Ombudsman
New South Wales

Submission to the Legislative Council Select Committee on the High Level of First Nations People in Custody & Oversight and Review of Deaths in Custody

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

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1 Introduction

Our office welcomes this inquiry and is pleased to provide this submission to assist the Committee in its deliberations. We would be happy to provide any further assistance the Committee may request.

Caution for Aboriginal readers:

This submission makes reference to a Coronial inquest that includes the name of an Aboriginal person who has died.

1.1 Context

The establishment by Parliament of this inquiry has occurred in the context of significant community concerns about the number and circumstances of deaths of Aboriginal people in the custody of police and corrective services. These concerns are not new.

In 1991, the Royal Commission into Aboriginal Deaths in Custody (Royal Commission) came to what was, at that time, by no means an obvious conclusion:[1]

> "*Aboriginal people die in custody…not because Aboriginal people in custody are more likely to die than others in custody but because the Aboriginal population is grossly over-represented in custody.*"[2]

Nearly thirty years later this remains the case.[3] As the Deputy State Coroner has recently said:

> "*if we are to reduce the number of Aboriginal deaths in custody we need to grapple with the underlying causes of over-representation.*"[4]

However, acknowledging that proportionally more Aboriginal people *die in custody* because proportionally more Aboriginal people *are in custody* does not mean that the issue of 'deaths in custody' and the issue of 'over-representation' should be treated as coterminous.

Even if the latter were fully resolved, it would still be necessary to focus close attention on the former, and in particular to the need to ensure that deaths in custody are subject to appropriate investigation and review. This is because:

- It could be that the number of deaths in custody of *both* Aboriginal and non-Aboriginal people is too high. By this we mean that there may be more that could and should be done to avoid preventable deaths in custody generally.
- The nature or circumstances of the deaths of Aboriginal and non-Aboriginal people in custody (as well as between other categories of detained people) may also differ systemically. Different patterns of death may give rise to different concerns, and call for different responses.
- Even if over-representation of Aboriginal people in custody "provides the immediate explanation for the disturbing number of Aboriginal deaths in custody",[5] it is not the *cause* of any one of those deaths. If any individual dies in custody as a result of possible wrongdoing, mistreatment, neglect or other preventable cause, then that is a matter that demands accountability and justice.

There are two other reasons why the 'deaths in custody' issue warrants distinct focus:

- Unless and until the over-representation issue is resolved, it will remain the case that Aboriginal communities will be disproportionately impacted by deaths in custody. This is occurring in a context in which Aboriginal communities already face broad-scale

economic and social disadvantage across a spectrum of metrics, therefore further exacerbating disadvantage and trauma.[6]

- The historic circumstances of colonisation, dispossession and associated traumas inflicted on Aboriginal people by those in positions of authority may now be associated with lower levels of trust among many Aboriginal people of Government institutions. In designing appropriate oversight regimes, it is appropriate to consider the perspective of those whose base level of trust in Government agencies and officials may be less than one's own. This reflects the importance of justice being both done and being *seen to be done*, including by those most closely affected.

None of the above should be taken to suggest that different investigation or review arrangements should apply in respect of Aboriginal deaths and non-Aboriginal deaths.

1.2 The focus and structure of this Submission

Given the above, and noting our role as an oversight agency, we have focused the first half of this Submission (Part 2) primarily on the 'deaths in custody' issue, as distinct from the 'over-representation' issue.

That is not, however, to suggest that the latter is less important or urgent. Indeed, in this regard what the Royal Commission said nearly thirty years ago (and quoted above) remains as true today as it did then. That this is so is in itself a sad reflection on what appears to be an abject failure of policy since that time.

In the second part of our submission (Part 3), therefore, we provide some comments on the underlying issue of over-representation. However, we are an independent oversight and integrity body, rather than a policy department or delivery agency. Accordingly, it is primarily through that oversight lens that we have also considered the issue of over-representation of Aboriginal people in custody.

We have attached a paper prepared by our Engagement and Aboriginal Programs Unit that sets out some of the key points from our earlier publications,[7] insights we have learned from our decades-long work with Aboriginal people and communities, and some of the important themes we are now hearing from those communities, about what should be considered when developing and implementing a plan to reduce Aboriginal over-representation (Annexure).

In the final section of this submission (Part 4) we provide supporting factual information, including a more detailed outline of those of our existing functions that relate to the matters under inquiry.

1.3 Suggestions

The following table sets out the specific suggestions we make in the body of this submission:

Suggestion	Reference
1. Consideration could be given to enacting legislation to confer functions on the NSW Ombudsman or other existing external oversight body to undertake independent statutory oversight and monitoring of the internal investigations of all deaths in custody. 2. If that happens, the NSW Ombudsman or other external oversight body should be given adequate resources to undertake that role.	Section 2, Page 7

3. Consideration could be given to conferring an express statutory function on the Coroner or other existing external oversight body to undertake systemic research and reviews of deaths in custody. 4. If that happens, then the NSW Coroner or other external oversight body should be given adequate resources to undertake that role.	Section 2, page 10
5. Consideration could be given to merging the Inspector of Custodial Services into the NSW Ombudsman's Office to enhance its independence, enable closer co-ordination of complaints-handling, inspection and investigation functions, and to support the more efficient use of resources.	Section 2, Page 11
6. The process of nominating one or more oversight bodies as NPMs to implement OPCAT in New South Wales should be expedited, and adequate resources be allocated to enable them to establish an operating model for implementation by January 2022.	Section 2, Page 12
7. Consideration could be given to prescribing the current and any new strategy to reduce Aboriginal over-representation in the custodial system as an 'Aboriginal Program' under Part 3B of the *Ombudsman Act 1974*, to empower the NSW Ombudsman to monitor and assess, and to report publicly, on the policy, its implementation and outcomes. 8. If that happens, the NSW Ombudsman should be given adequate resources to undertake the function.	Section 3, Page 14

2 Custodial Oversight

2.1 Existing oversight arrangements

Relevant oversight bodies

NSW Ombudsman

Any person can complain to the NSW Ombudsman under the *Ombudsman Act 1974* about the conduct of public authorities, as well as some private bodies that perform public functions. Several thousand complaints are made to us about the custodial system every year, including both public and privately-run prisons and youth detention facilities.

Most of these are received directly from those who are detained. And most of those are received orally, by way of dedicated phone lines available in all correctional and youth justice facilities.

The *Ombudsman Act 1974* (NSW) contains, in addition to the general right of any person to complain to us[8], a specific statutory right of those in detention to be permitted access to our office:

> *"Where a person is detained by, or in the custody of, a public authority and informs the public authority or another person having superintendence over him or her that he or she wishes to make a complaint to the Ombudsman, the public authority or other person so informed shall –*
>
> *(a) take all steps necessary to facilitate the making of the complaint, and*
>
> (b) *send immediately to the Ombudsman, unopened, any written matter addressed to the Ombudsman."*[9]

In the 2018-2019 financial year, we received 5,108 complaints about all custodial services.[10]

Under the *Children (Detention Centres) Regulation 2015*, our office also receives mandatory notifications of, and monitors the segregation of children in youth justice centres if the segregation extends beyond 24 hours duration.

We may also commence an investigation on receipt of a complaint, or in the absence of a complaint, if there appears to be conduct of the kind set out in section 26 of the *Ombudsman Act 1974*.

Further details about our functions and how we exercise them in relation to correctives services is set out in section 4.2 below.

Inspector of Custodial Services

The Inspector's principal functions are set out in the *Inspector of Custodial Services Act 2012* (NSW) and include: inspecting custodial and detention facilities, overseeing the Official Visitors program, and examining and reviewing custodial services.

NSW State Coroner

As noted below, all deaths in custody are examinable and subject to an inquest by the NSW State Coroner to establish the cause and manner of death.

In a recent inquest, the Deputy State Coroner described the Coroner's role as follows:

> *"The role of the coroner is to make findings as to the identity of the nominated person and in relation to the place and date of their death. The coroner is also to address issues concerning the manner and cause of the person's death. A coroner may also*

make recommendations, arising directly from the evidence, in relation to matters that have the capacity to improve public health and safety in the future."[11]

What happens now when a person dies in custody?

When a person dies in custody, it is mandatory that an inquest be held.[12] The inquest must be conducted by a senior coroner.[13] Upon a death occurring:

Notifications

- The State Coroner is notified of the death.
- NSW Police Force (NSWPF) is notified of the death.
- If the deceased is an Aboriginal person, there are additional notification requirements including to the Aboriginal Legal Services and Aboriginal Affairs NSW.[14]

Coronial investigation

- A coronial investigation scene is established and the State Coroner may direct a police officer 'concerning investigations to be carried out for the purposes of coronial proceedings or proposed coronial proceedings.'[15]
- A coronial inquest must be held.

Criminal investigation

- The State Coroner is to forward evidence of an indictable offence to the Director of Public Prosecutions.[16] The NSWPF may also commence a criminal investigation if warranted.

Internal investigation

- Corrective Services NSW (CSNSW) and/or the Justice Health and Forensic Mental Health (JH&FMHN) separately undertake an internal investigation. The State Coroner may be given a copy of the report of an internal investigation which may cause the State Coroner to undertake further inquiries or investigation prior to the inquest.[17]

What happens now when a young person dies in custody?

The same responsibilities of the State Coroner outlined above in respect to an adult death in custody also applies to young people in youth detention. However, a death in youth detention would also be a child death reviewable by the NSW Ombudsman.[18] This means that agencies involved with the young person would be required to provide our office with full access to records reasonably required to review the death. The death would be registered and reviewed by the NSW Ombudsman, from the perspective of identifying any strategies that could be implemented to prevent similar deaths in the future.

To date, there have been no deaths in youth detention recorded by the NSW Ombudsman.

2.2 Enhancing the independent oversight of deaths in custody

The NSW Ombudsman does not oversight prosecutorial or judicial (including coronial) conduct. Since the transfer of functions to the LECC in 2017 we also generally do not have jurisdiction in relation to the conduct of NSW Police, including in respect of criminal investigations.

Having regard to the observations set out in the "Context" above, in this and the next section, we offer two suggestions that the Committee may wish to consider for possible enhancements to oversight that could be made focused on avoiding future preventable deaths.

Independent monitoring of internal investigations

Under existing oversight arrangements, no independent agency is explicitly authorised to monitor internal investigations conducted by CSNSW or the JH&FMHN into a death in custody.

The NSW Ombudsman can, and does, make inquiries about certain issues when a complaint is received about a death in custody. At times, matters relating to the circumstances of a death may be raised with us (for example by witnesses to the incident) which need to be referred by us so they can be considered as part of the internal review or coronial process.

If we were to suspect that an internal investigation were being conducted in a manner which involved conduct to which section 26 of the *Ombudsman Act 1974* applies (eg., contrary to law, in an unjust or improperly discriminatory way, or based on improper motives) then we would have the power to formally investigate that alleged conduct.

However, we have no express function to pro-actively monitor and require CSNSW and/or JH&FMHN to provide an account of their internal investigation.

Internal review by CSNSW and/or the JH&FMHN following the death of a person in their custody is an important process. Internal review should identify, for example, whether all protocols were adhered to by staff, whether and how circumstances of custody contributed to a death, and if they did, what should be done to prevent this in future. It is equally important that such processes should be transparent and open to scrutiny.

We note that publicly available information about CSNSW's internal investigation process is limited. In particular, the excerpt from the CSNSW Custodial Operations Policy and Procedures document available online is not current, and is heavily redacted, most likely for security reasons.[19] The JH&FMHN appears to maintain a separate policy in respect of the management of a death.[20]

We suggest that there could be merit in considering the establishment of a pro-active statutory oversight of internal investigations of deaths in custody conducted by CSNSW and/or the JH&FMHN.

Increased independent oversight of internal investigations would provide external assurance that internal investigations are conducted appropriately and in accordance with policy and protocol. Capacity to report on the function directly to Parliament could provide for public reporting of emerging trends, issues identified and improvements made from the monitoring of internal investigation processes.

1. Consideration could be given to enacting legislation to confer functions on the NSW Ombudsman or other existing external oversight body to undertake independent statutory oversight and monitoring of internal investigations of all deaths in custody.
2. If that happens, the NSW Ombudsman or other external oversight body should be given adequate resources to undertake that role.

Capacity of the NSW Ombudsman

The proposed role of monitoring internal investigations could be established within the NSW Ombudsman's office, given our independence; current role and experience in oversighting custodial services; capabilities in oversight and investigation; and capabilities in death reviews.

It would also align with our existing jurisdiction over CSNSW and JH&FMHN and, in particular, our ability to commence our own investigation in the event that we identified wrong conduct in the monitoring of the internal investigation.

Historically, and until June 2017, the NSW Ombudsman performed monitoring functions in respect of NSWPF critical incident investigations in a similar way. Our office also monitored employment related child protection investigations until those functions were transferred to the Office of the Children's Guardian on 1 March 2020.

Importantly, the performance of this role would, where appropriate, be supported by our related functions under Part 3B of the *Ombudsman Act 1974* performed by our Engagement and Aboriginal Programs Branch and led by the Aboriginal Deputy Ombudsman, with capabilities in terms of Aboriginal cultural competency and Aboriginal community engagement.

The New Zealand Ombudsman currently performs a similar oversight role. The Department of Corrections (NZ) and the Office of the NZ Ombudsman entered into a protocol regarding deaths in custody. Under the protocol, the Ombudsman monitors the Department's investigation of a death in custody. The Ombudsman may commence an own motion investigation into any issues arising during the monitoring as appropriate. At the conclusion of the monitoring role, the Ombudsman generally provides the Department with a copy of its outcomes.[21]

In our view however, any authority to oversight internal investigations in NSW should be legislated to provide a clear authority for the discharge of that function.

It is also imperative that the conferral of the function be accompanied by adequate funding and resources to ensure that Parliament's mandate and the communities' expectations for the proper performance of the function are fulfilled.

Nature of the proposed function

The proposed oversight role could be modelled on the Police critical incident monitoring function, which was established and undertaken by the NSW Ombudsman until all Police oversight functions were transferred to the Law Enforcement Conduct Commission (LECC) in 2017. Elements from our other 'reviewable deaths' functions would also be relevant, including in particular, monitoring to ensure that systemic 'root cause' issues are properly identified and analysed as part of the investigation

Under the *Law Enforcement Conduct Commission Act 2016* (LECC Act) a critical incident is an incident involving a police officer or other member of the NSWPF 'that results in the death of, or serious injury to, a person'.[22]

The LECC monitors the NSWPF investigation of critical incidents from the time of the incident to 'ensure the critical incident is investigated in a competent, thorough and objective manner'.[23] In performing its critical incident monitoring function, the LECC gives consideration to whether the internal investigation is carried out in accordance with the NSWPF's *Critical Incident Guidelines*. Those guidelines are issued by the Commissioner of Police under the LECC Act and are publicly available.

The key features of a function, in respect of deaths in custody in the correctional setting, could include:

- Notification of a death in custody
- Monitoring adherence to relevant internal guidelines and protocols for investigation
- Power to require information for monitoring purposes
- Power to make comments during an internal investigation

- Power to take action such as, commence an investigation in respect of any conduct or administrative issues identified
- Requirement to report to Parliament on the performance of this function and issues identified.

Publicly available guidelines setting out the expected investigation process and protocols would provide the basis for oversight.

Any agency tasked with an oversight function in relation to internal investigations of deaths in custody will require detailed knowledge of the custodial system including the functions of CSNSW, Youth Justice NSW (YJNSW) and JH&FMHN as well as appropriate resources.

Given the over-representation of Aboriginal people in custody, and therefore their over-representation in deaths in custody, and noting the points raised in the 'Context' section in section 1, it will be important that the agency tasked with oversighting internal investigations of deaths in custody have well-established connections with, and can operate with the trust and respect of, Aboriginal communities. Ideally, the monitoring team should include Aboriginal employees.

The purpose and limits of the role would also need to be clearly articulated to avoid functional overlap with the role of the State Coroner.

Possible extension to 'near misses'

We have noted above the absence of a statutory mechanism to externally monitor internal investigations of deaths in custody. The same is true for a near fatal incident or an incident resulting in serious injury to a person in custody.

The current response to a death in custody by CSNSW and/or JH&FMHN (i.e. internal investigation) also applies to a "serious incident", defined by them as: an escape or attempted escape, death of an employee, serious assault of any person resulting in hospital treatment, riot, hostage taking, or major fire.[24]

If a statutory mechanism were established for monitoring internal investigations of deaths in custody as proposed above, consideration could also be given to extending that mechanism to include other serious incidents, particularly those involving serious injury, including self-harm.

In addition to ensuring adherence to policy and protocol, internal investigations into deaths should seek to identify 'root causes' including risk factors in the custodial setting that may have contributed to a death. This is necessary to enable strategies to be formulated to prevent deaths occurring in similar circumstances in the future.

In that context, investigation of serious injury as well as deaths in custody could provide for a more comprehensive approach to identifying risk and addressing issues that may reduce the likelihood of death in the future. It would also help to support a systemic review function (see section 2.3 below).

However, we acknowledge that extending the proposed independent monitoring of internal investigations of deaths in custody to also include other serious incidents would require substantial additional resources for the independent oversight body charged with that function.

2.3 Systemic reviews of deaths in custody

The value of research and systemic reviews of deaths

Our office has a long-standing jurisdiction to review certain deaths.

We convene the NSW Child Death review Team (CDRT) which registers, analyses and reports to the NSW Parliament on the deaths of all children aged 0 – 17 years that occur in NSW (Part 5a of the *Community Services (Complaints, Reviews and Monitoring) Act 1993*).

Separate to this function, our office is responsible for reviewing 'reviewable' deaths of people with disability living in supported group accommodation, and the deaths of certain children, including a child who, at the time of the child's death, was an inmate of a children's detention centre, a correctional centre or a lock-up (or was temporarily absent from such a place).[25]

Our death review functions are focused on preventing and reducing deaths.

Both functions maintain a 'Register of deaths', and information in the Register is analysed to identify any trends and patterns. Both functions undertake research and report to Parliament, including recommendations to address risk factors and prevent future deaths. Further information about our office's death review functions and role as convenor of the CDRT is below in section 4.

A similar function in respect of domestic violence death reviews is undertaken separately by the State Coroner.

Systemic research and reviews into deaths in custody

There is currently no statutory function for the undertaking of systemic reviews of deaths in respect of adults in custody that would be similar to those described above.

As noted, the NSW State Coroner is required to conduct an inquest if a person dies in custody and, as the Coroner notes:

> "*Coronial investigations into deaths in custody are an important tool for monitoring standards of custodial care and provide a window for the making and implementation of carefully considered recommendations.*"[26]

Under section 37(1) of the *Coroners Act 2009,* the Coroner must prepare an annual summary of all deaths in custody and deaths as a result of a police operation. The report is tabled in Parliament. The State Coroner's report also includes summaries of inquests completed for the reporting period and any recommendations. Progress on implementation of the State Coroner's recommendations are published separately on the Department of Communities and Justice (DCJ) website.[27]

While these functions serve an important role in monitoring deaths in custody through inquest, and reporting those deaths publicly, the role could be enhanced.

In particular, consideration could be given to expanding the existing role of the Coroner to include a more explicitly systematic review role. This would include establishing and maintaining a public register of deaths and a role to track trends and identify systemic issues. This may enhance the Coroner's ability to make recommendations in a report to Parliament, including progress on implementation of previous recommendations. Given the relatively small number of deaths in custody, this reporting may be most effective if required biennially or triennially.

Please note, in preparing this submission, we have not had an opportunity to consult with the NSW Coroner. We have proposed that the NSW Coroner be conferred this statutory function on the basis that all deaths in custody are already referred to the Coroner for investigation. However, the function would also be synergistic with the NSW Ombudsman's function of monitoring the internal investigations of deaths in custody suggested above and its existing death review functions in other areas.

3. Consideration could be given to conferring an express statutory function on the Coroner or other existing external oversight body to undertake systemic research and reviews of deaths in custody.
4. If that happens, the Coroner or other external oversight body should be given adequate resources to undertake that role.

2.4 Broader issues regarding the oversight of custodial services

The Inspector of Custodial Services

The *Inspector of Custodial Services Act (2012)* is currently subject to statutory review by DCJ. In our submission to that review, we have recommended that the office and functions of the Inspector be merged into the NSW Ombudsman.

The work of the Inspector closely relates to, and in some cases overlaps with, the functions of our office. Our office and the Inspector operate under a Memorandum of Understanding (MoU), which provides for information sharing and clarification of respective roles.[28]

Both of our agencies visit custodial facilities and interact with CSNSW and YJNSW on issues identified during those visits. Our office handles complaints, both individual and systemic. The Inspector cannot investigate individual complaints except insofar as they relate to systemic issues present in the custodial environment.[29] On occasion, the Inspector will refer matters identified through inspections that she believes can more appropriately be handled by our office as a complaint.

Our view is that the NSW Government should consider a merger of the Inspector with our office. There are clear benefits to co-locating the staff and functions of the two offices. Co-locating visits, complaint-handling and all investigation functions would provide greater clarity to both the agencies and complainants.

As a very small organisation with limited resources, the Inspector would also benefit from access to the broader resources of our office, including access to training and support. A merger would also enhance the independence of the Inspector's office. Currently the Inspector's staff are employed by DCJ and are reliant on DCJ for all corporate support. The existing dependency on DCJ (which also includes CSNSW and YJNSW, the agencies that are oversighted by the Inspector) may also mean that the Inspector could not currently meet international standards for nomination as a relevant oversight body under the OPCAT (see below).

5. Consideration could be given to merging the Inspector of Custodial Services into the NSW Ombudsman's Office to enhance its independence, enable closer co-ordination of complaints-handling, inspection and investigation functions, and to support the more efficient use of resources.

The Optional Protocol to the Convention Against Torture

The Optional Protocol to the Convention Against Torture (OPCAT) 'is an international treaty designed to strengthen protections for people in situations where they are deprived of their liberty and potentially vulnerable to mistreatment or abuse'.[30]

OPCAT requires the establishment of a system of independent monitoring for places of detention through domestic bodies known as National Preventative Mechanisms (NPMs). Once operational in NSW, OPCAT will establish a system of regular preventive visits by independent bodies to detention facilities with the aim of reducing the potential for mistreatment, torture and cruelty.

When it ratified OPCAT, Australia made a declaration that it would delay its NPM obligations for up to three years. As a result, NSW is required to operationalise its NPMs to inspect and report on places of detention, by no later than January 2022.

We understand that the NSW Government is considering designating existing agencies as NPMs rather than establishing a new NPM for all NSW places of detention. Our office generally supports this approach, noting that a proliferation of oversight agencies could result in inefficiencies and unnecessary complexity. Our office has sought nomination as the NPM for NSW, at least in respect of the correctional and youth justice facilities over which we already have jurisdiction.

The implementation of OPCAT will also impact on both our office and the Inspector's role, as it introduces more rigorous standards for inspecting places of detention. While legislation is still required in NSW to implement OPCAT, a merger of the two offices would reduce existing overlap and ensure that NSW is well placed to commence implementation, potentially with one NPM covering all aspects of custodial oversight.

In any case, we have raised with the Government our concerns that, irrespective of which oversight body or bodies are to be nominated as NPMs, that nomination process should occur as soon as possible and relevant resources provided to those bodies to ensure that they will be in a position to discharge their functions from commencement, now January 2022.

6. We suggest that the process of nominating one or more oversight bodies as NPMs to implement OPCAT in New South Wales should be expedited, and adequate resources be allocated to enable them to establish an operating model for implementation by January 2022.

3 The over-representation of Aboriginal people in custody

3.1 Oversight of Aboriginal over-representation policies and programs

The DCJ Aboriginal over-representation policy

In 2018, the Government released DCJ's plan to address the overrepresentation of Aboriginal people in the criminal justice system – *Reducing Aboriginal Overrepresentation in the criminal justice system 2018-2020* (*Aboriginal over-representation plan*).

It does not appear that the release of the Aboriginal over-representation plan involved the announcement of any new programs or any additional funding. Instead, the plan articulated a strategy based on existing or previously announced policies and initiatives.

The plan did, however, provide for a new quarterly dashboard to be prepared to "measure the impact of our work" and an Aboriginal Overrepresentation steering committee to monitor progress against the plan. We could find no public information on either the BOCSAR dashboards or the deliberations of the steering committee.

Our monitoring and assessment of 'Aboriginal programs'

In May 2014, legislation was passed to give the NSW Ombudsman, under the leadership of a dedicated Aboriginal Deputy Ombudsman, the important role of monitoring and assessing the delivery of designated Aboriginal programs in NSW.

This function is conferred by Part 3B of the *Ombudsman Act 1974*. The specific role of Deputy Ombudsman (Aboriginal Programs) is the first and only position of its kind in Australia.

The aim of our Aboriginal programs oversight function is to provide greater transparency and accountability for the delivery of services/programs to Aboriginal communities by government agencies in NSW and for the resulting outcomes. This function complements and builds on work our office has undertaken for four decades in relation to complaints-handling and systemic reviews of service delivery to Aboriginal communities.

On enactment of the new Part 3B, the NSW Government prescribed the Government's Aboriginal Affairs Plan – *OCHRE (Opportunity, Choice, Healing, Responsibility, Empowerment)* – as an Aboriginal Program that the NSW Ombudsman is required to monitor and assess.

We have provided two comprehensive reports on the NSW Government's implementation of OCHRE (see section 4 below) and we continue to monitor and assess the program, its initiatives and outcomes.

The Government is yet to prescribe any other Aboriginal program under Part 3B since its enactment.

Monitoring and assessment of the Aboriginal over-representation policy

As part of our responsibility to monitor OCHRE, we recently informed CSNSW that we would be considering how OCHRE initiatives translate into the case management, healing, therapeutic, educational and employment-related work being done with Aboriginal inmates. Our aim in doing this is to consider:

1. the impact current programs are having on reducing reoffending by Aboriginal people, and
2. how OCHRE and its subsidiary Government initiatives might be better directed towards addressing recidivism.

However, currently the NSW Ombudsman has neither the clear legislative mandate nor the resources to directly assess and monitor the Government's over-representation policies and initiatives.

Whether the current Aboriginal over-representation plan has had any impact will, we expect, be a significant and pressing issue for the Parliamentary Committee to consider. Likewise, any new plan should be continuously assessed and monitored, including for coherence in its design, fidelity of implementation, and achievement of intended outcomes.

7. Consideration could be given to prescribing the current and any new strategy to reduce Aboriginal over-representation in the custodial system as an 'Aboriginal Program' under Part 3B of the *Ombudsman Act 1974*, to empower the NSW Ombudsman to monitor and assess the policy, its implementation and outcomes.
8. If that happens, the NSW Ombudsman should be given adequate resources to undertake the function.

3.2 Improving the response to Aboriginal over-representation

As already noted, the NSW Ombudsman does not currently have a statutory monitoring and assessment function with respect to the Government's Aboriginal over-representation policy and associated initiatives.

As we have not undertaken a detailed assessment of, or reported on, that policy and those initiatives, we are not in a position to provide a detailed submission on questions such as, whether the policy has been coherently designed, whether its initiatives are being effectively implemented, whether and the extent to which they are working, and whether there needs to be change.

We do note that the policy itself is due to expire at the end of this year. It is a matter of relevance to the Committee, therefore, to consider what will replace it.

In the Annexure to this submission, our Engagement and Aboriginal Programs Branch has drawn on our experience in monitoring OCHRE, our engagements with community, and our long-standing work on complaints and systemic issues concerning service delivery to Aboriginal people, to offer some high level comments on that issue.

The comments are not intended to be exhaustive or definitive, but highlight some of the key themes that it appears to us should be given careful consideration in the development and implementation of any new policy to reduce Aboriginal over-representation.

4 Supporting information

4.1 The Committee's Inquiry

The Committee is conducting an inquiry into the high level of First Nations people in Custody and Review and Oversight of Deaths in Custody.

The Committee was established on 17 June 2020 and its terms of reference require it to inquire into and report on First Nations people in custody in New South Wales, and in particular:

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

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

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

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

(e) any other related matter.

The Committee is to report by the final working day in March 2021.

4.2 The current roles of the NSW Ombudsman relevant to the Inquiry

Our office is an independent integrity agency that holds NSW government agencies and certain non-government organisations accountable on behalf of the people of NSW.

We are committed to serving the needs of all NSW citizens. Integral to our values are fairness, inclusion and respect of diversity.

Below summarises the key statutory functions of our office which are directly relevant to the matters under inquiry. Further information about the work of our office can be found on our website and in our annual reports.

Complaints-handling, investigations and systemic improvement

Our office receives (in writing or orally) complaints about the conduct of public authorities, some private entities that perform public functions (including private prisons), and community service providers. We assist in the resolution of complaints, including by referral, conciliation or mediation, and by the making of preliminary inquiries and the provision of information and comments.

We may formally investigate (whether or not any complaint has been made) where it appears that conduct of the kind referred to in section 26 of the *Ombudsman Act 1974* has occurred.

Resolution of Individual complaints

Both adult and juvenile custodial systems provide avenues for people they detain to make complaints to us about their management and the administration of their centres or the system.

Our work with individual complaints and complainants means we have eyes and ears into all of the centres on a regular basis. We talk to inmates and detainees and then may raise their concerns – or those we hold after speaking with them – on a daily basis. For closed

environments such as prisons and detention centres, it is vital that those who work in them are aware that they may be asked to explain and account for their decisions and conduct.

Obviously, being a detained person in itself creates a significant barrier to lodging a complaint internally – a detainee may be reluctant to complain directly to the people who are responsible for opening their door, ensuring they are fed and controlling every other aspect of their day-to day life, about their actions or those of their colleagues. As a result of this, our role in respect of custodial complaints tends to be more 'hands on' than those in our general complaints jurisdiction. In particular, we have a strong focus on working with individuals to seek resolutions for their complaints. This work empowers the complainant and generally assists in keeping the custodial systems free of unnecessary angst and frustration.

In handling contacts and complaints from those detained in custody, we have established protocols and information sharing arrangements in relation to custody and detention including:

- Confidential communication between inmates, detainees and our office.
- Program of visits to correctional and youth justice centres.
- Receipt of a daily summary of incidents across all correctional centres.
- Access to incident reports in youth justice centres.
- Direct lines of communication with the offices of the Commissioner, CSNSW, the Executive Director of YJNSW, and senior staff of all correctional and detention (youth justice) centres.
- Direct access to a wide range of information held by CSNSW and YJNSW including internal policies and procedures.
- Memorandum of Understanding with the Inspector of Custodial Services.

The following is an example from last week of some of the many issues raised about corrections:

A female detainee called us from a correctional centre complaining that the toilet in the cell she shares with another woman was broken, and couldn't flush. The plumber had attended that day, but the toilet couldn't be fixed until the following week. She was not happy about being locked in a 12sq metre room with another person and a bucket to use to 'flush' their toilet. We contacted the centre immediately, and the manager in charge admitted they had not been made aware of the situation by staff and had it rectified by moving the two women to another cell that same afternoon.

Identification and resolution of systemic issues

We regularly look at systems issues within the custodial setting. Many of these arise from individual complaints, while others may come about after one of our visits to a correctional or youth justice centre.

Our work in this regard can result in significant change, but also it can be a catalyst, or lay the ground work, for others to continue the work in a more public arena.

For example, over several years we investigated both individual and systemic concerns about how force is used in the adult and youth correctional system. Our report, on the adult system contained many recommendations, which were largely adopted by CSNSW. While the report was not made public, it provided an important resource when the Independent Commission Against Corruption (ICAC) investigated public allegations of corruption about use of force at Lithgow Correctional Centre.[31]

We also provided our report in relation to the youth justice system, as well as further submissions and suggestions, to the Inspector of Custodial Services to help inform her

subsequent public report on the use of force, segregation and confinement in NSW juvenile justice centres.[32]

Our work leads to changes that may frequently be unnoticed or unappreciated by people who are not in custody. That makes them no less important. The following are examples from the last few years that we noted in our Annual Reports:

(a) We were concerned that CSNSW did not consider that the use of handcuffs to fixed objects (such as a bed or pole) needed to be reported as a use of force. We wrote to the Commissioner suggesting that legal advice be sought about whether handcuffing inmates to fixed objects are examples of 'authorised restraints' and whether restraining an inmate in this manner should be reported as a 'use of force'. The Commissioner sought the legal advice from the Crown Solicitor's Office, as a result of which changes were to be made to CSNSW Services policy. Those changes include a specific provision on use of force on tethering restraints to fixed objects. The provision means that, if it is necessary to tether an inmate to a fixed object in a correctional environment (other than a hospital), the action is to be reported as a use of force.[33]

(b) A legislative amendment was made to the *Crimes (Administration of Sentences) Act 1999* authorising the "separation" of inmates, but without any of the governance and oversight that was otherwise in the Act for people who are isolated in other ways. We acted on complaints from individuals who found themselves separated, and effectively isolated, without knowing why or for how long. We advocated for and ultimately achieved a policy and procedural change, with CSNSW agreeing to implement a similar system of approval and accountability for separating inmates as applies to other forms of isolation.[34]

(c) Over several years we received many complaints from inmates designated as either 'National Security' or 'Extreme High Risk Restricted' about the process and time taken to have their phone contacts and visitors approved, including their legal advisors. We had constant contact with CSNSW until a process was embedded and we were confident that in most cases an inmate was given an understanding of the process and the likely timeframes. This eventually led to a significant reduction in these complaints and we now have in place an understanding with the relevant section of CSNSW that it will advise us of any backlogs, so that we can assist in managing inmate and visitor expectations.[35]

(d) Frequently our work requires us to review case notes prepared by staff about inmates. We raised a concern with the Commissioner that many case notes written by staff were unprofessional, included inappropriate comments and subjective expressions of sometimes disparaging opinion. As these case notes are used for many reasons – including parole applications and complaint investigation - we were concerned that they may lead to unfair decisions or actions, by presenting an inaccurate, discriminatory or biased view of the person. As a result, the Commissioner conducted a review of case notes, subsequently issued a Memorandum to all staff about the information recorded in them, and introduced specific guidelines about structured case note writing as part of the case management training for staff.[36]

Investigations

As noted above, many of the complaints we receive require us to undertake inquiries and other investigatory actions. However, in most cases we are able to resolve both individual complaints and any related systemic concerns we may have without needing to invoke our Royal Commission-style powers of formal investigation.

However, we will do so where it is necessary or appropriate (for example to obtain evidence under compulsion from CSNSW) and the example of our investigations into use of force noted above is an example.

As at 1 September 2020, we have two formal investigations currently on foot in relation to custodial matters.

Under the *Ombudsman Act 1974*, formal investigations conducted by the Ombudsman must take place in the absence of the public.

Monitoring and assessment of Aboriginal programs

Our office is responsible for the monitoring and assessment of prescribed Aboriginal programs under Part 3B of the *Ombudsman Act 1974*.

To date the only prescribed program is the Government's OCHRE Plan. Reports on matters arising under this function are made to the Minister and Parliament.

Part 3B functions are led by our Deputy Ombudsman (Aboriginal Programs) and are supported by staff in our Engagement and Aboriginal Programs Branch including Aboriginal staff. We have an established network of communication with agencies such as, Corrective Services NSW (CSNSW), Aboriginal Affairs NSW, Department of Premier and Cabinet and peak Aboriginal organisations such as, the Coalition of Aboriginal Peak Organisations (CAPO) and NSW Coalition of Aboriginal Regional Alliances Accord (NCARA).

The Engagement and Aboriginal Programs Branch also undertakes systemic reviews and supports the office to handle complaints in a culturally competent way. In this regard, the Branch implemented an Aboriginal consultation protocol for all staff to ensure that the voices, views and perspectives of Aboriginal people inform the way in which staff discharge all of our statutory functions. A Cultural Competency Framework has also been established, including training for all staff in our office.

Recent reports we have published concerning the exercising of our Part 3B functions are:

OCHRE Review Report, October 2019

The OCHRE Review Report is a special report to Parliament that details our assessment of the implementation of key initiatives under OCHRE including: Healing; Aboriginal Language and Culture Nests; Local Decision Making; OCHRE Aboriginal Economic Prosperity Framework; Solution Brokerage; Opportunity Hubs; and Connected Communities over the past five years. The report is structured under each initiative with a preliminary chapter outlining the methodology. A common methodology was applied in assessing the initiatives with a particular focus on evidence and input from Aboriginal people living in locations where OCHRE initiatives operate. There are 69 recommendations in the report.

Fostering economic development for Aboriginal people in NSW, May 2016

Increasing the economic prosperity of Aboriginal people is critical to improving social outcomes in many areas, such as health, education, child protection and community safety. Economic development is also fundamental to sustaining and renewing Aboriginal culture and language into the future. This report was a way to ensure that our office's insights from working with Aboriginal communities informed the important work of the NSW State Government as they developed their Aboriginal Economic Prosperity Framework.

Earlier reports by the NSW Ombudsman that directly considered Aboriginal disadvantage and service provision to Aboriginal communities included:

Inquiry into Service Provision to the Bourke and Brewarrina Communities, December 2010

This report was the first released under Part 6A of the Community Services (Complaints, Reviews and Monitoring) Act 1993, which required the NSW Ombudsman to audit the

implementation of the NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities 2006-2011.

It became apparent during the audit that to address child sexual assault and broader disadvantage in Aboriginal communities required a competent service system. The primary focus of this report was on the actions required to improve the delivery of services to the Bourke and Brewarrina communities but was a 'litmus test' for other high need rural and remote communities.

Addressing Aboriginal disadvantage: the need to do things different, October 2011

This report was the second released during our audit of the NSW Interagency Plan to Tackle Child Sexual Assault in Aboriginal Communities. We released this report because it became apparent that addressing child sexual assault in Aboriginal communities could not be tackled in isolation from the broader issues of disadvantage, including poor health, education and employment outcomes, and the overrepresentation of Aboriginal children in the child protection and criminal justice systems.

Responding to child sexual assault in Aboriginal communities, December 2012

This report was our final report which outlined our findings and recommendations and highlighted a number of fundamental challenges which needed to be addressed if real progress was to be made in reducing disadvantage in Aboriginal communities, and tackling child sexual abuse.

Review of deaths

The NSW Child Death Review Team (CDRT) was established under Part 5A of *Community Services (Complaints, Reviews and Monitoring) Act 1993* (CS CRAMA) to undertake specific functions to prevent or reduce the deaths of children in NSW. Our office is the Convenor of the CDRT which consists of experts in healthcare, child development, child protection and research, as well as representatives of key government agencies.

The main functions of the CDRT are to:

- maintain a register of child deaths occurring in NSW
- classify those deaths according to cause, demographic criteria and other relevant factors, and to identify trends and patterns relating to those deaths
- undertake, alone or with others, research that aims to help prevent or reduce the likelihood of child deaths and to identify areas requiring further research
- make recommendations that may assist in preventing or reducing the likelihood of child deaths.

Part 6 of CS CRAMA prescribes our office's responsibilities for reviewing the deaths of children in care and certain other children and persons with disabilities in care.

Our main functions in relation to reviewable deaths are to:

- monitor and review reviewable deaths
- make recommendations as to policies and practices for implementation by government and service providers to prevent or reduce the likelihood of reviewable deaths
- maintain a register of reviewable deaths
- undertake, alone or with others, research that aims to help prevent or reduce or remove risk factors associated with reviewable deaths that are preventable.

Recent child death review reports include:

Biennial Report of the Deaths of Children in New South Wales: 2016 and 2017, Incorporating Reviewable Deaths of Children, June 2019

Tabled in Parliament 25 June 2019 – the report, made under sections 34G and 43(1) of CS CRAMA, examines the deaths of 981 children aged 0–17 years who died in NSW during the two years –

2016 and 2017. Until 2016, this report (s 34G) was prepared and tabled on an annual basis. The report presents a holistic overview of the deaths of all children in NSW, the underlying risk factors that may have contributed to preventable deaths, and what can and should be done to protect children in the future.

Deaths of People with Disability in Residential Care: Report of Reviewable Deaths (2014 to 2017), August 2018

Tabled in Parliament 31 August 2018 – the report, made under sections 43(1) of CS CRAMA, examines the deaths of 494 people with disability in residential who died in NSW during the four years – 2014 and 2017. The report presents issues identified in the course of our work over the four years, and a range of recommendation to address risk factors, particularly relating to the health care of people with disability in residential settings.

NSW Child Death Review Team Annual report 2017 and 2018, October 2018

Tabled in Parliament 22 October 2018 – annual report under s 34F of CS CRAMA about CDRT operations and activities during the preceding financial year, including details of progress regarding implementation of the CDRT's recommendations.

4.3 Definitions

Term	Definition
Aboriginal	In this document Aboriginal refers to the First Nations peoples of the land and waters now called Australia, and includes Aboriginal and Torres Strait Islander peoples.
ACCO	Aboriginal Community Controlled Organisations
BOCSAR	Bureau of Crime Statistics and Research
CAG	Australia's Council of Attorneys-General
CAPO	Coalition of Aboriginal Peak Organisations
CDRT	Child Death Review Team
CS CRAMA	*Community Services (Complaints, Reviews and Monitoring) Act 1993 (NSW)*
CSNSW	Corrective Services NSW
Custodial facilities	All facilities in NSW run by Corrective Services NSW, Youth Justice NSW and privately run correctional centres such as, Parklea, Junee and Clarence.
Deaths in custody	The State Coroner applies the following meaning of 'death in custody': '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: 1. 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); 2. 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; 3. 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

	4. 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: 5. while temporarily absent from a detention centre, a prison or a lock-up; and 6. 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.'[37] The focus of this submission is on prison custody and detention due to our role in relation to those custodial services.
DCJ	Department of Communities and Justice
Inspector	Inspector of Custodial Services
JH&FMHN	Justice Health and Forensic Mental Health Network
NCARA	NSW Coalition of Aboriginal Regional Alliances
NDICP	National Deaths in Custody Program
NSWPF	NSW Police Force
OCHRE	Opportunity, Choice, Healing, Responsibility and Empowerment – Aboriginal Affairs Plan
Royal Commission	Royal Commission into Aboriginal Deaths in Custody
Youth Justice	Youth Justice NSW

Annexure:

Observations on developing and implementing policies to reduce Aboriginal over-representation

> "Proportionally, we are the most incarcerated people on the planet."
>
> Uluru Statement from the Heart

The Australian Law Reform Commission has reported that Aboriginal adults make up around 2% of the national population, but constitute around 17% of the national prison population. Australia-wide, Aboriginal men are 14.7 times more likely to be imprisoned than non-Indigenous men, and Aboriginal women are 21.2 times more likely to be imprisoned than non-Indigenous women.[38]

And over-representation has grown: rates of Aboriginal incarceration increased 41% in the decade to 2016, and the gap between Aboriginal and non-Aboriginal rates widened over the decade.[39]

As noted earlier in our Submission, the NSW Ombudsman is an independent oversight and integrity body. We have not undertaken (as we have no statutory function or resources to undertake) a detailed assessment and monitoring of the Government's Aboriginal over-representation policy.

However, in this Annexure, the NSW Ombudsman's Engagement and Aboriginal Programs Branch has taken the opportunity to identify some of the key points from our earlier publications,[40] insights we have learned from our decades-long work with Aboriginal people and communities, and some of the important themes we are now hearing from those communities, about what should be considered when developing and implementing a plan to reduce Aboriginal over-representation.

In summary, the suggestions we make are that, in developing a new strategy to reduce Aboriginal over-representation in the custodial system, consideration should be given to:

(a) the recommendations of the ALRC's 2017 *Pathways to Justice* report, and the extent to which they have current relevance in New South Wales to addressing Aboriginal over-representation

(b) the need to address the underlying causes of Aboriginal over-representation

(c) ensuring clear links to OCHRE, especially its focus on the need for 'Healing' strategies to acknowledge and respond to underlying trauma

(d) empowering Aboriginal-led solutions, in alignment with the right of Self-determination

(e) emphasising therapeutic rather than punitive approaches

(f) targeting investments in "what works" (and in building the evidence-base for what works)

(g) public reporting, transparency and accountability.

Considering the recommendations of the ALRC's 2017 report

In 2017 the ALRC published its report - *Pathways to Justice—An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, December 2017. The ALRC concludes that its recommendations, if implemented, will:

- promote substantive equality before the law for Aboriginal and Torres Strait Islander peoples
- promote fairer enforcement of the law and fairer application of legal frameworks
- ensure Aboriginal and Torres Strait Islander leadership and participation in the development and delivery of strategies and programs for Aboriginal and Torres Strait Islander people in contact with the criminal justice system
- reduce recidivism through the provision of effective diversion, support and rehabilitation programs
- make available to Aboriginal and Torres Strait Islander offenders alternatives to imprisonment that are appropriate to the offence and the offender's circumstances
- promote justice reinvestment through redirection of resources from incarceration to prevention, rehabilitation and support, in order to reduce reoffending and the long-term economic cost of incarceration of Aboriginal and Torres Strait Islander peoples.

The development and implementation of a new Aboriginal over-representation plan should include consideration of the recommendations of the ALRC's report and their current relevance to addressing Aboriginal over-representation

Addressing the underlying causes of Aboriginal over-representation

While there have been some improvements over the past four decades since the Royal Commission, Aboriginal people continue to experience considerable disadvantage relative to the non-Aboriginal population.

Aboriginal people in NSW continue to experience poorer outcomes than non-Aboriginal people across almost every economic, health and environmental measure. The causes of this disadvantage are inextricably linked and complex. This fact has been recognised by States and Territory governments through the National Partnership Agreement to Close the Gap.

The available figures for New South Wales are alarming. In our 2011 report *Addressing Aboriginal disadvantage: the need to do things differently*, we noted that:

- The Aboriginal unemployment rate is approximately three times greater than for the rest of the population.
- Despite Aboriginal young people comprising just 4% of the general adolescent community in NSW, half of all juveniles sentenced to a period of detention are Aboriginal – in Western NSW, the proportion rises to over 80%.
- Aboriginal children and young people are also over-represented in the child protection system – they are the subject of over 20% of all child protection reports and represent one third of the 17,000 plus children in out-of-home care.
- Over one quarter of the child deaths that we review in accordance with our statutory function to do so, involve Aboriginal children.
- The reported state-wide attendance rate for Aboriginal students is 85%, compared to 92% for non-Aboriginal children. In some towns the rate is much lower. For example, in Wilcannia, the reported attendance rate is 68% and in Boggabilla it is 64%. However, we

know that the official attendance figures do not accurately reflect the true extent of the problem.

As the Uluru Statement from the Heart asserted: "We are not innately criminal people".

Addressing over-representation of Aboriginal people in the criminal justice system necessitates addressing underlying criminogenic causes associated with systemic disadvantage.

Of course, it is also the case that the high rate of imprisonment of Aboriginal people itself has become a contributor to the economic and social disadvantage that caused it.[41] This is further reinforced by the fact that the loss of a parent to prison also increases the likelihood of involvement in crime for the next generation as a consequence of parental absence, poor parental supervision and a higher risk of neglect and/or maltreatment. [42]

Any effective policy to reduce over-representation needs to work to break this cycle. If broken the feedback loops have the potential to become positive. As the ALRC states:

> "*Reduced incarceration and greater support for Aboriginal and Torres Strait Islander people in contact with the criminal justice system will, in turn, improve health, social and economic outcomes for Aboriginal and Torres Strait Islander peoples.*"[43]

Ensuring clear links to OCHRE, and especially its focus on the need for 'Healing' strategies to acknowledge and respond to underlying trauma

Any over-representation plan should demonstrate a clear connection to the Government's over-arching Aboriginal Affairs policy: Opportunity, Choice, Healing, Responsibility and Empowerment (OCHRE). That includes, most importantly, its recognition of the need for healing and trauma informed responses.

Violent offending is one of the top three reasons for Aboriginal people entering the justice system. CSNSW Inmate Census data released in 2018 lists the top offence for Aboriginal and Torres Strait Islanders as 'Acts intended to cause injury' with the second being 'Illicit drug offences'.

This is no surprise given Aboriginal communities have repeatedly highlighted that at times there is no clear delineation between perpetrators and victims of abuse. This is because the lines are blurred between offenders who have often been victims of abuse or intergenerational trauma themselves.

The House of Representatives' Standing Committee on Aboriginal and Torres Strait Islander Affairs noted in its June 2011 report, *Doing Time – Time for Doing* the high levels of mental, physical and/or sexual abuse affecting the wellbeing of many Aboriginal communities and highlighted the "substantial number" of Aboriginal people entering detention who have suffered trauma and have social and emotional health issues.

To have any effect on reducing the overrepresentation of Aboriginal people in the criminal justice system, addressing the significant and real trauma experienced by Aboriginal people and communities is essential. Aboriginal leaders have told us that targeted healing and trauma informed programs are needed in this regard.

We recommended the NSW government establish a Healing strategy in our report *Responding to Child Sexual Assault in Aboriginal Communities*. This recommendation was accepted by the NSW government and formed part of the NSW governments Aboriginal Affairs refresh – OCHRE.

OCHRE formally recognises the need for healing inter-generational trauma from the legacy of colonisation and commits to advance the dialogue on healing with Aboriginal communities. With the release of OCHRE, the NSW Government became the first government in Australia to include healing as a key priority in its Aboriginal Affairs plan.

As part of the policy refresh process to further strengthen OCHRE, we recommended that a state-wide healing framework be developed which seeks to clarify how government agencies will incorporate a healing-informed approach to carrying out their everyday business.

Empower Aboriginal-led solutions in alignment with the right to Self-determination

The right to self-determination

On 3 April 2009, the Australian Government gave formal support for the United Nations Declaration on the Rights of Indigenous Peoples (the Declaration). Self-determination is the central right of the Declaration.

The Community Guide to the Declaration states that for self-determination to be realised, three things must occur for Aboriginal people:

1. We have a choice in determining how our lives are governed and our developmental paths.
2. We participate in decisions that affect our lives.
3. We have control over our lives and future, including our economic, social and cultural development.

In order for Aboriginal people to live according to these principles they need to have the power to take responsibility for reshaping and creating a new vision for their communities. Governments have a critical role in facilitating this.

Rather than simply relying on government departments to deliver programs and assistance, Aboriginal organisations and individuals need independence and the knowledge to build their own communities. For this to be possible, the skills of individuals and community institutions need to be developed, and communities must be provided with the necessary resources and support.

The right to self-determination is also recognised through the OCHRE focus on Empowerment.

The capacity of ACCOs to deliver early interventions and through-care support

One of the most consistent messages we have heard from Aboriginal representatives is the value of community people providing services to their own communities. Over a number of years, and through our reports and submissions, we have highlighted the need for government agencies to partner with Aboriginal leaders, peak bodies and communities to 'invest in' building the capacity of ACCOs to deliver services needed to address disadvantage.

We note that government have also emphasised the importance of enhancing the capacity of ACCOs to ensure that a broad range of competent and culturally appropriate services are available in communities. Despite this however, there are too few ACCO's.

To address this issue, it is critical that at a local level, individual communities have a clear sense of the plans for, and active involvement in, building the capacity of Aboriginal services in their community. At a state-wide level, a clear plan should be in place for building the capacity of Aboriginal peak bodies which specifies their role in supporting the growth of individual Aboriginal organisations.

Finally, supporting the expansion of the Aboriginal service sector should involve experienced organisations with a proven track record of delivering quality services to Aboriginal people. In addition, corporate Australia could play a greater role in providing support and mentoring. Consistent with the principles of self-determination, the purpose of any support arrangements should be to work towards the establishment of Aboriginal organisations that provide high quality services.

Genuine and ongoing community engagement

In NSW we have met many strong Aboriginal leaders, organisations, peak bodies and advocates – both at a community and state-wide level. While over the past decade government agencies in NSW have made progress in their working relationship with Aboriginal people across a range of areas, there is significant scope to engage Aboriginal leaders and communities far more strategically.

An ongoing and robust dialogue between government agencies and Aboriginal leaders is a necessary component of formulating and delivering on the goals of Aboriginal people. For meaningful dialogue to occur, government must establish more formal mechanisms to engage with Aboriginal people and for this engagement to be embedded in a much stronger accountability framework.

It is vital that the overall focus of any plan to address the over-representation of Aboriginal people in the criminal justice system include genuine partnerships and ongoing engagement with Aboriginal peak organisations, leaders and communities.

We note that the current reducing re-offending strategy states that 'justice is committed to working with the LDM [Local Decision Making] process as well as other NSW Aboriginal Peak Organisations.[44]

NCARA raised with us in 2019, the issue of Aboriginal men and women 'cycling' through the criminal justice system. To this end, NCARA indicated the need for the Department of Communities and Justice (DCJ) to improve and increase their level of collaboration, engagement and working relationship with NCARA in order to support and assist the intended strategy outcomes.

The Coalition of Aboriginal Peak Organisations (CAPO) made up of Aboriginal Health and Medical Research Council of NSW (the peak body for Aboriginal Community Controlled Health Services across NSW), NSW Aboriginal Land Council (which represents 120 Local Aboriginal Land Councils), Aboriginal Education Consultative Committee (which represents 20 regional AECG's), Link –Up, Aboriginal Legal Service and the NSW Child, Family and Community Peak Aboriginal Corporation have also noted that they have had limited contact with DCJ.

We suggest that any refresh of the Aboriginal over-representation plan should clearly articulate consultation mechanisms with Aboriginal peak organisations, leaders and communities and how the information gathered will be used to shape services and respond to needs. We hope this would also involve providing Aboriginal leaders with the necessary information to inform their decision-making.

Whole-of-government plan

Addressing Aboriginal contact with the criminal justice system requires a coordinated whole-of-government approach with the inclusion of Aboriginal governance structures and Aboriginal Community Controlled Organisations (ACCOs).

However, while a coordinated whole-of-government approach is necessary, consideration should still be given to government prescribing lead responsibility to one agency. Serious consideration needs to be given as to which agency is best placed to undertake this work.

Emphasising therapeutic rather than punitive approaches

It is clear that responses to crime that rely on punishment alone have failed to deter Aboriginal people from entering the criminal justice system. As Weatherburn dryly notes:

> "*when you reach the point where nearly a quarter of the Indigenous male population has been arrested by police in the last five year, more than one in ten…have been imprisoned in the last five years…and one in every five Indigenous Australians have at some stage lost a*

parent to prison, contact with the criminal justice system has probably lost much of its deterrent effect."[45]

The average length of incarceration for Aboriginal inmates is under one year. This is enough time to disrupt employment, housing and relationships but is unlikely to be sufficient time to meaningfully address underlying causes of offending.

The system for the majority of Aboriginal inmates needs to be refocused from punitive to therapeutic. That sentiment is reflected in the state government's reducing re-offending strategy and the federal governments 'Close the Gap' priorities, which call for 'systemic and structural transformation of mainstream government services to improve accountability and respond to the needs of Aboriginal people'.[46]

The NSW government's Aboriginal over-representation plan aims to 'help Aboriginal people avoid contact with the criminal justice system'. One measure to achieve this was the introduction of the *Crime (Sentencing Procedures) Amendment (Sentencing Options) Act 2017* (NSW). This legislation allows courts the option of sentencing offenders to engage in rehabilitative and therapeutic programs in the community through the use of Intensive Corrective Orders (ICOs) rather than being given a prison sentence.

Recently the Bureau of Crime Statistics and Research (BOCSAR) found a 'significant increase' in the use of ICOs for Aboriginal offenders sentenced in the Local Court. However, this was not the case in the District and Supreme Courts. BOCSAR noted that this finding was likely 'due to the comparatively small number of … Aboriginal offenders sentenced in these jurisdictions during the study period'.

Our consultations have revealed widespread support for the use of ICOs to address offending behaviour. It has been suggested to us that ICOs could be applied for all matters where the proposed prison sentence is three years or less.

Programs that focus on rehabilitating offenders have a greater chance of success in preventing crime and improving the chances of deterring re-offending. Circle Sentencing is an alternative sentencing method for Aboriginal offenders. It is currently available in 12 locations. Under Circle Sentencing, magistrates works with 'Aboriginal elders, victims and the offender's family to determine an appropriate sentence'.

A recent study by BOCSAR also found that 'Aboriginal people who participate in Circle Sentencing have lower rates of imprisonment and recidivism than Aboriginal people who are sentenced in the traditional way'. The study found that, when compared to Aboriginal offenders sentenced in the traditional way, offenders participating in Circle Sentencing:

- are 9.3 percentage points less likely to receive a prison sentence
- are 3.9 percentage points less likely to reoffend within 12 months
- take 55 days longer to reoffend if and when they do.

BOCSAR noted that past research had already shown that Circle Sentencing 'reduces barriers between Aboriginal communities and the courts and improves confidence in the sentencing process'.[47]

A similar model has been proposed for adult offenders in the District Court – Walama, which in the Dharug language means to 'come back' and in this context means to come back to country, identity, community and a healthy crime free life. The Walama Court would involve Aboriginal elders in sentencing discussions with the judge, and during the rehabilitation and monitoring phase. The program is based on intensive supervision of participants. The proposal was first put in 2014 by the Chief Judge of the District Court, who proposed the establishment of an Aboriginal sentencing court as part of the NSW District Court. It is understood that the

Government is considering a five year trial to enable BOCSAR to undertake an evaluation of its effectiveness.

Supporting Aboriginal inmates leaving custody

Over the last 12 months, more than 19,000 people have left NSW prisons and returned to their communities. In NSW, there are a small number of not-for-profit community-based organisations providing post-release transitional support to people leaving prison. The organisations delivering these services are only able to support a small proportion of the thousands of people who leave prison each year.

We understand that facilitating community integration after release from prison is supposed to happen through CSNSW case management system. Our consultations have revealed however, that people in NSW continue to leave prison without some of the necessities required to successfully integrate into the community, particularly Aboriginal inmates. This is in the context of a prisoners chances of re-offending being at their highest within the two months of them being released. Without a clear and coherent transitional plan with solid supports put into place, a lot of these inmates may be set up to fail.

The use of Aboriginal organisations should be explored in this space. In order to break cycles of chronic disadvantage and imprisonment, local decision-making entities such as, the Regional Alliances (recognised and supported under OCHRE) should be explored as an option to provide immediate to long-term case management and support to Aboriginal people leaving prison.

The minimum age of criminal responsibility

In 2019, the United Nations Committee on the Rights of the Child recommended 14 years as the minimum age of criminal responsibility. The minimum age of criminal responsibility in Australia is 10. The United Nations has repeatedly highlighted Australia's failure to raise the age of criminal responsibility.

Contact with the criminal justice system is symptomatic of broader social and economic disadvantage faced by many Aboriginal young people. As noted above, in NSW, half of all juveniles sentenced to a period of detention are Aboriginal – in Western NSW, the proportion rises to over 80%. There is a strong link between the disproportionate rates of juvenile detention and the disproportionate rates of adult imprisonment.

Consideration of this issue will likely have a significant impact on Aboriginal children in detention.

We note that in response to advocacy by peak bodies, youth organisations, doctors, psychologists and lawyers, Australia's Council of Attorneys-General (CAG) has asked a working group to look into this issue and any reforms in NSW are likely to be made after the final report is presented to the CAG in 2021. Obviously, raising the age of criminal responsibility evidently involves consideration of how to respond to children whose behaviours are anti-social and would have previously met the threshold of incarceration.

Investing in '*what works*' (and building the evidence-base to evaluate what works)

In our report – *Addressing Aboriginal disadvantage: the need to do things differently* – our office found that the continuing disadvantage experienced by Aboriginal people does not reflect a failure by governments to dedicate financial resources to initiatives aimed at addressing it. In fact, significant public funds have been allocated by successive governments.

While Aboriginal people comprise 2.3% of the state's total population, expenditure aimed at services for Aboriginal and Torres Strait Islander peoples accounted for more than 5% of the government's overall expenditure on service delivery.[48]

The Australian Law Reform Commission reported that approximately $8 billion is spent on the incarceration of Aboriginal people Australia wide.[49]

We do not believe that increased funding is, of itself, the answer. Far more important is to use existing resources more effectively. Too often, in our work we find programs are inadequately designed, poorly targeted and their effectiveness not evaluated.

Inconsistent commitment to program evaluation across government agencies means that there is often not a clear picture of which programs have resulted in improvements. The history of Aboriginal policy and program development in NSW has been agency-centric. This has resulted in programs which are narrowly focused and often disjointed.

We are regularly told about communities' frustrations by what they perceive to be the imposition upon them of programs and services, combined with inadequate consideration of how service delivery can be truly integrated 'on the ground', and how it might best reach those who are most in need. Aboriginal communities want to see an end to the inefficiency and waste, and action resulting in tangible outcomes for individuals and their communities.

The nature of our ongoing role in reviewing the delivery of services to Aboriginal communities has highlighted the need for the provision of a broad range of competent and well targeted early intervention services to address disadvantage in Aboriginal communities.

Another strong theme which emerged is the need for a solid evidence base to be built, in relation to the types of approaches that have a proven track record of success; supported by a common framework for evaluating service outcomes, and related consistent data collection and reporting by agencies and funded organisations.

An example is the Maranguka project in Bourke NSW being led by Aboriginal leaders and supported by a number of agencies including, Just Reinvest NSW. In November 2018, an impact assessment of the project by KPMG was published, highlighting:

- A 23% reduction in police recorded incidents of domestic violence and comparable falls in reoffending rates
- A 31% increase in year 12 student retention rates and 38% reduction in charges across the top five juvenile offence categories
- A 14% reduction in bail breaches and 42% reduction in days spent in custody for adults

We understand that Just Reinvest NSW has proposed two new trial sites with the Mount Druitt and Moree Aboriginal communities.

Equally important is the need to ensure that evaluation is undertaken at appropriate stages in the implementation of policies and programs.

Circle sentencing was subject to an outcome evaluation in 2008, which found that there was no evidence that Aboriginal offenders were slower to reoffend than those dealt with in a conventional court.[50] It was only in April this year that a subsequent evaluation by BOCSAR found that "circle sentencing is associated with lower rates of incarceration and recidivism".[51]

If a new policy or program is trialled in the absence of already- existing proof that it will work to produce the intended outcomes, then the trial should be based on a formal or informal 'prospective evaluation' – that is, an assessment that there is underlying logic to support the belief that the proposed policy or program will have the intended effect (for example, because it will affect a factor that is understood to be a direct or indirect driver of the outcome desired) and that it is expected to deliver this effect more efficiently than any other alternatives.

In such a case, the trial may need to be subjected to a sequence of different evaluations, rather than proceeding as quickly as possible to a single outcome/impact evaluation with a binary decision point (ie. to continue or expand the trial, or to discontinue it entirely). For example, a trial may be subject to one or more formative or process evaluations - to assess how well the

policy or program is being implemented and to identify improvements. It may then be subject to an intermediate outcomes evaluation, to assess the extent to which the policy or program is impacting the intermediate factors through which it is intended to affect the intended ultimate outcome. Both forms of evaluations may result in adjustments to the trial being made. The point is that, when a trialled policy or program does eventually become subject to final outcome evaluation, what is being evaluated is the best version of that trial, not simply the first.

The use of stepped evaluation processes to fine tune the program in operation before any decision to discontinue is made is an essential component of incremental policy making.

Accordingly, while it is important that the Government be prepared to discontinue policies or programs that cannot be shown to work, it is also important that, when trialling new policies or programs, there be a sufficient commitment to the trial to ensure that any evaluation is robust and does not result in a pre-emptory conclusion of failure.

Public reporting, transparency and accountability

Consideration should be given to whether any new plan should collect and report publicly on data such as, Aboriginal peoples contact with police, diversion from court, how many courts imposed supervised sentencing options rather than custodial sentences in addition to the eight dashboard indicators that BOCSAR have established under the current plan.

Aggregating this data to a regional and local level would also assist agencies and Aboriginal organisations to better identify areas of higher rates of Aboriginal incarceration and re-offending for better targeting of early intervention services and healing programs.

In addition, outlining a robust accountability framework that includes independent oversight would likely improve the outcomes of any future plan.

Endnotes

[1] See Weatherburn, at 22-23, (citing Harding et al, 1995, *Aboriginal contact with the criminal justice system and the impact of the Royal Commission into Aboriginal Deaths in Custody,* at 3: "At the outset, the fundamental allegation was that Aborigines had been maltreated by police and prison wardens…such that they had higher risks of death in custody".

[2] Johnston E, *Royal Commission into Aboriginal deaths in custody*" Vol 1- 4, Australian Government Publishing Service, Canberra, para 1.3.3. (*Royal Commission*), http://www.austlii.edu.au/au/other/IndigLRes/rciadic/ .

[3] *Inquest in the Death of Tane Chatfield*, Magistrate Harriet Grahame, Deputy State Coroner, 26 August 2020, at [[10]-16].

[4] Ibid, at [16].

[5] ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, at 21-22.

[6] Ibid.

[7] See section 4 which lists some of these reports.

[8] Section 12 Ombudsman Act 1974 (NSW).

[9] Ibid, section 12(3).

[10] NSW Ombudsman Annual Report 2018–19, p 34 accessed at https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0006/74283/NSW-Ombudsman-Annual-Report_2018-19.pdf .

[11] *Inquest into the death of Tane Chatfield*, Magistrate Harriet Grahame, Deputy State Coroner, 26 August 2020, at [21].

[12] Section 27 *Coroners Act 2009* (NSW).

[13] Section 23 *Coroners Act 2009* (NSW).

[14] Department of Communities and Justice, Aboriginal Strategy & Policy Unit, 'Aboriginal Death in Custody' accessed at https://www.correctiveservices.justice.nsw.gov.au/Documents/aboriginal/ASPU%20-%20Aboriginal%20deaths%20in%20custody%20-%20v1.1%20-%2020052020.pdf .

[15] Section 51 *Coroners Act 2009* (NSW).

[16] Section 78 *Coroners Act 2009* (NSW).

[17] NSW State Coroner, 'Report by the NSW State Coroner into Deaths in Custody/Police Operations for the year 2019' April 2020, p 14, accessed at https://coroners.nsw.gov.au/documents/reports/158632_STATE_CORONERS_COURT_Deaths_in_Custody_2019_-_WEB_VERSION_LR.pdf .

[18] Part 6, *Community Services (Complaints, Reviews and Monitoring Act*).

[19] Corrective Services NSW, 'Custodial Operations Policy and Procedures – 13.3 Death in custody' accessed at https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/death-in-custody-redacted.pdf .

[20] Justice Health and Forensic Mental Health Network 'Management of a Death' accessed at https://www.justicehealth.nsw.gov.au/about-us/right-to-information/1-120_policy_0118.pdf .

[21] New Zealand Ombudsman, 'Department of Corrections protocol with Ombudsman regarding death in custody' accessed at https://www.ombudsman.parliament.nz/resources/department-corrections-protocol-ombudsman-regarding-death-custody .

[22] Section 110 *Law Enforcement Conduct Commission Act 2016.*

[23] Section 115 *Law Enforcement Conduct Commission Act 2016.*

[24] Corrective Services NSW, 'Custodial Operations Policy and Procedures – 13.3 Death in custody' accessed at https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/death-in-custody-redacted.pdf .

[25] Section 35(1)(e) *Community Services (Complaints, Reviews and Monitoring) Act 1993.*

[26] NSW State Coroner, 'Report by the NSW State Coroner into Deaths in Custody/Police Operations for the year 2019' April 2020, p 10, accessed at https://www.coroners.nsw.gov.au/documents/reports/158632_STATE_CORONERS_COURT_Deaths_in_Custody_2019_-_WEB_VERSION_LR.pdf .

[27] Department of Justice and Communities website accessed at https://www.justice.nsw.gov.au/lsb/Pages/coronial-recommendations.aspx.

It is also noted that under Premier's Memorandum 'M2009-12, Responding to Coronial Recommendations' a Minister or agency should write to the Attorney General within six months outlining any action to be taken or the reasons if no action is to be taken. Ministers and agencies are 'encouraged' to provide updates on implementation of coronial recommendations. Accessed at https://arp.nsw.gov.au/m2009-12-responding-coronial-recommendations.

The Corrective Services NSW website refers to a 'Management of Deaths in Custody Committee' which is tasked with monitoring recommendations and compliance with the above Memorandum, but no further information about the work of that Committee was located online. Accessed at https://www.correctiveservices.justice.nsw.gov.au/Pages/CorrectiveServices/custodial-corrections/management-of-deaths-in-custody/management-of-deaths-in-custody.aspx .

[28] Memorandum of Understanding Between the Inspector of Custodial Services and NSW Ombudsman, December 2014 accessed at https://www.ombo.nsw.gov.au/__data/assets/pdf_file/0013/20533/Memorandum-of-understanding-between-the-Inspector-of-Custodial-Services-and-the-NSW-Ombudsman-December-2014.pdf .

[29] Inspector of Custodial Services website accessed at http://www.custodialinspector.justice.nsw.gov.au/Pages/What-we-do.aspx .

[30] Commonwealth Ombudsman website accessed at https://www.ombudsman.gov.au/what-we-do/monitoring-places-of-detention-opcat .

[31] See our Annual Report 2017/18.

[32] Inspector of Custodial Services, Use of Force, separation, segregation and confinement in NSW Juvenile Justice Centres accessed at http://www.custodialinspector.justice.nsw.gov.au/Documents/use-of-force-seperation-segregation-confinement-nsw-juvenile-justice-centre.pdf.

[33] See our Annual report 2018/19.

[34] See our Annual reports (2016/17 and 2017/18).

[35] See our Annual Report 2016/17.

[36] Ibid.

[37] NSW State Coroner, 'Report by the NSW State Coroner into Deaths in Custody/Police Operations for the year 2019' April 2020, p 8 accessed at https://www.coroners.nsw.gov.au/documents/reports/158632_STATE_CORONERS_COURT_Deaths_in_Custody_2019_-_WEB_VERSION_LR.pdf

[38] ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, at 98.

[39] Ibid at 21-22.

[40] See section 4 which lists some of these reports.

[41] Weatherburn, D., *Arresting Incarceration – Pathways out of Indigenous Imprisonment,* Aboriginal Studies Press, 2014, pp 86-87.

[43] ARLC Summary Report (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, at 22.

[44] *Reducing Aboriginal overrepresentation in the criminal justice system 2019-2020, p12.*

[45] Weatherburn, D., *Arresting Incarceration – Pathways out of Indigenous Imprisonment,* Aboriginal Studies Press, 2014, pp 86-87.

[46] See https://www.closingthegap.gov.au/sites/default/files/files/national-agreement-ctg.pdf.

[47] See Bureau of Crime Research and Statistics (BOCSAR)- https://mailchi.mp/justice.nsw.gov.au/circle-sentencing-incarceration-and-recidivism?e=b1eb89f865 .

[48] Office of Aboriginal Affairs analysis of Strategic Review of Indigenous Expenditure - Report to the Australian Government, Department of Finance and Deregulation, February 2010 cited in our report *Addressing Aboriginal disadvantage: the need to do things differently, October 2011.*

[49] ARLC Report 133 (December 2017): *Pathways to Justice – An Inquiry into the Incarceration Rate of Aboriginal and Torres Strait Islander Peoples*, at 127.

[50] Fitzgerald J 2008, 'Does circle sentencing reduce re-offending?' *Crime and Justice Bulletin* no. 115, BOCSAR, Sydney.

[51] Yeong S & Moore E 2020 'Circle sentencing, incarceration and recidivism 'Crime *and Justice Bulletin* no. 226, BOCSAR, Sydney.