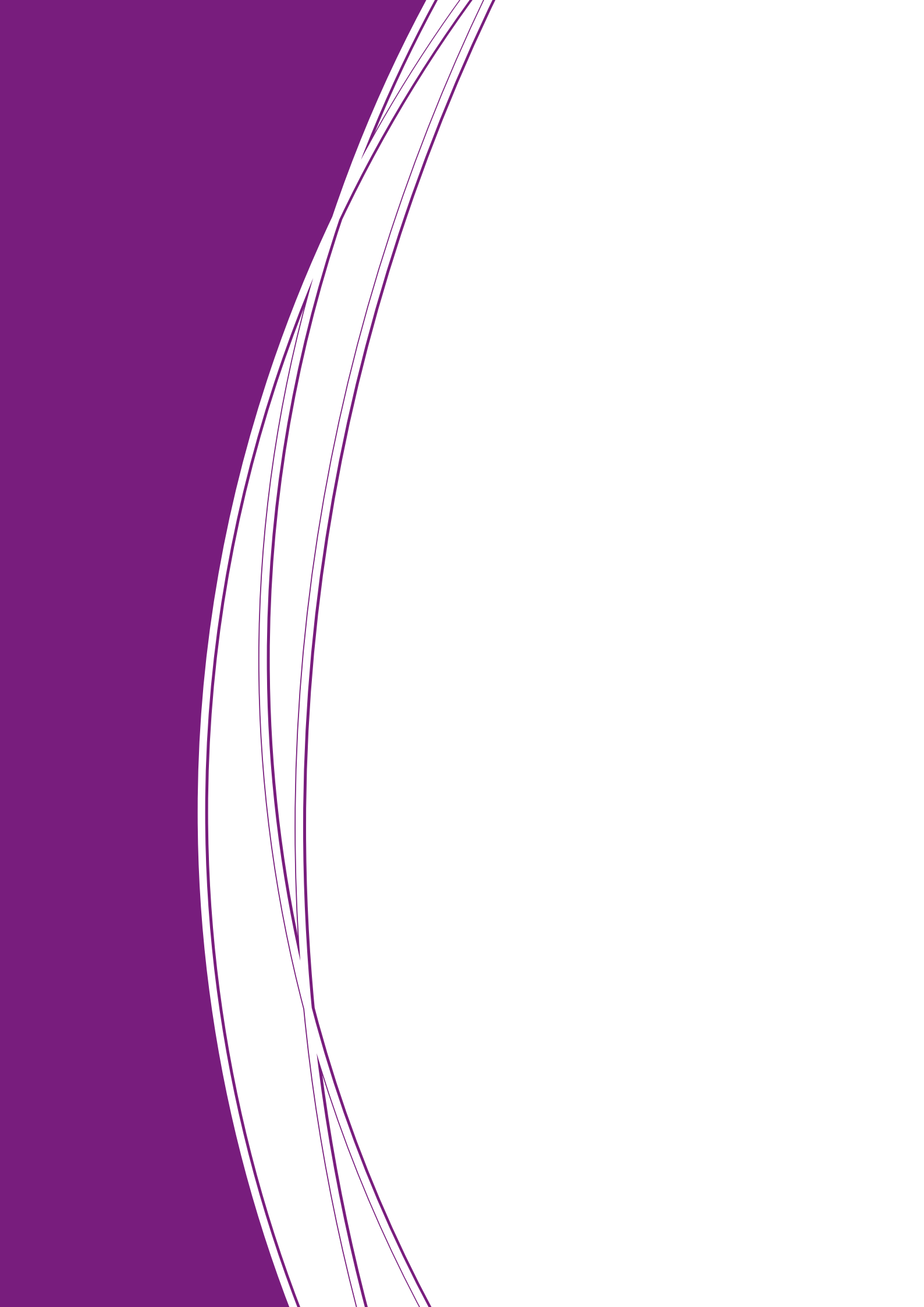
ICAC

INDEPENDENT COMMISSION AGAINST CORRUPTION

NEW SOUTH WALES

INVESTIGATION INTO THE CONDUCT OF NSW CORRECTIVE SERVICES OFFICERS AT LITHGOW CORRECTIONAL CENTRE

ICAC REPORT
JUNE 2019



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ICAC

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Mr President
Mr Speaker

In accordance with s 74 of the *Independent Commission Against Corruption Act 1988* I am pleased to present the Commission's report on its investigation into the conduct of NSW Corrective Services officers at Lithgow Correctional Centre.

I presided at the public inquiry held in aid of the investigation.

The Commission's findings and recommendations are contained in the report.

I draw your attention to the recommendation that the report be made public forthwith pursuant to s 78(2) of the *Independent Commission Against Corruption Act 1988*.

Yours sincerely

Stephen Rushton SC
Commissioner

Contents

Summary of investigation and outcomes

This investigation by the NSW Independent Commission Against Corruption ("the Commission") concerned allegations that:

1. On or about 19 February 2014, Corrective Services NSW (CSNSW) officers, including John O'Shea, Brad Peebles, Stephen Taylor, Brian McMurtrie, Terrence Walker, Elliott Duncan and Simon Graf, dishonestly exercised their official functions in relation to an assault of a prisoner ("inmate A") by:
    i. subjecting inmate A to a use of force (UOF), which was unwarranted and inappropriate in the circumstances
    ii. colluding for the purpose of providing a false and misleading account of the reasons for attending the cell occupied by inmate A and subjecting him to the UOF
    iii. submitting, reviewing and approving a UOF package that contained false and misleading information in relation to the reasons for attending the cell occupied by inmate A and subjecting him to the UOF
    iv. failing to record the UOF by way of video camera as required by the policy and procedures of CSNSW
    v. destroying or not maintaining closed circuit television (CCTV) footage of the area immediately outside the cell occupied by inmate A.
2. On 20 February 2014, CSNSW officers dishonestly exercised their official functions by falsely representing that 0.2 grams of buprenorphine (suboxone) was recovered during the search of the cell occupied by inmate A from his personal belongings.

Outcomes

The Commission is satisfied that Mr O'Shea engaged in serious corrupt conduct from February 2014. He dishonestly and partially exercised his official functions by participating in both the use of excessive force on inmate A by a fellow CSNSW officer, Mr Walker, on 19 February 2014, and the cover-up of the incident. More particularly, he:

- incited Mr Walker to enter inmate A's cell and "sort it out", knowing that Mr Walker would apply physical force to an inmate
- failed to complete an incident report in circumstances where he was a witness to the events, giving rise to the UOF and the UOF itself
- approved the UOF package concerning the UOF on inmate A, knowing that it contained false and misleading information prepared by other CSNSW officers; namely, Mr McMurtrie, Mr Walker, Mr Graf, and Mr Duncan
- approved the UOF package, knowing that it did not include his incident report or the incident reports of Mr Peebles, Mr Taylor and Wesley Duffy
- approved the UOF package in circumstances where he had a conflict of interest and was in breach of his obligations pursuant to Commissioner's Instruction No. 10 of 2011, "Reviewing Use of Force"
- failed to act on the complaint made by inmate A to his father on the telephone that he had been "flogged by the squad"
- concealed the incident report of Mr Duffy
- misled the CSNSW Investigations Branch during its investigation in January 2015, by giving a false account of the UOF on inmate A and his own involvement in the incident.

The Commission is satisfied that Mr Walker engaged in serious corrupt conduct from February 2014. He dishonestly and partially exercised his official functions by his use of excessive force on inmate A and the cover-up of the incident. More particularly, he:

- prepared an incident report containing false and misleading statements in relation to the application of physical force to inmate A
- encouraged Mr Graf and Mr Duncan to prepare false and misleading incident reports
- instructed Mr Duffy not to prepare an incident report
- prepared an Incident Reporting Module (IRM) containing false and misleading statements
- misled CSNSW during its 2015 investigation by giving a false account of the UOF on inmate A and the facts and circumstances leading to the UOF.

The Commission is satisfied that Mr McMurtrie engaged in serious corrupt conduct from February 2014. He also dishonestly and partially exercised his official functions by participating in the cover-up of the use of excessive force on inmate A by a fellow CSNSW officer, Mr Walker, on 19 February 2014. More particularly, he:

- created a false intelligence report concerning the presence of buprenorphine in cell 208
- assisted in the drafting of Mr Walker's false incident report
- failed to report a possible assault on inmate A, having observed inmate A's injuries and having heard inmate A's complaint to his father that he had been "flogged by the squad"
- created intelligence report "IR-366" in which he repeated the false intelligence that there was suboxone in cell 208.

The Commission is satisfied that Mr Graf engaged in serious corrupt conduct from February 2014. He dishonestly exercised his official functions by participating in the cover-up of the use of excessive force on inmate A by a fellow CSNSW officer, Mr Walker, on 19 February 2014. More particularly, he:

- prepared an incident report containing false and misleading statements in relation to the application of physical force to inmate A
- misled CSNSW during its 2015 investigation by giving a false account of the UOF on inmate A and the facts and circumstances leading to the UOF.

The Commission is satisfied that Mr Duncan engaged in serious corrupt conduct from February 2014. He dishonestly and partially exercised his official functions by participating in the cover-up of the use of excessive force on inmate A by a fellow CSNSW officer, Mr Walker, on 19 February 2014. More particularly, he:

- prepared an incident report containing false and misleading statements in relation to the application of physical force to inmate A
- misled CSNSW during its 2015 investigation by giving a false account of UOF on inmate A and the facts and circumstances leading to the UOF.

The Commission is satisfied that Mr Taylor engaged in serious corrupt conduct from February 2014. He dishonestly and partially exercised his official functions by participating in the cover-up of the use of excessive force on inmate A by a fellow CSNSW officer, Mr Walker, on 19 February 2014. More particularly, he:

- failed to prepare an incident report recording that inmate A had been bashed by Mr Walker and that Mr O'Shea was standing next to him outside cell 208 when this occurred

- recommended that no further action be taken following his review of the UOF package in circumstances where he knew:
    i. the incident reports were inconsistent with what he had observed and heard on 19 February 2014
    ii. the UOF package was incomplete, in that he and Mr O'Shea had not provided incident reports
    iii. entry into cell 208 by the immediate action team (IAT) was as a consequence of one of the inmates abusing Mr O'Shea over the knock-up system rather than a cell search for suboxone
- misled CSNSW investigators on 5 March 2015, during their investigation of the incident of 19 February 2014, by maintaining that he had no knowledge of Mr O'Shea approaching cell 208 or any "flogging" of inmate A.

Statements are made pursuant to s 74A(2)(a) of the *Independent Commission Against Corruption Act 1988* ("the ICAC Act") that the Commission is of the opinion that consideration should be given to obtaining the advice of the Director of Public Prosecutions (DPP) with respect to the prosecution of:

- Mr O'Shea for being a principal in the second degree to the offence of inciting an assault of inmate A, hindering an investigation of a serious indictable offence contrary to s 315 of the *Crimes Act 1900* ("the Crimes Act"), the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act, and the common law offence of misconduct in public office and the offence of wilfully obstructing the Commission contrary to s 80 of the ICAC Act
- Mr Walker for the offence of assault occasioning actual bodily harm, contrary to s 59(1) of the Crimes Act, the offence of hindering an investigation, contrary to s 315 of the Crimes Act, the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act, and the common law offence of misconduct in public office
- Mr McMurtrie for the offence of hindering an investigation, contrary to s 315 of the Crimes Act, the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act, the common law offence of misconduct in public office, and the offence of giving false or misleading evidence to the Commission contrary to s 87 of the ICAC Act
- Mr Taylor for the offence of hindering an investigation, contrary to s 315 of the Crimes Act, the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act, the offence of concealing a serious indictable offence, contrary to s 316(1) of the Crimes Act, and the common law offence of misconduct in public office
- Mr Graf for the offence of hindering an investigation, contrary to s 315 of the Crimes Act, the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act, the offence of wilfully obstructing the Commission contrary to s 80 of the ICAC Act, the common law offence of misconduct in public office, and the offence of giving false or misleading evidence contrary to s 87 of the ICAC Act
- Mr Duncan for the offence of hindering an investigation, contrary to s 315 of the Crimes Act, the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act, the common law offence of misconduct in public office, and the offence of giving false or misleading evidence contrary to s 87 of the ICAC Act.

Statements are made pursuant to s 74A(2)(b) of the ICAC Act that the Commission is of the opinion that, in all the circumstances, consideration should be given to the taking of disciplinary action against Mr Peebles, Mr Taylor, Mr Graf, Troy Dippel and Mick Watson.

Statements are also made pursuant to s 74A(2)(c) of the ICAC Act that, in all the circumstances, consideration should be given to the taking of action against Mr Taylor and Mr Graf with a view to dismissing, dispensing with the services of, or otherwise terminating their services.

Chapter 6 of this report sets out the Commission's review of the corruption risks identified during the course of its investigation. The Commission makes the following 19 recommendations.

Recommendation 1

That the personal assistant to a general manager (GM) of a correctional centre be required to enter all submitted incident reports into CSNSW's electronic systems.

Recommendation 2

That CSNSW ensures its policies and procedures discourage the sharing or misuse of passwords. These requirements should also be reflected in the relevant officer's training.

Recommendation 3

That CSNSW introduces controls to ensure that, if required information is not entered into the Offender Integrated Management System (OIMS) within a specified period of time, a report will be generated and a review conducted by an appropriate officer who will be required to report to the GM.

Recommendation 4

That CSNSW:

- supplies body cameras to correctional officers who are likely to be involved in UOF incidents and prioritises the supply of these cameras to correctional officers assigned to the IATs
- provides correctional centres with the means to readily obtain footage from these body cameras and store it for a sufficient period of time.

Recommendation 5

That CSNSW:

- mandates the videorecording of the destruction of contraband drugs found on inmates or in their cells
- provides correctional centres with the means to readily obtain such footage and store it for a sufficient period of time.

Recommendation 6

That CSNSW ensures all correctional centres have sufficient technical resources to retain all CCTV footage that is necessary or desirable to retain under CSNSW procedures concerning the UOF and targeted searches.

Recommendation 7

That CSNSW requires that all contraband at correctional centres is photographed at the time of discovery. This requirement should be reinforced via relevant CSNSW training, compliance and audit programs.

Recommendation 8

That CSNSW communicates to the GMs and managers of security (MoSs) at all correctional centres that they cannot be involved in a review of any UOF package if they were involved in or a witness to the UOF in question. Instead, the UOF package must be externally reviewed.

Recommendation 9

That the activities of the IATs be included in any relevant Operational Performance Review Branch reviews, such as reviews of correctional centres against service specifications.

Recommendation 10

That following review by the MoS and GM of a correctional centre, UOF packages be sent to a centralised CSNSW business unit, which should:

- receive this package before CCTV footage is overwritten
- have direct access to relevant CCTV footage
- receive any other related technical product, such as recordings or photographs
- review either (i) all UOF packages it receives or (ii) a proportion of the UOF packages it receives that is sufficient to readily identify systemic issues that relate to a particular correctional centre.

Recommendation 11

That CSNSW develops specific, independent assurance mechanisms surrounding the searching of cells. These mechanisms should examine whether CSNSW procedures are being complied with, and good practice is being applied, in relation to the:

- discovery of contraband, including videorecording requirements
- reporting of the discovery of contraband
- confiscation and disposal of prohibited substances.

Recommendation 12

That CSNSW implements a coordinated strategy to improve the cultural environment for correctional officers within its centres, with a view to alleviating the burden imposed on those officers who report the misconduct of others. Logically, those measures might include:

- focused training and education on the importance of reporting misconduct within a corrections environment
- support for complainants and protection of their identity
- avenues for making anonymous reports and identification

- exposure and action in response to those who engage in bullying, harassment or other forms of reprisal.

Recommendation 13

That CSNSW monitors the treatment of those officers who have assisted the Commission in this investigation.

Recommendation 14

That CSNSW takes sustained measures to prevent the practice of "therapy", "cell therapy" or like practices being applied to inmates.

Recommendation 15

That CSNSW investigators have ready access to (i) relevant CSNSW documents, such as UOF packages, and (ii) other evidence, such as CCTV footage, in a manner that does not in any way depend on, or alert, other CSNSW staff.

Recommendation 16

That CSNSW reviews its procedures for the initiation and escalation of investigations. Among other things, this review should address the need for independence and objectivity.

Recommendation 17

That CSNSW reviews its investigation function to ensure that it:

- is staffed in a manner that enables it to meet timeframe key performance indicators without compromising investigation quality
- has access to appropriate technical resources, including a case management system that sufficiently caters for its needs.

Recommendation 18

That CSNSW prioritises the completion of its investigation manual.

Recommendation 19

That staff responsible for CSNSW's project regarding systemic issues identified in this investigation consider and action the following issues:

- whether any of the conduct identified in the Commission's investigation occurs at other correctional centres
- the evidence and findings made by anti-corruption agencies in Queensland and Western Australia
- how data analysis of its information holdings can facilitate the identification of misconduct by correctional officers and issues that may be systemic within the corrections sector in NSW.

These recommendations are made pursuant to s 13(3)(b) of the ICAC Act and, as required by s 111E of the ICAC Act, will be furnished to CSNSW and the responsible minister.

As required by s 111E(2) of the ICAC Act, CSNSW must inform the Commission in writing within three months (or such longer period as the Commission may agree in writing) after receiving the recommendations, whether it proposes to implement any plan of action in response to the recommendations and, if so, of the plan of action.

In the event a plan of action is prepared, CSNSW is required to provide a written report to the Commission of its progress in implementing the plan 12 months after informing the Commission of the plan. If the plan has not been fully implemented by then, a further written report must be provided 12 months after the first report.

The Commission will publish the response to its recommendations, any plan of action and progress reports on its implementation on the Commission's website, www.icac.nsw.gov.au.

Recommendation this report be made public

Pursuant to s 78(2) of the ICAC Act, the Commission recommends that this report be made public forthwith. This recommendation allows either Presiding Officer of a House of Parliament to make the report public, whether or not Parliament is in session.

Chapter 1: Background

This chapter sets out some background information concerning the investigation conducted by the NSW Independent Commission Against Corruption ("the Commission"), the role of Corrective Services NSW (CSNSW) in the administration of sentences, the use of force (UOF) within the prison system, the law, policies and procedures that govern the UOF and the principal persons of interest.

On 21 May 2018, the Commission made non-publication orders pursuant to s 112 of the *Independent Commission Against Corruption Act 1988* ("the ICAC Act") to protect the identity of two inmates who gave evidence. Those orders are extant. For the purposes of this report, the inmates are referred to as "inmate A" and "inmate B".

How the investigation came about

A number of agencies, including the Commission, received complaints regarding the subject of this investigation before the Commission decided to proceed.

On 13 March 2014, the Commission received an anonymous complaint. The complaint was based on information allegedly supplied to the complainant by two CSNSW employees. The employees were not identified. The complainant provided a hearsay account of an assault perpetrated on inmate A on 19 February 2014 at Lithgow Correctional Centre (LCC) by a CSNSW officer, the preparation of false records to conceal what had occurred, and the possible planting of drugs in inmate A's cell, which were discovered on 20 February 2014 during a search. The complainant summed up what they claimed to have been told as follows:

> *What they told me sounds like something you see on television.*
>
> *To me it sounds like this-*
>
> *An inmate slagged off about a governor.*
>
> *He sends his thugs to teach the crim a lesson.*
>
> *The dumb thugs bash the wrong crim.*
>
> *Everyone panics so they have to fix it in case someone looks into it.*
>
> *The crim is threatened into saying he fell over.*
>
> *They make up bullshit reports about drugs and weapons.*
>
> *A 2 Pippa goes to* [inmate A's] *cell when he not in it.*
>
> *The next day the squad goes back and finds drugs.*
>
> *This all backs up the squad's reason for going to* [inmate A's] *cell on the day he was bashed and had his rib broken.*
>
> *If all this is true then those blokes are the crims. To bash any inmate without legal reason is wrong but to bash an innocent, scrawny young crim is unforgiveable.*

On 8 April 2014, the Commission advised CSNSW of the complaint and sought further information.

On 16 April 2014, the Commission received a further letter from the complainant who provided the names of three CSNSW officers who the complainant suggested knew what had occurred on 19 February 2014.

On the same day, the CSNSW Investigations Branch commenced a preliminary fact-finding investigation into the matter.

On 2 May 2014, CSNSW investigations director, Michael Hovey, submitted a report in respect of the preliminary investigation. The report highlighted a number of concerns regarding the events of 19 February 2014. He recommended that the matter be referred to the Professional Standards Committee (PSC) of CSNSW and that, in the event that the PSC proceeded with a formal investigation, those CSNSW officers allegedly involved in

the incident should be stood down until the investigation was finalised.

On 23 June 2014, the NSW Ombudsman received an anonymous handwritten complaint that appeared to concern the events of 19 and 20 February 2014. The contents of the complaint suggested that its author was either an inmate or a CSNSW employee. The complainant alleged that inmate A had been assaulted and that drugs had been "planted" in inmate A's cell by a named CSNSW officer. The Ombudsman referred the matter to the Commission pursuant to s 11 of the ICAC Act. This section of the ICAC Act requires the principal officer of a public authority (and certain other public officials) to report to the Commission any matter that the person suspects on reasonable grounds concerns, or may concern, corrupt conduct.

On 27 January 2015, CSNSW determined that there should be a formal investigation of the matter. On that day, the acting assistant commissioner of custodial corrections advised Mr Hovey that he or his nominated staff would conduct the investigation and prepare an investigation report.

A number of allegations concerning the conduct of three CSNSW officers on 19 February 2014 were to be the subject of the investigation. A CSNSW principal investigator carried out the investigation. On 20 March 2015, he issued three investigation reports, one in respect of each officer. The reports were sent to Mr Hovey. On the same day, Mr Hovey issued three director's reports in which he concurred with the findings of the principal investigator. He did so in his capacity as investigations director of CSNSW.

Those findings were:

- that there was no evidence that Terrence Walker, Elliott Duncan or Simon Graf assaulted inmate A
- that all three officers failed to use a videorecorder to "record the targeted intelligence based search of Cell 208, 5.1 Unit at Lithgow CC, contrary to requirements of section 13.7 of the Custodial Corrections Operations Procedures Manual (OPM), Using Force on Inmates"
- that each officer made a false report in the Incident Reporting Module (IRM), in that information contained in the IRM was not repeated in their individual reports. Although it was acknowledged Mr Walker drafted the IRM, the CSNSW Investigations Branch determined that Mr Duncan and Mr Graf had a responsibility to ensure it was correct.

As a result of those findings, Mr Walker was fined $1,000 and Mr Duncan and Mr Graf $500 respectively.

On 4 August 2016, Peter Severin, CSNSW Commissioner, received an anonymous complaint concerning the events of 19 and 20 February 2014. The complaint appears to have been made by unnamed employees of CSNSW. The complainants were critical of the investigation carried out by CSNSW, and suggested that the investigation was a "cover-up".

On 12 September 2016, CSNSW referred the complaint received on 4 August 2016 to the Commission, together with a schedule of unrelated complaints. The referral was made pursuant to s 11 of the ICAC Act. CSNSW advised the Commission that there was insufficient information to justify a formal investigation but the Commissioner had approved "fact finding enquiries and other action".

On 12 October 2016, the Commission advised CSNSW that it would not be taking any investigative action but requested a copy of CSNSW's final report of its enquiries.

On 27 October 2016, CSNSW referred further complaints it had received from a number of employees concerning various matters. One complainant alleged that inmate A had been assaulted by CSNSW officers

in February 2014 and that there had been a "cover-up". The referral was made by CSNSW pursuant to s 11 of the ICAC Act. CSNSW advised the Commission that a further investigation by the CSNSW Professional Standards Branch (PSB) had been suspended so as not to jeopardise any future investigative action that the Commission might undertake.

The complaint referred to the Commission on 27 October 2016 concerning inmate A was based upon hearsay.

On 9 December 2016, the Commission advised CSNSW that it had examined the material submitted and had determined not to proceed with an investigation. The Commission noted that the allegations would be best dealt with by CSNSW but that it should be notified if CSNSW's investigation disclosed corrupt conduct.

On 13 March 2017, the Commission received a public interest disclosure (PID). Under the *Public Interest Disclosures Act 1994* ("the PID Act"), a PID made to the Commission is a disclosure made by a public official of information that a person honestly believes, on reasonable grounds, shows or tends to show that a public authority or another public official has engaged, is engaged or proposes to engage in corrupt conduct. The disclosure contained new information not previously seen by the Commission that supported the allegations that inmate A had been assaulted on 19 February 2014, that drugs had been planted in his cell, and that a number of CSNSW officers had conspired to cover-up the assault.

On 31 March 2017, the Commission sought from CSNSW an update on the status of its investigation.

On 11 April 2017, CSNSW provided an update to the Commission, in which it was informed that the matter had been referred to an independent investigator and that the investigation was ongoing.

Between 13 March and early May 2017, the Commission reviewed the information provided to it by way of the PID of 13 March 2017.

On 17 May 2017, the Commission determined that the Commission should conduct a preliminary investigation. The preliminary investigation suggested that serious corrupt conduct may have occurred, and, accordingly, the matter was escalated to a full investigation on 1 September 2017.

Why the Commission investigated

One of the Commission's principal functions, as specified in s 13(1)(a) of the ICAC Act, is to investigate any allegation or complaint, or any circumstances which in the Commission's opinion imply, that:

> *(i) corrupt conduct, or*
>
> *(ii) conduct liable to allow, encourage or cause the occurrence of corrupt conduct, or*
>
> *(iii) conduct connected with corrupt conduct,*
>
> *may have occurred, may be occurring or may be about to occur.*

The role of the Commission is explained in more detail in Appendix 1. Appendix 2 sets out the approach taken by the Commission in determining whether corrupt conduct has occurred.

In deciding to investigate, the Commission took into account a number of matters, including the seriousness of the allegations, the seniority of staff allegedly involved, and the fact that a significant number of similar complaints had been made to the Commission indicating there might be systemic issues. This included the receipt by the Commission of a significant number of complaints concerning the use of excessive force and the misreporting of such incidents in 2017 and 2018.

In the circumstances, the Commission decided that it was in the public interest to conduct an investigation to establish whether corrupt conduct had occurred, the identity of those involved, and whether there were any corruption prevention issues that needed to be addressed.

Appendix 4 provides an overview of investigations undertaken by the Commission since 1998 into conduct involving departments under CSNSW.

Conduct of the investigation

During the course of the investigation, the Commission:

- obtained documents from various sources by issuing 22 notices under s 22 of the ICAC Act
- interviewed and/or took statements from numerous potential witnesses
- conducted nine compulsory examinations by issuing summonses pursuant to s 35 of the ICAC Act, and in some instances issuing orders pursuant to s 39 of the ICAC requiring the attendance of particular inmates at the Commission to give evidence.

The public inquiry

After taking into account each of the matters set out in s 31(2) of the ICAC Act, the Commission determined that it was in the public interest to hold a public inquiry to further its investigation.

In making that determination, the Commission had regard to the following considerations:

- the vulnerability of inmates to the use of excessive force
- the falsification of records pertaining to the management of inmates so as to conceal the use of excessive force, which has the capacity to undermine significantly public confidence in the corrective services system if not addressed in an open and transparent manner
- the need to educate correctional officers and the public about the risk and consequences of corruption in the corrective services system
- the conduct alleged was serious, premediated, allegedly involved a conspiracy to misreport an assault on an inmate and falsify records relating to that assault, and allegedly involved conspiracies to destroy evidence (closed circuit television (CCTV) footage) and to plant a prohibited substance within an inmate's cell
- the conduct suggested a culture of complacency in relation to the use of excessive force against inmates
- although there was a risk of prejudice to the reputations of affected persons, the evidence available to the Commission suggested that the affected persons had engaged in serious corrupt conduct that ought to be exposed
- the public interest in exposing alleged serious corrupt conduct outweighed preserving the privacy of the affected persons, and there is a strong public interest in exposing serious corruption in our corrective services system
- the Commission had received a significant number of more recent complaints that were of a similar nature, which indicated that the use of excessive force and its misreporting were systemic.

The public inquiry was conducted over 10 days, from 21 May to 5 June 2018. Commissioner Stephen Rushton SC presided at the public inquiry and Sam Duggan acted as Counsel Assisting the Commission. Evidence was taken from 19 witnesses.

The Commission received written submissions from Counsel Assisting and the legal representatives of affected persons, including CSNSW. During the course of preparing this report, further potential adverse findings were identified affecting certain parties. Further submissions were provided to those parties, who were given an opportunity to respond by way of further submission. The last submission was received on 29 April 2019. All submissions were considered in the preparation of this report. Further information concerning submissions is set out in Appendix 3 to this report.

Policing UOF in the NSW corrections system – an unfortunate history

UOF, and its misreporting within the NSW corrections system, has been a matter of concern for many years.

Between July 2009 and April 2010, the NSW Ombudsman conducted a major investigation into how CSNSW monitored and scrutinised UOFs, including how it dealt with and investigated complaints about UOFs. The Ombudsman examined policies and procedures, reviewed training, interviewed departmental staff and audited a sample of UOF reports. The investigation identified deficiencies in how CSNSW managed UOFs across the system. Seventeen recommendations for change were made, and all were accepted by CSNSW.

Two years after the conclusion of its investigation, the Ombudsman became concerned at the slow pace of change in what he regarded as a crucial area of CSNSW's day-to-day operations. His concerns were compounded when he received a complaint of excessive force at a large regional correctional centre four months after the conclusion of the investigation. The Ombudsman investigated the complaint and found that this individual UOF reflected the same systemic failings and deficiencies as those identified in the broader investigation. The substance of the matters that needed to be addressed were:

- correctional officers who use force on inmates needed to be trained in the lawful and proper use of force, instruments of restraint, recording and reporting UOFs
- general managers (GMs) needed effective tools to ensure trained staff were acting lawfully and appropriately in their management of inmates
- CSNSW needed functioning systems of accountability to satisfy the community that inmates were being managed lawfully and humanely and that CSNSW was ensuring a safe workplace for its staff.

In December 2011, the Ombudsman's report into the individual UOF incident referred to above concluded.

In July 2012, the Ombudsman published a special report to Parliament under s 31 of the *Ombudsman Act 1974*. The report was titled *Managing use of force in prisons: the need for better policy and practice*.

The Ombudsman reported that, since its last report in 2010 in which CSNSW had accepted major change was needed regarding how UOFs were managed, little was different in practice. The policy and procedure for using force on inmates was the same as when the Ombudsman had commenced his investigation in 2009. The only change had been the publication of a CSNSW Commissioner's memorandum on 13 October 2011, requiring details of UOF reviews to be recorded on the IRM.

A number of recommendations were made by the Ombudsman concerning policy and procedure, review of UOFs, officer training on UOF and reporting such incidents, data collection and analysis, and a statewide audit of CCTV cameras.

On 19 November 2012, CSNSW issued a media release responding to the Ombudsman's report (see below). The Commission's investigation of the events of February 2014, the considerable number of recent further complaints from inmates, and referrals made to the Commission pursuant to s 11 of the ICAC Act suggest that the representations made in the media release were, and remain, largely aspirational. Perhaps most importantly, the Commission is satisfied there has been little cultural change:

> *More than 3000 custodial officers will soon receive new training in how to better manage unruly inmates, Corrective Services NSW Commissioner Peter Severin said today.*
>
> *Mr Severin said a new education package, including footage of mock-up training scenarios, is being developed by Corrective Services (CSNSW) in consultation with the NSW Ombudsman's office.*
>
> *"CSNSW is introducing a raft of significant changes to its 'Use of Force' policy and procedures in correctional centres following recommendations by the NSW Ombudsman around management of non-compliant inmates," Mr Severin said.*
>
> *"We welcome the Ombudsman's advice and have been working hard to implement 38 separate recommendations and initiatives that are having a far-reaching impact across the agency. We're introducing the highest standards of transparency and rigour in managing and reporting on the use of force," he said.*
>
> *All custodial officers will undergo mandatory new interactive training – including watching footage of mock-up 'use of force' scenarios and then answering questions about them.*
>
> *"This is about getting our custodial staff to identify 'trigger points' in situations and take the time to think more about what they can do to avert and de-escalate incidents."*
>
> *Mr Severin acknowledged that use of force would always be required in some situations however the new training would provide staff with an opportunity to think about their roles, communicate better and ultimately ensure force is used appropriately and as a last resort.*
>
> *Centre managers and staff will also view footage of after-incident debriefings where they will learn to forensically consider incidents, the operational response and how they can improve.*
>
> *"This operational review process accords with the Ombudsman's recommendations in which all serious incidents are reviewed," Mr Severin said. The training packages and changes to CSNSW 'use of force' policy are intended to drive cultural change among staff."*
>
> *Changes being implemented include strengthening accountability for reporting on and reviewing incidents involving the use of force. In addition, a 'toolkit' for officers and senior staff who have had to resort to, or witnessed, the use of force, is now being trialled at South Coast, Mid North Coast and Silverwater Women's Correctional Centres.*
>
> *Actions that are considered and reported as a Use of Force include reasonable and justifiable force used in a multitude of circumstances. Any use of force must be justified–that is, it must be necessary and reasonable in the circumstances.*

The Commission notes the following matters.

First, contrary to the representation that more than 3,000 custodial officers would "soon" receive new training to manage unruly inmates, it was not until 15 August 2013 that an online Custodial Incident Management course was introduced as part of the Certificate III in Correctional Practice. It contained a UOF training module known as Module 2.

Secondly, the requirement to complete the online Module 2 was mandatory for new correctional officers/ overseers only.

Thirdly, as at February 2014, there were approximately 3,250 correctional officers employed by CSNSW. However, only 215 (approximately 7%) had completed the Custodial Incident Management course introduced in August 2013. These figures included officers up to the rank of senior assistant superintendent. As at 19 February 2014, none of the affected persons in the Commission's investigation had completed online Module 2.

Fourthly, it was not until October 2014 that Module 2 became mandatory for all staff. It was described as a "refresher module", however, there was no mandatory timeframe imposed by CSNSW for completion of the

module. Practically speaking, UOF education was discretionary. In September 2016, an updated version of the online Custodial Incident Management course was introduced, including Module 2 as a refresher module. As of 12 September 2016, the online refresher course became mandatory for all correctional officers, up to and including, the rank of senior assistant superintendent. It must be completed every three years.

Fifthly, the Commission remains concerned in relation to the course content and its effectiveness. The Commission was informed by CSNSW that the online Custodial Incident Management course consists of four modules, including Module 2. CSNSW considers that the online course, including Module 2, should take four hours to complete. The Commission understands that, despite CSNSW's media statement of 19 November 2012, correctional officers do not undergo mandatory interactive training, including watching footage of mock up UOF scenarios and then answering questions that relate to them.

Sixthly, the Commission is not satisfied that correctional centre managers and staff "view footage of after-incident debriefings where they will learn to forensically consider incidents, the operational response and how they can improve".

Finally, since the online Custodial Incident Management course was introduced in 2013, the completion rate remains unacceptably low. As at 10 April 2019, 79.3% of correctional officers, up to and including senior assistant superintendents, had completed the UOF module.

The Commission notes that the Ombudsman remains concerned, as does the Commission, that UOF on inmates, in circumstances where it is neither necessary nor reasonable, remains a significant problem within correctional centres. Since 2012, CSNSW has promised much but delivered little.

In his 2017–18 annual report, the Ombudsman singled out UOF, including force applied by immediate action teams (IATs) as a matter of considerable, continuing concern. He noted:

> *Although our investigations and reports are not recent, our conclusions and recommendations remain relevant today. The inquest into the death of an inmate during a use of force and an ICAC inquiry about alleged corrupt behaviour involving the use of force have again highlighted this as an issue. As well there has been an increase in serious complaints alleging that IAT have used excessive force, or assaulted inmates under the guise of using force. We have and will continue to raise the use of force with CSNSW. We have provided our earlier reports to inform their current review of the use of force and associated matters, and will provide assistance as requested.*

UOF and corruption risks – the experience of other states

Corruption risks within the corrections environment are not unique to NSW. A number of anti-corruption agencies in other states have conducted investigations into corruption and identified corruption risks within the corrections environment. Recent examples are referred to below.

In November 2017, the Victorian Independent Broad-based Anti-corruption Commission published the report titled, *Corruption risks associated with the corrections sector.* It noted that the corrections sector in Victoria faced corruption and integrity issues not encountered in other areas of the public sector. The provision of contraband, inappropriate relationships, excessive UOF and inappropriate access to information were risks created or increased by the specific nature of the corrections environment.

During 2018, the Western Australian Corruption and Crime Commission (WA CCC) published five reports that were the product of a joint investigation with the WA Department of Justice to identify misconduct risks and to investigate allegations of serious misconduct in the corrections system in that state. Three of those reports, which were published on 27 June 2018, concerned UOF by correctional officers and misreporting.

The first report, *Report into inadequate use of force reporting at Hakea Prison on 21 March 2016*, followed an investigation into UOF by a correctional officer on two occasions during and following a strip-search of a male inmate. The investigation focused on the integrity of the reporting of the UOF, rather than the actual UOF used against the inmate. Four other correctional officers were present. Each misreported what occurred. Their accounts were inconsistent with CCTV footage. They obscured and sought to minimise what occurred. The striking similarity between each officer's incident reports suggested they had colluded.

The second report, *Report into inadequate use of force reporting at Eastern Goldfields Regional Prison May 2017*, followed an investigation into an alleged use of a weapon – a chemical agent – by a correctional officer against two prisoners on two occasions. CCTV cameras caught what happened during the incidents. Again, the reports submitted by the correctional officer and his colleagues were at odds with the CCTV footage. Once more, the investigation focused on the integrity of the reporting of the UOF, rather than the actual UOF used against the inmates.

The third report, *Report into inadequate use of force reporting at Eastern Goldfields Regional Prison on 27 March 2017 and Bunbury Regional Prison on 14 November 2016*,

followed an investigation into UOF by a correctional officer on two occasions against two inmates. The WA CCC's investigation was directed at the inadequacies in the reporting and attempts to influence, and interfere with, the review of the correctional officer's UOF in both incidents. It concluded that there were serious misconduct risks in the reporting and management of UOF incidents within a culture where fear might lead correctional officers to minimise their accounts of other officers' conduct.

In October 2018, the WA CCC published its *Report into misconduct risks in WA prisons*, which was the final product of the joint investigation. Perhaps most significantly, it found that the WA Department of Justice had neither a corruption prevention nor a coordinated approach to the management of misconduct risks.

In December 2018, the Queensland Crime and Corruption Commission (Qld CCC) published *An examination of corruption risks and corruption in Queensland prisons*, which was the product of investigations carried out by Taskforce Flaxton. The Qld CCC established the taskforce in March 2018. Its charter was to identify corruption and risks of corruption in Queensland prisons, features of the legislative, policy and operational environment that enabled corrupt conduct to occur, and reforms to better prevent, detect and deal with corrupt conduct. The report noted that the custodial environment created circumstances that are inherently dangerous and conducive to corruption. They are worth repeating:

- Prisons house a particularly challenging part of the national population. Many inmates have poor social, educational and vocational skills, come from marginalised or vulnerable backgrounds, or have special needs that make them highly dependent on correctional officers and put them at risk of being exploited as a result of corrupt activity.
- Prisons hold drug users, violent offenders and seasoned criminals who desire to continue their criminal activities during their sentence and need correctional officers to assist them to carry them out, or at least turn a blind eye. The deprivation of liberty imposed by imprisonment creates conditions conducive to corruption, as prisoners seek to gain control over their own lives.
- The closed nature of the environment and lack of public visibility of what goes on behind prison doors creates favourable conditions for corruption and decreases the likelihood that corruption will be detected and exposed.

The corruption risks identified as particularly evident were failure to report corruption, inappropriate relationships, excessive use of force, misuse of authority, introduction of contraband, and misuse of information.

The Commission agrees with the Qld CCC's analysis of the corrections environment and its conclusion that such an environment is conducive to particular corruption risks.

Since its inception, the Commission has also conducted a number of investigations into corrupt relationships between inmates and correctional officers and has published a number of reports.

Although there appears to be considerable uniformity in the corruption risks within the various corrections environments across Australia, the way in which such risks are addressed may vary.

As with the investigations into UOF carried out by the WA CCC, the Commission's principal focus during its investigation was not on the actual UOF but the steps allegedly taken to cover it up. That is not to say that UOF investigated by the Commission was of no moment; it was particularly egregious not least because it was instigated by the governor of the prison and involved the bashing of an inmate who was entirely innocent of any wrongdoing.

CSNSW and UOF

CSNSW is a division of the NSW Department of Justice. It oversees 38 prison facilities throughout the state, housing approximately 13,000 inmates. This is the largest prison system in Australia. In addition, CSNSW oversees rehabilitation, education and vocational training for inmates, external parole and intensive correction orders.

The state's prisons house inmates who have been incarcerated for a wide range of offences. Some offenders are potentially violent and for this reason alone present challenges in relation to their management. Others simply resist directions issued by persons in authority and do not readily follow directions given to them by correctional officers.

The Commission accepts that, from time-to-time, it may be necessary for correctional officers to apply force to an inmate as part of his or her management to preserve the good order and discipline of the prison and the safety of other inmates and corrections personnel.

Apart from the use of excessive force, the Commission also heard evidence that there is at least one widespread practice employed within certain correctional centres that, although not necessarily involving UOF on an inmate, goes well beyond what is reasonably necessary to maintain good order and discipline. It is known as "therapy", "cell therapy" or "ramping". It involves correctional officers entering an inmate's cell without notice and ransacking it.

The Commission is satisfied that the practice is widespread. It is designed and intended to instil shock and

fear among inmates who are considered unruly or difficult to manage by undermining their sense of self-respect and self-worth – their human dignity. It is a practice that has been the subject of frequent complaints to the Commission. It was also the subject of evidence in the public inquiry. It is a practice that was acknowledged to exist by correctional officers. Regrettably, a number of witnesses did not appear to understand that the practice was wrong. Self-evidently, a correctional officer who engages in "cell therapy" engages in corrupt conduct. The practice is further addressed in chapter 6.

The courts have shown a reluctance to intervene at the behest of inmates in respect of the day-to-day conditions of a prison.[1] Indeed, inmates have few, if any, enforceable legal rights. That does not mean, however, that those confined to a prison are deprived of basic human rights. A prison sentence results in the loss of liberty. Persons deprived of their liberty must still be treated with humanity and with respect for the inherent dignity of the person.

The human rights of inmates, and the lack of enforceable legal rights are reflected in the objects of the *Crimes (Administration of Sentences) Act 1999* ("the CAS Act"). The objects of the CAS Act were not enacted until 2008. The *Crimes (Administration of Sentences) Legislation Amendment Act 2008* inserted s 2A (see below) into the CAS Act.

> *(1) This Act has the following objects:*
>
> *(a) to ensure that those offenders who are required to be held in custody are removed from the general community and placed in a safe, secure and humane environment,*
>
> *(b) to ensure that other offenders are kept under supervision in a safe, secure and humane manner,*
>
> *(c) to ensure the safety of persons having the custody or supervision of offenders is not endangered,*
>
> *(d) to provide for the rehabilitation of offenders with a view to their reintegration into the general community.*
>
> *(2) In the pursuit of these objects, due regard must be had to the interests of victims of the offences committed by offenders.*
>
> *(3) Nothing in this section gives rise to any civil cause of action or can be taken into account in any civil proceedings.*

[1] For example, *Horwitz v Connor* (1908) 6 CLR 38; *Flynn v The King* (1949) 79 CLR 1.

Until 1 September 2014, the Crimes (Administration of Sentences) Regulation 2008 was in force. On 1 September 2014, this regulation was repealed pursuant to s 10(2) of the *Subordinate Legislation Act 1989*, which was replaced by the Crimes (Administration of Sentences) Regulation 2014. The regulations that were relevant to the Commission's investigation are contained in the Crimes (Administration of Sentences) Regulation 2008 ("the CAS Regs"). The Commission notes that the CAS Regs (addressed below) were in large repeated in the 2014 Regulation and remain in force.

The CAS Regs required that order and discipline in a correctional centre were to be maintained with firmness, but with no more restriction or force than was required for the safe custody and well-ordered community life within the centre (CAS Reg 119(1)). Correctional officers were required to endeavour to control inmates by showing them example and leadership and by enlisting their willing cooperation (CAS Reg 119(2)). At all times, inmates were to be treated in a way that encouraged self-respect and a sense of personal responsibility (CAS Reg 119(3)).

The CAS Regs also addressed UOF in dealing with inmates.

Correctional officers were required to use no more force than was reasonably necessary in the circumstances. The infliction of injury on the inmate was to be avoided if at all possible (CAS Reg 121(1)). The nature and extent of the force that might be used in relation to an inmate were to be dictated by circumstances, but no more could be applied than was necessary for control and protection, having due regard to the personal safety of correctional officers and others (CAS Reg 121(2)). Once satisfactorily restrained, the only force that could be used against the inmate was that necessary to maintain that restraint (CAS Reg 121(3)).

The CAS Regs also set out particular circumstances in which, subject to the qualifications above, correctional officers were permitted to have recourse to force. Those circumstances included (CAS Reg 121(4)):

- the search of an inmate
- the seizure of a dangerous or harmful article
- to prevent an escape
- to defend himself or herself if attacked or threatened with attack (but only if the officer could not otherwise protect himself or herself from harm)
- to protect other persons from attack or harm (but only if there were no other immediate or apparent means available for their protection)
- to avoid an imminent attack on the correctional officer or some other person (but only if there were a reasonable apprehension of an imminent attack)

- to ensure compliance with a proper order, or maintenance of discipline, (but only if an inmate was failing to cooperate with a lawful correctional centre requirement in a way that could not otherwise be adequately controlled).

Unsurprisingly, there was no provision in the CAS Act or CAS Regs that, either expressly or by necessary implication, authorised a correctional officer to apply force to an inmate as punishment for misbehaviour.

The CAS Regs contained mandatory reporting requirements in relation to UOF by correctional officers. Regulation 123 provided as follows:

(1) Any correctional officer who uses force on an inmate must immediately furnish a report about the use of force to the general manager.

(2) The report:

(a) must be in writing; and

(b) must specify the name or names of the inmate or inmates and the name or names of the correctional officer or correctional officers involved in the use of force, and

(c) must specify the location where the use of force occurred, and

(d) must describe the nature of the force used and the circumstances requiring its use, and

(e) must be signed by the correctional officer involved in the use of force.

(3) This clause does not require a correctional officer to furnish information in a report if it is impossible or impracticable for the officer to obtain the information.

The CAS Regs imposed further obligations upon correctional officers in relation to their conduct. Those relevant to the Commission's investigation are addressed below.

Regulation 258 prohibited the use of abusive or insulting language by correctional officers and others and the deliberate provocation of inmates, as follows:

(1) A correctional officer, departmental officer, medical officer or nursing officer must not use insulting or abusive language to any other officer, to any inmate or to any person visiting a correctional centre.

(2) A correctional officer, departmental officer, medical officer or nursing officer must not say or do anything that is calculated to undermine discipline at a correctional centre or to prejudice the efficiency of, or to bring discredit on, Corrective Services NSW.

(3) A correctional officer, departmental officer, medical officer or nursing officer must not act deliberately in a manner calculated to provoke an inmate.

Regulation 260 imposed an obligation of honesty on correctional officers and others. It provided as follows:

(1) A correctional officer, departmental officer, medical officer or nursing officer must at all times be honest and truthful.

(2) A correctional officer, departmental officer, medical officer or nursing officer:

(a) must not make any statement that the officer knows, or ought reasonably to know, to be false or misleading in a material particular, and

(b) must not destroy or mutilate, or alter or erase any entry in, an official document.

Regulation 262(1) and Regulation 262(2) of the CAS Regs imposed obligations on correctional officers to report the misconduct of their professional colleagues, (subject to the exceptions set out in Regulation 262(3)). They provided as follows:

(1) If:

(a) an allegation is made to a correctional officer that another correctional officer has, while carrying out his or her duties as such an officer, engaged in conduct which, in the opinion of the officer to whom the allegation is made, constitutes a criminal offence or other misconduct, or

(b) a correctional officer sincerely believes that another correctional officer has engaged in conduct of that kind,

the correctional officer must report the conduct (or alleged conduct) to a correctional officer who is more senior in rank than the officer making the report.

(2) The senior correctional officer must report the conduct (or alleged conduct) promptly to the Commissioner if the senior correctional officer believes that it:

(a) constitutes (or would constitute) a criminal offence by the correctional officer, or

(b) would provide sufficient grounds for preferring a departmental charge against the correctional officer.

(3) Subclause (1) does not apply to conduct or alleged conduct:

(a) that has been made the subject of a

departmental charge, or

(b) that has been the subject of evidence or other material given, or submissions made, in the course of criminal proceedings, or

(c) that has already been reported under this clause to a more senior correctional officer.

Breach of any provision of the CAS Regs could be dealt with as misconduct. Regulation 263 provided as follows:

> *A correctional officer, departmental officer or casual employee who contravenes a provision of this Regulation is not guilty of an offence but any such contravention may be dealt with as misconduct, under Part 2.7 of the Public Sector Employment and Management Act 2002, or any other applicable provision of that Act.*

The work of correctional officers within the prison system at the time relevant to the Commission's investigation was also subject to a number of policies and procedures. There were three such policies and procedures relevant to this investigation.

The first was the "Custodial Policy and Procedure" (CPP) in relation to "Serious Incident Management". Section 5 concerned using force on inmates, and set out the following policy and procedures:

- The application of force was an option of last resort.
- The application of force was required to be videorecorded.
- An explanation was required if the UOF was not videorecorded, but it was unacceptable to fail to record a UOF simply because it was a spontaneous incident.
- An officer was prohibited from showing or discussing their report or evidence with anyone else.
- No matter how much or little force was used, it was mandatory to provide a report to the GM.
- UOFs were required to be recorded on the IRM as soon as possible.
- An after-action review was required for all UOF incidents.
- If the officer reviewing a UOF believed it was unwarranted, excessive, unethical or not in compliance with the policy, he or she was required to prepare and send a report immediately to the PSC, through the GM and assistant commissioner.

The second relevant policy was contained in section 13.7 of the OPM. It concerned UOF on inmates, and provided, among other things, as follows.

- A peaceful, injury free solution was the principal objective when managing problematic behavior.
- Correctional officers were required to use alternative non-physical methods to resolve problematic behaviour wherever possible.
- Force could only be used on inmates when all other options had been exhausted.
- When used, the force had to be reasonable and appropriate to the circumstances.
- When force was no longer necessary to restrain an inmate it had to stop. The continuing application of force past that point was unlawful.
- When the UOF was expected or planned, a video camera was required to be brought to the scene. Where there was no immediate risk to security, personnel or other inmates, force could not be applied until a video camera was on scene. If a video camera was not used, the most senior officer present was required to provide an explanation in his or her report. It was unacceptable to state that time did not allow a camera to be brought to the scene.
- If a UOF might result in a police investigation, the area where the incident occurred was required to be managed as a crime scene.
- Any officer who was involved in a UOF was required to write an incident report within two hours of the incident or as soon as circumstances allowed. Incident reports had to explain why the force was necessary, and any instructions given to the inmate, along with their response and the type of force used. It was unacceptable to describe the force used as "the minimum necessary".
- All witnesses to a UOF were required to write an incident report that described the incident, listed those personnel and inmates involved, and provided a description of the force used and who applied it.
- All custodial officers who wrote an incident report were prohibited from discussing their report or their evidence with anyone else. In addition, custodial officers were prohibited from showing their report, or allowing it to be read by anyone else.
- Within two hours of being notified, the GM, or most senior officer on duty, was required to report the incident by way of the IRM.

- All written reports were to be reviewed by the MoS or another delegated senior manager as soon as practicable. Video recordings were also to be reviewed. If the MoS were involved in the use of force, then a conflict existed and the reports and video recording needed to be examined by the GM.

The third relevant policy was contained in section 13.1 of the OPM. This policy concerned "Serious Incident Reporting". Of relevance, it stated that a GM or delegated officer was required to review the IRM report. A reviewing officer could not be a person involved in the incident reported. The policy stated that "this is most important if the incident involves any form of violence, but particularly the use of force".

Reporting a UOF

There was, and remains, a prescribed procedure for the reporting of a UOF. All correctional officers were, and remain, bound to follow it.

Use of force is not a technical term. Although there was some slight variation between witnesses called before the Commission in relation to the degree of force that would trigger reporting obligations, the general understanding was that anything other than incidental contact with an inmate, or contact without resistance from an inmate, fell within the concept of UOF and therefore triggered a reporting obligation.

The relevant policies and procedures have already been noted. They required that, in the event of a UOF involving an inmate, a "UOF package" was to be prepared, which was required to include at least:

- an incident report from all involved officers
- a completed injury questionnaire form
- photographs of any injuries.

The IAT was required to ensure that a video camera was used to record all actual or potential use of force incidents. Such video footage, together with any relevant CCTV, was also to be included in the UOF package.

The practice at LCC was for the package to be submitted to the manager of security (MoS) within 24 hours for review.

As a matter of course, a UOF was logged on an internal database, the entry of which was known as the IRM.

The Commission is satisfied that each of the correctional officers who gave evidence were well aware of the reporting procedures that applied to UOF.

Inmate obligations

There were a number of obligations imposed on inmates under the CAS Regs, which are also relevant to the investigation of the events that occurred on 20 February 2014; that is, the day following the alleged UOF. On that day, correctional officers allegedly retrieved a tablet and powder from inmate A's asthma puffer.

It was a correctional centre offence for an inmate to have any prohibited drug in their possession (CAS Regs 139 and definition of "drug" in the accompanying dictionary). Correctional officers were required to report any suspected offence to the GM of the prison immediately (CAS Reg 253(1)).

An allegation amounting to a correctional centre offence could be dealt with by the GM of the prison or by a visiting magistrate (s 52 and s 65 of the CAS Act). The GM had power to impose a penalty or take other action, such as dismissing the charge (s 53 of the CAS Act). For example, an inmate could have amenities or privileges withdrawn (CAS Regs 153). Penalties imposed by the GM were to be recorded (s 61 of the CAS Act).

Relevant ranks within CSNSW

The Commission received evidence from a number of correctional officers of various ranks. Correctional officers are either commissioned or non-commissioned officers. Generally, within any prison, the most senior correctional officer is the GM, sometimes referred to as the governor. The second most senior officer within the prison is the MoS. Deputy superintendents, senior assistant superintendents and assistant superintendents work to a roster and report either to the MoS or directly to the GM.

Non-commissioned correctional officers generally hold the rank of senior correctional officer or correctional officer (the latter is divided into first-class correctional officer and probationary officer).

The IAT

Within correctional centres, specially trained officers form IATs. Those officers have undergone additional training in weapons and munitions and in de-escalating confrontations. Their role is to preserve order in circumstances where there is a potential for inmate violence or there is a likely need for the application of force.

In 2014, section 12.1.9 of the OPM set out the policy and procedures for IATs. The roles and responsibilities of the IAT were detailed at 12.1.9.2 and included to:

- respond to security and emergency situations at the direction of the MoS

- develop, maintain and communicate effective response procedures for the correctional centre and review them on a regular basis or when there was a change to the operations of the correctional centre
- ensure all operations and responses complied with CSNSW policies, procedures and applicable legislation
- ensure a video camera was used to record all actual or potential use of force incidents.

OPM 12.1.9.3 required that the MoS approved the IAT's involvement in any incident except those incidents that presented an immediate threat to the safety of a person or to the security of a correctional centre. Further, the IAT was required to operate within existing policies, procedures and legislation – there were no additional powers or exemptions for the IAT beyond the powers generally available to correctional officers.

The description of the IAT's responsibilities makes it clear that IATs do not operate within correctional centres to give unruly inmates a dressing-down. They exist to respond to critical or high-risk incidents, particularly those relating to UOF.

An understanding of this role is important. It underscores the inappropriateness of the IAT at the LCC being directed to play any role in the events of 19 February 2014. Those events are addressed in the next chapter.

Principal persons of interest

In 2014, the principal persons of interest were working within the LCC.

John O'Shea was the GM (a commissioned officer position) of the facility. At the time of the public inquiry, he had approximately 27 years' experience with CSNSW. He had worked at many correctional centres around the state.

Brad Peebles was the MoS of the LCC. That position is also a commissioned position. By 2018, he had worked with CSNSW for approximately 30 years. Generally, he reported directly to Mr O'Shea although, at times during the period investigated by the Commission, he was "offline", working on specific projects. During those periods, Stephen Taylor or Philip Turton, both senior assistant superintendents at LCC, acted as MoS. In 2014, Mr Taylor had worked with CSNSW for 22 years. Both men were commissioned officers.

Mark Kennedy was another commissioned officer located at the LCC during the relevant period. He held the rank of deputy superintendent and had worked with CSNSW for at least 26 years.

Brian McMurtrie was the intelligence manager at the LCC, and held the rank of assistant superintendent. He had over 24 years' experience with CSNSW.

At the relevant time, Mr Walker was a senior correctional officer at the LCC, and the most senior member of the IAT unit. Mr Walker had worked with CSNSW for 15 years.

Mr Graf and Mr Duncan were both first-class correctional officers at the LCC. They were also trained to carry out IAT duties. Both men reported to Mr Walker, and both had worked for CSNSW for approximately nine years.

Wesley Duffy and Cameron Watson were both first-class correctional officers at the LCC. Both had previously received IAT training, although not assigned to the IAT at the relevant time. Mr Duffy had worked with CSNSW for 10 years. Cameron Watson had done so for six years.

Allan Michael Watson (known as Mick Watson) was a member of the Security Operations Group (SOG). Although he worked for CSNSW, SOG officers were not allocated to any particular prison. Rather, they were called on, as required. SOG consists of a number of units, including a dog squad. In February 2014, Mick Watson was the handler of a German shepherd dog that was used in searches for weapons and for security.

Other CSNSW officers were involved in less significant aspects of the matters that were the subject of the Commission's investigation. Their roles are addressed elsewhere in this report.

Witness credibility

In assessing the credibility of the evidence given by witnesses called before the Commission, the Commission has taken into account the fact that the relevant events occurred in 2014. However, it has also taken into account the fact that a number of those witnesses recounted their versions of events during the conduct of the CSNSW investigation in 2015. It is now largely common ground that the accounts provided to CSNSW investigators were false.

Chapter 2: 19 February 2014

This chapter examines the events of 19 February 2014 that led to inmate A receiving injuries and the conduct of officers later that day.

Background

In February 2014, inmate A was on remand facing serious drug-supply charges. Pending the availability of suitably safe accommodation, he was held at the LCC in segregation. This was considered necessary because of inmate A's alleged affiliations with an outlaw motorcycle gang. There were inmates within the LCC from rival outlaw motorcycle gangs. He was perceived to be at risk if he remained within the general prison population.

As at 14 February 2014, there was no suggestion that inmate A was a violent inmate or an inmate who was at risk of being violent to other inmates or corrections staff.

Inmate B was transferred to the same cell as inmate A a few days prior to the events of 19 February 2014.

A number of witnesses gave evidence of issues affecting the maintenance of order and discipline within the LCC in the months prior to 19 February 2014. There was significant inmate unrest, particularly in the segregation unit. The Commission was told that the unrest included inmate assaults on each other and on correctional staff, damage to cells, and calls by inmates for others to engage in riotous behaviour.

The segregation unit within the LCC is known as "5 Unit". It is divided into two distinct sub-units separated by corridors and custodial services offices. On one side is 5.1 Unit, in which the cell (number 208) of inmate A and inmate B was located. On the other side was 5.2 Unit, which mirrors that of 5.1 Unit. There is a large room dividing the two units, which is known as the day room.

Inmates within the LCC have access to an intercom system within their cells that can be operated by them if they need urgent assistance from corrections staff. Inmates and staff know it as the "knock-up system". The knock-up system in 5 Unit is connected to the officers' station within 5 Unit. Correctional officers rostered for work in that unit have access to it.

Unsurprisingly, the knock-up system is capable of misuse by inmates. More particularly, it can be used by inmates to make calls – perhaps offensive calls – that have nothing to do with any need for urgent assistance. Nevertheless, there is nothing within the CAS Regs that authorises correctional officers to punish such behaviour by the application of force or by engaging in conduct calculated to undermine the inmate's personal dignity and to deprive him or her of their humanity.

The morning of 19 February 2014

On 19 February 2014, the LCC was in lockdown to enable CSNSW officers to conduct searches of cells in 3 Unit. Rostered on to the IAT that day were Mr Walker, as the senior officer, with Mr Graf and Mr Duncan reporting to him. The IAT was allocated searching duties that morning. Mr Duffy, Cameron Watson and Mick Watson were also allocated searching duties and were working alongside IAT officers.

Mr Taylor was rostered on as acting MoS, as Mr Peebles was offline, working on special projects.

During the morning, inmate B used the knock-up system to contact officers in the officers' station of 5 Unit to complain about being in lockdown and not having a television. Inmate A was present in the cell when inmate B spoke over the knock-up system. Coincidentally, at the same time, Mr O'Shea was nearby and answered the knock-up call.

Mr O'Shea told the Commission that, during the morning, he and Mr Peebles had walked around the centre, as they did from time-to-time. Mr Peebles agreed he was present

in 5 Unit at the time the knock-up system was used by an inmate in cell 208 and heard the communications.

There is some debate as to what was actually said by Mr O'Shea and inmate B. However, it is common ground that both parties spoke "harsh" words. Both inmate A and inmate B told the Commission that they heard the officer who answered the call say words to the effect, "You're talking to the pipper" (a reference given to a commissioned officer).

Mr Peebles said he recalled, "a bit of a verbal abuse, you know, demands, stuff like that from one of the cells. Mr O'Shea attempted to reply on the knock-up system ... he fumbled a bit and you know, basically what he, he said was, you know 'shut up'". Mr Peebles could not recall exactly what was said but "it was harsh both ways".

The harsh words continued when Mr O'Shea approached cell 208, in which inmate A and B were housed. Mr O'Shea had mistakenly identified the inmate who made the knock-up call as inmate A, not inmate B.

Inmate A told the Commission that when the cell grille door was opening the pipper at the door said words to the effect of "you want to be tough through the knock-up system. You were speaking to me directly". Inmate A said he later learned that this person was Mr O'Shea. Mr Peebles told the Commission he saw Mr O'Shea speak to the inmates through the cell door and "there was a bit of yelling being exchanged".

At this stage, Mr Turton and another CSNSW officer, Jane Lohse, were walking past. Mr Turton gave evidence to the Commission that he saw Mr O'Shea up against the grille door and heard him say, "You think you are a tough cunt now. You won't be in a minute".

Mr Turton told the Commission that Mr Peebles and Mr Taylor were also in the vicinity. He also said he and Ms Lohse left the area because he was not comfortable with where matters were heading. A short time later, he heard Mr Taylor make a radio call requesting the IAT to attend 5 Unit.

Mr O'Shea told the Commission that he remembered answering the knock-up system call and the inmates "were just going off, abusing and saying 'Get us a fuckin' TV in here, what's going on, where's lock-in, why aren't we let go?' Just normal stuff like that". He said that he heard things like that "every day". Mr O'Shea denied using the word "pipper" but may have said it was the governor but "I don't think there's a need to". He told the Commission that the inmate making the call would not know who answered the call unless they were told. He agreed that, on occasion, he swore in discussions with inmates and that he had yelled at inmate A.

Although he could not recall using the words attributed to him by Mr Turton, Mr O'Shea agreed that he could not deny that he had said those words.

Mr Peebles could not remember what was said by Mr O'Shea, although he did recall that the exchange between inmate A and Mr O'Shea included many swear words, including "…the usual get fucks".

Ms Lohse told the Commission that she did not have a strong recollection of who was outside the cell but she recalled Mr O'Shea being in the vicinity. She recalled, "There was a bit of yelling going on".

Mr Taylor told the Commission that he was in 5 Unit delivering some papers when he heard some yelling. He entered the officers' station and spoke to a staff member (whose name he could not recall), who told him that Mr O'Shea had been abused over the knock-up system. He claimed that Mr Peebles was from three-to-four feet from the door into the day room and that Mr O'Shea was standing in front of cell 208. The door to cell 208 was open. He claimed that he saw another correctional officer, perhaps Mr Graf, holding another person against the wall outside, presumably inmate B. The Commission is satisfied that Mr Taylor sought to

create the impression that, by the time he looked out from the officers' station towards cell 208, the IAT had already entered the cell. The Commission rejects Mr Taylor's evidence. It is further addressed later in this chapter.

The Commission is satisfied that Mr Turton's account of the conversation is correct. It is also satisfied that the words spoken by Mr O'Shea were intended to convey to inmate A that he would shortly lose any sense of being a "tough cunt" because he would be taught a lesson and the lesson would involve the application of physical force.

Around 9 am, an internal radio call was made for IAT assistance in 5 Unit.

Mr Taylor denied that he had made the call.

The Commission does not accept Mr Taylor's evidence. A number of witnesses placed Mr Taylor in 5 Unit prior to the arrival of the IAT and identified him as the person who made the radio call seeking IAT assistance, and they recognised his voice. Mr Duffy informed the Commission that:

> *IAT were requested by Mr Taylor to attend 5 Unit and bring extra staff. That call was under duress in it there was a level of urgency in his voice as if there was something significant taking place in that unit*

The Commission accepts the evidence of Mr Duffy as a truthful account of what was said by Mr Taylor and the tenor of his call. It is also satisfied that Mr Taylor's request for extra staff reflected his understanding that the IAT would be entering cell 208 and there would be a physical confrontation that might require the deployment of additional correctional officers.

Upon hearing Mr Taylor's radio call, Mr Walker, Mr Graf and Mr Duncan responded immediately and made their way to 5 Unit. Mr Duffy and Cameron Watson also attended (both of whom had previously received IAT training). Mick Watson attended as a member of the SOG's dog unit, and arrived with a German shepherd.

Mr Walker informed the Commission that, upon his arrival at 5 Unit, he had a conversation with Mr O'Shea in the presence of Mr Peebles and Mr Taylor. It was Mr Walker's evidence that he was told that an inmate had abused Mr O'Shea over the knock-up system and to go and "sort him out". He believed it was Mr Taylor, in the presence of Mr O'Shea and Mr Peebles, who gave the instruction. Mr Walker told the Commission he knew what the instruction meant because of his previous experience in CSNSW.

His understanding was that he was to "go down and have words with the inmate and put him in his place, make him behave, let him know that what he did was not acceptable". He acknowledged that this could involve the use of physical force. Mr Walker was not told which of the inmates in cell 208 had abused Mr O'Shea.

Mr Peebles told the Commission that he was present when the IAT and other officers arrived in 5 Unit. He claimed that it was his understanding that the IAT had been called to remove the inmates from cell 208 and give them a dressing-down. He recalled that Mr O'Shea issued an instruction. He informed the Commission he could not remember the exact words used by Mr O'Shea but thought it was to the effect of "sort it out". In an earlier interview with Commission officers, Mr Peebles said that he recalled Mr O'Shea telling the IAT to "go down and sort the inmates".

A number of other witnesses who attended 5 Unit also understood the inmates were to be removed from cell 208 and assumed they would receive a dressing-down from Mr O'Shea. Inmate A and inmate B were eventually removed from cell 208. It is what occurred prior to their removal that is of significance.

Mr O'Shea informed the Commission that he accepted he was in the 5 Unit day room after the knock-up call exchange. He recalled that Mr Taylor was present, as was Mr Peebles. He had no recollection of seeing Mr Turton or Ms Lohse during that time. Mr O'Shea said he went to look at the cell identity cards outside the cell to identify which inmates were housed in cell 208. He did this because he was "going to talk to Mr Taylor about bringing those guys out, seeing what their issue is and, and sort it out…". He informed the Commission that "I actually got this [inmate B] mixed up, I thought it was another one … As in the other young fellow [inmate A]".

He said that Mr Taylor called the IAT for the purposes of removing the inmates from their cell "to sort out what their problem was, whether it was a TV, whether it was whatever. I don't know that's up to other people to sort out and talk to and find out what their issue is".

Mr O'Shea recalled Mr Walker arriving in 5.1 Unit but could not recall speaking to anyone except Mr Taylor. He said, "My focus would have been on Mr Taylor. It would have been, 'Steve, these blokes are kicking on. Don't want them to kick off the wing. Get them out and see what's going on. Sort it out. See what their problem is' ". He told the Commission that, while he could not recall who else attended 5.1 Unit, he recalled there were a number of people in attendance but maintained that his focus was on instructing Mr Taylor. He denied telling IAT "to go and take the inmate out sort it out".

The Commission is satisfied that Mr Taylor, in the presence of Mr O'Shea and Mr Peebles, instructed Mr Walker to "sort him out". In so doing, he was repeating the instruction given to him by Mr O'Shea. It was Mr O'Shea who requested Mr Taylor to have the

IAT attend. The Commission also accepts Mr Peebles' evidence that a similar instruction was given by Mr O'Shea upon the arrival of the IAT. That is, "sort it out" or "sort the inmates out".

Mr Walker's mental state

Mr Walker's mental health was the subject of some evidence to the Commission. While respecting his privacy, it is important to note that senior CSNSW officers were on notice that Mr Walker's mental health was deteriorating in the lead up to this event.

Witnesses told the Commission that Mr Walker had a temper and was not someone who could de-escalate high-pressure situations with inmates. Mr O'Shea acknowledged that Mr Walker was under considerable personal stress in the lead up to February 2014 and incidents of angry confrontations with others had been reported to him.

Mr Peebles told the Commission that Mr Walker's operational style was "problematic". He said that he had personally had "a couple of experiences with him when I'd be trying to de-escalate issues in the yards with larger groups of inmates, you know, where his comments had done just the opposite, had enflamed things. So I didn't feel he was a very good talker in terms of managing inmates."

On 14 February 2014, Mr Walker sent an email to Mr Peebles, Mr Taylor and Mr Turton, offering to stand down as he felt that some assistant superintendents had lost faith in his ability to do his job and, "I fear someone will be hurt and I do not want this to happen".

Shortly after the incident on 19 February 2014, Mr Walker took leave due to mental health issues. Less than two months later, he was back at work at the LCC in his role as senior correctional officer in the IAT.

Mr O'Shea was aware that Mr Walker was a volatile individual and that he was not someone who should be deployed to de-escalate a situation. He gave the following evidence:

[Counsel Assisting]: Did you have any concerns with Mr Walker's ability to de-escalate a situation?

[Mr O'Shea]: He's someone that I wouldn't sent [sic] *in to de-escalate, but on the flip side of that, he is very, has been very good with talking inmates down from self-harm or inciting others in the past as well. It can go both ways with Terry.*

[Q]: I'll ask you a question again. You just gave an answer there that was, "Terry wasn't someone I would send in to de-escalate a situation." Did that give you concerns that he was the senior officer of the IAT?

[A]: No, because I think we all had enough people around Terry, as in managers, whether it be through MoS, through a sector manager or through AS or just people in the wing, and the two people, the two, sorry, officers that were rostered with Terry on the day, Terry was good but he'd have a bad day every now and then.

The Commission is satisfied that Mr O'Shea did not send Mr Walker into cell 208 to de-escalate the situation. His true purpose is addressed below.

Mr O'Shea's deployment of the IAT was inappropriate

There was no legitimate reason for the IAT to be sent into cell 208. Inmates A and B were confined. There was no suggestion that they would harm themselves or each other. There was no proper basis for UOF.

Mr O'Shea wanted Mr Walker and the IAT to "sort out" the inmate who had abused him. What he had in mind is clear from what he said to the inmates when standing outside cell 208: "You think you are a tough cunt now. You won't be in a minute".

The purpose of IAT attending 5 Unit and cell 208 was not to de-escalate the situation. It was not to have the inmates removed. Removal of the inmates from cell 208 would have involved nothing more than the deployment of standard techniques, such as handcuffing them through the opening in the closed grill used for the delivery of food and other items and then removing them.

The situation was not so urgent that the IAT needed to act immediately and in the absence of a proper assessment of what was required.

The Commission is satisfied that Mr O'Shea wanted Mr Walker and other members of the IAT to teach the abusive inmate in cell 208 a lesson, and a lesson he would not forget. Mr O'Shea knew that the instruction to sort "him" or "it" out would be understood by Mr Walker as a licence to apply physical force. The Commission is satisfied that this is what Mr O'Shea intended. The behaviour of inmate B undermined Mr O'Shea's authority and was at odds with the good order and discipline of 5 Unit.

The fact that Mr O'Shea mistakenly singled out inmate A rather than inmate B for punishment was not merely an unfortunate twist of fate. It highlights the unacceptable consequences that can occur if correctional officers are permitted to take matters into their own hands and arbitrarily punish inmates they deem deserving of punishment by resorting to UOF. The role of a correctional officer is to assist in the administration of a sentence imposed by the courts. Their role is not one where it is permissible to impose idiosyncratic and extra-curial punishments upon inmates.

Inmate A is "flogged"

Following the conversation with Mr O'Shea, Mr Walker, Mr Graf, Mr Duncan, Mr Duffy, Cameron Watson and Mick Watson approached cell 208. Mr O'Shea and Mr Taylor were at the cell door for at least some of what occurred next.

Mr Peebles told the Commission that he left 5 Unit as the other officers approached the cell door. He thought Mr O'Shea may have left with him but he could not be sure. He later told the Commission that he recalled seeing Mr O'Shea near the cell door while the IAT was lining up.

There is no dispute that, at approximately 9.15 am, Mr Walker, Mr Duffy, Mr Duncan and Mr Graf entered the cell, in that order. What occurred next is in dispute.

Inmate A told the Commission that he was in bed when inmate B made the knock-up call. A few minutes later there were "between seven and 12" officers at the door. He said that some of them were in the "squad" (IAT) uniform, some were "contage" (a commonly used term for officers wearing dark blue overalls employed by SOG, such as Mick Watson) and "there was a pipper there". He recalled seeing a dog outside the cell. Inmate A said the solid door to the cell was opened and the pipper called him to the grille and said words to the effect of, "Do you want to be tough, you're talking through the, you're talking to me directly". He said the pipper clearly was not happy and was speaking in a stern manner.

Inmate A said that the grille door was then opened and an officer from the squad entered and almost immediately started punching him in the face. That officer said, "Stop resisting". Inmate A denied he was resisting. He claimed that he was punched in the face a number of times and then other officers entered, and he had three officers attacking him. He recalled that one arm was restrained and so he could only protect his face with one hand. At some stage, an officer kneed him in the ribs, but he could not identify that officer. Inmate A believes that he blacked out during the physical attack and when he came to, he said, "I've got asthma, I can't breathe". Inmate A is an asthmatic who requires both preventative medication by inhaler once daily and an inhaler to treat asthma attacks as they occur.

Inmate A was handcuffed and removed from the cell. He claimed that, on the way out of the cell, his head was smashed up against the grille door.

Inmate B sought to play down his part in the conversation with Mr O'Shea that led to the incident in cell 208. He claimed that when he used the knock-up system he was "polite" but the officer taking the call was "aggravated" and said, "Do you know who the fuck this is? It's the pipper".

The Commission does not accept that inmate B was polite to Mr O'Shea. There was a heated exchange. That is largely common ground. Inmate B did not see physical force being applied to inmate A. However, what he heard was consistent with the immediate application of physical force. Based on what inmate B heard and what he observed of inmate A as he was removed from cell 208, inmate B concluded that inmate A had been "bashed". He gave the following evidence:

[Counsel Assisting]:	*And what happened to him, if anything?*
[inmate B]	*He got bashed.*
[Q]:	*But did you see that?*
[A]:	*No but I could hear it.*
[Q]:	*What did you hear?*
[A]:	*"It wasn't me, it wasn't me." And I could hear like, crash banging in the cell and, "I didn't say it, chief, I didn't say it." And my, my head's up against the wall, mind you, next to the door on the left. I was told, on my hands and knees and don't like, put my forehead against the wall and don't move. And I could hear, "It wasn't me, it wasn't me. I didn't say it." Crash, bang and I got a sneaky look when they were dragging him out, like, that, over towards (not transcribable) and I could see a black eye. And he come back in the cell later that afternoon with a black eye and fat lips and, and then they brought a TV.*
[Q]:	*Who brought the TV?*
[A]:	*The officers, later that night, when he got back from hospital.*

The Commission is satisfied that inmate A was a truthful witness who recounted the incident to the best of his recollection. It accepts his evidence that he was struck by a member of the squad almost immediately upon Mr Walker entering the cell. Inmate A's evidence is consistent with the evidence of Mr Duffy. He was directly outside the cell when Mr Walker entered. His evidence was that "[t]he whole thing happened very quickly".

Mr Duffy said that, as he progressed into the cell, inmate A was backing up towards the rear of the cell with his hands out in front of him. It was at this point, as inmate A was moving backwards, that Mr Walker struck the inmate to the face. Mr Duffy only saw Mr Walker strike the inmate once but accepted it could have been more than one strike. Mr Duffy tackled inmate A and brought him to the ground. Mr Duncan entered the cell and landed on top of the group. Mr Duncan weighed over 130 kg when he was wearing his IAT vest. When he entered custody in late 2013, inmate A weighed 85 kg. After Mr Duncan landed on the group, Mr Duffy said "That's enough", which was directed at Mr Walker and Mr Duncan. Mr Duncan replied, "If you don't like what's going on, get out of the cell". Mr Duffy informed the Commission that he responded by requesting that inmate A be handcuffed and removed from the cell. Mr Duffy told the Commission that he had worked on the IAT with both Mr Walker and Mr Duncan previously and both officers knew that he did not approve of what he perceived as their heavy-handed techniques.

Mr Walker told the Commission that he entered the cell and had words with inmate A about abusing Mr O'Shea. He said, "things got a bit heated, I was yelling at him, he lunged towards me". Mr Walker said he thought he was going to be hit so he struck inmate A with a palm strike. He told the Commission that a palm strike was an open-handed pushing move using the lower part of the hand. He said that this occurred within 25 to 30 seconds, and "it just escalated".

Mr Walker said that a scuffle ensued, with inmate A throwing some punches and then inmate A was pushed towards the back of the cell against the wall to contain him. Mr Walker agreed he struck inmate A more than once and said it was "possible" some of those strikes were with a closed fist to the upper body or head. Mr Walker said that he did not recall inmate A saying he could not breathe or that he had asthma, although he would not necessarily remember such a statement because "they all say they can't breathe … it's just a standard ploy". Mr Walker did not recall anyone saying, "That's enough". Mr Walker informed the Commission that others took inmate A out of the cell, and that he remained in the cell to get his breath back.

The Commission is satisfied that, in certain respects, Mr Walker's recollection of what occurred within cell 208 is inaccurate. It does not accept that inmate A lunged at him or that inmate A threw any punches. It also does not accept that Mr Walker applied physical force because he thought he was going to be hit by inmate A.

Mr Walker informed the Commission that, when he left cell 208, Mr O'Shea, Mr Taylor and Mr Peebles had left the area.

Mr Taylor gave evidence that he was standing next to Mr O'Shea. Mr Taylor looked into the cell and observed that Mr Walker had inmate A up behind the toilet, with his hand around his throat. Mr Taylor identified on a plan of the day room the position in which Mr O'Shea was standing at the time. Mr O'Shea was facing cell 208 with hands on hips, red-faced, and demonstrably unhappy. Mr Taylor assumed that Mr O'Shea also saw what was occurring within the cell "because I was standing right next to him". Mr Taylor believed that when he left the day room Mr O'Shea and Mr Peebles were still there.

In his submissions to the Commission, Mr Taylor contended that Mr O'Shea was standing next to Mr Peebles, and not next to him. He claimed he was on the other side of the day room.

The Commission does not accept these submissions. It may be that, at some point, Mr Taylor stood next to Mr Peebles. However, his own evidence was that he was standing next to Mr O'Shea when he observed Mr Walker with his hand on inmate A's throat. Mr O'Shea informed the Commission that he went to the door of cell 208 with Mr Taylor and recalled Mr Taylor standing next to him outside the cell while the cell door was still closed. The Commission accepts the evidence of Mr Duffy as providing an accurate description of the position of Mr Taylor immediately prior to the IAT entering cell 208.

Mr Duffy informed the Commission that, when he entered the 5 Unit day room, he observed Mr O'Shea yelling and heard an inmate within cell 208 yelling back. Mr Taylor was also at the cell door. He thought it was Mr Taylor who opened the grille door. Mr Walker then entered the cell, followed by Mr Duffy and Mr Duncan.

The Commission is satisfied that Mr Taylor was standing next to Mr O'Shea outside cell 208 and that both officers observed the interaction between Mr Walker and inmate A. The Commission is satisfied that Mr Taylor saw more than Mr Walker placing his hand around inmate A's throat. He saw Mr Walker bash inmate A.

Mr O'Shea denied that he was present when the cell door was opened. He claimed he was walking out of the day room when he heard the cell door opening. For the following reasons, the Commission rejects Mr O'Shea's evidence.

Mr O'Shea provided a statement to CSNSW Investigations Branch in 2015. On that occasion, Mr O'Shea referred to attending the officer's station. However, he claimed he was unable to recall whether he had a conversation with inmate A "by attending the cell flap", which would mean he was in the day room "or whether it was conducted over the centre's knock up system". If the conversation occurred through the cell flap, he was within the day room; if it occurred over the knock-up system, he was not.

Commission officers also interviewed Mr O'Shea on 11 January 2018. That interview was only a few months before his testimony at the public inquiry. However, when interviewed by Commission officers, Mr O'Shea stated that he did not go into the "unit", by which he meant the day room, on that particular occasion. Mr O'Shea informed the Commission's officers that he did not think that he had ever "laid eyes" on inmate A. The substance of Mr O'Shea's account was that he and Mr Peebles were in the officers' station between 5.1 Unit and 5.2 Unit. The inmates in cell 208 were creating a disturbance by yelling abuse, kicking the cell door and by yelling further abuse over the knock-up system. He said to staff, "Get in there and see what their problem is and we'll get the IAT when youse have finished to get in there". According to Mr O'Shea, he and Mr Peebles then "walked straight out. We didn't even go into the unit".

Mr O'Shea also told those officers he had no "knowledge" of going to the cell to talk to the inmates.

There is a marked inconsistency between what Mr O'Shea told Commission officers in January 2018 and his evidence before the public inquiry on 5 June 2018. Mr O'Shea was unable to explain adequately the change in his evidence.

The Commission is satisfied that, in his statement to CSNSW and in his interview with officers of the Commission, Mr O'Shea intentionally sought to create the false impression that he was not in the day room at any relevant time.

However, by the time Mr O'Shea gave evidence in the public inquiry on 5 June 2018, a number of witnesses had placed him in the day room. The Commission is satisfied that Mr O'Shea realised that a finding, that he was in the day room at the time Mr Walker entered the cell, was all but inevitable. He sought to tailor his evidence accordingly.

The Commission is satisfied that Mr O'Shea's evidence, that he was exiting the day room as the cell door opened, is untrue. It is inconsistent with Mr Taylor's evidence that he observed Mr O'Shea standing next to him when Mr Taylor saw Mr Walker's hand around the throat of an inmate. Mr Taylor put a mark on a plan of the day room, placing Mr O'Shea right outside the cell door at this point in time. Mr O'Shea's evidence is also at odds with the evidence of Mr Duffy, who observed Mr O'Shea and Mr Taylor outside the door to cell 208.

Mr O'Shea's evidence also conflicted with Mr Duffy's evidence, which the Commission accepts, that on the CCTV, which he watched more than once, Mr O'Shea was seen leaving the day room halfway through the period of time during which Mr Duffy and other officers were in the cell. That evidence is addressed below.

Mr Graf told the Commission that, after Mr Walker and Mr Duffy entered the cell, he saw "a lot of movement up the back" of the cell and that was when he decided to take inmate B out of the cell. He said that he heard raised voices but told the Commission that regardless of whether there had been a "scuffle" or not, he would have taken inmate B out of the cell. He paid no real attention to what was happening with inmate A, Mr Walker and Mr Duffy at that time. Mr Graf said that he fell as he was removing inmate B from the cell. At that point, the German shepherd that had accompanied Mick Watson was but one or two metres away. Mr Graf told the Commission that he did not see Mr O'Shea outside the cell when he brought out inmate B.

Mr Duncan told the Commission that he could see the back of Mr Walker as he entered the cell but did not see Mr Walker strike inmate A. He said that, while he could see the point of entry to the cell, he could not see inside the cell. On hearing a commotion inside the cell after removing inmate B, Mr Duncan returned to assist, and either tripped or tackled the group using his full body weight to force the group down.

Cameron Watson recalled responding to a radio call by attending 5 Unit with Mr Walker, Mr Graf and Mr Duncan. On arrival, he saw Mr O'Shea in the office area of 5 Unit. He said that Mr Walker and the rostered IAT officers entered the cell and he stayed back in case he was needed. Mr O'Shea was also at the cell door at this time. Mick Watson and his dog were slightly behind him to the right. He saw Mr Graf take inmate B from the top bunk and place him on his knees in the day room. Cameron Watson then assisted in guarding inmate B. He told the Commission he could not see into the cell but he could hear a commotion within it a couple of seconds after the IAT had entered the cell. He agreed that Mr O'Shea was in the vicinity when the commotion was occurring.

Mick Watson told the Commission that he had a very poor memory and could not really remember the incident. His evidence was that he tagged along with the IAT as he thought they had finished searching in 3 Unit and were going to search in 5 Unit. He could not recall a radio call out for assistance. His evidence generally about this incident was vague. He recalled standing by the cell door

and "the next thing I knew two people came falling out the door". He thought it was an inmate and an officer. His dog reacted and he needed to control it to ensure no one was bitten. He claimed he could not recall seeing inmate A and suggested that he may have left before inmate A was brought out of the cell.

Once inmate A had been removed from cell 208, he was placed in an observation cell within 5 Unit. Inmate A informed the Commission that he was placed on his knees and someone he could not see struck him from behind in the rib area. He also said that Mick Watson's dog was close at that point. He heard an officer say "let the dog in" but another said, "no, leave it". The cell door was then closed.

As previously noted, the area immediately outside the cells in 5.1 Unit, including cell 208, is known as the day room. CCTV wall-mounted cameras are located in the day room and record movements within it.

CSNSW failed to produce to the Commission the CCTV footage covering the day room for 19 February 2014. This is further addressed in chapter 3.

Mr Duffy gave evidence that he and Mr Graf had discussed the fact that the German shepherd had been close to inmate B when he was removed from cell 208. Mr Duffy went to look at the CCTV footage to see how close the dog had been to inmate B. He viewed the CCTV footage in the control room, which is a tower-like structure with multiple screens that can display images from all the CCTV cameras in the LCC. In the absence of the CCTV footage, Mr Duffy's viewing, and reviewing, of the CCTV footage is the best evidence of what it contained. The Commission is satisfied that Mr Duffy was a truthful witness and accepts his evidence of what he observed on the CCTV footage.

Mr Duffy informed the Commission that he saw everything that had happened within the day room on the CCTV footage, including the following:

- Mr Walker going to the officer's station
- Mr Peebles, Mr O'Shea and Mr Taylor coming out of the office
- "all of us at the [cell] door" and the IAT officers and himself entering the cell
- Mr Turton and Ms Lohse walking through the day room to go to the officers' station
- Mr O'Shea and Mr Peebles leaving the day room after Mr Walker and Mr Duffy entered the cell
- Mr O'Shea gesturing to Mr Peebles to leave or vice versa, after which point both left the day room (Mr O'Shea gave evidence that it was Mr Peebles who gestured to him).

Mr Duffy did not recall seeing Mr Taylor leave the day room on the CCTV footage.

Mr Duffy informed the Commission that those officers, who entered cell 208, including himself, were not inside the cell for long. He said that the CCTV footage showed Mr O'Shea and Mr Peebles left the day room at the half-way point in time between when he and the other officers were inside the cell and the point in time at which those officers left the cell.

The Commission is satisfied that excessive force was applied by Mr Walker to inmate A in cell 208 and that this occurred as a consequence of Mr O'Shea's instruction to "sort him out" or "sort it out". Mr Walker punched inmate A on more than one occasion, with one or more of those punches connecting with his head. Prior to Mr Walker entering the cell, inmate A did nothing that warranted any officer entering the cell.

The Commission is also satisfied that inmate A did nothing to warrant the application of force once Mr Walker and the other correctional officers had entered the cell. To the contrary, he did no more than attempt to shield himself from injury. In so doing, he used his hands in a passive manner.

As noted above, Mr O'Shea denied that he was present when the door to cell 208 was opened. He claimed that he was walking out of the day room when he heard the cell door being opened.

The Commission does not accept Mr O'Shea's evidence. Mr Duffy, Mr Duncan, Mr Graf, inmate A, Cameron Watson, Mr Turton, Mr Taylor and Mr Peebles placed him at, or around, the cell door. Mr Duffy's report, drafted within a day of the incident, also placed Mr O'Shea in the day room when the IAT entered 5 Unit.

The Commission is satisfied that it was Mr O'Shea's intention that the inmate who had abused him over the knock-up system would be bashed. The Commission is further satisfied that Mr O'Shea not only caused the physical attack on inmate A by issuing the "sort him out" or "sort it out" direction, but that he stood by to watch it take place.

As a consequence of what occurred within cell 208, inmate A suffered bruising to his face, a split lip, bruising and suspected broken ribs. He was also traumatised.

No witness who gave evidence in the public inquiry sought to suggest that inmate A fell on the toilet as an explanation for his injuries, or that he had tried to dispose of contraband down the toilet. However, a number of those officers present when inmate A was bashed, subsequently reported falsely that his injuries were caused by a fall that occurred as he tried to dispose of contraband

by flushing it down the toilet. These matters are addressed in chapter 3.

Inmate A requires hospital treatment

At about 10.15 am, Mr Peebles tasked Mr Turton with completing an Inmate Assault/Injury Questionnaire with inmate A. At the time of completing the questionnaire, Mr Turton was unaware that inmate A was the person whom he saw Mr O'Shea shouting at in cell 208. Inmate A described the events surrounding the incident as a "use of force". He also indicated that he did not want the police to investigate. He was not prepared to identify his assailant. When asked who was responsible for the injuries, Mr Turton recorded that inmate A stated "myself".

After completing the questionnaire, Mr Turton contacted Mr Peebles and said that he would now complete the IRM as required by the policy. Mr Turton told the Commission that Mr Peebles responded, "There was no use of force. There will be no IRM".

Mr Peebles told the Commission that he could not recall this conversation but said that he could not imagine a situation where he would instruct an officer that there was to be no IRM.

At around 10.45 am, inmate A's injuries were assessed by the LCC's nurse unit manager in 5 Unit. Her medical notes recorded that inmate A had suffered a laceration and swelling to his lip on the left side, a bruise to the left eye and cheekbone, and tenderness and swelling to the right side of the ribs "post use of force". Another LCC nurse told the Commission that she was present during that assessment. She noted a boot-like imprint on inmate A's face and that the inmate's demeanour suggested that he was fearful of the CSNSW officers in attendance. She recalled that it was her strong recommendation that inmate A needed to be seen by a doctor at hospital. She could not recall which CSNSW officers had attended.

Mr Turton was then contacted by the clinic. He was advised that inmate A would require hospital attention for suspected broken ribs. He told the Commission that he then contacted Mr Peebles and again reiterated that an IRM was required.

Mr Turton informed the Commission that Mr Peebles repeated that it was not required as "there is no fucking use of force". Mr Turton responded "No problems Brad, but he's currently on his way to the hospital with suspected broken ribs". Mr Turton told the Commission that Mr Peebles' responded, "Oh fuck", and advised that Mr Walker would be doing the IRM.

Mr Peebles denied that the conversation took place in this way. While he could not specifically recall the conversation referred to above, he thought that, if it had taken place, he would not have said that there was to be no IRM, but rather that Mr Walker ought to do it as that was the policy.

The Commission is satisfied that Mr Turton gave truthful and accurate evidence concerning his conversations with Mr Peebles. It is further satisfied that, at the very least, Mr Peebles was aware there had been a UOF. The Commission is satisfied that Mr Turton's account of the conversation with Mr Peebles is accurate.

It was Mr Peebles who had instructed Mr Turton to complete the Inmate Assault/Injury Questionnaire. The Commission is satisfied that he issued this instruction because he knew there had been UOF. CSNSW policy required the preparation of an IRM no matter how minor.

By suggesting to Mr Turton that there was no UOF and therefore an IRM was not required was a significant dereliction of duty. On one view of the matter, Mr Peebles was seeking to cover-up what had occurred to inmate A and stymie any investigation of the matter. Nevertheless, upon being informed that inmate A needed to go to hospital, he ultimately accepted an IRM was required. That he insisted the IRM would be prepared by Mr Walker might be regarded as suspicious, however, Mr Walker was the most senior officer directly involved in the UOF within cell 208. Mr Turton was not directly involved. The Commission is not satisfied there was anything improper in Mr Peebles' instruction to Mr Turton that the IRM would be completed by Mr Walker.

Inmate A was referred to the LCC's clinic at around 12.05 pm. Clinical notes recorded at 12.50 pm noted that inmate A was seen in the clinic and was to be "taken to Lithgow Hospital for further investigations".

Shortly thereafter, an order for inmate A to be transferred to Lithgow Hospital was signed off by Mr Taylor in his capacity as acting MoS. Mr Turton completed an IRM regarding the hospital transfer at 1.20 pm.

At 1.29 pm, Mr Turton emailed Mr Taylor regarding inmate A's escort to hospital and included the advice that "Brad just told me not to do use of force IRM as IAT is doing it". This contemporaneous email supports Mr Turton's evidence that a conversation with Mr Peebles took place about the UOF IRM.

A doctor at Lithgow Hospital assessed inmate A. The clinical notes record injuries to his face, neck and chest, with periorbital bruising and a tender high "C" spine in midline, which can be assumed to be a reference to the high cervical spine or neck. The notes also referred to tender right lower ribs. The entry "LOC?" suggests that inmate A also reported a loss of consciousness.

These observations are consistent with the video footage of inmate A taken the next day, 20 February 2014, that shows bruising around his eye. Inmate A was clearly in physical pain, moving very gingerly, and is recorded holding his rib area. He had to be assisted to remove his clothes for the purpose of a strip-search. No one sought to suggest otherwise. One officer who accompanied inmate A to the hospital, and with whom he apparently had some rapport, appeared upset that inmate A had sustained injuries and told inmate A "we know it wasn't you that knocked up".

The knock-up call that led to the incident with inmate A emanated from a complaint about a television. When inmate A returned from hospital, his cellmate had been provided with a television and a "pouch" of cigarettes. In a conversation with inmate A about the provision of these items, inmate B inferred correctional officers had provided them. The most likely explanation is that these items were provided as a sweetener to ensure inmate B's silence.

At the public inquiry, inmate A gave evidence confirming his injuries were caused by the actions of correctional officers.

Chapter 3: The cover-up

This chapter addresses the various reports prepared by a number officers following the incident of 19 February 2014.

The Commission is satisfied that those correctional officers identified below who engaged in the cover-up of the physical attack on inmate A did so to avoid an investigation by CSNSW in relation to disciplinary offences and also the police in relation to possible criminal offences. In the normal course, the police would investigate an assault causing actual bodily harm. The Commission is in no doubt that those involved in the incident of 19 February 2014 would have been aware of this. Indeed, Mr Walker informed the Commission that his false account of what occurred on 19 February 2014 was driven by a concern that, if he were truthful, he might not only face disciplinary charges but "outside charges".

Mr Peebles gave evidence that "police have to be phoned on every occasion and advised there's been a use of force". That communication ordinarily generated a Computerised Operational Police System (COPS) event number.

In fact, one of the documents that must be completed as part of the UOF package was a report to police of the alleged incident/assault. It was required to be completed, and the police contacted, whether or not the Inmate Assault/Injury Questionnaire recorded any request by the inmate for police action. In the event that the inmate did not want the police to take action, the inmate was required to complete an indemnity form. It should also be noted that COPP s 5 required that, if an incident where force was used might result in a police investigation, the area where the incident occurred had to be managed as a crime scene.

This was a matter where a police investigation was on the cards and yet:

- cell 208 was never preserved as a crime scene
- the police were never contacted and no COPS event number was ever generated
- a report to police of the alleged incident/assault was not included in the UOF package
- inmate A never signed an indemnity.

UOF reporting at the LCC

As outlined earlier in this report, there were mandatory reporting obligations that applied in the event of any UOF against an inmate. At the LCC, the incident had to be documented within 24 hours for review by the MoS.

Correctional officers at the LCC were well aware of the reporting procedures that applied to UOF. In the months leading up to the incident of 19 February 2014, Mr Peebles sought to remind correctional officers within the LCC of the importance of proper compliance.

On 11 August 2013, Mr Peebles sent an email to a number of staff indicating that the quality of reporting and the review of use of force incidents was substandard and attached a "self-explanatory format for use of force reviews."

Mr Peebles sent a further email on 20 September 2013, noting that recent UOF reports had not been up to standard and stating that all UOF packages needed to include:

- the sector manager or assistant superintendent's covering report
- an incident/injury non-employee notification
- a police notification form (completed with COPS event number)
- an inmate injury questionnaire
- a Justice Health notification (or explanation that the inmate refused to sign a release)
- all involved officers' reports (vetted by the managing executive officer for quality)

- where applicable, a copy of the Critical Incident support email to staff
- a copy of injury notifications for any staff injured during the UOF
- colour photographs of each involved inmate (showing injuries if any)
- a completed and registered DVD copy of any CCTV footage (which was to be supplied by Intel and the IAT).

Mr Peebles' email attached all the relevant forms and checklists associated with the reporting requirements.

The IAT was obliged to ensure that a video camera was used to record all actual or potential UOF incidents. Such video footage, together with any relevant CCTV footage, would also be included in the UOF package.

As a matter of course, a UOF incident was logged on an internal database. This entry was known as the Incident Response Module or IRM.

The incident reports – CSNSW correctional officers fabricate the facts

Mr Walker told the Commission that he was contacted by either Mr Peebles or Mr McMurtrie and advised an IRM would be required because inmate A was being taken to the hospital. He said he was instructed to only obtain witness accounts from the two IAT officers who were present in addition to his own account.

Mr Walker said that he was told by Mr McMurtrie to include in his witness statement reference to a direction that the IAT had received to search cell 208 for drugs and to state this was the reason why the IAT entered cell 208. Mr McMurtrie told him he would draft an intelligence report to support this false story.

It is common ground that there was no search of inmate A or inmate B; nor was cell 208 searched on 19 February 2014.

Mr McMurtrie told the Commission that he did not contact Mr Walker; rather, Mr Walker contacted him. He said Mr Walker told him that an incident in 5 Unit had "gone pear shaped" and he (Mr Walker) had to try and "clean up the mess". Mr McMurtrie said Mr Walker read out a draft report that he had prepared. The draft report recorded that the inmate had run without warning towards the toilet, tripped and fell against the toilet, injuring himself.

Mr McMurtrie agreed he suggested to Mr Walker that he create a reason for entering the cell, namely, to search it for suboxone (buprenorphine). Whether Mr McMurtrie telephoned Mr Walker or Mr Walker telephoned Mr McMurtrie is of no moment; both knew that the reason that was to be advanced to explain the IAT's entry into cell 208 was false.

Suboxone, buprenorphine or "bupe", as it is often called, is a restricted substance that is used to treat withdrawal from heroin or methadone. A number of witnesses informed the Commission that illegal use of buprenorphine was a problem in the LCC.

Mr Walker informed the Commission that, following his telephone call with Mr McMurtrie, he discussed his report's contents with Mr Duncan and Mr Graf.

Mr McMurtrie gave evidence that Mr Walker sent him the draft report and that he added the false excuse for entering the cell. Mr McMurtrie told the Commission that, at the time, he did not know that a false story was being prepared to cover-up an assault. The Commission rejects this evidence. Mr McMurtrie knew that an incident in cell 208 had "gone pear shaped". He also knew that an inmate had been injured; albeit, Mr Walker intended to attribute his injuries to the inmate falling onto the toilet.

Sometime around midday on 19 February 2014, Mr McMurtrie created a false information report. His purpose was to support Mr Walker's IRM and witness report. Mr McMurtrie's information report was as follows:

> *Sir*
>
> *Today Wednesday 19th February 2014 the centre was attended by SOG to assist the local IAT with target searches of cell/inmates at Lithgow Correctional Centre. During the searching numerous inmates were questioned in regards to drug and weapon possession at the centre. During the informal interviews an informant stated that there was a large quantity of suboxone in a cell occupied by MIN* [number inmate A] *cell# 208 5.1.1 unit. The informant was confident in the information, and has previously been reliable. This is consistent with the current drug of choice at Lithgow CC. The Manager of Security was informed and instructed to have this information forwarded to the search teams and have* [inmate A] *included in the target searches.*
>
> *I informed the search 2 IC Mr T. Walker of the information and instruction from the Manager Of Security.*
>
> *Submitted for your information.*
>
> *B. McMurtrie*
>
> *Intel LCC*
>
> *Monday, 13 January 2014*

The date of 13 January 2014 was the consequence of Mr McMurtrie typing over an old memorandum and failing to change the date.

Around lunchtime on 19 February 2014, Mr Duffy visited the IAT office above 5 Unit. Mr Graf was present, and Mr Duffy asked Mr Graf what they were doing. Mr Graf replied that they were waiting for Mr Walker to come back. Mr Duffy gave evidence that Mr Walker subsequently returned to the IAT office and he had Mr McMurtrie's intelligence report in his hand. Mr Duffy realised that the information report contained information that was not truthful. He left the IAT office because he did not want to be a part of what was occurring.

Mr Graf confirmed in his evidence that Mr Walker was holding a report when he came back into the IAT office. He did not see the report but was told by Mr Walker that it was an intelligence report concerning cell 208 and there were supposedly drugs in the cell. Mr Walker instructed Mr Graf to record this in his report of the incident.

Mr Graf accepted that he knew at this point that it was a cover-up of what actually happened. He claimed that he was concerned and that he raised those concerns with Mr Walker. Mr Graf had already drafted his report. The report mentioned Mr Duffy as being present but made no mention of UOF, as he had not witnessed one.

Despite his concerns, Mr Graf altered his report in accordance with instructions from Mr Walker, including removing any reference to Mr Duffy and any reference to responding to a radio call from Mr Taylor as being the reason for attending cell 208. He claimed that he initially refused to change his report but then did so because Mr Walker told him to do it "or else", which he took as a physical threat. He claimed that Mr Walker had told him to "stick to his story", which he took as a threat. He also claimed he feared for himself and his family. Mr Graf said that Mr Walker made threats "whenever it was spoken about".

Mr Graf said he did not report Mr Walker to more senior officers "because Mr Walker insinuated it was, everyone was involved in it". Mr Graf's incident report was as follows:

> *I was carrying out my duties as IAT 2 when the following incident occurred:*
>
> *IAT attended cell 208 in 5.1 unit occupied by inmates known to me as* [inmate A] *and* [inmate B] *to search the inmates and cell. SCO Walker entered the cell and I followed and saw* [inmate A] *jump off the lower bunk and move towards the toilet and sink. I ordered* [inmate B] *to get off the top bunk and I then took hold of his wrists behind his back and we exited the cell. I directed* [inmate B] *to get onto his knees but* [inmate B] *laid on the floor so I handcuffed him and then helped him to his knees and knelt him against the wall and ordered him to stay there. SCO Walker escorted* [inmate A] *to cell 203 and I returned* [inmate B] *to cell 208 with no further incident. I submit this report for your information.*

Mr Graf gave evidence to a CSNSW investigation in 2015 and to the Commission in a compulsory examination on 8 March 2018. On both occasions, Mr Graf failed to disclose that he had been directed by Mr Walker to prepare a false incident report; nor did he say that he had been threatened. On both occasions, he claimed that his incident report contained an accurate account of what had occurred.

The Commission does not accept that Mr Graf was threatened by Mr Walker. It is satisfied that he was a willing participant in the cover-up and part of a culture where such conduct thrived.

By late July 2017, Mr Walker had left the employ of the CSNSW. Mr Graf still did not come forward with the truth. The compulsory examination of 8 March 2018

conducted by Commission officers was done so in private. The evidence was the subject of a non-publication order made pursuant to s 112 of the ICAC Act. Mr Graf was given every opportunity to give truthful evidence, but he failed to do so.

In evidence given during the public inquiry, Mr Duncan acknowledged there had been UOF and that he had been involved in a cover-up. He claimed, however, that although someone must have directed him as to what should be put into his incident report, he had no recollection of who gave the direction. He also claimed to have no recollection of Mr Duffy raising the need to prepare an incident report or that Mr Walker instructed him not to do so. Mr Duncan's incident report was as follows:

> *I was performing my duties as Immediate Action Team 3 (IAT3) at about 9.30 am. The IAT was called to search cell 208 in 5.1 Unit. Cell 208 is occupied by* [inmate A] *and* [inmate B]. *I entered the cell behind SCO IAT Mr Walker and IAT2 Officer Graf. Once inside cell 208 I assisted Mr Graf to apprehend* [inmate B] *who was on the top bunk. Mr Graf and I then removed [inmate B] from the cell.* [Inmate B] *was directed by Mr Graf to kneel on the ground outside cell 208. I then entered cell 208 and observed Mr Walker placing* [inmate A] *in handcuffs.* [Inmate A] *was then moved to cell 203. I submit this report for your information.*

Mr Duncan said that, while he could not remember any specific discussion about what would go into his report, "of course there would have been". He agreed that he was part of a cover-up but stated:

> *…people at my rank don't come up with the idea to come up with a cover story … I'm not the one pulling those strings. I don't recall, I would've been told what to write in a report, I don't recall who told me what to write but there's a reason my report would've reflected what it reflected.*

He later said that it was possible it was someone other than Mr Walker, but he did not think so.

Mr Duncan told the Commission that he did not ordinarily leave out information or put in false information in reports but he did not suffer from an ethical dilemma in this instance because of his friendship with Mr Walker. When asked why he was comfortable in covering-up Mr Walker's UOF, he stated, "Because I honour mateship above everything else, above, you know, leaving something out of a report".

The Commission notes Mr Duncan did not give evidence during a compulsory examination. However, on 24 February 2015 he was interviewed by CSNSW. He falsely claimed that his incident report was true and correct.

Mr Walker told the Commission that he discussed with Mr Duncan and Mr Graf what should be included in their reports. It was clear from this discussion that what occurred in cell 208 was to be covered-up. He instructed Mr Graf and Mr Duncan that they had to "clean this up. The inmate's been injured and we need to get a UOF package done". He could not remember the specifics of the conversation but said that he would have told them that he struck the inmate. Mr Walker denied being angry or aggressive towards Mr Graf or threatening him to change his report to exclude Mr Duffy and maintain the fabricated story.

Mr Walker admitted that his report was "all lies". He gave evidence that the suggestion inmate A attempted to throw something down the toilet was a "fabricated lie". He did not see inmate A trip over himself or cell furniture, and fall onto the cell toilet.

Mr Walker also gave evidence in a compulsory examination conducted by the Commission. His evidence was consistent with the account he gave during the public inquiry but inconsistent with the incident report he created on 19 February 2014 and a subsequent interview with CSNSW as part of its internal investigation. Mr Walker's report, addressed to Mr O'Shea, was as follows:

> *Subject: Minor Use of Force* [inmate A]
>
> *Sir*
>
> *During the course of the search operation today at Lithgow cc I attended cell # 208 in 5 unit MPU occupied by* [inmate A] *as information from another inmate during searches in 3 unit had implicated* [inmate A] *as having a large amount of tablets of buprenorphine.*
>
> *As I entered the cell the inmate now known to me as* [inmate A] *jumped up from the lower bunk where he was seated and appeared to throw an item towards the toilet at the rear of the cell as I attempted to retrieve the item* [inmate A] *moved between me and the toilet impeding my path to the toilet* [inmate A] *moved towards the toilet and as he reached to flush the toilet* [inmate A] *tripped on the plastic chair and his torso landed on the rim of the cell toilet and landed on the cell floor.*
>
> [Inmate A] *was placed in restraints the inmate* [sic] *and removed him from the cell and placed him in an empty cell as* [inmate A] *was searched.*
>
> *The inmate was compliant during the move and apologised for his actions.*

Mr Duffy found Mr Walker's conduct gravely concerning. Despite the instruction from Mr Walker not to complete an incident report, Mr Duffy did so. That report is addressed later in this chapter.

Mr McMurtrie acknowledged that the intelligence and alleged source of information contained in his information report were false, as was the evidence he gave to the Commission prior to the public inquiry.

In his compulsory examination by the Commission, Mr McMurtrie maintained that the information contained in his information report was true; that is, that he had received intelligence that there was suboxone in the cell occupied by inmate A and that he had informed the MoS of that information, and that the MoS directed that cell 208 be searched. In his evidence in the compulsory examination, Mr McMurtrie also said that he could not recall if that MoS was Mr Peebles or Mr Taylor. He further maintained that the information in his report, to the effect that he had informed Mr Walker of the direction to search cell 208, was true. This evidence was at odds with the evidence he gave during the public inquiry. During the public inquiry, Mr McMurtrie gave the following evidence:

[Counsel Assisting]: You had a compulsory examination with the Commission. Do you recall that?

[Mr McMurtrie]: Yes.

[Q]: And it was made very clear to you, wasn't it, that you had an obligation to tell the truth and if you didn't you'd be in trouble?

[A]: Yes.

[Q]: And there are a lot of things you've told us today, in particular the fabrication of your information report and your intelligence report, that you obviously didn't disclose in that compulsory examination.

[A]: Yes.

[Q]: Why now?

[A]: I've got to a point where I dug myself a hole that big to get out of and at that point I thought hopefully it would go away, if the other stuff stood up it would just go away and not impact me, would be the honest answer.

[Q]: You're no longer with Correctives.

[A]: No.

[Q]: Has that made it easier?

[A]: It's made it a lot easier.

In his submissions to the Commission, Mr McMurtrie contended that any inconsistent evidence given at the compulsory examination did not meet the requisite standard of proof to justify criminal charges. He also submitted that as Counsel Assisting did not specify the inconsistencies that further weight should be given to this submission.

The Commission is satisfied that the evidence Mr McMurtrie gave in his compulsory examination was false and that he knew it was false when he gave that evidence. Whether or not the admissible evidence is such as to warrant charges is a matter for the Director of Public Prosecutions (DPP). The evidence is sufficient to warrant obtaining the advice of the DPP. The Commission is also satisfied that the inconsistencies between the evidence given by Mr McMurtrie during his compulsory examination and that given by him during the public hearing are clear and that Mr McMurtrie is well aware of them. The two versions of the relevant events addressed above were totally inconsistent.

At 12.26 pm, Mr McMurtrie emailed his information report concerning false intelligence to Mr Peebles. Mr McMurtrie told the Commission that he sent it to Mr Peebles rather than Mr Taylor because Mr Walker had instructed him to do so.

At 12.54 pm, Mr Peebles forwarded the McMurtrie email and attached report to Mr Taylor stating, "Steve, As I'm offline, could you attend to this".

Mr Peebles acknowledged that the information report was inconsistent with his understanding of the reason cell 208 was entered; however, he could not recall reading the attachment to the email. He claimed that if he were aware of any inconsistency between the contents of the attached report and the true reason for entering cell 208 it was "only a very cursory thing and it hadn't really registered to me".

Mr Peebles submitted that the Commission should not make any adverse findings in relation to his knowledge of the contents of the attachment to Mr McMurtrie's email because the evidence did not meet the appropriate standard of proof. The Commission disagrees. Mr Peebles was present when Mr O'Shea became embroiled in a heated exchange with inmate A. He was aware that the IAT was called to "sort it out". He was aware inmate A was sent to hospital. He also issued an instruction to Mr Taylor to "deal with this" (Mr McMurtrie's report) in his email to Mr Taylor. It is inherently unlikely that Mr Peebles did not read Mr McMurtrie's information

report before providing that direction. The Commission is satisfied that he did so. It is also satisfied that, when he read the information report, Mr Peebles recognised that it was not an accurate account of the reason why the IAT had entered cell 208.

At 12.59 pm, Mr Walker emailed his witness report to Mr Peebles and Mr McMurtrie. It included the false intelligence supplied by Mr McMurtrie. It repeated the trip-and-fall explanation for the injuries suffered by inmate A. Mr Walker told the Commission he sent his witness report to both officers to proofread and to have a copy. He said he was instructed to send it to Mr Peebles and not Mr Taylor but did not say by whom.

Mr Duffy's incident report

Upon leaving 5 Unit after the incident of 19 February 2014, Mr Duffy asked Mr Walker when they would complete their reports as required by the UOF policy. According to Mr Duffy, Mr Walker responded that he (Mr Duffy) did not need to complete a report as "he was never there". Mr Duffy was not certain if this meant that the team was not to report or if it was specifically aimed at excluding him. He told the Commission that he responded to Mr Walker with words to the effect, "That isn't going to happen". Mr Duffy confided in Mr Graf that he was not comfortable with the direction to not do a report as he had witnessed Mr Walker punch inmate A in the face.

Mr Walker told the Commission that he was told to get reports from the IAT officers and not put any other reports in. He thought this direction came from either Mr Peebles or Mr McMurtrie. He said that he thought Mr Duffy may have spoken to him about a report but Mr Walker told him it was not required. He said that his memory was not clear on this. He later told the Commission that Mr Duffy was not mentioned in the IAT officers' reports because "…it was generally believed that Mr Duffy would have only wrote the truth and that would not have matched up with the fabrication that we wrote".

The Commission is satisfied that Mr Walker instructed Mr Duffy not to complete a report in relation to UOF on inmate A. It is further satisfied that he did so because he feared that Mr Duffy would truthfully report that he had bashed inmate A.

Despite being told not to complete a report by Mr Walker, Mr Duffy had grave concerns about Mr Walker's conduct and decided to ignore the instruction. Mr Duffy's incident report was as follows:

> *At approximately 10:00 am on 19 February 2014 I was carrying out my duties as Search team 6 when the following incident occurred:*
>
> *I was conducting search duties on lock down search day in 3 wing at Lithgow correctional centre. I was attached to IAT for the purpose of searching. At around 10:30 am there was a call for IAT to attend 5:2 unit over the radio. This call appeared to be a response situation. I immediately responded with IAT. Upon reaching 5 unit it seemed that the call was actually 5:1 unit. I entered 5:1 unit through the day room with IAT. In the office was General Manager Mr John O'Shea and Manager of Security Mr Brad Peebles. Mr O'Shea directed us to cell 208 and asked us to remove inmate MIN* [number inmate A] *from the cell.*
>
> *SCO Terry Walker entered the cell. I followed directly behind him.* [Inmate A] *backed up to the rear of the cell and raised his hands as though to strike officer Walker. Officer Walker retaliated with a strike to the side of* [inmate A's] *head. I then reached low and applied a figure 4 leg lock to* [inmate A's] *leg in an attempt to take him to the ground to apply hand cuffs.* [Inmate A] *continued to struggle.*
>
> *At this point Officer Elliot Duncan entered the cell to assist with restraining the inmate. In the struggle Officer Duncan tripped on the end of the bed and fell to the ground with SCO Walker and myself falling as well. At this point* [inmate A] *had three officers on top of him and could struggle no more.* [Inmate A] *was restrained and handcuffed and moved to a vacant cell opposite cell 208. I then left the cell washed up in 5:1 office and returned to the search in 3 wing.*
>
> *I submit this report for your information.*

During his evidence, it was drawn to Mr Duffy's attention that his report did not mention Mr Taylor, any instruction by Mr Taylor to remove the inmates from cell 208 or the position of Mr Taylor outside the cell. Mr Duffy agreed. In response to questions from Mr Taylor's solicitor, Mr Duffy asked whether he could clarify these matters. He informed the Commission the reason for writing the report was:

> *…purely to advise that the inmate had been struck by Mr Walker. The positioning and where management were at that particular point in time were of no real concern to me, it was more a generalisation that we were there.*

And later:

> *As I said, if I knew I was going to be here in four years' time, this page, sorry, this report would be three or four pages, it wouldn't be two-thirds of a page, sir. It was a generalisation to say these guys were present. I didn't think that it was even relevant at the time that Mr Taylor was there. He'd made the radio call to have us there. I didn't think he was required in the report.*

> *That's the only reason he's not there. But as far as what you're asking and if you're trying to suggest that Mr Taylor wasn't there, he was definitely there on the day, but I did not see the significance of putting him in my report*

The Commission accepts Mr Duffy's explanation. His concern was to report that inmate A had been struck by Mr Walker in circumstances where he had been instructed not to provide an incident report. He was concerned that there was a cover-up, and that was his primary focus.

As a result of his concerns, Mr Duffy decided to have his incident report registered in a register maintained by the deputy's clerk, an administrative role situated outside the governor's office. In 2014, first-class correctional officer Khili Jenkins occupied the position of deputy's clerk.

Ms Jenkins provided a statement to the Commission. She informed the Commission she maintained various registers on her "M" drive. One register was the Officer Report Register. Its purpose was to log officer reports, including the date, a folio number, the report date, officer's name, brief subject, the intended recipient, a return date, if applicable, and an outcome, if applicable. This register was not generally accessible on CSNSW's network.

Ms Jenkins recalled speaking with Mr Duffy on the day on which his incident report was registered. She said:

> *I recall having a conversation with Mr Duffy. My recollection is that he approached me in the Deputy's Clerk's office and said words to the effect 'Hi I need to register this report'. I did not read this report or at any time have this report in my possession and I believe it was either in an envelope or folded up. He said words to the effect of 'You don't want to know what this is about but I need it registered. He may have said, 'I'm taking this to the GM'.*

Ms Jenkins then registered Mr Duffy's incident report. She also recorded that the report was going to the GM. Mr Duffy provided this information to Ms Jenkins.

Mr Duffy informed the Commission he placed the incident report in a sealed envelope in Mr O'Shea's in-tray. The Commission is satisfied he did so.

Mr Duffy was never contacted by Mr O'Shea about his report, nor was he interviewed during the internal CSNSW investigation that was conducted in 2015. CSNSW investigators did not know he had any involvement in the incident of 19 February 2014, let alone that he had prepared an incident report.

Mr O'Shea agreed that he received Mr Duffy's report within a few days of the incident and reviewed it. He told the Commission that, given its contents, he determined that it ought to be forwarded elsewhere. He said he had a "vague recollection of writing something on [this] and sending it to either [the CSNSW Investigations Branch] or to PSB [Professional Standards Branch] or to S&I [the CSNSW Security & Intelligence Division] or to my director or someone and asking them to have a look at it". He said he sent it outside of the LCC because "there was a lot of friction in that centre", and he was not sure if there was something between Mr Duffy and Mr Duncan or Mr Walker.

This was the first occasion on which Mr O'Shea gave this version of events, and it makes little, if any, sense.

Following this evidence, the Commission made enquiries of CSNSW, including the head of the CSNSW Investigations Branch, the director to whom he reported in 2014, and the PSB. No one had any record, nor any recollection, of the receipt of Mr Duffy's incident report from Mr O'Shea.

On 11 March 2015, Mr O'Shea received an email from a junior CSNSW officer indicating that he had something important he wanted to discuss stating, "it's your MoS sniffing about that UOF incident". Mr O'Shea responded, "Which one I got three of the buggers". The response was "[name] has been worded up, and knows about Duffys report".

Mr O'Shea agreed that the email was referring to Mr Duffy's report. He disagreed that the contents of the email indicated that Mr Duffy's incident report was previously secret or unknown, stating that there were always rumours and allegations going on in the jail and that Mr Duffy himself had told a number of people about his report. Mr O'Shea said that the sender of the email "likes to stir things up and people up. It was very difficult to manage with all managers. And he saw, if he saw a split between whatever rank of staff, he would, he was quite witty and would stir problems up". He denied that the email did in fact stir up any problems.

The Commission rejects Mr O'Shea's evidence that he sent Mr Duffy's incident report to anyone. It is satisfied that Mr O'Shea knew that the report was inconsistent with the reports he had reviewed in the UOF package. The report also identified Mr O'Shea as the person who had instructed the IAT to enter the cell. It recorded that inmate A had been assaulted by Mr Walker. The Commission is satisfied that Mr O'Shea simply buried the report.

It is also relevant to note that, two days after the altercation in cell 208, namely, on 21 February 2014, Mr McMurtrie created a third record that contained false and misleading statements. This was his formal intelligence report IR-366. It was a more formal and considered document with wider circulation. The recipients included

Mr Peebles and Mr O'Shea. IR-366 was false or misleading in that it:

- referred to the fabricated intelligence relating to suboxone
- referred to an inmate tripping over a chair and falling onto the toilet
- selectively quoted from inmate A's telephone call with his father (conspicuous by their absence were the references inmate A made to the GM, which Mr McMurtrie accepted was omitting an important detail because of the threat that had been made in the call).

IR-366 is further addressed in chapter 4 of this report, as is the telephone call between inmate A and his father.

Mr Walker prepares a false IRM

Mr Walker told the Commission that, once the incident reports had been prepared, he took them up to Mr Peebles' office. He claimed that Mr Duncan and Mr Graf were with him at the time. In response to a query from Mr Peebles, he advised him he had not yet completed the IRM. He told Mr Peebles that he did not know what to write and Mr Peebles said, "I'll do it".

According to Mr Walker, Mr Peebles asked him for his password and logged onto his computer under Mr Walker's name. He then drafted the summary section of the IRM. Mr Walker did not have a clear recollection of whether the falsity of his incident report or those of Mr Graf and Mr Duncan were discussed. However, he claimed to have a clear recollection that, while typing up the summary section of the IRM, Mr Peebles said, "I think this one's gonna come back and bite us on the ass. We've got to tidy this up".

Mr Graf denied any involvement in the drafting of the IRM or that Mr Peebles had participated in the process. Mr Duncan had no recollection either way.

Mr Peebles told the Commission that he had no recollection of anything "remotely" like the version of events provided by Mr Walker. He claimed never to have used the login details of another officer. He denied typing the IRM summary. He also denied that Mr Walker had given him the impression that the incident reports were false.

The Commission is not satisfied to the requisite standard that Mr Peebles played a role in the creation of the IRM. The Commission is satisfied that it was drafted by Mr Walker.

The IRM summary stated:

> *During an intel based centre search, IAT were detailed by the MOS to search cell 208 in 5.1 unit with directions to specifically look for Buprenorphine. Inmates were spoken to at the cell door prior to entry and appeared compliant and reasonable. As officers entered the cell* [inmate A] *ran without warning towards the back of the cell in the direction of the toilet. During the action the offender tripped over cell furniture and fell heavily onto the toilet itself. IAT officers were unable to intervene in time to stop the offender disposing of an unidentified article in the toilet. The offender was handcuffed and did not resist. The cell was searched thoroughly with only nuisance items being found. Offender offered medical attention by Justice Health at Centre clinic. Reported as a technical use of force on direction of the General Manager.*

By the end of the public inquiry, any suggestion that inmate A's cell was entered on 19 February 2014 as part of a search operation had completely evaporated, so too had the suggestion of intelligence that suboxone was in inmate A's cell. Mr Walker acknowledged that the account contained in the IRM summary was false.

The IRM was inaccurate in a number of additional respects.

It stated there were still photographs taken as part of standard centre procedure; photographs were not taken. The Commission is satisfied there was a deliberate decision not to take still photographs because they would have revealed injuries to inmate A consistent with an assault. The Commission does not know the identity of the correctional officer who made this decision. However, it is satisfied that, when drafting the IRM, Mr Walker was aware no photographs had been taken.

A video of the search undertaken on 20 February 2014 (see chapter 4) showed some of the injuries suffered by inmate A on 19 February 2014. This search video post-dated the preparation of the UOF package. No one reviewing the package (for example, officers of the PSB) would have had the benefit of the 20 February 2014 video.

The IRM also stated that the incident was not recorded on a handheld video camera because there was "no force anticipated".

The IAT was conducting a search operation in 3 Unit. It can be inferred that, when called to attend 5.1 Unit, one of the IAT members had possession of the video camera but chose not to use it. The Commission is satisfied that the absence of any handheld video footage was deliberate.

While there was no CCTV footage of what occurred inside the cell, there was a CCTV camera in operation that covered the day room. There are a number of

policies dealing with video evidence, including CSNSW's OPM s 13.9 "Recording and Managing Video Evidence". Cl 13.9.6 provided:

> *When an incident is captured on CCTV recording equipment, the recording must be copied to non-rewritable DVD, registered on TRIM, reviewed and stored as stipulated in this policy.*

That policy also contained various audit procedures to protect the integrity of the collection and storage of videorecordings, both CCTV and handheld video. None of those integrity measures, if taken, prevented the disappearance of the CCTV footage of the day room from 19 February 2014.

Mr Taylor gave evidence he reviewed the CCTV footage with Mr McMurtrie. He also said that the UOF package was provided to Mr O'Shea with the disc containing the CCTV footage. His usual practice was to put the documents and the disc in a plastic sleeve. He claimed to have done so on this occasion. He took the material "upstairs" for Mr O'Shea's review.

Mr McMurtrie gave evidence that he never downloaded or viewed the CCTV footage.

The CCTV footage has never been found. It clearly existed and there is evidence it was part of the UOF package. The Commission is satisfied that he CCTV footage was deliberately destroyed as part of the cover-up of the events of 19 February 2014. The Commission has been unable to identify when, and by whom, the CCTV footage was destroyed.

The UOF package is reviewed and approved

A UOF package must include all witness reports. Mr Peebles' evidence was that this must include witness reports from all officers who put their hands on an inmate and those who saw it.

The Commissioner's Instruction No 10 of 2011 was issued for the information of all staff in relation to reviewing UOF. It provided:

> *General Managers must ensure that the Reviewing Officer* [in this case, acting MoS, Mr Taylor] *reviews all reports and available video evidence relating to a use of force, ensuring that:*
>
> - *all involved staff submitted incident reports (Note: Is there a report from all people identified in the IRM Involved Parties);*
> - *all identified witnesses submitted reports/ statements;*
> - *an appropriate written explanation is provided in the event that the incident wasn't captured on video.*

It should be noted that the GM's obligation, imposed by the 2011 instruction and in force in 2014, appears to have been watered down by COPP Part 13.7 on UOF that came into operation in December 2017. Clause 10.7 of that policy provides:

> *The governor must make a determination in consideration of the reviewing officer's comments and recommendations. The governor may decide to review the incident again before making a determination.*

This suggests that, in making a determination, the GM is not obliged to go beyond the cursory comments and recommendations made by a reviewing officer (intended to be recorded in a box on the MoS review form), which provides but a high-level commentary.

The change to the policy is undesirable. It is difficult to understand why a GM making a determination in respect of a UOF should not review the documentation.

On 20 February 2014, Mr Taylor signed-off on the UOF package in his capacity as acting MoS. Mr McMurtrie was also required to do so in his capacity as intelligence manager. The package contained:

- Mr McMurtrie's false intelligence report concerning the possible presence of suboxone in cell 208
- the Inmate Incident/Injury Questionnaire
- Justice Health clinical notes regarding the injuries to inmate A
- IRM of Mr Turton, concerning the transfer of inmate A to Lithgow Hospital
- IRM of Mr Walker, containing the false account of the reason for entering cell 208 and how inmate A was injured on 19 February 2014
- Mr Walker's incident report re "Minor Use of Force [inmate A]", dated 19 February 2014
- Mr Duncan's false incident report, dated 19 February 2014
- Mr Graf's incident report, dated 19 February 2014
- the incident/injury form completed by Mr Turton and signed-off by inmate A.

Under the heading "MoS Comments / Recommendations", Mr Taylor stated:

> *Reviewed UOF 20/02/2014 by A/MOS and INTEL Manager. All staff reports consistent with IRM. UOF within policy and appropriate to level of resistance of*

inmate. Spontaneous reaction resolved before camera could be turned on. I recommend NFA as all reports consistent with the UOF.

Mr Taylor was asked to explain how his comments were consistent with what he had witnessed the previous day at cell 208. He was unable to do so.

Mr Taylor agreed that the reason reported for entering the cell – that is, to search for suboxone – did not accord with his understanding of why the IAT entered the cell on that day. He denied that he was the MoS listed in Mr McMurtrie's false information report. That report stated that the MoS ordered a search of cell 208. Mr Peebles also denied being consulted about the intelligence and ordering a search.

There were other anomalies in the UOF package that should have raised alarm bells and resulted in Mr Taylor making further investigations or referring the package to PSB. Some of these are listed as follows.

- The IRM referred to the existence of still photographs. They were not part of the UOF package provided to Mr Taylor and he did not ask for them.
- There was no police report form, COPS event number, or indemnity from inmate A.
- There was no after action review conducted. Mr Taylor accepted that the absence of an after-action review was a breach of this policy requirement.
- The injuries sustained were inconsistent with a slip and fall, especially given the injuries were sustained to both sides of the body, in different areas of the body, and were serious enough to require hospitalisation.

Mr Taylor told the Commission that, in signing-off on the UOF package, he relied on the accuracy of the IRM and incident reports attached. It was not his usual practice to speak to any individuals involved. The Commission does not accept this evidence. He knew the incident reports and IRM were inaccurate. He could not have reasonably relied on the accuracy of the incident reports.

When asked whether he genuinely believed that inmate A's injuries were caused by a "trip and fall" as recorded in the official documentation, Mr Taylor claimed that, given the size of the cells, it was highly likely that could have occurred. He conceded that he knew at the time he reviewed the UOF package that the reason claimed for entering the cell was wrong. However, he also claimed he did not recommend further action because he had no proof. The following evidence is significant:

[Counsel Assisting]: So is it your evidence that you genuinely believed that tripping over cell furniture and falling heavily onto the toilet was how the inmate sustained his injuries?

[Mr Taylor]: Yeah. If you've been in the cell and seen how much room is in there, it's highly likely.

[Q]: But you accept when you reviewed this you knew that the reason for entering the cell given here is incorrect.

[A]: Correct.

[Q]: If you knew it was incorrect from your own personal knowledge, why did you recommend no further action be taken?

[A]: Because they had two senior managers there.

[Q]: So there were question marks raised in your mind when you reviewed?

[A]: Yeah. But I had no, what do you call it, proof, substantiation, other than they said the boss got abused, that's all I knew.

[Q]: No, I understand that, but you obviously knew that this wasn't the full truth when you reviewed it.

[A]: Yes. But I didn't know everything, so I've got to make, I suppose, a conscious decision of what I got supplied or what I received so that's what I did.

Part of the purpose of reviewing a UOF is to prevent the non-reporting, or misleading reporting, of excessive UOFs by correctional officers. In making a conscious decision to recommend no further action, notwithstanding his awareness that he was not provided with the "full truth", Mr Taylor exercised his public official functions dishonestly and partially. His conduct removed the opportunity for an immediate investigation into what had occurred on 19 February 2014.

In his submissions to the Commission, Mr Taylor urged that no adverse comment should be made against him. He claimed the evidence was "inconclusive, uncertain and accordingly insufficient…" He submitted as follows.

- He was entitled to accept the reports within the UOF package at face value, as they were consistent with each other. The Commission rejects this submission. Mr Taylor confirmed in his evidence that the incident reports were inconsistent with his understanding of the reason for the IAT's entry into cell 208. That they were all inaccurate in the same respects suggested collusion.
- Even if he was aware that the full truth had not had been disclosed in those reports, "it was nevertheless a situation where [he] could [have] appropriately recommended no further action because … he had received no other information upon which to come to a different decision". The Commission rejects this submission. Mr Taylor knew why the IAT had been called in. It was in response to the verbal abuse of Mr O'Shea.
- The incident reports were not inconsistent with what he had observed, as he did not witness any assault on the inmate. The Commission rejects this evidence. When the IAT entered cell 208, he was present with Mr O'Shea at the cell door. He observed what followed, including Mr Walker placing his hand against inmate A's throat.
- Entry of the IAT into cell 208, after an inmate had abused Mr O'Shea, was confirmed to Mr Taylor by both Mr O'Shea and Mr Peebles. The Commission does not accept that this is exculpatory of Mr Taylor. He knew the reason why the IAT entered cell 208. He was present. That this might have been confirmed, subsequently, only served to highlight that the incident reports and IRM were false.

It should also be noted that Mr Taylor approved the UOF package in circumstances where neither he nor Mr Peebles and Mr O'Shea had provided incident reports.

The thrust of Mr Taylor's submissions were as follows.

- Although he had said in evidence that he saw Mr Walker's hand around the inmate's throat, it might have been more precise to say that Mr Walker was restraining the inmate with his hand on the upper part of his chest at the bottom of his throat, which is a "normal restraining hold". He had not observed an application of force. The Commission rejects this gloss on Mr Taylor's evidence. The Commission is satisfied that Mr Taylor witnessed a UOF and was required to submit an incident report.
- The UOF package was not incomplete, in that he did not witness "the incident", and therefore did not need to provide a report. The Commission rejects this submission. The matters that Mr Taylor suggested he had seen and heard were enough, without more, to require an incident report.
- As GM, Mr O'Shea did not provide an incident report, and Mr Taylor was not required to obtain one, because Mr O'Shea was the "person who oversees the package". The Commission rejects this submission. Mr O'Shea was a witness to the application of physical force to inmate A. He was required to provide an incident report and Mr Taylor could not legitimately approve the UOF package without one.
- Although in hindsight it might be said that he could have insisted on an incident report from Mr Peebles, Mr Peebles had reviewed Mr McMurtrie's report and therefore it was open to him "to conclude that he [Mr Peebles] was also overseeing the package with Mr O'Shea". The Commission rejects this submission. Mr Taylor did not advance it in evidence. In any event, whether or not Mr Peebles had reviewed Mr McMurtrie's report before emailing it to Mr Taylor does not excuse Mr Taylor's failure to obtain a statement from Mr Peebles.

The Commission also notes that, on 5 March 2015, Mr Taylor provided a statement in connection with the CSNSW investigation. In that statement, he confirmed he had reviewed the incident reports of Mr Graf and Mr Duncan and the incident report and IRM prepared by Mr Walker. In relation to the telephone call made by inmate A to his father, in which he alleged the squad had flogged him, Mr Taylor claimed:

> *The* [inmate A] *does mention in the telephone call that the Governor come up to the door and spoke with inmate and the next thing that happened was he got flogged by the squad. I have no knowledge of this and at no time on that day did I speak with* [inmate A].

In his submissions to the Commission, Mr Taylor contended that he did not mislead CSNSW investigators. The evidence supported a finding that, although he was aware that both Mr O'Shea and Mr Peebles attended cell 208, he "most definitely did not observe any 'flogging'".

The Commission is satisfied that Mr Taylor's statement made to the CSNSW investigators was false and that Mr Taylor knew it was false when he made it. He was aware that Mr O'Shea had come to the door of cell 208 and had spoken to the inmates within that cell. He was present at the cell door with Mr O'Shea. He also knew that inmate A had been physically attacked. Mr Taylor was standing next to Mr O'Shea at the cell door when Mr Walker made his entry. The Commission is satisfied

that both Mr Taylor and Mr O'Shea observed the bashing of inmate A as it occurred.

The Commission is further satisfied that Mr Taylor was part of the cover-up as evidenced by the matters referred to above.

Mr McMurtrie told the Commission that he did not read the UOF package but "just signed it". He denied ever downloading or viewing the CCTV footage. The Commission is satisfied that whether or not Mr McMurtrie read the UOF package he knew that it must have contained false information.

On 20 February 2014, Mr O'Shea gave his sign-off on the UOF package. He approved Mr Taylor's comments and recommendations, noting "Agree A/MOS".

Mr O'Shea told the Commission, "I know I didn't read the package. I had a look at Mr, the MOS's recommendations, 'No further action required'. I ticked it so it was all no further action, stamped it, signed it, put it in the tray".

Mr O'Shea said that, when he was busy, he did not always review the documents contained in the UOF package and would simply just sign-off on the recommendation by the MoS. He told the Commission he had a positive recollection of not reading this particular matter.

The public inquiry was the first occasion on which Mr O'Shea suggested he did not read the UOF package. This evidence was contrary to what Mr O'Shea had earlier told Commission officers in an interview in January 2018. During that interview, he said that he:

- had asked Mr Taylor to "get me the [UOF] package"
- agreed that the general process was to look at the material provided in the UOF package
- could not remember reading the documents in the UOF package, but "was sure" he would have read them
- agreed his role was to undertake an independent review of what took place and this meant having to "review it all"
- could not remember Mr Walker's report but that he "would have looked at it yes"
- would have been interested in relation to this particular UOF package because of Mr Walker's involvement and his knowledge of Mr Walker's mental health at that time
- could not explain why the reason for entering the cell was said to be intelligence concerning the possible presence of suboxone (he claimed it may have been a cut-and-paste error from an old IRM).

On either version of the evidence given by Mr O'Shea, he must have known that it was not appropriate for him to sign-off on the UOF package, given his involvement the previous day, and if he read the reports he must have known that they were false.

In his submissions to the Commission, Mr O'Shea sought to rely on the evidence of Mr Peebles that he (Mr O'Shea) "wasn't the sharpest tool in the shed, you know, with documentation and things like that". Mr O'Shea submitted that it was highly likely "he rubber stamped Taylor's recommendations without reading the UOF package, given his ineptitude with paperwork".

The Commission is satisfied that Mr O'Shea reviewed the documents in the UOF package submitted by acting MoS, Mr Taylor, and knew they did not accurately record what had occurred on 19 February 2014 and, in particular, his own involvement in the bashing of inmate A.

Mr McMurtrie prepares a false intelligence report

CSNSW has dedicated intelligence officers who gather information concerning inmates to ensure the safety of inmates and officers and compliance with the law. Intelligence reports are circulated among senior officers within the relevant custodial facility and to the S&I of CSNSW for collation and review. Intelligence reports are kept on a database and can be accessed by authorised correctional officers.

On 21 February 2014, Mr McMurtrie drafted intelligence report number IR-366, which falsely recorded:

> *On Wednesday 19th February 2014 the local Immediate Action Team (IAT) and State Operations Group (SOG) western conducted a gaol contraband search on specified targets. During the searches an unknown human source (HS) stated that there was a quantity of Suboxone in in cell# 208 unit 5.1.1 occupied by MIN* [number inmate A]. *The IAT attended the cell and a subsequent search resulted in* [inmate A] *jumping up from the lower bunk where he was seated and appeared to throw an item towards the toilet at the rear of the cell. As IAT staff attempted to retrieve the item* [inmate A] *moved between them and the toilet impeding their path to the toilet* [inmate A] *moved towards the toilet and as he reached to flush the toilet* [inmate A] *tripped on the plastic chair and his torso landed on the rim of the cell toilet and landed on the cell floor. (IRM 92719)*

By now, the information about the previously unknown inmate A on the intelligence databases of CSNSW falsely included that a reliable source had indicated he had drugs in his cell and that he disposed of something in the toilet

when the IAT tried to enter. Following the events detailed in this chapter, further false entries were created on CSNSW databases concerning inmate A.

On 7 March 2014, in what appears to be a routine follow-up, an officer from S&I emailed Mr McMurtrie seeking further details about the source of the information who had been referred to as "previously reliable" in his initial information report. Mr McMurtrie responded, "The info was third hand via one of the SOG boys. We reacted because there was enough time with the search staff we had at the centre. It was not expected to be valid info".

Mr McMurtrie informed the Commission he could not recall receiving the email but recalled being concerned that S&I were enquiring into the source of information concerning inmate A. He knew the source did not exist at the time he responded to the S&I officer and agreed that he attempted to downplay the significance of the information, by suggesting it was "not expected to be valid info".

Chapter 4: 20 February 2014

This chapter examines the allegation that, on 20 February 2014, CSNSW officers dishonestly exercised their official functions by falsely representing that 0.2 grams of contraband was recovered from inmate A's belongings during the search of cell 208.

Inmate A telephones his father

On 20 February 2014, at around 10.45 am, inmate A telephoned his father. The Offender Telephone System (OTS) records all telephone calls made by inmates and allows CSNSW officers to listen to those calls. The contents of this call are significant for two reasons. First, it led to the events covered later in this chapter. Secondly, inmate A told his father about the assault the previous day and Mr O'Shea's involvement in it.

The relevant portions of this telephone call were:

> *Yeah I fuckin got – got fuckin "og flayed" by the squad. And they fuckin put me in this cage and I wanted to ring ya and they – it was a full day lock-in. They said oh you're not allowed to fuckin make a call, the only one making a call on the thingo.*
>
> …
>
> *No fuck (UNINTELLIGIBLE) me celly's buzzes up we've been–he's going I've been in here for fuckin twenty days we – we've been nice, we haven't done nothing, everyone's carrying on we can – we can go on with it too.*
>
> …
>
> *And I've said don't say that and I was half asleep. He said it to the Governor. The Governor's come up to the fuckin door you were talking to me cunt* [inmate A]. *I go it wasn't me, fuck boom the squad comes in and flog the fuck out of me. Fuckin cunt.*
>
> …
>
> *The – the squad flogged the fuck out of me. Black eye, fuckin big busted lip.*
>
> …
>
> *Yeah. I'm alright, like I went to hospital fuckin thought I had a fractured rib, but it was alright and they – they went into another room and said what do you (UNINTELLIGIBLE) another two pippas he said oh what – what happened, do you want anything to be done I said nah – nah – nah.*
>
> …
>
> *Didn't even know he was gonna hit me, he just comes in fuckin stop resisting I go what I'm not doing nothing bang king hit boom. Big cunts like a hundred and twenty kilo. I'm alright…*

Anyone who listened to that call would have known that inmate A had complained of being bashed by "the squad" (a commonly used nickname for the IAT) and that the GM was alleged to have been involved. However, it was the next part of the call that CSNSW officers focused on: "If they come in again I don't give a fuck I'm gonna go on with it, I have a blade ready and all [sic] fuck 'em."

Inmate A's father responded that he might wait outside the gates for officers, presumably to assault them.

The Commission accepts that any threat to CSNSW correctional officers must be taken seriously and that a search for a weapon was appropriate given the threat.

The allegation that inmate A had been bashed and the GM had been involved should also have been taken seriously. That is particularly so in circumstances where orders requiring the inmate to be taken to hospital had been signed and executed the previous day. Inmate A clearly had physical injuries that were consistent with the complaint to his father.

Correctional officers listen to the call

The Commission was informed that, at the LCC in 2014, the practice of listening to inmate telephone calls was not an assigned task or role but rather something that officers would do if they had the time or had information about a specific inmate.

The OTS audit log for the call between inmate A and his father indicates that seven CSNSW officers listened to it.

The first officer who listened to the call was Mick Watson, who did so at 11.41 am on 20 February 2014. Ms Lohse, Mr O'Shea and Mr McMurtrie also listened to it later on that day. Mr McMurtrie again accessed the call on 21 February 2014 and on 20 March 2014. The other officers who listened to it are not relevant to the Commission's investigation and had legitimate reasons for doing so.

Mr McMurtrie told the Commission it was after listening to this call he first became aware that his false reports had been used to cover-up an excessive UOF. He did not report this to a senior officer. The Commission is satisfied that Mr McMurtrie knew that inmate A had been assaulted. That was the very reason he sought to explain away the IAT's entry into cell 208 in his information report and later in his intelligence report.

The search operation of 20 February 2014

As a result of inmate A's telephone call to his father, a strip-search of inmates A and B and a search of cell 208 were organised to locate any weapons.

The following officers participated in the search operation: Mr Kennedy, Mr McMurtrie, Mick Watson, CSNSW officer Alan Murdoch, and CSNSW officer Troy Dippel.

The search commenced at approximately 1.30 pm on 20 February 2014.

The participants in the search were introduced on the videorecording of the search operation, save for the notable exception of Mr McMurtrie. No witness was able to provide an adequate explanation of why Mr McMurtrie was not introduced on the search video. Mr Kennedy described it as an "oversight".

Mr McMurtrie suggested that, after fabricating his information report on 19 February 2014, he deliberately distanced himself from the search. That evidence is inconsistent with his participation in the search operation. It is also inconsistent with the fact that Mr McMurtrie continued to listen to inmate A's telephone calls long after inmate A left the LCC.

On 20 February 2014, Mr Turton was rostered on as sector manager for 5 Unit. Mr Turton gave evidence that, during the morning, he went to visit inmate A to check on his welfare. Mr McMurtrie and Mr Kennedy met him in the hallway. Mr Turton was asked where he was going. When he told them, Mr Kennedy said, "No, you're not allowed … Because you were involved in the previous day and it would be inappropriate to interact with him again". He was directed to go back upstairs.

Mr Kennedy's logic is not readily apparent. Mr Turton's involvement had been limited to filling out the Inmate Assault/Injury Questionnaire and suggesting he complete the IRM. In contrast, Mick Watson was required to be involved in the search operation. He had participated in the previous day's incident. He had been present outside cell 208 with his German shepherd when the IAT had made its entry.

Mr Turton was concerned. He conveyed his concerns to Mr Taylor, who was acting MoS on that day. According to Mr Turton, Mr Taylor responded, "Don't worry, Kenno's [a reference to Mr Kennedy] there to lead a search operation, he's running it, don't worry about it, just stay upstairs". At no stage was Mr Turton informed that inmate A might have a weapon. Mr Taylor agreed that Mr Turton had called him with his concerns and he told him not to worry about it, as Mr Kennedy was in charge.

At the very least, these events were unusual. Mr Turton was the area manager for 5 Unit but was not briefed in relation to the search operation. Mr Turton's evidence was that he felt he was being sidelined, particularly as he had not been involved in the UOF itself but only in the follow-up paperwork. He felt he was being prevented from speaking to inmate A.

Mr Kennedy acknowledged that it was standard procedure to brief an area manager in relation to a search operation in their unit. Mr Kennedy recalled bumping into Mr Turton in the hallway on his way to cell 208. However, he denied telling Mr Turton to go upstairs. His evidence was that he said to Mr Turton, "Oh, hold off going to that cell, we're just about to search it". He claimed to have no knowledge of Mr Turton being sidelined from the search but thought it may have been "just due to personal safety of the staff that were going to that area".

Mr McMurtrie told the Commission that Mr Taylor organised the search together with Mr Kennedy and the MoS. He had no knowledge of Mr Turton being told he could not be involved. He said that Mick Watson was involved because he was the person who alerted him to the threat in the telephone call. He could not recall who asked Mick Watson to be involved in the search but said that it was his suggestion that those involved in the alleged UOF the day before not be involved in the search.

Mr McMurtrie agreed that Mr Turton was the sector manager that day but said that the decision to brief the sector manager was one made by the MoS. He could not recall any discussion between Mr Turton and Mr Kennedy, although he conceded it was possible that Mr Kennedy told Mr Turton he could not be involved in the search. He had no knowledge of Mr Turton being "sidelined".

Mr Turton was not the only person to give evidence about being sidelined in relation to the search operation.

Both Mr Duncan and Mr Graf gave evidence that they were told they could not be part of the search, as they had been involved in the incident the day before. Mr Taylor also gave evidence of a meeting with Mr O'Shea and Mr Peebles at which he was informed about a search operation to be conducted by Mr Kennedy and Mr McMurtrie. Mr Peebles then said, "You are not to be involved in this search". Mr Taylor believed he was "definitely sidelined".

Mr O'Shea told the Commission that he listened to the telephone call made by inmate A to his father and knew that a search for a weapon was to subsequently take place. He said he presumed that Mr McMurtrie or Mr Kennedy said that they would do the search of the cell. He could not recall if he was told in person or how he was informed a search was to take place.

Mr Peebles was not asked about the incident on 20 February 2014, as he was again off-line and Mr Taylor was acting MoS. There is no evidence that Mr Peebles was involved in the search operation.

It is possible that a decision was made to limit the number of correctional officers involved in the search of inmate A and cell 208 to minimise the number of officers who would observe what was about to take place. However, the evidence is ambiguous and the Commission makes no finding.

The strip-search of inmate A and inmate B

The strip-search of inmate A provides further insight into the cover-up of the use of excessive force the previous day.

The videorecording of the search shows inmate A being led from cell 208 for the purposes of a strip-search by Mick Watson, Mr Dippel and Mr Murdoch (who was operating the camera). Inmate A was clearly injured. He had bruising to his eye and lip and appeared to be tender around the rib area.

During the search, inmate A told Mick Watson that he was in pain and required some assistance to take off his socks. Inmate A was asked if he had anything in his pockets and he replied that he might have had an asthma puffer.

Quite apart from his physical appearance, there were two comments made by inmate A to Mick Watson that ought to have raised concerns in relation to what had occurred in cell 208 the previous day. This is particularly so, given Mick Watson had been standing outside the cell when inmate A was being bashed. He had also listened to the telephone call between inmate A and his father, in which inmate A complained of being flogged by the squad. The first relevant comment was inmate A's response to Mick Watson, asking about the weapon. Inmate A responded, "I wouldn't threaten officers after what's happened to me".

Mick Watson did not make any enquiries of inmate A in relation to his injuries. He did not query inmate A's response. In his evidence before the Commission, he proffered a remarkable explanation. He made no enquiries because, "It's none of my business. I'm there to search for weapons". He said that, as the injuries to inmate A occurred the previous day, inmate A would have received the medical attention he needed. His task was to search for a weapon; nothing more.

The second comment of relevance was one made by inmate A to Mr McMurtrie in the presence of Mick Watson. As Mr McMurtrie approached inmate A to tell him his visiting privileges had been revoked, inmate A said, "Please sir, enough, officer". Mick Watson denied hearing this comment but said that, in any event, it was a comment made to Mr McMurtrie. When it was put to him that it was a cry for help, he told the Commission, "That's to Mr McMurtrie, not to me".

Inmate A told the Commission that he made both comments because he was trying to avoid being further physically attacked and hoped the officers would give him at least a week to heal before hitting him again. Inmate A said that he feared the search operation was going to lead to another assault and he made those comments in front of Mick Watson because he was the first officer to speak to him and so he assumed he was in charge of the search operation.

In his submissions to the Commission, Mick Watson contended that, while he had operational control of the strip-search, he was subordinate to Mr McMurtrie and Mr Kennedy, both of whom were present. He further submitted that, although he listened to the telephone call between inmate A and his father, it was not incumbent upon him to accept that it was true, pointing out that inmate A's injuries could have been inflicted by another inmate. He claimed that he was entitled to assume that inmate A would receive treatment from Justice Health and that, as senior officers were present, they would deal

with inmate A's comments. To hold him to account for his failure to act would be grossly unfair, as it was part of a broader cultural problem within CSNSW.

That Mick Watson was junior to Mr McMurtrie and Mr Kennedy is no excuse for ignoring what he heard and observed. He was in operational control of the strip-search. His explanation says much about the culture that exists among correctional officers in respect of reporting the possible misconduct of others. His evidence, that inmate A may have been assaulted by another inmate, is nonsense. Inmate A had been in segregation. There has never been any suggestion that inmate A was assaulted by inmate B. In any event, Mick Watson made no enquiries.

The Commission is satisfied that many correctional officers are fearful of reporting misconduct up-the-line because of the risk of reprisals and ostracism. This culture is addressed in chapter 6. However, the culture existing between correctional officers is no more than an explanation. It is not a justification for ignoring professional obligations.

Mr McMurtrie agreed that inmate A had said, "Please sir, enough, officer", but claimed he thought it was for the benefit of the video tape rather than an actual plea for help, as nothing was being done to him at the time. Mr McMurtrie told the Commission that, despite this being the first time he became aware that inmate A had been injured, he did not think that his complaints were about what had occurred on 19 February 2014 but what was occurring on 20 February 2014. He claimed this was why he did not act on what he had heard; that nothing untoward was happening to inmate A at the time.

The Commission is satisfied that Mr McMurtrie did not report what he had seen or heard because he had been an active participant in the cover-up of the use of excessive force on inmate A the previous day.

Following the strip-search of inmate A, inmate B was also searched.

The search of cell 208

After the completion of the strip-search of inmate A, Mick Watson, Mr Murdoch and Mr Dippel took him to a holding cell in 5 Unit. They then returned to cell 208 to conduct a search of the cell. Because inmate A had been taken to a holding cell, he was not able to observe the search of his property or the recovery of the contraband referred to below. This was in breach of OPM 12.4.16, which required inmates to be present during targeted searches unless there were exceptional circumstances. There were no exceptional circumstances. The strip-search of inmate A had established that he was not in personal possession of a weapon. Further, he had been restrained. There would not have been any risk to the officers in attendance if inmate A had been permitted to observe the search.

Just before they reached the cell, Mick Watson instructed Mr Murdoch to cease videorecording. Mr Murdoch gave evidence that he remembered:

> *…walking back into the day room, day unit area and all his items were on the floor. I just thought that was a bit bizarre because all his items were out on the floor and there was already officers going through the cell…*

Mr Murdoch informed the Commission, "it wasn't something that we'd usually done". He recalled seeing Mr Kennedy and Mr McMurtrie at the cells but could not remember who else was there.

Mr Dippel had no clear recollection of entering the day room but recalled seeing plastic bags, mail and other items strewn on the floor of the day room.

Mick Watson, Mr Dippel and Mr Murdoch were all wearing stab vests and were tasked with searching the cell for a weapon, due to the threat inmate A made of having a blade.

Mr Murdoch did not remove anything from the cell and did not conduct any search inside the cell. Despite being tasked to search for a weapon, Mr Murdoch's attention was drawn by another officer to a plastic bag on the day room floor. He recalled being specifically requested to look in the bag and inside an asthma puffer within the bag. Mr Murdoch could not recall who requested him to do so, although it was possibly Mr Kennedy, Mr McMurtrie or Mick Watson. Both Mr McMurtrie and Mr Kennedy denied that they had directed Mr Murdoch's attention to the puffer. However, both accepted that it would be unusual for someone to do so in the context of searching for a weapon. Mick Watson said that, upon his return, he took inmate B to another area to be strip-searched. He could not recall giving or hearing any directions about searching specific items.

Inmate A told the Commission that, as he used his inhaler when he suffered from an asthma attack, he usually kept it in his pocket. As noted earlier, when questioned by Mick Watson if he had anything in his pockets during the strip-search, inmate A can be heard on the video footage making reference to his asthma puffer.

Mr Murdoch picked up the puffer and found a broken tablet and powder that was probably part of the tablet inside the puffer. He informed Mr Dippel. Since Mr Murdoch was new to the job and, so it was claimed, did not understand the procedure for dealing with a drug find, Mr Dippel took over. At that point, the videorecorder was again turned on. The videorecording clearly falsely represents that it was Mr Dippel, rather than Mr Murdoch, who had discovered the tablet.

Mr Dippel is seen to open up the puffer and highlights the tablet and powder found in it. Mr McMurtrie is heard to say, "Verified by the clinic [inmate A] is on a puffer and issued with Ventolin spray".

Mr McMurtrie told the Commission that he was notified there had been a find and then attended the cell area. He could not recall contacting the clinic to determine whether inmate A had been prescribed a puffer. He also could not recall if he checked if inmate B, who also occupied the cell, had been prescribed an asthma puffer. Had Mr McMurtrie checked with the clinic, he would have been informed that inmate B had also been issued a puffer.

Although the Commission does not make any finding that Mr Murdoch or Mr Dippel engaged in any wilful wrongdoing by having Mr Dippel represent during the videorecording that he had found the tablet, it should not have occurred. Basic rules concerning keeping an accurate record of continuity were simply ignored. The integrity of the search was compromised, as was any future prosecution or disciplinary charge.

Mr Dippel was directed to take the tablet to inmate A and question him about it. As Mr Dippel approached the cell in which inmate A was detained, he was told off-camera that "they are in there talking to him now". Two correctional officers then exit the cell. They are only partly visible on the video footage. The Commission has been unable to conclusively establish their identity, although it was likely to be Mr McMurtrie and Mr Kennedy.

Mr McMurtrie and Mr Kennedy interview inmate A off-camera

Mr Kennedy and Mr McMurtrie acknowledged they spoke with inmate A off-camera.

Mr Kennedy told the Commission it was so that Mr McMurtrie could talk to inmate A about the termination of his visiting rights and the UOF the day before. However, Mr McMurtrie is heard on the videorecording during the strip-search speaking to inmate A about his visitor privileges.

Mr McMurtrie agreed that he and Mr Kennedy spoke to inmate A about his visits, but he thought this had occurred in cell 208.

The reason for the search operation on 20 February 2014 was security-based; namely, the suggestion by inmate A that he had a weapon in his cell. However, the Commission is satisfied that the conversation between inmate A, Mr McMurtrie, and Mr Kennedy concerned the UOF on inmate A the previous day.

The conversation took place in the officers' station in 5 Unit and not in a cell. It was conducted off-camera, notwithstanding other aspects of the search operation were recorded on camera. No notes were taken. The safety of Mr McMurtrie and Mr Kennedy during the interview was apparently not a concern.

This interview must be considered in its proper context.

Mr McMurtrie had listened to the telephone call between inmate A and his father. He was aware of inmate A's complaint of being "flogged by the squad". He was in a position to observe inmate A's injuries first-hand. He had also fabricated his information report and falsified part of Mr Walker's witness report the previous day. Mr McMurtrie acknowledged that, during the conversation, inmate A was effectively saying correctional officers had assaulted him.

Mr McMurtrie claimed that inmate A indicated he did not want the police to take action. If true, this must have been an enormous relief to Mr McMurtrie. After all, he was one of the architects of the cover-up of the assault.

Mr Kennedy agreed that, during the conversation, inmate A suggested he was contemplating making a complaint to police. Mr Kennedy said that, "we talked him through that and let him know it's his call … I did say that can be quite problematic for him".

During an interview with Commission officers, Mr Kennedy recounted his version of the conversation as follows:

> *Me and Mr McMurtrie talked to one of the inmates in relation to his visits, and Mr McMurtrie on the day said that his visits were going to be terminated for some reason. We talked to him about the use of force the previous day, I think, and yeah, he was talking about police charges and we talked him through that, and let him know that it's his call, and wants to pursue that mind* [sic]. *Like a lot of inmates over the years that I've spoken to and they, you know, when I talk about, or pursue police charges providing them with information. I did say they can be quite problematic for him, being honest, but ultimately it was his decision.*

And later:

> *Well over 28 years in the department, it has been problematic for inmates to make police charges against prison officers. It's – it has you know a bit of a detrimental effect on the way that they're treated and seen within a correctional environment, and I wanted to make him well aware of the actions and course of actions that he had in relation to, you know, what was going to happen.*

Mr Kennedy was aware that there had been a UOF the previous day because Mr McMurtrie had informed him. He knew first-hand that inmate A was injured. However,

he did not believe he had discouraged inmate A from going to the police. He accepted in hindsight, however, that what he said could be taken that way. The possibility of inmate A being transferred out of the LCC was also discussed during the conversation.

Mr Kennedy did not feel obliged to report the conversation to the police or to a more senior officer, however, he accepted, in hindsight, that he should have reported the matter.

The evidence, as to what Mr Kennedy said during the interview, is ambiguous. It might be seen as Mr Kennedy placing pressure on inmate A not to report the incident to police. On the other hand, it might amount to no more than Mr Kennedy giving a genuine and realistic appraisal of the possible consequences to inmate A of making a complaint. The matter is one of emphasis. There is no evidence that contradicts Mr Kennedy's position that he was not seeking to discourage inmate A from going to the police. The Commission makes no finding.

The matter was not reported to the police at the time of the assault, as it should have been. Mr Walker's IRM falsely claimed under "Personnel Informed" that the incident had been reported to the police, GM or delegate, and Justice Health. The UOF package reference, to whether police had been contacted, was ticked "No". This may have been a consequence of the fact that Mr Turton had recorded on the Inmate Assault/Injury Questionnaire that inmate A did not want the police to take action.

Ultimately, the police did speak to inmate A, which was not until 30 April 2014. By that time, inmate A had been transferred from the LCC to another correctional centre. The contact with the police was in response to an anonymous complaint received by CSNSW, that inmate A had been assaulted by a correctional officer at the LCC. The police report, created by the NSW Police Corrective Services Investigation Unit, stated "[inmate A] declined to provide a statement or make a formal complaint at this stage". A handwritten note at the bottom of the report stated: "Noted. In the absence of a statement of complaint, Police are unable to take criminal action. Forwarded for information and consideration of other action".

After the conclusion of the search on 20 February 2014, Mr Kennedy continued to record a final segment of the search video, stating that there were "no complaints from either of the inmates in relation to the search operation". Although strictly correct, Mr Kennedy accepted that he had the perfect opportunity at that time to raise the assault allegations of inmate A, as discussed with him in the off-camera conversation that had just taken place. He failed to do so.

Inmate A allegedly admits to ownership of the contraband

Mr Dippel was filmed within the holding cell weighing the tablet and powder in front of inmate A. He then asked inmate A a number of questions. Inmate A answered those questions, as follows:

DIPPEL: Okay – okay we just searched – doing a cell search okay of your cell and amongst a plastic bag full of letters addressed to you there was a puffer okay within the puffer there was a small parcel of toilet paper which contained broken up tablet in a like – bit of white plastic bag. Okay do you agree that I found the described item in the area?

INMATE A: Yeah.

DIPPEL: So it's yours?

INMATE A: (UNINTELLIGABLE) it's in my puffer, the puffer's mine.

DIPPEL: Okay so what is it that we've found?

INMATE A: I – I don't know (UNINTELLIGABLE) –

DIPPEL: You don't know what it is?

INMATE A: I'm assuming it's a drug, but I don't know what (UNINTELLIGABLE) –

DIPPEL: Okay. Where did you get the item from?

INMATE A: (UNINTELLIGABLE) it's in the puffer.

DIPPEL: Where did you get the item inside the puffer from?

INMATE A: (UNINTELLIGABLE)

DIPPEL: You're saying that it's in your puffer, you're assuming it's a drug it didn't (UNINTELLIGABLE) come in there from (UNINTELLIGABLE) so I'm asking you where did you get that item from?

INMATE A: I've had the puffer from Parklea.

DIPPEL: So you got that item at Parklea?

INMATE A: Yeah (INAUDIBLE) Parklea.

DIPPEL: From who?

INMATE A: An old – old celly I had.

…

DIPPEL: Okay so why do you have this – this item in your possession?

INMATE A: It was in there the whole time (INAUDIBLE)

DIPPEL: What were you gonna do with it?

INMATE A: I was going to do nothing with it (UNINTELLIGABLE) can't do anything (UNINTELLIGABLE).

It is clear from the video footage that inmate A was puzzled by what was being put to him by Mr Dippel. His responses were vague.

Inmate A told the Commission:

I'd just had enough, I was sore and wanted to lay down, I thought what, like, it's only a tiny bit, I didn't really, I was trying to be selective with my words and I said that the, I do remember saying, "The puffer's mine," but I didn't admit that the drugs was mine".

Inmate A denied he had ever said he smoked the substance comprising the powder and tablet, as later reported by Mick Watson. Mr Kennedy, who was the officer in charge of the search operation, had no recollection of any such admission; nor was such an admission recorded on the search video. Inmate A told the Commission that he offered to undertake a urinalysis. Mr Kennedy confirmed this.

A urinalysis was never undertaken.

Reporting of the search operation

On his return to the IAT office, Mr Dippel typed up an incident report in which he noted that inmate A, "admitted ownership of the puffer *and its contents*" [emphasis added]. He further stated, "All aspects of this incident were recorded via video camera". Mr Dippel created an IRM. However, Mr Dippel used Mr Graf's login details. Mr Dippel's evidence was that he prepared the IRM using Mr Graf's login details "as a time saving exercise". Whether true or not, the IRM recorded, "Reported by: Graf, Simon".

The Commission is satisfied that, although inmate A admitted ownership of the asthma puffer, he made no admission as to the tablet and powder found within it.

Further, all aspects of the incident were not recorded on the video camera. The camera was turned off during the searching process. It was turned back on again once Mr Dippel had taken possession of the asthma puffer and the tablet and powder from Mr Murdoch. In addition, the conversation between inmate A, Mr McMurtrie and Mr Kennedy was never recorded.

The Commission is satisfied that Mr Dippel's incident report was misleading and he knew it to be so. After all, it was Mr Dippel who interviewed inmate A in relation to the tablet and powder. His conduct in preparing the report involved a dereliction of duty.

On 20 February 2014, Mick Watson completed his daily report on the activities of SOG members. His report noted that, while monitoring telephone calls, he listened to the call between inmate A and his father and noted that inmate A had said he had a weapon. The report also noted that he contacted the IAT and made those officers aware of this conversation, and it was then decided "to inform A/S Intel Mr McMurtrie … because of the nature of the call".

Details of the search operation were then provided, indicating "nil" weapons were found but that 0.2 grams of an unknown tablet and white powder were found "wrapped in paper secreted in an asthma puffer in a bag belonging to [inmate A]". The report stated, "[inmate A] was questioned about the contraband and *made full admittance* [sic], *stating* that he doesn't know what sort of drug it is but *he smokes it* and he got it off another inmate…" [emphasis added]. The report further stated, "All searches and interviews were recorded" on a disc and stored in the IAT safe.

During his evidence, Mick Watson was asked to identify when inmate A had made admissions of smoking the contraband, as recorded in his report. He claimed he could not recall but was adamant that he would not have made it up. He suggested another officer must have conveyed that information to him. He could not identify that officer. When further pressed, he claimed that the daily report was not intended to be used as evidence. It was merely a summary. It did not need to be accurate.

Contrary to Mick Watson's report, not all searches and interviews were recorded. There was no recording of inmate A admitting to ownership of the tablet, let alone smoking the substance. There was no record of Mr Kennedy and Mr McMurtrie speaking to inmate A. As indicated above, not all searches were recorded on disc, as the cell had already been searched prior to Mr Mick Watson, Mr Dippel and Mr Murdoch's return from the strip-search of inmate A. Mr Murdoch's discovery of the contraband was not recorded.

The Commission is satisfied that Mick Watson's report was misleading. It does not accept his claim there was no need for the report to be accurate. The Commission is satisfied that, at the time at which Mick Watson completed his report, he knew it was misleading. His conduct in preparing the report involved a dereliction of duty.

As has been noted, on 21 February 2014, Mr McMurtrie prepared intelligence report IR-366. In that report,

Mr McMurtrie cited the discovery of the contraband as a factor that supported the intelligence that suboxone was in inmate A's cell. He stated that, "The information indicating that [inmate A] had possession of suboxone is confirmed". However, Mr McMurtrie knew that the suboxone intelligence was fabricated. Using the discovery of the contraband contained in the puffer to validate his fabricated intelligence report further assisted the cover-up of the assault of inmate A. It gave further credibility to Mr Walker's incident report in which Mr Walker falsely claimed he had entered cell 208 to search for suboxone.

Inmate A speaks to his father

At 10.41 am, on 21 February 2014, inmate A made a second telephone call to his father in which he denied ownership of the contraband.

The first person to listen to the call was Ms Lohse at 12.53 pm. At 12.57 pm, Mr McMurtrie sent Mick Watson an email saying, "Listen to today's call". At 1.04 pm, Mr McMurtrie listened to 14% of the call, which was just enough to hear inmate A's denial in relation to the drug find. At 1.08 pm, Mick Watson listened to the call. At 1.09 pm, Mr O'Shea listened to the call.

In summary, within 16 minutes of Ms Lohse listening to inmate A's denial, Mr McMurtrie, Mr O'Shea and Mr Watson had themselves listened to that call and all were well aware of inmate A's denial in relation to the contraband.

The following matters should also be noted.

First, the GM has authority to deal with correctional centre offences under the CAS Act. Although Mr Murdoch and Mr Dippel both filed misconduct reports, no internal charge was ever pursued against inmate A. This should be contrasted with the approach taken in relation to an inmate in 3 Unit ("inmate C"), who was charged with a correctional centre offence – namely, possession of 0.2 grams of suboxone – found in his cell the previous day. That was precisely the same amount of contraband found in inmate A's puffer.

Secondly, there is no mention of the incident in inmate A's prison records.

Thirdly, the tablet was never tested. Whether it was a prohibited or benign substance has never been established.

Finally, the assistant commissioner's memorandum 6 of 2013 required the GM to order confiscation of the contraband and, in the absence of the police taking possession of it, required destruction to take place as soon as possible, if not immediately. The stated reason for the policy is to set out "controls to reduce the risk of the substance being lost, stolen or misplaced". The contraband was not destroyed immediately, there seems to have been no confiscation order, nor was any report made to police. The contraband found in inmate A's puffer was not destroyed until 3 May 2014. It was destroyed on the same day as the contraband found in the possession of inmate C was destroyed.

Was the contraband planted?

The Commission is satisfied that the contraband was planted by a correctional officer for the purpose of providing support for the claim that the IAT had entered cell 208 on 19 February 2014 to search for suboxone. It is likely too that the contraband was planted to dissuade inmate A from reporting to the police the assault that occurred the previous day. Once it became apparent that inmate A would not pursue police action, the discovery of contraband in inmate A's puffer was not further pursued.

Although the various matters addressed above give rise to serious concerns in relation to the conduct of the search operation, there is insufficient evidence to establish the identity of the officer responsible for planting the contraband or the officers, if any, present during the search operation who knew that inmate A had been set up.

Chapter 5: Corrupt conduct and s 74A(2) statements

Corrupt conduct

The Commission's approach to making findings of corrupt conduct is set out in Appendix 2 to this report.

In this investigation, both s 8(1)(a) and s 8(1)(b) of the ICAC Act are relevant.

Corrupt conduct within the meaning of s 8(1)(a) of the ICAC Act includes the conduct of one public official that adversely affects, or that could adversely affect, either directly or indirectly, the honest or impartial exercise of official functions by another public official. Instructions by one correctional officer to another correctional officer to "sort out" an inmate by using excessive force is an example of such conduct. So too is an instruction by one correctional officer to another correctional officer to draft an incident report that leaves out relevant information and/or provides false information.

Corrupt conduct within the meaning of s 8(1)(b) of the ICAC Act involves conduct of a public official that constitutes or involves the dishonest or partial exercise of any of his or her official functions. A correctional officer who acts on instructions from another correctional officer to single out a particular inmate and apply excessive force is an example of such conduct. So too is a correctional officer acting on instructions from another correctional officer to leave out relevant information and/or provide false information in an incident report.

The Commission makes findings of relevant facts on the balance of probabilities having due regard to the gravity of the consequences that may flow from such findings, including reputational damage. The Commission determines whether those facts come within the terms of s 8(1), s 8(2) or s 8(2A) of the ICAC Act. If they do, the Commission turns to a consideration of s 9 of the ICAC Act and the jurisdictional requirements of s 13(3A). In the case of subsection 9(1)(a), the Commission considers whether, if the facts as found were to be proved on admissible evidence to the criminal standard of proof and accepted by an appropriate tribunal, they would be grounds on which such a tribunal would find that the person has committed a criminal offence.

The Commission then considers whether, for the purpose of s 74BA of the ICAC Act, the conduct is sufficiently serious to warrant a finding of corrupt conduct.

John O'Shea

Mr O' Shea engaged in conduct that involved the dishonest or partial exercise of his official functions. He engaged in corrupt conduct within the meaning of s 81(a) and s 8(1)(b) of the ICAC Act by:

- inciting Mr Walker to enter inmate A's cell and "sort it out", knowing that Mr Walker would apply physical force to an inmate
- failing to complete an incident report in circumstances where he was a witness to the events giving rise to the UOF and the UOF itself
- approving the UOF package concerning the UOF on inmate A, knowing that it contained false and misleading information prepared by other CSNSW officers, namely, Mr McMurtrie, Mr Walker, Mr Graf, and Mr Duncan
- approving the UOF package, knowing that it did not include his incident report or the incident reports of Mr Peebles, Mr Taylor and Mr Duffy
- approving the UOF package in circumstances where he had a conflict of interest and was in breach of his obligations pursuant to Commissioner's Instruction No. 10 of 2011, "Reviewing Use of Force"
- failing to act on the complaint made by inmate A to his father on the telephone that he had been "flogged by the squad"

- concealing the incident report of Mr Duffy
- misleading the CSNSW Investigations Branch during its investigation in January 2015 by giving a false account of the UOF on inmate A and his own involvement in the incident.

For the purpose of s 9(1)(a) of the ICAC Act, Mr O'Shea's conduct could also constitute or involve the assault of inmate A causing actual bodily harm as a principal in the second degree. He issued an instruction to "sort him out" or "sort it out". He knew the inmate who had abused him would be bashed and stayed to watch it.

A principal in the second degree is any person who is present aiding and abetting or encouraging the principal in the first degree (that is, the person who actually commits the offence).

Pursuant to s 345 of the *Crimes Act 1900* ("the Crimes Act"), every principal in the second degree in "any serious indictable offence" is liable to the same punishment to which the person would have been liable had the person been the principal in the first degree.

Section 59 of the Crimes Act provides as follows:

> ***59 Assault occasioning actual bodily harm***
>
> *(1) Whosoever assaults any person, and thereby occasions actual bodily harm, shall be liable to imprisonment for five years.*
>
> *(2) A person is guilty of an offence under this subsection if the person commits an offence under subsection (1) in the company of another person or persons. A person convicted of an offence under this subsection is liable to imprisonment for 7 years.*

The Crimes Act defines a "serious indictable offence" to be an indictable offence that is punishable by imprisonment for life or for a term of five years or more. Assault causing actual bodily harm is a serious indictable offence.

For the purpose of s 9(1)(a) of the ICAC Act, Mr O'Shea's conduct could also constitute or involve the offence of hindering the investigation of a serious indictable offence contrary to s 315 of the Crimes Act. Mr O'Shea participated in the cover-up of the physical attack on inmate A, as particularised above.

Section 315 of the Crimes Act provides:

> ***315 Hindering investigation etc***
>
> *(1) A person who does anything intending in any way to hinder:*
>
> *(a) the investigation of a serious indictable offence committed by another person, or*
>
> *(b) the discovery of evidence concerning a serious indictable offence committed by another person, or*
>
> *(c) the apprehension of another person who has committed a serious indictable offence,*
>
> *is liable to imprisonment for 7 years.*
>
> *(2) For the purposes of subsection (1), a person is to be considered to have committed a serious indictable offence if a public officer engaged in the detection or investigation of offenders suspects on reasonable grounds that a person has committed the offence.*
>
> *(3) It is not an offence against this section merely to refuse or fail to divulge information or produce evidence.*

For the purposes of s 9(1)(a) of the ICAC Act, the conduct of Mr O'Shea could also constitute or involve the offence of perverting the course of justice or attempting or conspiring to do so.

Section 319 of the Crimes Act provides:

> ***319 General offence of perverting the course of justice***
>
> *A person who does any act, or makes any omission, intending in any way to pervert the course of justice, is liable to imprisonment for 14 years.*

Perverting the course of justice means "obstructing, preventing, perverting or defeating the course of justice or the administration of the law" (s 312 of the Crimes Act).

The expression "perverting the course of justice … or the administration of the law" demonstrates a legislative intention that liability extends to acts done with the proscribed intention in relation to contemplated proceedings (*R v Beckett* (2015) 256 CLR 305). Attempts to pervert the course of justice attract the same penalty as the substantive offence (s 344A of the Crimes Act).

The Commission is satisfied that those correctional officers who engaged in the cover-up of the assault on inmate A did so to avoid an investigation by CSNSW in relation to disciplinary offences and the police in relation to criminal offences. The offence of attempting or conspiring to pervert the course of justice may be committed before the jurisdiction of a court or tribunal is invoked. In *R v Rogerson* (1992) 174 CLR 268 at 277, Mason CJ noted that this was:

> *…because action taken before curial or tribunal proceedings commence may have a tendency and be intended to frustrate or deflect the course of curial or tribunal proceedings which are imminent, probable or even possible. In other words, it is enough that an*

act has a tendency to frustrate or defect a prosecution or disciplinary proceedings before a judicial tribunal which the accused contemplates may possibly be instituted even though the possibility … has not been considered by the police or the relevant law enforcement agency.

For the purpose of s 9(1)(a) of the ICAC Act, Mr O'Shea's conduct could also constitute or involve the common law offence of misconduct in public office. His involvement in the assault of inmate A and his failure to provide any incident report in relation to what occurred involved significant breaches of his duties as a correctional officer and GM of the LCC.

In *R v Obeid* (2017) 350 ALR 103, the NSW Court of Criminal appeal affirmed the elements of the offence as follows:

(1) a public official;

(2) in the course of or connected to his public office;

(3) wilfully misconducts himself; by act or omission, for example, by wilfully neglecting or failing to perform his duty;

(4) without reasonable excuse or justification; and

(5) where such misconduct is serious and meriting criminal punishment having regard to the responsibilities of the office and the officeholder, the importance of the public objects which they serve and the nature and extent of the departure from those objects.

For the purposes of s 9(1)(b) of the ICAC Act, Mr O'Shea's conduct could constitute or involve a disciplinary offence. The CAS Regs impose particular obligations upon correctional officers that include the obligations to be honest and truthful (Regulation 260(1)), the obligation not to make false or misleading statements (Regulation 260(2)), the obligation not to bring discredit upon CSNSW (Regulation 258(2)) and the obligation not to use insulting or abusive language in dealing with inmates (Regulation 258 (1)).

For the purpose of s 9(1)(c) of the ICAC Act, and for the same reasons, Mr O'Shea's conduct could also provide reasonable grounds for dismissing, dispensing with the services of or otherwise terminating his services.

The Commission understands that Mr O'Shea is no longer employed by CSNSW.

Section 9(2) of the ICAC Act makes it plain that in determining whether conduct could constitute or involve a disciplinary offence, reasonable grounds for dismissing, dispensing with services of or otherwise terminating the services of a public official, it does not matter that action can no longer be taken.

For the purpose of s 74BA of the ICAC Act, the Commission is satisfied that Mr O'Shea's conduct is serious corrupt conduct. Mr O'Shea was the most senior officer at the LCC. He exercised control over all correctional officers who worked within the centre. His conduct led to the assault of inmate A, and he endeavoured to conceal it.

The Commission is satisfied that the jurisdictional requirements of s 13(3A) of the ICAC Act have been met.

Brian McMurtrie

Mr McMurtrie engaged in conduct that involved the dishonest or partial exercise of his official functions. He engaged in corrupt conduct within the meaning of s 8(1)(a) and s 8(1)(b) of the ICAC Act by:

- creating a false intelligence report concerning the presence of buprenorphine in cell 208
- assisting in the drafting of Mr Walker's false incident report
- failing to report a possible assault on inmate A, having observed inmate A's injuries and having heard inmate A's complaint to his father that he had been "flogged by the squad"
- creating intelligence report IR-366 in which he repeated the false intelligence that there was suboxone in cell 208.

For the purpose of s 9(1)(a) of the ICAC Act, Mr McMurtrie's conduct could constitute or involve the:

- offence of hindering the investigation of a serious indictable offence contrary to s 315 of the Crimes Act (Mr McMurtrie assisted in the cover-up of the assault of inmate A in the manner described above)
- offence of perverting the course of justice or attempting or conspiring to do so contrary to s 319 of the Crimes Act
- common law offence of misconduct in public office.

For the purposes of s 9(1)(b) and s 9(1)(c) of the ICAC Act, Mr McMurtrie's conduct could constitute or involve a disciplinary offence or reasonable grounds for dismissing, dispensing with the services of or otherwise terminating with his services. More particularly, Mr McMurtrie's conduct could constitute or involve a failure to abide by the obligations imposed on him pursuant to the CAS Regs, namely, the obligation to be honest and truthful (Regulation 260(1)), the obligation not to make false

or misleading statements (Regulation 260(2)), and the obligation not to bring discredit upon CSNSW (Regulation 258(2)).

Mr McMurtrie is no longer employed by CSNSW. Because of s 9(2) of the ICAC Act, this is of no moment.

The Commission is satisfied that the jurisdictional requirements of s 13(3A) of the ICAC Act are satisfied.

The Commission is also satisfied that, for the purposes of s 74BA of the ICAC Act, Mr McMurtrie's conduct is serious corrupt conduct. It involved a deliberate cover-up of the bashing of an inmate and deliberate dishonesty in concert with others in the course of the performance of his duties as a correctional officer.

Terrence Walker

Mr Walker engaged in conduct that involved the dishonest or partial exercise of his official functions. He engaged in corrupt conduct within the meaning of s 8(1)(a) and s 8(1)(b) of the ICAC Act by:

- preparing an incident report containing false and misleading statements in relation to the application of physical force to inmate A
- encouraging Mr Graf and Mr Duncan to prepare false and misleading incident reports
- instructing Mr Duffy not to prepare an incident report
- preparing an IRM containing false and misleading statements
- misleading CSNSW during its 2015 investigation by giving a false account of the UOF on inmate A and the facts and circumstances leading to the UOF.

For the purpose of s 9(1)(a) of the ICAC Act, Mr Walker's conduct could constitute or involve the:

- offence of assault causing actual bodily harm, contrary to s 59(1) of the Crimes Act
- offence of hindering an investigation, contrary to s 315 of the Crimes Act
- offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act
- common law offence of misconduct in public office.

For the purposes of s 9(1)(b) and s 9(1)(c) of the ICAC Act, Mr Walker's conduct could constitute or involve a disciplinary offence or reasonable grounds for dismissing, dispensing with the services of or otherwise terminating with his services. More particularly, Mr Walker's conduct could constitute or involve a failure to abide by the obligations imposed on him pursuant to the CAS Regs, namely, the obligation to be honest and truthful (Regulation 260(1)), the obligation not to make false or misleading statements (Regulation 260(2)), the obligation not to bring discredit upon CSNSW (Regulation 258(2)), and the use of excessive force (Regulation 121).

Mr Walker is no longer employed by CSNSW. Because of s 9(2) of the ICAC Act, this is of no moment.

The Commission is satisfied that the jurisdictional requirements of s 13(3A) of the ICAC Act are satisfied.

The Commission is also satisfied that the conduct is serious corrupt conduct for the purposes of s 74BA of the ICAC Act. Mr Walker was the most senior officer in the IAT, he bashed an inmate without lawful excuse, and he encouraged more junior officers to falsify incident reports for the purpose of covering-up the assault.

Stephen Taylor

Mr Taylor engaged in conduct that involved the dishonest or partial exercise of his official functions. He engaged in corrupt conduct within the meaning of s 8(1)(a) and s 8(1)(b) of the ICAC Act by:

- failing to prepare an incident report recording that inmate A had been bashed by Mr Walker and that Mr O'Shea was standing next to him outside cell 208 when this occurred
- recommending that no further action be taken following his review of the UOF package in circumstances where he knew:
    i. the incident reports were inconsistent with what he had observed and heard on 19 February 2014
    ii. the UOF package was incomplete, in that he and Mr O'Shea had not provided incident reports
    iii. entry into cell 208 by the IAT was as a consequence of one of the inmates abusing Mr O'Shea over the knock-up system rather than a cell search for suboxone
- on 5 March 2015, misleading CSNSW investigators during their investigation of the incident of 19 February 2014 by maintaining that he had no knowledge of Mr O'Shea approaching cell 208 or any "flogging" of inmate A.

For the purpose of s 9(1)(a) of the ICAC Act, Mr Taylor's conduct could constitute or involve the:

- offence of hindering an investigation, contrary to s 315 of the Crimes Act
- offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act
- offence of concealing a serious indictable offence, contrary to s 316(1) of the Crimes Act
- common law offence of misconduct in public office.

In 2014, s 316(1) of the Crimes Act provided as follows:

> ***316 Concealing serious indictable offence***
>
> *(1) If a person has committed a serious indictable offence and another person who knows or believes that the offence has been committed and that he or she has information which might be of material assistance in securing the apprehension of the offender or the prosecution or conviction of the offender for it fails without reasonable excuse to bring that information to the attention of a member of the Police Force or other appropriate authority, that other person is liable to imprisonment for 2 years.*

Mr Taylor called in the IAT at Mr O'Shea's request to sort "it" or "him" out. Mr Taylor knew that Mr Walker had physically attacked inmate A. He observed the assault. The assault caused actual bodily harm. He failed to reveal what he had observed. He approved the UOF package, knowing that it contained no reference to the assault that he had observed. He sought to mislead the CSNSW by denying that he had any knowledge of the assault.

For the purposes of s 9(1)(b) and s 9(1)(c) of the ICAC Act, Mr Taylor's conduct could also constitute or involve a disciplinary offence or reasonable grounds for dismissing, dispensing with the services of or otherwise terminating his services. Mr Taylor's conduct could also constitute or involve a failure to abide by the obligations imposed on him pursuant to the CAS Regs, namely, the obligation to be honest and truthful (Regulation 260(1)), the obligation not to make false or misleading statements (Regulation 260(2)), and the obligation not to bring discredit upon CSNSW (Regulation 258(2)).

The Commission is satisfied that the jurisdictional requirements of s 13(3A) of the ICAC Act are satisfied.

The Commission is also satisfied that Mr Taylor's conduct is serious corrupt conduct for the purposes of s 74BA of the ICAC Act. It involved the deliberate cover-up of the full facts and circumstances leading up to the bashing of inmate A, namely, the abuse of Mr O'Shea by one of the inmates over the knock-up system and Mr Taylor's radio request for the IAT to attend to respond to that abuse. It also involved failing to report his own observations of the application of force to inmate A by Mr Walker, and approving the UOF package when he knew that Mr O'Shea was a person required to provide an incident report, but had failed to do so.

Simon Graf

Mr Graf engaged in conduct that involved the dishonest or partial exercise of his official functions. He engaged in corrupt conduct within the meaning of s 8(1)(b) of the ICAC Act by:

- preparing an incident report containing false and misleading statements in relation to the application of physical force to inmate A
- misleading CSNSW during its 2015 investigation by giving a false account of the UOF on inmate A and the facts and circumstances leading to the UOF.

For the purpose of s 9(1)(a) of the ICAC Act, Mr Graf's conduct could constitute or involve the:

- common law offence of misconduct in public office
- offence of hindering an investigation, contrary to s 315 of the Crimes Act
- offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act.

For the purposes of s 9(1)(b) and s 9(1)(c) of the ICAC Act, the Commission is satisfied that Mr Graf's conduct could constitute or involve a disciplinary offence or reasonable grounds for dismissing, dispensing with the services of or otherwise terminating his services. More particularly, Mr Graf's conduct could constitute or involve a failure to abide by the obligations imposed on him pursuant to the CAS Regs, namely, the obligation to be honest and truthful (Regulation 260(1)), the obligation not to make false or misleading statements (Regulation 260(2)), and the obligation not to bring discredit upon CSNSW (Regulation 258(2)).

The Commission is satisfied that the jurisdictional requirements of s 13(3A) of the ICAC Act are satisfied.

The Commission is also satisfied that Mr Graf's conduct is serious corrupt conduct for the purposes of s 74BA of the ICAC Act. It involved a deliberate cover-up of the assault of an inmate and deliberate dishonesty in concert with others in the course of the performance of his duties as a correctional officer.

Elliott Duncan

Mr Duncan engaged in conduct that involved the dishonest or partial exercise of his official functions. He engaged in corrupt conduct within the meaning of s 8(1)(b) of the ICAC Act by:

- preparing an incident report containing false and misleading statements in relation to the application of physical force to inmate A
- misleading CSNSW during its 2015 investigation by giving a false account of the UOF on inmate A and the facts and circumstances leading to the UOF.

For the purpose of s 9(1)(a) of the ICAC Act, Mr Duncan's conduct could constitute or involve the:

- common law offence of misconduct in public office
- offence of hindering an investigation contrary to s 315 of the Crimes Act
- offence of perverting the course of justice, or conspiring or attempting to do so, contrary to s 319 of the Crimes Act.

For the purposes of s 9(1)(b) and s 9(1)(c) of the ICAC Act, Mr Duncan's conduct could constitute or involve a disciplinary offence or reasonable grounds for dismissing, dispensing with the services of or otherwise terminating his services. Mr Duncan's conduct could constitute or involve a failure to abide by the obligations imposed on him pursuant to the CAS Regs, namely, the obligation to be honest and truthful (Regulation 260(1)), the obligation not to make false or misleading statements (Regulation 260(2)), and the obligation not to bring discredit upon CSNSW (Regulation 258(2)).

Mr Duncan is no longer employed by CSNSW. Because of s 9(2) of the ICAC Act, this is of no moment.

The Commission is satisfied that the jurisdictional requirements of s 13(3A) of the ICAC Act are satisfied.

The Commission is also satisfied that the conduct is serious corrupt conduct for the purposes of s 74BA of the ICAC Act because it involved a deliberate cover-up of an assault by correctional officers on an inmate and deliberate dishonesty in concert with others in the course of the performance of his duties as a correctional officer.

Section 74A(2) statements

In making a public report, the Commission is required by the provisions of s 74A(2) of the ICAC Act to include, in respect of each "affected" person, a statement as to whether or not in all the circumstances the Commission is of the opinion that consideration should be given to the following:

a) obtaining the advice of the Director of Public Prosecutions (DPP) with respect to the prosecution of the person for a specified criminal offence

b) the taking of action against the person for a specified disciplinary offence

c) the taking of action against the person as a public official on specified grounds, with a view to dismissing, dispensing with the services of or otherwise terminating the services of the public official.

An "affected person" is defined in s 74A(3) of the ICAC Act as a person against whom, in the Commission's opinion, substantial allegations have been made in the course of, or in connection with, the investigation.

The Commission is satisfied that Mr O'Shea, Mr Peebles, Mr McMurtrie, Mr Walker, Mr Graf, Mr Taylor and Mr Duncan are affected persons for the purposes of s 74A(2) of the ICAC Act. Section 38 declarations were made in relation to the evidence of these witnesses. Their evidence cannot be used against them in criminal proceedings, except in relation to prosecution for an offence under the ICAC Act. Mr Graf remains an employee of CSNSW. His evidence can be used against him in disciplinary proceedings.

The Commission is satisfied that there is sufficient admissible evidence to seek the advice of the DPP with respect to the prosecution of a number of affected persons for the offences detailed below. That evidence includes the evidence of inmate A and inmate B. It also includes the incident report and evidence of Mr Duffy, the evidence of Mr Turton, the incident reports of Mr Walker, Mr Graf and Mr Duncan, the reports of Mr McMurtrie, the IRM records, and the failure to include various required documents as part of the IRM.

John O'Shea

- principal in the second degree to the assault of inmate A causing actual bodily harm, contrary to s 59 of the Crimes Act
- the offence of hindering an investigation, contrary to s 315 of the Crimes Act
- the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act
- the common law offence of misconduct in public office.

Brian McMurtrie

- the offence of hindering an investigation, contrary to s 315 of the Crimes Act
- the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act
- the common law offence of misconduct in public office.

Stephen Taylor

- the offence of hindering an investigation, contrary to s 315 of the Crimes Act
- the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act
- the offence of concealing a serious indictable offence, contrary to s 316(1) of the Crimes Act
- the common law offence of misconduct in public office.

Terrence Walker

- the offence of assault occasioning actual bodily harm, contrary to s 59 of the Crimes Act
- the offence of hindering an investigation, contrary to s 315 of the Crimes Act
- the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act
- the common law offence of misconduct in public office.

Simon Graf

- the offence of hindering an investigation, contrary to s 315 of the Crimes Act
- the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act
- the common law offence of misconduct in public office.

Elliott Duncan

- the offence of hindering an investigation, contrary to s 315 of the Crimes Act
- the offence of perverting the course of justice, or attempting or conspiring to do so, contrary to s 319 of the Crimes Act
- the common law offence of misconduct in public office.

It is an offence to wilfully make any false statement to or mislead, or attempt to mislead, the Commission or an officer of the Commission in the exercise of functions under the ICAC Act (s 80(c)). It is also an offence to give evidence during a compulsory examination or public inquiry that is false or misleading in a material particular, knowing it to be false or misleading or not believing it to be true (s 87).

Mr McMurtrie gave evidence during a compulsory examination on 6 December 2017. The version of events provided by him was significantly at odds with the evidence given during the public inquiry. During his compulsory examination, Mr McMurtrie maintained the story concocted back in February 2014. However, by the time of the public inquiry, it was clear that he would need to make certain admissions about his involvement in creating false documents, which he did.

Commission officers interviewed Mr Graf on 2 August 2017. He also gave evidence during a compulsory examination on 8 March 2018. The version of events given by Mr Graf during his interview and compulsory examination was significantly at odds with the evidence given by him during the public inquiry. Prior to the public inquiry, Mr Graf maintained the cover-up story but in his evidence at the public inquiry he made certain admissions about changing his report to fit the version provided by Mr Walker.

Commission officers interviewed Mr O'Shea on 2 August 2017. He also gave evidence during the public inquiry. The version of events given by Mr O'Shea during his interview was significantly at odds with the evidence given by him during the public inquiry. It was only at the public inquiry that Mr O'Shea made admissions to being present for aspects of what occurred at cell 208, and having knowledge of matters afterwards, significantly, of the existence of Mr Duffy's report.

The Commission is satisfied that there is sufficient admissible evidence to seek the advice of the DPP with respect to the prosecution of Mr McMurtrie and Mr Graf in respect of offences against s 87 of the ICAC Act. The Commission is also satisfied that there is sufficient admissible evidence to seek the advice of the DPP with respect to the prosecution of Mr O'Shea and Mr Graf for offences against s 80 of the ICAC Act.

The Commission has given careful consideration to whether in all the circumstances it should seek the advice of the DPP with respect to the prosecution of Mr Walker for offences against s 80 of the ICAC Act. It has determined it will not do so.

Commission officers interviewed Mr Walker on 9 August 2017. The version of events he gave was untrue. He also gave evidence in a compulsory examination on 9 March 2018. During that compulsory examination, he readily

admitted that he had been untruthful in his interview. The account of events given by Mr Walker was broadly consistent with that given in the public inquiry.

It is a matter of discretion, but it is Commission policy that, where a person has misled the Commission and voluntarily returns to the Commission and cooperates by providing a full and truthful account, this will be taken into account when deciding whether consideration should be given to obtaining the advice of the DPP with respect to an offence under s 87 of the ICAC Act of giving false or misleading evidence. The policy can be found on the Commission's website.

By extension, the same reasoning applies to offences against s 80.

Mr Walker did not voluntarily attend the Commission to give evidence in his compulsory examination. He was summonsed. However, the Commission was made aware that Mr Walker wished to change his account of the events prior to his attendance. As has been noted, Mr Walker readily admitted that he had lied to Commission officers and proceeded to provide a full account, which was later substantially repeated during the public inquiry. Although the Commission has not accepted aspects of his evidence, it is satisfied that he was endeavouring to tell the truth to the best of his recollection.

There is a further consideration. It was clear from the public inquiry and other evidence gathered by the Commission that there was a closing of ranks in relation to the incident that occurred on 19 February 2014. While there was circumstantial evidence suggesting a cover-up, a number of correctional officers had provided false and misleading accounts to the CSNSW Investigations Branch in relation to what had occurred. The key persons of interest provided little in the way of genuine assistance to the Commission. Mr Walker was the first person to break ranks. While he was under an obligation to tell the truth in his compulsory examination, the assistance obtained by the Commission was considerable.

Pursuant to s 74A(2)(b) of the ICAC Act, the Commission must, in respect of each affected person, include in this report a statement as to whether or not in all the circumstances the Commission is of the opinion that consideration should be given to the taking of action against the person for a specified disciplinary offence.

Pursuant to s 74A(2)(c) of the ICAC Act, the Commission must also, in respect of each affected person, include in this report a statement as to whether or not in all the circumstances the Commission is of the opinion that consideration should be given to the taking of action against the person as a public official on specified grounds, with a view to dismissing, dispensing with the services of, or otherwise terminating the services of the public official.

Mr O' Shea, Mr Walker, Mr McMurtrie and Mr Duncan are no longer employed by CSNSW. The question of disciplinary action or terminating their employment does not arise.

Mr Taylor and Mr Graf remain employees of CSNSW. For the reasons addressed above, the Commission considers that in all the circumstances, it is of the opinion that consideration should be given to the taking of action against Mr Taylor and Mr Graf for a specified disciplinary offence or the taking of action against them as public officials on specified grounds, with a view to dismissing, dispensing with the services of, or otherwise terminating their services.

Brad Peebles

As previously noted, the Commission is satisfied that Mr Peebles is an "affected person" for the purposes of s 74A(2) of the ICAC Act. It is not satisfied that Mr Peebles engaged in serious corrupt conduct. Nevertheless, in certain respects, his conduct could constitute or involve the commission of a disciplinary offence. The expression "disciplinary offence" in s 9 of the ICAC Act includes any misconduct, irregularity, neglect of duty, breach of discipline or other matter that constitutes or may constitute grounds for disciplinary action under any law.

Mr Peebles' instruction to Mr Turton – that there was no UOF and that there would be no IRM – should never have been given. Perhaps Mr Peebles did not know the extent of the UOF on inmate A or that he had significant injuries. However, he certainly knew there had been some UOF on inmate A, not least because he had asked Mr Turton to complete the Inmate Assault/Injury Questionnaire.

Although it may not have been intended as such, the instruction had the capacity to impede any investigation of what had occurred in cell 208.

It is also regrettable that later Mr Peebles gave a further similar instruction to Mr Turton. There was to be no IRM because "there is no fucking use of force". However, during this conversation, Mr Peebles learned that inmate A had been taken to hospital with injuries. At that point, he advised Mr Turton that Mr Walker would do the IRM. It may have been appropriate for that direction to be given, having regard to Mr Walker's involvement in the matter as the most senior officer of the IAT.

The same might be said of Mr Peebles' receipt of Mr McMurtrie's false intelligence report. Being "offline", he asked Mr Taylor to deal with it. The false intelligence report was an attachment to Mr McMurtrie's email. The email contained no text. Mr Peebles must have

read the attachment to have issued the instruction to Mr Taylor. The Commission is satisfied that Mr Peebles recognised the contents of the report were inconsistent with his understanding of the reason why the IAT had entered cell 208.

Both Mr Peebles and Mr O'Shea were also emailed Mr Walker's incident report that contained Mr McMurtrie's false intelligence. Again, there was no text in the email sending the report. The Commission is satisfied that Mr Peebles opened the attachment and read it. He acknowledged to the Commission that the contents of the report, concerning the reason for entering cell 208, were inconsistent with his own understanding.

On 21 February 2014, Mr Peebles also received Mr McMurtrie's false IR-366. Metadata obtained from CSNSW indicates that Mr Peebles reviewed an electronic version on 28 February 2014. The report contained the same bogus reason for attending cell 208 and the same false intelligence.

The Commission is satisfied that Mr Peebles was aware of the inconsistencies between his own knowledge of the events of 19 February 2014 and the contents of the written communications he received.

The Commission is not satisfied that Mr Peebles was part of the cover-up of the bashing of inmate A. Nevertheless, he had sufficient knowledge of facts and circumstances that suggested a possible cover-up. Although offline on 19 February 2014, he was the MoS of the LCC. He was obliged to pursue the matter by conducting further enquiries or referring the matter to the PSB. He failed to do so. That he failed to do so was a significant dereliction of duty. It facilitated the cover-up of the bashing of inmate A by others.

The Commission considers that, in all the circumstances, CSNSW should give consideration to taking disciplinary action against Mr Peebles in accordance with s 74A(2)(b) of the ICAC Act.

The Commission is not satisfied that there is sufficient admissible evidence to refer the planting of the contraband to the DPP for his advice.

In respect of the misleading reports of Mr Dippel and Mick Watson, the Commission is of the opinion that, in all the circumstances, CSNSW should give consideration to the taking of disciplinary action, as referred to in s 74A(2)(b) of the ICAC Act. The conduct of Mr Dippel and Mick Watson could constitute or involve a serious breach of Regulation 260(2) of the CAS Regs. As previously noted, this regulation imposes upon correctional officers a duty not to make false or misleading statements.

Chapter 6: Corruption prevention

This chapter considers the facts addressed in the previous chapters of this report, identifies the corruption risks exposed by the evidence, and records a number of corruption prevention recommendations.

There are major challenges associated with managing correctional centre inmates. Inmates can engage in acts of violence towards other inmates or correctional officers, violate rules designed to ensure the health and safety of inmates and correctional officers, or make false allegations about correctional officers.

However, as noted in chapter 1, inmates are vulnerable to misconduct by correctional officers. The misconduct may include assault, improper confiscation or destruction of property, or the planting of contraband. Correctional officers have a large degree of control over inmates and therefore are in a position to engage in misconduct. Moreover, it is likely that, in most circumstances, the word of a correctional officer will be preferred over the word of an inmate.

A key challenge for CSNSW is ensuring that inmates are managed in a way that protects CSNSW staff, correctional centres and the NSW community in general, while still ensuring that inmates are treated lawfully and fairly. The Commission's investigation and the continued reporting – by inmates and CSNSW – of instances of alleged unlawful UOF and false reporting, have highlighted the challenge facing CSNSW in managing such conduct.

From a management perspective, it can be difficult to determine who is at fault if a complaint is made about a correctional officer's UOF on an inmate. As an example, if there is an allegation that an inmate was injured as a result of being assaulted by a correctional officer, establishing the injury arose from a UOF does not establish whether there was any misconduct. It may be, for instance, that:

- the incident involved a legitimate UOF on a non-compliant, dangerous inmate
- while an initial UOF on the inmate was justified, the force that was ultimately applied was excessive
- there was no justification for using force on the inmate at all.

CSNSW is certainly aware of this challenge. As previously noted, the NSW Ombudsman has taken an interest in the UOF on inmates since at least 2009. He made a number of recommendations in his report of 2012. Many were never implemented.

The Commission's investigation has identified a number of deficiencies with respect to the following types of controls:

- recordkeeping
- image recording
- review and oversight
- complaint management and investigation.

Recordkeeping

CSNSW procedures mandate a number of recordkeeping requirements regarding events such as UOF incidents, cell searches, and contraband finds. This investigation identified a number of control deficiencies regarding incident-reporting records, as follows:

- some correctional officers who ought to have filed incident reports did not do so
- a number of reports concerning the UOF on inmate A contained false information
- falsified reports were filed in relation to the discovery of contraband in inmate A's cell
- the report of one correctional officer whose account implicated others in the assault of inmate A was deliberately concealed

- an IRM was logged by one Offender Integrated Management System (OIMS) user using another user's login
- poor records were kept of the disposal of prohibited drugs.

UOF reports were either absent or contained false information

While incident-reporting requirements were understood by relevant LCC officers, Mr Walker's evidence to the Commission points to these recordkeeping requirements being deliberately disregarded in relation to the UOF on inmate A.

[Counsel Assisting]: *….And did you draft that document?*

[Mr Walker]: *I did.*

[Q]: *If I can take you to the subject. It says, "Minor use of force, inmate* [inmate A]*." Is that a correct description of what happened inside the cell?*

[A]: *No. That report is all lies.*

[Q]: *When you say, it was all lies, why would you put something in a report that was all lies?*

[A]: *Fabricated to make things look good and clean the mess up. We'd been advised that the inmate had been injured.*

[Q]: *So were you advised before doing this report that the inmate had to go to hospital?*

[A]: *I didn't know he'd gone to hospital but I knew he was injured.*

[Q]: *All right. And so if he wasn't injured, does that mean there would have been no reports?*

[A]: *At that stage, yes.*

[Q]: *And is that your understanding or was there a discussion that that was to occur until you found out he had an injury?*

[A]: *No, that was not discussion* [sic] *but it was just left that way.*

[Q]: *All right. So it wasn't as though you left the cell and were talking to the others and saying we need to do our reports, there was just no discussion about reports being necessary.*

[A]: *No, it was clear what we'd done was wrong.*

Mr Walker was instructed by either Mr Peebles or Mr McMurtrie to only obtain incident reports from Mr Graf and Mr Duncan despite the fact that other correctional officers were involved in, and/or witnessed, the UOF on inmate A. Mr Walker was aware that these other individuals were required to complete a report under CSNSW procedures.

Ultimately, the following individuals did not submit an incident report regarding the UOF on inmate A despite being required to do so under CSNSW procedures:

- Cameron Watson, who was involved in the incident
- Mick Watson, who was involved in the incident

- Mr Taylor, who made the radio call for the IAT to attend inmate A's cell, and saw Mr Walker assault inmate A
- Mr O'Shea, whose contact with inmate A and instruction triggered the incident
- Mr Peebles, who was with Mr O'Shea when the triggering event occurred.

Mr Walker also told Mr Duffy not to complete an incident report. To his credit, Mr Duffy completed an incident report anyway and offered it to Mr Walker who rejected it because he had already submitted the UOF package by this time. More importantly, although he was not aware of the contents of Mr Duffy's report at the time, Mr Walker gave evidence to the Commission that he thought that Mr Duffy's report was likely to be an honest and accurate account of the incident.

As has been noted, following Mr Walker's rejection of his incident report, Mr Duffy registered it with the deputy's clerk. He did this in the hope it would be investigated by management as an excessive UOF. However, during 2014, registering a report with the deputy's clerk did not result in it being recorded on CSNSW's electronic network, meaning that it was more difficult for interested parties such as CSNSW investigators or the PSB to discover.

CSNSW has advised the Commission that, while the deputy's clerk is no longer a position within correctional centres, it would be appropriate for the "Governor's Personal Assistant" to ensure that reports are placed on its electronic systems.

Recommendation 1

That the personal assistant to a GM of a correctional centre be required to enter all submitted incident reports into CSNSW's electronic systems.

CSNSW has advised the Commission that it supports this recommendation.

The UOF incident reports that *were* submitted in relation to the UOF on inmate A all contained false information. As discussed below, LCC officers colluded to ensure consistency amongst their false reports.

CSNSW's UOF procedures require that an individual who submits a UOF incident report must not discuss their "report or [their] evidence with anyone else". This requirement is designed to reduce the risk that correctional officers will collude regarding the contents of their incident reports.

This requirement was ignored in relation to the preparation of incident reports concerning the UOF on inmate A. Moreover, the discussions that CSNSW officers had concerning these reports were about presenting a consistent false account, as opposed to a true version of events.

Mr McMurtrie provided a false intelligence report stating that the entry into inmate A's cell was to search for suboxone. Mr McMurtrie also told Mr Walker to falsify his incident report to accommodate this false intelligence report and proofread a draft of Mr Walker's report.

Mr McMurtrie then instructed Mr Walker to ensure that Mr Graf's and Mr Duncan's incident reports included the search for contraband as the reason for entering inmate A's cell.

Mr Walker, Mr Duncan and Mr Graf colluded regarding the content of the incident reports they filed.

Mr Duncan gave evidence to the Commission that collusion over the content of incident reports happened frequently at the LCC, despite CSNSW officers knowing it was wrong:

> *[Counsel Assisting]: But when you say you would have, that's part of the mateship, this is what I'm going to put in my report?*
>
> *[Mr Duncan]: Look, it was often, I know you're not supposed to, you're meant to do your reports separately and what no* [sic] *but quite often we will sit there and go, can you remember what the time was, just getting little nuances correct.*

Following the preparation of these incident reports, the IRM for the UOF on inmate A was prepared. It was prepared so that it was also consistent with the false incident reports and, by extension, the false intelligence report.

As discussed in chapter 3, the IRMs and incident reports contained a variety of falsehoods regarding:

- why inmate A's cell was entered
- which correctional officers were involved in the incident
- what actually happened during the incident.

In summary, many of the documents pertaining to the UOF on inmate A in the UOF package gave a deliberately untruthful account of the incident in question.

The missing and falsified incident reports should have been detected and the subject of action when the UOF package was reviewed by Mr Taylor and Mr O'Shea.

False search reports were filed

The falsification of incident reports pertaining to inmate A was not limited to the UOF incident on 19 February 2014.

Inmate A's cell was searched the next day and a tablet and powder were found during this search. As discussed in chapter 4, false information about the search was presented in reports including:

- a misconduct report submitted by Mr Murdoch
- an incident report submitted by Mr Dippel
- the IRM for the search
- Mick Watson's report to SOG and the LCC concerning the find.

The falsehoods in these reports included that:

- Mr Dippel found the tablet and powder in inmate A's asthma puffer, when it was Mr Murdoch who found it
- all aspects of the search were videorecorded, as parts of the search were not recorded including the actual discovery of the tablet and powder
- inmate A admitted ownership of the tablet and powder.

In summary, all of the reports relating to the search of inmate A's cell contained false information.

This, in and of itself, raises serious questions about how the search was overseen and whether the incident reports were adequately reviewed, if at all.

Reports were filed using other officers' login credentials

As noted, the IRM is the official record of a given incident in CSNSW's OIMS database. It is important that the information contained in IRMs is accurate. It may be searched for purposes such as intelligence gathering and complaint investigation.

The integrity of OIMS data is compromised, however, if correctional officers log IRMs using the user accounts of other correctional officers. For instance, such an IRM may incorrectly imply the involvement or non-involvement of certain officers in a particular incident.

As noted in chapter 4, Mr Dippel completed an IRM in relation to the search of inmate A's cell on 20 February 2014 under Mr Graf's login. Consequently, the "Reported by" field of the IRM refers to Mr Graf, meaning that the use of personal pronouns in the "Summary" field gave the impression that:

- the IRM was Mr Graf's account of the search, when in fact it was Mr Dippel's
- Mr Graf was involved in, or had intimate knowledge of, the search, when in fact he had no involvement in it.

Three officers gave evidence to the Commission that entering electronic data using another officer's account occurred repeatedly at the LCC:

- Mr Taylor, who indicated that he did not do it personally but that such password sharing occurred "regularly"
- Mr Dippel, who indicated that entering information on OIMS under another user's login "sometimes" happened
- Mr Graf, who indicated that, while logging in as someone else was not common, it had occurred on other occasions.

Ensuring that all correctional officers only make IRM entries using their own login details will help protect the integrity of OIMS data. For instance, it will make it easier for CSNSW to hold officers accountable for any inaccurate information they enter into OIMS.

Recommendation 2

That CSNSW ensures its policies and procedures discourage the sharing or misuse of passwords. These requirements should also be reflected in the relevant officer's training.

Information concerning seized contraband was poorly recorded

This investigation also identified poor practices concerning the recording of information about contraband confiscated from inmates.

Under CSNSW's Operational Procedures Manual the most senior officer present at a search must record the details of a drug-find in the exhibits register. Additionally, the exhibit bag number pertaining to the drugs found should be recorded in the relevant register entry.

There was no exhibit number recorded in the exhibit register entry pertaining to the tablet and powder discovered in inmate A's asthma puffer.

Additionally, in relation to the tablet and powder taken from both inmate A's puffer and suboxone taken from inmate C the previous day, the following records could not be found (despite these records being required under CSNSW procedures):

- notification to police
- record of police refusal to deal with the matter
- order for the confiscation of the drugs made by the GM or his or her delegate
- records regarding the destruction of the drug, including relevant entries in the officer's journals and IRM event log.

CSNSW cannot have any comfort that recordkeeping controls at the LCC are working as intended. This invites the question of how well these controls operate at other correctional centres.

Recommendation 3

That CSNSW introduces controls to ensure that, if required information is not entered into the Offender Integrated Management System (OIMS) within a specified period of time, a report will be generated and a review conducted by an appropriate officer who will be required to report to the GM.

Image recording

Image recordings, such as videorecordings, CCTV and photographs, can act as a check on the accuracy of records such as IRMs and incident reports. For example, reviewing a videorecording of a UOF incident can substantiate or challenge an account presented in a relevant incident report.

Image recordings of incidents such as UOFs and cell searches also serve to protect both correctional officers and inmates from false allegations.

This investigation identified four control deficiencies concerning the use of image recordings:

- the planned UOF on inmate A was not videorecorded using a handheld camera
- there was inadequate videorecording of the search of inmate A's cell and removal of items into the day room
- CCTV footage was not preserved in relation to both the UOF on inmate A or the search of his cell
- still photographs were not taken in relation to the UOF on inmate A or the search of his cell.

Failure to videorecord planned UOF

CSNSW procedure required that, prior to the commencement of a planned UOF, a video camera must be brought to the scene, even if the area is subject to CCTV recording. A planned UOF is defined as one where "there is a prior indication that force *may* be necessary and there is time to prepare for its use" [emphasis in original].

Under CSNSW policy, the UOF on inmate A fell within this definition.

Inmate A was secured in his cell, and posed no immediate danger to himself, other inmates or correctional officers. Consequently, there was ample time to anticipate the potential UOF and the need for videorecording equipment.

The Commission is satisfied that the UOF was not recorded on video because there was no lawful justification for the UOF.

In any event, regardless of the reason why a video camera was not used to record the search, the Commission is satisfied that body-worn cameras can help facilitate the creation of an accurate record of all UOF incidents, and consequently protect both inmates and correctional officers. This was acknowledged by a number of CSNSW officers, including in evidence given to the Commission by Mr Graf:

[Counsel Assisting]: And can I suggest that you wouldn't have been put in that position if you had body cameras? Would that have assisted?

[Mr Graf]: Absolutely would have assisted.

[Q]: And is that because the camera doesn't lie and you can't fudge what's on the tape?

[A]: Correct.

[Commissioner]: Unless it's lost or deleted. Correct?

[A]: Correct.

[Counsel Assisting]: But I assume that there are less excuses in terms of turning on cameras if they're body cameras.

[A]: Absolutely.

[Q]: You seem to grasp that suggestion with some enthusiasm. Is there a reason for that?

[A] I've always been an advocate of them, I think they'd be great for IAT.

[Q]: And not only to avoid this situation, I assume, but to protect officers as well from- - -?

[A]: Yes.

[Q]: *- - -accusations.*

[A]: *Stops people being put in the wrong spot, too.*

Recommendation 4

That CSNSW:

- **supplies body cameras to correctional officers who are likely to be involved in UOF incidents and prioritises the supply of these cameras to correctional officers assigned to the IATs**
- **provides correctional centres with the means to readily obtain footage from these body cameras and store it for a sufficient period of time.**

CSNSW has advised the Commission that it partially supports this recommendation. It advises that it supports supplying body-worn cameras to IAT members and that there may be scope to provide body-worn cameras to staff within "other areas of CSNSW where it has been assessed that body cameras would be operationally useful", but that this is dependent on future funding.

Inadequate videorecording of the search of inmate A's cell

The search of inmate A's cell on 20 February 2014 should have been videorecorded because there was a potential need to use force. The purpose of the search was to find a weapon following inmate A's discussion with his father.

Much of the search of inmate A's cell was not videorecorded. This was despite the fact that there were CSNSW officers moving in and out of the cell. In an interview with Commission officers, Mr Kennedy, who oversaw the search of the cell, described the lack of videorecording as "bizarre".

As a result of the lack of continuous videorecording, continuity of evidence was broken in relation to securing inmate A's cell and obtaining any contraband.

To recap, the specific issues with the videorecording of the reported discovery of a tablet and powder find were that:

- not everyone involved in the search was introduced
- the camera was switched off when the cell was being searched and when the tablet and powder were found
- once the tablet and powder were found, the discovery was re-enacted for the camera with a different correctional officer "finding" it
- an interview, in which inmate A supposedly admitted ownership of the tablet and powder and alleged that IAT officers had assaulted him, was not videorecorded
- the destruction of the tablet and powder found in the search was not videorecorded.

The most crucial part of the search, namely, when the tablet and powder were discovered, was not videorecorded. Mick Watson ordered the cessation of videorecording once a strip-search of inmate A had been completed but before his cell had been searched. This led to a 10-minute gap in the videorecording, during which the tablet and powder were found. Mr Kennedy gave evidence that it was "unusual but not uncommon" for a cell search not to be filmed, and that it was an operational decision made by Mick Watson that was not discussed with Mr Kennedy.

As previously noted, the videorecording also provided a misleading account of which CSNSW officer actually discovered the contraband. Mr Murdoch discovered the contraband but the videorecording showed Mr Dippel finding it. This was because the find was re-enacted for the videorecording but it was decided that Mr Dippel should "find" it given he was more experienced with the processes surrounding such finds.

Mr Kennedy gave evidence to the Commission that Mr McMurtrie having off-camera conversations with inmates was not unusual, although the practice itself was "highly irregular". He also gave evidence that he was not aware of any off-camera admissions made by inmate A.

Supplying CSNSW officers with body cameras would make it easier to accurately record cell searches. As with the videorecording of anticipated UOFs, the recording of all targeted searches would limit the ability of correctional officers and inmates alike to falsely allege misconduct.

An additional issue regarding the search of inmate A's cell relates to how the contraband in question was destroyed. It is difficult to determine the precise process that was used because the destruction of the contraband was not videorecorded.

Mr Kennedy gave evidence that he videorecorded the destruction of drugs but that this practice is uncommon at correctional centres. Consistent with this, both Mr Taylor and Mr Peebles gave evidence to the Commission that they have never videorecorded the destruction of drugs at a correctional centre.

Recording the destruction of drugs found in the possession of inmates protects the correctional officers involved in the destruction. For instance, it allows them to respond to any allegations that they retained the drugs instead of destroying them.

Recommendation 5

That CSNSW:

- **mandates the videorecording of the destruction of contraband drugs found on inmates or in their cells**
- **provides correctional centres with the means to readily obtain such footage and store it for a sufficient period of time.**

CSNSW has advised the Commission that it supports this recommendation.

Failure to save CCTV footage

In addition to the use of handheld video cameras, CSNSW uses extensive CCTV recording within its correctional centres. Given it is very difficult to record everything that happens within a cell with one camera, CSNSW relies on CCTV footage to fill in gaps that may exist in videorecordings made by handheld cameras.

As previously noted, CCTV footage is required to be included with a UOF package, even if this footage does not directly show the UOF. This is because such footage might show relevant details, such as who was in the vicinity when the UOF occurred. Consequently, the CCTV footage relevant to the UOF on inmate A should have been included with the relevant UOF package, even if the footage showed nothing.

CCTV footage at the LCC and other correctional centres must be downloaded and saved if it is to be retained. This is because such footage is automatically overwritten after a defined period of time. This period varies across correctional centres but was 11 days at the LCC during the time period relevant to this investigation.

CCTV footage relevant to the UOF on inmate A was not included with the relevant UOF of package and now cannot be located. As noted, the Commission is satisfied it was intentionally destroyed.

Since the CCTV footage was not included in the UOF package, it was unavailable to CSNSW investigators when they conducted enquiries. Had this footage been available, it is highly likely that investigators reviewing it would have identified issues with the official account of the UOF on inmate A. At the very least, this footage would have identified the presence of a number of correctional officers whose involvement was not noted in the IRM or incident reports.

The same can be said in relation to the search of inmate A and cell 208 the next day.

The CSNSW practice is that CCTV footage must be retained (that is, not overwritten) when it relates to the discovery of contraband in an inmate's cell.

As he was in charge of the search, it was Mr Kennedy's responsibility to secure the relevant CCTV footage. Mr Kennedy did not secure this footage but, in an interview with Commission officers, claimed this was not problematic. He gave two reason for this:

- there was no need to retain the footage, as it was only a small contraband find when CSNSW officers were searching for a hidden weapon
- the LCC lacked the technical resources to retain the footage, as there would be too much CCTV footage retained if footage related to every such drug find was saved.

The Commission does not accept Mr Kennedy's reasoning. Whether or not the find of contraband was small in comparison with other finds within correctional centres, the lack of CCTV footage made it unnecessarily difficult to determine whether the contraband was planted. It should be noted that the discovery of the contraband allegedly occurred outside cell 208. That is, in an area covered by the CCTV camera. The Commission is satisfied that the contraband was planted in inmate A's asthma puffer. However, as noted, it has been unable to determine which correctional officers were involved.

The Commission is satisfied that CSNSW must ensure that all correctional centres have the technical resources to retain CCTV footage relevant to all UOFs and targeted searches that result in a find of contraband.

Recommendation 6

That CSNSW ensures all correctional centres have sufficient technical resources to retain all CCTV footage that is necessary or desirable to retain under CSNSW procedures concerning the UOF and targeted searches.

CSNSW has advised the Commission that it supports this recommendation.

Failure to take photographs

Photographs are another type of image recording that can provide valuable evidence in relation to allegations of misconduct concerning the UOF, whether on an inmate or correctional officer, and the discovery of contraband. For example, photographs can provide evidence concerning the extent of injuries suffered by an inmate or correctional officer, or an accurate representation of contraband that has been discovered in the possession of an inmate.

The Commission's investigation identified a failure to photograph:

- inmate A's injuries arising from the UOF on him
- the contraband allegedly discovered in inmate A's asthma puffer the next day.

CSNSW procedures require that photographs are taken following any UOF incident that results in an injury. The Commission understands the taking of photographs in such circumstances was standard practice within the LCC during the time period relevant to this investigation. Nevertheless, no photographs were taken of the injuries suffered by inmate A arising from the UOF on him.

The failure to take photographs of inmate A's injuries, and include them in the UOF package, should have been detected and immediately investigated when the package was reviewed by Mr Taylor and Mr O'Shea.

Likewise, the contraband discovered when cell 208 was searched was not photographed. Mr Taylor gave evidence that photographing drug finds was not standard practice at correctional centres:

[Counsel Assisting]: In terms of a drug find, would you ordinarily expect still photographs to be taken of the find itself?

[Mr Taylor]: No. Some gaols do, some gaols don't.

[Q]: What about at Lithgow in 2014?

[A]: Not that I can recollect, no.

Taking photographs of discovered contraband provides another source of real evidence, especially if any issue arises in relation to the retention and storage of video footage.

The Commission notes, again, that CSNSW already requires photographs of injuries following a UOF, which should extend to searches that result in the discovery of contraband.

Recommendation 7

That CSNSW requires that all contraband at correctional centres is photographed at the time of discovery. This requirement should be reinforced via relevant CSNSW training, compliance and audit programs.

CSNSW has advised the Commission that it supports this recommendation.

Review and oversight

The mere existence of procedural requirements provides no guarantee that they will be met. The failures identified by the Commission in this investigation demonstrate this to be so. Vigilant oversight within a robust review framework is vital in controlling the corruption risks addressed in this report.

The Commission identified a number of control deficiencies in relation to the review and oversight of correctional officers at the LCC, including:

- the managerial review of use of the UOF package by Mr Taylor and Mr O'Shea was inadequate
- CSNSW lacked sufficient independent assurance mechanisms.

The UOF package was poorly reviewed

Under CSNSW procedures, the MoS "or another delegated senior manager" must review incident reports and video footage relating to a UOF incident. Once the UOF package is reviewed by the MoS, the GM reviews it.

The Commission is satisfied that, if a MoS or GM identifies that any required materials, such as incident reports, video footage, CCTV footage or still photographs, are missing from a UOF package, immediate steps must be taken to obtain them. If there is no reasonable explanation for the absence of this material, the matter must be escalated and reported in writing to the PSB. The review of the UOF package and the glaringly obvious deficiencies in the process have been addressed in chapter 3.

It should also be noted there was no after-action review of the UOF on inmate A, despite the CSNSW Review Guide imposing such a requirement in respect of all UOFs. This is a requirement additional to the requirement for the MoS and GM to review the UOF package. Mr Taylor gave evidence to the Commission that such reviews are rarely carried out.

The Commission is satisfied that it was inappropriate for Mr Taylor or Mr O'Shea to have reviewed the UOF on inmate A; each had been involved in the incident, and their conflict of interest was obvious. CSNSW procedures required that "if the Manager Security was involved in the use of force, then a conflict of interest exists and the General Manager must review the reports and video recording(s)".

While CSNSW procedures did not address how the UOF package should be reviewed, if the GM were also involved in or witnessed the incident, Mr Peebles gave evidence that the usual practice was to send the UOF package for external review:

[Counsel Assisting]: If, for example, a general manager saw a use of force, would that affect their reviewing function of the UOF package?

[Mr Peebles]: Yeah. They'd have to exclude themselves from it.

[Q]:	*They would be conflicted, wouldn't they?*
[A]:	*Yes.*
[Q]:	*Yeah. Have you ever come across that before where the general manager was conflicted from the review process?*
[A]:	*Yes, I think I have. Yeah.*
[Q]:	*And does it stay within the centre or does it go outside the centre in those circumstances?*
[A]:	*No, it goes outside the centre.*

Had the UOF package regarding the UOF on inmate A been sent to an independent external reviewer, it is likely that a number of the deficiencies addressed in this report would have been identified.

The Commission accepts that, generally, it is acceptable for the MoS and GM to review UOF packages produced within their correctional centre; they are the most senior officers. As such, they ought to have a comprehensive understanding of the facility, the performance characteristics of the correctional officers who work within it and, to some extent, the inmates under their care and control.

However, in circumstances where either the MoS or GM are involved in a UOF incident, whether as a participant or as a witness, it is inappropriate for them to have any involvement in the review of the UOF package.

CSNSW has informed the Commission that this is current policy. If the policy existed in 2014, the evidence taken during the Commission's investigation suggests that it was either unknown or simply ignored.

Recommendation 8

That CSNSW communicates to the GMs and MoSs at all correctional centres that they cannot be involved in a review of any UOF package if they were involved in or a witness to the UOF in question. Instead, the UOF package must be externally reviewed.

CSNSW has advised the Commission that it supports this recommendation.

CSNSW lacked independent assurance mechanisms

The management of the LCC failed to provide adequate oversight of both the UOF on inmate A and the searching of his cell. In his review of the CSNSW internal investigation report, CSNSW investigations director Michael Hovey commented that:

> *...of greatest concern is that if the issues regarding this incident were not raised by the ICAC, it is highly probable that it would not have come to light under CSNSW processes. This is despite the incident being reviewed locally at the time. [emphasis in original].*

The Commission agrees with this comment. It raises the question of whether CSNSW's independent-assurance mechanisms are sufficient to ensure that a correctional centre's management can detect significant failings to enforce CSNSW's policies and procedures. The Commission examined these mechanisms in relation to CSNSW's UOF and cell searching procedures.

CSNSW has informed the Commission of four types of independent-assurance mechanisms utilised by it to ensure compliance with its UOF procedures.

First, performance reports are tabled at CSNSW executive meetings on a quarterly basis. Among the information provided in these quarterly reports is the following information for each correctional centre:

- the number of UOF incidents
- the number of UOF incidents for which there was video footage
- the number of UOF incidents for which there was handheld video footage
- the rate at which the MoS and GM of each correctional centre reviewed UOF incidents.

In the event that these figures suggest (1) non-compliance with procedural requirements, (2) a spike in the number of reported UOF incidents or (3) overdue reviews of UOF reports, an assistant commissioner would make enquiries of GMs who report to them.

As discussed earlier, if inmate A had not been injured in the relevant UOF incident, it is likely that this incident would never have been reported. Consequently, this mechanism, while undoubtedly valuable for other reasons, is not a foolproof, independent-assurance mechanism.

Secondly, when a UOF involves a specialised unit, the UOF package is reviewed by a MoS in that unit in addition to being reviewed by the MoS of the correctional centre. While sensible, this mechanism is not relevant to the current investigation because the IAT is not considered a specialised unit in this regard. This is because IAT officers are drawn from the staff of the correctional centre in which the IAT is based and the officer in charge of the IAT reports to the MoS of that correctional centre.

Thirdly, CSNSW's Corrections Intelligence Group (CIG) regularly compares and reconciles UOF IRMs and incident reports within OIMS, allowing the identification of any discrepancies and the subsequent follow-up of them. These reviews are carried out daily for UOF incident reports and are designed to ensure that the IRM is not finalised until all relevant information has been collected.

The effectiveness of these CIG reviews as an assurance mechanism is limited because they:

- do not consider whether the UOF was appropriate or reasonable
- are vulnerable to the type of collusion in respect of incident reporting that happened at the LCC
- do not appear to have detected the issues with lack of videorecording in relation to the UOF on inmate A (this may be because, at the time of the UOF on inmate A, there was no policy requirement to retain relevant CCTV or handheld footage once a UOF incident had been reviewed by the MoS).

Fourthly, CSNSW's Operational Performance Review Branch (OPRB) conducts reviews within correctional centres against operational standards in the areas of security, inmate management and services, and governance and administration. These operational reviews assess the centre's "overall compliance and performance against each standard and *not* the performance of individual staff" [emphasis in original].

Operational reviews conducted in 2014 identified similar issues surrounding the reporting of UOF incidents as those identified in this investigation. For example:

- there was missing documentation and video footage, and poor recordkeeping, regarding UOF packages reviewed at Cessnock Correctional Centre Maximum Security
- only two of five officers submitted a required incident report at the Compulsory Drug Treatment Correctional Centre, and parts of these two reports were almost identically worded
- reviews of videorecordings of UOF incidents at Long Bay Hospital 1 and 2 Correctional Centre indicated that responding or witnessing officers did not complete incident reports and their involvement was not recorded on the relevant IRMs.

The identification of these issues at correctional centres, other than the LCC, indicates that the compliance issues identified in this investigation regarding UOF incidents are of broader applicability across correctional centres.

While such reviews are valuable in identifying control deficiencies, the operational standards "do not include other more specialised operations including … Immediate Action Teams". This means that the systemic issues revealed by the Commission's investigation may not be within the scope of these reviews given that IAT officers were heavily involved in the UOF on inmate A.

Given that IAT officers are involved in many UOF incidents, and often assist with activities such as cell searches, the value of reviews conducted by OPRB would be enhanced if its scope included the activities of the IATs.

Recommendation 9

That the activities of the IATs be included in any relevant OPRB reviews, such as reviews of correctional centres against service specifications.

Additionally, similar to internal audit reports, these reviews should be designed to assess, in broad terms, whether controls are working at given correctional centres. By their nature, they are one-off activities and not ongoing assurance mechanisms – instead, they are a governance mechanism designed to assess whether relevant assurance mechanisms are working.

The Commission is satisfied that CSNSW has inadequate independent assurance mechanisms in relation to UOF incidents.

Mr Hovey told the Commission that "years ago" the Superintendent of Security and Intelligence reviewed every UOF package from across CSNSW. Such an external review might provide a better assurance mechanism for CSNSW. It was endorsed by Mr Kennedy.

However, if UOFs are reviewed externally *only*, it encourages a MoS and GM to "wash their hands" of managing use of force incidents within their correctional centre, resulting in an external reviewer having to manage relevant staff performance issues despite lacking the line authority to do so.

The Commission considers that the external review of use of force incidents should function as a check upon the MoS and GM review of use of force packages instead of replacing it.

Recommendation 10

That following review by the MoS and GM of a correctional centre, UOF packages be sent to a centralised CSNSW business unit, which should:

- **receive this package before CCTV footage is overwritten**

- **have direct access to relevant CCTV footage**
- **receive any other related technical product, such as recordings or photographs**
- **review either (i) all UOF packages it receives or (ii) a proportion of the UOF packages it receives that is sufficient to readily identify systemic issues that relate to a particular correctional centre.**

CSNSW has advised the Commission that it supports this recommendation.

In relation to its cell-searching procedures, CSNSW has informed the Commission that all cell searches undertaken by SOG are recorded and retained on file. Given this record is separate to the record of the search made by the relevant correctional centre, it may allow non-compliance to be identified independently of the correctional centre.

While this mechanism appears prudent in relation to searches undertaken by SOG, it may not be a valuable compliance mechanism more generally. It only applies to searches undertaken by SOG. Moreover, the involvement of Mick Watson in the search of inmate A's cell does not suggest that the involvement of SOG officers necessarily results in procedural compliance or good practice. His evidence very much suggested that although he observed a number of anomalies, he was prepared to ignore them because more senior officers were present.

CSNSW has also informed the Commission that since 2014 it has developed new independent assurance mechanisms in relation to the operations of its correctional centres. These involve the development of new "Service Specifications", "Key Performance Indicators" and "Performance Indicators".

The Service Specifications impose a number of requirements upon correctional centre management regarding cell searching. Those specifically relevant to this investigation include requirements to:

- implement comprehensive "strategies, systems and processes" surrounding:
  - searching within the correctional centre
  - reducing the amount of contraband within the correctional centre
- implement and maintain procedures, and an associated compliance framework, in relation to the detection of contraband
- ensure appropriate OIMS entries are made regarding cell searches and the discovery of contraband.

CSNSW has also advised that OPRB is responsible for overseeing operational performance of correctional centres and that it provides qualitative assessment of correctional centres against Service Specifications.

However, as discussed above, the role of OPRB appears to be more akin to governance than assurance. For example, the reviews conducted by OPRB seem to involve a sample of correctional centres. Consequently, if a correctional centre is not reviewed in a given year, there appears to be little independent information available to CSNSW about the extent of procedural compliance in that centre.

CSNSW would be in a better position to ensure compliance with its cell searching procedures if it had a specific mechanism to ensure that cell searches are being conducted in accordance with its procedural requirements. One possibility is an independent review mechanism similar to that recommended earlier in this section regarding UOF packages.

Recommendation 11

That CSNSW develops specific, independent assurance mechanisms surrounding the searching of cells. These mechanisms should examine whether CSNSW procedures are being complied with, and good practice is being applied, in relation to the:

- **discovery of contraband, including videorecording requirements**
- **reporting of the discovery of contraband**
- **confiscation and disposal of prohibited substances.**

CSNSW has advised the Commission that it supports this recommendation.

Complaint management and investigation

Functions such as internal reporting and investigations offer additional mechanisms to detect poor practice and procedural non-compliance.

While the UOF on inmate A was the subject of a CSNSW internal investigation, the poor reporting culture and investigation weaknesses meant that its investigation was unable to uncover what had occurred. The Commission's investigation has identified four control deficiencies in relation to the management and investigation of complaints at CSNSW, as follows:

- the poor reporting culture at the LCC
- the CSNSW Investigations Branch was unable to discreetly conduct fact-finding enquiries

- key allegations were not included in the scope of a CSNSW formal investigation
- the CSNSW internal investigation failed to identify key sources of evidence.

The discussion of control deficiencies in relation to CSNSW's internal investigations is not intended as criticism of Mr Hovey, or any other officer who was involved in conducting internal investigations at CSNSW; rather, it is directed at the systems and processes that governed the conduct of these investigations.

There was a poor reporting culture

At the LCC and other correctional centres, the term "on the dog" was commonly used to refer to correctional officers who reported the misconduct of their colleagues. This included correctional officers who submitted reports to commissioned officers, CSNSW's head office or the Commission. To be "put on the dog" generally resulted in ostracism or worse.

There was a fear amongst the LCC correctional officers that being put on the dog could result in professional and personal retribution. For instance, Mr Walker gave evidence to the Commission that individuals put on the dog would be severely isolated:

[Counsel Assisting]: And what does that mean on a day to day basis, what happens when you're on the dog?

[Mr Walker]: It's a bit like, it's a bit like having leprosy. No one wants to talk to you.

[Q]: All right.

[A]: You become an outcast, ostracised.

[Q]: And is that because you are seen to have given up your mates?

[A]: That is correct.

Within the LCC, both Mr Duffy and Mr Turton were treated differently because they had previously assisted with misconduct investigations. For example, Mr Turton was put on the dog by Mr O'Shea because he had previously been an honest witness regarding an incident at Parramatta Correctional Centre years earlier.

The effect of being put on the dog extended to individuals who associated with officers who had reported misconduct. For example, Mr Duncan told Mr Graf that Mr Graf's career progression would be adversely affected by associating with Mr Turton after Mr Turton had been put on the dog.

The fear of being put on the dog and suffering the detrimental effects that would follow was a significant barrier to the reporting of misconduct at the LCC. For example, in evidence given to the Commission:

- Mr Walker said that it was now easier for him to tell the truth about the UOF on inmate A because he no longer worked at CSNSW and the effects of being put on the dog would have been worse if he still worked there
- Mr Turton said that he had been afraid of physical reprisals in relation to the evidence he had given to the current investigation, such as being deliberately placed in a dangerous situation with inmates
- Mr Graf said that Mr Walker told him on five or six occasions that Mr O'Shea would ruin Mr Graf's career if he complained about the UOF on inmate A.

In such an environment, it is perhaps unsurprising that rumours were circulating about who may have made public interest disclosures (PIDs), with negative consequences for those named individuals. For example:

- Mr Turton's relationships with Mr O'Shea and Mr Peebles deteriorated because they falsely believed that he had made a report about another assault on an inmate
- there were rumours that Mr Turton had made a PID about the UOF on inmate A (Mr Turton made a complaint himself about these rumours as he had not made a PID)
- Mr Taylor believed he was being moved from one correctional centre to another because Mr Peebles and Mr O'Shea falsely believed that he had made a PID in relation to the UOF on inmate A.

At the LCC, correctional officers still fear retribution for reporting improper behaviour. Mr Graf and Mr Walker expected to be put on the dog for giving their evidence to the Commission and to suffer adverse professional and social consequences as a result.

This culture of hostility towards internal reporters extends beyond the LCC. Mr Turton said he had been subject to bullying, harassment, threats and intimidation as a result of having given evidence in relation to the Commission's Operation Inca investigation in 2005 (report released in 2006). This happened over a 12-year period at each of the 15 different correctional centres at which he had worked.

The Commission is satisfied that an unhealthy culture exists among correctional officers of putting their loyalty to other correctional officers above other public and legal

duties. The culture extends beyond the walls of the LCC. It is apparent from a number of more recent complaints received by the Commission involving the misreporting of UOF incidents at other correctional centres that misplaced loyalty to fellow officers is common.
The evidence of Mr Duncan confirmed that a culture exists of covering-up the misdeeds of others:

[Counsel Assisting]: And you felt comfortable at the time, did you, covering up for Mr Walker?

[Mr Duncan]: I wouldn't say I felt comfortable with it.

[Q]: But you were happy to do it?

[A]: Well, I did it.

[Q]: Did you value your friendship to Mr Walker and protecting him over putting in an honest report?

[A]: I did.

[Q]: You understand that at the time you had a duty as an officer of Corrective Services to be honest in your reporting function?

[A]: Yes.

[Q]: And you've described a moral code, if I can put it that way, of putting a friendship above that duty. Do you understand that?

[A]: Yeah.

It is likely that the involvement of Mr O'Shea in the UOF on inmate A compounded the unwillingness of other correctional officers to report the matter.

There were, and remain, disincentives for inmates to report officer misconduct externally. Mr Kennedy gave evidence that the willingness of inmates to make allegations against correctional officers was hampered by the potential for negative repercussions, as follows:

[Counsel Assisting]: I'm not talking about this specific case, but just generally, why is it problematic for an inmate?

[Mr Kennedy]: To make allegations or a charge with police whilst the correctional officers are in the centre, in that environment, it's quite, it's quite difficult because they are at the, at the mercy of the people that are in that location.

[Commissioner]: So there could be reprisal.

[Mr Kennedy]: There could be. Not often, Commissioner. But yes, there could have been.

[Counsel Assisting]: And in 2014, that was an issue. There was still a chance of reprisal against an inmate for making a complaint against an officer?

[Mr Kennedy]: There is now.

[Q]: Yes, there is now.

[A]: Yeah.

[Q]: And is that a Lithgow issue or is it broader, in your opinion?

[A]: I believe it's broader.

The Commission is satisfied that the culture among correctional officers at the LCC, and CSNSW correctional centres more generally, is a substantial impediment to the reporting of misconduct. The culture is entrenched, and it will take considerable effort on the part of CSNSW and its correctional officers to effect positive change. However, without such change, incidents such as those examined by the Commission in this investigation, will likely continue.

Recommendation 12

That CSNSW implements a coordinated strategy to improve the cultural environment for correctional officers within its centres, with a view to alleviating the burden imposed on those officers who report the misconduct of others. Logically, those measures might include:

- **focused training and education on the importance of reporting misconduct within a corrections environment**
- **support for complainants and protection of their identity**
- **avenues for making anonymous reports and identification**
- **exposure and action in response to those who engage in bullying, harassment or other forms of reprisal.**

Recommendation 13

That CSNSW monitors the treatment of those officers who have assisted the Commission in this investigation.

CSNSW has advised the Commission that it supports both of these recommendations and is "reviewing and considering implementing" the strategies used by the NSW

Police Force to protect staff who report misconduct.

There was a culture of mistreating inmates

The cultural issues at the LCC extend beyond hostility to reporting officer misconduct; it extends to the mistreatment of inmates. The many recent reports received by the Commission from inmates and CSNSW in relation to UOF incidents suggest that mistreatment of inmates is occurring in other correctional centres.

Mr Walker gave evidence that he was asked to "sort out" inmates on more than one occasion. Sorting out an inmate involved being physical with them. While the precise actions Mr Walker would take depended on how the inmate acted, there would be no disapproval of Mr Walker's actions if he applied force. However, unlawful application of force to an inmate was only part of the story.

The Commission is satisfied that the terms "ramping", "cell therapy" or "therapy" are well known to correctional officers. It refers to actions of officers directed at inmates, such as yelling abuse, trashing an inmate's cell or applying unnecessary physical force to an inmate. Mr Walker gave evidence to the Commission that such actions were used in relation to problematic inmates to "teach them a lesson".

Mr Duncan gave evidence to the Commission that, when "therapy" occurred, it was at the direction of senior CSNSW officers:

[Commissioner]:	*You were here when Mr Walker gave evidence, were you?*
[Mr Duncan]:	*No.*
[Q]:	*All right. He suggested one aspect of it might be to go in and, in effect, trash their cell.*
[A]:	*Yeah. I, look, I've done that. Yeah.*
[Q]:	*And when you were asked to do that, can we assume that it was a direction from a superior officer?*
[A]:	*Yeah.*
[Q]:	*Yes.*
[A]	*Yeah.*
[Q]:	*It's not the sort of thing you'd do on your own?*
[A]:	*No, you don't. People at my rank and even Terry's rank don't, "Mate, listen, go and give this bloke therapy, he's done this", or- - -*

Evidence given at the public inquiry indicates that the use of the term "therapy" for such practices extends beyond the LCC and has existed for years. For example:

- Mr O'Shea gave evidence that the term is used "across the department, outside the department and everywhere"
- inmate B gave evidence that he was aware of the term and indicated that "therapy" had occurred at each of the approximately 10 correctional centres at which he has been incarcerated
- Mr Peebles gave evidence to the Commission that the term has been in use for a considerable period of time.

Various correctional officers described therapy as:

- "…yelling abuse to completely trashing the cell and sometimes further … It's purely to teach them [inmates] a lesson"
- "…anything from, you know, tip an inmate's cell over when you search it, make it a mess, you know, I mean people will have their buy-up sheets go missing and, you know, just silly stuff, yeah, so the inmate knows maybe I shouldn't be such an arse next time … But not physical, that physical sort of therapy is something that went out a long, long time ago"
- "…just to show a presence, more than anything. Like put them in their place … it certainly doesn't mean go in and bloody belt someone, like you'd go in there and you tell them "Mate, you need to pull your head in." You might even make a mess of their cell, like stuff like that"
- buy-up forms and possessions go missing
- "…it was generally something that was carried out by junior staff, wing officers and such … it would be losing letters, losing buy-ups … Not so much having your cell trashed because you know, for junior officers in a wing that would probably end up getting you a smack in the mouth off the inmates, so it wasn't anything as overt as that, but just losing buy-ups, letters…".

Inmate B described therapy as follows:

> *Oh, just takin' buy-up forms um, thrashin'* [sic] *the cell, like tipping ashtrays in your pillows and open jams* [jars of jam] *and putting 'em on our bedsheets and takin' our towels and not giving us new ones, not letting us mop our cells down, yeah, just, I don't know, taking our, leaving the TV and the cord in the cell but taking the co-ax cable so we're sitting there watching nothing, got a blank screen, can mean a lot of things really.*

Inmate B told the Commission that he had been the subject of such conduct. He said he had been incarcerated in a substantial number of correctional centres. He had been the subject of therapy in each centre and had observed it applied to other inmates.

The Commission is satisfied that "therapy" is culturally entrenched within CSNSW. The fundamental need to preserve the basic human rights of inmates was addressed in chapter 1. Practices that undermine these rights in the interests of prisoner management or as extra-curial punishment cannot be condoned.

Recommendation 14

That CSNSW takes sustained measures to prevent the practice of "therapy", "cell therapy" or like practices being applied to inmates.

CSNSW has advised the Commission that it supports this recommendation and that "cell therapy" should not happen at any correctional centre, as it breaches both CSNSW's policies and procedures and its duty of care to inmates.

CSNSW has also suggested that there are a number of complaints mechanisms available to inmates, including:

- making an unmonitored call to the Corrective Services Support Line
- making a complaint to an official visitor or the NSW Ombudsman
- unrestricted access to legal representation
- making contact with the Office of the Inspector of Custodial Services.

CSNSW may find it useful to consult with inmates to understand their knowledge of these options and willingness to use them, as well as any perceived barriers to their use.

CSNSW's investigation was compromised

In addition to internal complaints that were made regarding the UOF on inmate A, a PID was also made to the Commission. Following the receipt of this PID, the Commission decided to conduct assessment enquiries and sent a letter to CSNSW requesting information pertaining to the alleged assault of inmate A at the LCC.

It is the role of PSB staff to assess and triage complaints. Once PSB has assessed a matter, it is passed to the PSC for a decision. The PSC consisted of the director of PSB, Mr Hovey, and the commander of the police unit responsible for investigating CSNSW-related matters.

To facilitate a response to the Commission's assessment enquiries, the PSC decided to conduct discreet fact-finding enquiries. In an interview with Commission investigators, Mr Hovey stated that such enquiries are made without talking to "any of the staff involved". Given he only had two weeks, Mr Hovey conducted the initial fact-finding enquiry himself, rather than assign it to another investigator. The purpose of his enquiries was to gather sufficient information on which a decision could be made whether a formal investigation ought to be carried out by CSNSW.

By searching OIMS, Mr Hovey was able to obtain the IRM related to inmate A without alerting any LCC officers.

However, once he had identified the IRM, Mr Hovey emailed Mr Peebles to request the UOF package and enquire if there was any video footage of the incident. Mr Peebles forwarded the request to Mr O'Shea, who in turn forwarded it to Mr McMurtrie. Mr McMurtrie then forwarded the documents to Mr Hovey and indicated that there was no video footage of the UOF incident.

The effect of Mr Hovey's email to Mr Peebles requesting the UOF package was to notify individuals, such as Mr O'Shea and Mr McMurtrie, that CSNSW Investigations Branch was examining the UOF on inmate A. Consequently, officers involved in the incident were able to prepare for the internal investigation that followed.

The Commission does not criticise Mr Hovey in respect of the manner in which he conducted the investigation. In an interview with Commission officers, he stated that he had no choice but to approach Mr Peebles for the UOF package:

> *…prior to the IRM being the overarching recording system for incidents around the state all packages were faxed to the duty officer at Silverwater. So they were held in a repository at Silverwater for the purposes of investigation all I would have had to have done was contact the duty officer and say use of force can I get the package. Now the packages remain local to the centre where the incidents occur and all we get is is the IRM entry as the point of referral. So my recollection is is I had no choice but get that package from Lithgow.*

The Commission accepts Mr Hovey's account of the system he was required to utilise in 2014.

Mr Hovey also outlined three additional factors that caused him to approach Mr Peebles. First, he knew Mr Peebles, had no reason to suspect him, and thought it would be the quickest and simplest way to discreetly get hold of information. Secondly, he needed to contact someone at the LCC to ascertain whether there was any

video footage of the incident. Thirdly, "quite regularly" CSNSW investigators did not have access to relevant documents in CSNSW's electronic recordkeeping system; while Mr Hovey and his investigators could see whether the documents existed, they needed to request that these documents be unlocked.

As a result of this limited access to information, Mr Hovey's first port of call in relation to an alleged improper UOF was generally the MoS or GM of the relevant correctional centre. Much would depend on the "[correctional] centre and my sort of network".

The ability of CSNSW investigators to discreetly access relevant information was not always this limited. Until about 2007 or 2008, all UOF packages were stored centrally, allowing investigators to examine them without alerting staff working at the relevant correctional centre. Excluding exceptional circumstances, such as a formal investigation, UOF packages now only leave a correctional centre if its GM refers the incident to the PSC.

An effective internal investigations unit must be able to conduct discreet enquiries if it wishes to avoid compromising an investigation; more so, in a cultural environment that is resistant to reporting.

Recommendation 15

That CSNSW investigators have ready access to (i) relevant CSNSW documents, such as UOF packages, and (ii) other evidence, such as CCTV footage, in a manner that does not in any way depend on, or alert, other CSNSW staff.

CSNSW has informed the Commission that it supports this recommendation in principle. It notes, however, that investigators should not have access to all information, at all times, but should obtain access to relevant material, as needed. It has also undertaken to review its systems if any investigation is impeded by a lack of access to information.

To ensure that such an approach does not impede the progress of an investigation, the means by which investigators gain access to relevant information will need to be quick and reliable. It is critical that potential persons of interest, witnesses, or associated parties are not alerted.

Key allegations were not included in the scope of CSNSW's internal investigation

It is usual practice within CSNSW that a completed factual investigation is referred back to the PSC, which then refers it to a "decision-maker" to determine what further action should be taken.

Once he completed his enquiries, Mr Hovey prepared a report, dated 2 May 2014, in which he:

- identified inconsistencies and other issues in the incident reports filled by Mr Duncan, Mr Graf and Mr Walker
- queried why a video camera was not used for a pre-planned search, which he identified as a "major issue"
- made reference to inmate A's telephone call to his father, in which he alleged being assaulted by IAT members
- noted that the management review of the UOF package failed to identify that the failure to use a video camera was an issue
- referred it back to PSC for consideration (which ultimately led to the internal investigation discussed in this and the next section of this chapter).

During 2014, the decision-maker in relation to alleged misconduct at the LCC was the assistant commissioner of custodial corrections, who is responsible for the management of all correctional centres. Across CSNSW, more generally, the decision-maker was the person responsible for the area in which the misconduct had occurred. Therefore, the officer who decided whether a formal investigation would take place was not independent. This was not consistent with best practice, including advice provided in the Australian Standard on Fraud and Corruption Control AS 8001-2008. It also had the potential to undermine statutory reporting to the Commission under s 11 of the ICAC Act.

The lack of independence created, at the very least, a perception that investigations might be compromised. Mr Hovey informed the Commission that there had previously been cases where PSB requested an investigation but the decision-maker from the operational business unit resisted, creating a "war of attrition". More generally, there were perceptions of self-interest if a decision-maker refused to authorise an investigation into his or her area. These perceptions could exist, even if the decision in question was entirely justified.

CSNSW's internal investigation into the UOF on inmate A provides a good example of these issues.

Subsequent to the completion of Mr Hovey's fact-finding enquiries in 2014, the Commission sent a further letter to CSNSW that included new allegations regarding the UOF on inmate A, including allegations that Mr Peebles and Mr O'Shea had directed the assault on inmate A. While the UOF on inmate A was ultimately the subject of a formal investigation, allegations regarding senior management were not included in its scope.

Beyond waiting for the possible referral of a formal investigation to it, CSNSW Investigations Branch was

essentially powerless in relation to investigating the additional allegations contained in the second letter from the Commission. Mr Hovey had no authority to investigate the matter given that his fact-finding investigation had been completed. CSNSW Investigations Branch had no power to conduct own-motion investigations.

Given the decision-maker was ultimately responsible for the conduct, or misconduct, of officers who might be the subject of investigation, there was a significant risk that the decision-maker's decision would be regarded as one infected by favouritism thereby affecting the willingness of correctional officers to report misconduct in the future.

Currently, the decision-maker in relation to alleged corrupt conduct at a correctional centre could be either the assistant commissioner of corrections or a director who reports to this position. Arguably, a director would be seen to have even less independence than an assistant commissioner because they are likely to be organisationally closer to the officers who might be the subject of a formal investigation.

Recommendation 16

That CSNSW reviews its procedures for the initiation and escalation of investigations. Among other things, this review should address the need for independence and objectivity.

CSNSW has advised the Commission that it supports this recommendation.

CSNSW's investigation unit unable to obtain key evidence

Mr Duffy was not surprised when CSNSW began an internal investigation into the UOF on inmate A. As noted earlier, Mr Duffy registered his incident report with the deputy's clerk in the hope that the incident would be investigated as an excessive UOF. Consequently, he assumed that his incident report had led to the commencement of the internal investigation. He was mistaken; Mr Duffy was never interviewed. CSNSW investigators were unaware of his incident report or that he had been involved in the incident.

The framework in which interviews were conducted was not conducive to unearthing the entire truth. Again, the culture of not reporting played a role. For example, while Mr Turton gave a truthful account to CSNSW investigators, he did not make any allegations against Mr O'Shea because:

- he was afraid he would face reprisals as he had not made a PID
- a CSNSW investigator had previously sent him a factually inaccurate statement to sign, even though he had not yet been interviewed at that time
- it had been suggested to him that CSNSW's investigations unit was involved in the cover-up of the UOF on inmate A
- the interview was held in a room that was close to Mr O'Shea's office, and Mr O'Shea was present when the interview was conducted.

The Commission's investigation identified a number of deficiencies in CSNSW's investigation function that have the capacity to negatively impact on the ability of CSNSW investigators to obtain relevant information, as follows.

- CSNSW Investigations Branch does not have ready-access to information such as incident reports.
- CSNSW does not have standard operating procedures for conducting investigations (the Commission notes, however, that it is currently in the process of finalising an investigations manual).
- CSNSW's investigation case management tool is limited. Mr Hovey informed the Commission that the tool was not designed to manage investigations but was "bastardised" from CSNSW's intelligence database. It is not an investigative tool but simply a repository for documents and information. Specific weaknesses with it include that:
  - it cannot store video material
  - functionality that would allow CSNSW investigators to produce a case report is broken
  - the CSNSW Investigations Branch cannot perform basic administration on it without involving other CSNSW business units (for instance, it took four weeks for a new manager of investigations to be granted access to the system and the access that was ultimately granted was insufficient).
- CSNSW timelines to complete investigations are not always realistic, given the peaks and troughs of investigative work. Having regard to the fact that CSNSW currently has approximately 8,500 employees, the CSNSW Investigations Branch, which is staffed by eight officers (including Mr Hovey), may be under-resourced.

Recommendation 17

That CSNSW reviews its investigation function to ensure that it:

- **is staffed in a manner that enables it to meet timeframe key performance indicators without compromising investigation quality**
- **has access to appropriate technical resources, including a case management system that sufficiently caters for its needs.**

Recommendation 18

That CSNSW prioritises the completion of its investigation manual.

CSNSW has advised the Commission that it supports both of these recommendations.

Review by CSNSW

CSNSW has commenced a project examining several of the systemic issues identified in this investigation. The Commission supports this project and the approach taken by Mr Severin to addressing the corruption risks.

In relation to the CSNSW project, the Commission notes that its investigation was primarily limited to the events taking place at a single correctional centre over five years ago. However, the receipt by the Commission of a number of complaints that are more recent, and recent referrals from CSNSW, suggest that like-conduct has occurred, and continues to occur, within a number of correctional centres across the state. The Commission notes that, in relation to some of the complaints and referrals, CSNSW has initiated misconduct proceedings and that a number have been resolved.

The Commission also notes, as discussed in chapter 1, the Western Australian Corruption and Crime Commission and the Queensland Crime and Corruption Commission have completed corruption prevention-driven enquiries into their respective corrections sectors.

Finally, CSNSW has information holdings that may facilitate the identification of misconduct by CSNSW officers and/or relevant systemic issues. However, effective use of these holdings may require CSNSW to develop new data analytic approaches.

Recommendation 19

That staff responsible for CSNSW's project regarding systemic issues identified in this investigation consider and action the following issues:

- **whether any of the conduct identified in the Commission's investigation occurs at other correctional centres**
- **the evidence and findings made by anti-corruption agencies in Queensland and Western Australia**
- **how data analysis of its information holdings can facilitate the identification of misconduct by correctional officers and issues that may be systemic within the corrections sector in NSW.**

CSNSW has advised the Commission that it supports this recommendation.

These recommendations are made pursuant to s 13(3)(b) of the ICAC Act and, as required by s 111E of the ICAC Act, will be furnished to CSNSW and the responsible minister.

As required by s 111E(2) of the ICAC Act, CSNSW must inform the Commission in writing within three months (or such longer period as the Commission may agree in writing) after receiving the recommendations, whether it proposes to implement any plan of action in response to the recommendations and, if so, of the plan of action.

In the event a plan of action is prepared, CSNSW is required to provide a written report to the Commission of its progress in implementing the plan 12 months after informing the Commission of the plan. If the plan has not been fully implemented by then, a further written report must be provided 12 months after the first report.

The Commission will publish the response to its recommendations, any plan of action and progress reports on its implementation on the Commission's website, www.icac.nsw.gov.au.

Appendix 1: The role of the Commission

The Commission was created in response to community and Parliamentary concerns about corruption that had been revealed in, inter alia, various parts of the public sector, causing a consequent downturn in community confidence in the integrity of the public sector. It is recognised that corruption in the public sector not only undermines confidence in the bureaucracy but also has a detrimental effect on the confidence of the community in the processes of democratic government, at least at the level of government in which that corruption occurs. It is also recognised that corruption commonly indicates and promotes inefficiency, produces waste and could lead to loss of revenue.

The Commission's functions are set out in s 13, s 13A and s 14 of the ICAC Act. One of the Commission's principal functions is to investigate any allegation or complaint that, or any circumstances which in the Commission's opinion imply that:

i. corrupt conduct (as defined by the ICAC Act), or

ii. conduct liable to allow, encourage or cause the occurrence of corrupt conduct, or

iii. conduct connected with corrupt conduct,

may have occurred, may be occurring or may be about to occur.

The Commission may also investigate conduct that may possibly involve certain criminal offences under the *Electoral Act 2017*, the *Electoral Funding Act 2018* or the *Lobbying of Government Officials Act 2011*, where such conduct has been referred by the NSW Electoral Commission to the Commission for investigation.

The Commission may report on its investigations and, where appropriate, make recommendations as to any action it believes should be taken or considered.

The Commission may make findings of fact and form opinions based on those facts as to whether any particular person has engaged in serious corrupt conduct.

The role of the Commission is to act as an agent for changing the situation that has been revealed. Through its work, the Commission can prompt the relevant public authority to recognise the need for reform or change, and then assist that public authority (and others with similar vulnerabilities) to bring about the necessary changes or reforms in procedures and systems, and, importantly, promote an ethical culture, an ethos of probity.

The Commission may form and express an opinion as to whether consideration should or should not be given to obtaining the advice of the Director of Public Prosecutions with respect to the prosecution of a person for a specified criminal offence. It may also state whether it is of the opinion that consideration should be given to the taking of action against a person for a specified disciplinary offence or the taking of action against a public official on specified grounds with a view to dismissing, dispensing with the services of, or otherwise terminating the services of the public official.

Appendix 2: Making corrupt conduct findings

Corrupt conduct is defined in s 7 of the ICAC Act as any conduct which falls within the description of corrupt conduct in s 8 of the ICAC Act and which is not excluded by s 9 of the ICAC Act.

Section 8 defines the general nature of corrupt conduct. Subsection 8(1) provides that corrupt conduct is:

(a) any conduct of any person (whether or not a public official) that adversely affects, or that could adversely affect, either directly or indirectly, the honest or impartial exercise of official functions by any public official, any group or body of public officials or any public authority, or

(b) any conduct of a public official that constitutes or involves the dishonest or partial exercise of any of his or her official functions, or

(c) any conduct of a public official or former public official that constitutes or involves a breach of public trust, or

(d) any conduct of a public official or former public official that involves the misuse of information or material that he or she has acquired in the course of his or her official functions, whether or not for his or her benefit or for the benefit of any other person.

Subsection 8(2) specifies conduct, including the conduct of any person (whether or not a public official), that adversely affects, or that could adversely affect, either directly or indirectly, the exercise of official functions by any public official, any group or body of public officials or any public authority, and which, in addition, could involve a number of specific offences which are set out in that subsection.

Subsection 8(2A) provides that corrupt conduct is also any conduct of any person (whether or not a public official) that impairs, or that could impair, public confidence in public administration and which could involve any of the following matters:

(a) collusive tendering,

(b) fraud in relation to applications for licences, permits or other authorities under legislation designed to protect health and safety or the environment or designed to facilitate the management and commercial exploitation of resources,

(c) dishonestly obtaining or assisting in obtaining, or dishonestly benefitting from, the payment or application of public funds for private advantage or the disposition of public assets for private advantage,

(d) defrauding the public revenue,

(e) fraudulently obtaining or retaining employment or appointment as a public official.

Subsection 9(1) provides that, despite s 8, conduct does not amount to corrupt conduct unless it could constitute or involve:

(a) a criminal offence, or

(b) a disciplinary offence, or

(c) reasonable grounds for dismissing, dispensing with the services of or otherwise terminating the services of a public official, or

(d) in the case of conduct of a Minister of the Crown or a Member of a House of Parliament – a substantial breach of an applicable code of conduct.

Section 13(3A) of the ICAC Act provides that the Commission may make a finding that a person has engaged or is engaged in corrupt conduct of a kind described in paragraphs (a), (b), (c), or (d) of s 9(1) only if satisfied that a person has engaged or is engaging in conduct that constitutes or involves an offence or thing of the kind described in that paragraph.

Subsection 9(4) of the ICAC Act provides that, subject to subsection 9(5), the conduct of a Minister of the Crown or a member of a House of Parliament which falls within the description of corrupt conduct in s 8 is not excluded

by s 9 from being corrupt if it is conduct that would cause a reasonable person to believe that it would bring the integrity of the office concerned or of Parliament into serious disrepute.

Subsection 9(5) of the ICAC Act provides that the Commission is not authorised to include in a report a finding or opinion that a specified person has, by engaging in conduct of a kind referred to in subsection 9(4), engaged in corrupt conduct, unless the Commission is satisfied that the conduct constitutes a breach of a law (apart from the ICAC Act) and the Commission identifies that law in the report.

Section 74BA of the ICAC Act provides that the Commission is not authorised to include in a report under s 74 a finding or opinion that any conduct of a specified person is corrupt conduct unless the conduct is serious corrupt conduct.

The Commission adopts the following approach in determining findings of corrupt conduct.

First, the Commission makes findings of relevant facts on the balance of probabilities. The Commission then determines whether those facts come within the terms of subsections 8(1), 8(2) or 8(2A) of the ICAC Act. If they do, the Commission then considers s 9 and the jurisdictional requirement of s 13(3A) and, in the case of a Minister of the Crown or a member of a House of Parliament, the jurisdictional requirements of subsection 9(5). In the case of subsection 9(1)(a) and subsection 9(5) the Commission considers whether, if the facts as found were to be proved on admissible evidence to the criminal standard of beyond reasonable doubt and accepted by an appropriate tribunal, they would be grounds on which such a tribunal would find that the person has committed a particular criminal offence. In the case of subsections 9(1)(b), 9(1)(c) and 9(1)(d) the Commission considers whether, if the facts as found were to be proved on admissible evidence to the requisite standard of on the balance of probabilities and accepted by an appropriate tribunal, they would be grounds on which such a tribunal would find that the person has engaged in conduct that constitutes or involves a thing of the kind described in those sections.

The Commission then considers whether, for the purpose of s 74BA of the ICAC Act, the conduct is sufficiently serious to warrant a finding of corrupt conduct.

A finding of corrupt conduct against an individual is a serious matter. It may affect the individual personally, professionally or in employment, as well as in family and social relationships. In addition, there are limited instances where judicial review will be available. These are generally limited to grounds for prerogative relief based upon jurisdictional error, denial of procedural fairness, failing to take into account a relevant consideration or taking into account an irrelevant consideration and acting in breach of the ordinary principles governing the exercise of discretion. This situation highlights the need to exercise care in making findings of corrupt conduct.

In Australia there are only two standards of proof: one relating to criminal matters, the other to civil matters. Commission investigations, including hearings, are not criminal in their nature. Hearings are neither trials nor committals. Rather, the Commission is similar in standing to a Royal Commission and its investigations and hearings have most of the characteristics associated with a Royal Commission. The standard of proof in Royal Commissions is the civil standard, that is, on the balance of probabilities. This requires only reasonable satisfaction as opposed to satisfaction beyond reasonable doubt, as is required in criminal matters. The civil standard is the standard which has been applied consistently in the Commission when making factual findings. However, because of the seriousness of the findings which may be made, it is important to bear in mind what was said by Dixon J in *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 362:

> *…reasonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or fact to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences.*

This formulation is, as the High Court pointed out in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 67 ALJR 170 at 171, to be understood:

> *…as merely reflecting a conventional perception that members of our society do not ordinarily engage in fraudulent or criminal conduct and a judicial approach that a court should not lightly make a finding that, on the balance of probabilities, a party to civil litigation has been guilty of such conduct.*

See also *Rejfek v McElroy* (1965) 112 CLR 517, the *Report of the Royal Commission of inquiry into matters in relation to electoral redistribution, Queensland, 1977* (McGregor J) and *the Report of the Royal Commission into An Attempt to Bribe a Member of the House of Assembly, and Other Matters* (Hon W Carter QC, Tasmania, 1991).

Findings of fact and corrupt conduct set out in this report have been made applying the principles detailed in this Appendix.

Appendix 3: Summary of responses to adverse findings

Section 79(A)(1) of the ICAC Act provides that the Commission is not authorised to include an adverse finding against a person in a report under s 74 unless:

a) the Commission has first given the person a reasonable opportunity to respond to the proposed adverse finding, and

b) the Commission includes in the report a summary of the substance of the person's response that disputes the adverse finding if the person requests the Commission to do so within the time specified by the Commission.

Counsel Assisting the Commission made written submissions setting out, inter alia, what adverse findings he contended it was open to the Commission to make against Mr O'Shea, Mr Walker, Mr McMurtrie, Mr Duncan, Mr Graf, Mr Kennedy, Mr Taylor, Mr Peebles and Mick Watson.

These were provided to parties on 13 July 2018. The Commission received written submissions in response made on behalf of the parties between 10 and 14 August 2018.

Further submissions were sent to Mr Walker's legal representative on 18 September 2018. A response to those submissions was received on 15 October 2018.

Further submissions were sent to Mr Taylor and Mr Dippel on 5 April 2019. A response was received from Mr Taylor on 15 April 2019. Responses to his submissions have been included in the body of this report. Mr Dippel's responses were received on 29 April 2019.

The Commission considers that, in these circumstances, the parties had a reasonable opportunity to respond to proposed adverse findings.

Where adverse findings have been made in the body of this report, submissions made in response by individual parties to that finding have been included, if requested by the party or if the Commission determined they ought to be reproduced.

Appendix 4

This table is a list of investigations undertaken by the Commission since 1998 into conduct involving the Department of Corrective Services (DCS) and CSNSW. The year represents the report release date.

2013	• CSNSW – allegations concerning possession and supply of steroids by a Corrective Services NSW corrections officer (*Investigation into the supply of steroids and other matters involving a Corrective Services NSW corrections officer*) • CSNSW – allegations concerning activities officer (*Investigation into the smuggling of contraband into the Metropolitan Special Programs Centre at the Long Bay Correctional Complex*)
2010	• DCS – investigation into whether a DCS correctional officer and others supplied contraband to inmates (*Investigation into the smuggling of contraband into the John Morony Centre*)
2006	• DCS – alleged cover-up of an assault on an inmate at Parramatta Correctional Centre (*Report on cover-up of an assault on an inmate at Parramatta Correctional Centre*)
2004	• DCS – smuggling of contraband into Metropolitan Remand and Reception Centre, Silverwater (*Report on investigation into the introduction of contraband into the Metropolitan Remand and Reception Centre, Silverwater*) • DCS – introduction of contraband into Goulburn Correctional Centre (*Report on investigation into the introduction of contraband into the High Risk Management Unit at Goulburn Correctional Centre*)
2000	• DCS (fifth report) – allegations of corruption in two inmate escapes (*Investigation into the Department of Corrective Services – fifth report – Two escapes*)
1999	• DCS (fourth report) abuse of official power and authority (*Investigation into the Department of Corrective Services – fourth report – Abuse of official power and authority*) • DCS (third report) activities of two correctional officers (*Investigation into the Department of Corrective Services – third report – Betrayal of trust – the activities of two correctional officers*)
1998	• DCS (second report) inappropriate relationships with inmates (*Investigation into the Department of Corrective Services – second report – Inappropriate relationships with inmates in the delivery of health services*) • DCS (first report) conduct of a prison officer and related matters (*Investigation into the Department of Corrective Services – first report – The conduct of prison officer Tosa Lila (Josh) Sua and matters related thereto*)

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