Submission No 3

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Name: Mr Terry Flanders

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Inquiry into the coronial jurisdiction in New South Wales

Date: 18 June 2021

Prepared by:

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[The contents of this submission includes material relating to suicide and First Nation people's deaths in custody. Should you need assistance contact Lifeline on 13 11 14]

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EXECUTIVE SUMMARY

1. Public safety is a core function of the principal NSW Government agencies, subject of this submission. Those agencies are the NSW Police Force (**NSWPF**), Corrective Services NSW (**CSNSW**), NSW Coroner, and SafeWork NSW. These agencies have a dysfunctional working relationship that endangers members of the public caught-up in police operations and prisoners in custody.

2. Evidence collected during the investigation shows that between the 2018 and 2019 calendar years the NSWPF and CSNSW only reported 19 per cent of work-related fatalities to SafeWork NSW (n. 19) compared to the number of work-related custody and police operational fatalities reported to the NSW Coroner (n 99). The practice of under-reporting work-related fatalities is sanctioned by the Legal Section of the Department of Community and Justice (**Legal Section**). Additionally:

    - Unlike SafeWork NSW, the NSW Coroner is not able to act in real time, taking years to make recommendations that may improve safe systems of work.
    - The NSW Coroner generally relies on administrative controls to ensure recommendations are implemented, not site inspections and audits.
    - The NSW Coroner seldom refers matters to SafeWork NSW even when requested. For example, the inquest into the death of Mr. David Dungay.

3. Non-government organisations, those not involved in the operation of private prisons (Parklea Correctional Centre, Junee Correctional Centre, and Clarence Correctional Centre) regularly face criminal prosecutions by SafeWork NSW for failing to report notifiable incidents such as work-related fatalities. The effect is that the NSWPF and CSNSW are avoiding benefits and criminal sanctions from WHS regulatory interventions, apparently with the assistance of the NSW Coroner and Legal Section.

4. Between 2007 and 2019, Safe Work Australia advised that reported work-related fatalities across industries had fallen by 53 per cent. During the same period, NSW Coroner data relating to deaths in custody and from police operations rose. It would be reasonable to expect that lives have been lost unnecessarily because the NSWPF and CSNSW have not followed the law.

5. Under-reporting fatalities reduces the WHS criminal antecedents of the NSWPF and CSNSW. Should they be convicted and sentenced in Court for other WHS crimes, they will receive a lighter penalty than non-government agencies that report notifiable incidents. Another benefit is that executives will be less likely to be charged with Industrial Manslaughter.

6. Flow-on effects of poor WHS leadership by the NSWPF has arguably contributed to the rise in annual workers compensation and recruitment costs, estimated by one source as being $800 million, and more suicide deaths of police officers than police officer homicide deaths.

7. This matter must be resolved now. Australian reported crime rates are at extremely low levels. This is likely to change due to global production of narcotics and methamphetamine. Increased crime rates will result in the incarceration of more people through police operations. Should the system not be changed, fatalities associated with custody and police operations will increase. As NSWP officers are struggling to cope with current crime rates; police suicides, costs associated with law enforcement and prison operations will continue to rise exponentially.

RECOMMENDATIONS:

Regulatory and custodial agencies must be held accountable to ensure public confidence is maintained in the NSW justice system. The Recommendations below are themed on that outcome.

The NSW Government should:

Recommendation 1:	Amend the NSW WHS legislation to close any loophole allowing NSW government departments to avoid reporting notifiable incidents to SafeWork NSW.
Recommendation 2:	Have the NSW Coroner and SafeWork NSW enter a memorandum of understanding so both departments can co-operate in the development of safer systems of work within the NSWPF and CSNSW. SafeWork NSW should be an agency that assists the NSW Coroner.
Recommendation 3:	SafeWork NSW conduct site inspections to ensure the NSWPF, CSNSW, and other PCBU's have implemented the NSW Coroner's fatality recommendations.
Recommendation 4:	Review recent NSW Coroner's inquest reports dealing with deaths in custody or fatalities from police operations with the purpose of initiating work health & safety prosecutions if needed as well as monitoring and reviewing change programs recommended by the NSW Coroner.
Recommendation 5:	Investigate under-reporting of fatalities by NSWPF and CSNSW to determine if any crimes have been committed by individuals or the agencies. For example, *Crimes Act 1900* (NSW), Section 317 'Tamper (Conceal or Suppress) Evidence.
Recommendation 6:	That suicide deaths in custody and resulting from police operations be a category of death reported on by the NSW Coroner and investigated by SafeWork NSW for failures in safe systems of work.
Recommendation 7:	If no WHS crimes have been committed, NSWPF executives should be referred to the Law Enforcement Conduct Commission to determine whether the practice of under-reporting WHS work-related fatalities is an unethical practice.

Recommendation 8: If the NSWPF and CSNSW are found to have not committed any WHS crimes, then non-government organisations (those not involved in the operation of private prisons) that have been prosecuted by SafeWork NSW (formerly NSW WorkCover) for failing to report serious incidents should have their WHS convictions removed from their WHS criminal antecedents.

Recommendation 9. If the NSWPF and CSNSW have not committed any WHS crimes, then non-government organisations (those not involved in the operation of private prisons) that have been prosecuted by SafeWork NSW (formerly NSW WorkCover) for failing to report serious incidents should have any costs associated with a conviction returned to the entity with interest.

Recommendation 10. Ensure NSWPF and CSNSW executives undergo remedial WHS Representative training from an authorised provider.

Recommendation 11. Review all other legal opinions provided by the Department of Community and Justice Legal Section relating to WHS advice to ensure those opinions conform to the spirit of the WHS legislation.

Recommendation 12. Review other custodial departments operating within NSW, for example Juvenile Justice or Child Protective Services, to ensure the practice of under-reporting fatalities and/or serious injuries to SafeWork NSW is not occurring in those agencies.

Recommendation 13. Review the WHS hierarchical order of risk controls to consider if Administrative Controls should be elevated given their importance.

Recommendation 14 If not already included, the NSW Bureau of Crime Statistics and Research should be advised to include:

i. Direct and indirect costs associated with deaths in custody and fatalities arising from police operations in their calculations of crime costs.
ii. First responder workers compensation, recruitment costs, and associated social costs in their calculations of crime costs.
iii. Costs associated with civil and work health and safety prosecutions against the NSW Police Force and Corrective Services NSW in their calculations of crime costs.

That is, treat WHS crimes as white-collar crimes the same as fraud crimes.

Recommendation 14. Fully resource any initiative arising from this Inquiry.

INTRODUCTION

8. This submission forms part of the evidence collected from an on-going investigation into corruption within the NSW Police Force (**NSWPF**). Recently, the investigation focused on the operation of the NSWPF work health and safety (**WHS**) system.

9. In 2018, a submission was accepted by The Senate Education and Employment References Committee 'The people behind 000: mental health of our first responders' which included investigative findings at that time. As the investigation continued, it became apparent that there was an anomaly between fatalities reported to the NSW Coroner by the NSWPF and fatality data reported by the NSWPF to SafeWork NSW.

10. This submission includes evidence collected since the Senate submission.[1] Investigation findings to date will be presented under the following headings.
    1. Limitations.
    2. Assumptions.
    3. Lexicon.
    4. Methodology.
    5. Work Health & Safety Fatality Reporting.
    6. Work-Related Fatality Data.
    7. Findings.
    8. Conclusion.

LIMITATIONS

11. Working from outside government with limited resources, research has been restricted to publicly available information. Should additional information become available then the assumptions, conclusions, and opinions in this submission may need to be reviewed.

12. No complex statistical analysis was undertaken. Tables and graphs presented in this submission are factually representative of data collected from listed sources.

13. Any commentary regarding laws and allegations of corruption or criminal conduct should not be viewed as legal opinion or as being directed against a particular individual.

ASSUMPTIONS

14. Assumptions, opinions, and conclusions are based on separate fields of knowledge including health and safety, criminology, and operational law enforcement. Having a Graduate Diploma in Applied Science (OHS Management Systems), a Diploma in Criminology, and

[1] Mr Terry Flanders Submission No. 5
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/Mentalhealth/Submissions

Graduate Certificate in Psychology of Risk coupled with 25 years of criminal investigative experience in the NSW Police Force and 21 years' experience providing safety, security, and investigative consultancy services. In that time, I have worked for state and federal government as well as non-government agencies. I believe I am qualified and able to assist the Inquiry with its investigation into the coronial jurisdiction in New South Wales, given the terms of reference.

15. The assumptions below are a reasonable interpretation of evidence collected during the investigation:

    a) NSWPF is a legal entity subject to NSW WHS laws.
    b) CSNSW is a legal entity subject to NSW WHS laws.
    c) CSNSW includes a number of privately run correctional facilities, e.g. Parklea Correctional Centre.
    d) WHS laws are criminal laws including, now, the crime of Industrial Manslaughter.
    e) WHS laws make the person conducting the business or undertaking (**PCBU**) responsible for any harm to workers or others injured (physically or psychologically) by the work-related activities of the PCBU.
    f) WHS due diligence is narrower than civil due diligence as the PCBU is required to know what risk(s) or hazards(s) may arise from their work activities.
    g) The NSW WHS regulator, SafeWork NSW, when determining a prosecution, may elect to prosecute the PCBU corporate entity, or an individual.
    h) Bystanders include members of the public and prisoners in custody. That is, people who are not workers employed by the NSWPF or CSNSW or engaged in the provision of services on behalf of the NSWPF or CSNSW.
    i) NSW criminal courts on sentencing a corporation or individual rely on past recorded criminal antecedents to determine an appropriate deterrent (sentence) for the crime charged.
    j) Under-reporting work-related fatalities to SafeWork NSW likely avoids penalties being increased at sentencing for the NSWPF and CSNSW.
    k) It is a WHS crime not to report work-related fatalities and/or serious injuries to SafeWork NSW.
    l) Non-government organisations are being prosecuted and convicted for failing to report notifiable incidents to SafeWork NSW (formerly NSW WorkCover).
    m) Large construction, mining, and manufacturing organisations who abide by WHS laws and report work-related fatalities are likely to be at greater risk of receiving higher penalties on sentence for other WHS offences due to their self-reported WHS criminal history (antecedents).
    n) The practice of under-reporting work-related fatalities by the CSNSW to SafeWork NSW is supported by the Department of Communities & Justice, Legal Services Section.
    o) Therefore, it is highly likely that the same practice by the NSWPF is also supported by the same Legal unit, given both the NSWPF and CSNSW operate within the justice system.
    p) In addition, unsafe systems of work within the NSWPF have likely contributed to:

        i. More police officer suicides than police officer homicides.
        ii. A rise in police officer resignations.

iii. A rise in police officer workers compensation claims.

16. Should additional material become available, it may be necessary to revise the assumptions, opinions, and conclusions in this submission.

LEXICON

17. WHS, like other fields, has developed a language of its own. Five concepts or terms featured in this submission need explanation. They are:

    A. Persons Conducting the Business or Undertaking (**PCBU**);
    B. Work Health & Safety Due Diligence;
    C. Work Health & Safety 'Safe' Systems of Work;
    D. Bystanders (others); and
    E. NSW Government.

A. Persons Conducting the Business or Undertaking

18. The person conducting the business or undertaking or PCBU is described by Safe Work Australia in the following terms: [2]

> *"The WHS Act places the primary duty of care and various other duties and obligations on a 'person conducting a business or undertaking' (PCBU). The meaning of a PCBU is set out in section 5 of the WHS Act.*
>
> *This is a broad concept used to capture all types of modern working arrangements.*
>
> *A 'person' may be an organisation or an individual.*
>
> *A 'person' is defined in laws dealing with interpretation of legislation to include a body corporate (company), unincorporated body or association and a partnership.*
> *An individual is also a 'person', but will only be a PCBU where that individual is conducting the business in their own right (as a sole trader or self-employed person). Individuals who are in a partnership that is conducting a business will individually and collectively be a PCBU.*

[2] Interpretive Guideline-Model Work Health and Safety Act. The Meaning of 'person Conducting a Business or Undertaking.' (Guide)
https://www.safeworkaustralia.gov.au/system/files/documents/1702/interpretive_guideline_-_pcbu.pdf

Section 5 (4) of the WHS Act makes it clear that an individual is not a PCBU if they are involved in the business or undertaking only as a worker or officer of the business or undertaking.

The Crown is also a person for the purposes of the WHS Act. The Crown may conduct a business or undertaking through its departments and statutory agencies."

19. The Guide continue and describes other concepts such as business, undertaking and work.

B. Work Health & Safety Due Diligence

20. SafeWork NSW provides the following advice to reasonably ensure that a PCBU has been diligent in their WHS duties of care.[3]

"The reasonable steps you must take include:

1. *maintaining up-to-date knowledge of work health and safety matters as they apply to your specific operation.*
2. *understand the nature of the business and its hazards and risks.*
3. *ensuring the business has, and uses, appropriate resources and processes to eliminate or minimise risks to health and safety associated with the operations of the business or undertaking.*
4. *ensuring the business or undertaking has appropriate processes to receive information about incidents, hazards and risks, and can respond to that information in a timely manner.*
5. *ensuring the business has processes – and implements those process – to comply with any WHS obligation.*
6. *verifying that these steps have been carried out."*

C. Work Health & Safety 'Safe' System of Work.

21. In defining WHS (formerly occupational health and safety or OHS) systems of work, the Australian Institute of Health & Safety (AIHS-formerly Safety Institute of Australia) relied upon AS/NZS 4801:2001 Occupational Health and Safety Management Systems to describe the concept:[4]

"*That part of the overall management system which includes organisational structure, planning activities, responsibilities, practices, procedures, processes and resources for developing, implementing, achieving, reviewing and*

[3] SafeWork NSW Due Diligence https://www.safework.nsw.gov.au/legal-obligations/employer-business-obligations/due-diligence
[4] 'Systems: Core body of knowledge for the OHS professional; SIA 2012, Tullamarine VIC; P. 7

maintaining the OHS policy, and so managing the OHS risks associated with the business of the organisation".

22. Systems exist all around us. All systems are open to direct or indirect influence. Causal factors that can converge to create a negative event pathway creating harm, loss, or a near miss event in a WHS system are more fluid than the concept of legal causality. For example, the influencing effect an organisational culture can have on workplace systems. Hopkins (2005) described this influencing feature in simple terms as "*the way we do things around here*",[5] or business as usual. Citing 'Schein' (P. 8), Hopkins (2005) later described the impact leaders can have on a safety system by the organisational culture they promote:

> *"Leaders create culture, he says, by "what they systematically pay attention to. This can mean anything from what they notice and comment on to what they measure, control, reward and in others (sic) ways systematically deal with."*

23. A system of work can be mechanical, financial, health based, or any other conceivable type of system of work. 'Safe' systems of work are the background systems that make all other systems of work safe for human operators. The NSWPF and CSNSW are not engaged in heavy industry, mining, or construction. Their systems of work are people-centric.

D. Bystanders (Others).

24. The nationally harmonised WHS laws refers to 'other persons' when describing the duty of care a PCBU has to non-workers (others).[6] Safe Work Australia has adopted the term 'bystander' for reporting purposes to describe non-workers injured by work-related activities.

25. SWA defines a 'bystander' fatality as:[7]

> *"The death of a person who dies from injuries sustained as a result of another person's work activity and who was not engaged in a work activity of their own at the time of the injury. A traffic incident death is only classified as a bystander fatality when attributable to someone else's work activity. Typically, this means the driver of a work vehicle is at fault. Cases where fault could not be determined with sufficient confidence are excluded".*

26. The NSW Coroner, discussing the need for inquests into deaths in custody or fatalities arising from police operations provides the following characterisation of a death in custody:[8]

[5] Hopkins A. (2005) '*Safety Culture and Risk: The organisational causes of disaster*'; CCH Australia Ltd P. 7.
[6] Work Health & Safety Act 2011 Section 19 Primary Duty of Care.
http://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/nsw/consol_act/whasa2011218/s19.html
[7] Safe Work Australia Work-related Traumatic Injury Fatalities, Australia 2019, Glossary P. 32
[8] NSW Coroners Reports for Deaths in Custody/Police Operations 2019 P. 8

"It was agreed by all mainland State and Territory governments in their responses to recommendations of the Royal Commission into Aboriginal Deaths in Custody that a definition of a 'death in custody' should, at the least, include:

- *the death, wherever occurring, of a person who is in prison custody, police custody, detention as a juvenile or detention pursuant to the Migration Act 1958 (Cth);*
- *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;*
- *the death, wherever occurring, of a person who died or is fatally injured in the process of police or prison officers attempting to detain that person; and*
- *the death, wherever occurring, of a person who died or is fatally injured in the process of that person escaping or attempting to escape from prison custody or police custody or juvenile detention.*

"Section 23 of the Coroners Act 2009 (NSW) expands this definition to include circumstances where the death occurred:

- *while temporarily absent from a detention centre, a prison or a lock-up; and*
- *while proceeding to a detention centre, a prison or a lock-up when in the company of a police officer or other official charged with the person's care or custody."*

27. The NSW Coroner describes a fatality arising from police operations as:[9]

"A death which occurs 'as a result of or in the course of a police operation' is not defined in the Coroner's Act 2009. Following the commencement of the 1993 amendments to the Coroners Act 1980, New South Wales State Coroner's Circular No. 24 sought to describe potential scenarios that are likely deaths 'as a result of, or in the course of, a police operation' as referred to in Section 23 of the Coroners Act 2009, as follows:

- *any police operation calculated to apprehend a person(s)*
- *a police siege or a police shooting*
- *a high speed police motor vehicle pursuit*
- *an operation to contain or restrain persons*
- *an evacuation*
- *a traffic control/enforcement*
- *a road block*
- *execution of a writ/service of process*
- *any other circumstance considered applicable by the State Coroner or a Deputy State Coroner."*

[9] NSW Coroners Reports for Deaths in Custody/Police Operations 2019 P. 9

28. Just like members of the public exposed to the work-related activities of a police operation. People in custody (prisoners) have little, if any, control over the work-related activities they are exposed to.

29. The NSW Coroner has a similar characterisation for the WHS concept of 'bystander'. Understanding that both the SWA definition of 'bystander(s)' and the NSW Coroner's description of a fatality event in custody or from a police operation are both, in their own way, describing the work-related activities of the NSWPF and CSNSW, is important as it connects fatalities in custody or from police operations involving bystander(s), to criminal offences under WHS laws.

30. Throughout the rest of the submission, the term 'bystander' will be used to describe those people, not employed by the NSWPF or CSNSW that are fatally injured while in custody or from a police operation. That is, prisoners and members of the public.

E. NSW Government

31. Any reference to the NSW Government includes all political parties whether in power or in opposition.

METHODOLOGY

32. During the investigation, material was collected from the following sources and analysed:

- Australian Institute of Criminology (**AIC**);
- Austlii data base;
- Australian Lawyers Alliance (**ALA**) – research paper;
- Corrective Services NSW (**CSNSW**) – internet search and email correspondence;
- Law Enforcement Conduct Commission (**LECC**)– Annual Reports;
- National Coronial Information System (**NCIS**);
- Newspaper articles-internet search;
- NSW Bureau of Crime Statistics and Research (**NSW BOCSAR**);
- NSW Coroner-inquest reports into deaths in custody and fatalities arising from police operations – internet search;
- NSW Police Force (NSWPF) – Government Information (Public Access) Act (**GIPAA**) and internet search;
- Research papers, journal articles, standards, and other academic material referenced in the submission;
- SafeWork NSW – GIPAA x 2, and correspondence;
- Safe Work Australia (SWA) – internet search;
- *Work Health & Safety Act 2011* (NSW);
- *Work Health & Safety Regulations 2017* (NSW);

33. One outcome from the Royal Commission into Aboriginal Deaths in Custody was an agreement by all Australian jurisdictions to report on deaths in custody and fatalities arising from police operations. The NSW Coroner began reporting statistical data for calendar year periods from 1994, until 2019. The 2020 NSW Coroner's finding into custody and police operational fatalities is yet to be published.

34. The NSW Coroner does not distinguish between CSNSW deaths in custody and NSWPF deaths in custody in the calendar year the fatality was first reported. It is only after an inquest one can determine publicly whether the custody fatality involved the NSWPF or CSNSW.

35. SafeWork NSW reports work-related fatality data involving workers and bystanders to Safe Work Australia as do other WHS regulators across Australia. Safe Work Australia releases all Australian reported work-related fatality data for calendar year periods.

36. Other sources of fatality data are the AIC and LECC. Fatality data from the AIC and LECC is based on financial year periods.

37. The NSWPF Honour Roll and NCIS has also been used as a source of fatality data. The NSWPF Honour Roll contains fatality data relating to police officers and includes homicides and suicides arising from their duties. It is assumed that the police officer homicide data is accurate. The police officer suicide data is inconsistently reported. The NCIS is the Australian database for all coronial matters.

WORK HEALTH & SAFETY FATALITY REPORTING

38. Except for Victoria, all other Australian jurisdictions operate under a harmonised WHS legal system, based on a Commonwealth model. Even New Zealand has adopted a similar WHS legal structure.

39. This section will identify and discuss relevant areas of the NSW WHS legislation as regulated by SafeWork NSW.

40. The vision and mission statements from SafeWork NSW focus on reducing work-related fatalities in the building and construction industry.[10] In part, the Object of the WHS Act is:[11]

> *"(1) The main object of this Act is to provide for a balanced and nationally consistent framework to secure the health and safety of workers and workplaces by--*

[10] https://www.safework.nsw.gov.au/resource-library/construction/building-and-construction-sector-plan/purpose,-vision-and-success#:~:text=To%20eliminate%20workplace%20deaths%2C%20serious,work%20health%20and%20safety%20obligations.

[11] Work Health & Safety Act 2011 Section 3 'Object' http://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/nsw/consol_act/whasa2011218/s3.html

(a) protecting workers and other persons against harm to their health, safety and welfare through the elimination or minimisation of risks arising from work or from specified types of substances or plant"

41. SafeWork NSW's stated vision and mission does not appear to encapsulate the breadth of the agency's regulatory focus.

42. The WHS Act Section 35 describes a 'notifiable incident' as:

"*(a) the death of a person, or*

(b) a serious injury or illness of a person, or

(c) a dangerous incident."

43. In part, Section 38 of the Act provides a penalty for failing to report a notifiable incident described in the following terms: [12]

"*1) A person who conducts a business or undertaking must ensure that the regulator is notified immediately after becoming aware that a notifiable incident arising out of the conduct of the business or undertaking has occurred.*

: Maximum penalty--

(a) in the case of an individual--115 penalty units, or

(b) in the case of a body corporate--575 penalty units.

(2) The notice must be given in accordance with this section and by the fastest possible means…."

44. Although a financial loss is the penalty associated with failure to report a notifiable incident, this is the law that is applied to others outside of the NSWPF and CSNSW. With the introduction of Industrial Manslaughter crimes in NSW and a penalty of 25 years imprisonment, work-related fatality under-reporting should be seen as a serious offence. Given the practice has been adopted by the NSWPF and CSNSW, with or without the knowing participation of the NSW Coroner, the practice must be considered reprehensible if not a step in proving 'recklessness'.

45. Data collected from two sources describes a loophole for government departments to avoid reporting fatalities to WHS regulators. The first source is the Australian Lawyers Association (**ALA**), the second source is CSNSW Executive Services.

46. Researchers from ALA identified an ambiguity at the Commonwealth level when fatalities and other serious incidents were under-reported by detention centre operators.[13] ALA

[12] Work Health & Safety Act Section 38 Duty to Notify of Notifiable Incidents http://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/nsw/consol_act/whasa2011218/s38.html

[13] Untold Damage Workplace health and safety in immigration detention under the Work, Health and Safety Act 2011 (Cth) (2016) Australian Lawyers Association (P. 17) https://www.lawyersalliance.com.au/documents/item/583

researchers made many Recommendations of which the Inquiry should take notice. One Recommendation included the following observation, which highlights the ambiguity identified by researchers:

> *"Comcare should review its interpretation of the WHS Act. A broad interpretation of the types of injuries, illnesses and incidents that it should investigate should be adopted. A broad interpretation of 'the conduct of the business or undertaking' should also be used. This is required to meet the objects of the WHS Act to enhance the health and safety of workplaces. Comcare should also ensure that penalty provisions are enforced for failure to comply with duties under the WHS Act in relation to other persons, including prosecuting offences where relevant*."

47. The CSNSW describes the purpose of its operations, in part, as being "***to reduce reoffending and enhance community safety*".** During the investigation email correspondence was sent from CSNSW Executive Services as a follow-up to an earlier telephone conversation with a staff member from that office. The staff member's name is being withheld to protect their privacy. A redacted copy of the email is contained in **Appendix A 'CSNSW Email Dated 18 March 2020'**.

48. The main body of the CSNSW email has been transcribed below:

> *"Dear Mr Flanders*
>
> *Further to our telephone conversation and in response to your enquiry, the following information has been provided by the Department of Communities & Justice Legal Services.*
>
> *The Work Health and Safety Act 2011 (NSW) (Act), the corresponding Work Health and Safety Regulations 2017 and the Guide to Work Health and Safety Incident Notification (Guide) have been reviewed and the following is noted:*
>
> • *The death of a person (whether worker or bystander) is only notifiable to WorkSafe NSW (WSNSW) (sic) where the death has arisen out of the conduct of the business. Section 38 of the WH&S Act.*
>
> • *Unless the death of an inmate/visitor (bystander) has arisen out of the conduct of the correctional facility, it is not notifiable to WSNSW under section 38.*
>
> • *The object of the Act is designed to primarily provide for a balanced framework to secure the health and safety of workers and workplaces. The Act does not define what comes within the meaning of arising out of the "conduct of the business'. However, the Guide states that it "generally" refers to business activities or work (including services) undertaken in the course of business…this would include ancillary activities or work (including services undertaken in the course of business…this would include ancillary activities such as arranging maintenance or supplies. Further, it states that although there must be a*

connection between the business activity and the notifiable incident, the business activity may not be the direct of sole cause of the notifiable incident.

- *In contrast, all deaths of an inmate must be reported to the NSW Coroner: s 74 of the Crimes (Administration of Sentences) Act 1999.*

- *A Senior Coroner is required to hold an inquest into these deaths: section 23 and section 27 of the Coroners Act 2009.*

- *In findings the Senior Coroner can make recommendations aimed at, amongst other things, improving public health and safety. The Senior Coroner can also recommend that the matter be investigated or reviewed by a specified body: section 82 of the Coroner Act 2009. The second part of the recommendation function gives the Senior Coroner scope to refer the death to WSNSW, should that be deemed appropriate.*

"If you require any statistical data regarding deaths that occur in Corrective Services NSW custody, you will need to make and application under the Government Information (Public Access) Act (GIPAA) 2009. Information and application forms for making a GIPAA application can be found of (sic) the Department of Communities & Justice web site at

https://www.justice.nsw.gov.au/contact-us/access-to-information

"With regard to NSW Police operations, as advised during our telephone conversation, NSW Police do not conduct operations at NSW correctional facilities. I you are seeking information in relation to deaths in police custody, you will need to contact NSW Police directly with your enquiry."

49. As evidenced in the CSNSW Email, the source of this advising is the Legal Section of the Department of Community and Justice (**Legal Section**). The Legal Section identifies the NSW Coroner as being the agency that CSNSW must report deaths in custody to. There are many points in the advising that are arguably contrary to the application of WHS in non-government organisations that do not operate private prisons. Those arguments will not be addressed in this submission.

50. The advising identifies an ambiguity in the WHS legislation. In layman's terms, the ambiguity appears to be one of specificity. The WHS legislation uses non-specific language 'arising from the conduct of the business or undertaking'**.**[14] This non-specific term is appropriate as WHS laws apply to a multitude of businesses or undertakings that are not specifically related to custody or police operations. The NSW Coroner could specifically define what in essence are the work-related activities of CSNSW and the NSWPF. Specificity should not provide a rationale for bypassing duties and responsibilities under WHS law as it is applied to other organisations.

[14] Work Health & Safety Act Section 38 Duty to Notify of Notifiable Incidents http://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/nsw/consol_act/whasa2011218/s38.html

51. This matter needs to be thoroughly investigated by the Inquiry. Relevant questions can include, but should not be limited to:

    - The Government identified an ambiguity with the WHS legislation, why was it not corrected, so that NSWPF and CSNSW would fall in line with other non-government organisations that do not operate private prisons?
    - How long has this practice been in operation?
    - Are there any other government agencies under-reporting work-related fatalities to SafeWork NSW?

52. Should questions like these remain unanswered, the evidence supports an argument that the Government is keeping two sets of WHS books. One for government agencies and one for non-government agencies that do not operate private prisons.[15]

53. SafeWork NSW is designed specifically to investigate, regulate, prosecute, advise, and support PCBU's to reduce the risk of harm to workers and bystanders from work-related fatalities. NSW Coroner's are not.

54. SafeWork NSW operates in real time. The NSW Coroners do not.

55. SafeWork NSW can physically inspect workplaces to ensure that recommendations have been adopted. NSW Coroners do not.

56. Another point of difference between SafeWork NSW and the NSW Coroner is that SafeWork NSW notifiable incidents include serious injuries. Serious injuries to bystanders are also to be reported immediately to SafeWork NSW, just like fatalities. Serious injuries are described as: [16]

    "*In this Part,*

    "serious injury or illness of a person" means an injury or illness requiring the person to have-

    (a) immediate treatment as an in-patient in a hospital, or

    (b) immediate treatment for--

    (i) the amputation of any part of his or her body, or

    (ii) a serious head injury, or

    (iii) a serious eye injury, or

    (iv) a serious burn, or

    (v) the separation of his or her skin from an underlying tissue (such as degloving or scalping), or

[15] SafeWork NSW v Grey Colt Pty Ltd [2019] NSWDC 68 (22 March 2019)
[16] Work Health & Safety Act Section What is a serious injury or illness.
http://www.austlii.edu.au/cgi-bin/viewdoc/au/legis/nsw/consol_act/whasa2011218/s38.html

(vi) a spinal injury, or

(vii) the loss of a bodily function, or

(viii) serious lacerations, or

(c) medical treatment within 48 hours of exposure to a substance,

and includes any other injury or illness prescribed by the regulations but does not include an illness or injury of a prescribed kind."

57. On 9 June 2016, Anne-Marie Petitfils, 74 years old was shot in the leg by a police officer during the arrest of Jerry Sourian, a knife-wielding man at Westfields Hornsby. Ms Petitfils is suing the NSWPF for negligence.[17] Two other elderly pedestrians were also seriously injured. As this was not a fatality, the NSWPF should have reported the matter to SafeWork NSW immediately.

58. If the NSWPF and CSNSW are enforcing WHS laws and not obfuscating their WHS duty of care, the matter of Petitfils, and other incidents where prisoners or members of the public were seriously injured in custody or because of police operations, should have been reported to the NSW WHS Regulator at the time of the incident. If these serious incidents have not, then this is further evidence of a 'guilty mind' at work and may legally be argued that the practice, over-time, exhibits reckless indifference on the part of the NSWPF and CSNSW.

59. The NSWPF clearly understood their duty to report both fatalities and serious injuries to SafeWork NSW. On 3 July 2013 NSWPF Officer A left her workplace and committed suicide.[18] Twelve months earlier, Officer A had attempted suicide and was taken to hospital. This early attempt was not reported to WorkCover NSW (now SafeWork NSW) nor investigated by the NSWPF. The NSWPF acknowledged that this was an error on their part. Officer A's death is listed in the NSW Coroner Reports and recorded on the NSWPF Honour Roll as being duty related.

60. Evidence supports the view that not only is the NSWPF not reporting serious injuries to SafeWork NSW, but they may also be under-reporting fatalities to the NSW Coroner. Or the NSW Coroner is not reporting all police operational fatalities. For example:
    1. On 17 August 2004 Senior Constable David John Guff committed suicide. The District Court found that his death was work related.[19] Senior Constable Guff's death was not located in the NSW Coroner's database as having occurred because of police operations. Senior Constable Guff's death is not recorded on the NSWPF Honour Roll.

    2. The suicide death of Sergeant Glenn Howard Stirton at Albury Police Station on 20 December 2012 was not located in a search of the NSW Coroner's database as having

[17] Sydney Morning Herald Article dated 20.04.2020 by Georgina Mitchell https://www.smh.com.au/national/nsw/bystander-suing-after-being-shot-during-police-stand-off-with-knife-wielding-man-20200416-p54kej.html
[18] NSW Coroner Report dated 18.12.16 Case No. 203515
[19] Guff v NSW Police (No 2) [2007] NSWDC 290 (24 Oct 2007)

occurred because of police operations. The NSW Police Honour Roll records the cause of Sergeant Stirton's death as:

"Sgt Glenn Howard Stirton - Death from Suicide resulting from their duties (awarded Commissioner's Valour Award)" [20]

61. It does appear that the NSW Coroner is also under-reporting fatalities to SafeWork NSW.

62. A search of the NSW Coroners custody and police operation fatality data base showed that from the 923 inquests recorded between 1995 and 2019 six inquests related to the NSW WHS Regulator. Three were reported to the NSW WHS regulator, two of these being prisoners on work release, falling from height on a worksite. The third involved a police officer shot by other police during an operation. The other three matters involved applications to have the matter referred to the NSW WHS regulator by the deceased family. An application refused by each of the coroners. Those matters are:

    1. On 18 March 2012 Mr Robert Curti died during his arrest of undetermined causes when police officers restrained him after he was acting irrationally. Senior Counsel representing the family requested that the matter be referred to WorkCover NSW. The coroner replied:

    "*Mr Hamill also submitted that I should refer to this matter to Workcover for investigation. I do not intend to do so as I view the issues raised by the evidence as being policing issues warranting investigation and review by policing bodies as opposed to a Workcover investigation*." [21]

    2. On 29 December 2015 David Dungay died while being restrained in custody at Long Bay Correctional Complex. The solicitor representing the family requested the matter be referred to the health and safety regulator.[22] The coroner replied in part:

    "*…in relation to further submissions made by the solicitor for the Dungay Family regarding potential work, health and safety prosecution. Having regard to each of these matters, the submissions cannot be accepted*."

    3. On 19 July 2016 Rebecca Maher died in police custody. Representations were made by Counsel for the family that the matter be referred to SafeWork NSW.[23] The coroner replied in part:

[20] NSWPF Honour Roll https://www.police.nsw.gov.au/about_us/remembrance_for_fallen_police_officers/remembrance/roll_of_honour#:~:text=The%20Honour%20Roll%20commemorates%20those,the%20execution%20of%20their%20duty.&text=Also%20included%20on%20the%20Honour,of%20any%20Australian%20Police%20jurisdiction.
[21] NSW Coroner Report dated 2012 Case No. 866602.
[22] NSW Coroner Report dated 2019 Case No. 381722.
[23] NSW Coroner Report dated 2019 Case No. 218940.

"... I accept Mr Spartalis' submissions in this regard and decline to make a referral to Safework NSW or forward a copy of my findings."

63. CSNSW custody deaths are also under-reported to the NSW Coroner. One Coroner identified another loophole with reporting deaths in custody. This loophole is created when CSNSW release a terminally ill patient from custody after they had been taken to hospital, shortly prior to their death. Under these circumstances, CSNSW excluded that death from being reported to the coroner. The coroner referred to the practice as a *'technical' reduction.*[24]

64. It is possible, given the problematic fatality reporting practices of the NSWPF and CSNSW, that the NSWPF and CSNSW are selecting what fatality data is reported to regulators.

65. Two matters that consistently result in fatal injuries over time and are yet to be resolved by the NSW Coroner are: torn bed sheets used to commit suicide in a correctional setting and fatalities caused by high-speed pursuits during police operations, the NSWPF safe driving policy. Table 1 provides a sample of reference sources.

66. A third area relates to those people who are mentally ill and are fatally injured or cause fatal injuries to others in custody or because of a police operation. However, submission time constraints prevent a deeper analysis of this issue. More references can be provided if required.

Table 1: References for reoccurring causes for fatalities not rectified by NSW Coroner	
Corrective Services NSW - Torn Bed Sheets	**NSW Police Force – Safe Driving Policy**
NSW Coroners Report 2002 Case No 1091	NSW Coroners Report 2004 Case No 187
NSW Coroners Report 2011 Case No 725	NSW Coroners Report 2012 Case No 174
NSW Coroners Report 2018 Case No.231300	NSW Coroners Report 2018 Case No 72079
NSW Coroners Report 2019 Case No.225920	NSW Coroners Report 2019 Case No 96394

67. Many of the coronial recommendations by the NSW Coroner regarding deaths in custody and police operations resulted in changes to systems of work for CSNSW and NSWPF. A review of the 2018 fatality reports found that 11 of the inquests involved a level of culpability that SafeWork NSW would have likely prosecuted if the fatalities were reported. Two involved non-government PCBU's that were also not reported to SafeWork NSW. [25]

68. The NSWPF does in fact report some WHS crimes to SafeWork NSW. In 2018, a search of the NSWP WHS convictions recorded on the Austlii website identified eight NSW WHS regulatory convictions against the NSWPF with one WHS offence outstanding. [26]

[24] 2018 NSW Coroner Deaths in Custody and fatalities arising from police operations (P. 7 & 8).
[25] NSW Coroner Report dated 2018 Case No.199540
NSW Coroner Report dated 2018 Case No.5348
[26] Mr Terry Flanders Submission No. 5
https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Education_and_Employment/Mentalhealth/Submissions

69. Data collected from other jurisdictions indicates under-reporting of work-related fatalities by government agencies to their WHS regulators is not confined to NSW. For example, the ALA research paper.

Conclusion:

70. Practices within the NSWPF and CSNSW show a pattern of behaviour that is consistent between both agencies and extends over time. Although not yet tested, this pattern of behaviour could fall within the definition of recklessness required to secure an Industrial Manslaughter conviction.

71. It is also highly likely that the NSWPF received a similar advising from the Legal Section as did CSNSW. If not, there is no explanation why the NSWPF is under-reporting work-related fatalities to SafeWork NSW. Fatalities that involve police officers and members of the public.

72. The stated purpose of the NSW Coroner is to improve public safety, yet the coroner seldom refers matters to the WHS regulator. Nor has the NSW Coroner been able to reduce the frequency of custody and police operational fatalities.

73. By under-reporting health and safety fatalities, the NSWPF and CSNSW will not learn from their failures. Failure learning is an import outcome associated with WHS corporate governance and part of the continuing upwards spiral of WHS improvement.27

WORK-RELATED FATALITY DATA

74. Data relating to custody and police operations fatality includes material from different sources that has been grouped by calendar year (NSW Coroner, GIPAA material, and Safe Work Australia) and financial year (Australian Institute of Criminology and Law Enforcement Conduct Commission). Fatality data from Barron,[28] the NSWPF Honour Roll and National Coronial Information System, will comprise a third grouping which has been extended to include serious injury data relating to the NSWPF only.

75. After reviewing a sample of coroner's reports, two issues were identified relating to the category or classification of death. Firstly, suicide deaths are not a category of death listed in custody and police operations fatality reports by the coroner.[29] Secondly, although some deaths are recorded as 'natural causes', failures in the system of work related to medical care can result in the acceleration of that death.[30]

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[27] Hopkins A. (2009) '*Learning from High Reliability Organisations'*; CCH Australia Ltd.& Hopkins A. (2008) '*Failure to Learn: The BP Texas City refinery disaster';* CCH Australia Ltd.

[28] Barron S. (2010) Police officer suicide within the New South Wales Police Force from 1999 to 2008, *Police Practice and Research: An International Journal*, 11:4, 371-382, DOI: 10.1080/15614263.2010.496568

[29] NSW Coroner Report dated 2018 P. 15.

[30] NSW Coroner Report dated 2018 Case No. 354840

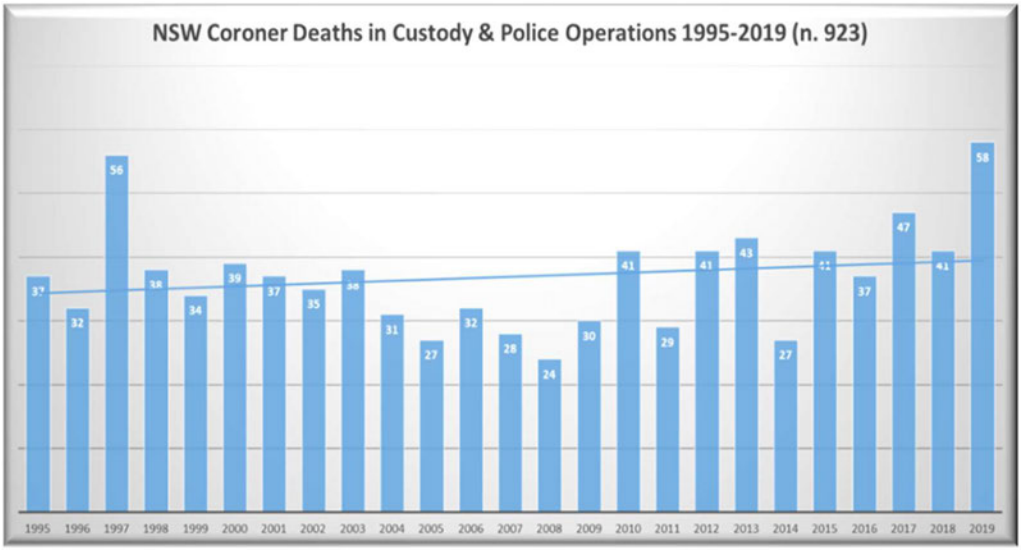
NSW Coroner Report dated 2018 Case No. 149781

Calendar Year Fatality Data

76. The data within the calendar year reporting period is sourced from the NSW Coroner custody and police operation fatality reports. SafeWork NSW GIPAA request and Safe Work Australia workers compensation fatality data.

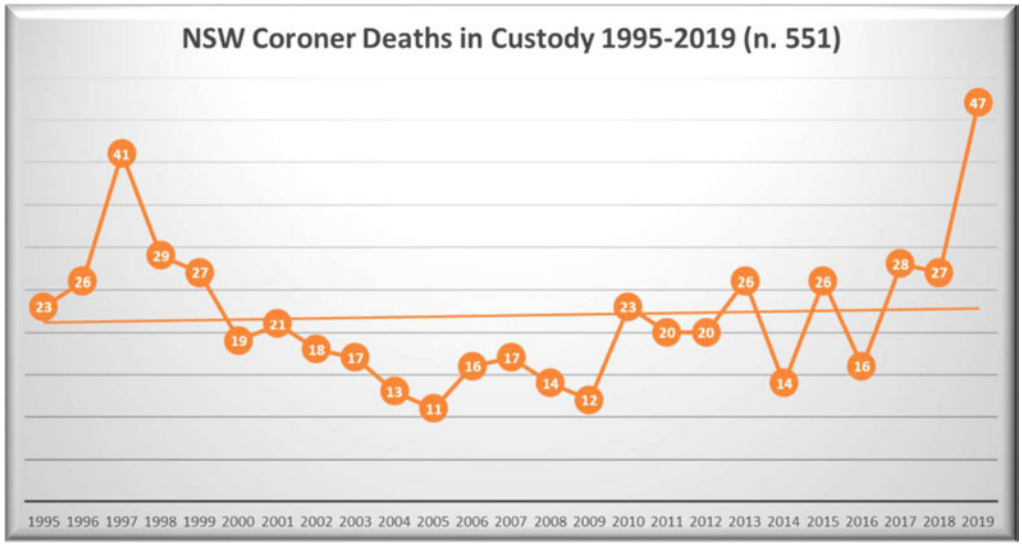
NSW Coroner

77. Accessible custody and police operational fatality data shows a total of 923 people have died in custody or because of police operations over the 25-calendar year period including 2019 (Graph 1). The 25-year fatality average for all reported fatalities is 37 deaths annually.



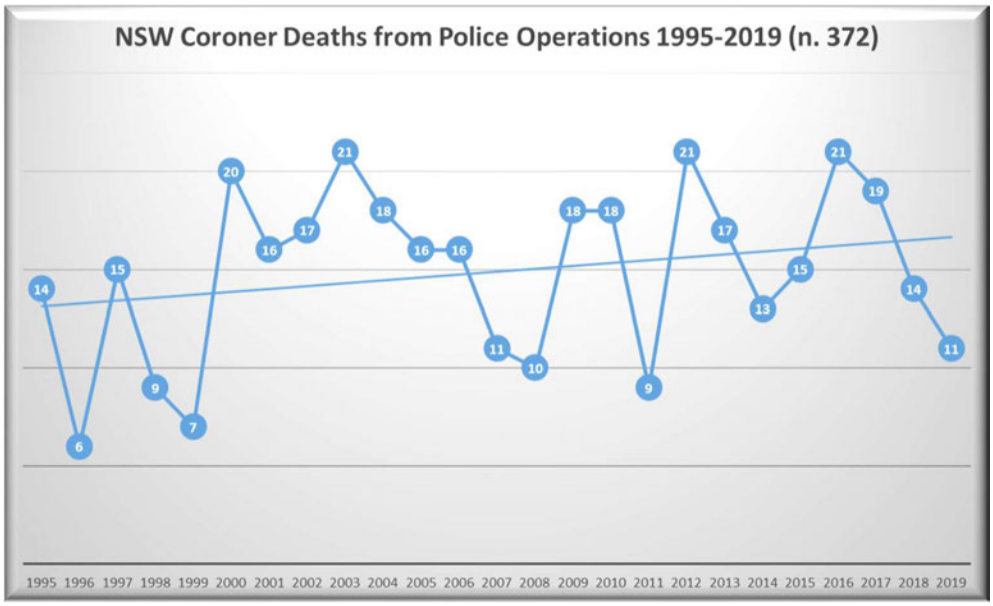
Graph 1.

The 25-year average (n. 551) for NSWPF & CSNSW deaths in custody is 22 deaths annually.



Graph 2.

Fatalities (n. 372) over the same period as custody deaths from police operations average 15 deaths annually.



Graph 3.

78. In 2019, the coroner allocated the 58 reported custody and police operational deaths to the following categories:[31]

    35 - Natural Causes
    3 - Fall/Jump
    8 - Gunshot/Firearm
    5 - Hanging
    2 - Asphyxiation/Choking
    3 - Stabbing
    1 - Drugs/Alcohol
    1 – Assault

79. No deaths were classified as motor vehicle or suicide deaths in the 2019 reports.

SafeWork NSW

80. In 2021, two GIPAA requests to SafeWork NSW relating to fatality and serious injury data reported to SafeWork NSW by the NSWPF and CSNSW for the calendar years 2018, 2019, and 2020 yielded the responses shown in the tables below. The GIPAA inquiry included a request for data in respect of custodial facilities generally. This expanded the field to include non-government prisons, juvenile justice centres and other government or privately operated custodial facilities in NSW.

[31] NSW Coroner Report dated 2019 P. 19.

81. Serious injury data was included in the GIPAA request for data should an investigative agency want to explore WHS under-reporting more deeply.

82. Table 2 data relates to all reported fatalities and serious injuries. This data would include workers and bystanders.

Table 2: SafeWork NSW GIPAA Response April 2021: All reported fatalities & serious injuries.				
NSWPF	**2018**	**2019**	**2020**	**Total**
1. The number of fatalities reported to SafeWork NSW by the NSW Police Force	1	3	2	6
2. The number of serious injuries reported to SafeWork NSW by the NSW Police Force	37	47	31	115
CSNSW	**2018**	**2019**	**2020**	**Total**
3. The number of fatalities reported to SafeWork NSW by Corrective Services NSW.	4	3	6	13
4. The number of serious injuries reported to SafeWork NSW by Corrective Services NSW.	51	73	54	178
Custodial Facilities	**2018**	**2019**	**2020**	**Total**
5. The number of fatalities reported to SafeWork NSW by other NSW custodial facilities.	0	0	0	0
6. The number of serious injuries reported to SafeWork NSW by NSW by other NSW custodial facilities.	2	9	8	19

Table 3 relates to all work-related reported fatalities and serious injuries. This data would include compensable worker related data and possibly bystander data.

Table 3: SafeWork NSW GIPAA Response April 2021: All reported fatalities & serious injuries.				
NSWPF	**2018**	**2019**	**2020**	**Total**
7. The number of work-related fatalities reported to SafeWork NSW by the NSW Police Force	1	1	1	3
8. The number of work-related serious injuries reported to SafeWork NSW by the NSW Police Force	34	47	30	111
CSNSW	**2018**	**2019**	**2020**	**Total**
9. The number of work-related fatalities reported to SafeWork NSW by Corrective Services NSW.	0	0	0	0
10. The number of work-related serious injuries reported to SafeWork NSW by Corrective Services NSW.	51	72	54	177
Custodial Facilities	**2018**	**2019**	**2020**	**Total**
11. The number of work-related fatalities reported to SafeWork NSW by other NSW custodial facilities.	0	0	0	0
12. The number of work-related serious injuries reported to SafeWork NSW by NSW by other NSW custodial facilities.	2	9	8	19

83. In a response dated 11 March 2020 to earlier correspondence,[32] SafeWork NSW provided the following information in relation to fatalities reported to SafeWork NSW by the NSWPF and CSNSW in the 2018 calendar year:

> *"NSW Police notified SafeWork NSW of two police employee fatalities in 2018. Neither incident was categorised as work-related activities.*
> *Corrective Services notified SafeWork NSW of five inmate fatalities in 2018. Four were determined as not work related, and one was outside of SafeWork NSW's jurisdiction."*

84. Given the NSW Coroner recorded 27 deaths in custody as occurring in 2018, many of those deaths could be expected to have related to prisoners in CSNSW custody. It is noteworthy, that the five deaths CSNSW reported to SafeWork NSW were not work-related and outside the jurisdiction of NSW. It is likely that CSNSW selects what fatalities to report to SafeWork NSW.

Safe Work Australia

85. Traumatic fatality statistical reports for calendar year periods focus mainly on reported workers compensation data but does include data on bystander fatalities. Bystander data is reported separately. Between the calendar years 2007 and 2019 SWA advised that reported work-related fatalities across Australia had fallen by 53 per cent.[33]

86. Table 4 provides a snapshot of nationally reported work-related fatality data in the 2019 calendar year for different industry groups. The NSWPF and CSNSW fall under the Public Administration & Safety Industry Group.

Table 4: Summary data from 2019 Safe Work Australia Reported Work-Related Traumatic Injury Fatalities

Ref	Descriptor	Data/Information
P. 5	Total number of reported work-related fatalities in Australia.	183
P. 5	Top three industry groups in order of reported work-related fatality rate.	1. *Transport, postal & warehousing* ***(n. 58)*** 2. *Agriculture, forestry & fishing* ***(n.30)*** 3. *Construction* ***(n. 26)***
P. 5.	Cause of most reported work-related fatalities.	Vehicle collision (n. 132)
P. 12.	Total number of Australian fatalities reported by Public Administration & Safety industry group in 2018 & 2019.	2019 – **n 12**
P. 32	Total number of reported bystander fatalities.	n. 39

[32] SafeWork NSW Correspondence Dated 11.03.20 (available not provided).
[33] 2019 Safe Work Australia Work-Related Traumatic Injury Fatalities Australia (P. 5). https://www.safeworkaustralia.gov.au/sites/default/files/2020-11/Work-related traumatic injury fatalities Australia 2019.pdf

P. 32	Cause of reported bystander fatalities in order of mechanism.	Vehicle collision	n. 18
		Being hit by moving objects	n. 7
		Drowning	n. 3
		Falls from height	n. 4
		Falls on the same level	n. 3
		Being hit by falling objects.	n. 1
		Other mechanisms	n. 3

87. If only the NSWPF and CSNSW had reported all their fatalities to SafeWork NSW in 2019 (n 58). Those two NSW agencies alone would have had the same number of work-related fatalities as the Transport, Postal & Warehousing Industry Group (n. 58).

88. Motor vehicle collisions are the primary mechanism for worker (n. 132/183) and bystander (n. 18/39) reported work-related fatalities in 2019. In 2019, the coroner found that no reported bystander fatalities were caused by motor vehicles. The other causes of death reported by the coroner in 2019 do not reflect the 2019 bystander mechanisms of death described by SWA as shown in Table 4.

89. SWA explanatory notes should be reviewed as they explain why there could be a discrepancy between reported deaths in custody and fatalities arising from police operations between data from different sources and SWA.[34] For example, the explanatory notes offer the following advice regarding suicide deaths which do not fall within the SWA description of deaths due to natural causes:

> *"Suicide*
> *The TIF excludes deaths resulting from self-harm because it is difficult to assess the extent of the connection between work and a decision to take one's own life."*

90. In relation to bystander deaths caused by the criminal activities of others. The explanatory notes (P. 2) offer this commentary:[35]

> *"Persons sustaining fatal injuries as a result of someone else's criminal activity are included in the TIF if the decedent was at work at the time of the incident. Where the criminal activity is incidental to legitimate work activity, for example, where a worker dies of an injury sustained while under the influence of legal or illegal substances, the fatality is also included. Non-working persons fatally injured in an incident involving criminals and law enforcement officers or security officers are included as bystanders. In the case of a bystander who is killed while the police are pursuing a vehicle for a traffic or other violation the death will be included regardless of whether they were hit by the police car or the offender's car."*

[34] https://www.safeworkaustralia.gov.au/system/files/documents/2002/explanatory-notes-tif-database-swa_1.pdf
[35] https://www.safeworkaustralia.gov.au/system/files/documents/2002/explanatory-notes-tif-database-swa_1.pdf

91. Murders of prisoners in custody by other prisoners would therefore be a reportable bystander fatality or notifiable incident.[36] Serious injuries from assaults would also be a notifiable incident.

Financial Year Fatality Data

92. The data within the financial year reporting period is sourced from the LECC and AIC.

Law Enforcement Conduct Commission

93. The LECC monitor critical incidents arising from police operations that result in death or serious injury. Critical incidents are described as follows:[37]

> *"A critical incident is an incident involving a police officer or NSWPF employee that results in death or serious injury to a person. It must also be declared to be a critical incident by the Commissioner of Police or his delegate. The LECC Act provides guidance about the features of a critical incident. These include*
>
> - *incidents where death or serious injury arises:*
> - *from the discharge of a firearm by a police officer;*
> - *from the use of force or defensive equipment by a police officer;*
> - *from the use of a police vehicle by a police officer;*
> - *while in police custody or while attempting to escape police custody; or*
> - *during any police operation where the injury or death is likely to have*
> - *resulted from the police operation."*

94. This definition, like that from the NSW Coroner, describes fatalities involving police officers and bystanders from the work-related activities of the NSWPF. Data relating to NSWPF critical incident fatalities for financial year reporting periods is shown below.

Table 5 Fatality Data Recorded by LECC for financial year periods relating to NSWPF critical incidents

	2017/18	2018/19	2019/20
NSWPF	**22**	**11**	**22**

95. Discrepancies in data from the LECC when compared to the NSW Coroner reports may be due to variances associated with different reporting periods, that is calendar year versus financial year.

[36] 2019 Coroner Reports Death in Custody Reference No 435610 of 2010 (P. 22) and Reference No. 272783 of 2012 (P. 22)
[37] 2019/20 LECC Annual Report (P. 53)
file:///C:/Users/Terry/AppData/Local/Temp/MicrosoftEdgeDownloads/f838de7a-fcee-4bee-9176-79892e10f6fe/LECC%20Annual%20Report%202019-2020%20(2).pdf

Australian Institute of Criminology

96. The Australian Institute of Criminology (AIC) provides data for fatality rates in prison custody and during police operations and police custody.[38] The AIC fatality data is for the 2017/18 and 2018/19 end of financial year period in relation to NSW deaths in police custody and from police operations as well as prison deaths (CSNSW) is shown below in Table 6.

Table 6: AIC Fatality Data: Deaths in NSWPF custody & police operations and deaths in NSW Prison Custody.

Agency	2017/18	2018/19	AIC Total
NSWPF	6	5	**11**
Prison	33	38	**71**
Total	**39**	**43**	**82**

Comment:

97. The LECC and AIC NSWPF custody and fatality data does not correspond with the fatality data reported by the NSWPF to the LECC or the NSWPF and CSNSW reported to the NSW Coroner. While the data reported to the NSW Coroner may be explained by different reporting periods (calendar year v financial year).

98. The difference in attributed to NSWPF deaths in police custody and from police operations as published by the AIC and LECC for the same reporting financial year reporting periods, cannot.

Other Fatality Data & Serious Injury Data

99. Research in this section is sourced from a variety of academic, NSWPF and news article sources. The material adds a deeper layer not only to work-related under-reporting by the NSWPF, but also consequences associated with poor WHS leadership in the NSWPF.

100. Research by Barron identified that between 1999 and 2008;[39] eight police officers were murdered at work and forty-one officers committed suicide. This is a police officer homicide to suicide ratio of 1:5. To put this into context, other research shows that ADF forces between

[38] https://www.aic.gov.au/sites/default/files/2021-05/sr31_deaths_in_custody_in_australia_2018-19_v2.pdf
[39] Barron S. (2010) Police officer suicide within the New South Wales Police Force from 1999 to 2008, *Police Practice and Research: An International Journal*, 11:4, 371-382, DOI: 10.1080/15614263.2010.496568 https://www.tandfonline.com/doi/abs/10.1080/15614263.2010.496568

2001 and 2016, reported 56 combat-related deaths and 373 non-combat suicides.[40] This is a combat to non-combat suicide ratio of 1:6. Barron (2010; P. 374) argues that data relating to police suicides is difficult to identify for several reasons including the avoidance of insurance claims citing the matter of Guff as an example. [41]

101. In 2019, the National Coronial Information System (**NCIS**) reported that between 2001 and 2016 there were 197 intentional self-harm deaths of emergency service personnel (police, ambulance, and fire officers) in Australia. [42] The majority of deceased first responders had been employed as police officers. For the year 2013, the NCIS reported that thirteen current or former NSW police officers were reported as committing suicide. In 2013, the NSWPF Honour Roll only recognises three police officer suicide deaths, attributing those deaths to the duties of the officers who died. [43]

102. A list of known police officer suicides from a variety of sources including the NSWPF Honour Roll was compiled. The collected names were searched individually to confirm if the officer's death was recorded in the NSW Coroner's reports relating to deaths in custody and from police operations. The results are shown below in Table 7.

Table 7: NSWP Officer Suicide Search Results.

Name	Date of Death	NSW Coroner Police Op Record	NSWPF Honour Roll Listing
Detective Chief Inspector Ken Henderson	2001	No	No
Senior Constable David James Guff	17.08.2004	No	No
Sergeant Glen Howard Stirton	20.12.2012	No	Yes
'Officer A' (publication restriction)	03.07.2013	Yes	Yes
Sergeant Thomas Patrick Galvin (Rtd)	16.07.2013	No	Yes
Detective Sergeant Ashley Newton Bryant (Rtd)	16.12.2013	Yes	Yes
Senior Constable Colin James Young (Rtd)	12.05.2016	No	Yes

103. Data in Table 7 shows that more police officer suicides are recorded on the NSWPF Honour Roll as being related to NSWPF systems of work than are found in the NSW Coroner's reports as having arisen from police operations. This inconsistency needs to be explained. Given the NSWPF acknowledgement during the inquest of Officer A. The NSWPF know that suicide deaths of police officers, when attributable to work-related duties, should be reported to SafeWork NSW. However, it is highly likely these work-related suicide fatalities are not.

[40] https://www.abc.net.au/news/2019-04-24/anzac-day-surprising-truth-veteran-suicides-mental-health/10772720

[41] Guff v NSW Police (No 2) [2007] NSWDC 290 (24 Oct 2007)

[42] National Coronial Information Systems (2019) 'Intentional self-harm deaths of emergency serv ices personnel in Australia'
https://www.ncis.org.au/publications/ncis-fact-sheets/intentional-self-harm-emergency-services/

[43] https://www.police.nsw.gov.au/about_us/remembrance_for_fallen_police_officers/remembrance/roll_of_honour

104. The NSWPF Honour Roll does not accurately record police officer suicides. It could, however, be expected to accurately record police officer homicides. Barron (2010) research concluded in 2008. A review of the deaths listed in the Honour Roll between 2009 and 2021 shows that three police homicides are recorded compared to six police suicides. Police homicide deaths included the death of Curtis Cheng, a police public servant. This finding supports Barron's research that there are more police officer suicides than homicides.

105. Nigel Gladstone, a Sydney Morning Herald reporter, has been reporting on the NSWPF rising workers compensations claims and resignations. Mr Gladstone's reporting showed that workers compensation is estimated to cost $220M and NSWPF separations cost $583M in recruitment costs.[44] [45] In another article, Mr Gladstone describes the NSWPF workplace as a toxic environment.[46]

106. Mr Gladstone's research and opinions are supported by the findings of a 2018 NSW House of Representative Committees' into mental health issues in NSW emergency service agencies, [47] and the 2019 the Senate inquiry.[48]

107. Data from the 1990/91 NSWPF Annual Report has been compared to data from the 2019/20 NSWPF Annual Report and provides an historical operational health snapshot of the NSWPF (Table 8).[49]

Table 8: Comparative Analysis NSWPF Annual Reports 1990/91 & 2019/20

Descriptor	1990/91	2019/20	% Increase
NSW Police Officers	13,203	17,428	31%
Discharged Medically Unfit	59	424	618%
Resignations	305	210	-31%

108. Higher resignations in the 1990/91 reporting cycle could be attributed to changes over time that now recognise mental stress as a compensable injury that did not exist in 1990/91. This would explain higher 1990/91 police officer resignations. Officers resigned rather than stay and risk harm. One reasonable explanation for the rise in mental stress claims in the NSWPF is that the system of work is toxic. This opinion is supported by a recent report from NSW BOCSAR stating that crime trends in reported property and most violent crime categories in NSW has fallen since 1990 (P. 1):[50]

[44] https://www.smh.com.au/national/nsw/soaring-annual-cost-of-dealing-with-injured-nsw-police-passes-220-million-20201209-p56m3p.html
[45] https://www.smh.com.au/national/nsw/police-leave-force-in-larger-numbers-during-583m-recruitment-drive-20200626-p556gz.html
[46] https://www.smh.com.au/national/nsw/toxic-force-police-claim-bosses-use-complaints-to-target-them-20201130-p56j7n.html
[47] https://www.parliament.nsw.gov.au/lcdocs/inquiries/2442/Government response - Emergency services agencies.pdf
[48] https://parlinfo.aph.gov.au/parlInfo/download/committees/reportsen/024252/toc_pdf/Thepeoplebehind000mentalhealthofourfirstresponders.pdf;fileType=application%2Fpdf
[49] https://www.opengov.nsw.gov.au/publications/11739
[50] http://bocd.lawlink.nsw.gov.au/bocd/cmd/crimetrends/csv/CrimeTrendsResults-2021-1303522-3.csv

"Some categories of crime in NSW are now at the lowest recorded levels they have been for over 25 years. Comparing per capita rates of crime in 2020 with per capita rates in 1990, lower rates were found for: robbery with a firearm (92% lower); break and enter non-dwelling (86% lower); motor vehicle theft (85% lower); break and enter dwelling (76% lower); robbery without a weapon (73% lower); robbery with a weapon not a firearm (60% lower) and murder (57% lower). Three of the ten offence types analysed in this report were found to have recorded rates higher in 2020 than in 1990: sexual assault (213% higher); other sexual offences (126% higher) and assault (55% higher)."

109. As most reported crime rates have dramatically fallen between 1990 and 2020, police whose mission focus is the reduction of violence, crime, and fear should not be as overworked as their contemporaries in 1990 when there were 4,225 fewer police officers and substantially higher crime rates. One reasonable explanation for the rise in resignations and mental health claims given the data is. If the external work environment is less stressful for police, then the internal work environment must have become more stressful, or toxic.

110. NSWPF officers are likely suffering from operational cognitive dissonance caused when there is a misalignment with policy and practice. Once perceived, this misalignment between what is said and what is happening can cause stress to build. As the evidence supports the NSWPF WHS system policy does not align with practice, it is likely that poor WHS governance is one causal factor in the rise in police officer workers compensation claims.

NSW CRIME RATES & INCARCERATIONS.

111. One reason put forward for low crime rates was the war in Afghanistan disrupted the Taliban opium production.[51] A United Nations article identified Talabani rebels as harvesting more opium now than before.[52] The 2017 opium production has increased 87per cent from the 2016 harvest to 9,000 metric tonnes. Over the same period, the land to cultivate poppies increased by 63 per cent to 328,000 hectares. Opium is the primary plant-based ingredient used in the production of heroin.

112. Unexpectedly, and over a similar period, internal disputes with drug lords operating in Myanmar saw locally produced heroin production fall.[53] One outcome was that Myanmar drug lords have turned to methamphetamine production. Cocaine suppliers complete the group most likely to target Australia.

[51] Flanders T.P. Heroin: Illicit drug or weapon of social destruction? ANZSOC 2019 Conference Presentation
[52] UN News November 2017 'Afghanistan opium production jumps 87 per cent to record level – UN survey'. https://news.un.org/en/story/2017/11/636182-afghanistan-opium-production-jumps-87-cent-record-level-un-survey
[53] Myanmar Opium Survey 2018 Cultivation, Production and Implications. https://www.unodc.org/documents/southeastasiaandpacific//Publications/2019/Myanmar_Opium_Survey_2018_web.pdf

113. It is likely that one outcome will be an illicit drug marketing war between plant (narcotic/cocaine) and chemical (methamphetamine) based illicit drug producers. A recent emergent property that likely disrupted illicit drug supply chains is COVID 19.[54]

114. As crime rates are linked to illicit drug use, another likely outcome is that once illicit drug suppliers overcome COVID 19 logistical issues, the plant and chemical based illicit drug suppliers will continue to attack the Australian market.

Conclusion

115. Given the available data, it is likely that crime in NSW will increase due to illicit drug use. Should crime increase, deaths in custody and from police operations, suicide deaths of police officers and costs associated with police and custody operations will also increase if the NSWPF and CSNSW do not follow the spirit of the WHS legislation and change their systems of work.

FINDINGS

116. This submission has identified failings within and between core agencies connected with the operation of criminal justice in NSW. Specifically, these failings relate to government agency responses to deaths in custody and fatalities arising from police operations. The agencies involved are the NSW Coroner, NSWPF, CSNSW, and SafeWork NSW.

117. Both the NSW Coroner and SafeWork NSW have similar functions. Those functions relate to making the public safe through regulatory processes involving the investigation into reported work-related fatalities. For those reported fatalities to be investigated, so that systems of work can be made safer, and criminals can be prosecuted.

118. Even though both agencies work in similar fields with a common purpose the co-operation and communication between agencies is dysfunctional. There are also operational differences between the NSW Coroner and SafeWork NSW in relation to resources and investigation timeliness.

119. Adding to the dysfunction by hindering co-operation and communication between the NSW Coroner and SafeWork NSW is the NSWPF and CSNSW practice of under-reporting work-related fatalities involving prisoners and bystanders fatally injured while in custody or during a police operation.

[54] 2020 National Wastewater Drug Monitoring Program. https://www.acic.gov.au/sites/default/files/2021-02/National%20Wastewater%20Drug%20Monitoring%20Program%20Report%2012.PDF

120. The architect behind this dysfunctional relationship is the Legal Section of the Department of Communities and Justice who supports the current practices of the NSWPF, CSNSW and the NSW Coroner. SafeWork NSW, appears not to have been privy to the Legal Section advising.

121. The primary functions of law enforcement and public safety as operated by the NSW Coroner, NSWPF and CSNSW have proven to be mutually exclusive. Enforcing laws results in harm to members of the public, prisoners and police officers. There can be no more vulnerable workplace population than prisoners in custody or members of the public directly or indirectly involved in a police operation.

122. Nationally harmonised WHS regulators have effectively saved hundreds of lives by reducing reported work-related fatalities by 53 per cent between 2008 and 2019. The NSWPF, CSNSW, and NSW Coroner have not.

CONCLUSION

123. Basically, all that must happen is for government agencies operating under the guidance of the justice system is to follow the law as it is applied and understood by others outside of those agencies.

124. In sanctioning the under-reporting of work-related fatalities by the NSWPF and CSNSW, the Department of Community and Justice has created an inequity in how WHS laws are applied in NSW. This situation has led directly to systemic failures in WHS governance that has resulted in fatalities not only of prisoners and police officers, but members of the public the system is designed to protect.

125. If under-reporting work-related fatalities to SafeWork NSW is allowed to continue, then the NSWPF and CSNSW, with the assistance of the NSW Coroner, will be to the Public Administration and Safety Industry what James Hardie was to the asbestos industry.

T.P. FLANDERS **CGOHSP; CPP**
18 June 2021

Appendix A: CSNSW Email dated 18 March 2020.

Note:

Contact details in the email have been redacted for privacy reasons.

Terry Flanders

From: ExecutiveServices [redacted]
Sent: Wednesday, 18 March 2020 11:17 AM
To: terryflanders[redacted]
Subject: FW: Deaths in Custody enquiry

Importance: High

Dear Mr Flanders

Further to our telephone conversation and in response to your enquiry, the following information has been provided by the Department of Communities & Justice Legal Services.

The *Work Health and Safety Act 2011* (NSW) (**Act**), the corresponding *Work Health and Safety Regulations 2017* and the *Guide to Work Health and Safety Incident Notification* (**Guide**) have been reviewed and the following is noted:

- The death of a person (whether worker or "bystander") is only notifiable to WorkSafeNSW (WSNSW) where the death has arisen out of the conduct of the business: section 38 of the WH&S Act.
- Unless the death of an inmate/visitor ("bystander") has arisen out of the conduct of the correctional facility, it is not notifiable to WSNSW under section 38.
- The object of the Act is designed to primarily provide for a balanced framework to secure the health and safety of workers and workplaces. The Act does not define what comes within the meaning of arising out of the "conduct of the business". However, the Guide states that it "generally refers to business activities or work (including services) undertaken in the course of business…this would include ancillary activities such as arranging maintenance or supplies". Further, it states that although there must be a connection between the business activity and the notifiable incident, the business activity may not be the direct or sole cause of the notifiable incident.
- In contrast, all deaths of an inmate must be reported to the NSW Coroner: s 74 of the *Crimes (Administration of Sentences) Act 1999.*
- A Senior Coroner is required to hold an inquest into these deaths: section 23 and section 27 of *the Coroners Act 2009*.
- In findings the Senior Coroner can make recommendations aimed at, amongst other things, improving public health and safety. The Senior Coroner can also recommend that the matter be investigated or reviewed by a specified body: section 82 of the *Coroners Act 2009*. The second part of the recommendation function gives the Senior Coroner scope to refer the death to WSNSW, should that be deemed appropriate.

If you require any statistical data regarding deaths that occur in Corrective Services NSW custody, you will need to make an application under the *Government Information (Public Access) Act (GIPAA) 2009.* Information and application forms for making a GIPAA application can be found of the Department of Communities & Justice website at:

https://www.justice.nsw.gov.au/contact-us/access-to-information

With regard to NSW Police operations, as advised during our telephone conversation, NSW Police do not conduct operations at NSW correctional facilities. If you are seeking information in relation to deaths in police custody, you will need to contact NSW Police directly with your enquiry.

regards

[redacted]

For Manager
Corrections Executive Services
Corrective Services NSW
GPO Box 31
SYDNEY NSW 2001
executiveservices@justice.nsw.gov.au

From: Terry Flanders [mailto[redacted]
Sent: Friday, 28 February 2020 4:15 PM
To: General Enquiries CSNSW
Subject: Deaths in Custody.

Afternoon,

I'm conducting research for a WHS presentation and article about deaths in custody and arising from police operations. My inquiry concerns what in WHS terms would be a 'bystander' fatality. That is the death of a person who is not a worker at a correctional facility. This is most likely going to be prisoner related fatalities unless visitors to a correctional facility have also been fatally injured.

My question is:

Over the following three financial year periods, how many 'bystander' fatalities were reported to SafeWork NSW (formerly NSW WorkCover)?

1. 2015/2016
2. 2016/2017
3. 2017/208.

I do not require personal information or event data, just raw statistics for reported workplace fatalities by those agencies over those periods.

All the best

Terry Flanders COSHProf; CPP
Manager

investigation systems

'Workplace health, safety & security consultancy'

[redacted]

[redacted]

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