



Law Council
OF AUSTRALIA

Response to Consultation Paper

OPCAT in Australia

Australian Human Rights Commission

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Table of Contents

About the Law Council of Australia.....	3
Acknowledgement	4
Executive Summary.....	5
Preliminary Comments.....	7
Responses to Questions for Discussion	13

About the Law Council of Australia

The Law Council of Australia exists to represent the legal profession at the national level, to speak on behalf of its Constituent Bodies on national issues, and to promote the administration of justice, access to justice and general improvement of the law.

The Law Council advises governments, courts and federal agencies on ways in which the law and the justice system can be improved for the benefit of the community. The Law Council also represents the Australian legal profession overseas, and maintains close relationships with legal professional bodies throughout the world.

The Law Council was established in 1933, and represents 16 Australian State and Territory law societies and bar associations and the Law Firms Australia, which are known collectively as the Council's Constituent Bodies. The Law Council's Constituent Bodies are:

- Australian Capital Territory Bar Association
- Australian Capital Territory Law Society
- Bar Association of Queensland Inc
- Law Institute of Victoria
- Law Society of New South Wales
- Law Society of South Australia
- Law Society of Tasmania
- Law Society Northern Territory
- Law Society of Western Australia
- New South Wales Bar Association
- Northern Territory Bar Association
- Queensland Law Society
- South Australian Bar Association
- Tasmanian Bar
- Law Firms Australia
- The Victorian Bar Inc
- Western Australian Bar Association

Through this representation, the Law Council effectively acts on behalf of more than 60,000 lawyers across Australia.

The Law Council is governed by a board of 23 Directors – one from each of the constituent bodies and six elected Executive members. The Directors meet quarterly to set objectives, policy and priorities for the Law Council. Between the meetings of Directors, policies and governance responsibility for the Law Council is exercised by the elected Executive members, led by the President who normally serves a 12 month term. The Council's six Executive members are nominated and elected by the board of Directors.

Members of the 2017 Executive as at 1 January 2017 are:

- Ms Fiona McLeod SC, President
- Mr Morry Bailes, President-Elect
- Mr Arthur Moses SC, Treasurer
- Ms Pauline Wright, Executive Member
- Mr Konrad de Kerloy, Executive Member
- Mr Geoff Bowyer, Executive Member

The Secretariat serves the Law Council nationally and is based in Canberra.

Acknowledgement

The Law Council of Australia acknowledges the assistance of its National Human Rights Committee, its Migration Law Steering Committee of the Federal Litigation and Dispute Resolution Section, the Law Society of the Northern Territory, the Law Society of South Australia, the Queensland Law Society, the Law Society of New South Wales, and the Law Institute of Victoria in the preparation of this submission.

Executive Summary

1. The Law Council of Australia is grateful for the opportunity to provide a submission in response to the Australian Human Rights Commission (**AHRC**) on the 'OPCAT in Australia Consultation Paper' (**Consultation Paper**).
2. Australia has taken a positive historic step in the campaign to end torture, through the Australian Government's announcement of its intention to ratify the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (**OPCAT**). OPCAT is designed to strengthen the protection of persons deprived of their liberty against torture and other cruel, inhuman or degrading treatment or punishment. It requires the government to establish a system of regular visits, to be undertaken by independent international and national bodies, to all places of detention in Australia, including prisons, youth and immigration detention and mental health facilities.
3. The Law Council has long pressed for ratification as OPCAT will assist in preventing torture from occurring in any place of detention in Australia, as well as encouraging a culture of transparency and accountability. The State's obligation not to impose such treatment or punishment or to expose anyone to the real risk of such treatment or punishment is an obligation which cannot be derogated from in any circumstances.¹
4. Ratification of OPCAT will build upon Australia's history as a nation determined to eradicate and prevent torture, cruel, inhuman and degrading treatment at home and abroad.
5. It will enhance the protection of the fundamental rights of people in detention in Australia and improve conditions in detention facilities where required. Independent and regular external scrutiny will provide an incentive for those running detention facilities to develop effective prevention strategies.
6. Accordingly, the Law Council welcomes the AHRC's Consultation Paper as an important part of facilitating consultations with civil society to provide advice back to the Australian Government. The Consultation Paper sets out a series of questions based on issues being considered in planning how OPCAT should operate in Australia.
7. The Law Council's responses to the questions in the Consultation Paper are set out below. Key recommendations include:
 - key elements of OPCAT implementation in Australia should preferably be documented in legislation or, at minimum, in a formal agreement;
 - the National Preventive Mechanism (**NPM**) should prioritise issues such as current practices on seclusion and restraint, conditions in immigration and youth detention, and the treatment of Indigenous Australians in detention;

¹ *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987) art 2 ('CAT').

- Australian NPM bodies should establish processes for engaging effectively with civil society representatives and existing inspection mechanisms, as well as key government stakeholders;
 - Australia can benefit from having access to the expertise of the UN Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (**SPT**); and
 - Australia should have reference to international standards when making detailed decisions about how to apply OPCAT in Australia.
8. The Law Council would be pleased to discuss its comments further with the AHRC, should it assist.

Preliminary Comments

Purpose of OPCAT

9. The existence of OPCAT is indicative of the collective acknowledgement that the existing system of human rights may not be enough to protect vulnerable people from ill treatment in places of detention. Signatory countries have agreed that a preventative approach is required to better safeguard compliance with human rights.
10. OPCAT focuses on preventing ill-treatment in places of detention through existing human rights. It is not a reactive treaty that focuses on new or continued mechanisms for addressing ill-treatment through the identification of human rights. The distinction is profound and should form the basis of the Australian mandate that establishes the NPM. As a preventative measure, OPCAT is unique in its purpose, and as a global solution to preventing ill-treatment in places of detention, OPCAT should remain distinct from other mechanisms that are ultimately reactive. The primary focus when implementing OPCAT must always be to maintain the intention of the treaty as a preventative measure.
11. Furthermore, OPCAT encourages a global approach to the prevention of torture and other cruel, inhuman or degrading treatment or punishment through the SPT. The benefits that follow a global cooperative approach through the SPT, which is based on international experts and international best practices that have the benefit of continually describing torture and ill treatment in a changing world, cannot be overstated.
12. If OPCAT is part of a global solution, the key question regarding implementation in Australia is: what different preventative measures will be put in place in Australia to ensure the purpose of OPCAT is realised? If existing measures, which embody a reactive approach to human rights, are simply continued, we may fail or fall short in carrying out the purpose of OPCAT.

Scope

Conduct to which OPCAT applies

13. Clear and unequivocal definitions for the terms 'torture' and 'cruel, inhuman and degrading treatment or punishment' should be developed, to ensure that each definition aligns with international human rights standards.
14. The *Migration Act 1958* (Cth) sets out definitions of 'cruel or inhuman treatment or punishment' and 'torture'.² These definitions may be adopted in amended form, following consultation with appropriate human rights bodies and experts, such as the Human Rights Council of Australia, Amnesty International Australia, and civil society, including the Law Council.

² *Migration Act 1958* (Cth) s 5.

15. The definition should be sufficiently broad to capture acts or omissions which may have a particular impact as a result of a person's ethnicity, religious beliefs or sexual or gender orientation.

Settings in which OPCAT applies

16. Article 4(1) of OPCAT defines places of detention to include where a person is or may be deprived of their liberty '...either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'.³ Article 4(2) of OPCAT defines the deprivation of liberty as '...any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority'.⁴
17. Article 4 of OPCAT poses little issue for traditional places of detention such as prisons or detention centres, however it becomes problematic for non-traditional places of detention where people are held on a voluntary basis or with their family's consent. The SPT has considered this issue as follows:

The preventive approach underpinning the Optional Protocol means that as extensive an interpretation as possible should be made in order to maximize the preventive impact of the work of the national preventive mechanism.

The Subcommittee therefore takes the view that any place in which persons are deprived of their liberty, in the sense of not being free to leave, or in which the Subcommittee considers that persons might be being deprived of their liberty, should fall within the scope of the Optional Protocol, if the deprivation of liberty relates to a situation in which the State either exercises, or might be expected to exercise a regulatory function. In all situations, the national preventive mechanism should also be mindful of the principle of proportionality when determining its priorities and the focus of its work.⁵

18. There are many people being deprived of their liberty, by virtue of their health and/or capacity, or the type of care, treatment or restrictive practices they are subjected to. Aged care facilities are an excellent example. They are closed environments where people may have restricted freedom of movement and are heavily dependent on their carers to provide them with basic life necessities like water, food and health care. The New Zealand Human Rights Commission, for example, has noted that '...aged care and residential disability care services – that is, situations in which people are or may be prevented from leaving at will – can be seen to fall within the ambit of Article 4 of the OPCAT'.⁶
19. The Law Council supports an expansive interpretation of article 4 of the OPCAT. Ratifying OPCAT presents a unique opportunity to develop a systematic and cohesive

³ OPCAT art 4(1).

⁴ *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 4 February 2003, 2375 UNTS 237 (entered into force 22 June 2006) art 4(2) ('OPCAT').

⁵ Committee against Torture, *Ninth annual report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 57th sess, Agenda Item 5, UN Doc CAT/C/57/4 (22 March 2016) annex.

⁶ Michael J V White, *He Ara Tika A pathway forward The scope and role of the Optional Protocol to the Convention against Torture (OPCAT) in relation to aged care and disability residences and facilities* (June 2016) <https://www.hrc.co.nz/files/7414/7796/9537/He_Ara_Tika_2016_web.pdf>.

oversight system across our institutions, private or public, where people are subjected to the care and/ or authority of others. As noted by the Chief of Operations for the Association for the Prevention of Torture, Barbara Bernath:

OPCAT is about securing an environment that reduces the risks of torture and ill-treatment as much as possible. It covers all places where persons are deprived of their liberty, including 'traditional' places such as prisons, as well as other places such as international ports, centres for migrants or juveniles, aged care homes, psychiatric facilities and modes of transportation. Under OPCAT, the aim is to identify gaps in protection in the system itself, rather than identifying and investigating individual instances of ill-treatment. It requires a systematic approach to inspecting places of detention, and a consideration of all relevant aspects, including the material conditions of detention; the level of contact with family members, legal representation and the outside world; whether adequate activities are available within detention facilities; and staffing issues, including pay levels and staff conditions.⁷

National NPM body

20. The Law Council supports either the Commonwealth Ombudsman or the AHRC for the national coordinating function. Three of the Law Council's Constituent Bodies have expressed the view that the Australian Human Rights Commission (**AHRC**) would be the most appropriate agency to fulfil the role of central coordinating NPM. The Queensland Law Society (**QLS**) notes that the AHRC has a statutory responsibility to ensure compliance with human rights and would be well placed to ensure compliance with OPCAT in relation to places of detention within Australia. The Law Society of New South Wales (**LSNSW**) considers that the AHRC is a preferable national oversight body given its human rights expertise and engagement with international human rights jurisprudence. It also notes its concern that the Commonwealth Ombudsman is not currently sufficiently resourced to perform OPCAT functions. The Law Council nonetheless recognises the investigatory operational experience of the Commonwealth Ombudsman which may prove valuable in this area.
21. The Law Council considers that the following are questions that should be asked in relation to the purported role of the Commonwealth Ombudsman:
 - a. will the role of the Commonwealth Ombudsman, as the national coordinator, include scrutiny powers of external investigators;
 - b. how will the effectiveness of the Commonwealth Ombudsman, as the proposed national coordinator, be appropriately measured; and
 - c. how will the Commonwealth Ombudsman's mandate need to be altered to facilitate its engagement with the SPT and with international sources of procedural and normative guidance relevant to an OPCAT NPM?

⁷ Australian Human Rights Commission, *Implementing the Optional Protocol to the Convention Against Torture in Australia Seminar hosted by the Australian Human Rights Commission and the Asia Pacific Forum of National Human Rights Institutions 25 November 2009, Sydney*
<https://www.humanrights.gov.au/sites/default/files/content/human_rights/opcat/opcat_seminar2009.pdf> 4.

22. Should the Commonwealth Government prefer to establish the Commonwealth Ombudsman as the designated national NPM body, the Law Council suggests consideration should be given to:
- a. amending the *Australian Human Rights Commission Act 1986* (Cth) to schedule the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT)*; and
 - b. establishing regulations under the *Ombudsman Act 1976* (Cth) to permit the Ombudsman to share or delegate some or all of its inspection functions to the AHRC (in light of its expertise and resources), or, alternatively, permitting the Commonwealth Ombudsman and AHRC to enter into a memorandum of understanding for the same.

The role of the NPM

23. The NPM must have sufficient authority to carry out its mandate. The Law Society of the Northern Territory has noted that the powers should be broader than ‘naming and shaming’, such that NPMs have the power to enforce their recommendations. The LSNSW has suggested that both state and federal enabling legislation for each NPM should be amended to grant the relevant body the power to issue ‘show cause’ notices to a detention facility where an issue is identified as being in breach of OPCAT or CAT (see, for example, section 33A of the *Inspector of Custodial Services Act 2003* (WA)).
24. The NPM must have functional independence, and independence for its personnel.⁸ Therefore, a priority for Australia is to ensure the ongoing independence of its NPM. This will require that it is structurally independent, operationally independent and avoids conflicts of interest in its personnel. Innovative mechanisms will be required to ensure the NPM represents OPCAT, without being beholden to other influences, and to ensure that Australia’s NPM has sufficient powers and resources to be effective.
25. NPMs must have the necessary resources for functioning.⁹ The Law Council considers that it would not be sufficient, for instance, to assign the responsibilities of the NPMs to existing bodies without providing them with additional resources.
26. An audit checking on compliance with these and the other requirements set out in OPCAT for NPMs should commence within 12 months of the agreement coming into effect. This could, if desired, be part of the review discussed below in section 5 of this submission.
27. While it is not a requirement set out in OPCAT, the Law Council also considers that transparency and accountability in relation to the processes and objectives of any body, agency or persons charged with facilitating the inspection framework is of paramount importance.
28. Accountability is key, not only to ensure efficiency, but to safeguard integrity and credibility of the system from both a domestic and international perspective. The Law

⁸ OPCAT art 18(1).

⁹ Ibid art 18(3).

Council supports the views of the SPT in this regard, including that the NPM should publicise opinions and findings through annual and thematic reports,¹⁰ and submit its visit reports to relevant official bodies and the Government as a basis for dialogue, and possibly publication and dissemination.¹¹ These reports, which should be produced by the central coordinating NPM, should include the information provided by the State/Territory NPM inspection bodies in each jurisdiction, as well as information in relation to any areas of offshore detention where relevant. The reports should also set out all relevant information which is reasonably required to appropriately report on the state of human rights and compliance with the CAT. This will ensure that Australia's adherence to the CAT can be understood, examined and publically assessed. Another mechanism that can assist in providing a high level of transparency and accountability is regular, mandatory reporting to the Commonwealth Attorney-General, with a requirement that the Attorney table NPM reports in Parliament within a certain period of time. The Law Council also notes the view previously expressed by the Inspector of Custodial Services Western Australia that direct reporting to Parliament provides a high level of transparency and accountability.¹²

State-based investigative agencies

29. The Law Council considers that the following are questions that should be asked in relation to existing State-based investigative agencies that are proposed to have a role within Australia's NPM:
- a. what changes to the legislative powers of existing State-based investigative agencies are needed to prepare them for serving as part of Australia's NPM;
 - b. what changes to the resourcing of existing State-based investigative agencies are needed to prepare them for serving as part of Australia's NPM;
 - c. what additional statutory measures to secure the independence of existing State-based investigative agencies are needed to prepare them for serving as part of Australia's NPM; and
 - d. what program of cultural change, and education of international standards relevant to OPCAT, needs to be put in place for existing State-based investigative agencies to prepare them for serving as part of Australia's NPM?
30. In addition, the Law Council suggests that bodies constituting Australia's NPM could be required to report and demonstrate to the national coordinating body their

¹⁰ Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Analytical assessment tool for national preventive mechanisms*, UN Doc CAT/OP/1/Rev.1 (25 January 2016) 8.

¹¹ *Ibid.*

¹² Inspector of Custodial Services WA, Submission No 9 to Queensland Government, *Independent Review of Youth Detention*, 25 October 2016 <<http://www.youthdetentionreview.qld.gov.au/submissions/index.html>>.

understanding of OPCAT's preventative approach to ill treatment in places of detention.

Staffing and professional expertise required for visiting inspections

31. OPCAT requires that States should take necessary measures to ensure that the experts of the NPM have the required capabilities and professional knowledge; and should strive for gender balance and adequate representation of ethnic and minority groups.¹³ The Law Council suggests that the following staff and professional expertise be included among visiting inspection teams.

Aboriginal and Torres Strait Islander community member

32. It is particularly important that Aboriginal and Torres Strait Islander people are represented in the visiting inspection team. The Aboriginal and Torres Strait Islander community are overrepresented in prison, youth justice centres, and residential care facilities. The Law Council strongly recommends that visiting inspections teams have a dedicate role for a member/s from Aboriginal and Torres Strait Islander communities. It is crucial that Aboriginal and Torres Strait Islander communities are given significant opportunity to provide input into all critical stages of implementation to ensure NPM's are culturally informed and responsive to the needs of Aboriginal and Torres Strait Islander peoples.

Professional with familiarity with the advancement of people who have cognitive impairment and the law relating to their circumstances

33. People with cognitive-behavioural difficulties such as acquired brain injury (**ABI**), intellectual disability and foetal alcohol spectrum disorder are also overrepresented in the system. ABI is sometimes referred to as the 'hidden disability' because there are generally no noticeable signs.¹⁴ The invisibility of some cognitive disabilities makes people even more vulnerable as their behaviour can often be misinterpreted negatively by those that may lack sufficient awareness and training. The Law Council recommends that the visiting inspection team has a dedicate role for a professional who has familiarity with the advancement of people who have a cognitive impairment and the law relating to their circumstances, including relevant legislation and the National Disability Insurance Scheme.

¹³ OPCAT art 18(2).

¹⁴ Suzanne Brown et al, *People with acquired brain injury and the Victorian criminal justice system* (Inkshed Press, 2015) 8.

Responses to Questions for Discussion

<p>1. What is your experience of the inspection framework for places of detention in the state or territory where you are based, or in relation to places of detention the Australian Government is responsible for?</p>

34. The Law Council's Constituent Bodies indicate there are a number of issues with the inspection frameworks for place of detention in the states and territories in which they are based. In some States, there are too many layers of regulation. The number of overlapping agencies and functions mean that the overarching framework is ineffective. In addition, existing investigative agencies with responsibility for monitoring of conditions in prisons and other situations of detention are typically under-resourced and lack sufficient powers to effectively perform their functions, particularly to the standard of an OPCAT NPM. Accordingly, the Law Council is concerned that the current frameworks may not be OPCAT compliant.

New South Wales

35. In New South Wales (**NSW**), responsibility for the inspection of correctional facilities currently lies with the Inspector of Custodial Services. In addition:
- a. the NSW Ombudsman has an officer responsible for visiting inmates and receiving complaints in NSW;
 - b. the Inspector of Custodial Services oversees 'Official Visitor' programs conducted in correctional facilities and juvenile justice centres. The role of Official Visitors is to receive grievances and complaints from inmates and report on custodial conditions, and each Official Visitor visits their designated facilities once a fortnight; and
 - c. section 10 of the *Inspector of Custodial Services Act 2012* (NSW) empowers the Inspector of Custodial Services to enter into an arrangement with the NSW Ombudsman regarding a complaint, inquiry, investigation or other action under the *Ombudsman Act 1974* (NSW).
36. It is not immediately clear how or why some functions are divided between the Inspector of Custodial Services and Official Visitors, or under what circumstances the NSW Ombudsman might take over some of the functions of the Inspector of Custodial Services. The LSNSW considers that the presence of both bodies is confusing and inefficient. Instead, for the purposes of OPCAT, it would be preferable to have a single NPM reporting body in NSW which in turn reports to a federal body to avoid the dilution of responsibility, and improve accountability and transparency, with regards to inspection standards.

37. The NSW Government would need to have regard to how it may implement and adapt existing principles such as the Standard Guidelines for Corrections in Australia,¹⁵ in order to make state-based bodies OPCAT compliant.
38. Consideration would also need to be given to whether Official Visitors under the *Mental Health Act 2007* (NSW) should be subsumed into a single NSW NPM body. Currently, it appears that Official Visitors to mental health inpatient facilities operate separately to Official Visitors who visit correctional facilities and juvenile justice centres, and report to the Principal Official Visitor and Minister for Health (NSW).
39. It would also be necessary to ensure that the inspections teams have suitably trained mental health staff, especially when visiting forensic hospitals and high risk management units, such as the High Risk Management Correctional Centre in Goulburn, to ensure that inmates' circumstances can be professionally assessed.

Victoria

40. The Law Institute of Victoria (**LIV**) considers that there are a number of crucial areas in the inspection framework in Victoria where gaps or overlaps exist.

Correctional facilities

41. The current oversight scheme in place in the Victorian prison system is the Independent Prisoner Visitors Scheme (**IPVS**). The IPVS is made up of volunteers and is currently run by, and reports to, the Justice Assurance and Review Office (formerly the Office of Correctional Services Review) under the Department of Justice and Regulation (the **Department**). The Department is also responsible for administering the detention of prisoners. The LIV notes that the IPVS is not independent of the Department, nor are its findings able to be fully disclosed in public reports. To be OPCAT compliant, the IPVS needs to be independent and impartial. While the LIV recognises the merit and benefit of volunteers, to be OPCAT compliant, the IPVS must be made up of expert staff that have the required capabilities and professional knowledge. Staff should also adequately represent gender, ethnic and minority groups. This concern was raised by LIV at the National Children's Commissioner's Roundtable discussion in May 2016.

Police Cells

42. The LIV is concerned about the lack of oversight and independent monitoring of people held in police cells on remand. Victoria has insufficient infrastructure to meet its high imprisonment rates. In the 2014 Victorian Ombudsman's report, 'Investigation into Deaths and Harm in Custody',¹⁶ the Ombudsman found that overcrowding had resulted in police cells designed for overnight or shorter stays being used as de-facto

¹⁵ Australian Institute of Criminology, *Standard Guidelines for Corrections in Australia* (2012) <http://www.aic.gov.au/media_library/aic/research/corrections/standards/aust-stand_2012.pdf>.

¹⁶ Victorian Ombudsman, *Investigation into Deaths and Harm in Custody* (March 2014) <<https://www.ombudsman.vic.gov.au/getattachment/2998b6e6-491a-4dfe-b081-9d86fe4d4921/publications/parliamentary-reports/investigation-into-deaths-and-harm-in-custody.aspx>>.

prisons to hold, at times, in excess of 350 detainees.¹⁷ Overcrowding presents many issues, including the inability to segregate people:

*...different types of detainees have to share cells when they would otherwise be kept separate, for example, young from old, intoxicated persons from others ... It impacts negatively on the safety and security of the detainees, often creating unnecessary tension and management issues.*¹⁸

43. At a 2006 conference, 'Conditions for Persons in Custody and the Role of the Victorian Ombudsman', John R Taylor, Deputy Ombudsman Victoria, noted that:

*While Victoria Police are accountable for the welfare of detainees in its watch houses and officers have a duty of care for these persons, there is currently no independent scrutiny of conditions and access to basic services and amenities, nor are they monitored internally in any systematic way. While Victoria Police has established policies and procedures for holding persons in custody, the Ombudsman's Report on Conditions and overcrowding in police cells (May, 2002) showed that detainees in police cells experience inadequate conditions, have limited access to services and amenities and that there is non compliance with many basic custodial standards.*¹⁹

44. According to the 'Investigation into Deaths and Harm in Custody':

*Critical incidents and deaths which occur in police cells are subject to independent scrutiny and oversight by the Independent Broad-based Anti-corruption Commission (IBAC). Deaths in police custody are investigated, on behalf of the Coroner, by the Homicide Squad, overseen by Victoria Police's Professional Standards Command Unit. The IBAC can independently review and monitor such investigations for any emerging issues which may require public reporting.*²⁰

Youth Justice Centres

45. In the LIV's view, there is currently insufficient oversight of Victoria's Youth Justice Centres (**YJCs**). The Ombudsman has jurisdiction to investigate matters at YJCs, but is not resourced to undertake regular ongoing visits. The Ombudsman reportedly visits each YJC in Victoria every six months; however officers of the Ombudsman are not permitted to speak to children under 16 years of age.
46. As highlighted in the LIV submission to the National Children's Commissioner's inquiry into ratifying OPCAT in the context of youth detention,²¹ the only other regular independent oversight of YJCs is conducted by the Commissioner for Children and

¹⁷ Ibid, 5.

¹⁸ Ombudsman Victoria and Office of Police Integrity Victoria, *Conditions for persons in custody* (July 2006) <<https://www.ombudsman.vic.gov.au/getattachment/9825922c-6883-4db4-bca2-4f1405863e8d>> 17-18.

¹⁹ John R Taylor, 'Conditions for Persons in Custody and the Role of the Victorian Ombudsman' (Australian and New Zealand Society of Criminology 19th Annual Conference, Hobart, 7-9 February 2006) <<https://www.ombudsman.vic.gov.au/getattachment/27452ab1-f9fc-4f32-bb99-e68cd4c4637f>>.

²⁰ Victorian Ombudsman, *Investigation into Deaths and Harm in Custody* (March 2014) <<https://www.ombudsman.vic.gov.au/getattachment/2998b6e6-491a-4dfe-b081-9d86fe4d4921/publications/parliamentary-reports/investigation-into-deaths-and-harm-in-custody.aspx>> 128.

²¹ Law Institute of Victoria, *Ratifying OPCAT in the Context of Youth Detention* (14 June 2016) <<https://www.liv.asn.au/Staying-Informed/Submissions/submissions/June-2016/Ratifying-OPCAT-in-the-context-of-youth-detention>>.

Young People (**CCYP**) Independent Youth Visitor Program (**IYVP**). This arrangement was outlined in the submission as follows:

The IYVP is made up of volunteers coordinated by a CCYP staff member. Visitors and the staff member attend at YJCs and observe the environment, speak to the young people and listen to any concerns that they have about their treatment, including their access to education, hygiene and safety. Independent Visitors attend Parkville Youth Justice Centre Precinct on a monthly basis and the YJCs know in advance when the Independent Visitors will be attending. After each visit, they meet with the General Manager of the Centre to discuss their observations and provide feedback on any complaints made by the young people. Within seven days of each visit, the Independent Visitor is required to provide a written report to the Principal Commissioner.²²

Children on Remand

47. The IYVP does not extend to supervision, oversight or inspection in relation to children or young people held on remand in a facility that is not a youth justice precinct. The National Interest Analysis of OPCAT in 2012 identified that there are, in Australia, ‘...many mechanisms in place for oversight and inspection of places of detention ... There are also some gaps in monitoring - the key area of significance being detention in police detention facilities...’²³
48. Under the *Children Youth and Families Act 2005* (Vic) (**CYF Act**), a child may only be remanded for an initial period not exceeding 21 days if the Court refuses bail.²⁴ The Australian Federal Police (**AFP**) has National Guidelines on persons in custody and police custodial facilities,²⁵ specifying that if it is necessary to keep a child or young person in any custodial facility they must be lodged separately from other persons. This requirement is reflected in the CYF Act.²⁶
49. In its 2015 report, ‘An escalating problem: Responding to the increased remand of children in Victoria’, the Jesuit Social Services (**JSS**) noted the increase in children on remand in Victoria.²⁷ In its 2013 report, ‘Thinking Outside: Alternatives to Remand for Children’, JSS had noted ‘...that children in custody are likely to be among the most vulnerable and disadvantaged in our community’.²⁸ In this report, JSS found that

²² Ibid, 7.

²³ National Interest Analysis [2012] ATNIA 6, *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment done at New York on 18 December 2002* [9].

²⁴ *Children Youth and Families Act 2005* (Vic) s 346(3)(b).

²⁵ Australian Federal Police, *AFP National Guideline on persons in custody and police custodial facilities* <<https://www.afp.gov.au/sites/default/files/PDF/IPS/AFP%20National%20Guide%20on%20Persons%20in%20Custody%20and%20Police%20Custodial%20Facilities%20and%20People%20in%20Custody%2010MAY2012.pdf>>.

²⁶ *Children Youth and Families Act 2005* (Vic) s 347.

²⁷ Jesuit Social Services, *An escalating problem: Responding to the increased remand of children in Victoria* (October 2015) <http://jss.org.au/wp-content/uploads/2016/01/An_escalating_problem_-_Responding_to_the_increased_remand_of_children_in_Victoria.pdf>.

²⁸ Jesuit Social Services, *Thinking Outside: Alternatives to Remand for Children (Research Report)* (2013) <http://jss.org.au/wp-content/uploads/2015/10/Thinking_Outside_Research_Report_-_Final_amend_15052013.pdf> 13.

'Eighty per cent of arrests happen outside business hours when support services are unavailable to decision makers to divert children from remand.'²⁹ It also found that:

More of the shortest remand episodes commence on the weekend compared with during the week, and these weekend admissions are more likely to end with a young person being released on bail ...almost twice as many weekend admissions (40 per cent) than weekday admissions (21 per cent) last between one and three days ... The 40 per cent of weekend admissions that last for one to three days indicate a practice whereby a child is remanded on either a Saturday or Sunday and then released when they are brought to the Children's Court early in the following week.³⁰

50. The Ombudsman is empowered under the *Ombudsman Act 1973* (Vic) to investigate individual complaints by prisoners about conditions and treatment while in custody, and in addition, may investigate systemic issues or specific concerns. Complainants are also able to make a complaint to the Chief Commissioner of Police, which may be referred to IBAC if it involves serious misconduct. However, there does not seem to be the same level of scrutiny or independent monitoring of police custody as there is of youth detention centres and young people in adult prisons. Regular Independent Visitor visits or monitoring of police cells or vehicles was not mentioned in LIV's consultations with stakeholders. The LIV is concerned that there does not appear to be effective, appropriate or independent oversight of police custody.

Residential Support Services

51. LIV members have raised concerns for children and young people in residential support services in Victoria. Children in residential care are highly vulnerable and the restrictive environment for children held in residential care is not dissimilar to YJCs.
52. In August 2015, the CCYP released the report of the Inquiry into the adequacy of the provision of residential care services to Victorian children and young people who have been subject to sexual abuse or sexual exploitation whilst residing in residential care (**the Inquiry report**).³¹ The Inquiry report confirmed reports of alleged sexual abuse and sexual exploitation in residential care of children as young as seven.³² The Inquiry reported the use of surveillance cameras in bedrooms,³³ and punitive and restrictive practices.³⁴
53. LIV members are concerned that children in residential care are particularly vulnerable to being exposed to the criminal justice system as their bad behaviour triggers a different and disproportionate response to that of children who live in the family home. For example, rather than a child being grounded for bad behaviour, a child in residential care can face explaining their actions to a police officer, with the potential of facing criminal charges for more serious behaviour. The highly tense environment of residential care, coupled with the findings of abuse from the Inquiry report, warrants

²⁹ Ibid, 66.

³⁰ Ibid, 65-66.

³¹ Commission for Children and Young People, "...as a good parent would..." (August 2015) <<https://ccyp.vic.gov.au/assets/Publications-inquiries/as-a-good-parent-would.pdf>>.

³² Ibid, 4.

³³ Ibid, 103.

³⁴ Ibid, 104-107.

urgent attention and reform of the current oversight system. The Inquiry report concluded that the Department of Health and Human Services (**DHHS**) does not adequately monitor or enforce compliance with the required practice standards, and made nine key recommendations. Of those recommendations, the CCYP called for the:

- a. establishment of an independent advocate to support children in residential care;³⁵ and
 - b. establishment of an independent visitor program to every residential care unit.³⁶
54. Following the Inquiry report, the Victorian Auditor General released a report, 'Follow up of Residential Care Services for Children'.³⁷ The Victorian Auditor General reports that DHHS are working closely with CCYP to implement the IYVP in residential care facilities. The report also notes that the Department has begun a program of unannounced audits of residential care units, which is complemented with the existing accreditation review which occurs every three years.³⁸ The report states that the audits include discussions with children and young people, personal observations, interviews with staff and review of formal records. Service providers are required to provide the Department with an action plan to respond to any problems identified.³⁹
55. The CCYP oversight of children in institutions has been strengthened by amendments to the *Commission for Children and Young People Act 2012* (Vic) (**CCYP Act**).⁴⁰ The CCYP Act requires the DHHS to disclose to the CCYP with any information about an adverse event relating to a child in out of home care or a person detained in a youth justice centre or a youth residential centre if the information is relevant to the Commission's functions.⁴¹ This may include, for example, allegations of physical and sexual assault, illness and accidental injuries requiring hospitalisation, and serious behavioural issues that impact on the individual's or others' safety.
56. Additionally, in response to the Betrayal of Trust inquiry, the Victorian Parliament recently passed the *Children Legislation Amendment (Reportable Conduct) Act 2017* (Vic) (**Reportable Conduct Act**). The Reportable Conduct Act establishes the reportable conduct scheme which requires:

*...an allegation of reportable conduct, or employee misconduct involving a child, committed by an employee within or connected to certain entities to be reported by that entity to the Commission for Children and Young People who will administer the scheme, including by overseeing investigations or conducting investigations itself.*⁴²

³⁵ Ibid, 117.

³⁶ Ibid, 116.

³⁷ Victorian Auditor-General's Office, *Follow up of Residential Care Services for Children* (June 2016) <<https://www.audit.vic.gov.au/sites/default/files/20160608-Resi-Care.pdf>>.

³⁸ Ibid, 14.

³⁹ Ibid.

⁴⁰ *Commission for Children and Young People Act 2012* s 60A.

⁴¹ Ibid.

⁴² Explanatory Memoranda, *Children Legislation Amendment (Reportable Conduct) Bill 2016* (Vic) 1.

57. Reportable conduct means:
- (a) *a sexual offence committed against, with or in the presence of, a child, whether or not a criminal proceeding in relation to the offence has been commenced or concluded; or*
 - (b) *sexual misconduct, committed against, with or in the presence of, a child; or*
 - (c) *physical violence committed against, with or in the presence of, a child; or*
 - (d) *any behaviour that causes significant emotional or psychological harm to a child; or*
 - (e) *significant neglect of a child;*⁴³
58. The Reportable Conduct Act gives the CCYP power to conduct an own-motion investigation into a reportable allegation against an employee of an entity.⁴⁴ In conducting an investigation, the CCYP may visit an entity in order to inspect any document in relation to the reportable allegation, or to conduct an interview of an employee, child, or employee who is the subject of a reportable allegation.⁴⁵ The Reportable Conduct Act further facilitates information sharing between organisations, regulators, Victoria Police, the Department of Justice and Regulation and the CCYP.⁴⁶
59. The Reportable Conduct Act and reform to the CCYP Act have given the CCYP significant scope across various institutions that are likely to fall within the OPCAT mandate. While the LIV welcomes the recent legislative changes and acknowledges that it has strengthened accountability of institutions to report incidences involving children, the reforms are not adequate in terms of satisfying OPCAT's requirements for a NPM. Similarly, while the IYVP is clearly very beneficial and important for young people detained in YJCs, LIV considers it is not adequate in terms of satisfying OPCAT's requirements for an NPM.
60. The IYVP does not have formal external reporting or investigation, and the visits occur by agreement of the Centre's management. There are no resources provided or legislative authority for the CCYP to conduct an own-motion investigation or compel entry, unless the CCYP initiates an own-motion investigation pursuant to the Reportable Conduct Act. It is also not clear that the IYVP operates effectively to ensure that the young detainees are not victimised by the YJC's staff if they ever ask to speak privately with the Independent Visitor from the IYVP.
61. The LIV strongly believes that an effective oversight system needs avenues for people to make a private complaint freely and safely. The child's right to express his or her views freely in all matters affecting him or her, and for those views to be given due weight, is set out in the Convention on the Rights of the Child (**CRC**).⁴⁷ It is considered

⁴³ *Children Legislation Amendment (Reportable Conduct) Act 2017 (Vic) s 5.*

⁴⁴ *Commission for Children and Young People Act 2012 s 16O.*

⁴⁵ *Ibid s 16P.*

⁴⁶ *Explanatory Memoranda, Children Legislation Amendment (Reportable Conduct) Bill 2016 (Vic) 1.*

⁴⁷ *Convention on the Rights of the Child*, opened for signature 20 November 1989 1577 UNTS 3 (entered into force 2 September 1990) art 12.

by the Committee on the Rights of the Child to be one of the four general principles of the CRC.⁴⁸ The Committee has emphasised the importance of ensuring that domestic law reflects these four principles.⁴⁹ The ratification of OPCAT presents a clear opportunity to better monitor quality and complaints, and explore other avenues to support young people to raise and articulate their concerns.

62. The LIV has previously expressed the view that the current oversight framework delivered by the Office of the Public Advocate (**OPA**) in residential services for young people with an intellectual disability who have had experience with the criminal justice system is effective:

Community Visitors, delivered by the OPA, help ensure accountability for good practice and drive holistic, person-centred practice. Community Visitors arrive unannounced and observe, ask questions, talk to residents and review documents, resulting in a report for DHHS.⁵⁰

63. The LIV has also previously recommended that:

Victoria could align youth justice complaint mechanisms with complaint mechanisms in the disability sector. This approach is supported by the significant numbers of children and young people who have lower level cognitive functioning or a diagnosed intellectual disability and are incarcerated. This approach ensures that an independent third party (e.g. Office of the Senior Practitioner (Disability)) oversees the management of restrictive intervention practices used by service providers and any compulsory medical treatment administered to the young people. This could include any significant modification of behaviour support plans such as changes to medication regimes or the use of restraints and isolation/solitary confinement.⁵¹

Aged Care

64. The risk of abuse in institutions or facilities where people are not free to leave at their own will is well established, yet there is no comprehensive data available on the prevalence of abuse of people receiving aged care in Australia. This is likely due to a number of complex factors, including lack of a central oversight body, under-reporting of incidents and the fact that restrictive interventions in aged care are compounded by issues of capacity.
65. The *User Rights Principles 2014* (Cth) made under the *Aged Care Act 1997* (Cth) provide that each care recipient has the right 'to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction.'⁵²
66. However, current monitoring of aged care facilities is a pro forma activity for accreditation and contractual requirements, rather than a way of ensuring standards of

⁴⁸ Committee on the Rights of the Child, *General Comment No.5 (2003) General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para.6)* UN Doc CRC/GC/2003/5 (27 November 2003) [12].

⁴⁹ *Ibid*, [22].

⁵⁰ Law Institute of Victoria, Submission No 21 to National Children's Commissioner, *Ratifying OPCAT in the Context of Youth Detention*, 14 June 2016, 8.

⁵¹ *Ibid*.

⁵² *User Rights Principles 2014* (Cth) Sch 1, s 1(g).

care are improved and abuse is mitigated. Under the current legislative framework, any person can make a complaint to the Aged Care Complaints Commissioner (**ACCC**) about an approved provider's responsibility under the *Aged Care Act 1997* (Cth), but this complaint or concern must first be raised with the aged care facility. If a response is not provided or if the response provided is not satisfactory, a complaint may then be made to the ACCC. The ACCC may investigate the complaint and/or may refer the matter to another body, such as the Australian Aged Care Quality Agency, the Australian Health Practitioner Regulation Agency, or, where the complaint involves the death of the care recipient, the Coroner. If the ACCC decides to investigate a complaint and determines that an approved provider is not meeting their obligations under the *Aged Care Act 1997* (Cth), it can issue binding directions on the aged care provider.

67. A federal inquiry is presently underway regarding the effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are practiced and maintained.⁵³ The inquiry is likely to provide a clearer understanding of the adequacy of the reporting framework and gaps that need to be addressed.
68. The OPCAT implementation consultation is fortunately timed as it coincides with the conclusion of the Australian Law Reform Commission (**ALRC**) Inquiry into Elder Abuse and the release of the final report, *Elder Abuse – A National Legal Response*, which has recommended a national prevalence study of elder abuse, and in relation to aged care, includes the following recommendations:
 - a. developing a serious incident response scheme, requiring approved providers to notify to an independent oversight body of an allegation or a suspicion on reasonable grounds of a serious incident and the outcome of an investigation into a serious incident, including findings and action taken;
 - b. the establishment of an independent oversight body to monitor and oversee the approved provider's investigation of, and response to, serious incidents, and be empowered to conduct investigations of such incidents;
 - c. defining 'serious incident' committed against a resident in residential care broadly to mean physical, sexual or financial abuse; seriously inappropriate, improper, inhumane or cruel treatment; unexplained serious injury and neglect;
 - d. defining a 'serious incident' committed by a care recipient against another care recipient as: sexual abuse; physical abuse causing serious injury; or an incident that is part of a pattern of abuse;
 - e. commissioning an independent evaluation of research on optimal staffing models and levels in aged care (to be conducted by the Department of Health). The results of this evaluation should be made public and used to

⁵³ Senate Standing Committee on Community Affairs, *Effectiveness of the Aged Care Quality Assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised*
<http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareQuality>.

assess the adequacy of staffing in residential aged care against legislative standards;

- f. aged care legislation should regulate the use of restrictive practices in residential aged care. Any restrictive practice should be the least restrictive and used only:
 - (a) as a last resort, after alternative strategies have been considered, to prevent serious physical harm;
 - (b) to the extent necessary and proportionate to the risk of harm;
 - (c) with the approval of a person authorised by statute to make this decision;
 - (d) as prescribed by a person's behaviour support plan; and
 - (e) when subject to regular review;
 - g. The Australian Government should consider further safeguards in relation to the use of restrictive practices in residential aged care, including: establishing an independent Senior Practitioner for aged care, to provide expert leadership on and oversight of the use of restrictive practices; requiring aged care providers to record and report the use of restrictive practices in residential aged care; and consistently regulating the use of restrictive practices in aged care and the National Disability Insurance Scheme; and
 - h. The Department of Health should develop national guidelines for the community visitors scheme. The guidelines should include policies and procedures for visitors to follow if they have concerns about abuse or neglect of care recipients.⁵⁴
69. The Law Council encourages the AHRC to consider the appropriateness of including age care facilities in the list of places of detention that can benefit from OPCAT monitoring.

Queensland

- 70. The QLS notes that the current inspection framework for places of detention in Queensland is multifaceted, and a number of agencies have overlapping responsibilities and functions. There are at least seven bodies or functions that have oversight of places of detention. This has led to a somewhat fragmented system of oversight for places of detention in Queensland.

⁵⁴ Australian Law Reform Commission, *Elder Abuse – A National Legal Response Final Report* (May 2017) <https://www.alrc.gov.au/sites/default/files/pdfs/publications/elder_abuse_131_final_report_31_may_2017.pdf> 10-12.

71. The Department of Justice and Attorney-General may receive complaints in relation to Corrective Services and Youth Justice Services. If the complainant is dissatisfied with the outcome, they may pursue the complaint through the Queensland Ombudsman.
72. The Queensland Ombudsman is an independent statutory body with broad powers under Part 4 of the *Ombudsman Act 2001* (Qld) to conduct investigations into an administrative action of an agency, including corrective services. This role is limited to administrative actions and does not extend to the review of an operational action.⁵⁵
73. The Crime and Corruption Commission (**CCC**) is a statutory body with powers to investigate police and public sector misconduct, including complaints of misconduct by officers, staff and management of prisons.⁵⁶ A CCC investigation may result in criminal charges being laid or disciplinary action being taken. The CCC may also make recommendations around anti-corruption strategies.
74. The *Corrective Services Act 2006* (Qld) provides for the appointment of official visitors. An official visitor must investigate a complaint made by a prisoner about an act or omission of the chief executive, a person purportedly performing a function or exercising a power of the chief executive, or a corrective services officer.⁵⁷ An official visitor has powers to enter the relevant facility at any time, interview a prisoner out of the hearing of other persons, and inspect and copy any document relating to the complaint being investigated, except where legal professional privilege applies.⁵⁸ The official visitor must then provide a written report to the chief executive.⁵⁹
75. The *Corrective Services Act 2006* (Qld) also provides for the appointment of a Chief Inspector.⁶⁰ The Chief Inspector is responsible for providing '...independent scrutiny regarding the treatment of offenders, and the application of standards and operational practices within the State's correctional centres'.⁶¹
76. There are also some bodies that have specific oversight roles relating to youth detention, such as the Office of the Public Guardian and the Queensland Family and Child Commission.
77. The National Children's Commissioner has made comment about the lack of independence in the Queensland model:

Victoria and Queensland have detailed inspection regimes run from within internal government departments. However, the lack of independence from the departments responsible for administering the detention of children and young

⁵⁵ *Ombudsman Act 2001* (Qld) s 7.

⁵⁶ *Crime and Corruption Act 2001* (Qld).

⁵⁷ *Corrective Services Act 2006* (Qld) s 290.

⁵⁸ *Ibid* s 291.

⁵⁹ *Ibid* s 292.

⁶⁰ *Ibid* s 296.

⁶¹ Queensland Corrective Services, *Office of the Chief Inspector*

<http://www.correctiveservices.qld.gov.au/Publications/Corporate_Publications/Miscellaneous_Documents/Chief%20Inspector.pdf>.

*people means these arrangements would not fully meet the OPCAT requirements.*⁶²

78. The overlap and gaps in the current inspection framework are significant and legislative change would be required for a Queensland NPM body to be OPCAT compliant. Also, many of the current oversight mechanisms rely on a complaint being made.⁶³ In contrast, the NPM is designed to take a preventative approach by identifying problematic detention issues before they escalate.⁶⁴

South Australia

79. The Law Society of South Australia (**LSSA**) advises that there are piecemeal and ineffective regimes for the monitoring of places of detention in South Australia. In respect of prisons, the *Correctional Services Act 1982* (SA) requires that correctional institutions be inspected on a regular basis.⁶⁵ However, the LSSA has identified the following problems in relation to the South Australian scheme:
- a. there are no provisions requiring that persons appointed as an ‘inspector’ under section 20 of the *Correctional Services Act 1982* (SA) have any suitable or relevant qualifications;
 - b. there are no protections of the independence of such persons;
 - c. there is no institutional framework within which such persons operate;
 - d. there are no provisions relating to the resourcing of such functions;
 - e. the standard to be applied is a vague and narrow; the inspector is permitted to enquire only ‘...for the purpose of ascertaining whether the provisions of this Act relating to the treatment of prisoners are being complied with’,⁶⁶ and not for the broad purpose of enquiring as to whether human rights standards are being met; and
 - f. the only outcome mandated is a report to the relevant Minister which may include recommendations, however it does not require public reporting, nor any requirement to inform prisoners who are complainants, or any institutional mechanism for following up on the implementation of recommendations made.
80. In light of these issues, the LSSA considers that this form of external review has proved ineffective and insufficient in South Australia.

⁶² Australian Human Rights Commission, *In safe hands? Protecting the rights of children and young people in youth justice centres*

<<https://www.humanrights.gov.au/sites/default/files/Executive%20Summary%20FINAL.pdf>> 7.

⁶³ Queensland Government, *Independent Review of Youth Detention Report* (28 June 2017)

<<https://www.youthdetentionreview.qld.gov.au/review-of-youth-detention-centres-report-updated-28-June-2017.pdf>> 204.

⁶⁴ Consultation Paper, 5.

⁶⁵ *Correctional Services Act 1982* (SA) s 20.

⁶⁶ *Ibid.*

81. The LSSA also considers that the Community Visitor system established by section 50 of the *Mental Health Act 2009* (SA), which applies to ‘treatment centres’ and ‘authorised community mental health’ facilities,⁶⁷ is equally as ineffective. The issues in relation to this system include:
- a. there are no provisions requiring that persons appointed as a Community Visitor have any suitable or relevant qualifications;
 - b. there are provisions securing the independence of Community Visitors, but these are badly undermined by the fact that appointments can be made on whatever basis is desired to a maximum of only three years;
 - c. the institutional framework within which such persons operate (the existence of a Principal Community Visitor) is weak;
 - d. there are no provisions relating to the resourcing of such functions;
 - e. there is no clear legislative standard to be applied by a community visitor in performing their functions, and no express mandate to enquire broadly as to whether human rights standards are being met; and
 - f. the only outcome mandated is a report to the relevant Minister. Although the report is required to be tabled in Parliament, there is no requirement for complainants to be informed of the outcomes of their complaints and no institutional mechanism for following up on the implementation of the recommendations made.
82. Notwithstanding the issues identified above, there are at least provisions for some form of review of correctional institutions and places of detention on mental health grounds. Other forms of detention fall outside any formal monitoring institution in South Australia.

⁶⁷ *Mental Health Act 2009* (SA) s 51.

2. How should the key elements of OPCAT implementation in Australia be documented?

83. Ideally, the key elements of OPCAT implementation in Australia should be documented in legislation. Legislation should be enacted in each jurisdiction to recognise the existence and role of the SPT and to establish the NPMs. Provision will also need to be made to ensure that NPMs have the relevant powers and privileges to undertake their functions under the OPCAT. This is consistent with guidelines on NPMs issued by the SPT. One of the basic principles identified by the SPT in the guidelines is that the mandate and powers of the NPM should be clearly set out in a constitutional or legislative text.⁶⁸
84. The Law Council has previously expressed this view.⁶⁹ In doing so, it noted the recommendation of a 2008 paper prepared for the AHRC by Professors Richard Harding and Neil Morgan that: 'A comprehensive Commonwealth statute should be enacted to enshrine OPCAT and to set out the processes through which it will be implemented across Australia. Complementary State and Territory legislation should follow.'⁷⁰
85. If legislation is not created for the purpose of implementing OPCAT, the Law Council considers that there should at least be a formal agreement to set out the core elements of how OPCAT will operate. This is important to clarify the role and responsibilities of each of the federal, state and territory agencies involved. The involvement of multiple bodies creates a risk of disconnect or duplication in their work. The national coordinating mechanism should have a clearly defined role in mitigating these risks.

3. What are the most important or urgent issues that should be taken into account by the NPM?

86. All place of detention must be subject to OPCAT oversight.⁷¹ However, there are some issues of importance that should be taken into account by the NPMs in setting their agendas. The Consultation Paper gives two examples of such issues – the indefinite detention of people with cognitive disabilities, and current practices on seclusion and restraint. The Law Council agrees that these issues warrant the prompt attention of

⁶⁸ Committee against Torture, *Fourth annual report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, 46th sess, UN Doc CAT/C/46/2 (3 February 2011).

⁶⁹ Law Council of Australia, Submission No 20 to Joint Standing Committee on Treaties, *Optional Protocol to the Convention Against Torture*, 30 March 2012, 22 [98].

⁷⁰ Richard Harding and Neil Morgan, *Implementing the Optional Protocol to the Convention against Torture : Options for Australia* (2008)

<https://www.humanrights.gov.au/sites/default/files/content/human_rights/publications/opcat/opcat.pdf> 45 a.

⁷¹ OPCAT art 20(c).

NPMs. The Law Council notes that it recently provided a submission to the Senate Community Affairs References Committee Inquiry into the indefinite detention of people with a cognitive and psychiatric impairment in Australia.⁷² In this submission, the Law Council identified that there is an urgent need to address factors leading to the indefinite detention of people with cognitive and psychiatric impairment across Australia and to end the practice as soon as possible.⁷³

87. In addition, the Law Council considers that there are three other issues that should be prioritised by the NPMs:
- a. conditions in immigration;
 - b. conditions in youth detention; and
 - c. the treatment of Indigenous Australians in detention.

The Law Council previously noted the opportunity to address these issues following the Government's announcement of its intention to ratify OPCAT.⁷⁴

88. The Law Council agrees that an assessment of existing inspection mechanisms should occur urgently to identify where OPCAT requirements are met and to uncover any gaps. The Victorian Ombudsman has commenced a process of reviewing existing inspection mechanisms to ascertain what practical changes are required to implement OPCAT, and the Law Council suggests that other jurisdictions should commence a similar process.

Current practices on seclusion and restraint

89. The LIV has concerns about current practices on seclusion and restraint in Victoria.
90. Under the *Disability Act 2006* (Vic), seclusion and restraint are lawful if certain necessary conditions are met.⁷⁵
91. A 2009 report commissioned by the Office of the Senior Practitioner, Department of Human Services, outlines the types of restraint and makes a series of recommendations in relation to the use of restraint and seclusion in disability services.⁷⁶ Although the report does not give particular examples of use of restraint on children with disabilities in schools and psychiatric facilities in particular, it does say:

With respect to physical restraint, given the known risk of harm to persons with disability and of known risk of death, the following recommendations are made:

⁷² Law Council of Australia, Submission No 72 to Senate Community Affairs References Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, 7 July 2016.

⁷³ Law Council of Australia, Submission No 72 to Senate Community Affairs References Committee, *Indefinite detention of people with cognitive and psychiatric impairment in Australia*, 7 July 2016, 16 [64].

⁷⁴ Law Council of Australia, 'Australia takes historic step to prevent torture' (Media Release, 9 February 2017).

⁷⁵ *Disability Act 2006* (Vic) s 140.

⁷⁶ Department of Human Services, *Physical restraint in disability services Current practices, contemporary concerns, and future directions* (March 2009)

<http://www.dhs.vic.gov.au/__data/assets/pdf_file/0010/607708/osp_physicalrestraintindisabilityservicescurrentpractices_300309.pdf> 6-10.

- *Prone (face down) or 'hobble (hog) tying' restraint is not used.*
- *No physical or mechanical restraint that inhibits the respiratory and/or digestive system is used.*
- *No physical or mechanical restraint that involves compliance through the infliction of pain, hyperextension of joints, and pressure on the chest or joints is used.*
- *No use of 'takedown' techniques in which the individual is not supported and/or that allows for free fall as the individual goes to the floor.*
- *An individual's physical condition is evaluated throughout the restraint in order to minimise the potential of individual harm or injury.*
- *Physical restraint does not exceed 30 minutes within any two-hour time period*
- *An individual is immediately released from physical restraint when they no longer present a danger to self or others.*
- *Support staff monitor the individual for signs of distress throughout the restraint process and for a period of time (up to two hours) following the application of a restraint.*
- *That observations conducted and recorded include vital clinical indicators such as pulse, respiration and temperature.⁷⁷*

92. The report also notes:

The most recent Australian public enquiry focusing on the needs of persons with disability subject to restraint and seclusion has been that conducted in Queensland by Justice Carter QC (2006). The Carter Report includes documentation concerning 312 people with complex and challenging behaviour identified as currently receiving supported either directly provided by or funded in the non-government sector by Disability Services Queensland (DSQ), and whose challenging behaviour was either being managed by the use of restrictive practices or was at risk of requiring restrictive practices. However, the Carter report does not report figures indicating rates of injury or death as a consequence of the use of restraint or seclusion.⁷⁸

93. In the LIV's view, it is clear that psychiatric and mental health facilities lack appropriate independent oversight and monitoring of a kind that would satisfy the requirements of a NPM.

Children with disabilities in schools

94. There is a large amount of evidence that seclusion and restraint practices are being used on children with disabilities in schools. However, there is less formal legislative oversight of these practices, compared to the use of seclusion and restraint in other contexts.

95. At the Roundtable meeting convened by the National Children's Commissioner in May 2016 in which the LIV participated,⁷⁹ concerns were raised by some stakeholders

⁷⁷ Ibid, 10.

⁷⁸ Ibid, 13-14.

⁷⁹ OPCAT Roundtable with Australian Children's Commissioner held on 18 May 2016, Melbourne.

about the use of restrictive practices on children in special schools, and some examples were provided indicating severe infringements on children's' rights. The LIV's Disability Law Committee has been concerned about these issues for some time, and has discussed the Australian and international context of restraint and seclusion in schools.

96. The Office of the Public Advocate has noted that:

In Victoria, the use of restrictive interventions in disability residential settings is regulated through the Disability Act 2006. There are limits on how and when restrictive interventions can be used, there are reporting requirements, procedural safeguards and an independent body, the Office of the Senior Practitioner, which monitors the use of restrictive interventions. But in Victorian educational settings, there is a lack of legislative or policy guidance around the use of restrictive interventions. There is no independent oversight or monitoring of the use of seclusion and restraint and there is no legal requirement for a teacher or school in Victoria to report the use of restrictive interventions, other than in the case of the use of 'physical force'.⁸⁰

97. The Victorian Equal Opportunity and Human Rights Commission (**VEOHRC**) report on the experiences of students with disabilities in Victorian schools includes some data on the incidence of the use of restraint and seclusion in schools.⁸¹ This supports anecdotal evidence published by Children with Disability Australia, which writes that:

Reports of aversive and abusive behaviour management practices (viewed by particular schools as appropriate for students with a disability) have been made over many years by students with disability, family members, advocacy groups and legal bodies...⁸²

98. Australia's Universal Periodic Review Disability Coordination Group has noted that:

There is significant concern about the use of restrictive practices in both 'special' and mainstream schools, with reports across Australia that children are being tied to chairs, locked in isolation rooms, being physically restrained and penned in outside areas under the guise of 'behaviour management' policies and practice.⁸³

99. The Victorian Government has recently introduced the *Education and Training Reform Regulations 2017* (Vic).⁸⁴ Regulation 25 replicates previous regulation 15 of the

⁸⁰ Office of the Public Advocate, *Position Statement: Restrictive Interventions in Educational Settings* (March 2013) <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/research-reports/disability/restrictive-interventions/276-restrictive-interventions-in-educational-settings-1>>.

⁸¹ Victorian Equal Opportunity and Human Rights Commission, *Held back: The experiences of students with disabilities in Victorian schools* (September 2012) <http://www.humanrightscommission.vic.gov.au/media/k2/attachments/1404-VEOHRC_HeldBack_-_StudentwithDisabilityReportW3.pdf>.

⁸² Children with Disability Australia, *Enabling and Protecting: Proactive Approaches to Addressing the Abuse and Neglect of Children and Young People with Disability* <<http://www.cyda.org.au/enabling-and-protecting>> 13.

⁸³ UPR Disability Coordination Group, *Australia's UPR 2015 NGO Coalition Fact Sheet 4 – Restrictive Practices* <<http://www.pwd.org.au/issues/periodicreview.html>> 1.

⁸⁴ *Education and Training Reform Regulations 2017* (Vic).

Education and Training Reform Regulations 2007 (Vic). This regulation continues to authorise a member of staff of a Government school to:

*...take any reasonable action that is immediately required to restrain a student of the school from acts or behaviour that are dangerous to the member of staff, the student, or any other person.*⁸⁵

100. Submissions were made during the consultation process for these regulations that raised concerns about the breadth of this provision and its ambiguity. For example, the VEOHRC's submission raised concerns that key terms in the regulation are not adequately defined and that the regulation is '...ambiguous in scope and operation'.⁸⁶ The VEOHRC's view is that the regulation fails to appropriately balance the rights, health and safety of educators and students with the human rights of children and '...should be reconsidered to strengthen compliance with the human rights protected by the Charter and provide clarity to teachers and students'.⁸⁷ The LIV is concerned that despite this submission and others raising these concerns, the regulation has been re-made with no amendments.
101. In 2015, the Victorian Government appointed a new Principal Practice Leader (Education) reporting to the Senior Practitioner (Disability) in DHHS. The Principal Practice Leader works with DHHS to develop best practice guidelines and oversees the use of seclusion and restraint in Victorian Government schools. DHHS also issued new guidelines for schools in 2017.⁸⁸ The guidelines provide detailed policy guidance on the use of seclusion and restraint on students and introduces 15 principles, based on principles developed by the US Department of Education. The guidelines also require all instances of seclusion and restraint to be reported to the DET Security Services Unit, and set out steps that must follow after an incident is reported, including notification of parents and review or development of a Behaviour Support Plan.
102. The LIV remains concerned about the continued use of seclusion and restraint on children and young people with disabilities in schools in Victoria. In particular, it is concerned by the broad scope of Regulation 25 of the *Education and Training Reform Regulations 2017* (Vic), and the fact that this may make it difficult for the parents of children to hold schools to account for actions of restraint and seclusion that impermissibly infringe on children's rights.
103. In the LIV's view, the use of restrictive practices such as the unplanned use of medications, physical, mechanical and special restraints on children and young people in inclusive and special schools, home schools and other educational settings, even taking into account the reporting and policy guidelines now in place in Victoria, may comply with the definition of torture under the CAT:

⁸⁵ Ibid r 25.

⁸⁶ Victorian Equal Opportunity and Human Rights Commission, Submission No 72 to the State of Victoria (Department of Education and Training), *Education and Training Reform Regulation Review*, (2017) 2.

⁸⁷ Ibid.

⁸⁸ State of Victoria (Department of Education and Training), *The Principles for Reduction and Elimination of Restraint and Seclusion in Victorian Government Schools* (2017)

<<http://www.education.vic.gov.au/Documents/school/principals/participation/15Principals.pdf>>.

*...any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.*⁸⁹

104. For this reason, the use of restrictive practices needs to be effectively monitored and oversighted by an independent body, over and above the role of the Principal Practice Leader. Similar to the LIV's views noted above in relation to young people in adult prison, an oversight and reporting framework that is not independent and which reports to the same Department that is responsible for the actions being reported, is not adequate in terms of OPCAT compliance.

Psychiatric and mental health facilities

105. Most psychiatric units in hospitals where people are held pursuant to the *Mental Health Act 2014 (Vic) (MHA)* use seclusion. On average about five per cent of admissions will have an episode of seclusion, which can range between 15 minutes to three days.⁹⁰ The use of seclusion varies between states, but it appears to be highest in Victoria and the Northern Territory.⁹¹
106. Under the MHA, seclusion and bodily restraint is referred to as 'restrictive intervention'.⁹² Under the MHA, seclusion '...means the sole confinement of a person to a room or any other enclosed space from which it is not within the control of the person confined to leave'.⁹³ The MHA sets out the circumstances under which restrictive intervention may be used as follows:

*A restrictive intervention may only be used on a person receiving mental health services in a designated mental health service after all reasonable and less restrictive options have been tried or considered and have been found to be unsuitable.*⁹⁴

107. Seclusion may be used in as follows:

*A person receiving mental health services in a designated mental health service may be kept in seclusion if seclusion is necessary to prevent imminent and serious harm to the person or to another person.*⁹⁵

108. Bodily restraint may be used as follows:

⁸⁹ CAT art 1.

⁹⁰ Australian Broadcasting Corporation, 'Seclusion and restraint: why are they still used in acute mental health care?', *Life Matters*, 1 May 2014 (Natasha Mitchell) <<http://www.abc.net.au/radionational/programs/lifematters/seclusion-andrestraint3a-why-are-they-still-used-in-acute-men/5421568>>.

⁹¹ *Ibid.*

⁹² *Mental Health Act 2014 (Vic)* s 3.

⁹³ *Ibid.*

⁹⁴ *Ibid* s 105.

⁹⁵ *Ibid* s 110.

A bodily restraint may be used on a person receiving mental health services in a designated mental health service if the bodily restraint is necessary—

(a) to prevent imminent and serious harm to the person or to another person; or

(b) to administer treatment or medical treatment to the person.⁹⁶

109. Further, where a person is authorised under the MHA to be taken to or from a designated mental health service, or any other place, bodily restraint or sedation may be used.⁹⁷
110. There are added protections, including that: the use of restrictive intervention must be reported to chief psychiatrist,⁹⁸ the use of restraint and seclusion must be authorised (though it can be used in urgent matters),⁹⁹ and the use of seclusion and restraint must be monitored.¹⁰⁰
111. When the use of a restrictive intervention on a person receiving mental health services in a designated mental health service is authorised or approved, services are under an obligation to ensure that the person's needs are met and the person's dignity is protected by the provision of appropriate facilities and supplies.¹⁰¹ An authorised psychiatrist must take reasonable steps to notify a nominated person, a guardian, carer, parent (if the person is under the age of 16) as soon as practicable after the restrictive intervention has been used.¹⁰²
112. The Victorian Government has identified seclusion and restraint as highly intrusive practices that have been linked to patient deaths.¹⁰³ The Australian Government has acknowledged that these practices have been linked to serious adverse events, including, in rare circumstances, patient deaths.¹⁰⁴
113. Several reports have noted the use of restrictive practices in Australia and Victoria:
- a. the ALRC discussion paper Discussion Paper 'Equality, Capacity and Disability in Commonwealth Laws' noted that: 'People with a disability who display 'challenging behaviour' or 'behaviours of concern' may be subjected to restrictive practices in a variety of contexts, including: supported accommodation and group homes; residential aged care facilities; mental health facilities; hospitals; prisons; and schools';¹⁰⁵

⁹⁶ Ibid s 113.

⁹⁷ Ibid s 350.

⁹⁸ Ibid s 108.

⁹⁹ Ibid s 111, 114.

¹⁰⁰ Ibid s 112, 116.

¹⁰¹ Ibid s 106.

¹⁰² Ibid s 107.

¹⁰³ State of Victoria (Department of Health), *A new Mental Health Act for Victoria Summary of proposed reforms* (October 2012) <<https://www.buv.com.au/documents/item/390>> 8.

¹⁰⁴ Australian Government Department of Health, *National safety priorities in mental health: A national plan for reducing harm* (2005) <[http://www.health.gov.au/internet/main/publishing.nsf/Content/DB6FC7B04519D195CA257BF000217B28/\\$FILE/safety.pdf](http://www.health.gov.au/internet/main/publishing.nsf/Content/DB6FC7B04519D195CA257BF000217B28/$FILE/safety.pdf)> 17.

¹⁰⁵ Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (22 May 2014) <<https://www.alrc.gov.au/publications/disability-dp81>> 196.

- b. The United Nations Committee on the Rights of Persons with Disabilities has stated that it: ‘...is concerned that persons with disabilities, particularly those with intellectual impairment or psychosocial disability, are subjected to unregulated behaviour modification or restrictive practices such as chemical, mechanical and physical restraints and seclusion, in various environments, including schools, mental health facilities and hospitals’;¹⁰⁶
- c. The Office of the Public Advocate has noted that: ‘According to the most recent report of the Office of the Chief Psychiatrist, Victoria had 4,265 episodes of seclusion in its mental health facilities in 2011-2012. This constitutes 12% of patients experiencing at least one episode of seclusion. A quarter of the episodes of seclusion lasted for between four and 12 hours’;¹⁰⁷
- d. The Victorian Chief Psychiatrist’s annual report 2011-2012 noted that there were 593 episodes of mechanical restraint,¹⁰⁸ and that the average duration of a restraint episode in 2011-2012 was just over six hours.¹⁰⁹ The report also noted that: ‘While the use of seclusion has reduced since its peak in 2006-07 ... the duration of seclusion episodes has increased since that time’.¹¹⁰
- e. The Australian Institute of Health and Welfare has recently noted that Victoria reported the longest average seclusion duration in 2015-2016 with an average of 8.3 hours per seclusion event.¹¹¹

Immigration detention

- 114. The Law Council continues to hold serious concerns about the practice and conditions of immigration detention.
- 115. These issues have also been noted by the United Nations Committee Against Torture (**UNCAT**). In 2014, UNCAT noted its concern:

...that detention continues to be mandatory for all unauthorized arrivals, including for children, until the person concerned is granted a visa or is removed from the State party. It is also concerned that the law does not establish a maximum length for a person to be held in immigration detention, reportedly resulting in protracted periods of deprivation of liberty. The Committee is further concerned at reports that

¹⁰⁶ Committee on the Rights of Persons with Disabilities *Concluding observations on the initial report of Australia, adopted by the Committee at its tenth session* UN Doc CRPD/C/AUS/CO/1 (21 October 2013) [35].

¹⁰⁷ Office of the Public Advocate, *Position Statement: Seclusion and restraint in mental health facilities* (December 2013) <<http://www.publicadvocate.vic.gov.au/our-services/publications-forms/research-reports/mental-health/mental-health-facilities-research/302-seclusion-and-restraint-in-mental-health-facilities-1>> 1.

¹⁰⁸ State of Victoria (Department of Health), *Chief Psychiatrist’s annual report 2011-2012* (2012) <<https://www2.health.vic.gov.au/about/publications/annualreports/chief-psychiatrists-annual-report-2011-2012>> 43.

¹⁰⁹ *Ibid*, 44.

¹¹⁰ *Ibid*, 40.

¹¹¹ Australian Institute of Health and Welfare, *Admitted patient care* (May 2017) <<https://mhsa.aihw.gov.au/services/admitted-patient/restrictive-practices/>> 12.

*stateless persons whose asylum claims have not been accepted and refugees with an adverse security or character assessment can be detained indefinitely...*¹¹²

116. In considering immigration detention, NPMs should also examine the particular experience of asylum seekers. The Law Council has previously expressed the position that it considers that all people seeking Australia's protection should be treated with humanity and dignity.¹¹³ UNCAT has also noted its concern about Australia's practices in relation to the treatment of asylum seekers in immigration detention as follows:

*... the State party's policy of transferring asylum seekers to the regional processing centres located in Papua New Guinea (Manus Island) and Nauru for the processing of their claims, despite reports on the harsh conditions prevailing in those centres, such as mandatory detention, including for children, overcrowding, inadequate health care, and even allegations of sexual abuse and ill-treatment. The combination of the harsh conditions, the protracted periods of closed detention and the uncertainty about the future reportedly creates serious physical and mental pain and suffering.*¹¹⁴

117. The purview of any national NPM should cover offshore detention, including regional processing centres such as Nauru, Manus Island, and any other newly created regional processing centres. The Law Council has previously expressed the view that the Commonwealth retains responsibility, either wholly or in part, for the health and safety of asylum seekers transferred to other countries for offshore processing and assessment under the *Convention relating to the Status of Refugees*.¹¹⁵
118. We consider that the conditions of regional processing centres and some Australian immigration detention centres are tantamount to '...cruel, inhuman or degrading treatment',¹¹⁶ and should be inspected as a matter of urgency, in close consultation with the AHRC which has already reported on conditions in immigration detention centres and the Commonwealth's OPCAT obligations.¹¹⁷
119. The AHRC has previously brought attention to the issues raised by the detention of children in immigration detention.¹¹⁸ Implementation of OPCAT protocols to investigate

¹¹² Committee against Torture, *Concluding observation on the combined fourth and fifth periodic reports of Australia*, 53rd sess, UN Doc CAT/C/AUS/CO/4-5 (23 December 2014) 6 [16].

¹¹³ Law Council of Australia, *Immigration Detention and Asylum Seekers*

<<https://www.lawcouncil.asn.au/policy-agenda/human-rights/immigration-detention-and-asylum-seekers>>.

¹¹⁴ Committee against Torture, *Concluding observation on the combined fourth and fifth periodic reports of Australia*, 53rd sess, UN Doc CAT/C/AUS/CO/4-5 (23 December 2014) 6[17].

¹¹⁵ Law Council of Australia, *Submission to the Select Committee on Recent Allegations relating to Conditions and Circumstances at the Regional Processing Centre in Nauru* (12 May 2015)

<http://www.lawcouncil.asn.au/lawcouncil/images/2988_-_S_-_Naru_Inquiry.pdf>; Law Council of Australia, *Serious allegations of abuse, self-harm and neglect of asylum seekers in relation to the Nauru Regional Processing Centre, and any like allegations in relation to the Manus Regional Processing Centre* (10 November 2016) <<https://www.lawcouncil.asn.au/resources/submissions/serious-allegations-of-abuse--self-harm-and-neglect-of-asylum-seekers-in-relation-to-the-nauru-regional-processing-centre>>.

¹¹⁶ CAT art 16.

¹¹⁷ AHRC, *Human Rights Standards for Immigration Detention* (2013)

<https://www.humanrights.gov.au/sites/default/files/document/publication/HR_standards_immigration_detention%20%284%29.pdf>; AHRC, *Asylum seekers, refugees and human rights: Snapshot report* (2nd ed, 2017)

<https://www.humanrights.gov.au/sites/default/files/document/publication/AHRC_Snapshot%20report_2nd%20edition_2017_WEB.pdf> 16.

¹¹⁸ Australian Human Rights Commission, *The Forgotten Children National Inquiry into Children in Immigration Detention* (2014)

<https://www.humanrights.gov.au/sites/default/files/document/publication/forgotten_children_2014.pdf>.

and improve the management of asylum seekers, and particularly children, should be urgently attended to by the NPM.

120. The Law Council is also concerned with the increased movement of immigration detainees between different facilities around Australia on claimed administrative grounds, when those movements often occur during an appeal process before the Administrative Appeals Tribunal or the Federal Courts. This often deprives the detainee to access to their legal representatives and all of their support networks. For example, it is not uncommon for a detainee held in Villawood Immigration Detention Centre in Sydney or Maribyrnong Immigration Detention Centre in Melbourne to be suddenly moved without notice to Yongah Hill Immigration Detention Centre in Western Australia or even Christmas Island. In considering immigration detention, NPM's should also examine the existence and appropriateness of this practice in terms of detainee's mental health and access to justice.
121. Ratifying OPCAT and establishing a national oversight mechanism for immigration detention facilities will enshrine Australia's obligations to protect vulnerable individuals from torture and other cruel and inhuman treatment or punishment to help prevent further future harm, and require Australia to be bound to comply with our obligations under international law.
122. There are currently several bodies that conduct independent oversight of Australia's immigration detention facilities. The two primary bodies are the AHRC and the Commonwealth Ombudsman. Visits to immigration detention centres are also conducted by the Australian Red Cross and Amnesty International Australia, UN human rights agencies including the United Nations High Commissioner for Refugees (**UNHCR**), and a range of civil society groups and individuals.
123. The monitoring of immigration detention facilities has been '...largely ad hoc and, in some cases, lacking in transparency'.¹¹⁹
124. Some of the major deficiencies with the current oversight bodies are:
 - a. the lack of financial resources to engage in systematic monitoring by organisations independent of the government;
 - b. reliance on the Australian Government and its contracted managers to gain access to sites of detention;
 - c. a further barrier or territorial sovereignty for bodies seeking access to sites of detention on Nauru and Manus Island; and
 - d. confidentiality conditions that inhibit some forms of monitoring.¹²⁰
125. Financial resources are a major restriction for monitoring and oversight bodies. Many immigration detention centres are located in remote parts of the Australian mainland,

¹¹⁹ Caroline Fleay, 'The Limitations of Monitoring Immigration Detention in Australia' (2015) 21(1) *Australian Journal of Human Rights* 26.

¹²⁰ *Ibid.*

or offshore on Nauru and Manus Island, such that travel costs make monitoring difficult.¹²¹

126. In addition, the LIV has been informed recently by one of its stakeholders that resourcing issues with one of the major oversight bodies is affecting its ability to effectively carry out the reviewing and monitoring role even in detention centres on the Australian mainland.
127. The Commonwealth Ombudsman is required under s 486O of the *Migration Act 1958* (Cth) to assess the ‘...appropriateness of the arrangements for person’s detention’,¹²² when it receives a report under section 486N for a person who has been in detention for more than two years.¹²³ Despite having inspected immigration detention centres, the Ombudsman’s work in this regard has been largely ‘complaints driven’.¹²⁴
128. Recommendations of the AHRC are not binding, but they are useful in shedding light on detention conditions and highlighting concerns that should be addressed. AHRC Human Rights Commissioners have consistently raised concerns about the impacts of detention following these visits and called for an end to mandatory detention.¹²⁵ But the expansion of the immigration detention network over the past four years and the lack of adequate resources to continue to visit all sites of detention have resulted in a reduction in the AHRC’s monitoring role.
129. The 2015 Moss Review into conditions in the Nauru processing centre found multiple incidents of sexual and physical abuse, which in many instances were going unreported.¹²⁶ The AHRC released a report last year detailing self-harm by children in immigration detention.¹²⁷
130. In 2015, Juan Méndez, the UN Special Rapporteur on torture and other cruel, inhuman or degrading treatment, inferred from the Australian Government’s unsatisfactory reply to allegations of mistreatment in the Manus Regional Processing Centre that it fails to ‘...comply with its obligation, under international customary law, to investigate, prosecute and punish all acts of torture and other cruel, inhuman or degrading

¹²¹ Ibid.

¹²² *Migration Act 1958* (Cth) s 486O.

¹²³ Ibid s 486N.

¹²⁴ Richard Harding, Submission No 4 to the Joint Standing Committee on Treaties, *Proposal for Australia to Ratify OPCAT* (28 February 2012) 4.

¹²⁵ See, eg, Australian Human Rights and Equal Opportunity Commission, *A Last Resort? National Inquiry into Children in Immigration Detention* (2004); Australian Human Rights and Equal Opportunity Commission, *Curtin: Observations from Visit to Curtin Immigration Detention Centre and Key Concerns across the Detention Network* (31 March 2013).

¹²⁶ Department of Immigration and Border Protection, *Review into recent allegations relating to conditions and circumstances at the Regional Processing Centre in Nauru* (6 February 2015) <<https://www.border.gov.au/ReportsandPublications/Documents/reviews-and-inquiries/review-conditions-circumstances-nauru.pdf>>.

¹²⁷ Elizabeth Elliot and Hasantha Gunasekera, *The Health and Well-being of Children in Immigration Detention* (2016) <<https://www.humanrights.gov.au/sites/default/files/document/publication/Health%20and%20well-being%20of%20children%20in%20immigration%20detention%20report.pdf>>.

treatment or punishment, as codified, inter alia, in the Convention Against Torture (CAT).¹²⁸

131. In relation to specific allegations concerning proposed legislation, Méndez concluded that:

*... the Government of Australia, by failing to amend the provisions of the two bills to comply with the State's obligations under international human rights law, particularly with regard to the rights of migrants, and asylum seekers, including children, has violated the rights of migrants and asylum seekers to be free from torture or cruel, inhuman or degrading treatment, as provided by articles 1, 3, and 16 of the CAT.*¹²⁹

132. The UN Special Rapporteur report on the human rights of migrants reiterated that the Government of Australia is accountable for any human rights violations that occur in the regional processing centres in Nauru or on Manus Island:

*All persons who are under the effective control of Australia — because, inter alia, Australia transferred them to regional processing centres, which are funded by Australia, and with the involvement of private contractors of Australia's choice — enjoy the same protection from torture and ill-treatment under the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*¹³⁰

133. At a time when the number of incidents of self-harm in immigration detention appears to be increasing, the Law Council is of the view that increasing the capacity for independent oversight bodies to properly monitor the conditions and trends is extremely important.

Youth detention

134. Careful consideration of the administration of juvenile justice in Australia is required to ensure that our systems are consistent with the rule of law and human rights obligations. The Law Council has previously expressed this view in its submission to the inquiry into the OPCAT in the context of youth detention.¹³¹ It also noted in this submission that children and young people in youth detention facilities need special protection because of the particular vulnerabilities associated with their age.¹³²
135. Although the special vulnerability of children and young people is recognised within criminal justice frameworks, concerns about the treatment of young people in

¹²⁸ Human Rights Council, *Report of the Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Juan E. Méndez*, 28th session, Agenda item 3, UN Doc A/HRC/28/68/Add.1 (5 March 2015), [25].

¹²⁹ Ibid, [31].

¹³⁰ Human Rights Council, *Report of the Special Rapporteur on the human rights of migrants on his mission to Australia and the regional processing centres in Nauru*, 35th session, Agenda item 3, UN Doc A/HRC/35/25/Add.3 (24 April 2017) [73].

¹³¹ Law Council of Australia, Submission No 4 to the National Children's Commissioner and Australian Human Rights Commission, *Inquiry into the Optional Protocol to the Convention against Torture in the context of Youth Justice Detention Centres*, 27 May 2016, 18 [76].

¹³² Ibid 18 [75].

detention continue to be raised across Australia. This includes in relation to inappropriate restraints, excessive force and isolation. The AHRC's *Children's Rights Report 2016* noted recent examples of alleged ill treatment of juveniles in youth justice centres in the Northern Territory and Queensland.¹³³ It also concluded that 'While jurisdictions meet a number of the NPM criteria, no jurisdiction currently meets all of them'.¹³⁴

136. In April this year, the Queensland Government released the report of an independent review into Queensland's youth detention centres. In response to the report, the Queensland Government noted that the report '...acknowledges significant trauma that many young people in the youth justice system have experienced'.¹³⁵
137. The Law Council also notes that the December 2016 report of the Australian Institute of Health and Welfare said that detention rates of young people are stable after long-term falls and despite recent rise in numbers.¹³⁶

The treatment of Aboriginal and Torres Strait Islander peoples in detention

138. The treatment of Aboriginal and Torres Strait Islander peoples in detention is a serious concern. It has been 26 years since the Royal Commission into Aboriginal Deaths in Custody reported its findings, and there has been an alarming lack of progress in improving the experience of this group in the justice system.¹³⁷
139. In 2014, UNCAT noted its concern that '...during the reporting period, the reported number of deaths in custody, including of indigenous people, is high'.¹³⁸ It also noted its concern '...at information received that indigenous people continue to be disproportionately affected by incarceration, reportedly representing around 27 per cent of the total prisoner population while constituting between 2 and 3 per cent of the total population'.¹³⁹

¹³³ Australian Human Rights Commission, *Children's Rights Report 2016* <<https://www.humanrights.gov.au/our-work/childrens-rights/publications/childrens-rights-report-2016>> 128.

¹³⁴ Ibid.

¹³⁵ Department of Justice and Attorney General, *Government response to the independent review of youth detention* (2017) <<https://www.youthdetentionreview.qld.gov.au/governments-response-to-the-report.pdf>> 1.

¹³⁶ Australian Institute of Health and Welfare, *Youth detention population in Australia 2016* (13 December 2016) <http://www.aihw.gov.au/publication-detail/?id=60129557387> 1.

¹³⁷ Anna Henderson and Nicolas Perpetch, 'Royal Commission into Aboriginal Deaths in Custody: Amnesty accuses Scullion of false 'progress' claims' *ABC News* (15 April 2016) <<http://www.abc.net.au/news/2016-04-15/amnesty-accuses-scullion-of-false-claims-over-custody-deaths/7328252>>.

¹³⁸ Committee against Torture, *Concluding observation on the combined fourth and fifth periodic reports of Australia*, 53rd sess, UN Doc CAT/C/AUS/CO/4-5 (23 December 2014) 4[11].

¹³⁹ Ibid 4 [12].

140. As of 2016, Aboriginal and Torres Strait Islander prisoners still represented 27 per cent of the total Australian prisoner population.¹⁴⁰ The devastating impacts of this over-representation on communities around Australia is well documented.¹⁴¹
141. The ALRC is conducting an inquiry into the incarceration rates of Aboriginal and Torres Strait Islander peoples. The final report of this inquiry is due in December 2017. The Law Council considers that any protocols developed as part of OPCAT implementation relevant to this group should be reconciled with the recommendations of the ALRC report after its release.

4. How should Australian NPM bodies engage with civil society representatives and existing inspection mechanisms (eg, NGOs, people who visit places of detention etc)?

142. Civil society representatives and existing inspection mechanisms are an invaluable source of expertise and information about conditions in detention. While they work towards the same goals as the NPMs will, they have different perspectives and organisational imperatives that will enable NPMs to have a more comprehensive understanding of the issues that they need to address. The Law Council suggests that NPM bodies establish both regular and ad hoc processes for consulting and liaising with these organisations and individuals. These might include, for example, an annual forum or roundtable to discuss issues of concern, as well as a reporting procedure for specific issues. The range of actors involved will necessitate a combination of formal and informal processes. This will ensure that engagement is not precluded by making NPMs difficult to access for individuals or organisations with limited resources. The Law Council would also suggest that liaison and consultation occur primarily at the state and territory level, to facilitate access to information by the NPMs that are best placed to address problems that are identified.
143. In New Zealand, for example, meetings with members of civil society have been held on a yearly basis in Auckland, Wellington and Christchurch. The Human Rights Commission of New Zealand said in its review of OPCAT implementation that ‘This has been a useful process for NPMs, and issues raised and contacts made at these meetings have helped to inform NPMs’ activities.’¹⁴²

¹⁴⁰ Australian Bureau of Statistics, *Aboriginal and Torres Strait Islander Prisoner Characteristics* (7 December 2016)

<<http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4517.0~2016~Main%20Features~Aboriginal%20and%20Torres%20Strait%20Islander%20prisoner%20characteristics~5>>.

¹⁴¹ See, eg, Australian Law Reform Commission, *Incarceration Rates of Aboriginal and Torres Strait Islander Peoples* (July 2017)

<http://www.alrc.gov.au/sites/default/files/pdfs/publications/discussion_paper_84_compressed_no_cover.pdf> 84.

¹⁴² Human Rights Commission, *OPCAT in New Zealand 2007-2012 A review of OPCAT implementation by New Zealand’s National Preventive Mechanisms* (July 2013)

<https://www.hrc.co.nz/files/2214/2398/7100/Opocat-2013_web.pdf> 17.

144. NPMs should also identify opportunities to engage with relevant work of civil society and existing inspection mechanisms. They might, for example, attend meetings or seminars held by these bodies.

5. How should the Australian NPM bodies work with key government stakeholders?

145. The national coordinating mechanism would be the best organisation to facilitate the relationship between NPM bodies and key government stakeholders, including the SPT. It is best placed to do so, having oversight of the work of all the NPMs across Australia. In New Zealand, for example, the coordinating government agency is involved in meetings between individual NPMs and the government agencies that they monitor. These meetings take place bilaterally, and the role of the coordinating government agency is to ‘...assist in following up recommendations as well as being a valuable source of advice and information at the NPM ‘table’’.¹⁴³

146. The UK provides a useful example of how to facilitate and coordinate communication across different NPMs. It has biannual business meetings that are attended by representatives from all of the 21 statutory bodies that constitute its NPM. These are:

*...its main forum for members to share findings, best practice, experiences and lessons from monitoring different types of detention and different jurisdictions. The NPM business plan is agreed by members and other decisions are taken at these meetings.*¹⁴⁴

147. In addition, it has a NPM steering group which meets three times a year and ‘...supports decision-making between business meetings, and develops the NPM business plan and proposals to members’.¹⁴⁵ Australia could apply a similar model for its national coordinating mechanism to communicate with different state and territory NPMs.
148. The Consultation Paper also raises the issue of whether specific processes should be developed to address the needs of vulnerable groups of people in detention. It is difficult to address this question without the benefit of seeing how the proposed system of NPMs might itself be able to address these needs. The Law Council would suggest a review be conducted of the NPMs within a reasonable timeframe of their establishment, either in conjunction with or independent of the SPT as appropriate. The issue of the needs of vulnerable groups of people in detention should be included in the terms of the review, with a view to revisiting the possibility of implementing

¹⁴³ Ibid.

¹⁴⁴ National Preventive Mechanism, *Monitoring places of detention Seventh Annual Report of the United Kingdom's National Preventive Mechanism 1 April 2015 – 31 March 2016* (January 2017) <https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/584051/npm-annual-report-2015-2016-print.pdf> 11.

¹⁴⁵ Ibid, 12.

specific processes to address these needs if the existing regime is found to be unsuitable.

6. How can Australia benefit most from the role of the SPT?

149. Australia can benefit from having access to the expertise of the SPT. The role of the SPT is to visit and make recommendations to States,¹⁴⁶ and to provide advice and assistance to States in establishing NPMs, as well as NPMs directly.¹⁴⁷ NPMs can also access training and technical assistance from the SPT.¹⁴⁸
150. In this regard, the opportunity to access the diversity of experience of the SPT is of great advantage to States. The SPT is constituted by experts from different fields and backgrounds. The OPCAT requires that members of the SPT are drawn from the field of administration of justice, particularly with experience in criminal law, prison or police administration, and other fields relevant to the treatment of persons deprived of their liberty.¹⁴⁹ The Consultation Paper notes that this has increasingly included medical experts, such as doctors, psychologists, and psychiatrists.¹⁵⁰ OPCAT also requires diversity of representation in the SPT, including equitable geographic distribution and the representation of different forms of civilisation and legal systems,¹⁵¹ gender balance¹⁵² and that no two members are from the same State.¹⁵³ This means that the members of the SPT are well placed to assist with the range of issues that Australia may encounter in establishing its NPMs.
151. The SPT has built up a wealth of knowledge, having had the opportunity to provide assistance in setting up NPMs in many different countries and contexts. Australia should make the most of its opportunity to access this expertise, particularly in the early days of establishing its system of NPMs. This is likely to be a complex undertaking, given that it will require coordination across federal, state and territory jurisdictions. The SPT is uniquely placed to provide assistance to both Australia and the NPMs directly in this process.
152. Australia's open and constructive relationship with the SPT would be extremely beneficial in ensuring NPM best practices. To ensure expert and specialist members of the NPM remain committed to the preventative approach of their role, ongoing interaction with the SPT and the best practice discourse should be encouraged and guaranteed. The Law Council suggests that inspectors could undertake continuing educational development and interaction with global best practice through the SPT.

¹⁴⁶ OPCAT art 11(1)(a).

¹⁴⁷ Ibid art 11(1)(b).

¹⁴⁸ Ibid art 11(1)(b)(ii).

¹⁴⁹ Ibid art 5(2).

¹⁵⁰ Consultation Paper, 6 [25].

¹⁵¹ OPCAT art 5(3).

¹⁵² Ibid art 5(4).

¹⁵³ Ibid art 5(5).

7. After the Government formally ratifies OPCAT, how should more detailed decisions be made on how to apply OPCAT in Australia?

153. The Law Council notes that the Australian Government intends to implement OPCAT over three years. Progressive implementation is provided for by Article 24 of OPCAT. The Law Council supports this approach. However, it is critical that appropriate milestones be set down so that each jurisdiction is cognisant of the expected implementation rate, and progress can be measured against these indicators accordingly. The SMART goal system may be one such methodology. The Law Council also suggests that leading human rights bodies and experts ought to be consulted in the development of any goal system for progressive implementation.
154. The Government should continue to consult with key stakeholders, including civil society, on how to apply OPCAT in Australia. It may wish to do so through the AHRC (as it has for this consultation), or through the responsible government agency.
155. Reference should be made to international standards in deciding how to apply OPCAT in Australia. An example of a relevant international standard is the Istanbul Protocol, which was developed to enable States to facilitate effective documentation of torture and ill-treatment.¹⁵⁴ While the NPMs take a preventative rather than a reactive complaints-driven approach, this document still has useful guidance that can be applied by NPMs in monitoring conditions in detention. A further example of a relevant international standard is the United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules).¹⁵⁵ The Nelson Mandela Rules ‘...set out what is generally accepted as being good principles and practice in the treatment of prisoners and prison management’.¹⁵⁶ At the time of its adoption, the United Nations General Assembly encouraged member States to improve conditions in detention in accordance with these rules.¹⁵⁷

¹⁵⁴ Office of the United Nations High Commissioner for Human Rights, *Istanbul Protocol: Manual on the Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (9 August 1999) <<http://www.ohchr.org/Documents/Publications/training8Rev1en.pdf>>.

¹⁵⁵ United Nations, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)*, GA Res 70/175, 70th sess, Agenda Item 106, UN Doc A/RES/70/175 (8 January 2016).

¹⁵⁶ *Ibid*, annex.

¹⁵⁷ *Ibid*, 9.