PUBLIC

THE WARD CASE AND LESSONS FOR THE WA GOVERNMENT:

System-Wide Dysfunction Requires A System-Wide Approach

Special Report of a Working Party
Submitted to the WA Attorney-General by the
(WA) Deaths in Custody Watch Committee

September 2009

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1. Introduction:'A Litany of Errors'

The chain of tragic neglect and flawed decisions that led to the death of Mr Ward in January 2008 is, amongst other things, evidence of institutional or systemic failure in the corrective and custodial systems, especially as they relate to Aboriginal peoples.

This report makes recommendations in a number of areas including the implementation of the Bail Act, the practices of the Office of the Inspector of Custodial Services, the prisoner transport system and WA Coronial Law.

It critiques the current incremental approach to change and argues for a more inclusive approach which is more directly accountable and responsive to the community for the provision of just, fair and inclusive outcomes.

The State Coroner, Mr Hope, accepted the observation of Mr Ward's family, submitted via counsel, that:

> While his loss was and is profound, the realization of what led to and caused his death – as evidenced during the course of the Coronial Inquiry – has caused substantial despair. Accordingly the family can only conclude that Mr Ward could be here today had it not been for the litany of errors that followed the detention at Warburton on 26 January 2008 coupled with a refusal by the Department of Corrective services and its various contractors to deal with an accept that the fleet of vehicles transportation of persons in detention in remote areas was wholly inadequate.[1]

While his basic human rights appeared invisible to the day-to-day providers of custodial services involved in Mr Ward's death, they were visible both to the Ward family and the Coroner as the evidence in the horrific tragedy at the hands of the state unfolded.

1.1 Social Costs and Implications

The cultural and community loss associated with Mr Ward's death is enormous. As well as being a central and supportive figure for his family, Mr Ward, the Coroner found, was "*a central figure in his community at Warburton and in the surrounding lands with a unique knowledge of culture, land and art; and a central figure who played a crucial role in forging relationships between his own community and non-Aboriginal communities in Western Australia and overseas.*"[2]

1 Inquest into death of Ian Ward, Record of Investigation into Death, Western Australian Coroner's Court, 9/09, at page 10 – 11.

2 Ibid at page 10.

A civil society expects that all people are subject to dignified treatment at the hands of the State. The "substantial despair" caused by the state's failure to protect its citizens can only be compounded for Aboriginal peoples, who have also historically endured racism at the hands of the state and who continue to suffer the effects of this legacy and with whom trust desperately needs to be restored.

The "litany of errors" identified in Mr Ward's case clearly points to an endemic invisibility of human rights and dignity in the delivery of services in the custodial system. Aboriginal peoples are disproportionately represented within that system in WA and their voices have been, and continue to be, the most disenfranchised in the justice system. This imbalance is a cause of grave concern and needs to be acted upon immediately through action on many fronts.

There need to be greater accountability mechanisms in the provision of custodial services to the whole community along with special measures that must be put in place in recognition of the important role Aboriginal communities have to play in delivering relevant, safe and effective services. The WA Government must examine this issue and reexamine services in this area.

Indeed, on what basis are Aboriginal peoples presently expected to feel safe in custody? Lack of faith is a substantial yet largely unquantifiable cost to society requiring a fundamental change of attitude and actions by government to dismantle. It requires the system to reevaluate the score card in the delivery of custodial services.

Trust is an essential requirement in any partnership and requires positive actions. The WA Government must come to terms with the intrinsic value of restoring trust with Aboriginal peoples and lead the nation by example. Blindness to this value is evidenced by an inability to do little more than tinker with a dysfunctional system, in a knee-jerk response to each new crisis.

Evidence pointing to systemic failings in the system becomes largely invisible when incidents are predominantly categorized as isolated incidents requiring narrowly framed solutions within narrowly framed budget parameters.

A dysfunctional system of custodial care tends to adopt a piecemeal approach to change primarily resulting in a reorganization of the dysfunction instead of its eradication. The system is tinkered with over time in response to further deaths and other incidents.

Evidence from around Australia suggests that an incremental approach has not solved endemic issues. Piecemeal changes have tended to result from isolating incidents and the failure to draw systemic links and ask hard questions. Deferral tactics such as constant requests for more evidence coupled with a lack of responsibility by the state in the internal reporting and identification of racial issues operate to manufacture the foundations of invisibility.

1.2 The Royal Commission into Aboriginal Deaths in Custody

We acknowledge the vast array of work and evidence that has been accumulated around Australia that points to a national problem in the justice system for Aboriginal peoples. The Royal Commission into Aboriginal Deaths in Custody (RCIADIC) was established in October 1987, following public agitation led by members of the Indigenous community, amid growing public concern that there were just too many black deaths in custody. Between 1 January 1980 and 31 May 1989, ninety-nine Aboriginal and Torres Strait Islander people died in the custody of prison, police or juvenile detention institutions.

In its national report, handed down in 1991, the Commission concluded that the high Aboriginal custodial death rate resulted, not from any special propensity of Aboriginals to die in custody, but from their gross over-representation in custody. This finding led the Commission to explore the underlying causes of Aboriginal overrepresentation in custody and to consider means for reducing the disproportionate incarceration of Indigenous people. The Commission addressed the disadvantaged and unequal position in which Aboriginal people find themselves in socially, economically and culturally and offered practical suggestions to reduce the risk of Indigenous incarceration and deaths in custody.

Many of the recommendations of the Royal Commission into Aboriginal Deaths in Custody yet remain to be implemented. These are still highly relevant and should be reconsidered as part of a review of the system of delivery of custodial services.

Based on the foregoing, the DICWC makes the following general recommendations:

RECOMMENDATION 1:

There must be a framework and mindset for broader consultation and accountability in the delivery of custodial services.

RECOMMENDATION 2:

Parliament should reexamine the merits of many of the recommendations of the Royal Commission into Aboriginal Deaths in custody that have not been implemented, as part of a review of the system of delivery of custodial services.

RECOMMENDATION 3:

There need to be greater accountability mechanisms in the provision of custodial services to the whole community along with special measures that must be put in place in recognition of the important role Aboriginal communities have to play in delivering relevant, safe and effective services.

2. Discussion and Detailed Recommendations

2.1 The Bail Act

The inquest into the Death of Mr Ward has highlighted the need for the provisions of the *Bail Act* to be strictly complied with.

It is submitted that, in order to ensure the rights of an accused person in remote areas to have bail considered in accordance with that Act, some amendments to that Act may be useful.

Proposal To Reduce Accused's Time In Custody Before Being Brought Before Court

The philosophy behind that *Bail Act* is that, upon being arrested, an accused should have his or her case for bail considered as soon as is practicable by the person making the arrest, or that, if bail is refused, the person arrested be brought before a court as soon as is practicable.

The DICWC submits that the right of an accused person to have bail considered according to law is so fundamental that it is inappropriate that an accused be allowed to remain in custody for any substantial period of time without appearing before a Court presided over by a Magistrate or Judge.

In remote areas, a Court may not be convened for several days following an arrest, particularly where the arrest is made over a weekend. In those circumstances, an arresting officer can either wait for a Court to be convened in the place of arrest (assuming that the Court sits there) or makes the decision to transport the prisoner to the nearest court. As was so tragically demonstrated in Mr Ward's case, a decision to transport a prisoner from a remote location is fraught with difficulties and dangers.

The DICWC is concerned that, in addition to the dangers associated with transporting prisoners over long distances in a hostile environment, for many Indigenous people, being removed from their country can be a distressing experience. The DICWC proposes that there be a requirement that, once a person has been arrested, she or he not be transported to another location in the absence of an order from a Magistrate.

The use of video link facilities is now routine in courts in Western Australia. The use of audio link facilities is also available and utilised by Courts in rural and remote areas. Under section 66B of the *Bail Act*, Magistrates are given specific power to use these facilities. The DICWC supports the increased use of these facilities where possible to alleviate the difficulties of delivering justice to remote areas.

The DICWC proposes the *Bail Act* be amended to reduce the time within which a person must be brought before a court after arrest by prescribing the use of video link and audio link facilities in circumstances where a Court cannot be convened at the place of an arrest within a prescribed period of time.

The DICWC proposes that section 5 of the *Bail Act* be amended to make it compulsory for a person making an arrest to consider a person's case for bail within 12 hours of a person's arrest and for the accused to be brought before a court within 24 hours of the arrest.

RECOMMENDATION 4:

That Section 5 (1) (a) of the Bail Act be amended by adding the words "in any event within no later than 12 hours" after the words "as soon as practicable."

That Section 5 (1) (b) of the Bail Act be amended by adding the words "in any event within no later than 24 hours" after the words "as soon as practicable."

That Section 6 (4) of the Bail Act be amended by adding the words "in any event within no later than 24 hours" after the words "as soon as practicable."

That Section 6 (5) of the Bail Act be amended by adding the words "in any event within no later than 12 hours" after the words "as soon as practicable."

That there be an addition to Section 6 of the Bail Act which states "the arrester shall not transport an accused more than 50km from the town nearest to the location of his arrest unless ordered to do so by a Magistrate."

Proposal For Provision Of Duty Magistrate To Service Remote Areas And To Sit Outside Traditional Court Times

The DICWC acknowledges that it will not always be practicable to convene a Court within the time frames contemplated under the proposed amendment to section 5(1) (b) of the *Bail Act*.

The DICWC proposes that the parliament make provisions for a duty magistrate service to hear bail applications for accused arrested in remote places where it would not be practicable to bring them before a court within 24 hours or where the distance to the nearest court is greater than 50km.

It is proposed that the *Bail Act* makes it a requirement that efforts are made to convene a court with a video link or, in the alternative, an audio link to the location of the arrest.

In the event that it is not practicable to convene a Court at a building or structure dedicated for that person, the definition of court should be expanded to allow a duty Magistrate to convene a Court from another location, provided that the Magistrate adjourns the matter to the nearest dedicated court sitting date.

Recommendation 5:

That the parliament prescribe regulations for the establishment of a duty magistrate to service those remote areas which are not serviced by a court sitting every day using video link or, alternatively audio link facilities if a court cannot be convened within 24 hours.

That the definition of "Court" be expanded to allow a Duty Magistrate exercising his or her functions under the Bail Act to hear applications for bail in a location other than a building or structure dedicated for that purpose, provided that the duty Magistrate adjourn the matter to the nearest dedicated court sitting day.

Presumption In Favour Of The Granting Of Bail For Offences Under The Road Traffic Act And Other Prescribed Minor Offences

The DICWC is of the view that it in the vast majority of cases, a refusal of bail on charges under the *Road Traffic Act* or for a number of minor offences, would be inappropriate. Indeed, in urban areas, it is the experience of the committee that a Magistrate would only in very rare circumstances refuse a person bail altogether on a charge under the *Road Traffic Act*. The committee notes that a Magistrate has very broad powers to impose conditions on the grant of bail to prevent the risk of an accused reoffending, should the risk of reoffending be established.

The DICWC proposes that the *Bail Act* include a presumption that a person charged with offences under the *Road Traffic Act* and certain prescribed minor offences unless there are exceptional circumstances.

RECOMMENDATION 6

That parliament insert into the *Bail Act* a provision which states "Where a person is charged with an offence under the *Road Traffic Act* and prescribed minor offences, a person should be granted bail unless there are exceptional circumstances and that the risk of reoffending is not an exceptional circumstance if conditions can be imposed to reduce or prevent the risk of reoffending."

Access To Legal Advice For People In Custody Following Refusal Of Grant Of Bail

The DICWC is concerned that people in remote areas are particularly vulnerable in that they lack access to legal advice.

The DICWC proposes that it be made a requirement of the *Bail Act* that, where bail is refused, it should be mandatory for the arresting officer to facilitate an accused having access to legal advice and representation.

RECOMMENDATION 7

The parliament amend section 6 (4) of the Bail Act to add the following: "As soon as practicable and, in any event, no later than 12 hours following an arrest, the arrester shall facilitate the accused having access to legal advice either in person or via telephone unless the arrester reasonably believes that the accused will have access to legal advice at his first appearance in court."

2.2 Office of the Inspector of Custodial Services

Issuance Of "Show Cause Notices"

The Coroner in the Ward case concluded that *"it is clear that the recommendations and observations of the Inspector were not acted upon in a timely manner and this failure to act resulted in the circumstances which contributed to the death."*[3]

He proceeded to recommend that *"a statutory system be put in place which would enable the inspector of custodial services to issue the department of corrective services with a show cause' notice in cases where the inspector is aware of issues relating to the human rights and safety of persons in custody."* [4]

The DICWC does not believe a "show cause" notice is sufficiently powerful to effectively prevent critical and other incidents in custody and that enforcement powers are required which will enforce codified standards particularised in a legislative framework.

A commitment to rectifying human rights, safety and welfare issues in the delivery of custodial services in an enforceable and expeditious way is a crucial foundation for the building of community trust, particularly with Aboriginal peoples who are significant stakeholders in the system.

The DICWC finds the submission of the current Inspector, Professor Neil Morgan, disappointingly symptomatic of a dysfunctional system supporting a bureaucratic, piecemeal approach rather than a preventative approach which puts welfare and overall public confidence first.

The DICWC observes that according the OICS own submission, a "show cause" notice is a "firmed up"[5] version the present practice of issuing "risk notices". A distinguishing feature of show cause notices, however, is that they are prescribed in legislation which also provides for a process of communication between the OICS, the Department, the Minister and Parliament in regard to the notices. In this case the statutory framework recommended merely institutionalizes and legitimizes a pre-existing framework for communication about risk evident in the use of "risk notices."

DICWC notes that "risk notices" were, from the evidence presented by the OICS, notices originally created by the OICS after the relevant Minister in June 2004 expressed a desire to be better informed of high risks, following the escape of 9 prisoners from the Supreme Court in WA at that time.

[3] Ibid at page 131

[4] Ibid at page 133

[5] Submission to the Coroner of Western Australia regarding the Ward Inquest, Neil Morgan, Inspector of Custodial Services at page 5.

Upon the abovementioned incident triggering this internal practice, risk notices were being sent to the Minister, with a copy to the CEO of the Department. The purported usefulness of the current practice was, according to the OICS's own submission, limited in that they were seen, "to have useful purpose of highlighting – if necessary, separately from the normal 3 -yearly inspection cycle – some areas of particular concern. As Professor Harding said, they appear also to have led to some action by the Department at least in the case of Roebourne Prison."[6]

Via the OICS's own submissions, it appears that since 2004 Risk Notices have been "sparingly used," with the OICS locating only 4 examples of their use.[7] Further, the OICS concedes the use of Risk Notices has been ad hoc, as the last time they have been used was in 2006.[8]

Practices concerning the use of Risk Notices provided little evidence of consistency in use, or positive outcomes achieved in the delivery of custodial services, yet the concept was revamped with the recommendation of a proposed "show cause notice" to the Coroner.

It is from this very basis, difficult to understand how such a proposal can reasonably provide a comforting commitment to the protection of a community facing endemic problems with the delivery of custodial services.

In their own submissions the OICS reject the viability of enforcement powers on the basis that such powers are seen as analogous to fettering the management of operational departments, which in turn is seen - despite the existence of urgent matters fundamental to human rights resulting in death – as an undesirable outcome.

Perhaps some clues to this narrow approach to perceiving and rejecting potential solutions (such as enforcement powers) by the OICS can be found in their own description, contained in their submissions, of how they perceive the OICS's role and to some extent, that of the Department.

Insight is provided by the OICS submission setting the framework for the rejection of enforcement powers in the Ward Inquiry at point 1.3:

> It is not generally OICS's role (or indeed the role of other custodial inspectorates around the world) to attempt to manage operational departments. That is the role of the relevant Departmental head in conjunction with the Government. OICS does not therefore 'run' services or direct the Department as to how they should implement recommendations. However, some matters that relate to human rights and some urgent matters are so fundamental or so significant that there is little room for debate. In such cases, the Department is really obliged to respond if it is to avoid criticism.[9]

[6] Ibid page 4.

[7] Ibid page 3.

[8] Ibid page 4.

[9] Ibid at page 2

Further insight is provided in part 4 of the OICS submissions rejecting the proposition that enforcement notices be issued at point 4.6;

> In summary, although some areas of the OICS work (such as hygiene in food preparation and environmental health) may appear to lend themselves to the idea of an enforcement notice, our general review and inspection processes are rather different. It would be a very significant change – and one that might well cut across our general methodology – if OICS was to be drawn into specifying operational requirements and 'enforcing' such requirements.

There appears to be an inbuilt assumption in the OICS submissions that any model of enforcement will make the OICS the determinant of the appropriate standard to be enforced, instead of Parliament. This is not necessarily the case and options should be canvassed and considered, each responsive to the community via legislative prescription of the standards to be applied and enforced in the delivery of custodial services.

There also appears an assumption in the submission cited above that the "avoidance of criticism" is a substantial safeguard and reasonable check on the Department and one that will cause them to "respond" appropriately to "fundamental" and "significant" matters. This assumption is a perception, not grounded in any meaningful evidence, and appears symptomatic of a culture habitually creating policy on the run to mitigate critism, where this may not be the appropriate approach.

The DICWC view is that the Attorney General should trigger Parliament's role in dealing with fundamental and significant matters concerning systemic failings in the justice system, as illustrated in the Ward case. The OICS may be required to change its methodology and role to adapt to community expectations concerning the enforceability of standards in the delivery of custodial services in the public interest. It is within the prerogative of Parliament to contemplate this and it is a recommendation of the DICWC that Parliament do so.

<u>Proposal For The Provision Of Enforcement Notices</u>

A system granting enforcement powers by Parliament creates an obligation to respond, in accordance with standards set by Parliament. This is a pro-active, as opposed to a reactive, approach which operates to increase community control, accountability and confidence over the standards of custodial services which are provided at the public expense.

What is surprising in the OICS submissions is a disengagement from the obvious fact that if enforcement powers existed in 2001 when the OICS formally raised serious concerns with the safety of the vehicles used (as in the Ward case), it is likely that Mr Ward would not have died from heatstroke as the OICS would have been empowered to enforce reasonable standards when the serious concerns were raised.

RECOMMENDATION 8

The Attorney General trigger Parliament's role in dealing with fundamental and significant matters concerning systemic failings in the justice system, as illustrated in the Ward case.

Proposal For An Enforcement Model Based On Powers Currently Existing In Occupational Safety And Health

In the submission of the current Inspector, Professor Neil Morgan, to the Coroner, two examples of the independent inspections roles carried out by other agencies are isolated as *"worth considering"* and then rejected as possible models of enforcement. Those examples are contained in the *Heath Act (WA)* and the *Aged Care Act (Cth).*

The DICWC is of the view that a more appropriate model worthy of consideration is contained in the *Occupational Safety and Health Act 1984* and *Occupational Safety and Health Regulations 1996 (WA).*This model may provide a basic framework for the enforcement of standards. The standards themselves are largely formulated within a framework set by Parliament in the public interest and are responsive to the community. These standards apply to G4S currently in relation to their employees and compliance can be enforced if necessary for the protection of employees.[10]

Under this model, necessary enforcement action depends on the circumstances of the case, particularly the seriousness of the breach as reflected in the penalty Parliament has prescribed. Non-compliance is addressed by: improvement notice, prohibition notice, prosecution action or verbal direction or any of the combined mechanisms therein. Verbal direction in regard to enforcing a standard only applies in cases where immediate rectification of the breach is possible prior to the inspector leaving the site.[11]

10It is well established that Prisoners are not "employees" enjoying the same rights and entitlements as employees employed via a contract of employment despite the fact that they are referred to as 'employees' under the Prisons Act (1981) and Regulations (1992) (WA). The most common and obvious reason is because the relationship is not categorized as an employment relationship. For example, see the decision of the Western Australian Industrial Appeal Court decision recently in Ireland v Ian Johnson, CEO of the Department of Corrective Services ([2009] WASCA 162) where a decision of the Full Bench was upheld on appeal. The original decision held that a prisoner was not entitled to make a claim for denial of contractual entitlements under the Industrial Relations Act (1979) (WA) because he was not an employee within the meaning of that Act.

11 For further information about the Enforcement policy of Worksafe a summary is contained at www.commerce.wa.gov.au/Worksafe/Content/About_Us/Policies/Enforcement_policy

2.3 The role of Worksafe: A model of enforcement?

Information available on the Worksafe website (www.wa.gov.au) provides the community with information about how Worksafe achieve their aims. Some of this information is presented below and is not exclusive of all the functions contained within the relevant legislation; however it is highlighted to serve of as example of how enforcement can be structured.

The aim of the *Occupational Safety and Health Act 1984* is to promote and improve standards of occupational safety and health at work.

WorkSafe, through its inspectors, is responsible for the firm and fair enforcement of the requirements of the Act and *Occupational Safety and Health Regulations 1996*. Where inspectors become aware of noncompliance with the Act or regulations (amongst other things) they may;

- issue verbal directions;
- issue written directions (improvement or prohibition notices); and/or
- commence prosecution action.

When dealing with possible breaches of the law, WorkSafe's enforcement policy guides inspectors.

Verbal Direction: A verbal direction is an instruction given by a WorkSafe inspector requiring a person to remedy (fix) an alleged breach of the Act or regulations. The breach must be rectified immediately and will be inspected prior to the inspector leaving the site.

Improvement Notice: An improvement notice is a written direction issued by a WorkSafe inspector requiring a person to remedy (fix) an alleged breach of the Act or regulations.

An improvement notice states the reasons for the inspector issuing the notice and must include a reference to a specific regulation or provision of the Act.

A person who receives an improvement notice must notify the Commissioner without delay, once the requirements of the notice have been satisfied.

Any improvement notice or prohibition notice issued must be displayed in a prominent place at, or near any workplace affected by the notice. These notices shall not be removed until the requirements have been satisfied.

Prohibition Notice: A prohibition notice is a written direction issued by a WorkSafe inspector that prohibits any activity the inspector believes involves or will involve a risk of imminent and serious injury or harm to the health of any person.

A prohibition notice states the reason the inspector issued the notice and may include a reference to a specific regulation or provision of the Act.

On issuing a prohibition notice, the inspector remains at the workplace until the employer is advised of the notice and the prohibited activity has ceased.

Failure to comply with a prohibition notice could lead to prosecution.

Review powers: Requests for review of **improvement notices** can be lodged with the WorkSafe Commissioner before the deadline given by the inspector to comply. Improvement notices are suspended while being reviewed by the Commissioner.

After considering a request for a review, the Commissioner can affirm, modify or cancel the notice. Decisions of the Commissioner on the review may be appealed before the Occupational Safety and Health Tribunal. Any appeal to the tribunal must be lodged with the Western Australian Industrial Relations Commission (WAIRC) within seven days of the Commissioner's decision.

Requests for review of a **prohibition notice** can be lodged with the WorkSafe Commissioner within seven days of the issue of the notice, or the Commissioner may allow further time.

Prohibition notices remain in force while they are being reviewed by the Commissioner.

After considering a request for a review of a prohibition notice, the Commissioner can affirm, modify or cancel the notice.

Decisions of the Commissioner about the review of a prohibition notice may be appealed before the Occupational Safety and Health Tribunal. Any appeal to the tribunal must be lodged with the WAIRC within seven days of the Commissioner's decision.

The above information is taken from the Worksafe Website. More detail of the substance of this model is obviously available in the *Occupational Safety and Health Act 1984* and *Occupational Safety and Health Regulations 1996 (WA)*.

Proposal For How This Model Can Be Adapted

The DICWC is of the view that enforcement powers are essential for prisoner standards. The aim of Parliament in the area of correctional services should be to ensure that appropriately safe and dignified levels are legislatively provided. Further, that

Legislation and Regulations could be created to codify standards and empower the enforcement of standards.

The State Administrative Tribunal in WA's jurisdiction (human rights division) could be expanded to incorporate review of decisions of the OICS enforcement inspectors.

Mechanisms for investigations into allegations of beach of standards by the community will need to be considered and provided.

There needs to be a funded advocacy function for consumers and complainants that is external to government.

There needs to be a prevention and education function maintained within the OICS.

There needs to be increased emphasis on the cyclical (3 year) long-term review function within the OICS investigating and recommending on important systemic human rights matters to Parliament, such as structural racism[12] and compliance with international obligations.

There needs to be consideration to the overall funding of the OICS and the division and separation of powers within the OICS in order to appropriately manage the following:

Enforcement;

review of enforcement decisions;

Inquiry handling;

longer term reviews and reports; and

longer term education and prevention functions.

RECOMMENDATION 9

That the OICS continue to evaluate and review custodial services in the area of prisoner safety and human rights with special attention to addressing systemic failings in relation to Aboriginal persons.

RECOMMENDATION 10

The Government implements codified standards concerning safety in the delivery of custodial services needs. Standards should reflect broad community expectations and be enforceable by the OICS.

RECOMMENDATION 11

Legislation and Regulations should be created to codify standards and empower the enforcement of standards.

[12] An example of the OICS great work in the area of investigation into systemic issues is Digest D, Digest of Aboriginality in Western Australian Prisons as reported in Published Inspection reports 2000 – 2005. Released June 2006 and published by the Office of the Inspector of Custodial Services.

RECOMMENDATION 12

The State Administrative Tribunal jurisdiction (human rights division) should be expanded to incorporate review of decisions of the OICS. This should be considered as part of a review of the OICS Act, and as part of the review of the SAT Act, presently taking place.

RECOMMENDATION 13

Mechanisms for investigations into allegations of beach of standards by the community must be considered and provided.

RECOMMENDATION 14

There needs to be a funded advocacy function for consumers and complainants that is independent of government.

RECOMMENDATION 15

There needs to be a prevention and education function maintained within the OICS.

RECOMMENDATION 16

There needs to be increased emphasis on the cyclical (3 year) long-term review function within the OICS investigating and recommending on important systemic human rights matters to Parliament, such as structural racism[13] and compliance with international obligations.

RECOMMENDATION 17

There needs to be consideration to the overall funding of the OICS and the division and separation of powers within the OICS in order to appropriately manage the following:

(a) Enforcement;
(b) review of enforcement decisions;
(c) Inquiry handling;
(d) long term reviews and reports; and
(e) short and long term education and prevention functions.

[13] An example of the OICS great work in the area of investigation into systemic issues is Digest D, Digest of Aboriginality in Western Australian Prisons as reported in Published Inspection reports 2000 – 2005. Released June 2006 and published by the Office of the Inspector of Custodial Services.

2.3 Private Member's Bill 2009

More specifically this section examines The Acts Amendment (Safety and Human Rights of Persons in Custody) Bill 2009 (WA) introduced by the Leader of the Opposition in September 2009 in response to Mr Ward's death. At the time of writing the Bill is under discussion.

The Coroner in the Ward case recommended that "the terms of section 34 and 39 of the terrorism (prevention and detention) act 2006 be inserted in relevant legislation dealing with the inspector's power so that those protections be extended to all persons in custody and to all areas of the inspectors jurisdiction."[14]

The DICWC believes that human rights standards for the delivery of safe, humane and dignified custodial services need to be codified, and enforceable through a comprehensive legislative regime set by Parliament after consultation with the community.

Such standards could incorporate the sentiments of the section 34 and 39 of The Terrorism (Prevention and Detention) Act 2006 (Cth). Further, the DICWC strongly agrees with the Coroner's view that there should be a power of review in order to monitor the State's compliance with international obligations. Further that this power should exist within the OICS as part of its function as an inspection and review body.

DICWC Response To The Private Member's Bill

The DICWC was advised of the Acts Amendment (Safety and Human Rights of Persons in Custody) Bill 2009 (WA) recently.

In general, DICWC's view is that there is scope to more effectively protect standards through an enforcement regime and our recommendations reflect this.

The bulk of our recommendations relate to changes to the *Inspector of Custodial Services Act 2003* in the proposed bill.

In addition to our views expressed elsewhere on the role of the OICS that may require additional amendment to this Act, in relation to the Bill, proposed section 31A needs to be substantially amended to:

1. Empower the formation and review of a variety of enforcement notices (modeled on the types provided in the Occupational Safety and Health Act 1984) and

2. Empower the establishment of regulations in respect of codification of standards.

DICWC's recommendations also support the legislative incorporation of important provisions in relation to general expectations of standards for the humane treatment of persons under proposed amendments in the Bill to the *Prisons Act 1981,* the *Court Security and Custodial*

14 op cit Ward Inquest at page 134

Services Act 1999, the *Criminal Law (Mentally Impaired Accused) Act 1996,* and the *Young Offenders Act 1994*.

DICWC strongly supports the proposed changes to these Acts in regard to humane treatment generally.

DICWC proposes the following amendments to the *Acts Amendment (Safety and Human Rights of Persons in Custody) Bill 2009 (WA),* (some of which are generally outlined and others more specifically drafted) for your consideration:

RECOMMENDATION 18:

Section 31A be renamed '*Enforcement Notices'*

The last paragraph of proposed Section 31A (1) be redrafted to read "the Inspector may issue an appropriate notice in accordance with Section 31B requiring the CEO to respond in relation to a matter which the Inspector has suspicions, by a date and time specified in that notice."

There be inserted a new Section 31A (5) stating that "Regulations codifying minimum standards in the delivery of custodial services, may be made in accordance with this provision."

The "appropriate notices" for the purpose of Section 31A (1) will be outlined in a new Section 31B (1) to be drafted. The most appropriate notice used will depend on the circumstances of the case and the models used are based on the types of notices provided in the *Occupational Safety and Health Act 1984*.

A new Section 31B (2) would set out powers to review notices modeled on the *Occupational Safety and Health Act 1984* with jurisdiction conferred on the State Administrative Tribunal (Human Rights division) to resolve matters relating to review of decisions and appeals.

RECOMMENDATION 19:

Prisons Act 1981.

That Section 95F (3) of the proposed Bill in Part 3 is amended to delete the words "*give advice or make recommendations as"* and replaced with the words, "issue appropriate notices that."

Court Security and Custodial Services Act 1999.

That Section 101 (3) of the proposed Bill in Part 4 is amended to delete the words "*give advice or make recommendations as"* and replaced with the words, "issue appropriate notices that."

Criminal Law (Mentally Impaired Accused) Act 1996.

That Section 26A (3) of the proposed Bill in Part 5 is amended to delete the words *'give advice or make recommendations as'* and replace with the words, 'issue appropriate notices that'.

Young Offenders Act 1994.

That Section 11G (3) of the proposed Bill is amended in Part 6 to delete the words "*give advice or make recommendations as"* and replaced with the words, "issue appropriate notices that."

RECOMMENDATION 20

That there should be a power of review in order to monitor the state's compliance with Australia's international legal obligations. This power should exist within the OICS as part of its function as an inspection and review body.

2.4 Coronial Law

The RCIADIC revealed a pervasive and troubling failure of the coronial structure in every State and Territory to supply the critical analysis needed to uncover the reasons for black deaths in custody. It concluded that the failure of coronial inquests to uncover the underlying causes of Aboriginal deaths in custody and recommend remedial action had contributed to the nation's massive failure to prevent many black deaths.

Thirty four of the Commission's three hundred and thirty nine recommendations concerned reform of the State and Territorial coronial systems. Major reforms of coronial systems recommended included:

- Ensuring that the coroner's powers and position were significant enough for the coroner to be able to control and supervise investigation of a death in custody.
- Strengthening coronial investigations.
- Ensuring adequate notification of deaths in custody to coroners and that all deaths in custody be the subject of a coronial investigation culminating in a public inquest.
- Enhancing the scope of coronial inquests to include proper custodial care.
- Instituting a public reporting and review system for coronial recommendations.

- Providing proper notification of family members and assistance in representing their concerns to the coronial investigation, particularly inquests.
- Resolution of any cultural conflicts raised by Aboriginal deaths in custody and the coronial process.
- Recognising the need to have Aboriginal legal and health services and communities involved in the coronial process.
- Establishing a uniform data base for Indigenous deaths in custody.

Many of the Commission's reforms have been implemented, many have not.

Critically, in the current context, Western Australia has never implemented the Commission's recommendations for instituting a public reporting and review system for coronial recommendations relating to deaths in custody.

Proposal To Amend Coronial Legislation

Mindful of the Ward case and as part of a fitting governmental response to it, the DICWC proposes that the WA government should incorporate a focus on prevention into WA coronial law. The WA government should also resolve to show leadership in securing national co-operation in reform of coronial law that ensures a focus on prevention in coronial systems throughout Australia.

Progressive reform of coronial systems has take place in recent years in Australia and New Zealand. The most recent general coronial reforms were implemented in Victoria in 2008, New Zealand in 2006, the Northern Territory in 2004 and Queensland in 2003. A focus upon prevention has been a critical aspect of this modern coronial reform.

The most recently revised coronial legislation, in Victoria, Queensland, and New Zealand assigns a central role to prevention in the coronial systems in those jurisdictions. But prevention is not central to the coronial function in the legislation in WA.

In Australia in the last two decades there have been only two public inquiries into the coronial process. Both inquiries emphasised the preventive role of coroners and recommended mandatory reporting of responses to coronial recommendations. First there was the RCIADIC. More recently there has been a public inquiry in Victoria. In September 2006 the Final Report of the Victorian Parliament Law Reform Committee Inquiry into the *Coroners Act 1985* reported on that Committee's public review of the coronial system in Victoria. The Committee recommended a focus on prevention, including the introduction of a mandatory reporting system for coronial recommendations in Victoria. The Victorian *Coroners Act 2008* will implement this recommendation later this year.

The Northern Territory already has a mandatory reporting system for coronial recommendations.[15] In South Australia and the Australian Capital Territory legislative reporting requirements relating to coronial recommendations and their implementation apply only to deaths in custody.

WA and all other State and Territory governments should act to guarantee that the preservation of life is central to their coronial systems by introducing appropriate prevention and reporting amendments into their coronial legislation.

In his report of the Ward Inquest, the coroner set out what he regarded as the correct approach to a modern coronial investigation, derived from the Royal Commission:

> *The Royal Commission's National Report provided an impetus for more widespread reform and modernisation of the coronial jurisdiction. It was concluded by the Royal Commission that Australian coronial systems should accord coroners the status and powers to enable comprehensive and coordinated investigations to take place. These investigations should lead to mandatory public hearings productive of findings and recommendations that seek to prevent future deaths in similar circumstances. The Royal Commission recommended an expansion of coronial inquiry from the traditional narrow and limited medico-legal determination of the cause of death to a more comprehensive, modern inquest; one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths. The Royal Commission provides a timeless reminder that every avoidable Indigenous death calls upon us to identify its underlying causes, consider Indigenous disadvantage, uncover the truth about the death and resolve upon practical steps to prevent others.*[16]

The DICWC recommends that the WA government confirm that it agrees with and adopts this preventive approach and amend Western Australia's coronal legislation accordingly.

Amendments to the WA C*oroners Act 1996* are necessary to ensure that the preservation of life is an effective core coronial function.

[15] In June this year the New South Wales Premier issued a memorandum to Ministers and government agencies which indicated that they should respond to coronial recommendations within six months of receiving them. The memorandum also indicated that the Attorney General would maintain a record of all coronial recommendations made, together with the responses received from Ministers and NSW government agencies. The Attorney General is to arrange for a report to be posted on his Department's website, in June and December of each year, summarising coronial recommendations made and the responses received from Ministers and NSW government agencies.

[16] Mr.Ward inquest at p. 116 citing Watterson R, Brown P and McKenzie J, "Coronial Recommendations and the Prevention of Indigenous Death" 2008 12 (SE2) *Australian Indigenous Law Review* 6

The *Coroners Act 1996* WA currently provides that a coroner may comment on any matter connected with the death including public health or safety or the administration of justice (ss.25(2)). While this section has in practice enabled coroners to make recommendations, it should be amended to make it explicit that coroners are empowered to do so.

Sub-section 25(3) provides that "where the death is of a person held in care, a coroner must comment on the quality of the supervision, treatment and care of the person while in that care." In his report of the Ward Inquest, the Western Australian State Coroner relied on this sub-section to justify his preventive approach to the Ward inquest. This provision should be maintained but amended to refer to recommendations in addition to comments.

As a result of s 27 of the *Coroners Act 1996* (WA), the State Coroner must provide an annual report to the Attorney General for tabling in Parliament on the deaths which have been investigated in each year, including a specific report on the death of each person held in care.

In this context, sub-section 27(3) provides that the State Coroner may make recommendations to the Attorney General on any matter connected with a death which a coroner investigated, including public health or safety, the death of a person held in care or the administration of justice. Sub-section 27(4) provides that the State Coroner must inform any relevant agency in writing of any such recommendation.

It is important to note that the legislation provides is no such reporting requirement for deaths other than deaths in care and statutory reporting requirements in relation to the implementation of recommendations, including those in relation to deaths in care.

RECOMMENDATION 21

That the Western Australian *Coroners Act 1996* is amended to ensure that the preservation of life is an effective core coronial function. Amendments should include:

- **a preamble which expresses the role of the coronial system to include prevention;**
- **purposive and objects provisions which include prevention;**
- **a provision empowering a Coroner to make recommendations to any Minister, public statutory authority or entity; and**
- **a mandatory reporting scheme for coronial recommendations and their implementation.**

Mandatory Reporting For Coronial Recommendations And Their Implementation

A critical foundation of a prevention focused coronial system is for governments to report on their action, or inaction, after all coronial recommendations. This is what the Royal Commission recommended almost two decades ago in relation to deaths in custody. This compulsory feedback would highlight how serious governments are about reforms. It would save lives.

A recent report, *Coroners and the Prevention of Indigenous Death* (Watterson R, Brown P and McKenzie J, 2008 12 (SE2) *Australian Indigenous Law Review* 6), the first national study undertaken on the implementation of coronial recommendations, should help make this clear. The report tracked the response of government agencies to 484 coroners' recommendations in 185 inquests around Australia, mostly in 2004.

The survey revealed that fewer than half of coroners' suggestions to prevent future deaths are being implemented by governments across Australia. Less than half had been fully implemented in NSW (48 per cent), ahead of only Tasmania (41 per cent) and Victoria (26 per cent). The ACT (70%) and the Northern Territory (65%) had the best implementation. In Western Australia 50% were fully implemented.

The survey revealed ad hoc implementation of coronial recommendations by State and Territory governments and agencies. The fate of coronial recommendations is often left to media pressure, advocacy group intervention, and family and community action.

The upshot of these systemic failures is that governments, coroners, families and the community know very little about whether or not coronial recommendations are in fact implemented.

As previously stated, only the Northern Territory currently mandates government agency response to all coronial recommendations. In the Northern Territory, unlike in some other jurisdictions, there were no matters identified in the survey in which coronial recommendations were not communicated to the relevant government agency or were lost or neglected within a government agency. The Northern Territory also achieved one of the highest rates of government agency implementation of recommendations.

The public have a right and a need to know about life and death decisions made by governments and public officials. Mandatory reporting of coronial recommendations and their implementation is essential to provide that right and serve that need.

The value of coronial recommendations lies ultimately in their effectiveness in saving lives. Proper reporting and, monitoring of coronial recommendations and their implementation enhances their life saving potential. Greater public accessibility to and improved co-ordination of information about coronial recommendations and their implementation will better inform government public health and safety decision making and better inform the public about those decisions.

Unfortunately, there is no uniform national public reporting system for coronial findings and recommendations which:

- provides ready public access to all coronial findings and recommendations;[17]
- guarantees that all coronial recommendations will be considered and responded to by the government agencies or entities to whom they are directed;
- records whether or not all coronial recommendations have been implemented by responsible government agencies or entities; and
- enables evaluation of the impact of coronial recommendations on the prevention of deaths.

To date no Australian government has even considered, let alone worked towards, the introduction of a uniform national system which reports whether or not coronial recommendations have been implemented by responsible government agencies.

The absence of an accessible and comprehensive public reporting system for coronial findings and recommendations is a damaging gap in public knowledge about preventable deaths in this nation. This knowledge gap may fatally compromise government and community efforts to save lives. Responsible government agencies and organizations committed to preserving human life and improving individual and community wellbeing are all adversely affected. These organizations include, of course, those concerned to 'bridge the gap' in Indigenous mortality and health.

It is also of fundamental importance that the families of the deceased have knowledge of coronial recommendations, especially whether or not coronial recommendations have been implemented and the associated reasons.

A national coronial reporting scheme should be seen as an essential part of Australia's social infrastructure and a public health initiative strengthening government efforts to prevent avoidable deaths. Coroners are the poor cousins of State and Territory justice systems. To be more effective they need federal support and national co-operation amongst State and Territory governments.

[17] The National Coronial Information Service(NCIS) is a national database for all coronial matters. It is advertised to contain information about every death reported to an Australian coroner since July 2000, or January 2001 for Queensland. (NCIS website http://www.ncis.org.au/, 'About NCIS'). The NCIS is an extremely valuable tool and a significant step forward in the prevention of untimely death. Its primary role is to assist coroners by providing them with the ability to review similar previous coronial cases. Approved research and government agencies may also gain access to NCIS data. http://www.ncis.org.au/ 16 July 2009. However, NCIS data about coronial findings and recommendations is not intended to be and is not readily publicly available. It appears that few public legal service providers acting for families seek access to NCIS data to assist in the preparation of their evidence and submissions at inquests. Although, from time to time lawyers representing government agencies and corporations whose action or inaction is to be called into question at an inquest apparently obtain NCIS data in preparation for an inquest. The NCIS does not hold data about the implementation of coronial recommendations.

A uniform national coronial public reporting system is needed.

RECOMMENDATION 22

As part of its considered response to the Ward case, the Western Australian government should resolve to co-operate with the federal and State and Territory governments to achieve a uniform national coronial public reporting system.

RECOMMENDATION 23

There must be an accessible and comprehensive public reporting system for coronial findings and recommendations.

2.5 Transparency and Accountability

2.5.1 The Smokescreen of Privatisation

Whilst implementation of many elements of the recommendations of the RADC were off the agenda during the last 15 years, privatisation was firmly on the agenda.

Since the Royal Commission made its findings there has been an increasing corporatisation and privatisation of custodial services throughout Australia. As a consequence, there are now more corporate stakeholders in the delivery of services than ever before. This has thrown up new challenges in regard to the accountability, transparency and control of government and the public in the provision of those services.

Proposal For Greater Transparency

One effect of the privatisation agenda has been the public's legislative empowerment to question the provision of services has been diminished in certain situations including:

- Under the Freedom of Information Act 1992 (WA).
- Some employees have lost protections under the Public Interest Disclosure Act 2003 (WA) for 'whistle blowing' about the provision of services – thus effectively outsourcing an important check on the expenditure of public funds for public purposes. This is because contracted services do not appear to be provided by 'public authorities' within the meaning of Section 3 (1) of the Public Interest Disclosure Act 2003 (WA).
- Public sector standards no longer apply unless contractually or legislatively incorporated into the provision of the service.
- Standards are increasingly managed via contractual relationships that are subject to less public scrutiny and control.

Given the public interest in restoring faith in the provision of custodial services the DICWC recommends that, regardless of who delivers the services, the public should be empowered to access documents and be afforded as much accountability, transparency and protections as are reasonably possible in relation to the delivery of all custodial services in the public interest.

RECOMMENDATION 24

DICWC recommends that, regardless of who delivers the services, the public should be empowered to access documents and be afforded as much accountability, transparency and protections as are reasonably possible, in relation to the delivery of all custodial services in the public interest.

Submissions And Recommendations On Contracting Out Of Prisoner Transportation And Termination Of Gsl/G4s Contract

The evidence given at the Coronial Inquest into the death of Mr Ward, the State Coroner's Findings and the Court Security and Custodial Services Contract ('CSCS') between the State of Western Australia and GSL/G4S establishes the following:

In relation to the CSCS Contract:

The CSCS contract defines a death in custody[18] and provides as follows (and as relevant) in relation to deaths in custody and material breach of contract[19]:

Death in Custody means the death of a person:

(a) by other than natural causes ; or

(b) caused by the failure of the Contractor to provide adequate medical treatment or a proper duty of care, where the circumstances attributable to that death arose whilst that person was a person in custody, as lawfully determined by a Coroner of Western Australia or other duly appointed person;

In relation to termination for material breach of the Contract:

Any of the following events constitutes a material breach of the Contract and entitles the State to terminate the Contract as to one or more specified aspects of the Services by providing to the Contractor a written notice of termination of that aspect of the Services specified in the notice:

(a) if any of the following events take place in any one Service Year:

(i) there are more than two (2) separate and isolated instances of a Death in Custody;

[18] See p.18 of the Contract between the State of Western Australia and Corrections Corporation of Australia Pty Ltd for Court Security and Custodial Services (January 2000) as novated to GSL Australia Pty Ltd in 2007 ('CSCS Contract').

[19] See Cl. 24.1, p.55 CSCS Contract.

By implication this clause of the Contract effectively permits:

- That there can be up to two deaths in custody **per service year** before termination on this basis alone can occur;
- Furthermore, the "two separate and isolated instances of a death in custody per year provision" can readily be interpreted to mean that multiple deaths in custody can occur as a result of a single incident during prisoner transportation that can be regarded in contractual terms as "separate and isolated instances of a death in custody."

For example the Mazda vehicle in which Mr Ward sustained fatal injuries is capable of holding up to nine prisoners at a time. If all nine prisoners held in such a van died during a single transportation, it is arguable that the Contract would be interpreted to mean that these nine deaths in custody can and should be classified as a separate and isolated instance of **a** death in custody. The very real and imminent potential for mass deaths in custody during a single transportation of prisoners is demonstrated by the 'Sandfire' incident.

The CSCS contract thus erected an insidious regime that remains permissive of multiple deaths in custody occurring each service year without automatic and contract-threatening consequences for GSL/G4S.

This regime continues and supports a pattern of acts and omissions by both the Department of Corrective Services and the Minister and GSL/G4S of placing people held and transported by GSL in life threatening, and ultimately in Mr Ward's case, fatal conditions.

The CSCS contract in itself creates an unacceptable and unviable regime for the delivery of the state's and it's contractors' statutory, duty of care and human rights obligations to people in its care and custody.

<u>The State Of WA's And The Minister For Corrective Services Failure To Ensure Compliance By GSL/G4S Of Its Duty Of Care, Contractual, Statutory And Human Rights Obligations To Mr Ward And Other People In Its Care And Custody:</u>

Mr Ward's death, inquest and the repeated reports and representations by the Office of the Custodial Inspector as well as the representations of the Aboriginal Legal Services of WA and Giz Watson, M.L.A, cumulatively demonstrate the institutional failure and incapacity of the state and successive Ministers for Corrections to discharge their non-delegable duties of care and to ensure that's the state's contractor GSL/G4S complied with it's contractual, statutory and human rights obligations and the failure to have procedures and practices in place to ensure that this occurred.

The findings of the State Coroner that the State and GSL/G4S contributed to Mr Ward's death are the most serious findings a coroner is empowered to make. These findings further emphasise that the contracting out of prisoner transportation as practised in Western Australia is unsustainable.

The Demonstrable Incapacity And Unfitness Of GSL/G4S To Operate Prisoner Transportation In WA

The incapacity and unfitness of GSL/G4S to continue operating prisoner transportation in WA is demonstrated graphically in their treatment and the death of Mr Ward. The evidence of the inquest demonstrated that the conduct of GSL officers Powell, Stokoe and Jenkins were not wholly individualized and aberrant acts and omissions but rather part of an institutional pattern of corporate conduct.

The demonstrated unfitness of GSL/G4S is further evidenced by the following:

- 15 February 1994 - The findings of a North Humberside Coroners Jury inquiring into the death of Mr Ernest Hogg who died due to 'lack of care' while being transported by Group 4 (now G4S) in May 1993[20]
- 26 April 2000 – State Coroner of Victoria finds Group 4 (G4S) contributed the hanging deaths of four men at their Port Phillip Prison through the failure to provide a safe environment
- 2005 - Serious adverse duty of care and operational findings made by Knowledge Consulting Report into the transportation of five immigration detainees by GSL from the Maribyrnong Immigration Detention Centre to the Baxter Immigration Detention Centre on 17/18 September 2004
- July 2006 - the Victorian Ombudsman and Office of Police Integrity issued a joint report, entitled *Conditions for Persons in Custody,* which included a review of prisoner transportation provided by GSL. The Report relevantly concluded:
  - (a) Inadequacies have also been identified in the way prisoners are transported.
  - (b) Insufficient attention is given to the conditions under which prisoners are
  - (c) transported, often without basic amenities for long trips and lack of consideration of alternatives to transporting prisoners, such as expanding the use of video conferencing between prisons and courts.[21]

[20] See 'Group 4 to be sued after jail death', the Independent, 16 February 1994, 'No charges in Group 4 Death' the Independent 12 August 1993, 'Man died after drink binge on prison bus. Group 4 admits failures in procedures', the Independent, 29 January 1994.

[21] Victorian Ombudsman and Office of Police Integrity, *Conditions for Persons in Custody,* 2006 at p.108.

The report also referred to the findings of a 2005 report by the Victorian Corrections Inspectorate which had previously outlined deficiencies in prisoner transport provided by GSL in the areas of:

> Incomplete staff refresher training, poor record keeping, no regular reviews or updating of emergency management procedures, little adherence to servicing and maintenance requirements for the vehicle fleet, high breakdown levels of electronic surveillance equipment in the vans compounded by poor quality vision, broken lights and 'blind spots', inoperative communications equipment which prevent prisoners from speaking with the driver and an inadequate emergency duress monitoring system.[22]

Furthermore on 4 December 2007 the President, Human Rights and Equal Opportunity Commission brought down serious and adverse findings of human rights violations against GSL in relation to the infliction of cruel, inhuman and degrading treatment and treatment that violates basic human dignity of detainees transported by GSL from the Maribyrnong Immigration Detention Centre to the Baxter Immigration Detention Centre on 17/18 September 2004.

On 9 July 2007 Victorian Coroner Audrey Jamieson's report on the inquest into the death in GSL custody of Ian Thomas Westcott found that the failure of GSL to maintain and comply with procedures to ensure the operability of intercom systems in place to ensure the safety and survival of prisoners effectively contributed to Mr Westcott's death and that his death was preventable.

GSL/G4S has in Australia alone been found by coroners to have contributed to the death of at least six people in custody, including Mr Ward in less than nine years. It has also been subject to severely critical findings in relation to its operational compliance and duty of care capacity and for violations of the human rights of people in its care and custody.

GSL/G4S has shown through its own conduct and especially in relation to prisoner and detainee transportation that it is incapable of discharging its most basic statutory, contractual, procedural, duty of care and human rights obligations owed to people in its care and custody as well as to the WA and broader public.

Termination of Contract with GSL/G4S

The State of Western Australia has multiple statutory, contractual and common law options through which it can terminate its arrangements with GSL/G4S. The CSCS Contract provides multiple provisions for the termination of the State's arrangements with GSL/GS4.

Given the death of Mr Ward and the totality of the evidence given at the inquests and the State's Coroner's damning findings disclosing gross violations of the Contract there is an imperative public interest in the State terminating its contract as soon as possible and not at the end of GSL/G4S's current term in 2011.

[22] Ibid at p. 105.

These termination mechanisms include (without limitation):

- Cl.24.1 Termination for material breach of the contract;
- Cl.24.5 Termination for Convenience;
- Cl.24.7 Statutory Remedies

DICWC recommends that the State of WA must resume control and management of all prisoner transportation from GSL/G4S.

RECOMMENDATION 25

GSL/G4S's contractual agreements for prisoner transportation in the state of WA must be terminated as soon as possible.

RECOMMENDATION 26

The Office of the Custodial Inspector ('OCIS') should independently audit and maintain an ongoing inspection and quarterly reporting role in relation to the transitioning of prisoner transport from GSL/G4S to the State for at least two years in order to ensure implementation with all of the State Coroner's Findings and Recommendations as well as the Findings and Recommendations of the two previous OCIS two reports on prisoner transportation; also to ensure that appropriate and effective duty of care and human rights procedures, standards and practices are enacted and entrenched with WA's management of prisoner transport.

RECOMMENDATION 27

Any financial penalties imposed on GSL/G4S as a consequence of their conduct in contributing to Mr Ward's death should be provided to Mr Ward's Family in addition to any compensation they may receive through common law remedies.

3. Summary of Recommendations

RECOMMENDATION 1:

There must be a framework and mindset for broader consultation and accountability in the delivery of custodial services.

RECOMMENDATION 2:

Parliament should reexamine the merits of many of the recommendations of the Royal Commission into Aboriginal Deaths in custody that have not been implemented, as part of a review of the system of delivery of custodial services.

RECOMMENDATION 3:

There need to be greater accountability mechanisms in the provision of custodial services to the whole community along with special measures that must be put in place in recognition of the important role Aboriginal communities have to play in delivering relevant, safe and effective services.

RECOMMENDATION 4:

That Section 5 (1) (a) of the Bail Act be amended by adding the words "in any event within no later than 12 hours" after the words "as soon as practicable."

That Section 5 (1) (b) of the Bail Act be amended by adding the words "in any event within no later than 24 hours" after the words "as soon as practicable."

That Section 6 (4) of the Bail Act be amended by adding the words "in any event within no later than 24 hours" after the words "as soon as practicable."

That Section 6 (5) of the Bail Act be amended by adding the words "in any event within no later than 12 hours" after the words "as soon as practicable."

That there be an addition to Section 6 of the Bail Act which states "the arrester shall not transport an accused more than 50km from the town nearest to the location of his arrest unless ordered to do so by a Magistrate."

Recommendation 5:

That the parliament prescribe regulations for the establishment of a duty magistrate to service those remote areas which are not serviced by a court sitting every day using video link or, alternatively audio link facilities if a court cannot be convened within 24 hours.

That the definition of "Court" be expanded to allow a Duty Magistrate exercising his or her functions under the Bail Act to hear applications for bail in a location other than a building or structure dedicated for that purpose, provided that the duty Magistrate adjourn the matter to the nearest dedicated court sitting day.

RECOMMENDATION 6

That parliament insert into the *Bail Act* a provision which states "Where a person is charged with an offence under the *Road Traffic Act* and prescribed minor offences, a person should be granted bail unless there are exceptional circumstances and that the risk of reoffending is not an exceptional circumstance if conditions can be imposed to reduce or prevent the risk of reoffending."

RECOMMENDATION 7

The parliament amend section 6 (4) of the Bail Act to add the following: "As soon as practicable and, in any event, no later than 12 hours following an arrest, the arrester shall facilitate the accused having access to legal advice either in person or via telephone unless the arrester reasonably believes that the accused will have access to legal advice at his first appearance in court."

RECOMMENDATION 8

The Attorney General trigger Parliament's role in dealing with fundamental and significant matters concerning systemic failings in the justice system, as illustrated in the Ward case.

RECOMMENDATION 9

That the OICS continue to evaluate and review custodial services in the area of prisoner safety and human rights with special attention to addressing systemic failings in relation to Aboriginal persons.

RECOMMENDATION 10

The Government implements codified standards concerning safety in the delivery of custodial services needs. Standards should reflect broad community expectations and be enforceable by the OICS.

RECOMMENDATION 11

Legislation and Regulations should be created to codify standards and empower the enforcement of standards.

RECOMMENDATION 12

The State Administrative Tribunal jurisdiction (human rights division) should be expanded to incorporate review of decisions of the OICS. This should be considered as part of a review of the OICS Act, and as part of the review of the SAT Act, presently taking place.

RECOMMENDATION 13

Mechanisms for investigations into allegations of beach of standards by the community must be considered and provided.

RECOMMENDATION 14

There needs to be a funded advocacy function for consumers and complainants that is independent of government.

RECOMMENDATION 15

There needs to be a prevention and education function maintained within the OICS.

RECOMMENDATION 16

There needs to be increased emphasis on the cyclical (3 year) long-term review function within the OICS investigating and recommending on important systemic human rights matters to Parliament, such as structural racism[23] and compliance with international obligations.

RECOMMENDATION 17

There needs to be consideration to the overall funding of the OICS and the division and separation of powers within the OICS in order to appropriately manage the following:

(a) Enforcement;
(b) review of enforcement decisions;
(c) Inquiry handling;
(d) long term reviews and reports; and
(e) short and long term education and prevention functions.

[23] An example of the OICS great work in the area of investigation into systemic issues is Digest D, Digest of Aboriginality in Western Australian Prisons as reported in Published Inspection reports 2000 – 2005. Released June 2006 and published by the Office of the Inspector of Custodial Services.

RECOMMENDATION 18:

That Section 31A be renamed '*Enforcement Notices'*

The last paragraph of proposed Section 31A (1) be redrafted to read "the Inspector may issue an appropriate notice in accordance with Section 31B requiring the CEO to respond in relation to a matter which the Inspector has suspicions, by a date and time specified in that notice."

There be inserted a new Section 31A (5) stating that "Regulations codifying minimum standards in the delivery of custodial services, may be made in accordance with this provision."

The "appropriate notices" for the purpose of Section 31A (1) will be outlined in a new Section 31B (1) to be drafted. The most appropriate notice used will depend on the circumstances of the case and the models used are based on the types of notices provided in the *Occupational Safety and Health Act 1984*.

A new Section 31B (2) would set out powers to review notices modeled on the *Occupational Safety and Health Act 1984* with jurisdiction conferred on the State Administrative Tribunal (Human Rights division) to resolve matters relating to review of decisions and appeals.

RECOMMENDATION 19:

Prisons Act 1981.

That Section 95F (3) of the proposed Bill in Part 3 is amended to delete the words "*give advice or make recommendations as"* and replaced with the words, "issue appropriate notices that."

Court Security and Custodial Services Act 1999.

That Section 101 (3) of the proposed Bill in Part 4 is amended to delete the words "*give advice or make recommendations as"* and replaced with the words, "issue appropriate notices that."

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- purposive and objects provisions which include prevention;
- a provision empowering a Coroner to make recommendations to any Minister, public statutory authority or entity; and
- a mandatory reporting scheme for coronial recommendations and their implementation.

RECOMMENDATION 22

As part of its considered response to the Ward case, the Western Australian government should resolve to co-operative with the federal and State and Territory governments to achieve a uniform national coronial public reporting system.

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There must be an accessible and comprehensive public reporting system for coronial findings and recommendations.

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DICWC recommends that, regardless of who delivers the services, the public should be empowered to access documents and be afforded as much accountability, transparency and protections as are reasonably possible, in relation to the delivery of all custodial services in the public interest.

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GSL/G4S's contractual agreements for prisoner transportation in the state of WA must be terminated as soon as possible.

RECOMMENDATION 26

The Office of the Custodial Inspector ('OCIS') should independently audit and maintain an ongoing inspection and quarterly reporting role in relation to the transitioning of prisoner transport from GSL/G4S to the State for at least two years in order to ensure implementation with all of the State Coroner's Findings and Recommendations as well as the Findings and Recommendations of the two previous OCIS two reports on prisoner transportation; also to ensure that appropriate and effective duty of care and human rights procedures, standards and practices are enacted and entrenched with WA's management of prisoner transport.

RECOMMENDATION 27

Any financial penalties imposed on GSL/G4S as a consequence of their conduct in contributing to Mr Ward's death should be provided to Mr Ward's Family in addition to any compensation they may receive through common law remedies.

4. Conclusion

In 1983 the death in custody of sixteen-year-old John Pat in Roebourne jail triggered shock and outrage across the nation and created a public movement to end the chilling rate of Aboriginal incarceration and fatalities in custody. This movement provided the impetus for establishment of the Royal Commission into Aboriginal deaths in custody.

A quarter century later, the horrific death of Mr Ward has again sent shock waves through the nation and made international headlines. The manner of Mr Ward's death, "the litany of errors" it brought to light within the custodial system, and the ongoing consequences for his family members and community have led to a number of expressions of public grief and anger.

The preventable tragedy of Mr Ward's death and the public momentum it has generated make it incumbent upon the government of WA to act. The DICWC calls on the Attorney-General of WA to take strong and credible action both to bring those responsible for Mr Ward's death to account and to ensure that such an appalling and wasteful death does not happen again.

The recommendations contained in this report are the initial, indispensable steps towards achieving this end.

Daisy Ward, cousin of Mr Ward, at the John Pat memorial outside Fremantle jail, September 2009

Photo: Desire Mallet

5. Contributors

Liz Carbone is a legal practitioner with further qualifications (academic) in Public Administration, Politics and Development studies. She works as an Industrial Advocate at the State School Teachers Uion of W.A. (Inc).

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Suvendrini Perera is a cultural theorist with a special focus on questions of race and ethnicity. She works at Curtin University.

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Deaths in Custody Watch Committee WA