acknowledge that, so long as police remain the ones primarily responsible for investigating deaths in police custody, perceived conflict of interest may remain a concern for our clients, particularly Aboriginal and Torres Strait Islander families of deceased. This may undermine public confidence in the independence and quality of investigative processes and findings in relation to deaths in police operations.

We submit, in principle, that NSW Police should not investigate the conduct of police. This

¹⁹⁹ *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Vol 1 [1.2.5]–[1.2.6].

is because such approaches may contribute to accommodating real or perceived bias, conflicts of interest, and lack of transparency and confidence in the independent nature of the process. However, according to our recent practice experience in relation to Critical Incident matters, police investigations have been of a relatively high standard in many cases, and there have been limited concerns about the quality or independence of the police investigation (though conclusions reached by some police experts on the actions of other officers are at times uncritical, and often challenged). We also note that LECC, which commenced operations on 1 July 2017, will oversee NSW Police Professional Command in Critical Incident investigations,²⁰⁰ who themselves oversight the Critical Incident investigation. We suggest below some ways in which any ongoing or perceived deficiencies in police investigation could be resolved through training and better resourcing.

In our experience, the personal qualities of the officer in charge of a coronial investigation, and the manner and frequency in which they engage with the deceased's family, can dramatically alter the experience for family members. Empathy and regular updates, together with following up on family requests, make a huge difference to family members, and are key attributes of a good investigating officer. Sadly, there are many cases involving Aboriginal deceased where these aspects are not reflected in the investigation. The historical and ongoing conflict that often occurs between NSW Police and the Aboriginal community, together with diminished levels of trust, create a significantly greater challenge for police officers investigating the death of an Aboriginal deceased.

Significant room for improvement exists in relation to levels of contact between investigating officers and Aboriginal families, and the development of rapport. Legal Aid NSW supports the training of investigating police to communicate appropriately with Aboriginal families and to better understand Aboriginal culture, including cultural beliefs regarding post-mortem procedures, and kinship structures. Consideration should be given by the NSW Commissioner of Police to providing Aboriginal cultural training for police investigating any Aboriginal or Torres Strait Islander death in custody or as a result of a police operation, and to the mandatory involvement of Aboriginal Community Liaison Officers in the investigation of any Aboriginal or Torres Strait Islander death in custody or as a result of a police operation.

Quality of the police investigation

Until about two years ago, death in custody investigations in the NSW prison system were conducted by experienced NSW Police detectives from the Corrective Services Investigation Unit, a specialist unit in NSW Police. We understand this is no longer the case, and that function has now devolved to individual Police Area Commands in the region where the death took place. This is of significant concern, because individual officers investigating deaths in custody may now have no experience.

²⁰⁰ Under Part 8 of the *Law Enforcement Conduct Commission Act 2016* (NSW), LECC has the power to independently oversight and monitor the investigation of critical incidents by the NSW Police Force if it decides that it is in the public interest to do so.

CSNSW have many different documents, systems and internal processes, many of which are paper-based, others electronic, that an inexperienced investigator may not know exist. The RCADIC recommended that police investigations be conducted by highly qualified investigators.²⁰¹ It is no longer the case that this will take place, now that detectives investigating are not from a specialised unit.

Legal Aid NSW recommends that the NSW Police Commissioner should consider returning the investigation function to the Corrective Services Investigation Unit. The Commissioner should also ensure that unit is adequately resourced to investigate death in custody matters in a timely and thorough manner. In our experience, that has not been the case in a number of past deaths in custody, due to resourcing issues.

Immediate briefing of independent legal practitioner to assist the Coroner

The RCADIC recommended that “as soon as practicable, and not later than 48 hours after receiving advice of a death in custody, the State Coroner should appoint a solicitor or barrister to assist the coroner who will conduct the enquiry into the death.”²⁰²

In our experience, the coroner will only be assisted by the Crown Solicitors Office in complex death in custody matters. Non-complex matters are handled by Coronial Advocates, who are NSW police officers attached to the Coronial Law Unit at the NSW Coroners Court. In many cases it can take more than a year for the Crown Solicitors Office to be briefed in complex matters. Lengthy delays exist before any legal practitioner is appointed to assist the Coroner. The impact of these delays is that important information may be lost, or investigations overlooked, particularly in complex cases. These delays greatly lessen the likelihood that family members will be provided with timely information about the death of their loved one.

Legal Aid NSW would strongly support a two-fold requirement in relation to deaths in custody. First, that all death in custody matters be referred to the Crown Solicitors Office, such that solicitors from that office can immediately take responsibility for ensuring a full and adequate inquiry, consistent with the recommendations of the RCADIC.²⁰³ Second, that referral by the State Coroner take place within 48 hours after receiving advice of a death in custody, and that arrangements be made for immediate acceptance of instructions by the Crown Solicitors Office in relation to all death in custody matters.

Legal requirement to investigate the quality of care, treatment and supervision of deceased prior to death

The RCADIC recommended that “a coroner enquiring 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.”²⁰⁴

²⁰¹ *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 34.

²⁰² *Ibid* Recommendation 26.

²⁰³ *Ibid* Recommendations 26–28, 30–31.

²⁰⁴ *Ibid* Recommendation 12.

No such requirement currently exists in the Coroners Act. Whilst care is normally taken to review any matters that may be causally linked to a death, there is no general obligation on a coroner to review the quality of care, treatment and supervision of a deceased prisoner. In certain circumstances, this may result in both an investigation and inquest that fails to address matters important to family members concerning aspects such as health care and custodial conditions of a loved one.

Recommendations were also made by the RCADIC to ensure police investigations would include investigation of the general care, treatment and supervision of the deceased prior to death, including a particular focus on whether custodial officers observed all relevant policies and instructions concerning care, treatment and supervision.²⁰⁵ In our experience, some police investigators reach conclusions on the basis of 'no suspicious circumstances', and fail to identify issues such as adequacy of medical or other care.

Legal Aid NSW considers that the Coroners Act should be amended to adopt this recommendation and mandate that the quality of the care, treatment and supervision of a person who dies in custody must be investigated and formally reviewed at inquest.

Improving accountability and the death prevention function, and greater accountability in tracking NSW Government responses

Legal Aid NSW is concerned about the framework which governs responses to coronial recommendations. At present, there is no legislative requirement under the Coroners Act for any interested party, including government agencies, to respond to coronial recommendations. If the coronial system is to fulfil its role in promoting death prevention, an essential component of the coronial system must involve a rigorous system for response to coronial recommendations, and accountability of those to whom the recommendations are directed. This view applies equally to recommendations in all inquests, as it does to recommendations arising from deaths in custody.

Premier's Memorandum M2009-12²⁰⁶ provides that, within six months of receiving a coronial recommendation, a Minister or NSW government agency should write to the Attorney General outlining any action being taken to implement the coronial recommendation. If it is not proposed to implement a recommendation, reasons should be given. Despite the operation of the Premier's Memorandum, Legal Aid NSW is concerned about the declining levels of adherence to Premier's Memorandum M2009-12 over recent years, and a potential for lack of proper consideration and attention to coronial recommendations by NSW Government agencies, particularly as they relate to deaths in custody.

²⁰⁵ Ibid Recommendation 35.

²⁰⁶ Premier's Memorandum M2009-12 sets out the process for responding to coronial recommendations directed at Ministers and NSW government agencies. The purpose of the Memorandum is to ensure that there is a consistent process across government for responding to coronial recommendations, and that there is increased accountability and transparency in responding to such recommendations.

In Victoria, the *Coroners Act 2008* requires that a public statutory authority or entity which is the subject of a coronial recommendation must provide a written response within three months after receiving a recommendation, and that response must specify a statement of action (if any) that has, is or will be taken in relation to the recommendation.²⁰⁷ The South Australian legislation requires the responsible Minister to table a report after six months in both houses of Parliament in relation to any recommendations, giving details of any action taken or proposed to be taken in consequence of the recommendations.²⁰⁸

We reiterate our recommendation to previous reviews of the Coroners Act, that there should be a legislative requirement for the provision and publication of a government agency response to coronial findings and recommendations.²⁰⁹ The written response should include a report as to whether any action has been taken, is being taken, or is proposed to be taken in response to the findings and recommendations, and should be provided within either three or six months of receipt of the Coroner's findings.

We also recommend that the State Coroner should be empowered "to call for such further explanations or information as he or she considers necessary, including reports as to further action taken in relation to the recommendations",²¹⁰ which is consistent with the recommendations of the RCADIC, but which has never been implemented in NSW.

We understand that in practice, NSW coroners do not follow up on recommendations made in relation to inquests that have been finalised. They are neither empowered nor resourced to do so. This results in a coronial system with limited accountability, and without any clear imperative for government agencies to tackle difficult issues raised at inquest.

The implementation of a mandatory response regime would support the clear public benefit in transparency and accountability of the coronial process, and substantially improve the ability of the coronial system to prevent death and injury.

The need to review all coronial findings and recommendations to identify and track systemic issues relating to deaths in custody

In relation to NSW deaths in custody, none of the inquest findings and recommendations are the subject of further systematic review or analysis by any NSW agency or body, in particular with a view to preventing or reducing the likelihood of further deaths in custody. This is contrary to the recommendations of the RCADIC. As a result, much of the good work being undertaken in death in custody inquests does not translate into significant

²⁰⁷ *Coroners Act 2008* (Vic) s 72. Similar legislative provisions exist in the ACT (*Coroners Act 1997* (ACT) s 76), and the Northern Territory (*Coroners Act 1993* (NT) ss 27, 35, 46A and 46B).

²⁰⁸ *Coroners Act 2003* (SA) s 25(5).

²⁰⁹ Legal Aid NSW, Submission to the NSW Department of Justice, *Statutory Review of the Coroners Act 2009: Draft Proposals for Legislative Change* (September 2016) <https://www.legalaid.nsw.gov.au/_data/assets/pdf_file/0004/25492/Legal-Aid-NSW-Submission-to-Coroners-Act-Statutory-Review-September-2016-.pdf>.

²¹⁰ *Royal Commission into Aboriginal Deaths in Custody: National Report* (Final Report, 1991) Recommendation 16.

systemic changes within the custodial system, in large part because there is no analysis or overall review of death in custody matters.

The coronial system and oversight of deaths in custody could be further improved if the collective findings and recommendations of similar inquests were analysed and reviewed to identify common themes and systemic issues, and to inform NSW Government policy responses to enhance death prevention. An example of such a function in practice is the NSW Domestic Violence Death Review Team (**DVDRT**).

Domestic violence deaths are the subject of such review by the DVDRT, which is constituted under Chapter 9A of the Coroners Act. The object of the legislation is to “provide for the investigation of the causes of domestic violence deaths in New South Wales, so as to reduce the incidence of domestic violence deaths, and facilitate improvements in systems and services.”²¹¹ The DVDRT is made up of a Secretariat, and includes statutory members from relevant NSW Government agencies, non-government organisations and other experts. The DVDRT reviews closed cases of domestic violence deaths, analyses data to identify patterns and trends relating to such deaths, and makes recommendations as to legislation, policies, practices and services for implementation by government and non-government agencies and the community to prevent or reduce the likelihood of such deaths. Importantly, the DVDRT multi-agency reviews provide a broader understanding of domestic and family violence related deaths than may be provided by investigations of discrete deaths, and are therefore able to inform policy and systemic change in a way that other review processes cannot. The DVDRT also assists Coroners on open cases and provides specialist expertise in respect of domestic and family violence in coronial matters.

It has also established and maintains a database, and undertakes, alone or with others, research that aims to help prevent or reduce the likelihood of domestic violence deaths. An annual report is tabled in Parliament every second year, and the NSW Government has provided a published response to these reports.²¹²

In addition to a death review team, consideration should also be given to the establishment of a the Coroners Prevention Unit (**CPU**), similar to the model in Victoria, which has been established as a specialist service for coroners to strengthen their prevention role and provide them with expert assistance. The CPU does this by reviewing a range of reportable and reviewable deaths, collecting and analysing data relating to reportable and reviewable deaths, assisting coroners and the development of prevention-focused coronial recommendations, and receiving and publishing coronial recommendations.

The central goals of the CPU are to improve the quality and applicability of coronial recommendations, increase their uptake and implementation, and contribute to the

²¹¹ *Coroners Act 2009* (NSW) s 101A.

²¹² The latest NSW Death Review Team report for 2017–19 reviewed 53 domestic violence related deaths in July 2014 to June 2016. Individual case reviews sought to identify common themes, issues and areas for recommendation. The report presented 34 recommendations to the NSW government and a wide variety of government agencies, together with detailed quantitative and qualitative review findings.

reduction of preventable deaths in Victoria. Amongst other things, the CPU undertakes both individual and collaborative research projects to support coronial investigations to generate a better understanding of preventable deaths in Victoria and identify intervention options. Since its inception, it has published reports which include understanding and preventing drug-related harms, gambling-related suicides, overdose deaths, and suicides of Aboriginal and Torres Strait Islander people.²¹³

Legal Aid NSW strongly supports the establishment of a unit similar to the CPU in Victoria, to assist coroners in the development of prevention-focused coronial recommendations. We also support the establishment of a specialist death review team with a statutory basis, based on the purpose and functions of the DVDRT, to monitor and inform policy and systemic change in relation to all deaths in custody, with a particular focus on Aboriginal and Torres Strait Islander deaths in custody.

Independent audit of the NSW coronial system

Legal Aid NSW recommends an independent audit or review of the NSW coronial system, to assess whether relevant government agencies are effective and efficient in supporting the NSW State Coroner in investigating and helping to prevent deaths. A similar audit was conducted in 2018 of the Queensland coronial system, which found significant systemic issues that affected the ability of the Queensland State Coroner to effectively fulfil its responsibility for the efficiency of the Queensland coronial system.²¹⁴

We acknowledge that the NSW Government has previously undertaken statutory reviews of the Coroners Act, however we consider that these reviews have not undertaken a holistic, systemic review of the coronial system.

Legal Aid NSW considers that there is a need for a broader independent review or audit of how the coronial inquest system operates in NSW with the aim of ensuring that the NSW model has a greater focus on preventing deaths. The review should consider the adequacy of funding of the coronial system, including legal services for families, delays and other inadequacies in relation to the provision of information and support to families.

An independent Coronial Council and a separate Coroners Court

In NSW, the Coroners Court is part of the NSW Local Court and is not separately constituted as a court. It has proven to be a major limitation on the functions of the court,

²¹³ See Coroners Court of Victoria website: <https://www.coronerscourt.vic.gov.au/>.

²¹⁴ In October 2018, the Queensland Audit Office delivered its report entitled 'Delivering Coronial Services', which assessed whether relevant government agencies were effective and efficient in supporting the Queensland State Coroner in investigating and helping to prevent deaths. The audit found that under the *Coroners Act 2003* (Qld), whilst the State Coroner is legally accountable for the efficiency of the Queensland coronial system, the role has little functional control over the resources needed to effectively fulfil this responsibility. The lack of functional control had resulted in a system that was under-resourced to meet existing and future demand. The audit found excessive delays and a declining clearance rate were leading to a growing backlog of coronial investigations, indicating a system under stress: Queensland Audit Office, *Delivering Coronial Services, Report 6: 2018–19* (Report, 18 October 2018).

and its capacity to adapt and reform so as to provide an effective death prevention function, and to cater adequately for families of the deceased. Serious consideration ought to be given to establishing the NSW Coroners Court as a separate court, as has occurred in Victoria,²¹⁵ Queensland,²¹⁶ South Australia²¹⁷ and Western Australia.²¹⁸

In Victoria, there is also a Coronial Council which was established under the *Coroners Act 2008* (Vic) and is the first body of its kind in Australia. It is independent from the Victorian Government and the Coroners Court. Under the *Coroners Act 2008* (Vic), the Council's role is to advise and make recommendations to the Attorney-General on issues of importance to Victoria's coronial system; matters relating to the preventative role played by the Coroners Court, the way in which the coronial system engages with families and respects their cultural diversity, and any other matters relating to the coronial system that are referred to the Council by the Attorney-General.²¹⁹

The Victorian Coronial Council acts in a way that does not impinge on the independence of coroners' professional tasks or the jurisdiction of the State Coroner; delivers strategic advice reflecting the changing physical and social environment with the aim of promoting a modern and responsive coronial system; strengthens collaboration between agencies across the service system, focuses on advice to enhance services to families, promotes the prevention role of the coroner, ensures that the views of bereaved families are reflected in the development of advice, complements existing governance structures in the State coronial system, and promotes transparency, accessibility and accountability regarding the functions of the Victorian coronial system.

The existence of both the Victorian Coronial Council and the Coroners Prevention Unit in Victoria are just two examples of how other jurisdictions have taken steps to enhance their coronial systems and promote their death prevention functions.

Legal Aid NSW considers that a review of the NSW coronial system should also consider the merits of establishing an independent Coronial Council to advise and provide recommendations to government on the coronial system.

National Coronial Information System

We are also concerned that it is difficult for the public to obtain accurate information about coronial matters. We consider that coronial cases should be made more easily accessible. Access to the National Coronial Information System, which is provided by the Victorian Department of Justice, is only available to third party researchers and death investigators.²²⁰ We support the National Coronial Information System (or other database of coronial cases and government responses) being made accessible to the public.

²¹⁵ *Coroners Act 2008* (Vic) s 89.

²¹⁶ *Coroners Act 2003* (Qld) s 64.

²¹⁷ *Coroners Act 2003* (SA) s 10.

²¹⁸ *Coroners Act 1996* (WA) s 5.

²¹⁹ *Coroners Act 2008* (Vic) s 110.

²²⁰ 'National Coronial Information System' (Web Page) <<https://www.ncis.org.au/>>.

Annexure A: Examples of applications under the *Terrorism (High Risk Offenders Act) 2017* (NSW)

State of NSW v RC (No 2) [2019] NSWSC 845

RC was a 19-year-old, cognitively impaired Aboriginal person who had never been convicted of any terrorist offence nor any serious violence offence. His criminal offending was described by the Court as “largely towards the lower end of the scale of seriousness of criminality.” RC suffered from psychotic disorder, borderline to extremely low range intellectual functioning levels and a neurological functioning detected to be in the extremely low range. He had spent a substantial portion of his life in custody, as a juvenile and then as a young adult. He professed conversion to Islam whilst in custody and made verbal threats associated with the conduct of ISIS.

The State applied for a 3-year Extended Supervision Order to keep RC under strict surveillance and monitoring at the conclusion of his sentence. In dismissing the application, the Court found that:

Taken in the context of the particular incidents.... the incidents amount to statements made by an immature young man confined in a correctional environment where it is necessary to affect a persona of toughness so as to avoid being the victim of other inmates. The incidents occurred in the course of a struggle for identity of a kind that most teenagers engage in and whilst being exposed to events of a kind which are entirely unfamiliar with the life that the defendant had previously led. As well, the expressions were of anger towards juvenile correctional staff for what was perceived to be unfair treatment.²²¹

The Court also accepted that statements relied on by the State were made in the context of RC trying to build up a reputation and to give the appearance of toughness as an individual:

*No doubt the defendant thought that, in light of his reasonably short stature, he needed to project himself as a tough, ruthless individual so as to avoid trouble whilst in custody.*²²²

State of New South Wales v GB by his Tutor [2020] NSWSC 913

The State of NSW applied for a 3-year Extended Supervision Order in relation to GB, an 18-year-old Aboriginal man from the Yuin Nation. GB had a mild intellectual disability and a history since infancy of severe abuse and neglect. He spent the majority of his adolescence in custody. He suffered from post-traumatic stress disorder as a result of

²²¹ *State of NSW v RC (No 2) [2019] NSWSC 845 [112]*.

²²² *Ibid* [71].

his early experiences of neglect and abuse and subsequent out of home care placement symptoms, and restraints, and period of confinement in juvenile detention. He had been also been diagnosed with a myriad of other mental health conditions including schizophrenia, substance use disorder and conduct disorder. He had self-harmed on a number of occasions.

The State alleged that GB was a terrorism activity offender, because of his historical 'association' with certain other youths in custody and an adult who had espoused violent extremist ideas in the past. All the relevant 'associates' were in custody at the time of the application. The State also relied on scrawlings alleged to have been made by GB in juvenile detention apparently advocating support for violent extremist ideologies.

GB had never committed a terrorist offence. The index offences for the purpose of the State's application were personal violence and property damage offences committed as a juvenile and for which he had been sentenced to a control order by the Children's Court.

Experts described GB as having a 'rudimentary understanding of the basic practices of the Islamic faith and that he rated low for commitment to an ideology that justifies the use of extreme violence'. GB had voluntarily engaged in a de-radicalisation program in custody and prior to COVID-19 had weekly face-to-face engagement with his mentor as well as telephone contact.

The Court noted that all instances of violence, outbursts apparently advocating support for violent extremist ideology, or graffitiing the walls with the same apparent ideology, were precipitated by self-harm and mental health breakdowns including head banging, hearing voices, gouging eyes, and cutting his face. Experts further opined that GB used terror related imagery and statements most likely related to his anger at staff and relative lack of power in the situation he found himself in.

A month before the ESO application GB was placed by the Mental Health Review Tribunal on a 12-month Forensic Community Treatment Order, to be converted to a Community Treatment Order on his release from custody.

The State's application was dismissed at the preliminary hearing on the basis that there was insufficient evidence to establish, even on a prima facie basis, that GB posed an unacceptable risk of committing a serious terrorism offence.

The Court described the "patriarchal approach [of the State] to this application, rather than a real identified risk that the defendant will commit a terrorism offence as defined."²²³

²²³ *State of New South Wales v GB by his Tutor* [2020] NSWSC 913 [77].

The Court was particularly critical of the “preposterously short timeframe” within which the proceedings had to be prepared: the application was filed nine days before GB’s sentence expiry date (and therefore required to be determined within that period) and involved voluminous and complex evidence. The Court observed:

It is of significant concern to me as a Judge of this Court that orders seeking to criminalise and curtail the movements and rights of an 18-year-old man, in custody for offending as a minor, who has significant mental illness and cognitive impairments, are sought on such a last minute basis.

On the morning of the preliminary hearing, the State successfully applied for a weapons and firearms prohibition order against GB.

Annexure B: Opportunities to improve the oversight and complaints system for prison health care

Overview

Responsibility for the oversight of prison health care is divided between the Inspector of Custodial Services, the NSW Ombudsman and the NSW Health Care Complaints Commission.

Inspector of Custodial Services

The Inspector of Custodial Services (**ICS**), established by the *Inspector of Custodial Services Act 2012* (NSW) (**ICS Act**), is appointed by government to inspect adult correctional centres and juvenile justice centres in NSW, and report to Parliament on the findings of its inspections. The ICS has a statutory obligation to inspect and report to Parliament on each adult correctional facility at least once every five years.²²⁴ The ICS may also choose to report on an issue of public interest or they may be requested by the Minister to report on a particular issue. The ICS cannot investigate individual complaints except insofar as they relate to systemic issues present in the correctional environment.²²⁵ Potential complainants are instead directed to the NSW Ombudsman (see below).

The ICS also oversees the Official Visitor programs conducted under the *Crimes (Administration of Sentences) Act 1999* (NSW) and the *Children (Detention Centres) Act 1987* (NSW). Official visitors are community representatives appointed by the Minister for Corrections to visit adult correctional facilities. Their role is to resolve inquiries and complaints by prisoners (or staff) and report on the condition of correctional centres. Every Official Visitor is assigned to specific correctional centres and visits each once a fortnight. To speak to the Official Visitor, prisoners must generally ask a correctional officer to book them into the Official Visitor book for the next scheduled visit. It is possible for prisoners to complain to an Official Visitor about their health care in prison.

The ICS performs an essential oversight and accountability function. The independent scrutiny of public and private custodial centres and services is fundamental to protecting the safety and dignity of people in custody, by helping to ensure compliance with human rights standards and continuous improvement as a matter of good practice.

Legal Aid NSW has made specific recommendations to improve the policy objectives of the ICS Act and to enhance the role of the ICS in our submission to the statutory review

²²⁴ *Inspector of Custodial Services Act 2012* (NSW) s 6.

²²⁵ 'What We Do', *Inspector of Custodial Services* (Web Page, 2017)
<<http://www.custodialinspector.justice.nsw.gov.au/Pages/What-we-do.aspx>>.

of the ICS Act.²²⁶

NSW Ombudsman

The NSW Ombudsman is an independent watchdog whose role is to monitor, scrutinise or investigate public services and some private sector agencies in order to improve their systems or performance. Traditionally, the Ombudsman performs this role by responding to complaints by individual members of the community, but it also has various other functions under the *Ombudsman Act 1974* (NSW).²²⁷

Within the NSW Ombudsman sits a specialist unit which is dedicated to helping people in custody who complain about problems with CSNSW or the operators of privately run prisons. This may conceivably include complaints about specific aspects of a prisoner's health care managed by CSNSW including access to psychologists or health clinics, the availability of medical escorts, lock-downs or mistreatment by correctional staff.

In the first instance, prisoners are encouraged to resolve complaints locally before complaining to the Ombudsman. If a complaint does not resolve, they can call the Ombudsman from the free-call list on a prison telephone.

NSW Health Care Complaints Commission

The NSW Health Care Complaints Commission (**HCCC**) is empowered to receive complaints about health services and health service providers in NSW under the *Health Care Complaints Act 1993* (NSW) (**HCC Act**).²²⁸ It performs a role akin to an independent medical ombudsman. HCCC's functions include to assess, resolve and investigate complaints about clinical care, standards and treatment. As part of that function, the HCCC may investigate complaints which raise a significant issue of public health or safety, or a significant question as to the appropriate care or treatment of a patient by a health service provider.²²⁹

The HCCC has the power to refer the complaint to the relevant professional council for disciplinary action,²³⁰ and to make recommendations or comments to a health organisation.²³¹ The HCCC also has own-motion powers under Part 3 of the HCC Act to investigate the clinical care and management of a client by a health service provider where

²²⁶ Legal Aid NSW, Submission to the Department of Communities and Justice, *Statutory Review of the Inspector of Custodial Services Act 2012* (NSW) (18 February 2020) <https://www.legalaid.nsw.gov.au/__data/assets/pdf_file/0010/39178/200218-Legal-Aid-NSW-submission-to-the-Statutory-Review-of-the-Inspector-of-Custodial-Services-Act.pdf>.

²²⁷ The Ombudsman is also empowered to deal with public interest disclosures under the *Public Interest Disclosures Act 1994* (NSW) and investigate complaints about community services under the *Community Services (Complaints, Reviews and Monitoring) Act 1993* (NSW).

²²⁸ More information about the powers and functions of the NSW Health Care Complaints Commission ('HCCC') are available on its website: <http://www.hccc.nsw.gov.au/>.

²²⁹ See *Health Care Complaints Act 1993* (NSW) Pt 2 Div 4 and 5.

²³⁰ Ibid Pt 2 Div 6.

²³¹ Ibid Pt 2 Div 7.

it appears “the matter raises a significant issue of public health or safety” .

We understand that currently, the HCCC does not have a systemic reporting function in respect of health services in correctional environments. The most recent Annual Report (2016-2017) does not mention prison-related issues and there appears to be only one published case study about a prisoner complaint.

Justice Health

Prisoners can make a complaint to Justice Health about their health care in custody. Procedures for addressing health problems in custody are set out in the Justice Health and Forensic Mental Health Network Policy 2.015 *Patient Complaints Handling*. Prisoners are first directed to speak to the Nursing Unit Manager (**NUM**) at their centre or the Nurse in Charge in the absence of the NUM. If the NUM is unable to resolve the issue, then prisoners may contact the Healthcare Complaints Line on their Common Auto Dial List²³² or write to the Chief Executive Officer of Justice Health.

Justice Health can also receive written complaints about health care in custody through a Client Liaison Officer. This is a complaint process which can be utilised for ‘local resolution’ of an issue. In an ordinary case, Legal Aid NSW corresponds with the officer setting out the client’s health concerns or grievance, and the officer contacts health staff on the ground at the centre to find out information, pass on the client’s concerns, arrange for nursing staff to interview the client and confirm appointments or treatment plans. In most cases, we receive a written reply to the complaint within 35 days, which may obviate the need to complain to the HCCC.

Systemic oversight and reporting

As outlined above, responsibility for the oversight of prison health care is divided between the ICS, the NSW Ombudsman and the HCCC.

Each agency performs discreet functions under enabling legislation and consequently, garners special expertise. The HCCC is a specialist health care oversight body which is primarily concerned with upholding clinical standards of care and receiving individual health care complaints. Every year, it receives many complaints by prisoners about their health care, but it has no specific functions relating to custodial health services. By contrast, the ICS is an oversight body focussed on custodial environments; it does not accept individual complaints but has the power to address systemic issues in the prison system, including health care.

Examining how these agencies use their functions and expertise differently to analyse issues in custodial health care helps to reveal certain disjunctures and opportunities for improvement.

²³² The Common Auto Dial List contains over 20 pre-set free call numbers which inmates can call from any correctional centre. It also includes the Hep C Helpline, Dental Hotline, Mental Health Hotline, Quitline and the NSW Ombudsman.

To begin with, there is no regular, systemic or universal inspection of custodial health standards in NSW. The ICS is empowered to play an important role in the oversight of custodial health care,²³³ however, it is currently not sufficiently resourced to do so effectively. The number of custodial centres in NSW and the breadth of issues which might arise for inspection place a practical limitation on the Inspector's capacity to consistently and specifically report on health services in custodial centres on a regular basis.

To make the most of its resources, the Inspector has adopted a theme-based model, where it inspects multiple facilities and reports to parliament under a theme. In the last three years, it has reported on issues as diverse as prison population growth, aged offenders, clothing and bedding, 24-hour court cells and radicalised inmates. Health care issues featured in only some of those reports and, where they did, they were not a primary focus. While the Inspector is currently preparing a themed report on the access and availability of health services which will draw on a number of correctional centre inspections, it will not have conducted inspections of all custodial centres in NSW. The consequence is that data from the forthcoming health inspection will only provide a limited snapshot of custodial health care issues.

Increased resources would enable the Inspector to conduct more regular, frequent and rigorous examinations of custodial health care issues and to exercise its functions with the aim of improving custodial health care over time.

The ICS Act provides that the Inspector may enter information sharing and referral arrangements with the NSW Ombudsman and the Independent Commission Against Corruption.²³⁴ This provision enables the Inspector to cooperate with these agencies to support the effective performance of its functions. However, the ICS Act does not refer to all relevant NSW agencies with oversight roles and responsibilities in custodial settings.

In light of this, there is an opportunity to improve cooperation and information-sharing between the ICS and the HCCC to enable the Inspector to examine custodial health complaints data, including individual complaints made to the HCCC, in the exercise of its functions. This would enhance the Inspector's ability to fulfil its function to monitor prisoner care and welfare.

Prisoners at correctional centres can make health complaints to the HCCC through a free call on prison telephones.²³⁵ Complaints about correction and detention facilities comprised 5.6% of all complaints that the HCCC received about health organisations in 2018-19 (142 complaints), 9.4% of all complaints in 2017-18 (229 complaints), and 11.6%

²³³ The Inspector's principle functions include the regular inspection of custodial centres and the examination and review of any custodial service at any time: *Inspector of Custodial Services Act 2012* (NSW) s 6(1)(a)-(c). The definition of "custodial service" includes the "care or welfare (including health care) of persons in custody, detained or residing at a custodial centre": *Inspector of Custodial Services Act 2012* (NSW) s 3.

²³⁴ Ibid ss 10 and 11.

²³⁵ By way of example, in 2017 the HCCC received approximately 1,500 calls from inmates: Legal Aid NSW meeting with HCCC staff on 22 March 2018.

of all complaints in 2016-17 (257 complaints).²³⁶

While we understand that the Inspector has obtained health complaints data from the HCCC for the purpose of its forthcoming health services report, the Inspector does not otherwise appear to examine individual health complaints made to the HCCC in the performance of its functions. Outside of the health services report, we are not aware of the Inspector undertaking ongoing, systematic monitoring or analysis of the health complaints data of people in prisons.

We suggest that the Inspector should have ongoing access to health complaints made to the HCCC and Justice Health from people in detention, as an important information source in the exercise of its function 'to examine and review any custodial service at any time' (s 6(1)(c)). While the Inspector does not have a role in dealing with individual complaints, we submit that its mandate to take a proactive approach to improve services, and to make recommendations to address systemic issues, requires that its recommendations are informed by relevant data. This should include individual health complaints.

We suggest that the ICS Act should be amended to facilitate cooperation, information sharing and reporting between the HCCC and the Inspector, with the aim of improving health care services and access to health care services in custodial centres.²³⁷

Amendments should also facilitate greater cooperation and information sharing with other relevant oversight agencies that are not currently referred to in the Act, for example with the LECC. This may help to address our concerns about people in short-term custody and the degree of oversight of correctional centres and services managed by the NSW Police Force.

Making health care complaints

Streamlining the system of oversight for custodial health care should also make it simpler for prisoners to lodge health complaints. In our experience, prisoners tend to be well aware of their right to complain, but the existence of multiple complaint pathways can be confusing. Prisoners do not necessarily differentiate between immediate health concerns and the custodial conditions that impact upon them. They do not always appreciate the division of responsibilities between various agencies which dictate to whom they should complain.

²³⁶ HCCC, *Health Care Complaints Commission 2018-19 Annual Report* (Report, 2019) 20. The HCCC reports that the drop off in complaints "appears to be a reflection of the changes to the Justice and Forensic Mental Health Network processes which enable inmates to raise concerns about their health care directly with their corrections facility. This facilitates a more timely response and direct intervention, often avoiding the need to lodge a formal complaint with the Commission."

²³⁷ A useful example of cooperation, referral and information sharing provisions is in the *Inspector of Correctional Services Act 2017* (ACT) Pt 5. See also the *Law Enforcement Conduct Commission Act 2016* (NSW) ss 33 and 165, which provide that the LECC and the NSW Ombudsman may enter into information sharing arrangements regarding certain investigations and reports, and that the NSW Ombudsman is required to report certain matters to the LECC.

As part of the HCCC assessment process, if a complaint does not proceed to investigation, the complainant is often encouraged towards local resolution with Justice Health. In response to written complaints to Justice Health itself, complainants are routinely advised to speak to the NUM if they have ongoing issues. This devolution of responsibility to the local level may be practical and more efficient, but it also weakens accountability in an already fractured oversight system.

Some of our clients also report limited success in achieving a favourable resolution to a health-related issue when they complain to the Official Visitor. This is likely to attest to the complexity of meeting health needs in the custodial environment more than the capacity or willingness of Official Visitors to intervene or advocate for an individual.

Adequate resources for Justice Health

Health resource allocation emerges as arguably the most critical underlying factor in realising a standard of health for prisoners which is equivalent to that available in the wider community. The introduction to the Inspection Standards on 'Physical health care' (Standards 76 – 88) offer some insights into the challenge:

The attainment of a “community standard” for this complex, high needs population inevitably involves a far greater disposition of resources than would be the case for a random cross-section of an equal number of people in the community across NSW. Correctional centres bring together people from various communities who are individually more in need of health services than average.

The attainment of a “community standard” may only thus be realised by providing health **resources allocated on the basis of need**. This may be a greater need than that which is available to a similar sized community sample because a high needs population is concentrated in one place rather than being distributed randomly across the community.²³⁸ (emphasis added)

According to the *Full House Report* (2015) by the ICS, “CSNSW has the lowest operating and capital cost per prisoner per day of any Australian correctional jurisdiction”.²³⁹ In practice, that means there are less staff available to receive a prisoner’s self-referral form, inmate request or general grievance. Even when staff are physically accessible, clients report that they are sometimes told “inquiries are closed” and sent away. The purely ‘notional’ availability of staff can also have deleterious effects on a prisoner’s mental health: as their complaints are deferred, dismissed or even spurned, they feel increasingly despondent about the prospect of getting help.

The inquest into the death of Glenn Russell offered insights into how deficiencies in access to forensic beds have a real impact on prisoner well-being. During that inquest, Dr Katerina Lagios, Justice Health’s Clinical Director (Primary Care) told the Court that in NSW the prison population had increased from 9,000 to 13,000 prisoners without a significant

²³⁸ Inspector of Custodial Services, *Inspection Standards for Adult Custodial Services in NSW* 63.

²³⁹ Inspector of Custodial Services, *Full House: The Growth of the Inmate Population in NSW* (Report, April 2015) 5.

increase in resourcing. She conceded that a number of timeframes for the provision of mental health services to prisoners were not met.²⁴⁰

The preponderance of evidence in the Russell inquest suggests that at Cessnock alone, at least as at June 2018, there were inadequate resources for people who were not immediately at risk. Instructions received from our clients in custody since that time suggest that those inadequacies persist.

Legal services for prisoners

The overall growth of the prison population has ensured a steady flow of inquiries and requests for legal help across our core areas of work, including criminal, family and civil law. While health issues cut across all these areas, they can easily go unaddressed due to a perception that they are less urgent or important than issues of bail or sentencing, or that there is simply no remedy for lack of access to health care.

We would welcome any additional support or funding which might enable our staff to assist more prisoners with health complaints. The growing prison population not only makes it likely that more prisoners will seek our services, but also creates tensions in the custodial environment which place prisoners at greater risk of experiencing health problems. We note, for example, that NSW has the highest rate of prisoner on prisoner assaults in the country.²⁴¹ Many of the most serious complaints which we have received about delay, inadequate pain management or lack of access to allied health care relate to incidents involving an assault in custody.

²⁴⁰ Transcript of Proceedings, *Inquest into the Death of Glen Russell* (NSW Coroners Court, Magistrate Stone, Deputy State Coroner, 26 June 2018) 37.

²⁴¹ Figures are reported for 2016–2017: Australian Government Productivity Commission, *Report on Government Services* (Report, 2018) Table 8.2.