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Commissioner Santow,
The Australian Human Rights Commission,
Level 3, 175 Pitt Street, Sydney NSW 2000

By email:

humanrights.commissioner@humanrights.gov.au

21st September 2018

RE: IMPLEMENTATION OF OPCAT

Dear Commissioner,

We welcome and appreciate the opportunity to make a submission in relation to the implementation of the Optional Protocol to the Convention Against Torture.

Preliminary Consideration: Our Background for Meaningful Comment

The Aboriginal and Torres Strait Islander Legal Service (Qld) Limited (ATSILS), is a community-based public benevolent organisation, established to provide professional and culturally competent legal services for Aboriginal and Torres Strait Islander people across Queensland. The founding organisation was established in 1973. We now have 26 offices strategically located across the State. Our Vision is to be the leader of innovative and professional legal services. Our Mission is to deliver quality legal assistance services, community legal education, and early intervention and prevention initiatives which uphold and advance the legal and human rights of Aboriginal and Torres Strait Islander people.

ATSILS provides legal services to Aboriginal and Torres Strait Islander peoples throughout the entirety of Queensland. Whilst our primary role is to provide criminal, civil and family law representation, we are also funded by the Commonwealth to perform a State-wide role in the key areas of Community Legal Education, and Early Intervention and Prevention initiatives (which include related law reform activities and monitoring Indigenous Australian deaths in custody). Our submission is informed by four and a half decades of legal practise at the coalface of the justice arena and we therefore believe we are well placed to provide meaningful comment. Not from a theoretical or purely academic perspective, but rather from a platform based upon actual experiences.

OVERALL COMMENTS

As a party to The Convention Against Torture and other Cruel, Inhuman and Degrading Treatment or Punishment (CAT), Australia must prevent torture and other acts of cruel, inhuman or degrading treatment or punishment. Following the announcement in February 2017 that Australia would accede to the Optional Protocol (OPCAT) and undertake obligations to prevent ill-treatment in places of detention by the establishment of a preventive-based inspection mechanism.

We welcome the introduction of preventive visiting which offers better protection against mistreatment and systemic failures over traditional monitoring and inspection methodologies. By identifying and analysing factors that may directly or indirectly increase or decrease the risk of torture and other ill-treatment, it mitigates or eliminates risk factors systematically and reinforces protective factors and safeguards. As noted by the then Attorney-General in February 2017, had OPCAT been in place earlier then, 'it may well be that either [the events at Don Dale] wouldn't have happened at all or they would have been arrested at a much earlier time.'[1]

Question 1: How should OPCAT be implemented to prevent harm to people in detention? How should the most urgent risks of harm be identified and prioritised?

In our view, the National Prevention Mechanism (NPM) to carry out preventive visiting should be comprised of multidisciplinary teams who are sufficiently independent from government to be able to carry out their functions freely and without fear of repercussions, such as loss of funding to their organisations. For that reason, we think the model of providing direct funding to charity organisations tasked with carrying out the visits would be unsuitable and would instead support the funding of positions from guaranteed funding through an independent organisation such as the Commonwealth Ombudsman's office.

We would also commend the Western Australian model in terms of the powers of the Inspectors of Custodial Services: *Inspector of Custodial Services Act 2003 (WA)* – noting for example that under s 25, no prior notification for an inspection is required; and under s27, an Inspector is invested with all things necessary or convenient for or in connection with the performance of their role.

Current Concerns

A number of systemic factors leading to harm to prisoners in correctional centres have been identified in evidence in coronial inquiries, and other systemic issues have been recently ventilated in Crime and Misconduct Commission hearings. Because of the limits on the types of findings that either of those bodies can make, there remains a body of concerning evidence left unaddressed.

Factors of current concern in the adult correctional centres include:

[1] Transcript available at https://foreignminister.gov.au/transcripts/Pages/2017/jb_tr_170209.aspx?w=tb1CaGpkPX%2FlS0K%2Bg9ZKEg%3D%3D

(a) Dangerous restraint techniques, including the strapping of a helmet to the prisoner, causing blackouts and difficulty breathing for prisoners ;[2]
(b) Excessive force or unlawful assault; especially employing excessive and painful holds, using capsicum spray on restrained prisoners, kicking prisoners who are on the ground and restrained by other guards;
(c) Unreasonable withholding of prescribed medications or access to medical treatment;
(d) Excessive use of strip searches on female prisoners;[3]
(e) Unreasonable calling of code yellows to cause a prisoner to be placed in the Detention Unit;
(f) Unreasonable failure to call a code yellow to allow bashings of prisoners to continue, especially where transgender prisoners are being assaulted;
(g) Sexualised treatment of prisoners and threats of sexual assault made to prisoners;
(h) Long waiting lists for access to beds in mental health wards for mentally unwell prisoners, failure to give access to proper health care for the mentally unwell;
(i) Punishment for unsubstantiated breaches;
(j) Bullying and payback for prisoners who lodge a complaint.

Composition of the NPM

Due to the over-representation of Aboriginal and Torres Strait Islanders in the prison population, currently at 30% of the total Queensland prison population, the NPM visitors should include appropriate community members with the same gender as the prisoners to be available to interview prisoners. Additionally, appropriate levels of cultural competence training should be provided to the non-indigenous members of the NPM.

Due to the high numbers of Aboriginal and Torres Strait Islander inmates, there should be at least one indigenous health expert available to the NPM. Cultural competence is crucial to improving systems in correctional centres to prevent deaths. There have been a number of occasions where indigenous inmates have died within a short time of entering a custodial facility. At the subsequent coronial inquiries, submissions made on behalf of the next of kin highlighted the lost opportunities for preventing a death because lack of cultural competence had meant that vital signs and symptoms were missed and not acted upon.[4]

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[2] These are current complaints. The concerns about blackouts are significant. In 2010 Lyji Vaggs died as a result of Hypoxic Brain Injury due to restraint in Townsville Hospital while in police custody; Inquiry into the death of Lyji Vaggs (2012).

[3] As noted in the Executive Summary of the Report of the Royal Commission and Board of Inquiry into the Protection and Detention of Children in the Northern Territory, "In closed institutions, such as detention centres, it is of paramount importance that the power be clearly defined and circumscribed." Available at https://childdetentionnt.royalcommission.gov.au/Documents/Royal-Commission-NT-Final-Report-Volume-1.pdf. Note also the findings of the Queensland Ombudsman in The Strip Searching of Female Prisoners Report: An investigation into the strip search practices at Townsville Women's Correctional Centre (2014) available at https://www.ombudsman.qld.gov.au/improve-public-administration/reports-and-case-studies/investigative-reports/strip-searching-of-female-prisoners-report--2014

[4] These inquests include: Inquest into the death of Hazel Wharton/Lalara (2013) Ms Wharton died at the Park Centre for Mental Health She died within four weeks of being admitted to custody. She had been put on a number of medications including Olanzapine which had side effects of suppressing breathing and she complained of feeling unwell. The prescribing doctor was outside the jurisdiction during the length of the entire inquest and could not be called to give evidence. Inquest into the death of Sheldon Douglas Currie

Also, due to the high level of psychological risk and psychiatric harm in correctional centres and places of detention, independent and appropriately qualified psychologists and psychiatrists should be retained to be part of the NPM.[5]

In a similar fashion to the Coroner's powers, The NPM should have ad hoc access to experts and subject specialists when their expertise is required to investigate root causes and systemic issues.

Matters for prioritisation

In our experience, a number of systemic problems in detention and correctional centres have been identified by the Royal Commission into Aboriginal Deaths in Custody and subsequent inquests into deaths in detention. Over the past few decades similar issues continue to be identified and similar recommendations continue to be made to the findings made by the Royal Commission. In our view priority should be given to the factors repeatedly identified as influencing risk of death of prisoners and unimplemented recommendations.

Recent comments by the Coroner have included comments on the inadequacy of care for Hepatitis C sufferers, which is a significant concern while Hepatitis C remains prevalent in the jail system.[6] Similarly, the inadequacy of palliative care for prisoners has been raised in inquests.[7]

Repeated failures to provide mental health treatment and for the appropriate medication to be made available for mentally unwell prisoners remains a live issue. Although in theory mentally unwell patients could access most drugs needed for treatment, in practice the prisons are very reluctant to authorise the prescription of many drugs. Similarly, prisoners are being denied better treatment options available in mental health wards.[8]

The use of isolation for distressed prisoners is one of the drivers that causes prisoners to deny self-harming or suicidal ideation (such is based upon first-hand feedback provided to our staff by prisoners). In many circumstances, isolating a distressed prisoner actually increases the risk of harm.

(2011). Sheldon Currie was 18 years old and after 11 days of complaining about flu like symptoms, slipped into a coma and died four days later in hospital. Inquest into the Death of Anthony (Tony) Gayle Costelloe (2009). Tony Costelloe died while playing football at the prison. A fellow inmate was stopped from giving CPR on the field and CPR was recommenced by nurses 6 minutes later. Tony Costelloe had complained of chest pain but as a secure inmate did not qualify for a next day assessment by a doctor.

[5] There are ongoing inquests in Queensland concerning deaths of prisoners recently admitted to correctional facilities from self harming. The adequacy of the Immediate Risk Needs Assessment (IRNA) process is a live issue in those inquests.

[6] Inquest into the death of Jay Maree Harmer (2018), see also https://www.sunshinecoastdaily.com.au/news/she-was-only-38-why-did-she-die-so-young/3378854/. Just as concerning was the failure to assist an 18 year old inmate who had only recently contracted the disease, Inquest into the death of Sheldon Douglas Currie (2011).

[7] Inquest into the death of Kenneth Wright, Inquest into the death of Jay Maree Harmer(2018)

[8] For example, in the Inquest into the death of Lyji Vaggs (2012), the Coroner concluded "it remains the case had better decisions been made on a number of occasions, it is likely Lyji would have received in-patient care before the fatal incident occurred or the restraint may have been truncated." Last year ATSILS was advised that a client was number 24 in the waiting list for a bed in a mental health ward from that prison.

Isolation can be particularly distressing to Aboriginal or Torres Strait Islander prisoners and cause greater psychological harm.

Another priority should be addressing the holding of young persons in watch-houses for extended periods when youth detention centres have reached capacity.

A review by the Queensland Ombudsman into excessive use of strip searches on female prisoners, not only found that automatic strip searching of females on the administration of S8 medication was contrary to law, but also that

> "*QCS does not have sufficient oversight mechanisms in place to ensure that all strip searches undertaken at correctional centres are appropriately authorised and reasonable in the circumstances, and this is unreasonable administrative action within the meaning of s.49(2)(b) of the Ombudsman Act.*"[9]

Finally, the issue raised by the Queensland Supreme Court regarding the welfare of the aged and infirm who are restrained under orders imposed under the Dangerous Prisoners (Sexual Offenders) Act deserves prioritisation.

> "*It seems to me that a time will come when there are enough offenders in the respondent's category of age and debility falling within the compass of the Dangerous Prisoners (Sexual Offenders) Act to require the setting up of supported accommodation for them. It is deeply troubling to think that people who could be managed and rendered relatively risk-free with appropriate support and accommodation, must instead, be imprisoned as the only option.*"[10]

Question 2: What categories of 'place of detention' should be subject to visits by Australia's NPM bodies?

As identified in the media statement by the Australian Government on 17 February 2017 to the Australian public and the international community,[11] the NPM mechanism will improve oversight of places of detention, including immigration detention facilities, prisons, juvenile detention centres, and various psychiatric facilities.

In our view the places that should be subject to NPM visits should include:

(a) Correctional Centres;
(b) Youth Detention Centres;

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[9] The Strip Searching of Female Prisoners Report: An investigation into the strip search practices at Townsville Women's Correctional Centre (2014) available at https://www.ombudsman.qld.gov.au/improve-public-administration/reports-and-case-studies/investigative-reports/strip-searching-of-female-prisoners-report--2014-

[10] *Attorney-General for the State of Queensland v Guy* [2017] QSC 179 at [20]

[11] Press release available at https://foreignminister.gov.au/releases/Pages/2017/jb_mr_171215b.aspx?w=tb1CaGpkPX%2FlS0K%2Bg9ZKEg%3D%3D

(c) Watch-houses;
(d) Vehicles used for the transport of arrested persons and prisoners, including regional flights;
(e) Secure and Forensic wards in Mental Health facilities;
(f) Places used to house those under a Forensic Disability Order;
(g) Community facilities with locked wards, such as for dementia patients and those with an intellectual disability;
(h) Accommodation used to house those under Continuing Detention Orders and Community Supervision Orders;
(i) Places where children are placed under Child Protection Orders;
(j) Courthouse Watchhouses, holding cells and the like;
(k) Places used for immigration detention.[12]

Question 3: What steps should be taken to ensure the measures to implement OPCAT in Australia are consultative and engage with affected stakeholders?

In our view affected stakeholders can help identify areas of concern for further inquiry and provide feedback on the rate of improvement following NPM intervention.

As happens with the Crime and Corruption Commission, submissions can be sought from organisations able to make useful comment about systemic issues.

A complaints' mechanism should be enacted which allows particular problems to be referred to the NPM. This procedure should be highly confidential and not subject to the Right to Information legislation as those under detention often hold well-founded fears of retribution for the making of complaints.

The critical element to the success of the NPM is how systemic issues are in fact addressed and how any progress or lack of progress is monitored.

It would be worthwhile for progress reports or report cards on changes 6 months, 12 months or 2 years later to be produced by the NPM and for affected stakeholders to be able to provide input on those report cards.

Question 4: What are the core principles that need to be set out in relevant legislation to ensure that each body fulfilling the NPM function has unfettered, unrestricted access to places of detention in accordance with OPCAT ?

A review of NPM in other countries and their applicability to Australian conditions and other literature has suggested the following as minimum requirements for implementing an NPM here:

(a) full independence,

[12] Surprisingly Aboriginal and Torres Strait Islanders have been taken to immigration detention. One recent example is reported in http://www.abc.net.au/news/2018-09-19/aboriginal-man-facing-deportation-to-png-takes-case-high-court/10262952

(b) unfettered access to all detention settings, and the ability to make surprise visits and to be afforded reasonable opportunity of inspection around lockdowns;
(c) the right to access information deemed relevant to its inquiries,
(d) an ability to conduct private interviews with detainees and staff free from the threat of reprisal and
(e) powers to comment on legislation, policy and other issues pertinent to its mandate.

We would urge the AHRC to look at the model of visits used by the International Committee of the Red Cross to jails and detention centres under international law. Unlike prison inspection visits which are arranged with one weeks notice, the arrival of ICRC inspectors is truly confidential and unannounced. In our view this is essential for NPM visits to be effective.

In our experience, many prisoners report to us that they fear reprisal action for writing blue letters (letters of complaint about the prison system) so instead seek urgent changes to their parole status as a means of addressing unsafe situations. To support the NPM visits we would also urge the creation of three new offences to avoid interference with the NPM process:

(a) threats or adverse treatment of those making a complaint or comment to the NPM should be criminalised; and
(b) obstruction of NPM visits should be criminalised; and
(c) intentional destruction of recordings made for the purpose of NPM complaints should be criminalised.

In our view, reports by the NPM should be privileged and the NPM should be able to publish findings to the relevant stakeholders.

We thank you for the opportunity to provide input at this initial stage and thank you for your careful consideration of these submissions.

Yours faithfully,

Mr. Shane Duffy
Chief Executive Officer
ATSILS (Qld) Ltd.