Aboriginal & Torres Strait Islander
Legal Service (Qld) Ltd

www.atsils.org.au

Level 5, 183 North Quay Brisbane Qld 4000
PO Box 13035, George Street Brisbane Qld 4003
T: 07 3025 3888 | F: 07 3025 3800
Freecall: 1800 012 255
ABN: 116 314 562

Committee Secretary
Legal Affairs and Safety Committee
Parliament House
George Street
Brisbane Qld 4000

By email lasc@parliament.qld.gov.au

18th November 2021

Dear Chair,

RE: THE INSPECTOR OF DETENTION SERVICES BILL 2021

We welcome and appreciate the opportunity to comment on the *Inspector of Detention Services Bill 2021.* We welcome the creation of an Inspector of Detention Services to inspect places of detention, and to review detention services and we welcome the creation of a framework for greater transparency and accountability. These changes arise in response to several reviews of the Queensland's Criminal Justice system held since 2016[1] including the CCC Report from Taskforce Flaxton and The Queensland Parole System Review. An important outcome is to have a single inspectorate for adult corrections, youth detention and watch-houses.

We note the purpose of the legislation is to promote and uphold national and international standards for the humane treatment and corrections of people detained. In our view there is much to commend the inspectorate model used in Western Australia[2] and we note that the

[1] Apart from the *Queensland Parole System Review Final Report (2016)*, "*the Sofronoff Report*", reports in recent years include three reports released by the Queensland Ombudsman, the report into prison breach processes, the strip searching of female prisoners, and the overcrowding of women in Brisbane Women's Correctional Centre in September 2016. Additionally, the Crime and Corruption Commission conducted the Operation Flaxton inquiry, and there was the Independent Review of Youth Detention, "*the McMIllan Report*" released in 2017.

[2] Established by the Western Australian *Inspector of Custodial Services Act* 2003 as amended in

Bill also draws from inspectorate models from New South Wales, the Australian Capital Territory and Tasmania.

We welcome the commitment to Human Rights standards already recognised in the *Human Rights Act 2019* and also recognition of the import of various international law instruments including:

a) *The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules),*
b) *the United Nations Principles for the Protection of All Persons Under Any Forms of Detention,*
c) *the United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules) and*
d) *the United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders (the Bangkok Rules).*

Preliminary Consideration: Our background to 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 24 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 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 are informed by nearly five 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.

COMMENT

We welcome the creation of an independent inspector of adult correctional centres (community correctional centres, prisons, work camps), and youth detention centres and police watchhouses whose independence is protected by their status as an officer of the Parliament.

2011

We welcome that, similar to other jurisdictions, the role of the Inspector will be to inspect places of detention and to review detention services.

We note that improved conditions and safety in correctional services leads not only to more humane and safe conditions for the prisoners but also improves the conditions and safety of correctional staff as well.

The need for a single inspectorate to inspect places of detention and to review detention services

There are strong reasons for having a single independent body charged with oversight of places of the detention and detention services.

Both here, in other Australian jurisdictions, and overseas, it is recognised that a centralised Inspectorate to oversee the provision of detention services and places of detention is essential for humane treatment and conditions of those detained, safer conditions for detainees and those who work in prisons, and upholding basic human rights.

Inspectorates of detention services and places of detention help discharge several obligations of the state including the right to life (or better expressed as the right to protection against arbitrary interference with life) and the protection of prisoners or others from being subjected to harm including torture and cruel, inhumane or degrading treatment. It also helps discharge the positive obligation on states to uphold the humane treatment of detainees.

The purpose of the overarching inspection regime of the inspector is to overcome fragmented or siloed investigations by other bodies. For that reason, we would soften the legislative language in clause 19 to 'avoid unnecessary duplication' or to 'avoid duplication where appropriate'. We note that clause 19 (2) refers to unnecessary duplication and so would recommend the same phrase be used in clause 19 (1).

Assistance with Inspections

We welcome the provisions contained in clause 9 for the Inspector to be able to arrange for a suitable person to help carry out the review, taking into account assistance for cultural issues, and issues surrounding disability, age, language barriers and trauma. Clause 9(5) takes into account circumstances where a need arises for assistance from someone with cultural authority and the introduction of this provision is very much welcomed.

These provisions will help overcome the misunderstandings, misinterpretations or silences that would otherwise hinder successful outcomes.

Powers of the Inspector

The Inspector's preventative, proactive and independent mandate is supported by a broad power to do all things necessary or convenient for, or in connection with, the performance of the Inspector's functions.

We welcome clause 22 which recognises that the inspector may report on one or more places of detention, one or more detention services and a mixture of detention places and detention services.

Clause 22 may encompass, but if it does not, then the language should be broadened to include the conditions under which prisoners are being transported between prison and hospital for medical treatment and their physical treatment while under guard in hospital.

We welcome the powers contained in clause 14 and especially welcome specific powers for access to vehicles, equipment or other things at a place of detention. We also welcome the power for the Inspector to talk to any detainee at the place of detention at any time but would seek for clause 14(3)(b) to be expanded so it is not confined to a prisoner at that specific place of detention. The reason for that is that there is a high level of churn of prisoners being transferred between places of detention so it is quite foreseeable that to discharge an inspection properly the Inspector would also need to talk to detainees recently transferred out of the place of detention being inspected. Similarly, it would be desirable for the Inspector to be able to speak to detainees within 12 months of their being released from places of detention when they would be freer to talk.

We agree that the Inspector should have the power to both protect information due to public interest considerations but also to disclose information due to public interest considerations.

The interaction between systemic reviews and dealing with or referring individual complaints.

While the role of the Inspector of Detention Services is to undertake systemic reviews, the explanatory notes state that the Inspector will not investigate specific incidents or complaints.

We recognise and wholeheartedly support the importance of systemic reviews of places of detention and detention services and improvements as they overcome the deficiencies of piecemeal approaches. The need for systemic review was highlighted in the Western Australian inquest in *Ward*. Ward's case involved the death of an aboriginal person in custody who died of heatstroke in unsafe and unsuitable custodial transport. As noted by the Coroner in *Ward*:

> *Evidence from around Australia suggests that an incremental approach has not solved endemic issues. Piecemeal changes have tended to result from isolating incidents and the*

failure to draw systemic links and ask hard questions[3].

The lessons learned from the Western Australian Coroner's *findings and recommendations in the death of Mr Ward* and the Report of a Working Group for the Deaths in Custody Watch Committee in 2009, *The Ward Case and Lessons for the WA Government: System-wide Dysfunction Requires a System-Wide Approach* led to amending legislation in 2011 in Western Australia. As noted in the explanatory memorandum to that amending legislation:

> *These amendments recognise that process failures of different agencies and organisations are not always readily apparent from static inspections of facilities or equipment and it is for these reasons that the additional auditing powers to be given to OICS are being implemented.*

It is thus important to not just look at individual cases but to look deeper to address the systemic issues. However, it is also important to address individual issues uncovered during the reviews in situations when there is a clear and present threat to the safety of an individual prisoner or circumstances that amount to inhumane treatment.

The legislative changes In Western Australia brought about two major changes. First, the ability to undertake audits of individual prisoners; thereby enabling audits to be undertaken on individual prisoners moving through the custodial system, and secondly to issue "Show Cause" notices to the Western Australian Department of Corrective Services where the Office of the Inspector of Custodial Services has reasonable cause to suspect the existence of either a serious risk to life, personal safety, welfare, security or control, or of the treatment which is cruel, inhumane or degrading.

While the role of the Inspector of Detention Services will be largely to add systemic issues and bring about changes in conformity with national and international standards, in some circumstances the Inspector should be able to respond to an immediate situation.

Such an approach was adopted in the United Kingdom to supplement the inspection process by HM Inspector of Prisons (UK) with an urgent notification process. The urgent notification process was established in 2017. An urgent notification is made when there is significant concern about the treatment and conditions of prisoner(s). The urgent notification process is not part of an inspection, it is a separate process in its own right.

[3] *Inquest into the death of Ian Ward, Record of Investigation into Death*, Western Australian Coroner's Court, cited in WA Deaths in Custody Committee, *The Ward Case and Lessons for the WA Government: System-wide Dysfunction requires a System-wide Approach* available at: https://parliament.wa.gov.au/Parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/F2F923A0187E968E482578310042EFD7/$file/ev.tdp.100526.Deaths+In+Custody+Watch+Committee+2.sub30.d.doc.pdf

The HM Inspector of Prisons considers various factors when issuing an urgent notification, including:

- Poor healthy prison assessments
- The type of establishment and the risks it presents
- The vulnerability of those detained
- The failure to achieve Inspectorate recommendations from previous inspections
- The confidence of the Inspectorate in the establishment's capacity to change and improve

After the Inspectorate of Prisons raises an urgent notification, the [relevant minister] responds within 28 calendar days of receiving the letter. The Minister also sends the Inspectorate an Action Plan, which shows how the establishment will address the concerns along with a target date for completion. Both the notification and response and Action Plan are published in the Inspectorate's report.

As noted by the Coroner in *Ward* when reviewing the circumstances of death of Mr Ward (an aboriginal person in custody who died of heatstroke in unsafe and unsuitable custodial transport):

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

It is important that the powers of review are not so constrained that serious failings in individual cases that become visible in the course of inspections by the Inspector of Detention Services cannot then be addressed.

We do however note the recognition contained in section 17(1) for an urgent response if the Inspector suspects on reasonable grounds that a detainee is or has been subjected to torture or cruel inhumane or degrading treatment at a place of detention.

We agree that this should be treated as a relevant matter that justifies a truncated notice period. That period however runs for three days and we would suggest that in some circumstances some form of witness protection should be afforded to the prisoner subjected to such Illegal treatment.

A second aspect of the systemic versus individual conundrum is that some systemic issues can be so closely intertwined with individual cases that they should not be separated. For example, for resolving issues of access for terminally ill prisoners going without appropriate palliative care, the future improvement of access to palliative care will be too abstract an outcome for those presently suffering from lack of palliative care.

A three year not a five year cycle is needed for inspection of places

In the *Queensland Parole System Review Final Report* ("The Sofronoff Report"), the report outlined that in Western Australia:

> *Full Inspection is a routine inspection conducted according to the legislative requirement for each custodial facility or service to be inspected at least once every three years….*

As noted in the report these full inspections are supplemented by on-site liaison visits:

> *The number of visits required is determined by the assessed level of risk that the facility poses and encompasses such factors as size, security level, and previous inspection findings and assessments. At a minimum each facility is subject to at least four liaison visits per year[4].*

Powers of Review for Compliance with Human Rights obligations, addressing systemic Human Rights matters and functions under OPCAT and the NPMS.

Australia is a signatory to and has ratified the *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (OPCAT). The international agreement has been adopted by governments who reaffirm torture, cruel, inhuman and other degrading treatment or punishment are prohibited and are against human rights. The convention directly deals with the need to provide and strengthen the protection for persons deprived of their liberty, like those who are in prison This requires State parties, including Australia, to implement a National Preventative Mechanism (NPM), which is, in effect, a national body responsible for coordinating the independent inspections of all places of detention by independent inspectorates in each state or territory. As an example of an NPM, the HM Inspectorate of Prisons fulfills part of the United Kingdom's obligations under OPCAT.

At the time of writing of the *Sofronoff Report*, Australia had not yet ratified OPCAT although preparations to do so were in advanced stages. As noted in the *Sofronoff Report*, [if an independent prison inspection process were to be implemented as recommended in the report then] it is important that any changes made accord to the requirements of the NPM framework in OPCAT[5].

Along similar lines, the Working Party of the Deaths in Custody Committee in their report to the Western Australian Parliament[6] on issues arising from the Coroner's findings and

---

[4] *Queensland Parole System Review Final Report (2016) para 1228*

[5] *Ibid, para 1254*

[6] WA Deaths in Custody Committee, *The Ward Case and Lessons for the WA Government: System-wide Dysfunction requires a System-wide Approach* available at: https://parliament.wa.gov.au/Parliament/commit.nsf/(Evidence+Lookup+by+Com+ID)/F2F923A0187E968E482578310042EFD7/$file/ev.tdp.100526.Deaths+In+Custody+Watch+Committee+2.sub30.d.doc.pd

recommendations in the Ward inquest, made a number of recommendations with a human rights focus: They recommended that:

> *RECOMMENDATION 16 There needs to be increased emphasis on the cyclical (3 year) long-term review function within the OICS investigating and recommending on important systemic human rights matters to Parliament, such as structural racism and compliance with international obligations*.

Further, the Deaths in Custody Watch Committee strongly agrees with the Coroner's view in the Ward inquest that there should be a power of review in order to monitor the State's compliance with international obligation and further that this power should exist within the OICS as part of its function as an inspection and review body.

> *RECOMMENDATION 20 That there should be a power of review in order to monitor the state's compliance with Australia's international legal obligations. This power should exist within the OICS as part of its function as an inspection and review body.*

We would echo those recommendations and seek an explicit reference to those powers in the provisions of the Bill addressing the powers of review of the Inspector of Detention Services.

CONCLUSION

The Human Rights for prisoners include relevantly: the right to humane treatment when deprived of liberty; the right to a fair hearing; and the right to protection from torture and cruel, inhumane, or degrading treatment. Additionally, for children, there is the right of every child to have protection as is in their best interests. For all prisoners and detainees, there is the right to an equivalent level of health services in custodial settings as are available in the community, and, especially important for young detainees, there is the right to an equivalent level of education (and uninterrupted education) in the youth detention centres.

None of these rights can be taken for granted. As also noted in the explanatory notes, there have been a number of reports since 2016 which have highlighted problem areas and there have also been a number of inquests containing important recommendations which need to be implemented or at least addressed. The creation of the Inspector of Detention Services offers a way to ensure consistent follow up on unimplemented recommendations and to ensure that human rights of those in places of detention are recognised, honoured, and upheld.

We thank you for the opportunity to comment on the Bill and to identify issues that we see as

---

f. The working group found that it was likely that Mr Ward would not have died from heatstroke in prison transport vehicles if the OICS had been empowered to enforce reasonable standards when serious concerns were raised years earlier.

fundamental to the success of establishing an independent inspector it to oversee adult prisons, youth detention centres, and police watchhouses.

Yours faithfully,

Shane Duffy
Chief Executive Officer