23rd October 2009

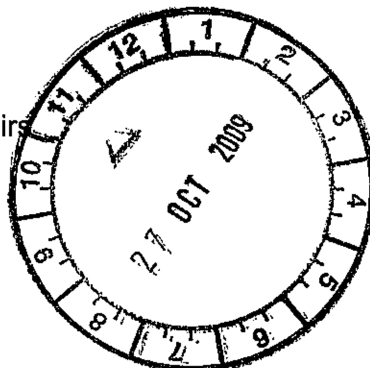
Hon Brian Ellis MLC

Chairman

Standing Committee on Environment and Public Affairs

Parliament House

PERTH WA 6000



Dear Mr Ellis

Re: Petition No. 43 – Transportation of detained persons

Thank you for your letter of 23 September 2009 inviting me to provide a written submission.

I confirm that I do wish the Committee to inquire into the matters raised in the petition. We have not raised the items in the petition with the Parliamentry Commmissioner for Administrative Investigations.

Please find attached our submission which deals with petition items 1,3,6,8 and 9. I am aware the the Hon. Giz Watson has also been invited to make a submission and has made comment on petition items 2,4,5,7,8 and 10. We support her comments.

Our submission makes reference to and draws extesnsively on the *Special Report of a Working Party of the Deaths in Custody Watch Committee: The Ward Case and Lessons for the WA Government: System-Wide Dysfuntion Requires a System Wide Approach.* I have included a copy of this report and would appreciate it being made available to members of the Standing Committee on Enviroment and Public Affairs for their reference.

I look forward to hearing from you and please do not hesitate to contact me directly on mobile number 0415-074-602 email dicwc@iinet.net.au and newbone@bigpond.com. We are happy to provide further information or any assistance you may require.

Thank you for your consideration.

Yours sincerely

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Marc Newhouse

PUBLIC AFFAIRS OFFICER

DEATHS IN CUSTODY WATCH COMMITTEE OF WESTERN AUSTRALIA INC.

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This submission deals with petition items 1, 3, 6, 8 and 9

Item 1: We note that the Government response to the Coroners findings claims to provide, *'in principle support*' for **recommendations 1 & 2**. We draw to Committee's attention that the Coroner recommended an explicit obligation to treat all detainees humanely be inserted into legislation governing the powers of the Inspector of Custodial Services. We note with concern that the government's response does not do this. Instead it proposes legislation to empower the Inspector to "audit a certain proportion of the total population of persons in custody each year." We believe that the power to audit needs to be linked to monitoring the state's compliance with Australia's international human rights obligations including OPCAT. Further, the over representation of Aboriginal people in custody needs to be reflected in the audit sample. According to the government's response, "a key feature of the audit process would be the creation of a statutory power for the Inspector to issue Show Cause notices to the DCS." 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 to enforce codified standards particularized in a legislative framework. We urge the Committee to inquire into why this should not occur[1]. We note with concern that responses to **recommendations 1, 2, 6** have no implementation timeframes. Further, that recommendation **3,4,5,7, 8, 12, 13 and 14** claim to be in the implementation process however there does not appear to be any specified timeframe for completion. Some aspects of these recommendations appear to be in the implementation process while other parts are not and do not appear to have completion deadlines. Response to **recommendation 9** explains that the replacement of the current fleet began in Nov 2004 and took until April 2008 for a new prototype to be agreed to. All original vehicles will be replaced by Dec 2010. Put succinctly, Mr. Ward died in tortuous condition in Jan 2008. History tells us that this timeframe was fatal. The December 2010 timeline is clearly unacceptable by reasonable community standards. We also note that the response claims that there was "significant consultation on the design." DICWC a key stakeholder was not consulted. Response to **recommendations 10 & 11** appeared to be fully implemented. We note with concern that many of the government responses are subject to a 'business case' being presented and being subject to the 'normal budgetary process.' We are concerned that this process may further delay changes and we are concerned about the notion that basic human rights can be conceptualized as a 'business case.' Further, we are concerned that there does not appear to be any attempt to engage key community stakeholders in the government's implementation plan. **We are not convinced that the government's response constitutes a full and prompt implementation of the Coroners Findings and further inquiry and scrutiny is necessary.**

Item 3: The findings of the 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 emphasize that the contracting out of prisoner transportation as practised in Western Australia is unsustainable. We understand from media reports that, a) the contract is not going to be terminated and will continue until its current term expires in 2011 and, (b) the contract is currently being reviewed. We bring to the Committee's attention that the contract creates 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 systemic 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 contract creates an unacceptable and unviable regime for the delivery of the State and its contractors statutory, duty of care and human rights obligations to people in its care and custody. 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

[1] Refer to DICWC Special Report to the AG for a full explanation of an Enforcement Model

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custody as well as to the WA and broader public. We note that 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 States arrangements with GSL/GS4. Given the death of Mr. Ward and the totality of the evidence given at the inquests and the State's Coroners 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. DICWC recommends that the State of WA must resume control and management of all prisoner transportation from GSL/G4S.[2]

Item 6: We are encouraged by the government's response to the Coroners rec. 7, 8 & 9 however we urge the Committee to inquire into further measures detailed in section 2.1. of the Special Report submitted to the AG by the DICWC. We also note with concern the recent incident involving two juveniles who were transferred into a canvass covered 'paddy wagon' with no seats belts at Warradarge and transported a further 175kms in 30degree heat. One of the juveniles was so distressed that he got "leather from the canopy undid it and put it around his neck." [3] This incident again highlights the need for urgent systemic changes to be made.

Item 8: We draw to the Committee's attention that in a meeting we had with the current AG and Corrective Services Minister he invited DICWC to provide him with 'evidence' of systemic racism in the administration of Justice. DICWC does not receive state or federal government funding and relies on donations and membership fees. We are not in a position to gather this evidence. Gathering such evidence requires a major systemic inquiry into relevant legislation, policies, routine practices across a number of government agencies and assessing the impacts and outcomes for Aboriginal people. We therefore urge the Committee to consider the merits of the AG directing and resourcing the Commissioner for Equal Opportunity to conduct such an Inquiry under Section 80 of the Equal Opportunity Act 1984. The onus should be on the State to collate existing evidence, investigate and modernize current evidence gathering reporting systems within government to identify issues of systemic racism and recommend changes to address systemic racism. This should form part of the terms of reference of an inquiry.

Item 9: We draw to the Committee's attention that the RCIADIC revealed a failure of the coronial structure in every State and Territory to supply the critical analysis needed to uncover the reasons for Aboriginal 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 Aboriginal deaths. WA has never implemented the Commission's recommendations for instituting a public reporting and review system for coronial recommendations relating to deaths in custody. Amendments to the WA *Coroners Act 1996* are necessary to ensure that the preservation of life is an effective core coronial function. 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. We therefore urge the Committee to consider the merits of amendments to the Western Australian *Coroners Act 1996* to ensure that the preservation of life is an effective core coronial function. Amendments should include: 1) a preamble which expresses the role of the coronial system to include prevention; 2) purpose and objects provisions which include prevention; 3) a provision empowering a Coroner to make recommendations to any Minister, public statutory authority or entity; and 4) a mandatory reporting scheme for coronial recommendations and their implementation. We further recommend that there must be an accessible and comprehensive public reporting system for coronial findings and recommendations.[4]

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[2] Refer to DICWC Special Report to the AG for more detailed analysis.
[3] West Australian 21 October 2009.
[4] Refer to DICWC Special Report to the AG for more detailed analysis.

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 200[illegible]

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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.

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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.

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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.

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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.

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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.

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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."

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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.

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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

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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.

Proposal For The Provision Of Enforcement Notices

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.

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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

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