Submission No 120

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

Organisation: Aboriginal Legal Service (NSW/ACT)

Date Received: 17 September 2020

ALS

Aboriginal Legal Service (NSW/ACT) Limited

ABN: 93 118 431 066

15th September 2020

Mr Adam Searle MLC
Chair
Select Committee into the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody
Parliament House, Macquarie Street
Sydney NSW 2000
By email: First.Nations@parliament.nsw.gov.au

Dear Chair,

I write to you on behalf of the Aboriginal Legal Service (NSW/ACT) Limited ('ALS') and thank you for the opportunity to provide a submission to the Senate Commitee's Inquiry into the high level of First Nations people in custody and oversight and review of deaths in custody.

The ALS is a proud Aboriginal Community Controlled Organisation and the peak legal services provider to Aboriginal and Torres Strait Islander men, women and children in NSW and the ACT. The ALS currently undertakes legal work in criminal law, children's care and protection law and family law. We have 24 offices across NSW and the ACT, and we assist Aboriginal and Torres Strait Islander people through representation in court, advice and information, as well as providing broader support programs and undertaking policy and law reform work.

We provide this submission based on our direct experience representing Aboriginal and Torres Strait Islander people who have too often been forced into the quicksand of the criminal legal system, as well as representation of many of the families that have had loved ones die in custody.

The ALS would welcome the opportunity to discuss this submission further. Please contact Shannon Longhurst (Policy and Communications Manager) at to arrange a meeting.

Karly Warner
Chief Executive Officer
Aboriginal Legal Service (NSW/ACT) Limited

Please reply to Head Office

ALS

Aboriginal Legal Service (NSW/ACT) Limited

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

15 September 2020

About Us

The Aboriginal Legal Service (NSW/ACT) Limited ('ALS') welcomes the opportunity to provide a submission to the Inquiry into high rates of First Nations people in custody and oversight and review of deaths in custody.

The ALS is a proud Aboriginal Community Controlled Organisation and the peak legal services provider to Aboriginal and Torres Strait Islander men, women and children in NSW and the ACT. The ALS currently undertakes legal work in criminal law, children's care and protection law and family law. We have 24 offices across NSW and the ACT, and we assist Aboriginal and Torres Strait Islander people through representation in court, advice and information, as well as providing broader support programs and undertaking policy and law reform work.

We provide this submission based on our direct experience representing Aboriginal and Torres Strait Islander people who have too often been forced into the quicksand of the criminal legal system, as well as representation of many of the families that have had loved ones die in custody.

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Principles for reform:

- *Aboriginal and Torres Strait Islander communities, their organisations and representative bodies must be directly involved in decision-making about matters that affect Aboriginal and Torres Strait Islander peoples. This includes ensuring that the voices of Aboriginal and Torres Strait Islander people with lived experience of the criminal legal system, and families who have had loved ones die in custody, are centered in all policy responses and law reform initiatives;*
- *Aboriginal and Torres Strait Islander community controlled organisations are the preferred provider of culturally safe services and supports that understand and are, therefore, responsive to the particular needs and requirements of Aboriginal and Torres Strait Islander peoples;*
- *Aboriginal and Torres Strait Islander community controlled organisations, including legal services, must receive adequate levels of funding to have the capacity to respond to community needs and demand;*
- *More flexible funding models should be established to enable Aboriginal and Torres Strait Islander community controlled organisations to deliver holistic wrap around services that are responsive to community needs and to ensure the collaboration of unique expertise across sectors; and*
- *Governments must shift away from punitive and law enforcement focused approaches, and towards approaches that prioritise prevention, early intervention and diversion from the criminal legal system.*

Recommendations:

1. *The NSW Government invest in the Walama court proposal.*
2. *The NSW Government support the development of place-based justice reinvestment and community-led approaches.*
3. *The NSW Government invest in decarceration strategies.*
4. *The NSW Government voluntarily adopt ambitious state-based Justice targets, as part of the development of the NSW Closing the Gap jurisdictional plan, to end the over-imprisonment of Aboriginal people within 10 years.*
5. *The NSW Government raise the minimum age of criminal responsibility to at least 14 years of age, without delay and without exception.*
6. *NSW Police immediately discontinue applying the STMP to all children and young people under the age of 18.*

7. *NSW Police remove targets/quotas for 'proactive' policing strategies, which disproportionately impact on Aboriginal people, and other people of colour and culturally diverse groups.*

8. *The NSW Government abolish the offence of offensive language, by immediately repealing section 4(A) of the Summary Offences Act 1998 (NSW).*

9. *The NSW Government increase resourcing for specialist drug and alcohol rehabilitation and treatment services across NSW, with a focus on expanding access to services in regional and rural areas.*

10. *The NSW Government undertake research to develop a model for the decriminalisation of the use and possession for personal use of prohibited drugs.*

11. *The NSW Government establish a regional Drug Court.*

12. *The NSW Government legislative to mandate arrest is a last resort for Aboriginal and Torres Strait Islander people.*

13. *The NSW Government implement the 125 recommendations of the Family is Culture Report, prioritising legislative reform.*

14. *The NSW Government amend the Coroners Government amend the Coroners Act 2009 (NSW) to reflect all the relevant RCIADIC recommendations. This would include:*

    a. *Copies of the findings and recommendations made by the Coroner in relation to a death in custody must be provided to all parties who appeared at the inquest, to the Attorney-General, to the Minister with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.*

    b. *Within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner must provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person, or reasons for a decision not to implement a recommendation.*

    c. *The NSW State Coroner should be empowered to call for such further explanations or information as s/he considers necessary, including reports as to further action taken in relation to the recommendations.*

    d. *Section 37(1) of the Coroners Act 2009 be amended so that the State Coroner is to make a written report to the Minister containing not only a summary of the details of the deaths or suspected deaths, but also a summary of the recommendations made by Coroners and the responses to those recommendations provided by the relevant agency or department.*

15. *The NSW Government listen to the families whose loved ones have died in police or prison custody and meaningfully and respectfully involve them in all relevant policy and legal reforms. It is critical that families' voices are centred in all reforms and changes that aim to end Aboriginal deaths in custody.*
16. *The NSW Government resource and fund the ALS to provide wraparound support and advocacy to ensure that Aboriginal people receive culturally safe, timely, and fair legal assistance before, during, and after all coronial processes.*
17. *The Coroner be provided with discretion to hold a "Recognition Mention" whereby, following a significant investigation into a death and a decision that no inquest is required, such a mention is held where the Court receives a family statement, expresses the cause and manner of death and makes orders dispensing with the request.*
18. *The NSW Government consult with the ALS and the families of Aboriginal and Torres Strait Islander people who have had a loved one die in custody about adopting a process whereby the Coroner writes to, and meets with, the family of an Aboriginal and Torres Strait Islander person who has died in custody to seek their views on the adequacy of an agency's response to recommendations made to them.*
19. *The NSW Government legislate making it mandatory for a Coroner to notify the ALS of any recommendations relating to the death in custody of an Aboriginal and Torres Strait Islander person. Similarly, it should be mandatory for statutory bodies and agencies to provide copies of responses to recommendations to the ALS.*
20. *The State Coroner consider issuing a practice note containing guidance on issues including the notification of families as to coronial process, communications with lawyers, provision of briefs of evidence and the approach to legal objections by police officers.*
21. *The NSW Government expand the definition of a "death in custody" to include a death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention.*
22. *The NSW Government, in conjunction with the National Coroners Information System, consider the establishment and resourcing of a comprehensive, categorised and readily searchable online database of all recommendations by State and Territory coroners, as well as published responses from state and federal authorities, and individuals and communities who are affected by the recommendations.*
23. *The NSW Government monitor and publicly report against the implementation of the recommendations of the 1991 Royal Commission into Aboriginal Deaths in Custody.*
24. *The NSW Government review international best practice and consider reforms to existing police oversight and complaints handling mechanisms.*
25. *The NSW Government designate an independent, adequately resourced and culturally competent NPM.*

1 - Introduction

Almost 30 years ago, the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) highlighted the mass incarceration of Aboriginal and Torres Strait Islander people across Australia, noting that Aboriginal people were over-represented in police and prison custody in "grossly disproportionate numbers, compared with non-Aboriginal people...and it is this fact that provides the immediate explanation for the disturbing number of Aboriginal deaths in custody."[1] The Report went on to outline 339 recommendations for reform, which were underpinned by a holistic non-punitive approach - focused on self-determination, addressing systemic issues and ensuring imprisonment was a measure of last resort.[2]

Since the RCIADIC, there have been numerous other Royal Commissions, inquiries, reports and recommendations which have focused on ending the imprisonment of Aboriginal and Torres Strait Islander people and preventing Aboriginal deaths in custody.[3] For instance, the Australia Law Reform Commission's (ALRC) *Pathways to Justice* report, the Northern Territory's R*oyal Commission into the Detention and Protection of Children,* the House of Representatives *Doing Time - Time For Doing* report, and the I*nquiry into the adequacy of youth diversionary programs in NSW.* Yet these reports continue to sit on the shelf gathering dust, and many of the recommendations remain unimplemented both in NSW, and other states and territories.

Aboriginal people continue to offer up solutions, but they continue to be ignored. And organisations like ours continue to offer our expertise, but it means our services have to deliver more with fewer resources. Whilst governments fail to act, more Aboriginal people are dying in custody and more families are being forced to grieve and seek justice simultaneously. This is not a choice we need to keep making. We're not lacking in solutions to address these issues; but we have been lacking the political will.

The ALS notes that this Inquiry has emerged within the context of global protests around Black Lives Matter. We do not need to look to overseas to see the consequences of systemic discrimination - we see it right here. Aboriginal kids, mums and dads are too often unfairly targeted by police and are subjected to disparate treatment at every stage of the justice system. Aboriginal people are now imprisoned at a higher rate than at the time of the RCIADIC, and more than 440 Aboriginal people have died in custody since the Royal Commission's report was handed down.[4]

It is critical that the NSW Government acts without delay to rapidly and radically transform the

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[1] Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991), vol 1, [9.4.1]

[2] *Ibid.*, vol 1.

[3] See for example: the Australia Law Reform Commission's (ALRC) *Pathways to Justice* report (2018); the Northern Territory's *Royal Commission into the Detention and Protection of Children* (2017); the House of Representatives *Doing Time - Time For Doing* report (2011); the *Inquiry into the adequacy of youth diversionary programs in NSW* (2018); NSW *Special Commission of Inquiry into the Drug 'Ice'* (2020); Senate Inquiry into *Aboriginal and Torres Strait Islander experience of law enforcement and justice services* (2016); NSW Law Reform Commission report into *Sentencing of Aboriginal Offenders*, Report 96 (2000); *Family Is Culture Review Report: Independent review of Aboriginal children and young people in out of home care* (2019).

[4] Rawsthorne, S. (2020). "Indigenous people incarcerated more than ten times the rate of the general population ABS", *Sydney Morning Herald*, accessed via: https://www.smh.com.au/national/nsw/indigenous-people-incarcerated-at-more-than-10-times-the-rate-of-the-general-population-abs-20200604-p54zoa.html#:~:text=By%20Sally%20Rawsthorne&text=Indigenous%20people%20in%20NSW%20are,Australian%20Bureau%20of%20Statistics%20shows.

justice system – Aboriginal peoples' lives depend on it. We recognise the advocacy work and fight for justice that has been undertaken for generations - by Aboriginal people who have lived experience of the justice system and families who have had loved ones die in custody. It is vital that all law reform and policy responses centre their voices and experiences.

2 - Ending the mass imprisonment of Aboriginal People in NSW

Within NSW, Aboriginal people are currently imprisoned at a rate of more than 10 times the general population.[5] In the past 10 years the number of Aboriginal people charged by police in NSW has increased by more than 67 per cent.[6] For non-Aboriginal people the increase has been just 8 per cent.[7] This is despite a fall in crime rates across the State.

This data aligns with previous research by the Bureau of Crime Statistics and Research (BOCSAR), which found that Aboriginal people are over policed relative to non-Indigenous people, and that changes to the rates of incarceration of Aboriginal people in NSW are largely attributable to changes in polices and police practices rather than changes in crime rates.[8] The BOCSAR report found that over a 15-year period (2001 to 2015) the number of Aboriginal people in prison in NSW more than doubled, whilst during the same period the rate of Aboriginal people's involvement in various offence types decreased.[9]

This submission does not seek to replicate in full the recommendations of the numerous inquiries referenced above, aimed at ending the mass imprisonment of Aboriginal people in NSW. However, we wish to draw this Inquiry's attention to several critical areas which should be actioned in NSW as a matter of urgency.

In our view, it is critical that any justice system reform takes a holistic life-course view, and acknowledges the way that systemic racism, care criminalisation, discriminatory laws and targeted policing, force Aboriginal people into the quicksand of the criminal legal system. There is a need for a fundamental shift by government, away from a punitive and law enforcement focused approach, towards an approach that addresses systemic discrimination and prioritises prevention, early intervention and diversion from the criminal legal system.

Case Study – Jake*

Jake is 15 years old and he has been in and out of the justice system since he was 10, the age when he could be held criminally responsible.

Both of Jake's parents suffer from substance abuse issues and his father, the most stable person in his life, died recently. His housing is unstable with the family being in and out of accommodation. He suffers from a range of mental health issues, behavioural issues and addiction. He is on daily psychiatric medication. He engages in self-harm to the point of hospitalisation. He is currently in juvenile detention.

The minimum age of criminal responsibility has resulted in Jake, from the age of 10, being held in custody on remand for a total of 132 days for matters that were either dismissed or

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[5] Australian Bureau of Statistics (2020), cat. no. 4512.0 – Corrective Services March Quarter 2020 (viewed 18 August 2020), https://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4512.0Main+Features1March%20Quarter%202020?OpenDocument

[6] Cormack, L. (2020), "Criminal justice system 'inherently racist' towards Aboriginal people', *Sydney Morning Herald*, accessed online via: https://www.smh.com.au/national/nsw/criminal-justice-system-inherently-racist-towards-aboriginal-people-20200605-p5500l.html

[7] *Ibid.*

[8] Weatherburn, D. & Ramsey, S. (2016). What's causing the growth in Indigenous Imprisonment in NSW? (Bureau Brief No. 118). Sydney: NSW Bureau of Crime Statistics and Research, accessed via: https://www.bocsar.nsw.gov.au/Pages/bocsar_publication/Pub_Summary/BB/bb118-Whats-causing-the-growth-in-Indigenous-Imprisonment-in-NSW.aspx

[9] *Ibid.*

withdrawn at hearing. With each charge, Jake was subjected to various, continuous and ultimately unnecessary and harmful interactions with the criminal justice system.

Jake has been arrested for a range of crimes ranging in seriousness, for example, climbing on a building at school to on another occasion, break and enter. Rather than providing holistic support to address the underlying causes of this behavior, the current low age of criminal responsibility creates a situation where all of these behaviours are characterised as crimes to be punished.

Before Jake turned 10, he was already being targeted by policy and monitored on a Suspect Target Management Plan. On the date of Jake's 10th birthday, he was visited by Police who interviewed him, openly recording that they were doing so, in order to create evidence to rebut the presumption of Doli Incapax on the expectation that Jake would offend.

By forcing Jake into the quicksand of the criminal justice system, the government has compounded trauma, rather than supporting him. By creating a legal response – rather than a therapeutic or rehabilitative response – Jake has been forced on a trajectory that has led directly to more trauma, more contact with the criminal justice system and to escalating criminal behaviour.

Whilst there were some limited intervention responses and diversionary approaches in Jake's life, these approaches have rarely had time to work because they are always enacted within the wider context of a harmful criminal justice system, and disrupted by overriding legal responses rather than therapeutic and social support.

2.1 Principles for Reform

As has been noted previously by the National Aboriginal and Torres Strait Islander Legal Services (NATSILS), any reform process aimed at achieving improved justice outcomes for Aboriginal and Torres Strait Islander men, women and children, must be underpinned by the following key principles:[10]

- *Aboriginal and Torres Strait Islander communities, their organisations and representative bodies must be directly involved in decision-making about matters that affect Aboriginal and Torres Strait Islander peoples. This includes ensuring that the voices of Aboriginal and Torres Strait Islander people with lived experience of the criminal legal system, and families who have had loved ones die in custody, are centered in all policy responses and law reform initiatives;*
- *Aboriginal and Torres Strait Islander community controlled organisations are the preferred provider of culturally safe services and supports that understand and are, therefore, responsive to the particular needs and requirements of Aboriginal and Torres Strait Islander peoples;*
- *Aboriginal and Torres Strait Islander community controlled organisations, including legal services, must receive adequate levels of funding to have the capacity to respond to community needs and demand;*

[10] See National Aboriginal and Torres Strait Islander Legal Services, 'Submission to the Australian Law Reform Commission's Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander peoples' (September 2017), http://www.natsils.org.au/portals/natsils/NATSILS%20-%20ALRC%20Submission_%20at%2022082017_new.pdf?ver=2017-09-22-152515-350; National Aboriginal and Torres Strait Islander Legal Services and National Family Violence Prevention Legal Services, 'Redfern Statement Joint Communique – Family Violence and Justice Workshop' (27 June 2017).

- *More flexible funding models should be established to enable Aboriginal and Torres Strait Islander community controlled organisations to deliver holistic wrap around services that are responsive to community needs and to ensure the collaboration of unique expertise across sectors; and*
- *Governments must shift away from punitive and law enforcement focused approaches, and towards approaches that prioritise prevention, early intervention and diversion from the criminal legal system.*

2.2 Community resourcing and a whole-of-government approach

2.2.1 Supporting and resourcing community-led approaches

Aboriginal people and organisations are best placed to design and deliver services and programs for their communities and have been developing and putting forward solutions for generations. What's needed now is a shift by governments at all levels towards appropriately supporting, resourcing and investing in community-led initiatives.

There is a particular need for a greater focus on funding holistic community-led programs which help to identify and address the range of complex factors that force Aboriginal people into the quicksand of the criminal legal system at vastly disproportionate rates. For instance, we know that culture is an important protective factor for kids. When you take kids away from their families and communities, placing them into juvenile detention, you remove that protection too. With strong Aboriginal community-led programs in place, we can provide supports early on and prevent kids from being forced into the criminal legal system at a young age.

One example of community-led initiatives in NSW is the work of the Maranguka Justice Reinvestment Initiative in Bourke.[11] Justice Reinvestment involves a place-based, data-driven and community-led approach, with a focus on redirecting resources away from the justice system towards investment in communities.[12] For justice reinvestment to succeed, Aboriginal people must be central in the design and implementation – and this is reflected in the leadership of the Bourke Tribal Council and Bourke Aboriginal community who established Maranguka Justice Reinvestment with the support of Just Reinvest NSW.

A 2018 KPMG impact assessment of the Maranguka Justice Reinvestment Initiative recorded improvements in:[13]

- *Family strength: 23% reduction in police recorded incidence of domestic violence and comparable drops in rates of re-offending*
- *Youth development: 31% increase in year 12 student retention rates and a 38% reduction in charges across the top five juvenile offence categories*
- *Adult empowerment: 14% reduction in bail breaches and a 42% reduction in days spent in custody.*

[11] For more information see: https://www.justreinvest.org.au/justice-reinvestment-in-bourke/

[12] For more information see: https://www.justreinvest.org.au/policylawreform/

[13] KPMG (2018), *Maranguka Justice Reinvestment Project: Impact Assessment*, p.6, accessed online via: https://www.justreinvest.org.au/landmark-report-demonstrates-economic-impact-of-3-1-million-in-2017-and-estimates-additional-impact-of-7-million-over-five-years-through-justice-reinvestment-in-bourke/

The ALS encourages the NSW Government to continue to support and resource community-led approaches.

Culturally-specific courts also play a critical role in providing holistic and wraparound support for our communities. Courts that involve Elders, Aboriginal community-controlled organisations and culturally-appropriate members, provide the most effective support for our communities. As a result, we reiterate our calls for the NSW Government to act without delay to establish a Walama Court in NSW.

The Walama Court is aimed at diverting Aboriginal people away from the criminal justice process and reducing police contact by involving Aboriginal elders in the decision-making process within the District Court of NSW.[14] 'Walama' is a word from the Eora language meaning 'come back' or return – and in the context of the Walama Court is about people coming back to identity, country and community. The Walama Court proposal is unique because, "unlike the Children's Koori Court and other programs designed to reduce the number of Aboriginal people in custody, it would be enshrined in legislation, with the guarantee of redistributing resources into…Aboriginal communities, not the police."[15]

It is also critical that Australian governments work in partnership with Aboriginal people to urgently implement broader decarceration strategies, including by addressing the issue of 'postcode justice' and criminalisation of poverty. This involves ensuring that communities have access to income support, appropriate healthcare, and safe and affordable housing, as well as increased access to culturally safe diversion, support, rehabilitation and therapeutic programs.

2.2.2 Developing a whole-of-government approach

The ALS welcomed the release of the new Closing the Gap Agreement last month. We commend the inclusion of strong 'care targets' aimed at reducing the number of Aboriginal kids in out-of-home-care, however we are disappointed that the Commonwealth, State and Territory Governments have chosen not to increase the ambition of the national justice targets. Whilst it is historic for national justice targets to be included in the Closing the Gap agreement, the ALS and the broader Aboriginal and Torres Strait Islander Legal Services (ATSILS) network, have continually emphasised that justice targets must be ambitious and drive real change to end the over-incarceration of our communities.[16] For this reason, we have consistently called for the adoption of national justice targets that would see a reduction of at least 23% (adults) and 28% (youth) year-on-year in order to reach parity on incarceration rates with mainstream levels within the 10 year life of the agreement.[17]

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[14] Reid, T. (2020). "Premier needs to act on model to save black lives", *Sydney Morning Herald*, accessed via: https://www.smh.com.au/national/premier-needs-to-act-on-model-to-save-black-lives-20200609-p550wq.html

[15] *Ibid.*

[16] See for example: NATSILS (2020), *NATSILS Media Release: Once in a generation opportunity to embed strong national justice targets in the Closing the Gap Agreemnet*, accessed via: http://natsils.org.au/portals/natsils/030720%20Media%20Release%20Closing%20the%20Gap%20Targets0e34.pdf?ver=2020-07-03-194445-193; NATSILS (2020), *NATSILS Media Release: "We must see change in our lifetimes": Historic Closing the Gap Agreement is missed opportunity for ambitious national justice targets"*, accessed via: http://natsils.org.au/portals/natsils/Media%20Releases/300720%20Media%20Release%20Closing%20the%20Gap%20Agreementf12f.pdf?ver=2020-07-30-100903-650

[17] *Ibid.*

In the coming months, each State and Territory Government will be developing jurisdictional plans to progress action towards the national Closing the Gap agreement and targets. We believe this is an important opportunity to drive a whole-of-government approach to improving justice outcomes for Aboriginal men, women and children in NSW. An important first step would be for the NSW Government to show leadership by voluntarily committing to stronger and more ambitious state-based justice targets

Recommendations:

- *The NSW Government invest in the Walama court proposal.*
- *The NSW Government support the development of place-based justice reinvestment and community-led approaches.*
- *The NSW Government invest in decarceration strategies.*
- *The NSW Government voluntarily adopt ambitious state-based Justice targets, as part of the development of the NSW Closing the Gap jurisdictional plan, to end the over-imprisonment of Aboriginal people within 10 years.*

2.3 Law Reform Priorities

2.3.1 Raise the Age

The ALS strongly supports raising the minimum age of legal responsibility to at least 14, due to the overwhelming medical, social and legal evidence of the deleterious impact that contact with the criminal legal system has on children and young people.

Currently there are close to 600 children under the age of 14 years who are in youth prisons across Australia each year. Children who are taken to a barbed wire facility, strip searched on entry, given limited access to peers, teachers and supports, and separated from family and community.[18] And it is Aboriginal and Torres Strait Islander children who are most impacted by this injustice. In 2019, 70% of the kids aged 10-13 years in youth prisons in Australia were Aboriginal and Torres Strait Islander.[19]

We should be supporting kids to thrive in community and culture, not separating them from their families by locking them up in harmful prisons. Rather than harming, stigmatising and marginalising these 600 children in the criminal legal system, we should change the law to give kids every possible opportunity to succeed.

There is also a clear policy imperative to raise the minimum age of legal responsibility to at least 14 years. We know that detention has adverse effects on an individual and only serves to compound existing issues for vulnerable children and young people.[20] The families and

[18] 2017, Australian Bureau of Statistics (ABS), Recorded Crime - Offenders, 2016-17, Youth Offenders, Supplementary Data Cube, Table 21, Cat No 4519.0, ABS, Canberra and 2018, Australian Institute of Health and Welfare (AIHW), Youth Justice in Australia 2016-17, 'Table S78b: Young people in detention during the year by age, states and territories, 2016-17', available at https://www.aihw.gov.au/reports/youth-justice/youth-justice-in-australia-2016-17/data

[19] See Jesuit Social Services, Australian Government Must Stop Locking Up 10 Year Old Children, https://jss.org.au/australiangovernments-must-stop-locking-up-10-year-old-children/

[20] Novack, M. (2019). UN Global Study on Children Deprived of Liberty, p. 8, https://undocs.org/A/74/136

communities of children and young people in custody bear additional social and economic costs. Research tells us that children who encounter the criminal legal system at an early age tend to go on to have further and more severe interactions with police and courts than young people who have similar experiences at a later age.[21]

Recommendation:

- *The NSW Government raise the minimum age of criminal responsibility to at least 14 years of age, without delay and without exception.*

2.3.2 End the targeted policing of Aboriginal communities

The ALS is concerned that within NSW there is an increasing reliance on policing strategies, which disproportionately target Aboriginal people, people of colour, and lower socio-economic communities, and have a particularly detrimental impact on young people. In our experience, 'proactive' policing strategies - such as move-on orders, routine personal searches, strip searches, and excessive bail and curfew enforcement checks – often draw Aboriginal people into unnecessary, and ultimately harmful and detrimental, interactions with police.

One particularly stark example in NSW is that of the Suspect Target Management Plan (STMP). The STMP is a deeply invasive policy which has significant adverse impact on Aboriginal young people and their families. Data from NSW Police demonstrates that the STMP disproportionately targets Aboriginal people and has been used against children as young as ten, as well as children who have no previous history of contact with the criminal legal system.

Case Study – Jeremy*

Jeremy is a 15-year-old Aboriginal boy who lives in a regional town.

Jeremy described getting constantly stopped by police almost every day when walking to school or walking down the street.

It was causing so much distress that his mother moved him to another town.

Jeremy wanted to return home to his mum and siblings but felt that he couldn't because of the harassment.

The ALS made inquiries with the local Sergeant who confirmed that the young person was on an STMP, despite having no criminal record. They said "his father needed to be watched and so he did as well".

About 6 months later and after much agitation from the ALS and the young person's family we were advised by the Sergeant that the young was no longer on the STMP.

[21] Chris Cunneen, 'Arguments for Raising the Minimum Age of Criminal Responsibility' (Research Report, Comparative Youth Penalty Project, University of New South Wales, 2017) citing S Chen et al, 'The Transition from Juvenile to Adult Criminal Careers' (2005) 86 Crime and Justice Bulletin 1; Jason Payne 'Recidivism in Australia: Findings and Future Research' (Research and Public Policy Series No 80, Australian Institute of Criminology, 2007); L McAra and S McVie, 'Youth Justice? The Impact of System Contact on Patterns of Desistance from Offending' (2007) 4(3) European Journal of Criminology 315.

This heavy-handed approach to policing, only serves to corrode the relationship between young people and police. It also undermines efforts to support kids through therapeutic responses, diversion and rehabilitation, and often targets young people with mental and cognitive disabilities. As a result, the ALS recommends that the STMP be immediately repealed for all children and young people under the age of 18.

In addition, earlier this year it was revealed that NSW Police are required to meet targets and quotas for a range of police powers, including personal and strip searches.[22] Official data highlights that in last few years the number of strip searches conducted by NSW Police has increased by 47%.[23] And Aboriginal and Torres Strait Islander people are disproportionately represented in these figures, accounting for 10% of all recorded strip searches in the field and 22% of all recorded strip searches in custody.[24] Policing practices should be focused on community safety and wellbeing. In our view, any system of 'quotas' or 'targets' creates a concerning incentive for police to excessively conduct searches and will ultimately erode the relationship between the public and law enforcement.

Recommendations:

- *NSW Police immediately discontinue applying the STMP to all children and young people under the age of 18.*
- *NSW Police remove targets/quotas for 'proactive' policing strategies, which disproportionately impact on Aboriginal people, and other people of colour and culturally diverse groups.*

2.3.3 Abolish offensive language provisions

The offence of using offensive language under s 4A of the *Summary Offences Act 1988* (NSW), and its discretionary application by police, has consistently been recognised as having a disproportionate impact upon Aboriginal and Torres Strait Islander people and communities. In 1991, the RCIADIC recommended that "the use of offensive language in circumstances of interventions initiated by police should not normally be occasion for arrest or charge", with Commissioner Wootten noting;

> *In this day and age many words that were once considered bad language have become commonplace and are in general use amongst police no less than amongst other people. Maintaining the pretence that they are sensitive persons offended by such language... does nothing for respect for the police...Charges about language just become part of an oppressive mechanism of control of Aboriginal [people]. Too often the attempt to arrest or charge an Aboriginal [person] for offensive language sets in train a sequence of*

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[22] ABC News (2020). *NSW Police Set Quota for 241,000 personal searches and strip searches in 12 months, documents reveals* (13 February 2020). Accessed online via: https://www.abc.net.au/news/2020-02-13/nsw-police-strip-search-quota-revealed-in-foi-documents/11960682

[23] Grewcock, M. & Sentas, V. (2019) "Unlawful strip searches are on the rise in NSW and police aren't being held accountable"*UNSW Newsroom*. Accessed via: https://newsroom.unsw.edu.au/news/business-law/unlawful-strip-searches-are-rise-nsw-and-police-aren%E2%80%99t-being-held-accountable#:~:text=Earlier%20this%20year%2C%20questions%20on,nothing%2064%25%20of%20the%20time

[24] Grewcock, M. & Sentas, V. (2019) *Rethinking Strip Searches by NSW Police* (Report, August 2019). Accessed via: https://rlc.org.au/sites/default/files/attachments/Rethinking-strip-searches-by-NSW-Police-web_0.pdf

> *offences by that person and others---resisting arrest, assaulting police, hindering police and so on, none of which would have occurred if police were not so easily 'offended.'*[25]

In 2009, the NSW Ombudsman published a report indicating that the number of Aboriginal people proceeded against for offensive language offences from 2002 to 2008 was much higher than would be expected for a group that makes up just 2% of the population in NSW. Indeed, in 2007, Aboriginal people were "the subject of 20% of all proceedings relating to offensive language incidents."[26] These findings were supported by the NSW Law Reform Commission in 2012, which also recognised that the offence of offensive language has a disproportionate impact upon Aboriginal people.[27] More recently, in 2017, it was reported that 17% of criminal infringement notices for offensive language were issued to Aboriginal and Torres Strait Islander people.[28]

In describing the impact of offensive language offences in rural areas with large Aboriginal populations, BOCSAR found that:

> *In circumstances where police are called to an incident, charges of offensive behaviour and/or offensive language appear most likely to ensue when police find themselves unable to calm a situation or when they themselves become the subject of abuse.*[29]

The ALRC also found in its *Pathways to Justice* Report that most offensive language criminal infringement notices (CINs) are issued for language directed at police and, if tested in court, may not meet the legal definition of 'offensive'.[30] Indeed, a recent study of offensive language offences in the Kings Cross Local Area Command (LAC), Sydney City LAC and Surry Hills LAC found that in 77 of 82 cases in the dataset (94%), the language assessed (by the police) as constituting criminal offensive language was directed at police officers.[31] In the majority of cases they were the sole targets of the offensive language. Accordingly, through the mechanism of criminal infringement notices, police are the 'victim, enforcer and judge' of the law, which provides strong foundation for conflict and misuse.[32]

In our view, repealing archaic provisions relating to offensive language offences would be a step towards ultimately reducing the number of Aboriginal and Torres Strait Islander people in prison.

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[25] Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) Vol 3 [21.1.7]; Commissioner JH Wooten, R*eport of the Inquiry into the Death of David John Gundy* (1991).

[26] New South Wales Ombudsman. (2009). Review of the impact of criminal infringement notices on Aboriginal communities. Sydney: NSW Ombudsman, 58–59.

[27] New South Wales Law Reform Commission. (2012). Penalty notice (NSWLRC Report No. 132). Sydney, 301.

[28] Elyse Methven, 'Dirty Talk: A Critical Discourse Analysis of Offensive Language Crimes' (PhD Thesis, Faculty of Law, University of Technology Sydney, 2017) 5. See also Australian Law Reform Commission. (2017). Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples: Final Report (ALRC Report No. 133) 424.

[29] Jochelson, 'Aborigines and Public Order Legislation in New South Wales' (1997), Crime and Justice Bulletin, NSW Bureau of Crime Statistics and Research 34, 1, 15.

[30] Australian Law Reform Commission. (2017). Pathways to Justice – Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples: Final Report (ALRC Report No. 133) 424.

[31] Hannah Trollip, Luke McNamara & Helen Gibbon (2019) The factors associated with the policing of offensive language: a qualitative study of three Sydney Local Area Commands, Current Issues in Criminal Justice, 31:4, 493-512, 506.

[32] *Ibid.*

Recommendation:

- *The NSW Government abolish the offence of offensive language, by immediately repealing section 4(A) of the Summary Offences Act 1998 (NSW).*

2.3.4 Repeal low-level drug offences

The ALS considers that drug addiction should be treated as the health issue that it is rather than as a criminal justice issue. We know that without appropriate and timely rehabilitation and adequate diversionary programs, Aboriginal people proactively seeking treatment are forced into the criminal legal system and taken away from the love and support of their families and communities.

The criminalisation of low-level drug offences has a harsh and highly disproportionate impact on Aboriginal and Torres Strait Islander people. Recent data from the Bureau of Crime Statistics and Research shows that between 2013 and 2017, NSW police disproportionately used the criminal justice system to prosecute Aboriginal people for the possession of small amounts of cannabis, despite the existence of a cannabis cautioning system which was introduced in 2000 to provide police with a discretion to divert people away from the court system.[33] The data showed that 82.55% of all Aboriginal people found with a non-indictable quantity of cannabis were pursued through the courts, compared with only 52.29% for non-Aboriginal people.[34] Further, in the five years to 2017, police issued cautions to 11.41% of Aboriginal people found with small amounts of cannabis, compared to 40.03% of non-Aboriginal people.[35] These figures demonstrate how criminalisation for the possession of cannabis and other drugs forces Aboriginal men, women and children into the quicksand of the criminal legal system at vastly disproportionate rates.

Last year the Special Commission of Inquiry into the Drug 'Ice' ('Ice Commission') released their final report, which noted that:

> *Evidence before the Inquiry confirms that those at the highest levels of global drug policy unanimously support the removal of criminal sanctions for simple possession. The World Health Organization, the United Nations System Chief Executives Board for Coordination and the Global Commission on Drug Policy all support decriminalisation of low-level personal drug use offences. At least 26 countries, including Switzerland, Denmark, Brazil, France, Germany, Portugal and 11 states in the United States have decriminalised simple possession of drugs in some form.*[36]

The Ice Commission went on to highlight that there is a "very substantial amount of evidence and numerous submissions in favour of a broader model of decriminalisation for simple

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[33] McGowan, M. & Knaus, C. (2020). "NSW police pursue 80% of Indigenous people caught with cannabis through courts", *Guardian Australia*, accessed via: https://www.theguardian.com/australia-news/2020/jun/10/nsw-police-pursue-80-of-indigenous-people-caught-with-cannabis-through-courts

[34] Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report* (1991) Vol 3 [21.1.7]; Commissioner JH Wooten, R*eport of the Inquiry into the Death of David John Gundy* (1991).

[35] New South Wales Ombudsman. (2009). Review of the impact of criminal infringement notices on Aboriginal communities. Sydney: NSW Ombudsman, 58–59.

[36] Report of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, xxxi [43].

possession in NSW", including from the NSW Bar Association, Legal Aid NSW and the NSW branch of the Royal Australian & New Zealand College of Psychiatrists, among others.

As a result, the Ice Commission recommended:

> *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, which includes the following elements:*
>
> - *removal of the criminal offences of use and possession for personal use of prohibited drugs*
> - *at the point of detection, prohibited drugs to be confiscated and a referral made to an appropriately tailored voluntary health/social and/or education intervention*
> - *no limit on the number of referrals a person may receive*
> - *no civil sanctions for non-compliance*.[37]

The ALS notes our strong endorsement of this approach.

Recommendations:

- *The NSW Government increase resourcing for specialist drug and alcohol rehabilitation and treatment services across NSW, with a focus on expanding access to services in regional and rural areas.*
- *The NSW Government undertake research to develop a model for the decriminalisation of the use and possession for personal use of prohibited drugs.*
- *The NSW Government establish a regional Drug Court.*

2.3.5 Implement legislative provisions to enable consideration of Aboriginality in bail and sentencing

The ALS reiterates our position that bail and sentencing legislation in NSW be amended to allow Aboriginality to be considered in recognition of the unique position of Aboriginal and Torres Strait Islander people as a result of colonisation and dispossession.

Bail

As noted in our recent submission to the statutory review of the NSW Bail Act, the ALS recommends that the NSW Bail Act be amended to include a standalone provision for Aboriginality, which makes the consideration of culture mandatory and ensures consideration throughout the entire bail determination process.[38]

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[37] Report of the Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, xxxi [43].

[38] ALS (2020), Submission to the Administrative review of the Bail Act 2013 (NSW), accessed via: https://www.alsnswact.org.au/submission_to_the_administrative_review_of_the_bail_act_2013_nsw

The current bail regime in NSW unfairly impacts on Aboriginal and Torres Strait Islander people in several ways, including for example:

- *Aboriginal and Torres Strait Islander people are disproportionately represented in the NSW remand population, including children;*
- *Aboriginal and Torres Strait Islander people are forced into contact with the justice system, due to racially discriminatory and targeted policing, increasing the likelihood of imprisonment;*
- *Aboriginal and Torres Strait Islander people, including children, are less likely to be granted bail in NSW compared to non-Indigenous people. This is due to a range of factors including unconscious bail in the bail determination process, and housing and employment instability, as a result of socio-economic disadvantage caused by the ongoing impacts of colonisation and dispossession; and*
- *Courts often impose restrictive bail conditions which fail to consider specific cultural and community obligations.* [39]

When making a bail determination it is important that bail authorities give consideration to the particular impact of imprisonment on an Aboriginal or Torres Strait Islander person given the ongoing impacts of past and current discriminatory policies and practices, including colonisation, dispossession, and continuing experiences of targeted policing and racial discrimination. Currently in NSW, s18 of the Bail Act provides only insufficient reference to "any special vulnerability or needs...because of youth, being an Aboriginal or Torres Strait Islander or having a cognitive or mental health impairment."[40]

Furthermore, whereas s18 applies to the consideration of bail in the context of a 'bail decision'[41], enforcement action by police following an alleged breach of bail is guided by s77(3) and only requires consideration of the "personal attributes and circumstances of the person" to the extent known.[42] As a result, there is no specific reference or requirement to consider cultural background, cultural obligations or community ties particular to Aboriginal and Torres Strait Islander people. This is compounded by insufficient cultural awareness training for decision makers.

In our view, a mandatory legislative provision which requires a court, when making a bail determination in relation to an Aboriginal or Torres Strait Islander person, to consider all of these factors is necessary to ensure Aboriginal and Torres Strait Islander do not continue to be treated unfairly by those implementing bail regimes and imprisoned at a rapidly increasing rate.

A useful example to draw upon is Section 3A of the *Bail Act 1977* (Vic), which provides that: In making a determination under this Act in relation to an Aboriginal person, a bail decision maker must take into account (in addition to any other requirements of this Act) any issues that arise due to the person's Aboriginality, including— (a) the person's cultural background, including the

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[39] NATSILS (2017), Submission to the Australian Law Reform Commission's Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander peoples, accessed via: http://www.natsils.org.au/portals/natsils/NATSILS%20- %20ALRC%20Submission_%20at%2022082017_new.pdf?ver=2017-09-22-152515-350

[40] Bail Act 2013 (NSW), Section 18(1)(k)

[41] See Bail Act 2013 (NSW) section 8 for bail decisions that can be made under the Bail Act

[42] Bail Act 2013 (NSW), s77(3)(c)

person's ties to extended family or place; and (b) any other relevant cultural issue or obligation. The ALS recommends a similar provision be developed and implemented in New South Wales.

The benefit of a standalone provision is that it ensures consideration of Aboriginality occurs across the entire spectrum of decisions under the Act, but the court still retains a discretion as to the appropriate weight to give these issues in particular circumstances. This includes decisions on the issue of unacceptable risk under Part 3 Div 2 of the Act, as well as decisions on appropriate bail conditions, extending bail in an accused's absence, determining whether an accused has satisfied the show cause requirements in s16A, and determining whether an accused has reasonable cause for failing to attend court. However, in implementing such a provision, it is important to note that the "effect of this provision may be diminished through limited application and use by legal advocates, and deficiencies in culturally appropriate bail support services and diversion programs"[43] and training in this provision ought be mandatory.

For instance, the Victorian Aboriginal Legal Service (VALS) has previously commented that the s3A provision in the Bail Act 1977 (Vic) has to date, not had the intended impact of reducing the number of Aboriginal and Torres Strait Islander people being held on remand in Victoria. This is due for a range of shortcomings, including poor interpretation by sitting magistrates, a general tightening of bail law and a range of broader social and legal issues such as lack of transitional housing.[44]

Hence, is important that legislative amendment is supported by a broader bail reform package - including adequate provision of holistic support services and training for bail authorities, lawyers and the judiciary in the appropriate and consistent interpretation of the standalone provision.

Sentencing

The ALS also supports legislative reform in NSW that requires the court to consider the unique systemic and background factors affecting Aboriginal and Torres Strait Islander peoples when sentencing Aboriginal and Torres Strait Islander people.

Whilst presentencing reports are commonly utilised in Australia, Aboriginal and Torres Strait Islander identity and cultural background factors are not the express focus of the authors of these reports.[45] In Canada, the use of what are known as *Gladue* reports allows the specific background and broader circumstances of a person's Aboriginal community to be considered.[46]

In addition to changes to pre-sentence reporting, ALS supports the incorporation of *Gladue* style reporting in NSW. *Gladue* style reports would increase the information available to a

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[43] Australian Law Reform Commission, Pathways to Justice - Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples, ALRC Report, p.150

[44] Victorian Aboriginal Legal Service (2017), Submission to the Australian Law Reform Commission's Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander people, https://www.alrc.gov.au/wpcontent/uploads/2019/08/39._victorian_aboriginal_legal_service_vals.pdf

[45] See National Aboriginal and Torres Strait Islander Legal Services, 'Submission to the Australian Law Reform Commission's Inquiry into the Incarceration Rates of Aboriginal and Torres Strait Islander peoples' (September 2017), http://www.natsils.org.au/portals/natsils/NATSILS%20-%20ALRC%20Submission_%20at%2022082017_new.pdf?ver=2017-09-22-152515-350;

[46] See Canadian Supreme Court in R v Gladue [1999] 1 SCR 688.

sentencing court on the background of an individual and their community, and of available community-based rehabilitation options. This would increase the focus of the sentencing process on addressing the needs of the individual and the community, and reduce existing over-reliance on assessments of risk.

The ALS has established the *Bugmy Evidence Project* to develop reports on communities with significant populations of Aboriginal people in NSW. These reports will provide narrative and statistical information on these communities. The aim of the project is to provide evidence of disadvantage and discrimination at a community level, where it exists or has existed, to support an individual's experience in that community. It is intended that the library will be freely available for the use of the legal profession and the judiciary. The ALS recommends that community reports prepared through the *Bugmy Evidence Project* be used by the court as part of any *Gladue* style reporting.

In addition, in order for an equivalent of *Gladue* style reporting to be successfully influential over sentencing practices in Australia, such reports must be underpinned by legislation that directs the courts to consider Aboriginal and Torres Strait Islander identity and the impacts of colonisation as sentencing factors, and also to consider each and every alternative to prison for Aboriginal and Torres Strait Islander peoples as per section 718.2(e) of the Canadian Criminal Code. ALS submits that there should be a sentencing principle in s. 3A of the *Crimes (Sentencing Procedure) Act 1999* (NSW) which acknowledges the unique systemic and background factors affecting Aboriginal and Torres Strait Islander peoples. This sentencing principle should recognise the following as unique systemic and background factors affecting Aboriginal and Torres Strait Islander peoples:

- history of dispossession of land
- history of paternalistic attitudes and policies imposed by government; and
- removal of children

There should also be a sentencing factor in the *Crimes (Sentencing Procedure) Act 1999* (NSW) which acknowledges the principles set out in *Bugmy.*[47] Further, there should be a new provision in the *Crimes (Sentencing Procedure) Act 1999* (NSW) directed towards encouraging diversion, which would require the court to make inquiries in relation to the availability of intervention programs and allowing for time to engage in therapeutic programs

In addition, the development of *Gladue* style reports in NSW must also be supported by appropriate investment in diversionary programs, case workers, report writers and appropriate training for judiciary.

Recommendations:

- *The NSW Government develop standalone legislative provision around Aboriginality in the Bail Act (NSW). This provision should be modelled on s3A of the Bail Act 1977 (Vic) and be developed in collaboration with peak legal bodies.*
- *The NSW Government work in partnership with Aboriginal and Torres Strait Islander organisations to support the use of Gladue style Aboriginal Community Justice Reports*

[47] Bugmy v The Queen [2013] HCA 38

and consideration of a person's Aboriginality in sentencing.

2.3.6 Strengthen legislation for arrest to be a measure of last resort

It is well established under common law that arrest should only be used as a measure of last resort. However, in the ALS' experience, arrest is routinely used against Aboriginal people in the first instance, rather than police utilising a range of alternatives such as issuing warnings, cautions or Court Attendance Notices (CAN).

The RCIADIC noted that, "all police services should adopt and apply the principle of arrest being the sanction of last resort" (Rec. 87a) and "police administrators should train and instruct police officers accordingly and should closely check that this principle is carried out in practice"(87b).[48]

Within NSW, the Law Enforcement (Powers and Responsibilities) Act 2002 ('LEPRA') provides some additional guidance in this regard, however it is still open to police discretion and there is no legislated requirement that arrest should be a last resort for suspected offending or breach of bail. In our experience, the discretion of a police officer in determining what course of action to take is a major contributor to the high rate of incarceration of Aboriginal and Torres Strait Islander people.

As a result, the ALS recommends that the NSW Government introduce a legislative reform to ensure that police are mandated to ensure that arrest is a last resort when dealing with Aboriginal and Torres Strait Islander people.

Recommendation:

- *The NSW Government legislative to mandate arrest is a last resort for Aboriginal and Torres Strait Islander people.*

2.3.7 End the criminalisation of kids in care

As noted above, beyond criminal justice system reforms, it is also important to look at the broader systemic issues that are forcing Aboriginal families and kids into the criminal justice system at vastly disproportionate rates. Aboriginal children in NSW are currently 11 times more likely to be removed from their families than non-Aboriginal children.[49] And we know that children and young people who have been involved in the child protection system are too often forced into the quicksand of the youth justice system.

Of the 99 Aboriginal people whose deaths were examined by the RCIADIC, almost half had experienced childhood separation from their family through intervention by the State and other institutions.[50] And the recent *Royal Commission into the Protection and Detention of Children* in the Northern Territory, as well as the landmark *Family is Culture* Report which was tabled in NSW last year, have highlighted the issue of 'care criminalisation' and the strong link

[48] Commonwealth, 'Royal Commission into Aboriginal Deaths in Custody, National Report' (1991)

[49] AbSec (2020), "The Growing link between child protection and incarceration", accessed via: https://www.absec.org.au/growing-link-between-child-protection-and-incarceration.html

[50] Commonwealth, Royal Commission into Aboriginal Deaths in Custody, National Report (1991) vol 1, [2.2.9].

between involvement in the out-of-home-care system and future contact with the criminal legal system.[51]

It is the experience of the ALS that improving outcomes for families depends on the extent to which they are engaged in prevention and early intervention activities. Yet within NSW there continues to be a lack of investment in prevention and early intervention services and a lack of mandated early intervention and prevention engagement with families. As a result, we reiterate our previous calls for the NSW Government to urgently implement the 125 recommendations of the *Family Is Culture* Report. In our view, this should involve a priority focus on legislative reform, including - the introduction of legislative amendments to incorporate 'active efforts'; a requirement for the court to take into account the harm to Aboriginal children from being removed - when it is determining risk to a child; and mandatory use of early intervention legal tools that promote Aboriginal and Torres Strait Islander children remaining with families and within their communities.

Recommendations:

- *The NSW Government implement the 125 recommendations of the Family is Culture Report, prioritising legislative reform.*

[51] David, M. (2019).*Family Is Culture*: *Review Report,* accessed via: https://www.familyisculture.nsw.gov.au/__data/assets/pdf_file/0011/726329/Family-Is-Culture-Review-Report.pdf

3 - Improving oversight and accountability, to prevent deaths in custody

The RCIADIC made 35 recommendations relating to reform of investigations and coronial inquiries in the event of an Aboriginal or Torres Strait Islander person dying in custody.[52] Following the RCIADIC, all states and territories have made some reforms to the coronial system and other oversight bodies.[53] However, in the 30 years since the RCIADIC report was handed down, more than 440 Aboriginal people have died in custody across the nation - yet no police officer has ever been held criminally responsible. Within NSW there continues to exist a system of 'police investigating police' in respect of the most serious incidents of potential police misconduct, particularly deaths in custody. This fundamentally undermines public confidence in the credibility of these investigations, regardless of their outcome and the findings that have been made, because of the perceived conflict of interest that arises where police are required to report on their own potential misconduct or systemic wrongdoing.

International best practice in relation to oversight bodies has demonstrated that both the *fact* and *appearance* of independence are central to the maintenance of public trust in the justice system. Indeed, elements of an effective oversight system must include the power and capacity to conduct independent investigations into all deaths in custody and critical incidents, as well as sufficient resourcing, and an appropriate framework to allow for recommendations from oversight bodies to be properly implemented by government. This section will examine the current role and function of oversight bodies in NSW and outline a series of recommendations for reform.

As noted above, families who have had loved ones die in custody have been leading the way on advocacy and justice reform for decades. It is critical that the stories of Aboriginal people who have died in custody remain at the forefront of any inquiry concerning justice reform, and that the voices of the families whose loved ones have die in custody are central. As Apryl Day recently noted:

> *Governments across Australia must put an end to police brutality and racism and commit to independent investigations of deaths in custody. When someone dies at the hands of the police, the law should require a transparent, independent investigation, so that there can be truth and accountability.*
>
> *If the police remain untouchable, then Aboriginal people will continue to die in custody and the police will continue to inflict colonial violence on grieving families. For my family, there can't be justice without accountability.*[54]

A death in custody causes immense trauma and grief for families and communities. It also creates a serious risk that public confidence in the justice system will be eroded unless rigorous and independent processes are carried out - which not only identify the manner and cause of death, and ensure accountability for misconduct, but also ensure that steps are taken to stop any further tragic and preventable deaths occurring in the future.

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[52] ALRC, *Pathways to Justice* report, p. 465-466; Commonwealth, Royal Commission into Aboriginal Deaths in Custody, National Report (1991) Vol 2.

[53] Amnesty International and Clayton Utz, Review of the Implementation of RCIADIC - May 2015 (2015) 162–184.

[54] Day, A. (2020), "Without accountability there is no justice for my mother's death in Australian police custody", *The Guardian Australia*, accessed via: https://www.theguardian.com/commentisfree/2020/sep/03/without-accountability-there-is-no-justice-for-my-mothers-death-in-australian-police-custody

Nathan Reynolds

Nathan Reynolds was a 36-year-old Aboriginal man. Nathan was a father, a brother and a son. Nathan had a chronic asthma condition. He was serving a 4-month fixed term. Corrective Services knew of Nathan's health condition. He was due for release on 7 September 2018. On 31 August, Nathan had an asthma attack. He alerted the guards, they arrived and attempted to put him into a wheelchair. Then they called the nurse on site. She arrived and gave naloxone to Nathan, a drug given to patients to counteract the effects of an overdose. An ambulance was called. The ambulance officers arrived. They attempted to resuscitate Nathan, but nothing could be done. He was pronounced dead on 1 September 2018. The inquiry into the death of Nathan Reynolds will be held in October 2020.

Nathan's death highlights the inadequate medical care being provided by Justice Health.

Douglas "Mootijah" Shillingsworth

Mr Shillingsworth, a 44-year-old Aboriginal man, died at Westmead Hospital on 15 February 2018 from a temporal lobe abscess.

On 8 January 2018, during a period in custody at the Metropolitan Remand and Reception Centre, a mental health nurse reviewed Mr Shillingsworth following complaints he had a headache and had put toilet paper in his ear to relieve the pain. The nurse observed a white substance in Mr Shillingsworth's ear that could not be manually removed. A lubricant was applied to the ear canal and Mr Shillingsworth was advised to contact nursing staff if the pain did not resolve.

Mr Shillingsworth exhibited worsening symptoms and, on 12 January 2018, was admitted to Westmead Hospital Emergency Department. On admission, he was non-verbal and did not respond to visual or verbal cues. On 13 January 2018, Mr Shillingsworth underwent emergency surgery to treat the abscess and was transferred to palliative care on 14 February 2018, where he subsequently passed away.

Douglas was a father to two children. He grew up all around NSW, in Brewarrina, Bourke, Enngonia and Kempsey. He had a history of ear infections from a young age. Ear disease and associated hearing loss remain highly prevalent in Aboriginal children and adults. He was awaiting sentence in the District Court where it was expected he would be released in April 2018.

The inquest into Mr Shillingsworth's death has yet to be given a date.

Douglas' death highlights the need for Justice Health to be aware of those medical conditions that are prevalent in the Aboriginal community and pay proper attention to them.

Danny Whitton

Danny Whitton was a 25-year-old Aboriginal man who died in Royal Prince Alfred Hospital (RPA) on 9 November 2015. Mr Whitton became ill on Tuesday 3 November 2015 at Junee Correctional Centre. His cellmate reported that Danny had taken a regurgitated dose of methadone. On Wednesday he was unwell and sent to the Prison Clinic. He remained there until Saturday 7 November when he was transported to Wagga Wagga Base Hospital. The Doctors at Wagga base very quickly determined he was extremely unwell and organised for him to be airlifted to RPA in Sydney. Danny Whitton was pronounced life extinct on 9 November 2015.
The Autopsy revealed the cause of death to be paracetamol toxicity.

Danny's mother was not informed her son was unwell until he was to be airlifted to RPA. She was able to be with him as he passed away but was told she could not touch him and that he was the "property of corrective services" and that if she touched him, she would be charged with 'tampering with evidence". This inhumane treatment by the officers at the hospital has left lifelong trauma for Ms Knight.

Danny was only 25 years old and had applied to be on the opioid substitution program and had remained on the waiting list for some time. The inquest will explore whether the treatment available at the time was adequate.

The Inquest into Danny's death will be held in February 2021, some five years after his death.

Jordan Cruickshank

Jordan Cruickshank was 24 years old when he died in Shoalhaven District Hospital in the early hours of 6 May 2018. He had been taken there by ambulance after he was found unconscious in the backyard of a house in Bomaderry, the town where he lived in NSW's south coastal region.

On the night of Jordan's death, a police operation was underway to arrest him for outstanding driving charges. He was the subject of an arrest warrant and two police officers had been pursuing him on foot before they lost sight of him. It was very shortly after this that he was found unresponsive and taken to hospital.

The inquest into his death was held in 2019. The main issue for the inquest was the failure by the police to provide an opportunity to Jordan's family to identify his body before it was transported to Glebe Morgue. This failure lead to suspicion in the community around the cause of death and only exacerbated the grieving process for Jordan's family.

Although this issue could have been considered outside the parameters of the coronial inquest, the decision to explore the issue at inquest revealed there were some recommendations that needed to be made to ensure no family would have to go through that added trauma again.

3.1 Governments must be accountable for implementing coronial recommendations

The terms of reference for this Inquiry refer to the suitability of several existing oversight bodies which oversee deaths in custody, including the NSW Coroner. This section considers best practice when it comes to the accountability (or current lack thereof) that exists in relation to recommendations made by a coroner following an inquest into a death in custody.

The role of the coroner as outlined in the *Coroners Act 2009* (NSW) is to examine unnatural, unexpected, sudden and suspicious deaths, suspected deaths (in the case of missing persons), as well as fires and explosions that cause serious injury or damage to property. In particular, the coroner has jurisdiction to hold an inquest where a person has died while in police custody or other lawful custody, while escaping or attempting to escape from custody, as a result of police operations or while temporarily absent from a detention centre or correctional centre.[55]

The coronial system is intended to be inquisitorial in nature, with a focus on fact-finding and prevention of future deaths. And yet at present there exists an inherent failure of government, in setting up a process to provide recommendations for reform – which it ultimately often fails to act on.

3.1.1 Ministers and government departments must be required to respond to coronial recommendations

Under s 81 of the *Coroners Act 2009* (NSW), a coroner holding an inquest concerning the death or suspected death of a person must record their findings as to the manner and cause of the person's death. Under s 82, the coroner may make such recommendations as they consider necessary or desirable to make in relation to any matter connected with the death, including matters of public health and safety. However, s 82 currently does not impose any obligation on a government entity or public statutory authority to respond to the recommendations made by the coroner. This is a crucial area where reform is needed in NSW.

In Victoria, the *Coroners Act 2008* (Vic) provides that a public statutory authority must provide a written response to recommendations made by the coroner, not later than 3 months after the date of receipt of the recommendations.[56] This response must specify a statement of action (if any) that has, is or will be taken in relation to the recommendations made by the coroner.[57]

The legislation in Victoria reflects the fact that coronial recommendations "may be a wasteful exercise if the recommendations can be ignored by those to whom they are directed".[58] Indeed, as the Victorian Law Reform Committee noted in its review of the *Coroners Act 1985* (Vic):[59]

> *A key issue for the effectiveness of the coronial system in preventing deaths and injuries is the extent of the obligations government departments and other organisations have to take notice of and implement a coroner's recommendations. The Committee has*

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[55] *Coroners Act 2009* (NSW) s 23.

[56] *Coroners Act 2008* (Vic) s 72(3).

[57] *Coroners Act 2008* (Vic) s 72(4).

[58] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Australian Indigenous Law Review,* 4-26, 7.

[59] Parliament of Victoria, Law Reform Committee, Coroners Act 1985 – Final Report (September 2006), 386.

discussed above the potential of such recommendations to save lives and prevent injuries in the community. However, as the New Zealand Law Commission has observed in relation to coronial recommendations in that jurisdiction: the problem that has arisen is that there is no process for ensuring recommendations are brought to the attention of relevant agencies or individuals. Further, where recommendations are brought to the attention of the appropriate agency, there is no requirement that the agency must consider the recommendations or act on them. The ability of recommendations to achieve their purpose is therefore limited.

The RCIADIC made the recommendation that:[60]

> *"within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner shall provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person" (Recommendation 15).*

This has not been fully implemented in NSW, and the legislation should be amended in order to do so.

In NSW, the Premier's Memorandum (M2009-12) states that a Minister or NSW government agency should provide a written response to a coronial recommendation which outlines any action being taken to implement the recommendation or provides reasons why it is not proposed to implement a recommendation.[61] Responses are meant to be provided to the Attorney-General and published on the Attorney-General's Department website.[62] Based on searches of the content of that website, it appears that responses are provided by agencies, such as NSW Police, though responses to recommendations regarding deaths in custody are not always substantive.[63]

The existence of the Premier's Memorandum reflects that there is already an existing consensus in NSW to adopt the substance of RCIADIC Rec. 15. However, the Memorandum has its own deficiencies in that it makes it discretionary for a Minister to respond to a coronial recommendation and it does not have force of law as the Memorandum sits outside the legislative framework of the *Coroners Act 2009* (NSW). Further, the Memorandum refers to a time period of 6 months to provide a response to a coronial recommendation rather than 3 months as per the Victorian legislation and RCIADIC Rec. 15. Accordingly, the Coroners Act should be amended to adopt RCIADIC Rec. 15.

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[60] Royal Commission into Aboriginal Deaths in Custody, Final Report – Volume 5, Recommendations, [15].

[61] NSW Government, Premier & Cabinet, M2009-12 Responding to Coronial Recommendations (April 6, 2009). See: https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations.

[62] Ibid.

[63] See: https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

3.1.2 The Coroner must have expanded powers to follow up responses

As noted above, a key issue with the existing coronial system is that responses to coronial recommendations are not necessarily monitored and may not lead to any substantive action.[64] Indeed, as stated by the Victorian Law Reform Committee in its review of the *Coroners Act (VIC) 1985*: [65]

> *At present the main imperative for compliance with recommendations probably arises from the publicity given to coronial proceedings by the media and the resulting effect on public opinion. However, in many cases organisations have been able to disregard coroners' recommendations with impunity, even if another death occurs as a result of ignoring them. This problem was highlighted by the [RCIADIC], which referred to numerous instances where coronial recommendations were 'ignored or paid scant regard by the relevant authorities'.*

For this reason, Rec. 16 of the RCIADIC noted 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".[66] RCIADIC Rec.17 went on to note that the State Coroner should "be required to report annually…as to deaths in custody generally within the jurisdiction and, in particular, *as to findings and recommendations made by the Coroners…and as to the responses to such findings and recommendations"* (emphasis added).[67]

In our view, the implementation of these recommendations in NSW would significantly increase the accountability of government to adopt coronial recommendations. Further, the creating of a dialogue between government and the State Coroner would increase public confidence that action is being taken to end future tragic and preventable deaths in custody arising in a similar manner or from similar causes.

In order to ensure that relevant bodies, government departments and Ministers are held accountable to their responses, additional review processes should also be put in place. While a statutory body or agency may undertake a review itself, monitoring should be independent to ensure accountability and transparency. Independent monitoring may be undertaken through:

- A central body tasked with the purpose of overlooking implementation of coronial recommendations;
- A public register of coronial recommendations (outlined below); or
- The coroner who made the recommendation given their familiarity with the facts of the investigation (the approach suggested by RCIADIC).

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[64] See Ray Watterson, Penny Brown and John McKenzie, 'Coronial recommendations and the prevention of indigenous death' (2008) 12(2) *Australian Indigenous Law Review* 20; Raymond Brazil, 'The coroner's recommendation: fulfilling its potential? A perspective from the Aboriginal Legal Service (NSW/ACT)' (2011) 15(1) *Australian Indigenous Law Review* 94; Mandy Shircore 'Lessons learned; accountability and closure: Is the coronial process providing what is needed to indigenous communities?' (2010) 7 *Journal of the Australasian Law Teachers Association* 55.

[65] Parliament of Victoria, Law Reform Committee, *Inquiry into the Review of the Coroner's Act 1985, Final Report,* 386.

[66] Royal Commission into Aboriginal Deaths in Custody, Final Report – Volume 5, Recommendations, [16].

[67] Royal Commission into Aboriginal Deaths in Custody, Final Report – Volume 5, Recommendations, [17].

The benefits of an effective implementation and monitoring scheme can be seen in the context of work by the Inspector of Custodial Services (ICS) in this regard. In its Annual Report of 2018-19, ICS noted that:

> "*In the 2015-16 reporting period, it was clear that there was a need to establish a monitoring program to oversee the implementation of recommendations that result from inspections and review. Regular reporting on the implementation of recommendations encourages their timely implementation which can help to achieve system improvements.*
>
> *During 2016-17, the Inspector of Custodial Services implemented a desktop monitoring and reporting framework to monitor the progress made by each agency in relation to recommendations which were supported or partially supported.*
>
> *The reporting program is now supported by six-monthly desktop monitoring, with implementation data provided by CSNSW, JJNSW and JH&FMHN. This desktop monitoring data is verified through on-site visits.""*[68]

This model has been effective, with data indicating that the recommendation achievement progress of Corrective Services NSW increased from 49.3% in June 2017 to 55% in June 2018 and 64.7% in June 2019.[69]

Recommendations:

The NSW Government amend the Coroners Government amend the Coroners Act 2009 (NSW) to reflect all the relevant RCIADIC recommendations. This would include:

- *Copies of the findings and recommendations made by the Coroner in relation to a death in custody must be provided to all parties who appeared at the inquest, to the Attorney-General, to the Minister with responsibility for the relevant custodial agency or department and to such other persons as the Coroner deems appropriate.*
- *Within three calendar months of publication of the findings and recommendations of the Coroner as to any death in custody, any agency or department to which a copy of the findings and recommendations has been delivered by the Coroner must provide, in writing, to the Minister of the Crown with responsibility for that agency or department, its response to the findings and recommendations, which should include a report as to whether any action has been taken or is proposed to be taken with respect to any person, or reasons for a decision not to implement a recommendation.*
- *The NSW State Coroner should be empowered to call for such further explanations or information as s/he considers necessary, including reports as to further action taken in relation to the recommendations.*
- *Section 37(1) of the Coroners Act 2009 be amended so that the State Coroner is to make a written report to the Minister containing not only a summary of the details of the deaths or suspected deaths, but also a summary of the recommendations made by Coroners and the responses to those recommendations provided by the relevant agency or department.*

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[68] Inspector of Custodial Services, *Annual Report 2018-2019* (October 2019) 20.

[69] Inspector of Custodial Services, *Annual Report 2018-2019* (October 2019) 22.

- *The NSW Government amend the Coroners Act 2009 (NSW)*[70]

3.2 The perspectives of Aboriginal and Torres Strait Islander families must be central to the coronial process

3.2.1 Families should be provided with wraparound support during the coronial process

The ALS is currently constrained in its ability to provide wraparound support to vulnerable people taken into custody and to the families whose loved ones have died in police or corrective services custody. The government does not fund the ALS to provide holistic support for Aboriginal and Torres Strait Islander people taken into custody nor at the coronial inquest stage after a family member has been taken from them.

In our view, this type of wraparound support is essential to ensuring that families are appropriately supported through the coronial process. The current coronial system can often re-traumatise families because of the formality and complexity of the process. In particular, the severe delays that can arise between the time of death and the release of coroner's findings can lead to a great deal of uncertainty and grief for families. This is often combined with a lack of understanding about what to expect from coronial proceedings, as well as a high level of formality in the manner and style of communications from the court. There is also a lack of clarity about the role of the police, who often act as preliminary investigators and can be seen in discussion with Counsel Assisting and the coroner. In addition, families often feel that barriers exist for their voice to be heard in coronial proceedings. The importance to families of telling their story cannot be understated.

There are also significant social, emotional and financial costs to families being able to meaningfully engage and participate in the coronial process. For instance, families might need to travel a long distance to attend coronial hearings and take time off from work to participate in the process. All whilst also working through the grief and trauma associated with the death of a loved one. As a result, it is critical that families are provided with adequate wraparound support is provided to alleviate these concerns for families.

Further issues often arise upon release of the coroner's findings following an inquiry or inquest. For many families, a fundamental aspect of the process is to ensure that similar incidents do not happen again, which would cause harm to other families that could have been avoided. Yet families may not be able to see how recommendations are being monitored or implemented, and communities may feel that systemic issues have not been addressed despite the length and complexity of the coronial process which was designed to consider the issues. Indeed, the flow-on impact of a family's negative experience during the coronial process is that broader communities may feel that justice has not been delivered and that similar incidents are at risk of occurring again.

In light of the numerous barriers faced by families during the coronial process, it is important

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[70] These recommendations could be further developed with guidance from the Commonwealth Ombudsman's *Principles for good practice in responding to coronial recommendations:* Commonwealth Ombudsman, Principles for good practice in responding to coronial recommendations, < https://www.ombudsman.gov.au/__data/assets/pdf_file/0015/36213/Principles-of-Good-Practice.pdf>.

that families are provided with wraparound support throughout the process. In our view, the ALS is best placed to provide support to families, namely culturally appropriate services designed and delivered by Aboriginal people for Aboriginal people, so that solutions are in community-controlled hands. By providing Aboriginal people with access to a mobile support team that can provide holistic civil law services, advocacy, community capacity-building and support, as well as the expertise of a social worker or grief counsellor, this would create improved restorative justice outcomes for individuals and families and improve trust in the coronial process.

3.2.2 The Coroner should have a discretion to hold a "Recognition Mention"

Under s 46 of the *Coroners Act 2009* (NSW), "coronial proceedings" can involve an investigation to determine whether or not to hold an inquest or inquiry. This preliminary investigatory process can be very lengthy and involve a detailed examination of statements from relevant witnesses and material evidence. Ultimately, a coroner may determine that an inquest is not required following this investigation,[71] which means that any further hearing may not occur.

In these circumstances, the family of the deceased is informed by written correspondence of the outcome of the investigation and the manner and cause of death. As a result, the family of the deceased person loses the opportunity to appear in person in coronial proceedings and make a statement of their feelings about the deceased and their death.[72] This mandated step in coronial inquests is fundamental in order to provide a measure of closure to families of the deceased person.

The ALS proposes that the Coroner should have the discretion to hold a "Recognition Mention" whereby, following a significant investigation into a death and a decision that no inquest is required, such a mention is held where the Court receives a family statement, expresses the cause and manner of death and makes orders dispensing with the request. This would enable families to achieve some level of closure after a long investigatory process that mirrors a coronial inquest.

3.2.3 The Coroner should consult with Aboriginal and Torres Strait Islander families and organisations in relation to the adequacy of government responses to recommendations

Another avenue for reform is to place a formal obligation on the Coroner to consult with Aboriginal and Torres Strait Islander families and/or Aboriginal and Torres Strait Islander community-controlled organisations when a response to findings and recommendations is received.

This type of informal conferencing is frequently used in Ontario, Canada, as an alternative to formal inquests. The Ontario coronial system is often referred to in reports, such as the Parliament of Victoria's Law Reform Committee's report on the Coroners Act because of its success in achieving implementation of recommendations.[73] The Law Reform Committee report acknowledged that informal conferencing will not always be appropriate, and it is difficult to see how it would be effective or desirable as a replacement for an inquest in the context of

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[71] *Coroners Act 2009* (NSW) s 25.

[72] *Coroners Act 2009* (NSW) s 57.

[73] Parliament of Victoria Law Reform Committee, *Review of the Coroners Act 1989 (Vic).*

deaths in custody.[74] There may, however, be scope for this kind of model to be used when the Coroner is considering the adequacy of responses to recommendations. For example, the Coroner responsible for assessing the response could write to, meet with, or receive submissions from, the family of an Aboriginal or Torres Strait Islander person to seek their views on the adequacy of an agency or Minister's response.

3.2.4 The Coroner should consider issuing a practice note to clarify aspects of coronial procedure and processes

Under s 52 of the *Coroners Act 2009* (NSW), the State Coroner may issue practice notes for or with respect to the practice and procedure to be followed in coronial proceedings. The ALS submits that the State Coroner should consider issuing a practice note which contains guidance on certain issues, including:

- A general protocol for coroners to notify the family of the deceased person as to the upcoming process for the coronial inquiry and/or inquest, the contact details for the ALS and/or Legal Aid NSW; and information about the time required for the process.
- A protocol providing for notices of appearance or other formal process to ensure that the lawyer on the record receives correspondence from the Coroner's Court.
- Guidance on the process and protocols for the provision of briefs of evidence (including, e.g. that standard practice is for photos of the deceased's body and of the autopsy to be removed from the copy of the brief that is served).
- Guidance on the approach to legal objections made by police officers in the Coroner's Court, which otherwise feeds into the mistrust of Aboriginal families as to the involvement of the police in the coronial process.

In our view, providing a practice note on these areas would be a critical step in improving our clients' experience of the coronial system.

Recommendations

- *The NSW Government listen to the families whose loved ones have died in police or prison custody and meaningfully and respectfully involve them in all relevant policy and legal reforms. It is critical that families' voices are centred in all reforms and changes that aim to end Aboriginal deaths in custody.*
- *The NSW Government resource and fund the ALS to provide wraparound support and advocacy to ensure that Aboriginal people receive culturally safe, timely, and fair legal assistance before, during, and after all coronial processes.*
- *The Coroner be provided with discretion to hold a "Recognition Mention" whereby, following a significant investigation into a death and a decision that no inquest is required, such a mention is held where the Court receives a family statement, expresses the cause and manner of death and makes orders dispensing with the request.*
- *The NSW Government consult with the ALS and the families of Aboriginal and Torres Strait Islander people who have had a loved one die in custody about adopting a process whereby the Coroner writes to, and meets with, the family of an Aboriginal and Torres*

[74] Ibid.

Strait Islander person who has died in custody to seek their views on the adequacy of an agency's response to recommendations made to them.

- *The NSW Government legislate making it mandatory for a Coroner to notify the ALS of any recommendations relating to the death in custody of an Aboriginal and Torres Strait Islander person. Similarly, it should be mandatory for statutory bodies and agencies to provide copies of responses to recommendations to the ALS.*
- *The State Coroner consider issuing a practice note containing guidance on issues including the notification of families as to coronial process, communications with lawyers, provision of briefs of evidence and the approach to legal objections by police officers.*

3.3 The definition of a 'death in custody' should be amended to align with RCIADIC recommendations

Under s 23 of the Coroners Act 2009 (NSW), the definition of a "death in custody" in NSW includes a death while in the custody of a police officer or in other lawful custody, or escaping or attempting to escape from that custody. The definition also extends to include a death as a result of, or in the course of, police operations, but does not include the actions of prison officers.

Crucially, however, this definition does not extend to include deaths caused or contributed to by traumatic injuries sustained whilst in custody or detention, or caused by a lack of proper care whilst in detention, if the death occurred after the person was released from 'custody'. This was specifically recommended by the RCIADIC in Rec. 6, which stated that the definition of death should include "*at least* the following categories: … The death *wherever occurring* of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention" (emphasis added).

This amendment is particularly relevant given that the risk of death is especially high for people in the first month after release from custody, and this frequently can be attributed to a lack of proper care while in custody or during the process of release from custody. The Australian Institute of Health and Welfare found that "[t]he risk of death is especially high in the first month after release, and the causes of death in this time are usually preventable, and include suicide, injury, and overdose".[75] Further, many people are released unexpectedly from prisons, particularly those on remand. The Report of the Special Commission of Inquiry into the Drug 'Ice' ('The Ice Inquiry') noted evidence from Justice Health that "approximately 20% of people on opiate substitution therapy in custody are released unexpectedly. This makes it difficult to ensure continuity of care, including the provision of OST [opiate substitution therapy] by community providers".[76] Further, the Drug 'Ice' Report stated that "[u]nexpected release from custody has two significant impacts. First, people are often released *without medication* to meet their immediate and short-term needs and with *no transitional healthcare arrangements* in place. Second, people are released without identification, which can affect their ability to

[75] Australian Institute of Health and Welfare, *The health of Australia's prisoners* (2018) 158.

[76] Special Commission of Inquiry into crystal methamphetamine and other amphetamine-type stimulants, Report – Volume 3, January 2020, 922 [20.448].

access other services in the community" (emphasis added).[77]

The findings of the Ice Inquiry reflect the importance that deaths following release from custody are investigated through rigorous and independent coronial processes where the evidence suggests that the death was caused or contributed to by traumatic injuries sustained or by a lack of proper care whilst in custody.

Recommendation

- *The NSW Government expand the definition of a "death in custody" to include a death wherever occurring of a person whose death is caused or contributed to by traumatic injuries sustained or by lack of proper care whilst in such custody or detention.*

3.4 Recommendations and responses should be monitored

3.4.1 There should be a database to monitor implementation of coronial recommendations

Justice Action – a grassroots organisation which represents people locked in Australian prisons – has recently published a proposal calling for the establishment of a National Database into Deaths in Custody.[78] The proposal suggests the development of a centralised information hub containing coronial findings on deaths in custody and recommendations from all Australian jurisdictions, as well as published responses from state and federal authorities, individuals and communities who are affected by the recommendations.

The Justice Action proposal acknowledges that the National Coronial Information System ('*NCIS*') and the Australian Institute of Criminology ('*AIC*') already examine data on deaths in custody. However, it notes in relation to data collection:[79]

> *[The data] is not updated regularly and has restricted access. The compartmentalisation of information leads to each Coroner existing within their own silo. This is contrary to the Coroners' purpose of preventing further death.*
>
> *In response to this issue, a new database system is proposed to include coronial findings on deaths in custody and recommendations from all Australian jurisdictions, distributed nationwide as well as published responses from state and federal authorities who are affected by the recommendations.*
>
> *The database should utilise a clearinghouse model to create one central agency for information collection, classification, and distribution. The data would be collated and automatically distributed to all relevant government authorities, while also allowing for public access. It is crucial for it to be regularly updated, and require government responses to inquests, which will be searchable by catchword and report content.*
>
> *It is proposed that the implementation of such a national database and follow up functions be facilitated by the NCIS and/or the AIC. The implementation of the proposed*

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[77] Ibid 920 [20.438]. The additional consequence of a lack of appropriate health care for persons on remand is that upon release, recidivism rates are high because underlying issues were not addressed or treated, particularly for those persons with drug or alcohol addiction.

[78] Justice Action, *National deaths in custody database proposal* <http://www.justiceaction.org.au/images/stories/CmpgnPDFs/NtnlDICDbsPfpsl.pdf>

[79] Justice Action, *National deaths in custody database proposal* <http://www.justiceaction.org.au/images/stories/CmpgnPDFs/NtnlDICDbsPfpsl.pdf> 3–4.

database would promote accountability among government authorities to address recurring issues that endanger the lives of incarcerated individuals. It is clear that by inducing collective learning, accessible solutions can be developed to prevent needless deaths across Australia.[80]

The ALS notes that there is merit in having a central body where responses to recommendations, along with other data, might be collated.[81]

3.4.2 The NSW Government should monitor and report against the implementation of RCIADIC recommendations

The low rate of implementation of coronial recommendations is certainly not a new phenomenon. As noted, despite the RCIADIC being tabled almost 30 years ago, most recommendations remain unimplemented by Commonwealth, state and territory governments - including the NSW Government.[82]

Beyond political will, a significant cause of the low rate of implementation of recommendations is the failure to establish an appropriate system to monitor and report against the implementation. The need for such a system was outlined as the very first recommendation of the RCIADIC. Accordingly, the NSW Government should immediately take steps to monitor and publicly report against the implementation of the recommendations of the RCIADIC.

Recommendations:

- *The NSW Government, in conjunction with the National Coroners Information System, consider the establishment and resourcing of a comprehensive, categorised and readily searchable online database of all recommendations by State and Territory coroners, as well as published responses from state and federal authorities, and individuals and communities who are affected by the recommendations.*
- *The NSW Government monitor and publicly report against the implementation of the recommendations of the 1991 Royal Commission into Aboriginal Deaths in Custody.*

3.5 Limitations in existing police oversight in NSW

The NSW Law Enforcement Conduct Commission (LECC) was established in 2017, in response to recommendations made by the 2015 Tink Review into Police Oversight (‘*the Tink Review*’).[48] It

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[80] This is different to the work being done by Professor Tamara Walsh (University of Queensland), who has created a publicly available database searchable by range of search fields, including Aboriginal or Torres Strait Islander status, cause of death, type of custody, specifics of death and personal characteristics. The database does not record to which specific agencies, entities or Ministers coronial recommendations are addressed, nor does it record whether responses are received and provide links to those responses. See the Deaths in Custody Project: <https://deaths-in-custody.project.uq.edu.au/record>.

[81] Some academics have also argued for uniform national legislation which would provide a mandatory reporting and review scheme for all coronial recommendations in order to improve public accountability. In a study which looked at 185 coronial matters and 484 recommendations across all jurisdictions (except Queensland), implementation rates of recommendations were found to be as follows: 27% in Victoria; 41% in Tasmania; 48% in New South Wales; 50% in Western Australia; 52% in South Australia; 65% in the Northern Territory; and 70% in the Australian Capital Territory. See Ray Watterson, Penny Brown and John McKenzie, 'Coronial recommendations and the prevention of indigenous death' (2008) 12(2) *Australian Indigenous Law Review* 20.

[82] This was examined in detail by Amnesty International and Clayton Utz in their report on the implementation of RCIADIC recommendations: see Amnesty International Australia and Clayton Utz, *Review of the Implementation of RCIADIC*, May 2015 (Change the Record).

was intended to function as a single civilian oversight body, which would improve the effectiveness of police oversight in NSW by amalgamating the functions carried out by the Police Integrity Commission (*PIC*), the Inspector of the Crime Commission and the Police and Compliance Branch of the NSW Ombudsman's office (*PCB*). However, since its inception there have been several critiques of the effectiveness of the LECC as a complaints body, as well as ongoing concerns with broader oversight of police in NSW.

3.5.1 Independent police oversight bodies must be appropriately resourced

A core critique of the LECC is that its poor resourcing limits its effectiveness as an oversight body. For example, a 2018 report by a NSW parliamentary committee found that the LECC's critical incident monitoring unit may not have enough staff to properly perform its function.[63] For instance, the report cited the fact that of the 81 critical incident investigations underway on 1 July 2017, the LECC decided to monitor only 29 of those investigations.[64] The report found that even monitoring less than half of all critical incident investigations put an enormous strain on the five person team that worked in that unit, with the Commissioner for Integrity giving evidence that this level of monitoring was unsustainable without additional funding.[65]

Concerns by various organisations were again reported in November 2019, when it was revealed that the LECC's funding would be cut by $6 million.[66] This occurred despite the fact that the LECC was only able to run full investigations for approximately two percent of the 2547 complaints made against police officers in the 2018-2019 financial year.[67]

3.5.2 Police policies must ensure accountability and independence in investigations

It is critical that police policies ensure accountability and independence in investigations. For instance, Rec. 33 of RCIADIC provided:

> *That all officers involved in the investigation of a death in police custody be selected from an Internal Affairs Unit or from a police command area other than that in which the death occurred and in every respect should be as independent as possible from police officers concerned with matters under investigation. Police officers who were on duty during the time of last detention of a person who died in custody should take no part in the investigation into that death save as witnesses or, where necessary, for the purpose of preserving the scene of death.*

In NSW, this recommendation has not been fully implemented. The NSW Police Force Handbook does not mandate that on-duty officers must take no part in the investigation except to say that officers connected with the circumstances of, or leading up to, the death must not accompany the body to the mortuary. This does not, however, sufficiently exclude them from other parts of the investigation. While the Handbook provides for a Professional Standards Command ('PSC') reviewing officer who has an "independent function and should ensure a competent investigation is carried out by the team",[59] this does not mean that the investigation team must also be totally removed from the circumstances of the death in custody.

In our view, there needs to be explicit emphasis that police officers who were on duty or otherwise involved at the time of death must take no part in the investigation save as witnesses or for the purpose of preserving the scene of death. Further, while the Handbook refers to the need for independence of the reviewing officer, it should be clearly stated that all officers involved in the investigation were subject to a conflict of interest check, which assesses for both actual and perceived conflicts of interest.[60]

3.5.3 Oversight of police should be guided by international best practice

International minimum requirements

The United Nations Office on Drugs and Crime (***UNODC***) outlines minimum requirements for independent police oversight and complaints bodies in its *Handbook on police accountability, oversight and integrity*.[83] At a minimum, an independent police oversight body must:

- Have capacity to receive complaints directly from both the public and government;
- Have capacity to initiate investigations at its own accord;
- Record all complaints filed against police;
- Have sufficient investigative powers to make an assessment of the case, including the power to hear any person, subpoena, obtain required information, conduct searches and seizures, and compel the presence of witnesses and police;
- Have the power to recommend penal or disciplinary action; and
- Have capacity to follow up on its recommendations by way of publishing findings and responses, compelling police to disclose reasons for not following recommendations and publicising failures to follow recommendations.[84]

Additionally, the UNODC states that an independent body must investigate all deaths suffered in police detention or as a result of police action. Further, it must be mandatory for the police to report these incidents to the independent body and the investigation must commence immediately where the allegation may lead to disciplinary outcomes.[85]

Best practice examples

Having 'police investigate police' in relation to the most critical incidents including deaths in custody is also at odds with international best practice for police accountability, which involves a prompt and rigorous independent investigation of critical matters. Some best practice examples of external agencies that investigate police conduct in relation to deaths in custody include the Police Ombudsman for Northern Ireland and the Independent Police Conduct Authority of New Zealand.[86]

These examples were canvassed in the ALRC's *Pathways to Justice* Report, and the ALRC report recommended that these international models be reviewed and considered as part of reforms to police complaints handling mechanism in Australia. For a brief summary of these models, see *Appendix 2.*

Recommendation:

[83] United Nations Office on Drugs and Crime, Handbook on police accountability, oversight and integrity, Criminal Justice Handbook Series, 2011, 53, <https://www.unodc.org/pdf/criminal_justice/Handbook_on_police_Accountability_Oversight_and_Integrity.pdf>.

[84] Ibid.

[85] Ibid 52.

[86] For further detail, see Police Accountability Project, 'Why the NSW Law Enforcement Conduct Commission is no model for Victoria' <http://www.policeaccountability.org.au/independent-investigations/why-the-nsw-law-enforcement-conduct-commission-is-no-model-for-victoria/>

- *The NSW Government review international best practice and consider reforms to existing police oversight and complaints handling mechanisms.*

3.6 Improving oversight in NSW through the implementation of an effective National Preventive Mechanism

Australia is a party to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), which requires the systematic review of arrangements for the custody and treatment of persons subjected to any form of arrest, detention or imprisonment. In December 2017, the Australian Government ratified the Optional Protocol to the CAT (OPCAT), which requires the establishment of a system of independent national bodies to regularly inspect places of detention to prevent ill-treatment (these bodies are known as the 'national preventive mechanism' (NPM) under the OPCAT). It is our view that OPCAT and the designation of independent, adequately resourced and culturally competent NPMs throughout Australia are a crucial tool in addressing the mass incarceration of Aboriginal and Torres Strait Islander peoples, and their deaths in custody.

3.6.1 Key elements of an effective NPM

We support the NATSILS' position that for NPM bodies to be effective, and provide effective oversight and accountability, as well as serve a preventative and protective function, they must include the following features[87]:

> *(a) A mandate to undertake regular preventive visits (Articles 4(1) and 19(1));*
>
> *b) Organisational and functional independence from government, including independence of NPM members and staff and financial autonomy;*
>
> *(c) Multidisciplinary and diverse expertise, including gender balance and representation of ethnic and minority groups, specifically Aboriginal and Torres Strait Islander people;*
>
> *(d) Free and unfettered access (to all places of detention, whether announced or unannounced; to all relevant documents and information; and to all persons including public employees and privately engaged contractors, including the right to conduct private interviews);*
>
> *(e) The power to make recommendations to authorities, accompanied by a corresponding obligation for authorities to examine recommendations and enter into dialogue about their implementation;*
>
> *(f) The power to submit proposals and observations to Parliament or the public concerning existing or proposed legislation;*
>
> *(g) Appropriate privileges and immunities (no sanctions or reprisals for communicating with the NPM; confidential information should be privileged); and*

[87] NATSILS in their submission o the Australian Human Rights Commission consultation on the implementation of the Optional Protocol to the Convention Against Torture and Cruel, Inhuman or Degrading Treatment in Australia (OPCAT) in July 2017 accessed http://www.natsils.org.au/portals/natsils/NATSILS%20OPCAT%20Submission_AHRC_Submitted%20at%209.39AM%20020820 17.pdf?ver=2017-08-23-164926-817

(h) Ability to directly contact the UN Special Rapporteur Torture

3.6.2 The establishment of an NPM in NSW

The ALS is aware that there is currently a working group in place in NSW to explore the establishment of an NPM in this jurisdiction. We have previously submitted that, in our view, the Inspector of Custodial Services (ICS) is currently the best-placed body in NSW to fulfill obligations under OPCAT. However, there are a number of areas which should be strengthened to ensure that the Inspector of Custodial Services is fully OPCAT compliant.[88] This includes a consideration of:

- Functional independence, adequate resourcing and full access to information;
- Frequency of visits;
- Government response to ICS reports and enforcement of recommendations;
- Effective oversight and coverage of all custodial setting in NSW;
- Representation of ethnic and minority groups; and
- Importance of providing space for the voice of young people.

We refer the Committee to our previous submission to the Statutory Review of the *Inspector of Custodial Services Act 2012 (NSW)* which provides further discussion of these issues.[89]

Recommendation:

- *The NSW Government designate an* ***independent, adequately resourced and culturally competent NPM.***

[88] ALS (2020), *Submission to the Statutory Review of the Inspector of Custodial Services Act 2012 (NSW)*, https://www.alsnswact.org.au/statutory_review_of_the_inspector_of_custodial_services_act_2012_nsw

[89] *Ibid.*

Appendix 1 – Terms of Reference

That a select committee be established to inquire into and report on First Nations people in custody in New South Wales, and in particular:

(a) the unacceptably high level of First Nations people in custody in New South Wales;'

(b) the suitability of the oversight bodies tasked with inquiries into deaths in custody in New South Wales, with reference to the Inspector of Custodial Services, the NSW Ombudsman, the Independent Commission Against Corruption, Corrective Service professional standards, the NSW Coroner and any other oversight body that could undertake should oversight;

(c) the oversight functions performed by various State bodies in relation to reviewing all deaths in custody, any overlaps in the functions and funding of those bodies; and

(d) how those functions should be undertaken and what structures are appropriate.

Appendix 2 – Best practice examples – police accountability

(a) Police Ombudsman for Northern Ireland

The Police Ombudsman for Northern Ireland (***PONI***) is a civilian body tasked with investigating various forms of police misconduct. It has been described as the 'gold standard' of independent police-complaint investigation mechanisms.[90] PONI is 'considered to be one of the most robust and independent bodies in the world tasked with adjudicating on [the Police Service of Northern Ireland] operational and disciplinary matters where the prospect of police misconduct exists'.[91] As such, it may provide significant guidance for reform to the LECC.

PONI was established in 2000 following a recommendation endorsed by the Independent Commission for Policing for Northern Ireland.[92] It is constituted as a corporation and headed by an Ombudsman appointed by Royal Assent for a term of 7 years.[93] It is accountable to the Northern Irish Assembly and financed by the Department of Justice from whom it is required to accept guidance.[94]

PONI has exclusive legal jurisdiction to investigate police complaints in Northern Ireland. It also undertakes investigations in relation to matters received by the Chief Constable of the Police Service of Northern Ireland. This includes civilian deaths occurring in police custody.[95]

Once an investigating officer completes an investigation, the officer is to submit a report to the Ombudsman. The Ombudsman then considers the report and determines whether a criminal offence has been committed and whether disciplinary proceedings should be brought against the police officer. If so, the Ombudsman must forward these recommendations to the Director of Public Prosecutions or Chief Constable.[96] PONI is the only police oversight body in the world which can issue mandatory recommendations.[97]

It is noted that PONI is considerably larger than the LECC, employing 150 staff, including 120 professional investigators. PONI is also equipped with a wide range of powers that exceed the LECCs powers in respect to deaths in custody. PONI investigators have the power to arrest, seize evidence, interview civilians and officers, secure incident scenes, search premises, compel information from police and use investigative techniques such as forensics.[98]

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[90] Sinéad O'Brien Butler, 'Policing the Police: Independent Investigations for Victoria' (2018) 41(3) *University of New South Wales Law Journal*, 1-44, 30.

[91] Topping, John (2015), 'Accountability, policing and the Police Service of Northern Ireland: Local Practice, Global Standards?', 10, in S. Lister and M. Rowe (eds.) Accountability of Policing (Routledge Frontiers of Criminal Justice).

[92] Lenny Roth, *External oversight of police conduct,* Briefing Paper No. 6/2015, NSW Parliamentary Research Service, 39.

[93] Ibid.

[94] Sinéad O'Brien Butler, 'Policing the Police: Independent Investigations for Victoria' (2018) 41(3) *University of New South Wales Law Journal*, 1-44, 31.

[95] Police Ombudsman for Northern Ireland, *Annual Statistical Bulletin: The Office of the Police Ombudsman for Northern Ireland, 2019/20*, 26 May 2020, 38.

[96] Lenny Roth, *External oversight of police conduct,* Briefing Paper No. 6/2015, NSW Parliamentary Research Service, 40-1.

[97] It is noted that this statement was made in 2011 and may be outdated. United Nations Office on Drugs and Crime, Handbook on police accountability, oversight and integrity, Criminal Justice Handbook Series, 2011, 53, <https://www.unodc.org/pdf/criminal_justice/Handbook_on_police_Accountability_Oversight_and_Integrity.pdf>.

[98] Sinéad O'Brien Butler, 'Policing the Police: Independent Investigations for Victoria' (2018) 41(3) *University of New South Wales Law Journal*, 1-44, 31-2.

(b) Independent Police Conduct Authority of New Zealand

The Independent Police Conduct Authority of New Zealand (***IPCA***) is a statutory authority tasked with a number of police oversight functions. This includes the responsibility to investigate all incidents of death caused or appeared to have been caused by the police acting in the execution of their duty, where there are reasonable public interest grounds to do so.[99] IPCA is required by legislation to act independently in performing its functions and duties.[100]

Where a police officer causes or appears to have caused the death of a person, the Commissioner of Police is required to notify IPCA in writing as soon as practicable.[101] IPCA then has the power to compel any information or documents, and summon and examine any person on oath, where it is relevant to the investigation.[102] IPCA may also hear or obtain information from persons where it considers that cultural matters are a relevant factor to the investigation.[103] This provision forms particular guidance for the current committee given the alarming number of Aboriginal and Torres Strait people represented in deaths in custody rates.

IPCA will then form an opinion on whether any act, omission, conduct, policy, practice or procedure relevant to the investigation was illegal, unjustified or unreasonable.[104] IPCA may then make recommendations to the Commissioner of Police as it sees fit, including in relation to disciplinary or criminal proceedings.[105] The Commissioner is required to, as soon as reasonably practicable, notify the authority of its action to implement or depart from the recommendation.[106] These recommendations are not mandatory, however if IPCA is not satisfied of the response, it must send a copy of its opinion and recommendations to the Attorney-General and the Minister of Police.[107]

(c)The Garda Síochána Ombudsman Commission in Ireland

The Garda Síochána Ombudsman Commission (***GSOC***) in the Republic of Ireland is responsible for conducting investigations in circumstances where police conduct may have resulted in the death of, or serious harm to, a person.[108]

The GSOC is an independent body, established in 2007, and has the mandate of providing fair, efficient and independent oversight of policing in the Republic of Ireland. It is made up of three Garda Síochána Ombudsman Commissioners, appointed by the President of the Republic of Ireland on the nomination of Government and the passage of resolution by the Oireachtas (the

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[99] Independent Police Conduct Authority, *Annual Report 2017-2018*, 8; *Independent Police Conduct Authority Act 1988* (NZ) s 12(1)(b).

[100] *Independent Police Conduct Authority Act 1988* (NZ) s 4AB.

[101] *Independent Police Conduct Authority Act 1988* (NZ) s 13.

[102] *Independent Police Conduct Authority Act 1988* (NZ) s 24.

[103] *Independent Police Conduct Authority Act 1988* (NZ) s 23(3)(a).

[104] See *Independent Police Conduct Authority Act 1988* (NZ) s 27(1) for a full list of what IPCA may form an opinion on.

[105] *Independent Police Conduct Authority Act 1988* (NZ) s 27(2).

[106] *Independent Police Conduct Authority Act 1988* (NZ) s 29(1).

[107] *Independent Police Conduct Authority Act 1988* (NZ), s 29(2).

[108] *Garda Síochána Act 2005* (Republic of Ireland).

Ireland national parliament). One of the Commissioners is appointed as Chairperson. A Commissioner's term of office is 3 to 6 years, and they may be reappointed for a second term.[109]

The GSOC has a responsibility to conduct independent investigations, following referral by the Garda Síochána, in circumstances where it appears that the conduct of a garda may have resulted in death of, or serious harm to, a person.[110]

The GSOC is empowered to directly and independently investigate complaints against members of the garda (the police),[111] to investigate any matter (even where no complaint has been made) where it appears that a garda may have committed an offence or behaved in a way that would justify disciplinary proceedings,[112] and investigate any practice, policy or procedure of the garda with a view of reducing the incidence of related complaints.[113]

Criminal investigations are conducted by GSOC in accordance to s 98 of the *Garda Síochána Act 2005* by the GSOC's own investigators. Independent investigations following death or serious harm is adherent to the five principles developed by the European Court of Human Rights, which are: independence, adequacy, promptness, public scrutiny and victim involvement. In the 2019 Annual Report, the GSOC reported receiving 40 referrals, 16 of which related to fatalities. Out of 40 referrals, 32 investigations were closed in 2019 and 2 criminal investigations undertaken were ultimately referred to the Director of Public Prosecutions to prosecute.[114]

(d) The Special Investigations Unit in Canada

In the province of Ontario, Canada, the Special Investigations Unit (***SIU***) is an independent civilian agency with the power to investigate and charge police officers with a criminal offence.[115] The SIU is independent of the police and is at arm's length to the Ministry of the Attorney General of Canada.

The SIU consists of a director appointed by the Lieutenant Governor in Council on the recommendation of the Solicitor General, and investigators appointed under Part III of the Public Service of Ontario Act, which also stipulates that a person who is a police officer or former police officer shall not be appointed as director, and persons who are police officers shall not be appointed as investigators.[116]

The SIU's goal is to ensure that criminal law is applied appropriately to police conduct, as

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[109] *Garda Síochána Act 2005* (Republic of Ireland), s 66.

[110] *Garda Síochána Act 2005* (Republic of Ireland), s 102(2).

[111] *Garda Síochána Act 2005* (Republic of Ireland), s 102(1).

[112] *Garda Síochána Act 2005* (Republic of Ireland), s 102(4).

[113] *Garda Síochána Act 2005* (Republic of Ireland), s 106.

[114] *Garda Síochána Ombudsman Commission*, Annual Report 2018-2019.

[115] *Special Investigations Unit,* Annual Report 2016-2017 (2017).

[116] *Police Services Act*, R.S.O. 1990, c. P.15, s 113.

determined through independent investigations, and increasing public confidence in the Canadian police services.[117] The SIU conducts independent investigations to determine whether there are grounds to charge a police officer in relation to incidents involving death, serious injury or allegations of sexual assault. Where such grounds exist, the SIU director is compelled to charge the police officer. Where the grounds do not exist, the SIU director cannot lay charges and instead issues a public report summarising the investigation and their reasons for the decision.

The SIU was established in 1990 under the *Police Services Act*,[118] following a crisis of public confidence about the integrity of the process in which police officers investigated police shootings where a member of the public has been wounded or killed.[119]

A common criticism that the SIU has faced over the years is, however, that it employs a large amount of former police officers, which calls into question its impartiality.[120] An Ontario ombudsman's report from 2008 had called attention to a perception of pro-police bias among the work of the SIU, but ultimately concluded that there was no objective evidence that any individual case had been tainted by improper motives.[121]

According to the SIU 2019 Annual Report, the unit filed charges against 15 officers in 13 instances out of 363 closed cases, amounting to a 3.6 per cent charge rate. In 2018, criminal charges were laid in 15 cases against 17 officers, again accounting for 3.6 per cent of the 416 cases that were closed that year. On average, the SIU takes around 136 days to finish an investigation and close a case. The SIU did note in its report that it has made "significant inroads" in reducing its backlog of cases, with 151 open cases as of the end of 2019, compared to 231 at the end of 2018.[122]

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[117] *Special Investigations Unit,* Annual Report 2016-2017 (2017).

[118] *Police Services Act*, R.S.O. 1990, c. P.15, s 113.

[119] *Police Services Act*, R.S.O. 1990, c. P.15, s 113(5).

[120] Adam Carter, 'Cops policing cops and their duty to talk: The questions surrounding Ontario's police watchdog', *CBC News* (online, 10 July 2020) <https://www.cbc.ca/news/canada/toronto/special-investigations-unit-1.5642604>.

[121] Ombudsman Ontario, *Oversight Unseen: Investigation into Special Investigation Unit's operational effectiveness and credibility* (September 2008).

[122] *Special Investigations Unit,* Annual Report 2018-2019 (2019).