Submission No 124

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

Organisation: Reynolds Family

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Reynolds family submission to the *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody*

We are the family of Nathan Reynolds. This submission was prepared by Taleah Reynolds and Makayla Reynolds, Nathan's sisters.

Nathan was a proud Aniwen and Dunghutti man. Nathan was the first child of Jodie and Steven, he was the first grandchild to all his grandparents, first nephew for his Aunties and Uncles. This meant Nathan was loved and spoilt from the day he was born. Nathan started working from the age of 16, Nathan worked most of his life. He was the proud father to his daughter and step-father to two other children who he adored and loved. Nathan loved his footy and played up until his adult life. He only stopped competition footy due to injury. Nathan would light up a room when he entered; he had the best sense of humour. He would do anything for his family and friends.

On 1 September 2018, our brother died in the Outer Metropolitan Multi-Purpose Correctional Centre. He was 36 years old. The details of his death are currently before an inquest.

We are making our submission to the *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody* because we want no other First Nations family to endure what we have endured since Nathan passed away.

We're making these submissions so that lessons we have learned over the last two years don't get overlooked. We do so acknowledging that the Committee is not in a position to directly review individual cases — but we ground this submission in what happened to Nathan because this is where our advocacy and expertise now comes from.

Taleah told the Guardian[1] a year after Nathan died —

> "Why aren't they prioritising deaths in custody? Why does it take so long? We're coming up to a year since he died and we still don't know anything more.
>
> I feel like they don't have any remorse; they hide behind the system. No one's held accountable, that's the most frustrating part. The care factor is zilch. They don't care about the inmates."

The unacceptably high level of First Nations people in custody in New South Wales

First Nations people in NSW are often put on paths to prison outside of their control without a meaningful way to walk back.

Parole conditions

[1] theguardian.com/australia-news/2019/aug/25/why-does-it-take-so-long-the-desperate-wait-for-answers-after-a-death-in-custody

One example of how this happened to our brother is through the parole system in NSW. It has a ‘one size fits all’ philosophy. They set the same expectations for everyone, regardless of their circumstances on the outside.

When he was released on parole in 2018, Nathan was trying to work. He had worked his whole life, it was how he stayed grounded and provided for his family. He worked full-time when he was on parole. He was still expected to report in three times a week. Even though he was working full time, parole wouldn’t accept a letter from his employer.

On top of his reporting obligations, and his full time work, Nathan was also required to go to counselling, Alcoholics Anonymous (even though he was not an alcoholic), and do community service. This schedule was gruelling. His mental and physical health suffered because of it.

One day when he was stretched to the limit in fulfilling these parole obligations, he asked Taleah to drop him off at a weekend community service. Nathan, because of his chronic serious asthma, could barely breathe when he got in her car. She said ‘I am not taking you there like this. You can’t breathe. There’s no way you can go out there safely.’ Taleah took him to the doctor instead. Nathan was put on a nebuliser machine for an hour. His doctor wanted to send him to a hospital. Nathan said ‘No, I have to go to my community service’, even though we had a doctor’s certificate that could excuse him.

Nathan had a chronic illness, and he worked hard to manage it. That did not always matter to parole. Nathan was told that even if he did supply a medical certificate that meant he could not report or attend community service on a particular day, that he shouldn’t ‘make up too many of them’ and that he ‘can’t keep having sick days.’ Even though he couldn’t breathe, even though his doctor wanted to send him to a hospital, his main concern was getting to that community service.

Nathan told us once that it was easier to do that time in gaol than doing what parole set him up for. Like so many other Aboriginal people who get caught in this system, he was repeatedly set up to fail.

We recommend —

- That if a person on parole can provide a letter from an employer that they are working, this must be taken into account when parole are assessing what requirements are set upon the parolee;
- That if a parolee has a chronic illness it should be stated on their record and the parolee should not feel that they have to attend even though they have a medical certificate stating they are unfit that day

Remand and charge strategies

56% of First Nations people who have died in custody since 2008 were on remand or not serving sentences.[2] The unacceptable number of Aboriginal people inside unsentenced contributes to the high rate of deaths in custody.

There is no support for people who are denied bail because they might have a substance dependency issue or a problem finding stable housing. They are put in prison to wait instead of offering support.

While all this is happening, delays in court and routine police overcharging mean that Aboriginal people are kept inside and brought into courts while charges are dropped and downgraded, and court is repeatedly adjourned, until they are released after sentencing for time served. Sometimes for offences that rarely even get custodial sentences.

Our other brother Shannon is a great example of being overcharged. Shannon was originally charged for aggravated break and enter (this is a serious indictable offence). Then downgraded to break and enter and eventually he was charged and found guilty of Larson therefore the short time on remand means he served time and was released from goal.

We recommend —

- NSW Police to be audited to ensure they are charging offenders with the appropriate charge from the beginning. This will decrease the number of inmates on remand and serving time that is not appropriate.

AVO conditions

There were conditions and orders issued to Nathan that were impossible for him to fulfil and set him up to fail, because of shared parenting and work arrangements.

We are also concerned that the wide range of police discretion means that some people are treated differently than others in the application of AVOs. Nathan had previously told us that he got ‘a bad cop on a bad day’. We believe that the way that he was treated was based on his race and gender as an Aboriginal man.

We recommend –

- The person who requested the AVO be held accountable if they make contact with the offender and break the order.

Why send First Nations people to gaol?

Sending Nathan to gaol served no purpose. It was a waste of time. It cost our brother his life. He was close to being released back into the community when he died.

He was in gaol for four months, much shorter than the waiting list on any program that might have been useful to him. He received no counselling while he was in there. He would have been

[2] theguardian.com/australia-news/2018/aug/30/more-than-half-of-147-indigenous-people-who-died-in-custody-had-not-been-found-guilty

better off, and in better health, staying in the community with us, working, getting independent help and having better access to health care. In March—June 2020, about a third of First Nations people in custody are there on remand (34.3%).[3] When they are sentenced prisoners, First Nations peoples are also more likely than non-Indigenous people to be there on sentences shorter than twelve months (22% of sentenced Indigenous prisoners).[4]

This help has to be funded the equivalent that prisons are funded to take people in for short sentences like Nathan's. There need to be broader service criteria and fewer chances to exclude people for particular offence categories.

We recommend —

- An audit into the use of short sentences for First Nations people, and development of short-sentence alternatives;
- Equivalent funding that would otherwise go on a short prison sentence be spent on counselling, rehabilitation and healthcare programs for these people instead.

The suitability of the oversight bodies tasked with inquiries into deaths in custody in New South Wales

Notifying families of a death in custody — NSW Police and Corrective Services

On 1 September 2018, our family experienced something no First Nations family should suffer. That was the day we found out Nathan had died in custody. We were told in a chaotic and callous way.

NSW Police came to the door of our grandfather at 4am. My grandfather called his other granddaughter Jasmine and said the police were there and could she speak with them. The police asked Jasmine who Nathan's next of kin was and said it was about a AVO and phone call. They then attended Nathan's mother Jodie and they police asked Jodie if she has a son named Nathan Reynolds and she said yes. The police said 'We think he passed away.' Jodie asked how and they said 'Breathing difficulties.' Jodie replied 'What do you mean you think?" Jodie started crying and walked away. The police left. Jodie then called Taleah.

The rest of the day, Taleah spent calling Corrective Services NSW, where she was listed as Nathan's next of kin. She could not find out where Nathan's body was, she wanted to make sure it was not still in the prison, which was unthinkable to the Reynolds family as they grieved. Everyone she attempted to contact was 'in a meeting'. She was not told where Nathan was until she called someone she knew who worked at Glebe Morgue and they confirmed he had been taken to Glebe at the State Coroners Court and forensic centre.

We recommend —

- That Corrective Services or NSW Police make contact with the family again a few hours later in case the family have any questions whether they can be answered or not.

[3] bocsar.nsw.gov.au/Pages/bocsar_custody_stats/bocsar_custody_stats.aspx
[4] alrc.gov.au/publication/incarceration-rates-of-aboriginal-and-torres-strait-islander-peoples-dp-84/4-sentencing-options/short-sentences-of-imprisonment/

Custody of loved ones' belongings

We met with the Commissioner of Corrective Services NSW 18th March 2019. At that meeting, Taleah discussed with them about wanting to collect Nathan's belongings from Outer Metropolitan. She had to ask to collect his belongings, which she was told she had to collect them from the jail.. There was no offer from Corrective Services to deliver Nathan's personal belongings, Taleah was told the person who usually looks after this sort of issue was on leave at the time. Taleah had to return to the place where Nathan died to pick them up. Taleah advised this was a very distressing time, a painful memory that she shouldn't have to live with.

We recommend —

- That Corrective Services should make contact in the following days advising they can arrange for the inmate's belongings to be delivered to the family. If a staff member is on leave there should be a back-up person that can make arrangements.

The role of families

The role of families cannot be underestimated. Without Taleah's work in representing the Reynolds family in public, in front of media, and with lawyers and investigators, we would not be where we are today. Taleah is across the details of the case in a way that protects the rest of our family from having to know and be involved in everything. Makayla has also become an advocate against deaths in custody, launching a petition[5] to get First Nations people out of prison during the pandemic that received nearly 20 000 signatures.

> "My family is one of many left behind after a loved one has been killed in custody.
>
> The COVID-19 pandemic impacts us all. The most at risk are people like my brother: Aboriginal, chronically ill and imprisoned. My brother, a proud Aboriginal man and loving dad with a known asthma condition couldn't even survive the conditions of a minimum-security prison."

It has been difficult for Nathan's whole family as we push for the justice he deserves, for reforms in his legacy, and for answers. Not everyone has a Taleah in their family, or a Makayla. The system should not have to rely on them shouldering the burden of the system.

The NSW Coroner relies on families at inquests as a de facto representative of the interests of the deceased. They are also the only party at an inquest that knows the person who died in custody as a full person, as they lived, not just as they died. They fulfil a critical, human and oversight role in the inquest process. Despite this, First Nations families are not always supported in investigations or at inquests.

There is no systematic way that First Nations families are even offered legal support after their loved ones have died in custody. We were contacted by the Aboriginal Legal Service because they had field officers who knew our family — they were notified about Nathan's death via the custody notification service. Corrective Services would not give the ALS Taleah's contact details as the next of kin because of 'privacy concerns'. Where would we be if they didn't find another way to reach us?

[5] alsnswact.org.au/free_our_people

We know some families aren't even contacted by the Coroners Court until a few months out from inquest, at which point the issues are set, the witness list is done, and lawyers have little time to plan out case strategy. Even once families have lawyers, sometimes they have to crowdfund to afford to get the whole family to attend. Families are also not always taken seriously by Counsel Assisting and the Crown Solicitors Office, whose response times to families can sometimes take months.

There is a role that the State can play in supporting families.

We recommend —

- Having an Aboriginal engagement unit, this will ensure the families have someone they can approach and trust. This will allow families to ask questions they do not understand (most families will feel out of depth).

The oversight functions performed by various State bodies in relation to reviewing all deaths in custody

Overlap of functions — overlap of blame

Something that was obvious early in how these systems responded to Nathan's death is that there is little cooperation between the organisations that are involved in deaths in custody. Justice Health NSW and Corrective Services NSW have each been pointing the finger at each other, even in early questions to Justice Health and Corrective Services from the Deputy Chair of this inquiry David Shoebridge MLC. For example —

> **Forrest (Justice Health):** Action was taken as soon as Justice Health was made aware of it […] I think that [notification time] is something that you would need to put to Corrective Services.
>
> […]
>
> **Severin (Corrective Services NSW):** Again, this is something I would have to raise with the chief executive and the board of Justice Health and the Forensic Mental Health Network.[6]

This has made it harder for us as a family to have answers on what happened in Nathan's final moments that night, and to know just what happened in Outer Metropolitan that made this asthma attack fatal. We have received contradictory information from both Justice Health NSW and Corrective Services NSW. How do we take that on, as a family? How do we make sure that we're good advocates at Nathan's inquest, if we are being dealt with this way by two large state agencies?

It has also made it difficult for us to see what could be done to make sure that something like this doesn't happen to another Nathan or another family.

After initial meetings, we have repeatedly over the last two years chased up Justice Health for information on how their resources, policies and procedures had changed since Nathan passed,

[6] Report on Proceedings before Portfolio Committee No. 4 – Legal Affairs Parklea Correctional Centre & Other Operational Issues, at Macquarie Room, Parliament House, Sydney on Friday 28 September 2018.

using their own internal review processes. They repeatedly delayed and ignored us. When they did send us the document, it was not substantial.

The Commissioner of Corrective Services has met with us, but again didn't offer us anything substantial. Corrective Services NSW invited Taleah to speak at a meeting with the Aboriginal advisory committee about her experience of the oversight system after a death in custody. They did not write back after she accepted this invitation and the meeting never eventuated. This left us feeling disrespected and tokenised.

What is really troubling to us is that Justice Health and Corrective Services both work so closely in the day to day that chronically ill people in prison and their loved ones experience them as the same organisation. That, in the review process, they are suddenly operating as two distinct entities, to us is an unfair bureaucratic barrier to answers and justice.

We recommend —

- Both Justice Health and Corrective Services should attend meetings with the families at the same time not as separate organisations. This will stop *some* of the frustration while meeting with the organisations and it will stop some of the blame both organisations do to avoid being held accountable
- That Justice Health keep families updated on the progress of the RCA report
- Both Justice Health and Corrective Services should be joined as one when both parties are involved in a death in custody.

Keeping families informed of the investigation

From the beginning of the investigation into Nathan's death, we have been kept informed by Detective Monique Cini as the investigation progresses. Taleah said she thinks that "we were lucky with the detective, she understood our families anger and upset from the beginning and showed compassion".

What little things went right for our family are because she made an extra effort that was not required for her. Even though we still don't have all the answers, we know that many families have less. We have been treated through the investigation process with a little bit of respect.

With that said, the waiting time between Nathan's death and inquest has been traumatic. There are times when the drip-feeding of information drags out our pain. Our lives are a series of meetings about this and we aren't even at inquest yet.

It should not be up to the whim of an individual officer as to whether families are kept in the loop of an investigation's progress into their loved ones' death in custody. It should be standard procedure. Every First Nations family should be able to take for granted that they will be informed, and that they can trust the transparency and sensitivity of the review into their loved one's death.

We recommend —

- That an independent, specialist investigation body investigates deaths in custody;
- That the NSW Coroners Court and the Coroners Act 2008 (NSW) provide for an Aboriginal Coroners Court liaison officer.

More than reviewing death — ensuring welfare

We know that many deaths in custody are preventable. We also know that many oversight procedures are only initiated when someone dies in custody.

An important role of an independent investigation body into deaths in custody is one that could also monitor conditions inside prisons and offer independent, arms-length, state-funded welfare services to affected First Nations people inside and support them as they leave prison. This should include independent monitoring and harm-reduction of: drug dependency in prison, the growing prescription of sedatives and anti-depressants to people inside, and the quality of healthcare inside prisons.

We think this also means providing genuinely independent counselling to people inside who experience trauma like seeing a person die in custody, which is what happened to many of Nathan's friends inside Outer Metro.

We recommend —

- That any deaths in custody independent investigation body also monitor conditions inside prisons and offer independent and funded welfare services to First Nations people inside prisons;
- That there be genuinely independent counselling provided to people inside prisons (not provided by Justice Health or Corrective Services).

How those functions should be undertaken and what structures are appropriate

Our recommendations are above.

Any other related matter

We recommend —

- Families impacted by a death in custody should deliver a component of the cultural awareness training that details the lasting effects of inaction and/or inappropriate behaviours when dealing with Aboriginal inmates. This training then should become mandatory for all staff that work with the Department of Justice (including Justice Health staff).