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OPCAT in Victoria:
A thematic investigation of practices related to solitary confinement of children and young people

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The Victorian Ombudsman pays respect to First Nations custodians of Country throughout Victoria. This respect is extended to their Elders past, present and emerging. We acknowledge their sovereignty was never ceded.

Letter to the Legislative Council and the Legislative Assembly

To

The Honourable the President of the Legislative Council

and

The Honourable the Speaker of the Legislative Assembly

Pursuant to sections 25 and 25AA of the *Ombudsman Act 1973* (Vic), I present to Parliament my report *OPCAT in Victoria: A thematic investigation of practices related to solitary confinement of children and young people.*

Deborah Glass OBE
Ombudsman

5 September 2019

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Foreword

> *I found solitary confinement the most forbidding aspect of prison life. There is no end and no beginning; there is only one's mind, which can begin to play tricks. Was that a dream or did it really happen? One begins to question everything.*
>
> – Nelson Rolihlahla Mandela

This is my second report into the practical realities of a United Nations treaty: the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, widely known as OPCAT.

Australia ratified OPCAT in December 2017, shortly after my first report, to the collective sound of 'At last!' from the human rights community here and around the world. Australia has finally joined the club of 90 countries who open their closed environments to regular independent inspection. Australian states and territories have three years to designate the body or bodies to do that. More than half that time has passed.

My first investigation looked at the landscape of closed environments and inspected Victoria's women's prison to OPCAT standards. I launched this second investigation to continue the dialogue about implementing OPCAT in Victoria.

My work was greatly assisted by an Advisory Group consisting of both key oversight agencies and representatives of civil society, who not only contributed to the decisions and methodology behind the inspections, many also provided staff to the inspection team. We have not yet seen this multi-agency, multi-disciplinary approach, including non-government partners, in Australia and it was a resounding success. I thank all the members of the Group and their staff for their invaluable work, which powerfully demonstrated the passion and commitment so many people feel about this important subject.

I also thank the facilities we inspected, and the staff and young people who engaged with us, and whose frank feedback was critical to our understanding of the issues.

This report is in two parts. The first part looks at models for the National Preventive Mechanism (NPM) Victoria needs to decide within the next 16 months. The 'unified' model I recommend for Victoria draws on the existing expertise both of my office and the wider network represented by my Advisory Group. It is underpinned by principles of efficiency and effectiveness in recommending the Ombudsman as NPM supported by a legislatively mandated Advisory Group. This should provide a strong single voice for Victoria, benefiting from the expertise of oversight agencies and civil society, who all play a vital role.

The second part contains a thematic inspection of solitary confinement of children and young people in three different closed facilities: a secure welfare facility, a youth justice centre and an adult prison.

Why focus on the solitary confinement of children and young people? There are many reasons, not least that the practice is inherently harmful and on a long-term basis, internationally condemned. The scientific evidence is compelling that young people, until around 25 years, are still developing physically, mentally, neurologically and socially. It is why solitary confinement on children and young people poses such a serious risk of long-term harm.

'Solitary confinement', as a term, does not exist in official parlance in Victoria. But the practices that may lead or amount to solitary confinement occur daily and exist by different names: isolation, separation, seclusion, lockdown.

These practices are not inherently bad. Forms of isolation are sometimes necessary, for the safety of staff, the young person affected, and other young people. But in reviewing the use of these practices across three different facilities we observed that the same behaviour in a young person had very different consequences in each facility.

The lived experience of a young man we call Jake, abused as a child and exposed to substance abuse and family violence, is a telling example. Jake's traumatic childhood, from which he felt unloved and unlovable, left him with a legacy of challenging behaviour. Within three years Jake was in Secure Welfare, then in Malmsbury, finally in Port Phillip Prison. Incidents of him attacking property and shouting in the first two facilities resulted in his isolation for two and five hours respectively. At Port Phillip an allegation of assault on another prisoner resulted in his isolation for 432 hours, much of that time after he had been cleared of the assault.

Of the three facilities, only Secure Welfare appeared to adopt a consistently therapeutic ethos in which seclusion was used as a last resort and kept to a minimum, somewhat undermined by the bleak, custodial-like conditions.

Malmsbury presented a mixed picture. We found a genuine commitment at many levels to the welfare of young people and their rehabilitation but were disturbed by a culture that appeared to prioritise security. For example, we observed compliant young people being moved around the facility in handcuffs, each escorted by eight members of staff. This appeared to be driven more by fear of negative headlines in the event of an incident, than the risks actually presented.

We also found a limited understanding by staff of the dangers of isolation, its impact on mental health and its effects on behaviour. This showed in several alarming cases, including that of Jackson, a 16-year-old Aboriginal youth known to self-harm in isolation, who nonetheless was isolated for many hours until his condition required hospital treatment.

> *Isolation is the only tool we've got and now you're going to take that away from us.*
>
> – Staff Member at Malmsbury

At a systemic level, the experience of Aboriginal youth is particularly disturbing. They are not only over-represented within the system, we found a disproportionate use of isolation on Aboriginal young people. This is against the backdrop of high rates of exposure to child protection, family violence, and loss of culture, and repeated recommendations going back decades, acknowledging the 'extreme anxiety suffered by Aboriginal prisoners committed to solitary confinement'.

The frequency of lockdowns at Malmsbury was also notable. Whether the result of an incident, in which all felt punished for the actions of a few, or as a result of staff shortages, they were widely and justifiably perceived by young people to be unfair. The inspection also found some, but not enough, improvement in the impact of lockdowns from staff shortages – still some 40 per cent of the 13,653 reported lockdowns the preceding year – commented on in previous enquiries by Parliament's Legal and Social Issues Committee and the Commission for Children and Young People.

While the Department of Justice and Community Safety's recruitment campaign for youth justice custodial workers is positive, those responsible for youth justice have been on notice for years about the impact of lockdowns caused by staff shortages, including the overwhelming frustration they cause young people. It is also apparent that many dedicated staff in the youth justice system are frustrated by the apparently never-ending cycle of isolation and lockdown that does not ultimately reduce the harm to themselves and others.

Of the three facilities inspected, we found Port Phillip Prison particularly ill-equipped to deal with the challenging behaviour of young people. While young people accounted for some 18 per cent of the prison population, they were disproportionately subject to isolation practices. The conditions of separation almost invariably amounting to solitary confinement; combined with an 'Intermediate Regime' with similar conditions, we found an alarming number of instances of prolonged solitary confinement, a practice prohibited by the international standards known as the Mandela Rules.

For example, the case of Mubiru, who was effectively separated for 170 days after a potential weapon was found under his cellmate's mattress during a routine search, despite his denial of any involvement and no apparent evidence to support it.

In many cases we reviewed, the justification for separation seemed questionable and punitive. Young people were often separated for weeks in circumstances where there appeared to be little or no ongoing risk of harm to others; victims were separated for the same time as perpetrators, sometimes for months; and good behaviour did not appear to result in less separation.

Some examples in this report include Kane, isolated for 59 days after threatening to hit someone; Jasper, the victim of an assault, isolated for the same time as his perpetrator; and Trent, separated for 20 days for concealing an anti-depressant tablet.

> *It's becoming the norm to just separate and sort it out later.*
>
> – Staff Member at Port Phillip Prison

Staff views about the practices ranged from understanding of the effects of isolation, to outright denial of any concerns, although only 26 per cent of staff surveyed thought separation was 'usually effective' in addressing behaviour.

> *Separation should be done more often and people with little knowledge of prisons should stay away. A stay in Charlotte is treated as a holiday / short break by prisoners.*
>
> – Staff Member at Port Phillip Prison

> *In total I was put in the slot [Charlotte Unit] for nine months. I've never been the same since. A letterbox flap would drop outside, and I'd jump. Or it would be just the sounds; people walking around behind me … The day I was let out of here, they led me out of the slot in handcuffs to the front gate … I jumped off the bus early and started crying … Do you know how hard that is, when the only person you've seen for the last nine months was yourself in the mirror?*
>
> – Prisoner at Port Phillip Prison

What lessons can be drawn from inspection of these very different facilities? There was, fundamentally, a difference in ethos and motivation underpinning each. We found a direct correlation between the use and length of isolation practices, and the extent to which a facility recognised the harm caused by them. At one extreme was the comparatively therapeutic model implemented by Secure Welfare; at the other, the priority given to 'security and good order' within Port Phillip appeared to make solitary confinement the preferred behaviour-management tool, rather than the exception.

It must be acknowledged that correctional facilities can be highly challenging and at times, dangerous places, both for detainees and staff. Children and young people can be irrational, volatile and unable to self-regulate, presenting behaviour that is more challenging and extreme than many adults. But isolation practices should not be the only tools available to respond to such behaviour.

Legislation and official procedures already acknowledge that children and young people should be isolated only as a last resort and for the minimum time necessary. But we found the procedures do not translate into practice.

The direct impact is that many of the practices in both our youth justice and prison systems are likely to be contrary to law, incompatible with Victoria's human rights legislation, unjust, oppressive, discriminatory or simply, wrong.

What, then, is the answer to this depressing state of affairs? A myriad of enquiries in Victoria and around Australia have condemned many of these practices, yet little seems to have changed.

The comparison of facilities leads to the inescapable conclusion that while the systems designed for children and young people are far from perfect, the adult prison system is particularly poorly equipped to deal with young people.

I urge the government to review how young people are managed in the adult system, with a view to moving them out of mainstream prisons into a closed environment capable of addressing their behaviour in a way that does not make it worse.

Much good work is already being done to improve youth justice facilities and it is encouraging to see initiatives to reduce separation in the adult system. But cultural shifts are still needed, along with a full suite of tools: therapeutic spaces, trauma-informed behavioural management, training in mental health and de-escalation techniques.

As Victoria moves to implement OPCAT, with its focus on prevention and dialogue, it is time to look beyond the 'tough on crime' rhetoric to consider what will genuinely lead to safer communities and safer correctional facilities. We should ask ourselves: are we best served by a practice that promotes security over rehabilitation, and then provides neither? Smarter investment in both facilities and people should deliver far better returns than strengthened perimeter fencing.

Victoria has been a leader in correctional reform; in addressing these issues, and looking to the future to implement OPCAT, we have the chance to be so again.

Deborah Glass

Ombudsman

Glossary

CAT	United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. Australia became a signatory to the CAT in 1985 and ratified it in 1989.
OPCAT	Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, adopted in 2002 by the UN General Assembly and ratified by Australia in 2017.
NPM	Localised inspection bodies known as National Preventive Mechanisms as set out in OPCAT.
SPT	UN Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.
Solitary confinement	The physical isolation of individuals for 22 or more hours a day without meaningful human contact, according to rule 44 of the Mandela Rules.
Prolonged solitary confinement	Fifteen or more days of consecutive solitary confinement according to rule 44 of the Mandela Rules.
HMIP	Her Majesty's Inspectorate of Prisons – an inspection body (NPM) in the United Kingdom.
APT	Association for the Prevention of Torture – the Geneva-based peak international organisation promoting OPCAT implementation.
Centralised model	An NPM model adopted by 90 per cent of countries where one body is designated to fulfil the NPM mandate.
Decentralised model	An NPM model adopted by 4 countries where the function is split across multiple bodies based on specific areas of expertise/existing jurisdiction.
Ombuds Plus model	An NPM model such as in Denmark, where the Ombudsman alone is designated to perform the OPCAT mandate, however, collaborates with other bodies.
Child	A person aged 17 years and under.
Young Person	A person aged between 18 and 24 years.

Mandela Rules	Standard Minimum Rules for the Treatment of Prisoners, adopted in 2015 by the UN General Assembly.
Havana Rules	Rules for the Protection of Juveniles Deprived of their Liberty, adopted in 1990 by the UN General Assembly.
Beijing Rules	UN Standard Minimum Rules for the Administration of Juvenile Justice, adopted in 1985 by the UN General Assembly.
Istanbul Statement	A Statement made in 2007 by a working group of 24 experts at the International Psychological Trauma Symposium in Istanbul about the use and effects of solitary confinement and calling for the practice to be limited to only very exceptional cases, for as short a time as possible, and only as a last resort. The Statement was submitted to the UN General Assembly in 2008.
Paris Principles	The Paris Principles relate to the status and functioning of national institutions for the protection and promotion of human rights, adopted by the UN General 1993.
Ill-treatment	A collective term in this report for Cruel, Inhuman or Degrading Treatment or Punishment.
DJCS	Victorian Department of Justice and Community Safety.
DHHS	Victorian Department of Health and Human Services.
Human Rights Act	*Charter of Human Rights and Responsibilities Act 2006* (Vic) – commonly referred to as 'the Charter'.
Corrections Act	*Corrections Act 1986* (Vic).
Corrections Regulations	*Corrections Regulations 2009* (Vic) as in force at the time of the inspection. The Regulations have now been updated to the *Corrections Regulations 2019* (Vic).
CYF Act	*Children, Youth and Families Act 2005* (Vic).
CFY Regulations	*Children, Youth and Families Regulations 2017* (Vic).

Terms specific to Port Phillip Prison	
Separation	A practice authorised by regulation 27 of the Corrections Regulations 2009 – 'If reasonable for the safety or protection of the prisoner or other persons, or the security, good order or management of the prison, the Secretary may, in writing, order the separation of a prisoner from other prisoners.'
Run-out time	The time a prisoner is allowed out of their cell while on a separation order or an Intermediate Regime.
Sentence Management Panel	A panel established to carry out the functions of prisoner classification which includes: • determining a prisoner's security rating • determining a prisoner's placement • developing a prisoner's sentence plan.
Management Unit	A unit to accommodate people on a 'management' regime. At Port Phillip, this is Charlotte Unit.
Step-down (Management) Unit	A unit to accommodate people on an Intermediate Regime. At Port Phillip, these include Borrowdale Unit and Alexander South Unit.
Intermediate Regime	Intermediate Regimes and units provide more intensive supervision than mainstream or 'protection' units, but not the level of restriction and supervision provided by a high security or management unit placement. Restrictions imposed under Intermediate Regimes include the number of out-of-cell hours, associations and access to amenities.
Violence Reduction Strategy	The Violence Reduction Strategy provides that a prisoner who commits a 'low-level' physical assault on staff or another prisoner, threatens to assault a member of staff or another prisoner; or who is verbally abusive or aggressive may be confined to their cell for a maximum of 23 hours, without the need for a formal separation order.
12-month reporting period	25 February 2018 to 25 February 2019 (the day the inspection was announced). Unless stated otherwise, the graphs set out in the Chapter about Port Phillip were generated from data from this reporting period.
the Manual	Corrections Victoria's 'Sentence Management Manual'.
Operational Instruction	Local operating procedures at Port Phillip Prison.
Guiding Principles for Corrections in Australia	A statement of national intent, around which each Australian State and Territory jurisdiction must continue to develop its own range of relevant legislative, policy and performance standards that can be expected to be amended from time to time to reflect 'best practice' and community demands at the state and territory level.
RRT	Risk Review Team comprised of the Manager, Clinical and Integration Services, Area and Duty Supervisors, clinical services staff, case workers and other staff responsible for endorsing a Risk Management Plan developed when a prisoner is identified as being 'at risk' of suicide or self-harm.

Terms specific to Malmsbury Youth Justice Precinct	
Isolation	A practice authorised by section 488 of the CYF Act – the officer in charge of a youth justice centre may authorise the isolation of a child or young person detained in the centre – ie placing the person in a locked room separate from others and from the normal routine of the centre.
Lockdown	A practice authorised by section 488(7) of the CYF Act – a child or young person may be isolated 'in the interests of the security of the centre'. Isolation for this purpose is referred to as a 'lockdown' and is exempt from the legislative safeguards ordinarily applicable to isolation under the Act.
Rotations	A term used to describe the use of 'lockdowns' on a rotating basis, where children and young people are confined in their rooms for one hour, then out for one hour, and so on.
12-month reporting period	28 February 2018 to 28 February 2019 (the day the inspection was announced). Unless stated otherwise, the graphs set out in the Chapter about Malmsbury were generated from data from this reporting period.
Separation Safety Management Plan (SSMP)	When a child or young person in a youth justice centre is formally separated from their peers as a 'time limited response to incidents and extreme acts of aggression or other unsafe behaviour', a Separation Safety Management Plan is developed to assist the child or young person to change violent and maladaptive behaviours.
Terms specific to Secure Welfare Services	
Seclusion	A practice authorised by section 72A of the CYF Act – 'Seclusion means the placing of the child in a locked room separate from others and from the normal routine of the Secure Welfare Service.'
12-month reporting period	26 February 2018 to 26 February 2019. Unless stated otherwise, the graphs set out in the Chapter about Secure Welfare were generated from data from this reporting period
The SWS Manual	The Department of Health and Human Services' 'Secure Welfare Practice Manual'.

Executive summary

Introduction

1. This report considers the practical implications of implementing the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (**OPCAT**) in Victoria. It:

    - compares inspection bodies operating in different countries and recommends an appropriate model for Victoria
    - sets out the results of a thematic OPCAT-style inspection of Port Phillip Prison, Malmsbury Youth Justice Precinct and Secure Welfare Services, looking at practices related to 'solitary confinement' involving children and young people.

2. OPCAT is an international human rights treaty that aims to prevent abuse of people in detention by opening places where people are deprived of liberty – prisons, police cells, psychiatric hospitals and so on – to regular independent inspections by:

    - a UN committee of international experts called the Sub-Committee on the Prevention of Torture
    - local inspection bodies called National Preventive Mechanisms (**NPMs**).

3. The Commonwealth Government ratified OPCAT on 21 December 2017 and made a declaration to postpone implementation of its obligation to establish an NPM for three years. On 1 July 2018, the Commonwealth Ombudsman commenced as Australia's NPM Coordinator and as the NPM body for Commonwealth places of detention.

4. In Victoria, this means the State Government will need to open places of detention to the UN committee and 'designate' or appoint one or more local NPMs to conduct regular inspections, by December 2020.

5. To contribute to discussions about OPCAT's implementation in Victoria, in 2017, the Ombudsman conducted her first investigation that scoped the number and types of places of detention in Victoria, considered how they are monitored, and compared those arrangements against the requirements of OPCAT. The investigation also included a pilot inspection of Victoria's main women's prison, the Dame Phyllis Frost Centre, using OPCAT standards where possible. This allowed the investigation to test how OPCAT inspections might work in practice in Victoria.

6. To assist this second 'thematic' investigation, the Ombudsman established an Advisory Group consisting of oversight bodies and civil society organisations, including the Commissioner for Children and Young People and Commissioner for Aboriginal Children and Young People, Mental Health Complaints Commissioner, Health Complaints Commissioner, Disability Services Commissioner, Victorian Equal Opportunity and Human Rights Commissioner, Public Advocate, Victorian Aboriginal Community Controlled Organisation, Human Rights Law Centre, Jesuit Social Services, Victorian Aboriginal Legal Services and RMIT University.

7. When the Advisory Group's terms of reference were discussed and agreed, the Ombudsman made clear that her purpose was not to seek consensus; ultimately the report and recommendations would be hers alone, enriched as they would be by the diverse views of the members. Ultimately however there was strong consensus among the Group for the findings of the inspections. Some members endorsed the recommendations fully, others in part, and some did not comment.

Part One: Implementing OPCAT in Victoria

8. Each State and Territory in Australia must decide for itself the appropriate NPM model for its unique context. International experience shows there are three main options:

    - creating a new inspection body
    - designating one existing body
    - designating several bodies.

9. Although OPCAT does not prescribe the structure or model for an NPM, there are several principles the NPM must satisfy. Pursuant to OPCAT, an NPM must:

    - have functional independence (Article 18(1))
    - be adequately resourced (Article 18(3))
    - have the power to:
        - regularly examine the treatment of people deprived of their liberty (Article 19(a))
        - make recommendations to the authorities to improve the treatment of people deprived of their liberty (Article 19(b))
        - submit proposals and observations concerning existing or draft legislation (Article 19(c))
        - conduct private interviews with detainees and any person they wish to interview (Article 20(d))
        - choose the places they want to visit and the people they want to visit (Article 20(e))
        - share information with the Subcommittee on the Prevention of Torture (Article 20(f))
    - have access to:
        - all information regarding people in closed environments, including the number of detainees and their location and the number of places of detention and their locations (Article 20(a))
        - all information regarding the treatment of people in closed environments and the conditions of their detention (Article 20(b))
        - all places of detention and their installations and facilities (Article 20(c)).

10. Most countries have designated existing bodies to fulfil the NPM mandate, usually the Ombudsman or a Human Rights Institution. Some have designated a group of existing bodies.

11. This second investigation has explored two distinct NPM models operating in other jurisdictions, to identify an appropriate model for Victoria. The models are described as 'centralised', being a single body NPM (which engages external expertise), and 'decentralised', a multi-body NPM.

The 'centralised' NPM model

12. Under the centralised model one existing body is designated to fulfil the entire NPM role. Of the 64 international jurisdictions to adopt the centralised model, 13 have designated their National Human Rights Institution, 15 have created new bodies, and 34 have designated the Ombudsman.

13. Norway, Georgia and Denmark are examples of the centralised NPM model. While each is constituted differently, importantly all have formalised arrangements with civil society to fulfil the NPM mandate. The benefits of the centralised (single body) NPM include:

    - The mandate is exercised in a consistent and uniform manner, regardless of sector or geographic area. This enables consistent measuring and reporting.
    - The NPM can conduct 'thematic' work in closed environments across multiple portfolios.
    - A more efficient use of public resources, avoiding the need for coordination of several scattered bodies within the one jurisdiction.
    - The confusion of legislative and operational changes to multiple agencies is also avoided.
    - In line with sound public policy, overlapping jurisdiction and duplication of functions are avoided.
    - A single body provides a visible point of contact for the UN's Sub-Committee on the Prevention of Torture, other States' NPMs, civil society, the public and the media.

14. The Ombudsman in Norway and Georgia also has a legislatively mandated Advisory Group to assist fulfil the NPM mandate.

15. At the Commonwealth level, the Commonwealth Government has opted for a centralised (single body) NPM in its jurisdiction and designated the Commonwealth Ombudsman.

The 'decentralised' NPM model

16. Under the decentralised model, the NPM function is split across multiple bodies based on specific areas of expertise. Internationally, only four out of 71 countries have adopted a decentralised NPM model: New Zealand, the United Kingdom, the Netherlands and Malta.

17. In New Zealand, the NPM inspection function is shared by four bodies and coordinated by the Human Rights Commission. The NPM includes the Ombudsman, the Independent Police Conduct Authority, the Children's Commissioner and the Inspector of Service Penal Establishments.

18. In the United Kingdom, the NPM consists of 21 bodies, supported by a small secretariat within Her Majesty's Inspectorate of Prisons. To address the challenges inherent in a 21-member NPM, a Steering Group represents all members of the NPM and facilitates decision making and strategic direction.

19. The designation of the various NPM bodies in New Zealand and the UK is not based in legislation, but rather by Gazette or Ministerial statement.

An NPM model for Victoria

20. The designation of an NPM in Victoria is complicated by many factors, including the vast number of oversight bodies with different functions and potentially overlapping jurisdictions and powers, and the complex landscape of closed environments. The overall picture is further complicated by Australia's federated nature, in which each State and Territory will make its own arrangements.

21. Core public interest principles of resource efficiency and effectiveness should underpin the designation of an NPM. Significant expertise already exists in both existing oversight bodies and civil society, although no single body has jurisdiction

over all closed environments, and no oversight body currently and routinely carries out inspections to the rigorous standards required by OPCAT.

22. Recognising the experiences of other jurisdictions implementing OPCAT, an NPM model should seek to unify and build on existing expertise.

23. As a constitutionally entrenched officer of the Parliament, the Victorian Ombudsman has the broadest remit and jurisdiction of existing oversight bodies, as well as the necessary independence and powers. While legislation would be required to fully implement OPCAT, this report recommends the Ombudsman be designated NPM for Victoria, to operate with a legislatively mandated Advisory Group.

24. The Advisory Group should be composed of oversight bodies and civil society members with expertise in mental health, disability, human rights, culturally and linguistically diverse communities and the wellbeing and interests of First Nations peoples, and children and young people.

25. Members of the Advisory Group could be further involved in the NPM's work through participation on inspections, developing inspection tools and materials, choosing themes and locations, and other preventative work, as determined by the NPM.

26. Such a 'unified' NPM model would complement, and not replace, the important roles of existing oversight bodies and civil society in Victoria.

Size and cost of a Victorian NPM

27. An NPM conducting regular inspection of all primary places of detention in Victoria would require approximately 12 Full Time Equivalent staff and have an operating budget of approximately $2.5 million, including allocation of resources to other agencies assisting in inspections as appropriate.

Part Two: Thematic inspections of Port Phillip, Malmsbury and Secure Welfare

28. The Victorian Ombudsman's 'thematic' OPCAT-style inspection took place over three weeks in March and April 2019. It focussed on practices that may lead or amount to solitary confinement of children and young people, being isolation 'for 22 or more hours a day without meaningful human contact', as described in the UN Standard Minimum Rules for the Treatment of Prisoners (called the 'Mandela Rules').

29. To prepare for the inspections, Ombudsman officers researched and consulted with international OPCAT experts, including existing NPMs and civil society organisations such as the Geneva-based Association for the Prevention of Torture, the 'Public Defender of Georgia (Ombudsman) and Her Majesty's Inspectorate of Prisons (UK). This research and engagement was critical in designing an appropriate inspection methodology involving children and young people.

30. The aim of the inspection, consistent with OPCAT's purpose, was to identify risks that increase the potential for torture and other cruel, inhuman or degrading treatment at the facilities, and protective safeguards that reduce those risks.

31. The Ombudsman chose to focus on the experience of children and young people because their ongoing development makes them particularly vulnerable to the adverse impacts of solitary confinement.

32. A vast body of research confirms that young people, until around 25 years, are still developing physically, mentally, neurologically and socially, and as a result, solitary confinement poses a serious risk of long-term harm. It also means, however, that children and young people can be irrational, volatile and unable to self-regulate. It means they may present behaviour that is more challenging and more extreme than many adults.

33. Multiple studies confirm that the use of isolation in institutional settings is often harmful; there is 'unequivocal evidence' that solitary confinement has a profound impact on health and wellbeing, and that children and young people are particularly susceptible.

34. With assistance from her Advisory Group, the Ombudsman assembled a multi-agency, multi-disciplinary inspection team with expertise in key areas impacting children and young people, including:

    - five Victorian Ombudsman officers with expertise in human rights, youth justice, child protection and prison inspections
    - four senior employees from the Commission for Children and Young People with expertise in youth justice, and working with Aboriginal and Torres Strait Islander children and young people and others from culturally diverse backgrounds
    - the Deputy Mental Health Complaints Commissioner
    - a Senior Lawyer within the Aboriginal and Torres Strait Islander Rights Unit of the Human Rights Law Centre
    - the Senior Practitioner and qualified psychiatric nurse from the Community Services Directorate in the ACT
    - an expert on young people with disabilities from the Office of the Public Advocate
    - the Lead Inspector for facilities detaining children and young people from Her Majesty's Inspectorate of Prisons in the UK.

35. The inspection occurred over three weeks in March and April 2019, and the team spent a total of 12 days in the three facilities. The inspection spoke extensively with staff and children and young people in each facility, observed daily operations, analysed extensive documentation, and surveyed staff and children and young people about conditions.

36. The evidence of staff across the three facilities ranged from informed understanding of the impact of isolation, to concerns about the practice but without the tools to respond in other ways, to outright denial that isolating young people may be a problem. In both the prison and youth justice environments the investigation's survey suggests a particular lack of understanding about the mental health impact of isolation on young people.

37. The inspection also observed that greater reliance on the use of isolation within a facility did not appear to correspond with an increased sense of safety or lower levels of work-related stress amongst staff.

38. The inspection highlighted some areas that need to be addressed to ensure each facility meets local and international human rights laws and Rules.

Port Phillip Prison

39. The inspection found that at Port Phillip, a total of 265 separation orders had been issued to young people within the 12-month reporting period. Approximately 20 per cent were because the young person had assaulted someone, and another 30 per cent were made pending investigation into the young person's involvement in an alleged assault. An additional 30 per cent of separation orders were made for reasons relating to the young person's own safety, namely they were the victim of an assault, they needed protection, or they had self-harmed.

40. With a median duration of 10 days, the use of separation at Port Phillip almost invariably amounted to solitary confinement under the accepted international definition. In almost a third of cases, the young person's separation was followed by a period on an 'Intermediate Regime', often lasting 49 days, and in many cases, also meeting the definition of solitary confinement.

41. In the context of practices that may lead or amount to solitary confinement, the inspection observed several factors that increase the risk of cruel, inhuman or degrading treatment or torture at Port Phillip, including instances of young people being subject to 'prolonged solitary confinement' (greater than 15 days under the Mandela Rules) and young people remaining in separation despite their separation order ending.

42. The inspection was also concerned to note that recent amendments to the Corrections Regulations effectively authorise indefinite solitary confinement 'for the management, good order or security of the prison', without the requirement that the separation not be longer than is necessary to achieve that purpose, contrary to the Mandela Rules and possibly incompatible with section 10(a) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic).

43. The inspection found separation of young people in mainstream units had unintended and unjust consequences for those people, others on the unit and staff because facilitating the separated prisoner's one-hour run-out would result in the rest of the unit being locked down for that period. Where there were multiple separated prisoners on the unit, it would be locked down for several hours.

44. The inspection was concerned that young people separated on mainstream units would often refuse their run-outs due to pressure (or perceived pressure) from other prisoners.

45. The inspection found that the medical and psychiatric conditions of prisoners are not routinely considered before making separation orders, contrary to the Regulations, and that consideration as to whether and how a young person's mental illness or disability may have contributed to their conduct is not routinely given before disciplinary sanctions are imposed.

46. The inspection also observed what appeared to be the use of isolation and observation without active treatment or therapeutic interventions for those at risk of suicide or self-harm.

47. The material conditions of Charlotte Unit, when coupled with the terms of a separation regime, appeared particularly ill-suited to accommodate vulnerable people, meaning that accommodating young people and those with mental health issues or disability may be incompatible with obligations under the Mandela rules.

48. Similarly, the inspection considered the run-out areas in Charlotte and Borrowdale Units fall short of the international human rights standards applicable to exercise and recreation in a custodial setting.

Malmsbury Youth Justice Precinct

49. At Malmsbury, there were 1,214 isolations for behavioural reasons within the 12-month reporting period. Almost 60 per cent of behavioural isolations were designated as 'immediate threat to safety (others)'. Only six per cent were for the child or young person's own safety. The median recorded period of isolation for behavioural reasons was approximately one hour, the average was somewhat higher – approximately two and a half hours.

50. The inspection found that as a result of the way in which isolation is recorded (starting and stopping with each run-out and overnight lockup), the register inevitably understates the effective period of isolation.

51. The inspection also found there were 13,653 reported lockdowns at Malmsbury during the 12-month reporting period, with the median duration being less than an hour. Approximately 40 per cent of lockdowns at Malmsbury were attributed to staff shortages at the facility.

52. The inspection attributed the high rate of lockdowns at Malmsbury to what appeared to be a very low appetite for risk at the youth justice centre. It was apparent that Malmsbury was under considerable external pressure to reduce the rate of unrest within the facility and that this pressure appeared to manifest in greater reliance on restrictive practices, including the use of isolation and mechanical restraints.

53. In the context of practices that may lead or amount to solitary confinement, the inspection observed several factors that increase the risk of cruel, inhuman or degrading treatment or torture at Malmsbury. These included instances of isolation not being used as a last resort or in response to an immediate threat; instances of isolation lasting longer than was recorded in the Isolation Register, and longer than the relevant officer was delegated to approve; and other instances of non-compliance of the Isolation Register with the Regulations.

54. The inspection was also particularly concerned about the disproportionate use of behavioural isolation involving Aboriginal and Torres Strait Islander young people, representing 14 per cent of the population but 20 per cent of behavioural isolations.

55. The inspection observed the routine use of Malmsbury's tactical response team 'SERT', including during medical consultations and to open cell door traps and the routine use of restraints, without any contemporaneous risk assessment.

Secure Welfare Services

56. At Secure Welfare, there were 62 reported incidents of seclusion over the 12-month reporting period. Seventy-three per cent occurred at Ascot Vale, and 27 per cent occurred at Maribyrnong. Of the seclusions reported at Ascot Vale, almost half where attributed to a physical assault of a member of staff or another adult, and another quarter to 'aggressive behaviour'. At Maribyrnong, most seclusions (71 per cent) were attributed to 'aggressive behaviour' and 18 per cent to an actual physical assault. At both services the median reported seclusion period was 30 minutes.

57. The inspection noted there were no reported seclusions at Secure Welfare during the previous five years capable of meeting the definition of solitary confinement.

58. However, the inspection noted several factors that increase the risk of ill-treatment at Secure Welfare, including instances where the conditions of a young person's detention met the definition of seclusion. However, these were not recorded on the Seclusion Register, and there were other instances of non-compliance of the Seclusion Register with the requirements of the Regulations.

59. The inspection also considered the seclusion rooms at both sites were not fit for purpose, and that the confinement of children in those spaces may be incompatible with sections 17(2) and 22(1) of the Charter of Human Rights and Responsibilities Act.

60. The inspection observed that Secure Welfare's therapeutic ethos was in some ways undermined by the material conditions of the Ascot Vale and Maribyrnong facilities. Ascot Vale in particular was showing signs of having grown beyond its original design capacity. The facility was not purpose-built, and the inspection observed that staff sometimes struggled to keep on top of client dynamics due to idiosyncrasies in facility design.

61. The inspection was disappointed to observe little superficial difference between the bedrooms at the Ascot Vale service and those at Malmsbury, both in terms of design and state of upkeep. The bedrooms at the Maribyrnong service were comparatively better in terms of upkeep and fit-out, although could still be improved.

Conclusions

62. The different legislative mechanisms across the three closed environments give different names to practices that may lead or amount to solitary confinement. They include 'separation' in prison, 'isolation' in youth justice, and 'seclusion' in secure welfare. While in many of the cases we observed the practices do not amount to solitary confinement, each has the potential to involve the physical isolation of individuals 'for 22 or more hours a day without meaningful human contact'– or solitary confinement as defined in the Mandela Rules.

63. These are not the only practices that may lead or amount to solitary confinement. Lockdowns, which may be unit or facility-wide, can be made as a result of staff shortages as well as in response to challenging behaviour. Port Phillip's Violence Reduction Strategy, Malmsbury's Separation Safety Management Plans, the withdrawal of privileges and Port Phillip's Intermediate Regime, and the separation of people at risk of suicide or self-harm, pose similar risks.

64. Overall, the inspection found that whatever name, and for whatever reason, the practice of isolating children and young people is widespread in both the prison and youth justice environments. It is equally apparent that the practice is seen as punitive, even when that is not the intention; young people can be isolated both for acts of violence and for being the victim of an act of violence – and when used in response to challenging behaviour may exacerbate rather than improve the situation.

65. The evidence in this report, from detainees, staff and the facilities themselves, is both overwhelming and distressing. While legitimate reasons will always exist to isolate or separate, the rate and duration of separation at Port Phillip and the rate of isolation at Malmsbury are too high. Such practices are also counter-productive; in the youth justice context, for example, the investigation saw unrest causing lockdowns, causing more unrest, causing more lockdowns.

66. The experience of Aboriginal youth is particularly distressing, not only the over-representation of these young people within the system, but against the backdrop of particularly challenging life circumstances including high rates of exposure to child protection, family violence, and loss of culture.

67. Isolation is not, invariably, solitary confinement. It must be acknowledged that mechanisms authorising separation or isolation are necessary and may be a reasonable and appropriate response to some situations. Prisons and youth justice facilities can be highly challenging and at times, dangerous places, both for detainees and staff.

68. The inspection observed that although subject to many of the same legal and policy safeguards, there was a difference in ethos and motivation underpinning the work of staff at each of the three facilities. The comparatively therapeutic model implemented by Secure Welfare appeared reasonably successful in limiting the use of extended isolation at the Ascot Vale and Maribyrnong facilities. At the other end of the spectrum, the priority afforded to deterrence and considerations of 'good order' within Port Phillip appeared to make solitary confinement the preferred behaviour-management tool, rather than the exception.

69. The comparison also leads to the inescapable conclusion that while the youth justice system is far from perfect, and work is needed to bolster Secure Welfare, the adult prison system is particularly poorly equipped to deal with young people.

70. If staff in these environments feel that separation or isolation are the only tools they have to respond to challenging behaviour, they are being set up to fail. It should be one of many, and one that is used only as a last resort and for the minimum time necessary. While this is plainly set out in legislation and acknowledged in official procedures, in prisons and youth justice facilities it does not translate into practice on the ground.

71. There are lessons such systems can learn to ensure that when presented with challenging behaviours and situations, facilities are empowered to guarantee the safety and dignity of both detainees and staff, and by extension, the community more broadly.

Background

72. In 1984, the United Nations General Assembly adopted the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* (**CAT**). The CAT aims to prevent torture and other acts of cruel, inhuman, or degrading treatment or punishment around the world, and requires states to take effective measures to prevent torture within their jurisdiction. Australia became a signatory to the CAT in 1985 and ratified it in 1989.

73. In 2002, the UN adopted the *Optional Protocol* to the CAT (**OPCAT**) which aims to prevent abuse of people in detention by opening places where people are deprived of liberty – prisons, police cells, psychiatric hospitals and so on – to regular inspection visits by:

    - an international committee
    - local inspection bodies known as National Preventive Mechanisms (**NPM**).

74. OPCAT recognises that places of detention are usually hidden from public view, and people in them are particularly vulnerable to torture and other cruel, inhuman and degrading treatment.

75. OPCAT inspections help:

    - individual detainees by protecting their human rights
    - detention authorities, by providing early warnings about poor practices that could lead to abuses and helping them manage that risk.

76. In February 2017, the Commonwealth Government announced that Australia would ratify OPCAT by the end of 2017.

Victorian Ombudsman's first investigation about OPCAT

77. In March 2017, the Victorian Ombudsman commenced an 'own motion' investigation into the conditions in a custodial facility, with a view to contributing to the debate about OPCAT's implementation in Victoria.

78. The investigation was undertaken pursuant to section 16A of the *Ombudsman Act 1973* (Vic), which provides that the Ombudsman may conduct an own motion investigation into any administrative action taken by or in an 'authority'. The definition of 'authority' includes a department such as the then Department of Justice and Regulation. The Ombudsman also used her powers of entry and inspection pursuant to section 21 of the Ombudsman Act.

79. The investigation scoped the number and types of places of detention in Victoria and how they are monitored currently, compared these arrangements against the requirements of OPCAT, and considered changes needed to implement OPCAT in Victoria.

80. The investigation also conducted a pilot inspection of Victoria's main women's prison, the Dame Phyllis Frost Centre, using OPCAT standards where possible. This allowed the investigation to test how OPCAT inspections might work in practice in Victoria.

81. The Ombudsman's report *Implementing OPCAT in Victoria: report and inspection of the Dame Phyllis Frost Centre* was tabled in Parliament in November 2017.

82. The Commonwealth Government ratified OPCAT on 21 December 2017 and made a declaration under Article 24 of OPCAT to postpone implementation of its obligation to establish an NPM for three years. At the time, the Commonwealth Government said it would use the three years to work with states and territories on implementing OPCAT including the establishment of Australia's NPM:

> It is proposed that Australia's NPM will be established as a cooperative network of Commonwealth, state and territory bodies responsible for inspecting places of detention and will be facilitated by an NPM Coordinator.

83. On 1 July 2018, the Commonwealth Ombudsman commenced as Australia's NPM Coordinator and as the NPM body for Commonwealth places of detention.

Victorian Ombudsman's second investigation about OPCAT

84. On 30 November 2018, the Victorian Ombudsman notified the Attorney-General, Minister for Corrections and Youth Justice, Minister for Child Protection and Disability Ageing and Carers, Minister for Youth, Minister for Mental Health and Secretaries of the Department of Health and Human Services and Department of Justice and Regulation (as it was at the time) of her intention to conduct a second 'own motion' OPCAT-style investigation.

85. This second investigation sought to further contribute to discussions about OPCAT's implementation in Victoria through analysis of NPM models operating in different jurisdictions, and a 'thematic' inspection of the use of 'solitary confinement' and children and young people in three distinct closed environments, using OPCAT standards where possible. This allowed the investigation to test how thematic OPCAT inspections might work in practice in Victoria.

86. The investigation:

- researched the legal and policy framework authorising practices that may lead or amount to solitary confinement in Victoria
- engaged with leading NPMs operating in other countries, including Denmark, Georgia, New Zealand, Norway and the United Kingdom – representing different models of inspection bodies
- engaged with experts and non-government organisations, including the Geneva-based Association for the Prevention of Torture, the peak international organisation promoting OPCAT implementation.

87. To enable contribution from a variety of experts, the Ombudsman established an Advisory Group of leading oversight bodies and civil society organisations to assist her investigation, including:

- Human Rights Law Centre, Ruth Barson, Director
- Commissioner for Children and Young People, Liana Buchanan
- Mental Health Complaints Commissioner, Lynne Coulson Barr
- Health Complaints Commissioner, Karen Cusack
- Jesuit Social Services, Julie Edwards, CEO
- Victorian Equal Opportunity and Human Rights Commissioner, Kristen Hilton
- Commissioner for Aboriginal Children and Young People, Justin Mohamed
- Professor Bronwyn Naylor, RMIT University
- Public Advocate, Colleen Pearce
- Victorian Aboriginal Community Controlled Health Organisation, Trevor Pearce, A/CEO
- Disability Services Commissioner, Arthur Rogers
- Victorian Aboriginal Legal Services, Nerita Waight, A/CEO.

88. The Advisory Group met five times throughout the investigation and provided specialised staff and other expertise to the inspection team. Further information about the role of the Advisory Group is in Part 2, Chapter One.

89. The investigation was greatly assisted by Her Majesty's Inspectorate of Prisons in the UK (**HMIP**). HMIP has been conducting OPCAT inspections for 16 years. The Deputy Chief Inspector of Prisons, HMIP seconded his Lead Inspector for facilities detaining children and young people to the Victorian Ombudsman to assist the thematic inspection.

About this report

90. The first part of this report examines the principles of an effective NPM under OPCAT, and different models operating in other jurisdictions, and outlines practical changes needed to implement OPCAT in Victoria.

91. The second part focuses on a 'thematic' inspection of Port Phillip Prison, Malmsbury Youth Justice Precinct and the Secure Welfare Services at Ascot Vale and Maribyrnong. As well as providing insight into the process for thematic OPCAT work, the inspection highlighted some areas that need to be addressed to ensure the facilities meet local and international human rights standards. Once OPCAT is implemented, Victorian detention authorities will find themselves measured against these standards more regularly.

92. Under section 25A(3) of the Ombudsman Act, any individual who is identifiable, or may be identifiable from the information in this report, is not the subject of any adverse comment or option. They are identified in this report as:

    - the Ombudsman is satisfied that it is necessary or desirable to do so in the public interest, and
    - the Ombudsman is satisfied that identifying those persons will not cause unreasonable damage to the person's reputation, safety or wellbeing.

93. It is hoped that this report will contribute to the implementation of OPCAT in Victoria – an important symbol of the State's commitment to human rights and community safety.

Part One:

Implementing OPCAT in Victoria

NPM Principles

94. Article 3 of the OPCAT requires State Parties to set up, designate or maintain at the domestic level one or several visiting bodies for the prevention of torture and other cruel, inhuman or degrading treatment or punishment, being an NPM.

95. In accordance with Article 4, State Parties shall allow an NPM to visit any place under its jurisdiction and control where persons are or may be deprived of their liberty, either by an order given by a public authority or at its instigation or with its consent or acquiescence.

96. The Ombudsman's first OPCAT-related investigation identified at least 50 Acts of Parliament in Victoria that allow people to be detained. The Ombudsman noted that although the UN encourages a broad approach to the definition of 'detention', for practical purposes, the Victorian Government and its NPM could be expected to focus OPCAT inspections on places which hold the greatest number of people at the greatest risk.

97. The Commonwealth Government has also indicated the NPM/s will focus on 'primary' places of detention including immigration detention facilities, prisons, juvenile detention centres, police cells and various psychiatric facilities.

98. Although OPCAT does not prescribe the structure or model for an NPM, there are several principles that the NPM must satisfy. Pursuant to OPCAT, an NPM must:

    - have functional independence (Article 18(1))
    - be adequately resourced (Article 18(3))
    - have the power to:
        - regularly examine the treatment of people deprived of their liberty (Article 19(a))
        - make recommendations to the authorities to improve the treatment of people deprived of their liberty (Article 19(b))
        - submit proposals and observations concerning existing or draft legislation (Article 19(c))
        - conduct private interviews with detainees and any person they wish to interview (Article 20(d))
        - choose the places they want to visit and the people they want to visit (Article 20(e))
        - share information with the Subcommittee on the Prevention of Torture (Article 20(f))
    - have access to:
        - all information regarding people in closed environments, including the number of detainees and their location and the number of places of detention and their locations (Article 20(a))
        - all information regarding the treatment of people in closed environments and the conditions of their detention (Article 20(b))
        - all places of detention and their installations and facilities (Article 20(c)).

99. OPCAT also requires that State Parties must:

    - give 'due consideration' to the 'Principles relating to the status of national institutions for the promotion and protection of human rights' (the Paris Principles) when establishing the NPM/s (Article 18(3))
    - examine the recommendations of the NPM and enter a dialogue on possible implementation measures (Article 22)
    - publish and disseminate the annual reports of the NPM (Article 23).

100. People and organisations providing information to the NPM must also be protected from punishment or reprisals for providing that information (whether true or false) (Article 21(1)). Similarly, members of the NPM/s must be accorded such privileges and immunities as are necessary for the independent exercise of their functions (Article 35).

101. Globally, there are currently 90 States Parties to OPCAT, of which 71 have designated their NPM. Each State must decide for itself the most appropriate NPM model for the unique context within which it will operate.

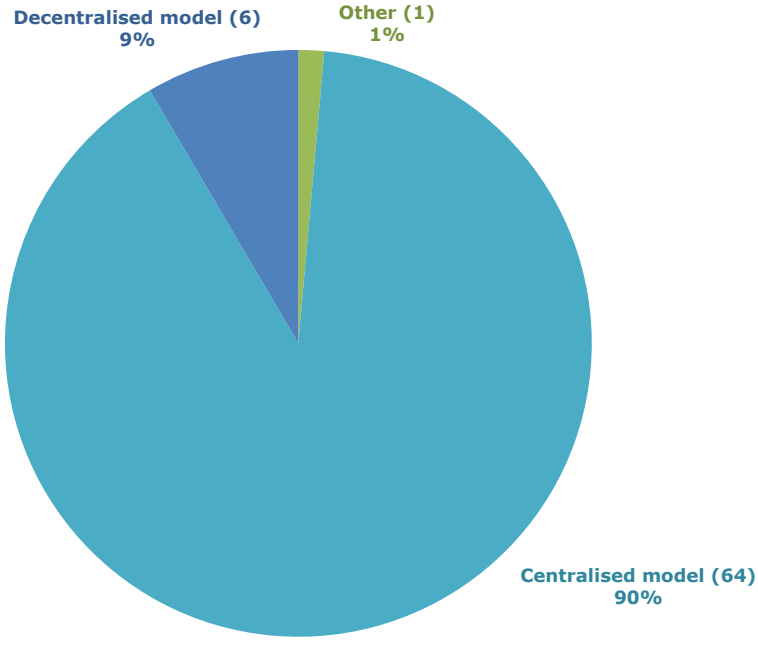
So far, several models have emerged:

- creating a new inspection body
- designating an existing body
- designating several bodies to fulfil the NPM function.

102. Of the 71 States that have designated their NPM, most (90 per cent) have adopted the 'centralised' model.[1] This is discussed further in the following section.

103. Of the 64 State Parties that have adopted the centralised model, most (69 per cent) have designated an existing body, of which Ombudsman comprise the clear majority (36 of 64).

Centralised vs Decentralised NPM models globally



1 Two of the six 'decentralised' models exist in Federal States (Brazil and Argentina) where there are National Preventive Mechanisms and Local Preventive Mechanisms.

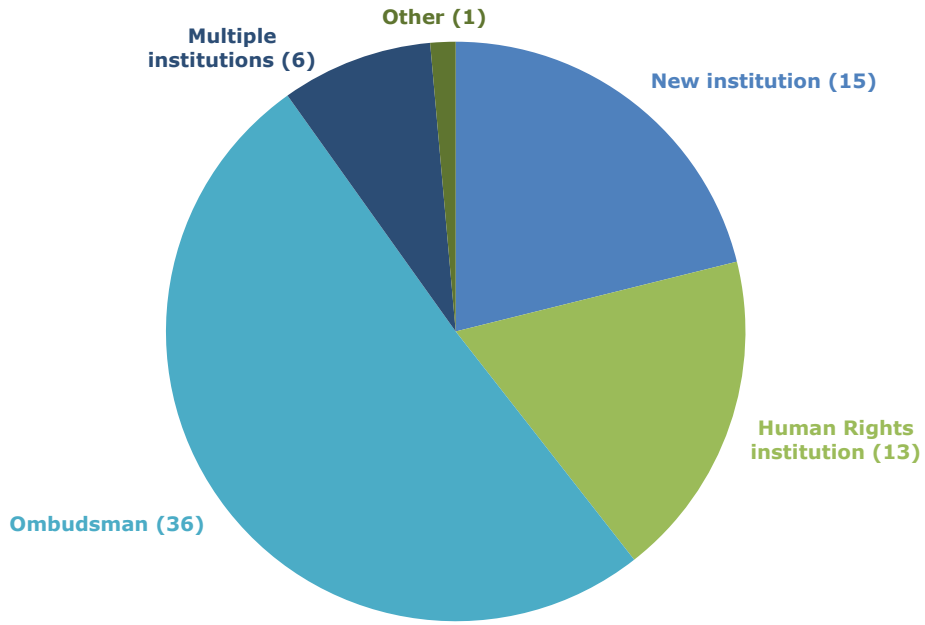
104. Six of the 36 Ombudsman NPMs are described by the Association for the Prevention of Torture (**APT**) as 'Ombuds Plus' models. For example, in Denmark, the Ombudsman alone was designated to perform the NPM function, however, collaborates with a non-government organisation and the Danish Institute for Human Rights.

105. In its guide to establishing and designating NPMs, the APT recommends that the process 'determining the NPM should start with a factual "inventory" of bodies that already carry out visits to places of detention.' This was completed in the Victorian context when the Ombudsman, in her 2017 report on OPCAT, mapped places of detention in Victoria and assessed the existing oversight arrangements against the requirements of OPCAT.

106. The 2017 report found that Victoria has a network of at least 13 bodies that monitors conditions in places of detention and noted that the powers, jurisdiction and independence of these bodies differ widely.

107. This report explores two distinct NPM models operating in other jurisdictions in the context of the NPM principles, to identify what could be an appropriate model for Victoria. The models are described as 'centralised', being a single body NPM (which may engage external expertise), and 'decentralised', a multi-body NPM.

NPM models in other parts of the world



The Centralised Model

108. Under the 'centralised model' one existing body is designated to fulfil the entire NPM role. In most international jurisdictions, the Ombudsman assumes the function, utilising its existing independence from government, coercive powers, powers of entry and inspection, accessibility, and powers to make recommendations for improvement and hold authorities to account in implementing those recommendations.

109. Norway, Georgia and Denmark are examples of the centralised NPM model.

Norway Ombudsman

Designating an NPM

110. Much like Victoria, Norway has a comprehensive statutory oversight framework, including the Ombudsman and bodies like the Victorian Commission for Children and Young People and Victorian Equal Opportunity and Human Rights Commission.

111. Article 75 of the Constitution of the Kingdom of Norway provides for an independent officer of the Parliament (Storting) 'to supervise the public administration and all who work in its service, to assure that no injustice is done against the individual citizen', being the Sivilombudsmannen (Ombudsman).

112. In June 2011, an Inter-Ministerial Working Group (**the Working Group**) proposed an NPM model for consultation to more than 150 government and civil society organisations, including Amnesty International (Norway), the Norwegian Bar Association and the National Institution for Human Rights (**NI**).

113. Given the large number of existing regulatory bodies performing statutory oversight at places of detention, the Working Group also contemplated whether one or multiple bodies should be designated NPM, as provided for in Article 17 of OPCAT.

114. The Working Group identified the following benefits of a single body (centralised) model:

- the NPM mandate would be exercised in a uniform manner, regardless of sector or geographic area
- resource-intensive coordination of several bodies would be avoided
- a single body would provide a visible point of contact for the UN's Sub-Committee on the Prevention of Torture (**SPT**), other States' NPMs, civil society and the media
- the challenges of legislative and operational changes to multiple agencies would be avoided
- other Nordic countries had/were proposing to adopt a similar model and consistency would better allow for international cooperation.

115. As an alternative, NI advocated for a 'coalition model', in which the NPM would consist of a 'troika' with the Ombudsman, NI and an 'actor with relevant medical expertise.' Proponents of the coalition model considered it could:

- provide better protection against torture through broader professional competence
- be better suited to the proactive and preventive nature of OPCAT work
- provide interdisciplinary composition with different perspectives, networks, impulses and knowledge
- better ensure gender and ethnic representation.

116. The Working Group considered the coalition model, however concluded that the 'proposed governance model would necessitate much coordination and be disproportionately demanding to manage'.

117. The Working Group ultimately recommended that the Ombudsman alone be designated NPM, noting that:

> the Ombudsman is an established institution in Norway, and has extensive experience in monitoring the administration's activities, including in areas where persons are deprived of their liberty. It was further shown that the Ombudsman has high credibility and legitimacy and enjoys great respect both in public administration and in the Norwegian population.

118. The Working Group considered that the NPM function would complement the Ombudsman's existing mandate to ensure the administration 'does not practice injustice against the individual citizen' to contribute to administrative improvement and 'securing human rights'.

119. The Working Group noted that the Ombudsman legislation would require amendment to include the OPCAT mandate. It also considered that the professional practice, in terms of inspection methodology, and frequency of inspections would need to change. The Working Group also considered it would be necessary for the Ombudsman to be 'strengthened with health-related and other relevant expertise' through recruitment or other engagement as required and according to different detention settings.

120. The Ministry of Foreign Affairs (**the Ministry**) accepted the Working Group's reasoning and proposed to the Storting that the Ombudsman alone be designated as an NPM.

The Ministry said:

> It is clear that the Ombudsman today has primarily a verifiable role for the administration, based on individual complaints, and that the Ombudsman, as a national preventive mechanism, must have a more proactive and outreach role. It appears from the Ombudsman's consultation statement that he understands this, and by proposing changes to the Civil Ombudsman Act and instructions and increased appropriations, the Ombudsman will be able to fulfil the role of national preventive mechanism.
>
> The combination of the Ombudsman's various roles could have a valuable synergy effect. Through complaints, the Ombudsman can become aware of circumstances at places of deprivation of liberty that should be investigated more closely through visits as a national preventive mechanism, and through visits, the Ombudsman will acquire knowledge that can be useful in connection with complaints handling. At the same time, deprived persons could become better acquainted with the opportunity to complain to the Ombudsman.
>
> It is also a strength that the Ombudsman can assess whether other existing supervisory bodies within the administration function so that they too help prevent torture, etc. within their areas of responsibility.

121. On the recommendation of the Working Group, the Ministry also proposed that the Ombudsman establish an 'Advisory Committee' with representatives from NI and civil society, to provide 'valuable competence and experience' to the NPM.

122. Importantly, in choosing the centralised NPM model, the Ministry noted that the NPM would 'be a supplement and not a substitute for other actors working against torture and other cruel, inhuman or degrading treatment or punishment.'

123. The Working Group's report and the Ministry's response are available on the Government's website and may be translated to English.

Legislation

124. On 21 June 2013, the Storting decided that Norway would ratify OPCAT and amended the Ombudsman legislation to include, among other things, the following new provision:

> **Section 3a. National preventive mechanism**
>
> The Ombudsman is the national preventive mechanism as described in Article 3 of the Optional Protocol of 18 December 2002 to the UN Convention of 10 December 1984 against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
>
> The Ombudsman shall establish an advisory committee for its function as the national preventive mechanism.

125. At this time the Storting also amended the Ombudsman 'Instructions' (subordinate legislation) to include:

> **§ 8a. Special rules for the Ombudsman as a national preventive mechanism**
>
> The Ombudsman can receive assistance from persons with special expertise in connection with the work as a national preventive mechanism pursuant to Section 3a of the Civil Ombudsman Act.
>
> The Ombudsman shall establish an advisory committee that will contribute with competence, information, advice and input to the work as a national preventive mechanism.
>
> The advisory committee shall be composed of members with, among other things, vocational skills and competence in human rights and psychiatry. The sample shall have a good gender balance and each gender shall be represented by at least 40 per cent. The committee may be composed of both Norwegian and foreign members.

Resourcing

126. In 2012, the working group estimated that an additional 6.2 million Norwegian krone (**NOK**) (approximately AU$1.03 million at the time) would be necessary for the Ombudsman to be able to perform the NPM mandate.

127. In its 2018 Annual Report, the Ombudsman recorded its budget and accounts for its NPM mandate (converted from NOK to AU$ on 14 May 2019, see Table 1 on the next page).

128. The Norwegian NPM is organised in a separate team within the Ombudsman's office and does not consider individual complaints. Complaints received during visits are passed on to the appropriate team.

129. The NPM is a multidisciplinary team of eight and includes employees with degrees in law, criminology, sociology, psychology, social science and human rights. The NPM team regularly includes staff from the complaints team on visits to provide additional expertise and increase case officers' knowledge of places of detention.

130. Pursuant to Instruction 8a above, the NPM also engages external experts for individual visits. According to the Ombudsman's 2018 Annual Report:

> External experts are assigned to the NPM's visit team during the preparation for and execution of one or more visits. They can also assist in writing the visit report and provide professional advice and expertise to the visit team. In 2018, the NPM was assisted by external experts at five visits.

131. As prescribed by Norway's Ombudsman legislation, the Ombudsman has established an Advisory Committee for its function as the NPM. In practice, the advisory committee meets quarterly to be briefed on the Ombudsman's NPM activities. In addition, a theme is chosen for each meeting and committee members can present on that topic. The committee also provides intelligence to the Ombudsman on emerging issues.

Table 1: Norway Ombudsman's budget and accounts for its NPM mandate		
Category	**Budget 2018**	**Accounts 2018**
Salary	1,338,004.13	1,143,282.67
Operating expenses	553,458.38	
Production and printing of visit reports, the annual report and information material		38,157.38
Procurement of external services (including translation and interpretation services)		25,525.04
Travel (visits and meetings)		87,908.93
Other operations		49,012.89
Share of the Parliamentary Ombudsman's shared costs (including rent, electricity, IT services, security, cleaning etc.)		351,909.72
Total (AUD)	**1,891,462.50**	**1,695,796.63**

132. According to the Ombudsman's 2018 Annual Report, the Advisory Committee held three meetings in 2018 and discussed the European Committee for the Prevention of Torture's (**CPT**) visit to Norway, the UN Committee against Torture's examination of Norway in 2018, mental health care for the elderly, and substance abuse treatment in Norway.

133. In 2018, the Advisory Committee comprised representatives of the following organisations:

- Norway's National Human Rights Institution
- The Equality and Anti-Discrimination Ombudsman
- The Ombudsman for Children
- The Norwegian Bar Association's Human Rights Committee
- The Norwegian Medical Association represented by the Norwegian Psychiatric Association
- The Norwegian Psychological Association's Human Rights Committee
- The Norwegian Organisation for Asylum Seekers
- The Norwegian Association for Persons with Developmental Disabilities
- Jussbuss (a free legal-aid clinic run by students)
- The Norwegian Association of Youth Mental Health
- We Shall Overcome (an organisation for human rights, self-determination and dignity in mental health)
- The Norwegian Research Network on Coercion in Mental Health Care
- The Norwegian Helsinki Committee (an NGO for human rights)
- Amnesty International Norway.

Georgia Ombudsman (Public Defender)

Designating an NPM

134. Georgia signed the CAT in June 2005 and ratified OPCAT in August 2005. In June 2007, an inter-agency Coordination Council (**the Council**) was created by Presidential decree to designate an NPM and submit an action plan to Parliament. The Council comprised 'high level government officials' from multiple Ministries as well as representatives from civil society, the UN, Penal Reform International and the US Embassy.

135. According to a briefing document on Georgia's implementation of OPCAT from April 2008, all members of the Council agreed that the NPM:

> should not be subordinate to the MOJ [Ministry of Justice], given that the prisons are generally its responsibility, but an organization which would be truly independent, such as the Public Defender Office (PDO) [the Ombudsman].
>
> Civil society and the Public Defender's Office representatives support amendments to the law which would broaden PDO's authority and resources to do the job which would have a permanent framework.

136. On the Council's recommendation the Public Defender (Ombudsman) was designated NPM in July 2009. Correspondence from Permanent Mission of Georgia to the Office of the UN High Commissioner for Human Rights dated 28 October 2009 said:

> ... the PD [Public Defender] was always entrusted with a function to monitor and prevent human rights violations in places of deprivation of liberty. ... The PD was authorized to reveal facts of violation of human rights and freedoms and to report to the corresponding bodies and officials. Pursuant to previous functions of the PD and discussion process it was unanimously agreed that the role of NPM should be fully transferred to the PD.
>
> Existing functions and extensive expertise of the PD constituted the main reason of designation of the Office of Public Defender as a national preventive mechanism.

Legislation

137. Designation occurred through amendments to the *Organic Law on the Public Defender* to include, among others, the following new provisions:

> **Article 3**[1]
>
> 1. The Public Defender of Georgia exercises the functions of the National Preventive Mechanism, envisaged by the Optional Protocol to the United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.
> 2. The Public Defender of Georgia is provided with the necessary logistical and financial resources required for performing the functions stipulated in paragraph one of this article.

138. Prior to 2009, the existing powers and functions of the Public Defender included dealing with complaints about violations of human rights from people in detention, conducting inspections, and making recommendations to the Parliament of Georgia.

139. As set out in legislation, the Public Defender was granted the new function to:

> examine the situation with regard to human rights and freedoms in prisons and confinement facilities, other places of detention and restriction of liberty, as well as psychiatric facilities, old people's homes and children's homes.

140. To fulfil this function and conduct regular inspections, the Public Defender received express new powers to:

- meet and talk with detainees personally or with assistance of an interpreter and without witnesses
- inspect relevant documentation.

141. Like Norway, the centralised NPM model adopted in Georgia involves civil society. In Georgia, legislation provides for the establishment of a 'Special Preventive Group':

> 1. In order to implement the National Preventive Mechanism, the Special Preventive Group shall be set up under the auspices of the Public Defender of Georgia. The group shall regularly monitor the condition and treatment of detainees and prisoners or persons whose liberty is otherwise restricted, convicted persons, as well as persons in psychiatric facilities, old people's and children's homes in order to protect them from torture and other cruel, inhuman or degrading treatment or punishment.
> 2. A member of the Special Preventive Group may be a person who has appropriate education, professional experience and has professional and moral qualities to carry out the functions of the National Preventive Mechanism.
> 3. A member of the Special Preventive Group may not be a member of any political party or participate in political activity.

142. The Special Preventive Group comprises:

- six lawyers
- five doctors
- two experts of health issues
- two psychiatrists
- six psychologists
- five social workers
- four experts in discrimination issues (including two persons with disabilities)
- two experts in juvenile justice issues.

143. In addition to the Special Preventive Group, in December 2014, the Public Defender established an Advisory Council as a consultative body to support their activities and inspections.

144. The Advisory Council fulfils a similar function to the Norwegian Advisory Committee and includes academics with expertise in relevant fields and members of civil society, including local and international NGOs.

145. The Advisory Council presents their views to the Public Defender on potential NPM activities, inspection methodology, thematic research, and other matters important to the efficient functioning of the NPM.

Resourcing

146. In September 2018, the CPT visited Georgia and met with the Public Defender. In its report of that visit dated May 2019, the CTP wrote:

> The delegation was told, among other things, that since the Committee's last visit (in 2014) the NPM had been given more financial and human resources, which had enabled it to increase its fast-reaction capacity and carry out more analytical and research work. In addition to the core staff, the NPM could rely on the assistance of 36 experts (members of the Special Preventive Group) including doctors specialised in somatic medicine and psychiatry, psychologists and social workers. Thanks to these increased resources, the NPM could carry out frequent visits to various types of places of deprivation of liberty, both scheduled and unannounced. The visit programme was adopted in consultation with members of the Advisory Council, composed of members of academia and NGO representatives. The delegation was told that the current tendency was to increase the number of visits to police and psychiatric establishments.

147. In 2017 the budget for the NPM function of the Public Defender (Ombudsman) was 963.000 Georgian lari or AU$536,000 (at the time). In 2017, and in addition to the 36 experts in the Special Preventive Group, the NPM team employed seven people, five of whom carried out visits to places of detention. The remaining two team members dealt with secretarial, analytical and research tasks.

Denmark Ombudsman

Designating an NPM

148. On 19 May 2004, the Danish Parliament (Folketing) adopted a proposal to ratify OPCAT. It wasn't until October 2007, however, that the Ministry of Foreign Affairs announced that the Parliamentary Ombudsman would be designated as NPM.

149. According to a report by the UN Special Rapporteur on Torture, Manfred Nowak on his visit to Denmark in May 2008:

> Given that inspecting places where persons are deprived of their liberty is one of the core activities of the Ombudsman, this designation was not surprising. However, some observers pointed out that although the institution of the Ombudsman carries out inspections regularly, it is presently unable to carry out visits systematically as envisaged by the Optional Protocol. Apart from the fact that a significant increase in resources, including staffing (e.g. health professionals), would be needed, it has been argued that the designation as NPM would transform the character and functioning of the current institution of parliamentary Ombudsman into a more inspection-focused body, which may require legislative amendments.

Legislation

150. The Ombudsman's NPM mandate is not legislated, however, section 21 of the Danish Ombudsman legislation requires the Ombudsman to assess whether an authority has contravened an 'applicable law'. According to the Danish Parliament's Committee on Legal Affairs, the appointment of the Ombudsman as NPM under OPCAT implies that the '[protocol], international practice attached to it and other ratified conventions on protection against torture' forms part of the Ombudsman's assessment.

151. Despite there being no express reference to OPCAT or the NPM mandate in legislation, some amendments were made to Ombudsman legislation in 2009 to empower the Ombudsman to fulfil the role. In particular, the Ombudsman's powers of inspection and access to information were expanded to cover private detention institutions.

152. Prior to its designation as NPM, the Ombudsman was already an independent body that reported to the Folketing, with the responsibility to hear complaints on actions of the public administration and conduct 'own-motion' investigations and inspections.

Ombuds-plus model

153. While the Ombudsman is Denmark's only designated NPM, in practice, it works alongside the Danish Institute for Human Rights (**DIHR**) and a non-government organisation DIGNITY (Danish Institute Against Torture) to fulfil the role.

154. The cooperation between the Ombudsman, DIHR and DIGNITY is outlined in a memorandum of understanding, being 'The OPCAT Tasks: General Principles':

> The PO (*Parliamentary Ombudsman*) has been appointed NPM but the Folketing has presupposed that in connection with the OPCAT task the Ombudsman may call upon the special medical and human rights expertise of the RCT (*now DIGNITY*) and the DIHR (*Danish Institute for Human Rights*).

155. The General Principles and Denmark's first OPCAT Annual Report emphasised that while DIGNITY and the DIHR formally function in an advisory capacity, in practice they play a greater role:

> Formally, the RCT and the DIHR function only in an advisory capacity within the OPCAT cooperation. However, the Ombudsman has stated that he will attach decisive significance to the opinion of two organisations, and that the reports will always reflect any divergent views.

and

> The RCT and the IMR (*Danish Institute for Human Rights*) play an advisory role in the OPCAT cooperation. However, the Ombudsman has indicated that he will consider the contributions he receives from the experts to be of decisive importance, and that in cases of divergent opinions he will let this difference be reflected in the reports if the organisations would so wish.

156. Cooperation between the organisations occurs through two channels: the OPCAT Council and the OPCAT Work Group. The Council consists of senior representatives from each institution who meet several times a year to prepare guidelines for OPCAT work, the Annual Report and press releases.

157. The OPCAT Work Group consists of appointed staff from each institution, who participate in continuous OPCAT tasks such as conducting inspections and drafting reports.

Resourcing

158. In December 2008, the Folketing raised the Ombudsman's budget for the 2009 financial year by 1,430,000 Danish krone (**DKK**) (AU$376,500 at the time) to accommodate the NPM function.

159. In 2017 the Ombudsman's total operating budget was DKK82,800,000 (AU$16,265,000 at the time).

160. Officers from the Danish Ombudsman told the investigation that they conduct on average 40 inspections of adult facilities and 10 inspections of child facilities per year. There are nine lawyers working in the 'adult department' and eight lawyers working in the 'children's department', law students and secretarial staff.

The Decentralised Model

161. Under the 'decentralised model' the NPM function is split across multiple bodies based on specific areas of expertise/ existing jurisdiction. Only four countries have adopted a decentralised NPM model: New Zealand, the United Kingdom, the Netherlands and Malta.

New Zealand

162. In New Zealand, like Australia, the power to enter treaties is held by the Executive, as a prerogative power of the Crown. Ratification of an international instrument by the Executive, however, does not establish its contents as domestic law. Legislation is required for a treaty or other international instrument to confer powers or duties on persons in New Zealand, as is the case in Australia.

163. New Zealand signed OPCAT in September 2003 and ratified it in June 2006. In December 2006 the *Crimes of Torture Amendment Act 2006* (NZ) was passed into law.

164. In New Zealand, the NPM inspection function is shared by four bodies and coordinated by the Human Rights Commission. The NPM includes the Ombudsman, the Independent Police Conduct Authority, the Children's Commissioner and the Inspector of Service Penal Establishments.

Legislation

165. The amended *Crimes of Torture Act 1989* (NZ) is the most detailed implementation of OPCAT of any jurisdiction analysed in this report. The Act uniquely incorporates the full text of OPCAT, contains specific provisions on granting access to the UN Subcommittee on Prevention of Torture, and allows for the creation of a 'Central NPM.'

166. The Crimes of Torture Act requires at least one NPM to be designated by notice in the *Gazette*, and provides a detailed list of NPM functions:

> **27 Functions of National Preventive Mechanism**
>
> A National Preventive Mechanism has the following functions under this Act in respect of the places of detention for which it is designated:
>
> (a) to examine, at regular intervals and at any other times the National Preventive Mechanism may decide, –
>
> (i) the conditions of detention applying to detainees; and
>
> (ii) the treatment of detainees:
>
> (b) to make any recommendations it considers appropriate to the person in charge of a place of detention –
>
> (i) for improving the conditions of detention applying to detainees:
>
> (ii) for improving the treatment of detainees:
>
> (iii) for preventing torture and other cruel, inhuman or degrading treatment or punishment in places of detention:
>
> (c) to prepare at least 1 written report each year on the exercise of its functions under the Act during the year to which the report relates and provide that report to –
>
> (i) the House of Representatives, if the National Preventive Mechanism is an Officer of Parliament; or
>
> (ii) the Minister, if the National Preventive Mechanism is not an Officer of Parliament:
>
> (d) to provide a copy of each report referred to in paragraph (c) to the Central National Preventive Mechanism (if designated).

167. The Act also includes powers of an NPM's access to information, access to places of detention and persons detained and the ability to conduct interviews.

168. The *Crimes of Torture Amendment Bill 2006* (NZ) was supported over its passage through the Foreign Affairs, Defence and Trade Committee and Parliament. The primary point of criticism of the Bill was that the NPM/s were not designated or established by legislation, but rather by ministerial appointment in the Government Gazette. As argued during the second reading of the Bill:

> There is certainly no practical reason why we should not give Parliament, rather than the Executive, full control over the designation, and the revocation of designation, of preventive mechanisms. I think there is a good reason for us here in New Zealand, as people in a strong democracy, to set a good example to the world in terms of the full independence of these mechanisms from the Executive branch of Government.

169. The Minister of Justice designated the Human Rights Commission to be the 'Central NPM' in 2007. Under the Crimes of Torture Act, the role of the Central NPM is to:

> **32 Functions of Central National Preventive Mechanism**
>
> (1) The functions of the Central National Preventive Mechanism, in relation to this Act, are to –
>
> (a) coordinate the activities of the National Preventive Mechanisms; and
>
> (b) maintain effective liaison with the Subcommittee.

170. The most recent designation of NPMs and their responsibilities are:

Table 2: Designation of NPMs and their responsibilities in New Zealand

Body	Examining/monitoring treatment of persons detained
Ombudsman	• in prisons and otherwise in the custody of the Department of Corrections • on premises approved or agreed under the *Immigration Act 1987* (NZ) • in health and disability places of detention including within privately run aged care facilities • in youth justice residences and care and protection residences established under section 364 of the *Oranga Tamariki Act 1989* (NZ) • in residences established under section 114 of the *Public Safety (Public Protection Orders) Act 2014* (NZ); in court facilities.
Independent Police Conduct Authority	• in court facilities, in police cells, and of persons otherwise in the custody of the New Zealand Police.
Children's Commissioner	• children and young persons in care and protection and youth justice residences established under section 364 of the *Oranga Tamariki Act 1989* (NZ).
Inspector of Service Penal Establishments	• in service penal establishments as defined in section 2 of the *Armed Forces Discipline Act 1971* (NZ).

171. Of note, as an independent 'Officer of Parliament' the Ombudsman reports directly to the New Zealand Parliament, whereas the Human Rights Commission, Children's Commissioner, Independent Police Conduct Authority and Inspector of Service Penal Establishments do not, and report to their respective Ministers.

172. Both the Human Rights Commission and the Children's Commissioner are within the Ombudsman's jurisdiction to investigate.

Resourcing

173. In 2013, the UN Subcommittee for the Prevention of Torture (SPT) visited New Zealand and commented that most of its NPMs 'have not received extra resources to carry out their mandate under the Optional Protocol, which, together with general staff shortages, has severely impeded their ability to do so.' The SPT was impressed by the 'commitment and professionalism of the experts of the national preventive mechanism' but 'concerned at the lack of expertise in medical and mental health issues.'

174. According to budget documents, in 2017-18 the New Zealand Ombudsman's operating budget was NZ$18,551,000 (AU$17,686,000 at the time). The 'monitoring people detained' or NPM function was budgeted at NZ$1,178,000 (NZ$1,127,000 plus NZ$51,000 for furniture and technology for additional OPCAT staff). In 2018-19, the Ombudsman's NPM function was allocated NZ$1,165,000 (AU$1,064,600).

175. The New Zealand Children's Commission has two mandates, being a regular monitoring mandate and a specific mandate to carry out visits under OPCAT, as set out in Table 2 on the previous page. NZ Officers told the investigation that 'whenever we go into a residence, we have two hats on.' The Children's Commission did not receive specific funding for the NPM mandate.

United Kingdom

Designating an NPM

176. The United Kingdom ratified OPCAT in 2003, however, has not implemented its text or NPM requirements into domestic legislation. Instead, the UK NPM is designated by written ministerial statement to Parliament:

> The Government intends that the requirements of OPCAT be fulfilled in the UK by the collective action of existing inspection bodies.

177. The NPM, which now comprises 21 bodies, is supported by a small secretariat within Her Majesty's Inspectorate of Prisons (**HMIP**). Although coordinating the NPM is not part of HMIP's statutory duties, it is performed at the request of Ministers and was formally set out in an agreement between HMIP and the Ministry of Justice in 2017. The NPM comprises:

England and Wales

- Care and Social Services Inspectorate Wales (**CSSIW**)
- Care Quality Commission (**CQC**)
- Children's Commissioner for England (**CCE**)
- Healthcare Inspectorate Wales (**HIW**)
- Her Majesty's Inspectorate of Constabulary (**HMIC**)
- Her Majesty's Inspectorate of Prisons (**HMIP**)
- Independent Custody Visiting Association (**ICVA**)
- Independent Monitoring Boards (**IMB**)
- Lay Observers (**LO**)
- Office for Standards in Education, Children's Services and Skills (**Ofsted**)
- Independent Reviewer of Terrorism Legislation (**IRTIL**).

Scotland

- Care Inspectorate (**CI**)
- Her Majesty's Inspectorate of Constabulary in Scotland (**HMICS**)
- Her Majesty's Inspectorate of Prisons for Scotland (**HMIPS**)
- Independent Custody Visitors Scotland (**ICVS**)
- Mental Welfare Commission for Scotland (**MWCS**)
- Scottish Human Rights Commission (**SHRC**).

Northern Ireland

- Criminal Justice Inspection Northern Ireland (**CJINI**)
- Independent Monitoring Boards (Northern Ireland) (**IMBNI**)
- Northern Ireland Policing Board Independent Custody Visiting Scheme (**NIPBICVS**)
- Regulation and Quality Improvement Authority (**RQIA**).

178. Table 3 on the following page provides an overview of the respective jurisdiction of each authority.

179. According to a joint submission to the 66th session of the Committee against Torture from May 2019, the organisations were designated as part of the NPM because of their existing detention monitoring functions:

> All were deemed by the UK Government to have sufficient independence and to fulfil the main criteria of an NPM set out in OPCAT (Articles 18–20). Given the prior experience of these organisations, and the well-accepted processes they already had in place for visiting, monitoring and inspecting places of detention, this was considered by the Government a more useful way of establishing an NPM than by creating a new organisation.

180. To address the challenges inherent in a 21-member NPM, a Steering Group represents all members of the NPM and facilitates decision making and strategic direction.

181. The NPM is also divided into three sub-groups which focus on information-sharing and support between the many institutions.

182. The first is the Scottish sub-group which coordinates NPM activities in Scotland and provides support to its NPM members.

183. According to the eighth Annual Report of the UK's NPM, the second is the mental health network, which:

> brings together the different members who have a specialist interest in areas relevant to mental health detention in the UK, met four times during the year. This sub-group provides an opportunity for organisations with responsibilities for the monitoring and protection of people in health and social care detention settings to work collaboratively on issues with specific mental health impacts. The group is chaired by the Regulation and Quality Improvement Authority.

184. The third sub-group is focused on children and young people in detention and provides a forum for NPMs to share information and consider common issues affecting detained children. It is chaired by staff from the Children's Commissioner of England.

Table 3: NPM responsibilities of each authority in United Kingdom				
	England	**Wales**	**Scotland**	**N. Ireland**
Prisons and juvenile justice centres	HMIP with CQC and Ofsted	HMIP with HIW	HMIPS with CI and SHRC	CJINI and HMIP with RQIA
	IMB			IMBNI
Police custody	HMIC and HMIP		HMICS	CJINI with RQIA
	ICVA		ICVS	NIPBICVS
Escort and court custody	Lay Observers and HMIP		HMIPS	CJINI
Children in secure accommodation	Ofsted (with HMIP for secure training centres)	CSSIW	CI	RQIA
				CJINI
Children (all detention settings)	CCE		CI	
Detention under mental health law	CQC	HIW	MWCS	RQIA
Deprivation of liberty and other safeguards in health and social care	CQC	HIW	CI and MWCS	RQIA
		CSSIW		
Immigration detention	HMIP and IRTL			
	IMB			
Military detention	HMIP			
Customs custody facilities	HMIC, HMIP, HMICS and IRTL			

Legislation

185. The designation of NPMs in the UK is not based in legislation. In the joint submission the NPM expressed dissatisfaction with the lack of a legislative mandate:

> … we have repeatedly raised the need for the NPM to be placed on a statutory footing, in line with SPT advice. Currently, only two of the 21 members of the NPM have any reference to their OPCAT mandate written into the legislation that created them and which defines their role. The NPM itself is not recognised more generally in any legislation and has no separate legal identity.

186. In January 2018, the SPT noted its concern about the lack of a clear legislative basis for the NPM:

> We are aware that some take the view that [a clear legislative basis] is not legally necessary under OPCAT. The SPT disagrees with this position, and should the SPT visit the UK on an official basis it is incontrovertible that this failing would feature in its report and recommendations …
>
> Practical effectiveness is dependent on functional independence, and the independence is threatened when the NPM is vulnerable to political pressure or political exigencies.

Resourcing

187. The joint submission also says that in the UK, some NPM members face challenges with the budgets necessary to carry out their NPM work and in some cases are significantly under-resourced.

188. For each of the 21 NPM bodies, their budget for the OPCAT mandate is not separated from the organisation's broader finances which poses challenges in terms of competing priorities and annual planning. Budget cuts and other freezes to NPM members would result in many having to reduce the number of inspections and monitoring visits undertaken, as has already happened for one NPM member. Again, according to the joint submission:

> In addition, most members report that additional funding would allow them to increase their preventive work through providing training to their own staff and those working in places of detention, promoting best practice, carrying out stakeholder engagement work and contributing to research and thematic work (including jointly with other NPM members).

189. The NPM's coordination by HMIP is nominally funded in part by the Ministry of Justice (£61,155), and in part by its members who make annual contributions (£19,500). In 2018, the Scottish Government agreed to support the NPM's activities in Scotland by funding a 0.5 FTE member of staff to help coordinate the work of NPM members in Scotland.

The Australian Context

190. The Commonwealth Government ratified OPCAT on 21 December 2017, and made a declaration pursuant to Article 24 to postpone implementation of its obligation to establish an NPM for three years. At the time, the Commonwealth Government said it would use the three years to work with states and territories on implementing OPCAT including the establishment of Australia's NPM:

> It is proposed that Australia's NPM will be established as a cooperative network of Commonwealth, state and territory bodies responsible for inspecting places of detention and will be facilitated by an NPM Coordinator.

191. It was announced at this time that the Commonwealth Ombudsman would be appointed Australia's NPM Coordinator.

192. On 1 July 2018, the Commonwealth Ombudsman commenced his coordinator role and was designated NPM for Commonwealth places of detention, including defence detention facilities, immigration detention facilities and Australian Federal Police cells.

193. In April 2019, the *Ombudsman Amendment (National Preventive Mechanism) Regulations 2019* (Cth) formally conferred on the Commonwealth Ombudsman the roles and functions of the NPM Coordinator and of the NPM for places of detention under the control of the Commonwealth.

194. The Regulations clarify that as Australia's NPM Coordinator, the Commonwealth Ombudsman has national oversight of arrangements to prevent torture and mistreatment in places of detention under Australia's jurisdiction and control and performs a facilitative and collaborative role for the NPM Network, and assists, but must not compel or direct, State and Territory NPM bodies in their work.

195. Pursuant to regulation 16:

> **16 National Preventive Mechanism Body function**
>
> (1) For the purposes of paragraph 4(2)(a) of the [Commonwealth Ombudsman] Act, the National Preventive Mechanism Body function is conferred on the Ombudsman.
>
> (2) The National Preventive Mechanism Body function is to be performed for the purposes of giving effect to the Commonwealth's obligations under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the **Optional Protocol**), so far as those obligations relate to places of detention under the control of the Commonwealth.
>
> (3) The National Preventive Mechanism Body function includes the following:
>
> (a) undertaking regular inspections of places of detention;
>
> (b) giving information to the United Nations Subcommittee on Prevention of Torture and other Cruel or Degrading Treatment or Punishment to facilitate the inspection of places of detention by the Subcommittee;
>
> (c) functions incidental to the function of National Preventive Mechanism Body
>
> (4) For the purposes of this section, the Commonwealth's obligations under the Optional Protocol do not include the obligations of each of the States and Territories under the Optional Protocol.

196. The functions of the NPM Coordinator include consulting on the development of standards regarding the treatment and conditions of persons detained, research, proposing options and developing resources to facilitate improvements in oversight arrangements and communicating with the UN Subcommittee on Prevention of Torture.[2]

197. Although the Ombudsman Amendment (National Preventive Mechanism) Regulations, together with section 4(2)(a) of the *Ombudsman Act 1976* (Cth), articulate the functions of the Commonwealth Ombudsman, no new powers have been provided, and therefore the NPM mandate would have to be performed under existing powers. It is likely that this could mean that an inspection carried out by the Commonwealth Ombudsman in the performance of its NPM function would, at law, be an investigation within the meaning of the Ombudsman Act (Cth).

2 *Ombudsman Amendment (National Preventive Mechanism) Regulations 2019* (Cth), reg 17.

An NPM Model for Victoria

Comparing the 'centralised' and 'decentralised' models

198. In the absence of establishing a new body to fulfil the inspection role, the Victorian Government will need to decide whether to implement a single body (centralised) or multi-body (decentralised) NPM model in Victoria. Lessons can be drawn from other jurisdictions to design an effective model.

199. New Zealand and the UK were some of the first jurisdictions to implement OPCAT. Both designated a multi-body (decentralised) NPM model, although countries considering their designated NPMs in more recent times have moved strongly towards a single body (centralised) model. Norway, for example, implemented its NPM most recently in 2013 where an inter-ministerial working group considered in detail which body or bodies to designate.

200. Reflecting on the experiences of other jurisdictions, the benefits and challenges of each model may be summarised as follows:

Table 4: Centralised model – eg Norway, Georgia, Denmark	
✔	Ninety per cent of State Parties to OPCAT have adopted a centralised model
✔	The Commonwealth has adopted a centralised model
✔	Consistency with the Commonwealth and other NPMs would allow for better interstate/international cooperation
✔	The NPM mandate is exercised in a consistent and uniform manner, regardless of sector or geographic area. This enables consistent measuring and reporting
✔	The NPM can conduct thematic work in closed environments across multiple portfolios (eg thematic inspection on solitary confinement across prison, youth justice and child protection)
✔	Resource-intensive coordination of several bodies is avoided
✔	Legislative and operational changes to multiple agencies is avoided
✔	A single body provides a visible point of contact for the UN's Sub-Committee on the Prevention of Torture (SPT), other States' NPMs, civil society, the public and the media
✔	Norway, Georgia and Denmark all have formalised arrangements with civil society to fulfil the NPM mandate
✔	Greater capacity to coordinate components of the 'preventative package'
✔	Avoids overlapping jurisdiction and duplicating functions
✗	May have more limited interdisciplinary composition, perspectives, networks, and knowledge (unless it is supported by an Advisory Group)

Table 5: Decentralised model – eg New Zealand and United Kingdom	
✔	Can rely on existing expertise where dedicated inspection bodies already operate (UK)
✔	May ensure broader professional competence
✔	Provides interdisciplinary composition with different perspectives, networks, impulses and knowledge
✗	The mandate may not be exercised in a uniform manner across different NPMs and sectors
✗	Limited capacity to conduct thematic work in closed environments across multiple portfolios
✗	Resource-intensive coordination of several bodies is required
✗	Legislative and operational changes to multiple agencies is required
✗	The mandates of NPMs in New Zealand, the UK, the Netherlands and Malta (the four decentralised models) are not established in legislation
✗	In New Zealand, one NPM (the Ombudsman) has the jurisdiction to investigate the actions and decision of another NPM (the Children's Commissioner) and the Coordinating NPM (the Human Rights Commissioner)
✗	Potential for overlapping jurisdiction and duplicating functions contrary to sound public policy
✗	Decentralised NPMs in New Zealand and the UK do not have formal arrangements with civil society

201. Victoria has a network of bodies that in different ways monitor conditions in places of detention. The powers, jurisdiction and independence of these bodies differ widely. Only a few bodies visit places of detention regularly to check detainees' conditions and treatment. Many were set up to resolve or investigate individual complaints or examine specific issues. Some are independent, but many operate within government departments, sometimes out of public view.

202. No single body has complete jurisdiction over all places of detention in Victoria.

What would a single-body (centralised) NPM in Victoria look like?

203. This section considers what would be required to implement a single body (centralised) NPM model in Victoria similar to those in Norway, Georgia, and Denmark where the Ombudsman is designated.

Does the Victorian Ombudsman have the OPCAT requisite level of independence?

204. The Victorian Ombudsman is one of three independent officers of Parliament whose independence is enshrined in the Victorian Constitution. Being an independent officer of the Parliament means the Ombudsman reports directly to the Parliament, rather than to the government of the day through a Departmental Secretary or Minister.

205. From July 2020, the Ombudsman will have budgetary independence and will be funded through a direct appropriation from Parliament.

Would an NPM function align with the Ombudsman's existing functions?

206. The principal function of the Victorian Ombudsman is to enquire into or investigate any administrative action taken by or in an authority, which includes a decision or an act, or the refusal or failure to take a decision or to perform an act. The Ombudsman also has an express function to investigate whether such decisions or actions are incompatible with the *Charter of Human Rights and Responsibilities Act 2006* (Vic) (**Human Rights Act**). In this regard, the Ombudsman's functions align with OPCAT, as section 10 of the Human Rights Act provides protection from 'torture and cruel, inhuman or degrading treatment.' Similarly, section 22(1) provides that 'all persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.'

207. The conferral of a specific human rights investigative function utilises the Ombudsman's legislative independence, accessibility, Royal Commission style investigation powers, powers of entry and inspection, and ability to make and follow up on remedial recommendations for administrative improvement.

208. Article 19(a) of OPCAT requires that NPMs have (at a minimum) the power to regularly examine the treatment of the persons deprived of their liberty in places of detention, with a view to strengthening, if necessary, their protection against torture and other cruel, inhuman or degrading treatment or punishment.

209. Consistent with the preventive nature of OPCAT work, the Ombudsman investigates systemic issues on her 'own motion' (ie without a complaint), which are human rights focussed. In addition, from 1 January 2020 the Ombudsman's legislation will include an objective to prevent maladministration, and an express education function.

210. Over time, the Ombudsman's focus on the conditions and treatment of persons held in custody or in secure facilities has necessitated regular site visits. While an inspection function is not expressly provided for in the Ombudsman Act, or separately funded, in practice, routine visits of places of detention (which do not have the full rigour of inspections) have long been an important element of Ombudsman work, utilising powers of entry and inspection.

211. Noting the limitations of the New Zealand and UK models, designation of an NPM in Victoria should be entrenched in legislation, which could be achieved through amendments to the Ombudsman Act expressing the NPM mandate as a function of the Ombudsman.

Does the Ombudsman have access to all places of detention in Victoria?

212. OPCAT applies to 'places of detention', being any place under a state's jurisdiction and control where persons are or may be deprived of their liberty, either by an order given by a public authority or at its instigation or with its consent or acquiescence.

213. Pursuant to Article 20(c) of OPCAT, NPMs must have access to 'all places of detention and their installations and facilities'.

214. In 2017, the Ombudsman mapped places of detention in Victoria and identified at least 50 pieces of legislation that allow people to be detained, including the following 'primary' places of detention:

- Sixteen adult prisons
- Twenty-three police gaols
- Two youth justice centres
- Eighteen designated mental health facilities where people can be detained for compulsory psychiatric treatment under mental health laws, or if they are found unfit to stand trial or not guilty because of mental impairment
- Disability residential services. The Department of Health and Human Services (**DHHS**) Disability Forensic and Assessment Treatment Service (**DFATS**) and Long-Term Residential Program accommodate people with an intellectual disability detained for compulsory treatment under disability laws, as well as people found unfit to stand trial or not guilty because of mental impairment. Community-based disability service providers may also detain people subject to supervised treatment orders under disability laws. The number of people subject to such orders, and their locations, change over time
- DHHS's Secure Welfare Service for children and young people located in Melbourne.

215. Other significant places of detention are prison transport vehicles and court cells, which hold people temporarily.

216. The Ombudsman's jurisdiction encompasses all places of detention listed above, with one exception, being Victoria Police. The Independent Broad-based Anti-corruption Commission is responsible for investigating complaints about police conduct in Victoria, however, does not have a dedicated program for conducting inspections of police cells.

217. The Ombudsman takes complaints about three police gaols – Melbourne Custody Centre, Moorabbin Justice Centre and the Ringwood Court Cells – and has visited and investigated conditions in the past. The Ombudsman has jurisdiction over these gaols because Victoria Police has contracted out their operation, and the contractor falls within the scope of the Ombudsman's investigative jurisdiction.

Does the Ombudsman have unqualified powers of entry and inspection?

218. Pursuant to section 21 of the Ombudsman Act, the Ombudsman, or an authorised member of Ombudsman staff, may at any reasonable time, enter any premises occupied or used by an authority, and inspect those premises or anything for the time being therein or thereon.

Can the Ombudsman access information and conduct private interviews?

219. Articles 20(a) and 20(b) of OPCAT provide than an NPM has access to all information concerning:

- the number of persons deprived of their liberty
- the number of places of detention and their locations
- the treatment of people deprived of liberty the conditions of their detention.

220. The Ombudsman has powers related to access of information. For example, the Ombudsman may conduct an 'own motion' enquiry to determine whether a matter should be investigated or may be resolved informally. Pursuant to section 13A(3) of the Act, the principal officer of an authority must assist the Ombudsman in the conduct of an enquiry.

221. Enquiries can be made with any person or body and are not limited to the authority whose actions or decisions are under consideration. This, for example, would allow the Ombudsman to make enquiries with an oversight body such as the Commissioner for Children and Young People and obtain information to determine whether the Ombudsman should investigate the treatment of people in a particular closed environment.

222. In addition to enquiry powers, in the context of an investigation, the Ombudsman can:

- summons witnesses, require the attendance and production of documents and take sworn evidence
- issue a summons to obtain and protect evidence, including CCTV footage and electronic records
- enter the premises of an authority to inspect the premises or anything in them
- obtain information from such persons and in such manner as she thinks fit – there is no obligation to hold a hearing
- in relation to the Crown, override certain privileges which usually protect disclosure of information
- conduct her investigations in private and regulate her investigatory procedures as she thinks fit
- issue a Confidentiality Notice to any person prohibiting them from disclosing specified information relating to an investigation to other parties.

223. An Ombudsman investigation must be conducted in private and it is an offence to:

- wilfully obstruct, hinder or resist the Ombudsman
- refuse or wilfully fail to comply with her lawful requirements
- fail to attend or produce any documents when summonsed
- wilfully make a false or misleading statement.

224. The breadth of the Ombudsman's existing powers of entry and inspection, combined with her ability to conduct an investigation on her own motion, obtain information from such persons and in such manner as she thinks fit and require the production of information, are consistent with Articles 19(a), 20(c), 20(d) and 20(e) of OPCAT.

Can the Ombudsman collaborate with others and share information?

225. The importance of civil society to the work of an NPM is formally recognised in Norway and Georgia through legislation providing for the establishment of an advisory body.

226. The Ombudsman Act permits the Ombudsman to share information with other Victorian oversight bodies, subject to limited conditions including the nature and relevance of the information to the other body (section 16L).

227. In addition, the Ombudsman Act, allows the Ombudsman to disclose information to a person, body or authority where the Ombudsman considers the disclosure is necessary to prevent or lessen the risk of harm to a person's health, safety or welfare (section 16M).

228. The Ombudsman can also disclose information to the public which relates to the commencement or progress of an 'own motion' investigation.

229. The Ombudsman has used these provisions to share relevant information with members of her Advisory Group throughout this OPCAT related investigation.

230. OPCAT also requires that the NPM be able to share information with the SPT (Article 20(f)). This could be achieved through existing information sharing provisions in the Ombudsman Act or through a report tabled in Parliament.

Does the Ombudsman make recommendations for improvement?

231. On a practical level, the preventive nature of OPCAT is articulated through Articles 19(b) and (c) which grant an NPM the power to:

    - make recommendations to the relevant authorities with the aim of improving the treatment and the conditions of the persons deprived of their liberty and to prevent torture; and
    - submit proposals and observations concerning existing or draft legislation.

232. The Ombudsman's role is to ensure fairness for Victorians in their dealings with the public sector, improve public administration and protect human rights. Legislative amendments coming in to effect on 1 January 2020 further articulate the objectives of the Ombudsman Act to provide for the identification, investigation, exposure and prevention of maladministration – which includes breaching human rights.

233. If, after an investigation, the Ombudsman is of the opinion that the matter to which the investigation relates was contrary to law, unreasonable, unjust, oppressive or improperly discriminatory or wrong, she can make recommendations for improvement, including that a relevant law, policy or practice be reconsidered.

234. As an independent officer of the Parliament, she has the power to report directly to Parliament on any matter arising in connection with the performance of her functions and make those reports publicly available.

235. In practice, the Ombudsman also submits observations on existing or draft legislation to Parliament and the Government as it relates to accountability and oversight and human rights.

Amending the Ombudsman Act

236. In summary, the Ombudsman Act provides the Ombudsman with the requisite level of independence and powers to fulfil an NPM mandate for all places of detention in Victoria, except police cells.

237. Amendments to the Act could be made to express an NPM mandate and expand the Ombudsman's jurisdiction for that mandate to police cells.

What would a multi-body (decentralised) NPM in Victoria look like?

238. This section considers what would be required to implement an NPM model in Victoria by designating multiple bodies as has occurred in New Zealand and the UK.

239. If Victoria was to adopt a multi-body model, the jurisdiction to inspect places of detention could be thematically divided among existing oversight bodies, as shown in Table 6 below.

Do the bodies each have the OPCAT requisite level of independence?

240. Article 18(1) of OPCAT requires State Parties guarantee the 'functional independence' of an NPM. According to the APT, there are various aspects of functional independence, including the appointment and dismissal processes and financial arrangements.

241. Like the Victorian Ombudsman, the Independent Board-based Anti-Corruption Commissioner (**IBAC**) is an independent officer of the Victorian Parliament. The Ombudsman and IBAC Commissioner can only be removed from office following a resolution of both Houses of Parliament.

242. The Commissioner for Children and Young People (**CCYP**), Mental Health Complaints Commissioner (**MHCC**), Health Complaints Commissioner (**HCC**) and Disability Services Commissioner (**DCS**) (collectively, the Commissioners) are all statutory officers appointed by the Governor in Council. Each may be removed from office by the Governor in Council, in most cases on the recommendation of the relevant Minister.

243. The *Commission for Children and Young People Act 2012* (Vic) provides that CCYP must act independently and impartially in performing its functions.

244. According to the Association for the Prevention of Torture (APT) guidance material on establishing and designating an NPM:

> In line with the Paris Principles, financial autonomy is a fundamental requirement: without it, a national preventive mechanism would not be able to exercise its operational autonomy, nor its independence in decision-making … The law should also specify the process for the allocation of annual funding to the NPM, and that process should not be under direct executive government control.

Table 6: Possible responsibilities under a multiple-body NPM in Victoria

NPM	Place of detention
Victorian Ombudsman	• adult prisons (incl. prison transport) • court cells
Independent Broad-based Anti-Corruption Commission	• police gaols • police cells
Commission for Children and Young People	• youth justice centres • secure welfare service
Mental Health Complaints Commissioner	• designated mental health facilities
Health Complaints Commissioner	• closed wards in public health services
Disability Services Commissioner	• closed disability services

245. The financial operations of the Commissioners are consolidated into those of the Department of Health and Human Services, which provides financial services. Like the Ombudsman, from 2020 IBAC will receive its budget by direct appropriation from Parliament.

246. The Commissioners would require an increased level of independence to satisfy Article 18 of OPCAT.

Would an NPM function align with existing functions?

Independent Broad-based Anti-Corruption Commission

247. The objects of the IBAC Act provide for the identification, investigation and exposure of corrupt conduct and police personnel misconduct, and to assist in preventing such conduct. IBAC has the power to conduct 'own motion' investigation about police conduct, which could include the treatment of people in police cells and the conditions of their detention.

Commission for Children and Young People

248. CCYP provided the following information to the Ombudsman about their role:

> The CCYP Act empowers the Commission to monitor services provided to children and young persons in youth justice and those in out-of-home care, which includes secure welfare. DHHS and DJCS are required to report all adverse events to the Commission relating to a child or young person in these settings. The Commission must be provided any information requested relating to any of these incidents and routinely examines documentation, CCTV footage, photographs and other material relating to the care provided to a child in custody.
>
> The Commission regularly attends Youth Justice Centres to monitor the treatment of detainees through engagement with children, young people, staff and service providers. It also runs an Independent Visitor program which includes visitors from diverse and relevant cultural backgrounds. The Commission maintains ongoing dialogue with Youth Justice administrators and is regularly briefed by management on procedural improvements and operational issues affecting detainees.
>
> In the event a significant risk is identified in the treatment of detainees, the Commissioners formally advise respective Ministers and Secretaries. The Commission may also establish a group, individual or systemic inquiry in response to a significant risk being identified. The reports are prepared independently of government and the Commission may table systemic inquiries in Parliament. Legislation requires that all tabled inquiries included standard adverse comment processes and that the final report is provided to relevant Ministers 14 days prior to tabling.
>
> Both Commissioners regularly comment publicly on issues relating to treatment of children in detention and secure environments. The Commission is regularly consulted by government when new, or amended, legislation affecting children and young people is in development.

Mental Health Complaints Commissioner

249. MHCC is a specialist statutory officer established under the *Mental Health Act 2014* (Vic) to safeguard people's rights, resolve complaints about Victorian public mental health services and recommend service and system improvements.

250. The functions of MHCC focus on handling complaints, rather than regular preventive inspections as envisaged by OPCAT. Although MHCC does not have 'own motion' powers to conduct systemic reviews, it may be requested by the Minister to investigate and report on, 'any matter relating to mental health service providers'. Arguably, the Minister could request MHCC investigate the treatment of persons detained in designated mental health facilities.

Health Complaints Commissioner

251. HCC is also a specialist statutory officer established under the *Health Complaints Act 2016* (Vic) to support safe and ethical healthcare in Victoria by resolving complaints, investigating providers who pose a serious risk to the health, safety or welfare and other related functions.

252. HCC has the power to initiate investigations about the provision of a health service. Arguably, this could extend to the treatment of a person detained on a closed ward at a public hospital. Before HCC can initiate such an investigation, however, she must consult with an Advisory Council appointed by the Minister pursuant to section 141 of the Health Complaints Act.

Disability Services Commissioner

253. DSC is another specialist statutory officer established under the *Disability Act 2006* (Vic) whose role is to resolve complaints about disability service providers and work to improve outcomes for people with a disability.

254. The Commissioner also has the power to initiate his own investigation into the provision of disability services where there is a persistent or recurring systemic issue about abuse or neglect in the provision of services, or, where DSC receives information that abuse or neglect may have occurred in the provision of a service to a person with a disability.

255. A report on a systemic investigation is provided to the Minister for Housing, Disability and Ageing, and the Secretary of the Department of Health and Human Services and may be tabled in Parliament.

Do the bodies have unqualified powers of entry and inspection?

256. Section 86 of the IBAC Act provides an express power of entry and inspection of police personnel premises, in the context of an investigation.

257. Pursuant to section 254 of the Mental Health Act, MHCC may enter the premises of a mental health service provider for the purposes of investigating a complaint. A similar power is given to an authorised officer of the DSC in the context of an accountability investigation under section 132E of the Disability Act.

258. Under the Health Complaints Act, HCC can apply to a magistrate for a search warrant for a particular premise, if the Commissioner believes on reasonable grounds that there is evidence on the premises that is relevant to an investigation. This is also reflected in the Disability Act.

259. Under section 16P of the *Child Wellbeing and Safety Act 2005* (Vic), CCYP may visit an entity and inspect any document or conduct an interview when undertaking an own motion investigation into a 'reportable allegation' as defined in that Act. CCYP also has a role under the *Terrorism (Community Protection) Act 2003* (Vic) to meet and communicate with a detained child without being monitored, inspect premises and access any relevant documentation.

260. Although not akin to an express power of entry and inspection, the Commissioners have a general provision in their respective Acts 'to do all things necessary or convenient to be done for or in connection with the performance of its functions.'

Can the bodies access information and conduct private interviews?

261. Subject to certain conditions in some circumstances, each of the bodies are able to access information about:
    - the number of persons deprived of their liberty
    - the number of places of detention and their locations
    - the treatment of people deprived of liberty the conditions of their detention.

262. Some of the bodies can compel attendance and call for evidence and documents.[3] Others 'may have and must be given access to' information required for an inquiry or investigation.

263. In some form or another, each of the bodies may also conduct interviews. In practice this would occur in private.

Can the bodies collaborate and share information?

264. Effective collaboration and information sharing would be critical to the success of a decentralised model, including engagement with civil society. Consideration would need to be given to each of the bodies' legislative information sharing provisions to determine if the current arrangements are sufficient.

Do the bodies make recommendations for improvement?

265. Each of the bodies also has the power to make recommendations for improvement. In some cases, the functions of the bodies include providing advice to Ministers or Secretaries.

Amending the legislation

266. In light of the varied levels of independence, different powers and functions, significant legislative amendments would be required for a multi-body model to comply with OPCAT.

3 For example, pursuant to section 255 of the *Mental Health Act 2014* (Vic), MHCC has the power to compel attendance and call for evidence and documents in an investigation.

The Ombudsman's recommended NPM model for Victoria

267. The designation of an NPM in Victoria is complicated by many factors, including the number of oversight bodies with different functions and powers, and the complex landscape of closed environments. The overall picture is further complicated by Australia's federated nature, in which each state and territory will make its own arrangements. The Commonwealth Ombudsman, in his role as Co-ordinating NPM, has a challenging task attempting to identify which of hundreds of oversight bodies might need to be co-ordinated, ideally to deliver some measure of common standards across the country.

268. Core principles of efficiency and effectiveness should underpin the designation of an NPM. Significant expertise already exists in both existing oversight bodies and civil society, although it needs to be recognised that no oversight body currently and routinely carries out inspections to the rigorous standards required by OPCAT. Recognising the experiences of other jurisdictions implementing OPCAT, an NPM model should seek to unify and build on that expertise, in a way that is unique to Victoria.

269. Under a 'unified' model, and to avoid unnecessary duplication, a single independent body should be designated NPM for Victoria, to operate with a legislatively mandated Advisory Group as described in the following paragraphs. The NPM mandate should be distinct from existing functions, fully comply with the principles and requirements of OPCAT, and be enshrined in legislation.

270. In accordance with advice from the UN's Subcommittee on Prevention of Torture, the NPM should also be empowered and able to deliver a 'preventive package' including:

    - examining patterns of practices from which risks of torture may arise
    - advocacy, such as commenting on draft legislation
    - providing public education
    - undertaking capacity-building
    - actively engaging with State authorities.

271. The NPM should be sufficiently empowered and resourced, both to second experts to assist in conducting inspections and other related work, and to remunerate seconded experts for their involvement (eg to allow their parent organisation to backfill their position.)

272. The NPM should include adequate representation of gender and ethnic diversity, and representation of First Nations peoples.

273. The NPM would liaise with agencies responsible for closed environments, civil society, other oversight bodies, and the Commonwealth Ombudsman as the Co-ordinating NPM, to provide a strong single voice for Victoria.

A legislatively mandated Advisory Group

274. To incorporate specialist expertise, legislation should require the NPM to establish an Advisory Group to provide competence, information, advice and input to the NPM's work.

275. The Advisory Group should be composed of oversight bodies and civil society members with expertise in mental health, disability, human rights, culturally and linguistically diverse communities and the wellbeing and interests of First Nations peoples, and children and young people.

276. Members of the Advisory Group could be further involved in the NPM's work through participation on inspections, developing inspection tools and materials, choosing themes and locations, and delivering the preventative package, as determined by the NPM.

277. On a practical level, for example, it would be expected that the NPM would not inspect a mental health facility, youth justice centre or police cells without the involvement of the relevant specialist oversight body, such as the Mental Health Complaints Commissioner, Commissioners for Children and Young People, IBAC or the Public Advocate.

278. Members of the Advisory Group should be authorised under law to disclose information to the NPM for the purposes of assisting the NPM to fulfil its mandate.

279. The unified NPM model would complement, and not replace the roles of existing oversight bodies and civil society.

280. The Victorian Ombudsman is best placed to be designated Victoria's NPM as described in Article 3 of OPCAT and deliver this unified model described above.

NPM inspections in Victoria

281. Building on work undertaken in 2017 to map primary places of detention in Victoria and drawing on the experience of other jurisdictions, this section considers the resourcing implications of the proposed 'unified' NPM model.

282. The Association for the Prevention of Torture (APT) provides useful guidance for NPMs on establishing an inspection program, including suggestions about the length and frequency of visits and composition and size of an inspection team.

283. To apply this guidance to the Victorian context, the Ombudsman has also drawn on her own experience conducting OPCAT-style inspections of the Dame Phyllis Frost Centre, Port Phillip Prison, Malmsbury Youth Justice Precinct and the Secure Welfare Services and considered inspection practices from Norway and the United Kingdom.

Length of inspections

284. The APT suggests that inspections should be long enough for the visiting team to be able to speak with the facility's management and other staff, and a representative sample of the people held there, and to examine the facilities and living conditions. The length of an inspection can be estimated considering the following factors:

- the size of the inspection team
- how much is already known about the facility
- the size of the facility and the number of people detained there.
- the type of place of detention – it may take longer to move around a high security facility
- the staffing or institutional conditions
- the demographics and languages spoken by detainees and the possible need for interpretation
- the work needed to compile relevant data
- travelling time.

285. Noting that each 'in-depth' inspection should include interactions (interviews and conversations) with a substantial number of detainees, the APT suggests that a visit will last a minimum of one to three full working days, subject to the size of the facility. Accordingly, the APT estimates that an inspection of a prison could follow the following guidelines:

- less than 50 detainees – the visit should last at least one working day
- 50–99 detainees – it should last at least two days
- 100–299 detainees – it should last at least three days
- more than 300 detainees – it should last at least four days.

286. This guide is broadly consistent with the Ombudsman's experience conducting OPCAT-style inspections. For the purposes of modelling the resources for NPM inspections in Victoria, the Ombudsman has used the following guidelines:

Table 7: Length of inspections under proposed model for Victoria

Number of persons detained	Estimated days to inspect
Less than 50	1
50-99	2
100-299	3
300-499	4
500-749	5
750 +	6
≈ 1,000	7

Frequency of inspections

287. In accordance with Article 19(a) of OPCAT, an NPM must have the power to '**regularly** [emphasis added] examine the treatment of people deprived of their liberty'.

288. It is well recognised that the repetition that comes with regular inspections is essential for an NPM to establish and maintain constructive and ongoing dialogue with authorities; examine improvements or deterioration of the conditions of detention over time; protect detainees from abuse through the general deterrent effect of external scrutiny; and protect detainees and staff from reprisals for cooperating with the inspection.

289. The APT recommends that any estimate of the frequency of NPM inspections should be based on a programme that:

- combines longer in-depth visits (one to four days, by a multidisciplinary visiting team of at least three experts), with shorter ad-hoc visits (at random intervals, capable of being done by smaller teams)
- allocates approximately one-third of the overall visiting time of the NPM to ad-hoc visits
- on average, carries out an in-depth visit to each place within the following categories at least once per year, with the continuous possibility of ad-hoc visits in between:
    - police stations with known problems, plus a random sample of other police stations
    - remand or pre-trial detention centres
    - places with high concentrations of especially vulnerable groups
    - any other place known or suspected to have significant problems with torture or other ill-treatment, or known to have poor conditions relative to other institutions in the country
- on average, carries out an in-depth visit to each other place at least once every three years (with ad-hoc visits in between), but preferably more frequently
- never carries out in-depth visits to any official place of detention less frequently than once every five years, and at such an extended interval only on the basis of relevant information about the place in the interim.

290. In practice, HMIP in the UK has developed a program of regular inspections of facilities that includes 'risk slots' to ensure that facilities that fail an inspection can be returned to sooner without impacting on the whole programme.

291. HMIP inspects prisons, young offender institutions holding young adults (aged 18 to 21) and specialist units at least every five years, but usually more frequently, and on a risk-assessed basis. For example, if a prison receives a particularly poor assessment, HMIP may issue an urgent notification and return for a full inspection within the year. Similarly, facilities that receive mainly poor or not sufficiently good assessments will likely receive a review approximately eight to 12 months after the inspection to assess progress against recommendations.

292. HMIP inspects children's establishments annually, and police custody at least once every six years; or more often if concerns have been raised during a previous inspection.

293. As a starting point, consistent with the above, a Victorian NPM could inspect facilities detaining children (youth justice centres and Secure Welfare Services), designated mental health facilities and the Disability Forensic and Assessment Treatment Service annually. Adult prisons and police custody could be inspected at least once every one, two or three years depending on a profile and risk assessment.

294. Consistent with APT's advice and HMIP's practice, the Victorian NPM could allocate approximately one-third of its annual inspection time to ad-hoc visits to account for urgent inspections, follow-up reviews and thematic work.

Number of inspectors

295. The APT recommends that in-depth visits be conducted by a multidisciplinary team of at least three experts, and ideally eight. The size of an inspection team will, of course be determined by a number of factors, including, the type of inspection and the size and complexity of the facility.

296. The Ombudsman's first OPCAT-style inspection of the Dame Phyllis Frost Centre involved a team of 12, with an average of eight inspectors on any one day.

297. The size of an inspection team will also depend on the NPM's methodology and broader strategic approach to fulfilling its mandate.

298. The Norwegian NPM is well regarded for its pre-inspection research and analysis. According to the Norwegian Ombudsman's 2018 Annual Report:

> To be able to carry out systematic and expedient prevention work, it is crucial that the NPM has full, unabridged access to sources. Reviewing relevant documentation in advance enables the NPM to identify potential risk factors for undignified and inhuman treatment, thereby ensuring that the visits address the challenges at the place in question.

299. In practice, the thorough pre-inspection work undertaken by the Norwegian NPM means that most of the time in a facility is spent engaging directly with detainees and staff, rather than reviewing documents.

300. The Norwegian NPM consists of eight staff and additional experts are seconded for specific inspections. On average, the NPM conducts 30 inspection days per year. This equates to each member of the team spending approximately nine per cent of their time physically inspecting, allowing for thorough planning, analysis and reporting.

301. The Victorian Ombudsman's approach to OPCAT-style work is consistent with the Norwegian methodology in terms of conducting significant pre-inspection research and post-inspection analysis and reporting.

Inspecting places of detention in Victoria

302. According to the APT, the ideal size for a visiting team can be estimated as being between two and eight experts. The APT recommends that a visiting team for in-depth visits consist of a minimum of three experts and that 'ad-hoc visits' (which are usually shorter than in-depth visits) can be undertaken by smaller visiting teams. The APT further recommends that approximately one-third of the overall time spent by an NPM carrying out visits should be allocated to ad-hoc visits.

303. The tables on the following pages seek to consolidate the maximum number of people in primary places of detention in Victoria, estimate the resources required to conduct OPCAT compliant inspections of each facility based on the advice of the APT and existing NPMs, and the Ombudsman's own experience conducting OPCAT-style inspections in Victoria.

Size and cost of a Victorian NPM

304. An NPM conducting regular inspection of all primary places of detention in Victoria should comprise approximately 12 Full Time Equivalent staff and have an operating budget of approximately $2.5 million.

305. There are further efficiencies in designating a single NPM, as the inspection function can be subject to a single budget bid taking into account the full range of work required, and the NPM can provide resources to other agencies as necessary within the overall allocation.

Recommendation: Part One

306. The Ombudsman recommends the Victorian Government:

a. designate an NPM in accordance with the principles set out in paragraphs 267 to 280; and

b. resource that NPM adequately to allow it to demonstrate compliance with OPCAT standards. .

Table 8: Inspecting prisons in Victoria, estimated duration and frequency

	Number of facilities	Number of people detained* (maximum capacity)	Average number of days required to inspect each facility (three experts)	Inspection frequency (1 = annually)	Number of inspection days per year	Kilometres from Melbourne CBD
PRISONS	**15**	**8530**			**30.4**	
Barwon Prison	1	478	4	0.3	1.2	69
Beechworth Correctional Centre	1	210	3	0.3	0.9	288
Dame Phyllis Frost Centre (Women)	1	512	5	0.5	2.5	26
Dhurringile Prison	1	328	4	0.3	1.2	173
Fulham Correctional Centre	1	893	6	0.3	1.8	208
Hopkins Correctional Centre	1	783	6	0.5	3	202
Judy Lazarus Transition Centre	1	25	1	0.3	0.3	2
Langi Kal Kal Prison	1	428	4	0.3	1.2	163
Loddon Prison Precinct (Middleton)	1	716	5	0.3	1.5	121
Marngoneet Correctional Centre (Karreenga)	1	859	6	0.5	3	69
Melbourne Assessment Prison	1	256	3	1	3	2
Metropolitan Remand Centre	1	883	6	1	6	25
Port Phillip Prison	1	1087	7	0.3	2.1	21
Ravenhall Correctional Centre	1	1000	7	0.3	2.1	27
Tarrengower Prison (Women)	1	72	2	0.3	0.6	147

* Prison capacity sourced from Corrections Victoria website as at 12 August 2019.

Table 9: Inspecting police custody in Victoria, estimated duration and frequency

	Number of facilities	Number of people detained* (maximum capacity)	Average number of days required to inspect each facility (three experts)	Inspection frequency (1 = annually)	Number of inspection days per year	Kilometres from Melbourne CBD
POLICE CUSTODY	**23**	**390**			**7.6**	
Bairnsdale	1	11	1	0.3	0.3	282
Ballarat	1	30	1	0.3	0.3	115
Bendigo	1	18	1	0.3	0.3	151
Broadmeadows	1	11	1	0.3	0.3	18
Dandenong	1	22	1	0.3	0.3	36
Frankston	1	16	1	0.3	0.3	54
Geelong	1	21	1	0.3	0.3	74
Heidelberg	1	18	1	0.3	0.3	15
Knox	1	8	1	0.3	0.3	40
Melbourne Custody Centre (G4S)	1	67	2	0.5	1	1
Melton	1	16	1	0.3	0.3	46
Mildura	1	16	1	0.3	0.3	546
Mill Park	1	10	1	0.3	0.3	38
Moonee Ponds	1	9	1	0.3	0.3	8
Moorabbin (G4S)	1	14	1	0.3	0.3	19
Morwell	1	14	1	0.3	0.3	150
Ringwood (G4S)	1	17	1	0.3	0.3	29
Shepparton	1	10	1	0.3	0.3	190
St Kilda	1	10	1	0.3	0.3	8
Sunshine	1	12	1	0.3	0.3	14
Wangaratta	1	16	1	0.3	0.3	251
Warrnambool	1	10	1	0.3	0.3	258
Wodonga	1	14	1	0.3	0.3	323

* Police custody capacity sourced from *Update on conditions in Victoria Police cells* report by the then Office of Police Integrity (2010).

Table 10: Inspecting designated mental health facilities in Victoria, estimated duration and frequency

	Number of facilities	Number of people in mental health beds* (maximum capacity)	Average number of days required to inspect each facility (three experts)	Inspection frequency (1 = annually)	Number of inspection days per year	Kilometres from Melbourne CBD
MENTAL HEALTH	**32**	**1,144**			**30**	
Albury Wodonga Health	2	**44**	1	1	1	
Albury (adult)		24				327
Wangaratta (adult)		15				251
Wangaratta (aged)		5				
Alfred Health	2	**69**	2	1	2	
Alfred Hospital (adult)		54				5
Caulfield General (aged)		15				12
Austin Health	1	**42**	1	1	1	
Austin Hospital (adult)		19				16
Austin Hospital (youth and adolescent)		11				
Austin Hospital (child)		12				
Ballarat Health Services	1	**35**	1	1	1	
Ballarat (adult)		23				117
Ballarat (aged)		10				
Ballarat (youth and adolescent)		2				
Barwon Health	1	**34**	1	1	1	
Geelong (adult)		28				77
Geelong (aged)		6				
Bendigo Health Care Group	1	**55**	2	1	2	
Bendigo (adult)		35				154
Bendigo (aged)		20				
Eastern Health	3	**117**	3	1	3	
Box Hill (adult)		25				20
Box Hill (youth and adolescent)		12				
Maroondah (adult)		50				31
Peter James Centre (aged)		30				28
Goulburn Valley Health	1	**20**	1	1	1	
Shepparton (adult)		15				193
Shepparton (aged)		5				
Latrobe Health	1	**41**	1	1	1	
Latrobe (adult)		29				158
Latrobe (aged)		10				
Latrobe (youth and adolescent)		2				
Melbourne Health	6	**195**	3	1	3	
Royal Melbourne (adult)		25				2
Sunshine (adult)		25				24
Sunshine (aged)		20				
Broadmeadows (adult)		25				18
Broadmeadows (aged)		19				
Bundoora Extended Care (aged)		15				18
Northern (adult)		50				35
Western - Orygen Youth (youth and adolescent)		16				6

Mercy Health	2	**54**	**2**	**1**	**2**	
Werribee (adult)		38				29
Ursula Frayne Centre (adult)		16				9
Monash Health	4	**169**	**3**	**1**	**3**	
Monash (adult)		31				25
Monash (youth and adolescent)		15				
Monash (child)		8				
Dandenong (adult)		50				35
Dandenong (aged)		20				
Casey (adult)		25				48
Kingston Centre (aged)		20				25
Mildura Health	1	**14**	**1**	**1**	**1**	
Mildura Base Hospital (adult)		10				546
Mildura (aged)		2				
Mildura (youth and adolescent)		2				
Peninsula Health	1	**44**	**1**	**1**	**1**	
Frankston (adult)		29				56
Frankston (aged)		15				
South West Healthcare	1	**15**	**1**	**1**	**1**	
Warrnambool (adult)		10				258
Warrnambool (aged)		5				
St Vincent's Hospital (Melbourne) Limited	2	**64**	**2**	**1**	**2**	
St Vincent's (adult)		44				2
St Georges Health (aged)		20				10
The Royal Children's Hospital	1	**16**	**1**	**1**	**1**	
Royal Children's (youth and adolescent)		16				5
The Victorian Institute of Forensic Mental Health (Thomas Embling)	1	**116**	**3**	**1**	**3**	
Thomas Embling		116				7

* Mental health capacity sourced from Ambulance Victoria's Retrieval and Critical Health Information System as at 12 August 2019. It is noted that not all patients are 'detained'. This table represents capacity. This estimate could be refined with MHCC and the Public Advocate.

Table 11: Inspecting child and youth facilities in Victoria, estimated duration and frequency

	Number of facilities	Number of people detained* (maximum capacity)	Average number of days required to inspect each facility (three experts)	Inspection frequency (1 = annually)	Number of inspection days per year	Kilometres from Melbourne CBD
CHILD AND YOUTH	**4**	**277**			**8**	
Parkville Youth Justice Precinct	1	123	3	1	3	6
Malmsbury Youth Justice Precinct	1	134	3	1	3	97
Secure Welfare - Maribyrnong	1	10	1	1	1	10
Secure Welfare - Ascot Vale	1	10	1	1	1	7

* Victorian Ombudsman: *Investigation of allegations referred by Parliament's Legal and Social Issues Committee, arising from its inquiry into youth justice centres in Victoria* (September 2018); Department of Health and Human Services.

Table 12: Inspecting DFATS in Victoria, estimated duration and frequency

	Number of facilities	Number of people detained* (maximum capacity)	Average number of days required to inspect each facility (three experts)	Inspection frequency (1 = annually)	Number of inspection days per year	Kilometres from Melbourne CBD
DISABILITY	**1**	**14**			**1**	
The Disability Forensic Assessment and Treatment Service	1	14	1	1	1	7

* Although the capacity of DFATS is 14, people may be detained in other Disability Residential Services pursuant to the Disability Act 2006. For example, during the Ombudsman's first OPCAT investigation in November 2017 there were 39 people detained in Disability Services under Supervised Treatment Orders or Compulsory Treatment under Part 8, Division 1 of the Act.

Table 13: Estimated total inspection days per year, and number of inspectors

	Number of potential facilities	Possible number of people detained in Victoria	Number of inspection days per year
SUBTOTAL	**71**	**10,380**	**77**
Add: Allocation for ad hoc inspections			38.5
TOTAL (for a team of three)			116
Total inspection days			346.5
Maximum allowable days per inspector*			30
Required no. of inspectors			11.6

*The Norwegian NPM comprises 8 inspectors and conducts 30 inspection days per year. Approximately 9% of each inspector's time is spent inspecting.

Part Two:

Inspection Report

Chapter One:

Background and methodology

A thematic inspection

307. Following her 2017 report about OPCAT, the Ombudsman decided to conduct a second own motion investigation, in light of her investigative human rights function and to further contribute to discussions about OPCAT's implementation in Victoria.

308. In deciding to conduct this investigation, the Ombudsman noted the ratification of OPCAT is an important symbol of Australia's commitment to human rights and community safety, and its implementation in Victoria is equally important in ensuring that commitment is not merely symbolic.

309. As an alternative to facility-based inspections, inspection bodies in other jurisdictions regularly publish thematic inspection reports. A 'thematic' inspection focuses on one issue (or theme) across multiple sites, examining different institutional responses to the same emerging issue.

310. This chapter provides background and context to the inspection reports set out in the following chapters. It explores why the Ombudsman chose to investigate practices related to solitary confinement, how the three facilities were selected, and the practical methodology used to conduct the inspections.

Why investigate the theme of solitary confinement?

311. During the first OPCAT-style investigation, Ombudsman delegates met with a number of external stakeholders and in a meeting with the Mental Health Legal Centre concerns were raised about mental health services in Victoria, and in particular, the use of seclusion of clients with autism spectrum disorders in closed psychiatric wards.

312. Similarly, in November 2017, the Public Advocate wrote to the Ombudsman expressing her concerns about the treatment of people in the disability sector. The Public Advocate requested that the Ombudsman conduct an OPCAT-style inspection of a disability facility citing a number of areas of concern, including the use of seclusion.

313. In September 2018, the Ombudsman received a request from Jesuit Social Services to investigate the use of isolation in Victorian prisons. This request followed the Jesuit Social Services' report on young adults in the justice system and their experience of isolation, *All Alone: Young adults in the Victorian justice system*.

314. The use of isolation cells was also considered in the context of litigation in 2016-17 following the establishment of the Grevillea Youth Justice and Remand Centre at Barwon Prison. In that case, Justice Garde in the Supreme Court found 'evidence that one or more young persons have, or may have, been subject to a breach of s 10(b) [of the Human Rights Act] by reason of the harsh conditions at the Grevillea unit … including very long periods of solitary and prolonged confinement of young people in cells formerly used for high security adult prisoners' and 'uncertainty as to the length and occurrence of lockdowns…'

315. The UN's Special Rapporteurs on Torture, Manfred Nowak and Juan Méndez, have both repeatedly stated that prolonged solitary confinement is cruel, inhuman or degrading treatment, and may amount to torture. Reports of the Special Rapporteurs to the UN General Assembly have led the UN to include long-term to indefinite solitary confinement in the group of practices that violate the Universal Declaration of Human Rights (Article 5), the International Covenant on Civil and Political Rights (Article 7) and the Convention Against Torture (Article 1.1 and Article 16).

What is 'solitary confinement'?

316. The Association for the Prevention of Torture (APT) identifies several practices of detaining authorities that increase the risk of torture and ill-treatment. 'Solitary confinement' is at the top of the list.

317. In 2007, a working group of 24 experts at the International Psychological Trauma Symposium in Istanbul adopted a statement (**Istanbul Statement**) on the use and effects of solitary confinement, calling for the practice to be limited to only very exceptional cases, for as short a time as possible, and only as a last resort. The Istanbul Statement described solitary confinement as:

> the physical isolation of individuals who are confined to their cells for twenty-two to twenty-four hours a day. In many jurisdictions prisoners are allowed out of their cells for one hour of solitary exercise. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, are generally monotonous, and are often not empathetic.

318. Solitary confinement is described in the UN Standard Minimum Rules for the Treatment of Prisoners (**Mandela Rules**) as the physical isolation of individuals 'for 22 or more hours a day without meaningful human contact'.

319. Although most obvious in correctional settings, 'solitary confinement' can occur in many closed environments in Victoria, including youth justice, disability and mental health settings.

320. The term 'solitary confinement' is not used in Victorian legislation. Instead, practices are described as 'isolation' under the *Children, Youth and Families Act 2005* (Vic), 'seclusion' under the *Mental Health Act 2014* (Vic), 'restrictive intervention (seclusion)' under the *Disability Act 2006* (Vic) and 'separation' under the *Corrections Regulations 2019* (Vic).

321. While the practice of isolation, seclusion and separation each have distinct requirements, all may have the same effect – people deprived of their liberty are detained alone. Each practice could amount to 'solitary confinement' where there is an inherent risk that cruel, inhuman or degrading treatment or torture may occur.

322. The use of separation was considered in the Ombudsman's 2017 inspection of DPFC where she commented on the impacts of solitary confinement on mental health. In consultation with civil society, the investigation heard that the use of prolonged solitary confinement is an issue of concern across the prison system in Victoria.

323. In its response to the Ombudsman's draft report in 2017, the Department of Justice and Regulation (as it was then) advised that it does not use the term 'solitary confinement' but 'separation regimes':

> A variety of regimes and privileges exist to provide a range of conditions necessary to maintain the security, safety and management requirements of the individual prisoner and the prison system. Prisoners are managed under the least restrictive conditions consistent with the reasons for placement.

324. In her final report, the Ombudsman concluded that long-term separation in an environment such as the Management Unit at DPFC may amount to treatment that is cruel, inhuman or degrading under the Human Rights Act and is incompatible with the Mandela Rules.

325. According to Special Rapporteur Nils Melzer, solitary confinement may amount to torture where it is intentionally inflicted for a prohibited purpose and causes severe mental or physical pain or suffering. 'Prohibited purpose' includes punishment and intimidation.

326. It is widely recognised that isolation can have serious deleterious effects on mental and physical health. Dr Sharon Shalev, an expert on the impact of solitary confinement, has observed the common psychological effects of isolation to be:

- anxiety, ranging from feelings of tension to panic attacks
- depression, ranging from feelings of hopelessness and social withdrawal to clinical depression
- anger, ranging from irritability to rage
- cognitive disturbances such as poor concentration, confusion and disorientation
- perceptual distortions, including hypersensitivity to noise and smells as well as hallucinations
- paranoia and psychosis, ranging from obsessional thoughts to psychotic episodes.[4]

4 Sharon Shalev, *A Sourcebook on Solitary Confinement* (Mannheim Centre for Criminology, 2008) 15–17.

327. Shalev considers:

> the lack of access to fresh air and sunlight and long periods of inactivity are likely also to have physical consequences.[5]

Frequently observed physiological effects of isolation include insomnia, deterioration of eyesight, heart palpitations, back and joint pain, weight loss, self-harm; or suicide.[6]

328. It is also well recognised that the physical and psychological risks increase exponentially after 15 days of consecutive solitary confinement.[7] At this point, Special Rapporteur Méndez noted, 'some of the harmful psychological effects of isolation can become irreversible.' This practice is called 'prolonged solitary confinement' and is prohibited under the Mandela Rules.

329. The risk of harm is significant where there is little oversight and where vulnerable people are isolated. Special Rapporteur Melzer noted in the 2018 interim report that vulnerability is often a reflection of 'power asymmetry, structural inequalities, ethnic divide and socioeconomic or sociocultural marginalization'.

Why focus on children and young people?

330. Children and young people are particularly vulnerable to the adverse impacts of solitary confinement.

331. Until around 25 years, people are developing physically, mentally, neurologically and socially.[8] Subjecting children and young people to isolation and solitary confinement during this crucial stage of development exposes them to serious risks of long-term psychiatric and developmental harm.[9]

332. The Mandela Rules and other international rules encourage the prohibition of solitary confinement against children. In 2011, Special Rapporteur Méndez concluded the imposition of solitary confinement, of any duration, on juveniles is cruel, inhuman or degrading treatment.

333. Méndez recognised that children and young people require 'special safeguards and care', including legal protection.

5 Ibid.

6 Ibid; Jesuit Social Services, All Alone: Young adults in the Victorian justice system (Report, 2018) 22–23; Stefan Enggist et al (eds), Prisons and Health (World Health Organisation, 2014) 27–30.

7 Juan E Méndez, Special Rapporteur, Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, GA Res 65/205, UN GAOR, 66th sess, Agenda Item 69(b), UN Doc A/66/268 (5 August 2011) [26], [58], [61], [76], [79], [88]; Sharon Shalev, A Sourcebook on Solitary Confinement (Mannheim Centre for Criminology, 2008) 21.

8 National Children's Commissioner, Australian Human Rights Commission, Children's Rights Report 2016 (Report, 2016) 186; Commons Select Committee – Justice (UK) Parliamentary Inquiry into the Treatment of Young Adults in the Criminal Justice System (2016). <https://publications.parliament.uk/pa/cm201617/cmselect/cmjust/169/16909.htm#_idTextAnchor060>.

9 Stuart Grassian, 'Psychological Effects of Solitary Confinement' (1983) 140 American Journal of Psychiatry 332; Juan E Méndez, Special Rapporteur, Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, GA Res 65/205, UN GAOR, 66th sess, Agenda Item 69(b), UN Doc A/66/268 (5 August 2011) [64]–[66], [79]; British Medical Association, Royal College of Paediatrics and Child Health and the Royal College of Psychiatrists, Joint position statement on solitary confinement of children and young people (2018) 1; Laura Dimon, 'How solitary confinement hurts the teenage brain' (2014) The Atlantic <https://www.theatlantic.com/health/archive/2014/06/how-solitary-confinement-hurts-the-teenage-brain/373002/>.

334. Their vulnerability is exacerbated when they are deprived of liberty. This heightens the risk of depression, anxiety, psychological trauma or cognitive developmental issues. Shalev considered the comparative experience of young people to adults in closed environments and commented:

> It does not require a great leap of imagination to reach the conclusion that for vulnerable people including those with intellectual or mental disabilities or young people, who have often had difficult and troubled lives, the experience of being in solitary confinement in prison is likely to be significantly more traumatic and damaging.[10]

335. Although the same justifications for prohibiting solitary confinement of children apply to young people aged 18 to 24, this cohort has no statutory protections. Their needs are only implicitly recognised through the existence of dedicated youth units in some adult prisons. These young people are subjected to the same isolation practices as adults, while the risk of long-term serious pain or suffering is higher.

Solitary confinement and human rights

336. As described above, practices related to solitary confinement engage several human rights protected at international law. Protection of human rights is further articulated in Victoria through the Human Rights Act. Importantly, the Human Rights Act operates in addition to other rights and freedoms that arise or are recognised under any other law, including international law.

337. It enshrines rights to humane treatment and dignity for people deprived of liberty and to protection from torture and cruel, inhuman or degrading treatment (sections 10 and 22). It also enshrines specific rights for people detained without charge, providing they must be treated in a way that is appropriate for a person who has not been convicted (section 22(3)).

338. Children also have specific rights to such protection – in their best interests, to be segregated from adults in detention and when convicted of an offence, to be treated in a way that is appropriate to their age (sections 17(2) and 23).

10 Sharon Shalev, 'Solitary Confinement is No Place for Children' (6 February 2019) Probono Australia <https://probonoaustralia.com.au/news/2019/02/solitary-confinement-no-place-children/>.

Methodology

339. Drawing on the experience of NPMs in other jurisdictions, the Ombudsman established an Advisory Group comprised of Victorian oversight bodies and civil society organisations with experience in areas that are important to preventive monitoring to assist her investigation.

The OPCAT Advisory Group

340. As noted in paragraph 34, the Advisory Group included the heads of relevant statutory authorities as well as representatives of civil society.

341. The Advisory Group met for the first time on 14 December 2018 and agreed on the following terms of reference:

> In the spirit of collaboration, while also recognising the independent role of the Ombudsman, the Ombudsman is seeking the expert assistance of oversight bodies and civil society organisations or individuals who play a role in Victoria in dealing with the treatment of vulnerable members of the Victorian community in closed environments – to be known as the 'OPCAT Advisory Group'.
>
> The purpose of the group is to:
>
> 1. inform and advise the Ombudsman's investigation on potential inspection locations and practices relating to the use of solitary confinement of children and young people in Victoria
> 2. provide a forum to discuss OPCAT's implementation in Victoria more broadly.

342. When the Advisory Group's terms of reference were discussed and agreed, the Ombudsman made clear that her purpose was not to seek consensus; ultimately the report and recommendations would be hers alone, enriched as they would be by the diverse views of members. Ultimately however there was strong consensus among the Group for the findings of the inspections. Some members endorsed the recommendations fully, others in part, and some did not comment.

343. Following the inspections, the Advisory Group was also assisted by Director of Legal at IBAC. Throughout the investigation, the Advisory Group met five times:

Date	Topic of discussion
14 Dec 2018	Potential inspection locations
22 Feb 2019	Methodology and inspection team
11 Apr 2019	Preliminary observations and feedback on the inspections
30 May 2019	Potential NPM models for Victoria
3 Jul 2019	Improvement

Selecting the three facilities to inspect

344. At the first Advisory Group meeting, the Ombudsman put forward a proposal to inspect Port Phillip Prison, Parkville Youth Justice Precinct and the Secure Welfare Services at Ascot Vale and Maribyrnong. The Advisory Group supported the inclusion of three distinct systems and suggested the Melbourne Assessment Prison and Malmsbury Youth Justice Precinct as alternates to Port Phillip and Parkville.

Deciding between Port Phillip Prison and the Melbourne Assessment Prison

345. In deciding to inspect Port Phillip over the Assessment Prison, the Ombudsman noted that private providers will be an important part of the landscape for NPMs across Australia in all sectors, from immigration detention and prisons, to the disability sector. Inspecting privately run facilities may pose different challenges from the public sector, which would be worth exploring.

346. The Ombudsman also considered that an inspection of Port Phillip could compare whether there is a difference between treatment of young people held in the prison's dedicated youth unit and those held in mainstream areas of the prison.

347. Finally, the Ombudsman noted that as at 30 June 2018, there were considerably more young people at Port Phillip (177) than at the Assessment Prison (35).

Deciding between Malmsbury and Parkville Youth Justice Precincts

348. In deciding to inspect Malmsbury over Parkville, the Ombudsman noted the concerns expressed by the Commissioner for Children and Young People and the Commissioner for Aboriginal Children and Young People about the use of solitary confinement at Malmsbury, particularly in relation to Aboriginal young people.

349. The overrepresentation of Aboriginal and Torres Strait Islander peoples in closed environments is a major issue across all States and Territories, and their experiences should be a priority for all future Australian NPMs. The Ombudsman therefore considered it appropriate to choose a facility where greater concerns in relation to use of solitary confinement and Aboriginal people have been identified.

Preparing for the inspections

350. To prepare for the inspections, Ombudsman officers researched and consulted with international OPCAT experts, including existing NPMs and civil society organisations. This research and engagement was critical in designing an appropriate inspection methodology involving children and young people.

351. Ombudsman officers engaged directly with:

- Association for the Prevention of Torture, Ben Buckland, Independent Oversight Adviser
- Norwegian Ombudsman Office, Helga Fastrup Ervik, Head of the NPM and Mette Jansen Wannerstedt, Senior Adviser
- Her Majesty's Inspectorate of Prisons, Angus Mulready-Jones, Lead Inspector for facilities detaining children and young people
- Georgian Ombudsman Office, Nika Kvaratskhelia, Head of the NPM and his Deputy, Akaki Kukhaleishvili
- Danish Ombudsman Office, Erik Dorph Sørensen, Head of Division and Morten Engberg, Manager
- New Zealand Ombudsman Office, Emma Leach, Assistant Ombudsman, Jacki Jones, Chief Inspector and Ruth Nichols, Principal Adviser (OPCAT)
- New Zealand Children's Commission, Sarah Hayward, Principal Advisor, Monitoring and Investigations.

352. The Ombudsman received helpful information about areas of concern in Victoria from Victorian Legal Aid, the Centre for Excellence in Child and Family Welfare and Centre for Multicultural Youth.

353. The Ombudsman also engaged two law-student interns from the University of Melbourne to research:

- the legal and policy framework for practices related to solitary confinement across adult prisons, youth justice and secure welfare
- international and local standards and laws relating to the detention and solitary confinement of children and young people

- methodologies for inspecting closed environments where children and young people are detained, especially those used by NPMs or inspection bodies
- relevant recommendations from other reviews, inquiries and investigations.

Establishing a multi-disciplinary, multi-agency inspection team

354. OPCAT requires NPMs to have appropriate capabilities and professional knowledge, to strive for gender diversity and adequate representation of ethnic and minority groups.

355. The Ombudsman sought to assemble a multi-disciplinary inspection team with expertise in key areas impacting children and young people. These included capabilities in engaging children and young people, as well as professional expertise in youth justice, Aboriginal and Torres Strait Islander interests and well-being, mental health, disability, child protection, human rights and OPCAT-style inspections.

356. The inspection team comprised the following 14 officers:

    - five Victorian Ombudsman officers, including investigators with expertise in human rights, youth justice, child protection and prison inspections – two of whom were the Inspection Lead and Inspection Coordinator
    - four senior employees from the Commission for Children and Young People (two of whom worked with the Commissioner for Aboriginal Children and Young People) with expertise in youth justice, working with children and young people from culturally diverse backgrounds and Aboriginal and Torres Strait Islander well-being
    - the Deputy Mental Health Complaints Commissioner
    - a Senior Lawyer within the Aboriginal and Torres Strait Islander Rights Unit of the Human Rights Law Centre with a background in young people in conflict with the law
    - the Senior Practitioner and qualified psychiatric nurse from the ACT Community Services Directorate
    - an Advocacy and Guardianship expert for young people with disabilities from the Office of the Public Advocate
    - the Lead Inspector for facilities detaining children and young people from Her Majesty's Inspectorate of Prisons in the UK.

357. All external members of the inspection team were sworn in as members of Ombudsman staff within the meaning of the Ombudsman Act. Each received delegated powers and authorisation of entry and inspection. As members of Ombudsman staff, the inspection team had the legal protections under the Ombudsman Act and were subject to strict confidentiality obligations. Potential conflicts of interest were declared and managed by the Ombudsman.

358. The inspections were organised to ensure members of the team were able to inspect the locations and issues within their area of expertise. For example, at Port Phillip, it was important to allow the mental health expert to inspect the St Paul's Psycho-Social Unit, and the disability expert to inspect Marlborough Unit accommodating people with intellectual disabilities. The meticulous pre-inspection planning and setting out which member of the inspection team would go where and when was balanced with the necessary flexibility to adapt to changing circumstances on the ground.

Pre-inspection training

359. To ensure that the inspection methodology and approach was informed about the potential impact of trauma, the Ombudsman engaged expert consultants Dr Jenny Dwyer and Sue-Anne Hunter to provide tailored training for the inspection team.

360. The training provided an overview of the impacts of trauma on children and young people, considered the needs of Aboriginal children and young people, explored strategies for ensuring psychological and cultural safety during the inspections and considered the potential impact of trauma on the inspection team themselves.

361. The training also provided a forum for the team to share knowledge, resources and experiences before the inspections began.

Inspection tools

362. Ombudsman staff developed several tools to assist the inspection, including aide-memoires (inspection prompts), conversation guides, surveys and a list of relevant international standards.

363. The aide-memoires focused on solitary confinement and incorporated standards from:

- the Human Rights Act
- the legislative and policy framework surrounding isolation in each of the respective facilities; and
- international instruments such as the Mandela Rules and the *United Nations Rules for the Protection of Juveniles Deprived of their Liberty* (**Havana Rules**).

364. On 15 February 2019, the Ombudsman hosted a workshop to refine the draft inspection tools and methodology with staff from organisations represented on the Advisory Group.

365. The proposed inspection methodology and tools were also presented to the full Advisory Group on 22 February 2019 where final feedback was incorporated.

Obtaining information from children and young people

366. Section 17(3) of the Ombudsman Act provides that in the context of an investigation, the Ombudsman may obtain information from such persons and in such manner as she thinks fit.

367. Consistent with inspection methodologies from other jurisdictions, the Ombudsman surveyed detainees and staff about their experiences of practices related to solitary confinement. The surveys were voluntary and used as the basis for a broader conversation between detainees and members of the inspection team. Some people chose to complete the survey individually, while others preferred a group conversation.

368. Surveys were tailored to each facility and the different ways that people could be isolated. As far as possible, the questions were broadly kept the same to allow for later comparison.

369. On the recommendation of the Advisory Group, the Ombudsman avoided leaving hard copy surveys with children and young people where possible. Instead, the inspection used tablet devices and an app that would work offline to administer the survey.

370. Staff were invited to complete their survey online or in hard copy.

Announcing the inspections

371. NPMs can conduct both unannounced and announced inspections under OPCAT, and many do both. For practical reasons, the Ombudsman chose to announce her inspection.

372. The Ombudsman notified the relevant Ministers and departmental Secretaries of her intention to conduct this 'own motion' investigation on 30 November 2018. A public statement was released on 6 December 2018 (it did not include any information about which facilities would be inspected or the proposed timing).

373. Four weeks before each inspection, in late February and early March 2019, Ombudsman staff met with the management of each facility to announce the site for the OPCAT-style inspection. They explained that the purpose of the inspection was preventive, rather than an investigation into specific allegations. They also discussed the practical arrangements and requested preliminary information.

374. Posters were provided to each facility before the inspection to raise awareness among staff, children, young people and visitors. The posters described when the inspection would occur, who would be involved and why it was happening.

Safeguards for children and young people

375. Before the inspection, Ombudsman staff consulted with community and support-service stakeholders about how to support children and young people before, during and after the inspection.

376. Children and young people were always told that their participation was voluntary, and they could terminate the conversation at any point. Moreover, their participation depended on their informed consent.

377. In addition, all children and young people were given the opportunity to have a support person present while talking with the inspection team if they wished, including for example, an Aboriginal or Multicultural Liaison Officer, staff from Parkville College or a friend.

Triangulation of evidence

378. The investigation drew on a wide range of sources including the inspection team's observations, survey data, information provided by the facilities, documents collected during inspections and anecdotal evidence collected through conversations with children, young people and staff at the three facilities.

379. The Department of Justice and Community Safety (**DJCS**), the Department of Health and Human Services (**DHHS**) and the three facilities responded promptly to requests for information. The Ombudsman acknowledges the significant time and resources required to compile this information.

The following chapters

380. The following chapters detail the inspections of Port Phillip Prison (Chapter Two), Malmsbury Youth Justice Precinct (Chapter Three) and the Secure Welfare Services at Ascot Vale and Maribyrnong (Chapter Four). Chapter Five compares the three facilities.

381. Each chapter is structured according to the APT's six recommended areas for detention monitoring, with the standard section on 'purposeful activity' focussing on 'meaningful human contact'. Each chapter also includes an additional section on diversity, which addresses the issues affecting particular groups of children and young people at the facilities. The sections covered by each chapter are:

    - humane treatment
    - protective measures
    - material conditions
    - meaningful human contact
    - health and wellbeing
    - diversity
    - staff.

382. The chapters set out the inspection team's observations regarding each facility and identify risks that increase the potential for torture and other cruel, inhuman or degrading treatment – ill-treatment to occur at the facilities.

383. The Ombudsman notes that many of the risks and protective measures identified within the three facilities may well exist more broadly in Victoria across other facilities.

Chapter Two:

Inspection of Port Phillip Prison

About Port Phillip Prison

384. Port Phillip is a maximum security adult men's prison located in Truganina, approximately 22km west of Melbourne. It is one of three maximum-security men's prisons operating in Victoria, and currently accommodates both sentenced and remand prisoners.

385. Port Phillip commenced receiving prisoners in September 1997, with an original design capacity for 577 prisoners. The operational capacity of the prison has since expanded to 1,087 prisoners.

386. Port Phillip has a total of 14 'mainstream' accommodation units. These include:

- a 35-bed unit for young people (Penhyn)
- a unit for prisoners with intellectual disability (Marlborough)
- a psychosocial rehabilitation unit (St Paul's)
- a management unit (Charlotte)
- two 'step-down' management units (Borrowdale and Alexander South).

387. The facility also includes four 'protection' units (Alexander North, Sirius East, Sirius West A and Sirius West B) and a subacute healthcare unit (St John's).

388. Port Phillip is managed and operated by G4S Custodial Services Pty Ltd (G4S) pursuant to a correctional services agreement with the State of Victoria.

Table 1: Capacity of Port Phillip Prison	
Mainstream prisoner accommodation	**Capacity**
Fishburn	118
Gorgan	70
Matilda	118
Salamander	71
Scarborough North	65
Scarborough South	71
Swallow	70
Waaksembyd	70
Borrowdale — (Step-down Management Regime)	34
Alexander South — (Step-down Management Regime)	75
Marlborough — (Intellectually disabled prisoners)	35
Penhyn — (Young Offenders' Unit)	35
St Paul's — (Psychosocial Rehabilitation Unit)	30
Charlotte — (Management Unit)	35
Protection prisoner accommodation	
Alexander North	75
Sirius East (Protection Management Unit)	24
Sirius West A	51
Sirius West B	40
Total capacity	**1,087**

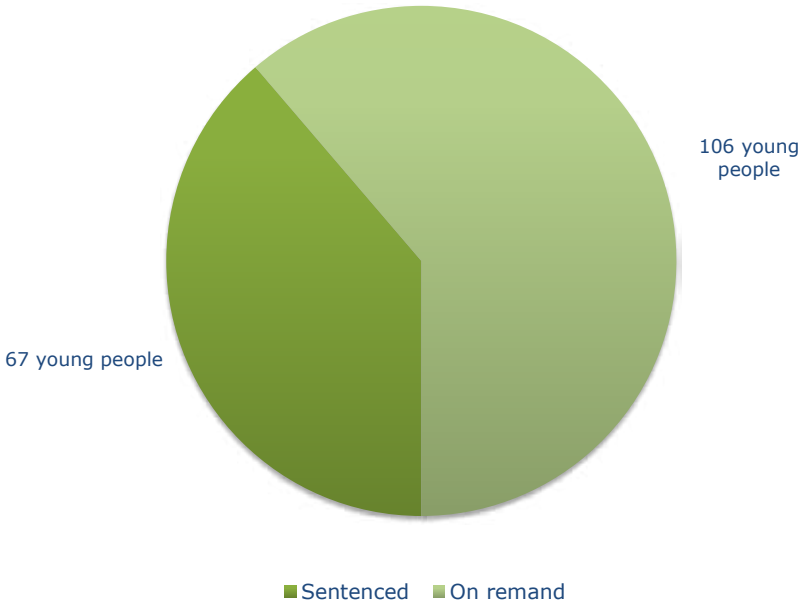
Young people accommodated at Port Phillip

389. As at 25 February 2019, there were a total of 173 persons aged between 18 and 24 years accommodated across the various units at Port Phillip.

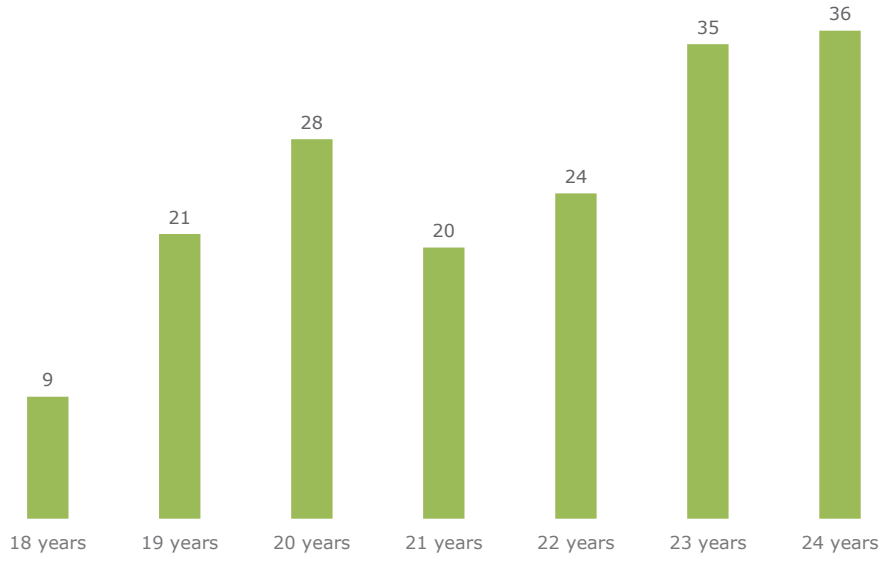
390. Although Port Phillip may in some circumstances receive children aged 16 and over, there were no children accommodated in the facility on this date.[11]

11 Children aged 16 and over may be transferred from a youth justice centre to a prison by direction of the Youth Parole Board pursuant to section 467(1) of the *Children Youth and Families Act 2005* (Vic).

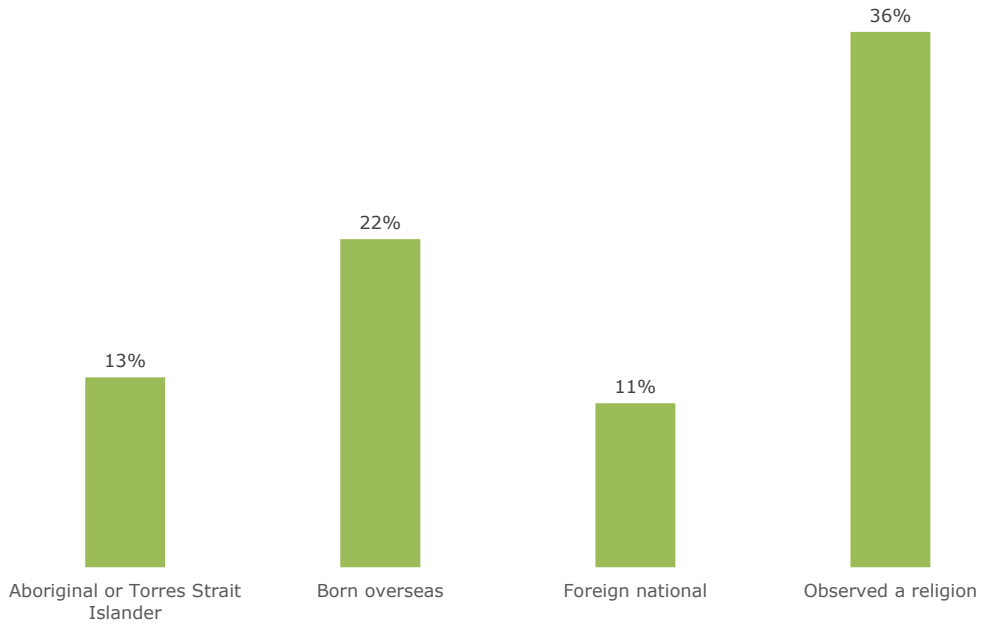
Young people in Port Phillip by status (25 Feb 2019)



Young people in Port Phillip by age (25 Feb 2019)



Young people in Port Phillip demographics (25 Feb 2019)



The inspection

391. On 25 February 2019, the Inspection Coordinator, Inspection Lead and other Ombudsman officers met with the then General Manager to advise of the Ombudsman's OPCAT-style inspection the following month. They explained that the purpose of the inspection was preventive rather than an investigation into specific allegations, discussed the practical arrangements, and requested preliminary information.

392. The Ombudsman sought copies of relevant registers and other operational information for the period from 25 February 2018 to 25 February 2019 (the day the inspection was announced). Unless stated otherwise, the graphs set out in this chapter were generated from data from this reporting period (**the 12-month reporting period**). Additional information was obtained during and after the inspection.

393. The inspection of Port Phillip was conducted over five days, from Wednesday 20 March to Sunday 24 March 2019.

394. The inspection met with the General Manager on the first morning of the inspection and then attended a briefing on the facility's security protocols.

395. Port Phillip made keys and radios available to each Area Inspection Lead, allowing full and unescorted access to the prison's units.

396. Port Phillip also allocated an administration room to the team to use as a base throughout the inspection.

397. A list of young people accommodated in the facility and their locations was provided to the inspection and updated each morning.

398. At commencement of the inspection there were a total of 168 young people accommodated in Port Phillip. Twenty-three were accommodated in Penhyn Unit, with the remaining 145 young people dispersed throughout the rest of the facility.

399. The inspection observed that Port Phillip was in a state of lockdown during the first afternoon of the inspection. The inspection was informed that the facility would enter a lockdown on most Wednesday afternoons to allow prison officers to attend staff training.

400. During the first afternoon, the inspection split into groups and visited the different units, introducing themselves to the young people accommodated in the facility and describing the purpose of the inspection. Owing to the lockdown, it was necessary to communicate with some young people through the traps in their cell doors. The assistance of unit staff was required to unlock the traps.

401. The inspection spent the following days visiting each unit of the facility to administer the survey with the young people who wished to participate in the process.

402. The inspection completed the survey with a total of 52 young people, a response rate of 31 per cent. Forty-four respondents used a tablet device and eight respondents requested to complete the survey using pen and paper.

403. The inspection also observed the activities around the prison and spoke with staff, young people and older prisoners.

404. The staff survey was distributed by email at the end of the first day. The next day the inspection was informed that a number of unit staff were unable to access the survey owing to restrictions on internet access within the facility. The inspection subsequently arranged to leave paper copies of the survey at each unit on the final day of the inspection.

405. During the second day, the General Manager contacted the Inspection Coordinator to express his concern about the staff survey, requesting it be withdrawn or modified. The inspection declined this request.

406. The inspection received 68 responses to the staff survey, an engagement rate of approximately 10 per cent. Forty-five respondents completed the survey online and 13 respondents returned a paper survey.

407. On the final day of the inspection, the Inspection Coordinator and Area Inspection Leads met with the General Manager to provide preliminary feedback about the inspection's observations.

The following sections

408. Throughout this chapter, the experiences of young people in some form of isolation are set out in case study narratives gathered from individual's files. For privacy, the names in this report are not the real names of the individuals involved.

409. The chapter sets out the inspection's observations of Port Phillip and, in particular, the practices that may lead or amount to the solitary confinement of young people. In doing so, the investigation identifies the risks that increase the potential for torture and other cruel, inhuman or degrading treatment at the facility, and protective measures that can help to reduce those risks.

Humane treatment

410. The inspection identified several practices at Port Phillip which had the potential to lead or amount to the solitary confinement of children and young people, namely:

    - separation orders made under the *Corrections Regulations 2019* (Vic) (*or the Corrections Regulations 2009* (Vic) as they were at the time of the inspection)
    - prisoner lockdowns made under the facility's Violence Reduction Strategy (**VRS**)
    - unit and facility-wide lockdowns
    - the withdrawal of a prisoner's privileges to associate with other prisoners and to access full out-of-cell hours through the disciplinary process.

411. The inspection examined the legislative and policy frameworks applicable to each of these practices and sought to establish the rate and circumstances of their use at the prison.

412. It was observed that the separation of a prisoner under the Corrections Regulations had the greatest risk of leading to ill-treatment of young people at the facility.

413. In this regard, the inspection observed that the use of separation at Port Phillip almost invariably amounted to solitary confinement under the Mandela Rules.

414. The inspection observed that it was not uncommon for young people to be placed under separation at Port Phillip and was particularly concerned by the duration for which young people were being isolated as a result of separation orders at the facility.

415. The inspection observed that Port Phillip's practice of confining prisoners to their cells under its VRS also had the potential to lead to the solitary confinement. Although the use of this practice at Port Phillip did not always result in solitary confinement; it was not uncommon for lockdowns to reach this threshold.

416. Although young people did not appear to be regularly isolated for more than 22 hours per day at Port Phillip as the result of unit and facility lockdowns or through the disciplinary process, there was still the potential for solitary confinement to arise from the use of these practices.

417. Overall, the inspection considered that the rate and circumstances of isolation at Port Phillip, particularly arising from the use of separation orders, created a significant risk of ill-treatment.

Separation

418. Regulation 32(1) of the Corrections Regulations provides that the Secretary to the Department of Justice and Community Safety (DJCS) may order the separation of a prisoner from some or all other prisoners if he or she believes, on reasonable grounds, that the separation is necessary:

    - for the safety and protection of the prisoner
    - for the safety or welfare of any person
    - for the management, good order or security of the prison.[12]

419. According to Corrections Victoria's Sentence Management Manual (**the Manual**) the power to separate a prisoner is delegated to the General Manager, Operations Manager and Supervisor of a prison.

12 The *Corrections Regulations 2019* (Vic) commenced operation on 28 April 2019. During the period of the inspection, the power to separate a prisoner was conferred by regulation 27 of the *Corrections Regulations 2009* (Vic) (now superseded). Regulation 32 differs from the old regulation 27 in several ways. In particular, regulation 32 introduces a subjective element to the threshold.

420. The Regulations set out a number of requirements surrounding the practice of separation including:

- A separation order must be made in writing and the prisoner must be given a copy of the order and advised of the reasons for the separation.
- Where a prisoner is separated from other prisoners for their own safety or for the safety of another person, the amount of time that the prisoner is separated must not be longer than is necessary to achieve that purpose.
- Before making a separation order, the Secretary must consider any medical and psychiatric conditions of the prisoner.
- Since 28 April 2019, if proposing to separate a prisoner under the age of 18, the Secretary must also consider the prisoner's age, best interests and vulnerability, provided it is 'reasonably practicable' to do so.
- A separation order ceases in any of the following circumstances:
    - on expiration of the order
    - when the prisoner's classification is determined by a Sentence Management Panel
    - when the order is revoked by the Secretary.

421. A prisoner subject to a separation order will ordinarily be placed on an incentive-based separation regime, which, operates to restrict the prisoner's out-of-cell hours and the exercise of various other freedoms.

422. This notwithstanding, section 47 of the *Corrections Act 1986* (Vic) provides that every prisoner has the right to be in the open air for at least one hour per day, weather permitting.

423. The inspection observed a very high rate of separation at Port Phillip.

424. The prison's dedicated Management Unit 'Charlotte' was observed to be at or near capacity throughout the period of the inspection. In addition, there were many prisoners separated to cells in the mainstream and step-down units. Several prisoners were also observed to be in separation in the medical units.

425. A senior officer at the facility informed the inspection that approximately 20 per cent of prisoners at Port Phillip were subject to a form of isolation, including separation, on any given day. This was consistent with the inspection's observations of the facility and with the data reviewed during and after the inspection.

426. Seventy-nine per cent of young people surveyed by the inspection reported that they had been placed in a form of isolation while at Port Phillip. Twenty-seven per cent reported being isolated 'pretty often' at Port Phillip.

427. A review of the separation orders implemented at Port Phillip established that a total of 265 young people were placed in separation within the 12-month reporting period — approximately 22 orders per month. There were no children placed in separation at Port Philip during this period.

428. This review established that young people were being separated at Port Phillip at a higher rate than other prisoners. Twenty-four per cent of all separation orders implemented in the 12-month period were made in respect of young people, despite young people accounting for less than 18 per cent of the prison population at time of the inspection.

429. In response to the Ombudsman's draft report DJCS advised that young people at Port Phillip were involved in almost 30 per cent of 'behavioural type incidents' in the 2018-19 financial year.

430. Young people accommodated in the dedicated Youth Unit, Penhyn, were significantly less likely to report experience of isolation than young people who were accommodated in the other units (50 per cent versus 91 per cent, respectively). The inspection noted, however, that separations from Penhyn Unit were not uncommon, and that young people often appeared to be transferred out of the youth unit following a period of separation.

431. Although the Corrections Regulations provide that a person placed in separation must be advised of the reasons for the separation, 15 per cent of the young people surveyed by the inspection reported that they did not usually know the reason why they were placed in a form of isolation at Port Phillip, and 31 per cent of respondents agreed with the statement, 'Sometimes I don't know the reason why I am kept alone by myself.'

432. In response to the Ombudsman's draft report, DJCS clarified that 'supervisors interview every separated prisoner as part of the separation process and have a conversation about the reasons for the separation. In most cases, a Sentence Management Panel will also discuss the separation with the prisoner, including the reasons for the separation.'

433. The perception of young people that they don't always know the reason for their separation may suggest that explanations provided by Supervisors or the Sentence Management Panel are not clear enough.

434. The inspection noted that most separation orders implemented at Port Phillip within the 12-month reporting period concerned an alleged assault at the prison.

435. Twenty per cent of separation orders alleged that the young person had committed an assault. A further 37 per cent of separations were made pending investigation into a young person's involvement in an alleged assault or were otherwise made in circumstances where the young person's alleged involvement was not identified.

436. Many of the separation orders reviewed by the inspection appeared at least somewhat punitive. Young people were often separated 'pending investigation' into incidents which had taken place hours or days earlier, in circumstances where, due to unit transfers or for other reasons, there appeared to be little ongoing risk of harm to others.

437. The inspection noted that the use of separation in such circumstances appeared contrary to rule 45(1) of the Mandela Rules, which require that solitary confinement be used only in exceptional cases and as a last resort.

Charlie

A member of staff looked up from her desk and observed 19-year-old Charlie, being pushed by an older prisoner. Before the staff member could intervene, Charlie's fellow prisoners stepped in and separated the pair.

The Unit Supervisor was informed of the incident and later spoke to Charlie and the older prisoner, who both said that it was just a bit of pushing and that the issue had been resolved. The Supervisor nevertheless arranged to view the CCTV footage and noted that the incident appeared more serious than first described.

The Supervisor spoke to Charlie again. Charlie disclosed that he had seen the older prisoner talking to himself. Charlie said that he asked the older prisoner if he was OK, but the older prisoner 'just exploded' and attacked him.

The Supervisor then spoke with the older prisoner. The older prisoner said that he thought that Charlie had been harassing him.

The Supervisor decided that the incident should be the subject of a disciplinary hearing, to be convened at a later date. Both Charlie and the older prisoner were then taken to their cells and placed in separation. Charlie was separated for four days in total – about 96 hours.

438. Despite this, observations by the inspection do not support the proposition that separations at Port Phillip are always for the minimum time necessary.

439. In many cases, the use of separation appeared to pre-empt the outcome of a disciplinary process, where it was not unusual for the allegations leading to separation to be dismissed.

440. In response to the Ombudsman's draft report, DJCS submitted that the observation above is not correct, and considered that prisoners are placed on a separated regime to manage risk pending a full review of related factors.

441. DJCS noted:

> separations are used as a tool to manage risk to the individual as well as the risk they might pose to others. Investigations must take place to ensure that these risks are mitigated, and the period of separation in these circumstances is for the minimum time necessary.

442. Geoff's story (later) demonstrates this is not the case.

443. Forty-six per of young people surveyed by the inspection believed that they had been isolated at Port Phillip as a form of punishment. This was also consistent with the perception of prison staff; 44 per cent of staff members surveyed by the inspection identified punishment as a common reason for a young person to be separated at Port Phillip.

444. The inspection noted that 11 per cent of separation orders resulted from the young person being the victim of an alleged assault. In total, 29 per cent of separation orders concerning young people were made for reasons relating to the young person's own safety.

Mubiru

Nineteen-year-old Mubiru was interviewed by prison staff after a potential weapon was found under his cellmate's mattress during a routine search.

Both Mubiru and his cellmate denied any knowledge of the item, and prison staff decided to refer both parties to a disciplinary hearing. The item was seized by staff and, the next morning, Mubiru was taken to the area of Port Phillip's management unit known as 'the spine' and placed in separation. On arrival, staff classified Mubiru to a 'handcuff regime', meaning that he was always to remain handcuffed when around staff and workers.

Mubiru's case was reviewed by a Sentence Management Panel two days later. Mubiru became upset when addressing the Panel; he said that it wasn't right that he had been placed in a management unit for something his cellmate had done. The Panel told Mubiru that it was possible that he had encouraged his cellmate to take ownership of the item for him. Mubiru said that this wasn't the case; he maintained that what his cellmate had in his possession was his cellmate's business. The Sentence Management Panel informed Mubiru that he would be separated for a further seven days.

Mubiru spent a total of 15 days in separation before he was cleared to an 'Intermediate Regime.' He then spent a further 155 days subject to the Intermediate Regime before he was reclassified to a mainstream unit. In total, Mubiru was isolated for 170 days — approximately 4,080 hours.

Peter

Twenty-three-year-old Peter told staff at Port Phillip that he needed to be urgently transferred out of his unit.

The Unit Supervisor met with Peter and asked him what the problem was. Peter said that he didn't feel safe in the unit and disclosed that he had been assaulted by a group of other prisoners. Peter said that the other prisoners had threatened to stab him on the next occasion.

The Supervisor arranged for Peter to receive medical treatment and then reviewed the previous day's CCTV footage. This footage depicted several prisoners entering Peter's cell. The Supervisor formed the view that these prisoners had been the ones to assault and threaten Peter.

The Supervisor then placed each of the suspected perpetrators in separation, 'pending investigation' into the incident. The incident report states that Peter was also placed in separation 'as the victim'.

The incident report does not explain why the Supervisor felt it necessary to separate Peter, given that the alleged perpetrators were themselves confined to their cells.

Peter spent a total of seven days in separation – about 168 hours. The alleged perpetrators were separated for a similar period.

445. Many of the young people surveyed by the inspection reported that they had been placed in isolation for significant periods of time while at Port Phillip. Several young people reported being isolated for multiple months, and one young person reported that he had been isolated for a period of 15 consecutive months.

446. This young person may have conflated his time on a separation order with time on an Intermediate Regime.

It fucks with your head, it goes against you. It makes you want to get back on the drugs. If you get in a punch-on at Malmsbury you're out of your cell in four hours — they make you talk with the others about it.

– Young person on an Intermediate Regime

447. Forty-six per cent of young people surveyed by the inspection attributed negative emotions to their experiences of isolation at Port Phillip. Just six per cent of survey respondents attributed positive emotions to their experience of isolation.

448. The inspection observed that the median duration of a separation order at Port Phillip within the 12-month reporting period was 10 days, or approximately 240 hours.

449. The review established that 77 young people had been separated for more than 15 days, meeting the definition of 'prolonged solitary confinement,' a practice prohibited by rule 43(b) of the Mandela Rules.

450. The review identified two young people who had been separated for more than 140 consecutive days. Both individuals had been transferred to other prisons by the time of the inspection.

451. The inspection noted that in many cases a young person's isolation would extend beyond the date at which they exited separation. This was because the young person would then transition to an Intermediate (step-down) Regime.

452. Although pursuant to the Manual it is Corrections Victoria policy that prisoners subject to an Intermediate Regime are eligible to receive up to six hours of out-of-cell time per day, prisoners at Port Phillip are eligible to receive a maximum of just three hours of out-of-cell time under the local Operational Instruction.

It was pretty shit. It has a toll on you. You take yourself to when you were 19 or 20; you have all these things you want to do. And when you get out it takes time to remember how to talk to [others] again.

– Young person

It is what it is.

– Young person

I feel worn out, I don't feel like making any changes. A week in here [Borrowdale] is like a month on the open units. You can only stare at the four corners [of your cell] for so long. You don't even get any sun.

– Young person on an Intermediate Regime

453. Most of the young people on the Intermediate Regime who were surveyed by the inspection reported receiving just one and a half hours out of their cell per day.

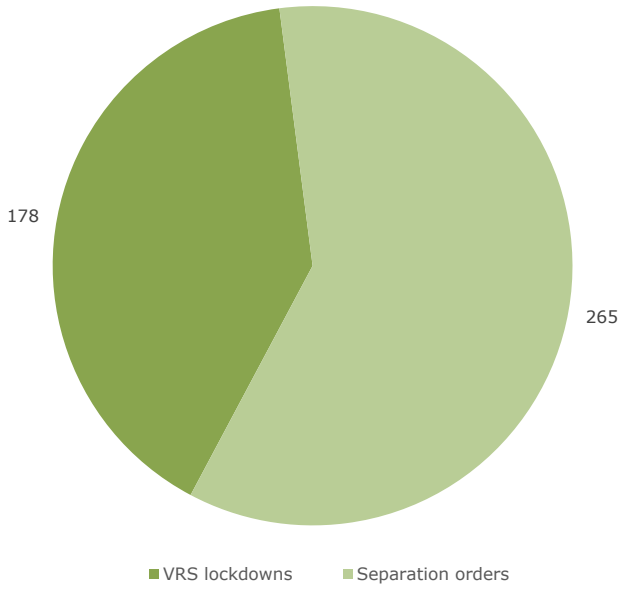
454. The inspection observed that in terms of isolation, there often appeared to be little difference between the separation and Intermediate Regimes at Port Phillip.

I hate being alone.

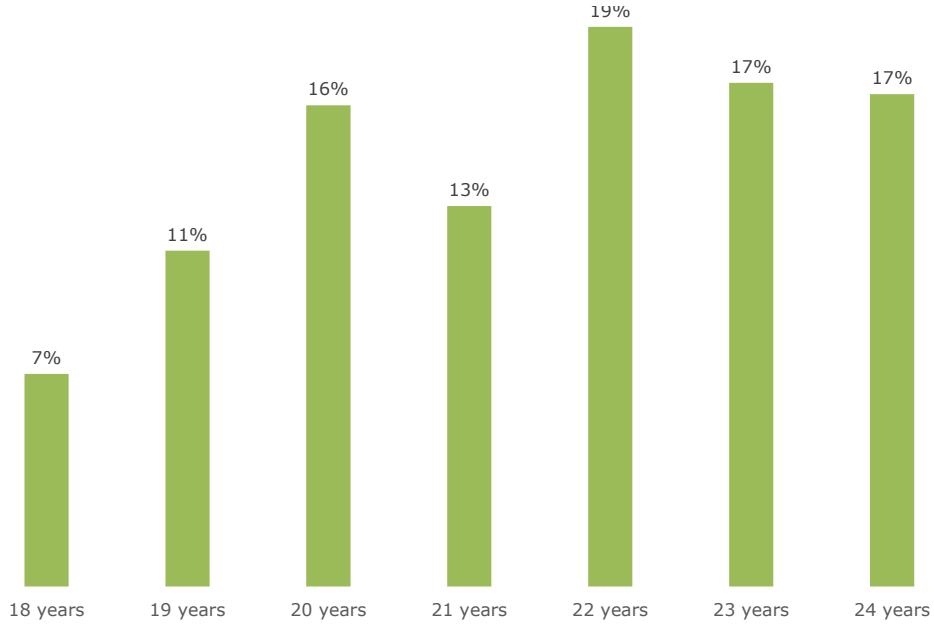
– Young person

455. Of the 265 separation orders made within the 12-month reporting period, 29 per cent resulted in the young person being subsequently placed on an Intermediate Regime. The median length of this placement was 49 days, or approximately 1,176 hours.

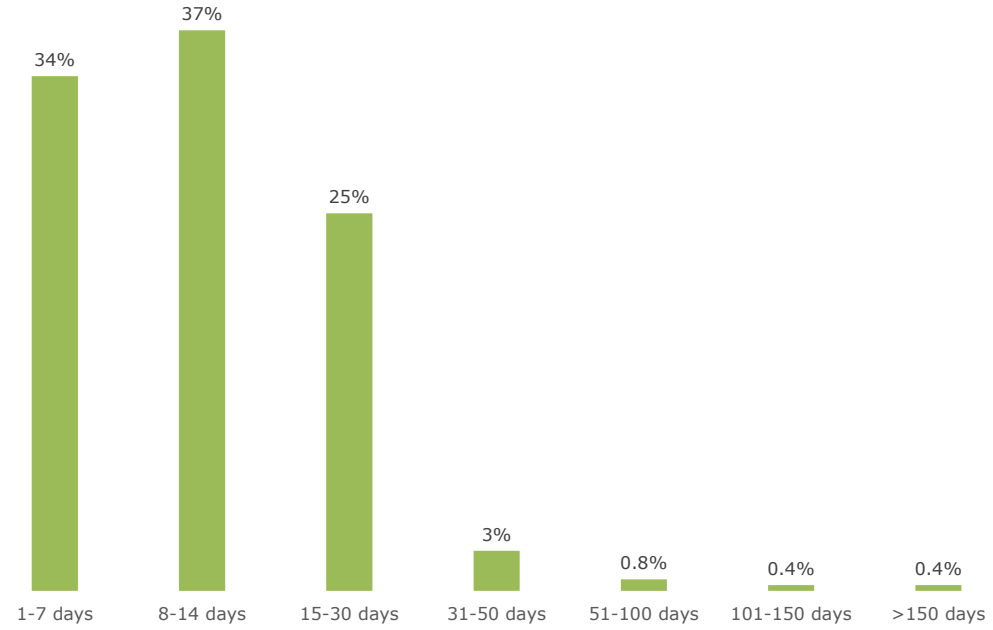
Instances of young people isolated at Port Phillip



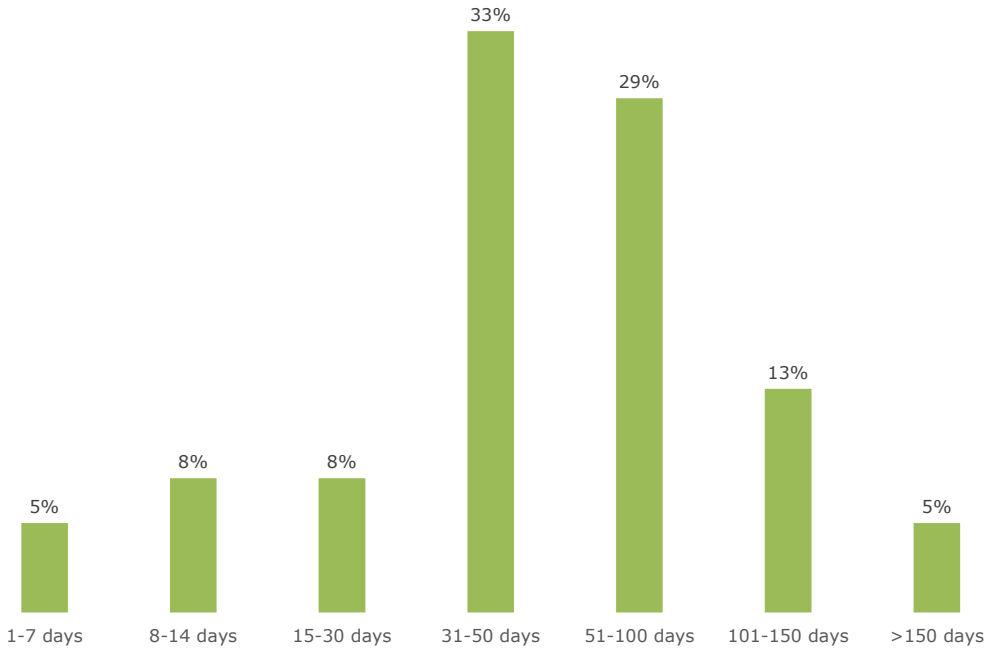
Separation of young people at Port Phillip by age



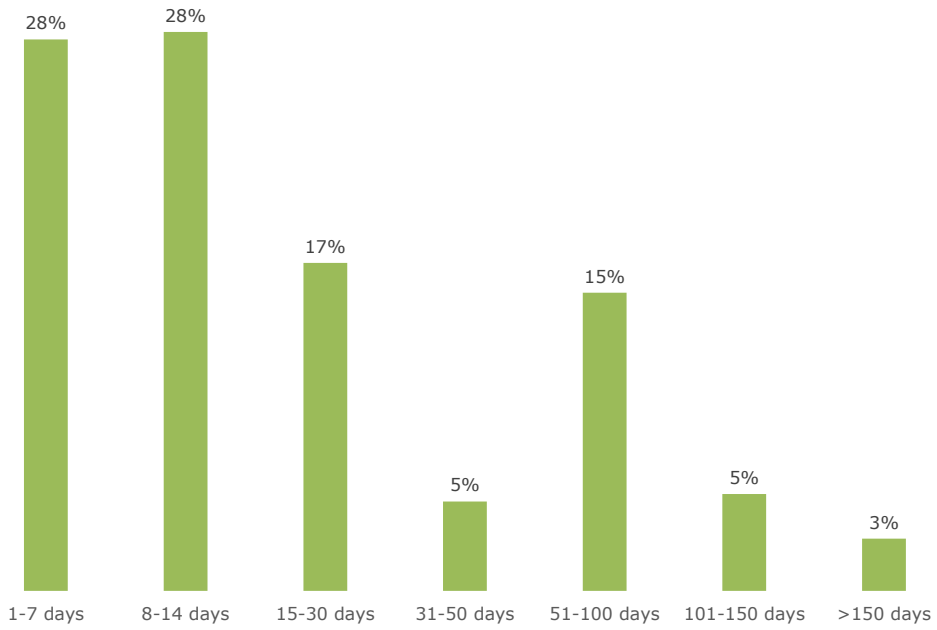
Duration of separation orders concerning young people at Port Phillip



Period young people spent on Intermediate Regime following separation at Port Phillip



Total period of isolation following separation at Port Phillip, including period spent on Intermediate Regime



456. The Manual requires that prisoners subject to a separation order be placed on an 'incentive-based' regime. In most cases, prisoners are initially restricted to a maximum of two hours out-of-cell time per day (referred to as a 'run-out'), are prohibited from contact visits and are restricted to a maximum of 15 phone calls per week.

457. The inspection observed that prisoners subject to a separation order were provided with only one hour out of their cell per day, the minimum period required under the Corrections Act. This suggests that the use of separation at Port Phillip invariably amounted to solitary confinement.

458. The inspection observed that young people subject to a separation order at Port Phillip were ordinarily not permitted to speak with other prisoners during their 'run-out' time.

459. In response to the Ombudsman's draft report, DJCS advised there has been effort to increase the number of yards and introduction of communication yards to enable prisoners in adjoining yards to speak to each other, even if physically separated.

460. Some of the young people surveyed by the inspection were subject to a 'handcuff regime'. They were required to be handcuffed during any interaction with staff and other workers, including when escorted to and from the run-out area and during their separation review meetings.

461. The inspection observed that even prisoners who had been separated for their own protection were sometimes handcuffed when moved around the unit.

462. The inspection did not observe any prisoners who were handcuffed when in the run-out area, although this is permitted under Port Phillip's *Operational Instruction 59: Use of Mechanical Restraints*.

463. The inspection did not consider that the routine use of restraints under the 'handcuff regime', absent a contemporaneous risk assessment, was consistent with the Mandela Rules, which state that instruments of restraint should only be used 'when no lesser form of control would be effective to address the risks posed by unrestricted movement' and should be removed 'as soon as possible after the risks posed by unrestricted movement are no longer present.'

464. The inspection observed that within the mainstream units all other prisoners were required to return to their cells during a separated prisoner's run-out. This was a significant source of dissatisfaction amongst staff and the young people who spoke with the inspection. Owing to the number of prisoners separated, some mainstream units would be in this state of lockdown until the early afternoon.

465. DJCS acknowledged this issue and attributed it to a shortage of mainstream beds across the maximum-security prisons due to a surging remand population. It also noted 'the significant funding announced in the 2018-19 State Budget for new beds across the prison system.'

466. Many young people who had been separated in a mainstream unit informed the inspection that they did not ordinarily make full use of their run-outs, because of perceived or actual pressure from other prisoners.

467. Staff reported similar observations to the inspection. Some staff said that when their unit was under significant pressure, separated prisoners would sometimes be permitted to take their run-outs with other prisoners to minimise the disruption to the rest of the unit.

A lot of the fellas in the unit say don't do your run-out. It impacts on them.

– Young person

468. In addition, run-outs in the mainstream units would ordinarily commence early in the morning. Several young people who had been separated in a mainstream unit informed the inspection that they would sometimes decline early morning run-outs due to cold conditions or to maximise sleep.

469. The inspection considered that the run-out arrangements affecting prisoners separated in the mainstream units at Port Phillip created a risk of ill-treatment insofar as they appeared to incentivise young people to abstain from accessing fresh air and exercise.

I don't take my run-outs. It's too early, like 7am. What's the point; it's only an hour. What am I going to do, make a phone call?

– Young person

470. In response to the draft report, DJSC described this quote as misleading because 'units do not open until 8am'.

471. The inspection noted that at the current rate of separation, Port Phillip would struggle to provide more than one hour out-of-cell time to prisoners in separation. This was because Charlotte Unit appeared to be regularly at capacity, necessitating short rotations, and because of the impact that longer run-outs would have on non-separated prisoners in the mainstream units.

[If I was the boss for a day] I'd make the time for a run-out two hours instead of one and a half ... But I understand there's rules.

– Young person on Intermediate Regime

Lockdowns under the Violence Reduction Strategy

472. Port Phillip's Violence Reduction Strategy (VRS) seeks to reduce the incidence of violent behaviour within the facility.

473. The VRS provides that a prisoner who commits a 'low-level' physical assault on prison staff or another prisoner, threatens to assault a member of prison staff or another prisoner or who is otherwise verbally abusive or aggressive may be confined to his or her own cell for a maximum of 23 hours, without the need for a formal separation order.

474. Under the VRS, a prisoner who continues to engage in such behaviour, or who otherwise commits an assault that is not deemed to be of a 'low-level', must be formally separated.

475. The inspection reviewed the records concerning the use of the VRS over the 12-month reporting period.

476. The review determined that young people at Port Phillip were disproportionately subject to lockdowns under the VRS. Thirty-one per cent concerned a young person, despite young people accounting for approximately 18 per cent of the prison population.

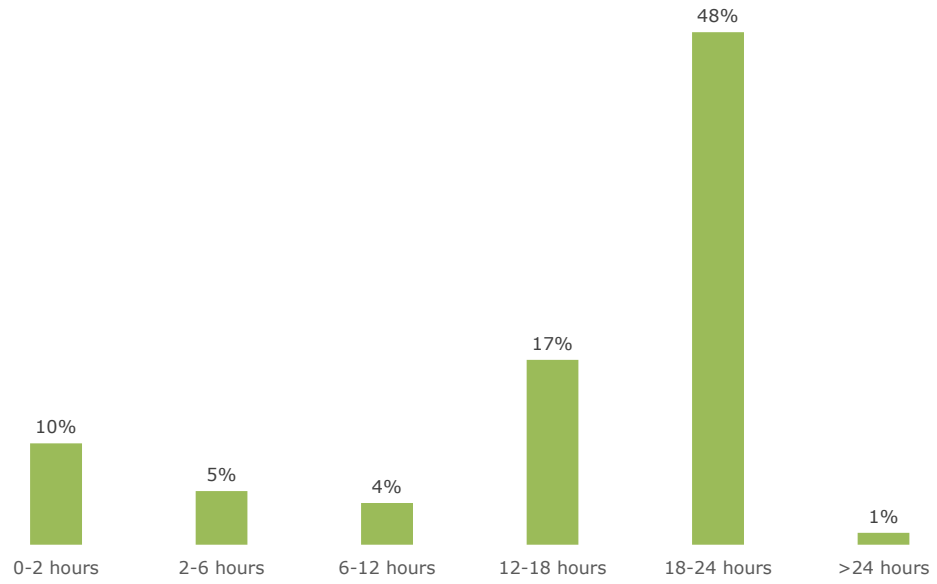
477. The review determined that of the 178 lockdowns under the VRS in respect of young people over the 12-month reporting period, over one-third resulted in the young person being isolated for more than 22 hours (meeting the definition of solitary confinement).

478. The inspection determined that when accounting for lockdowns under the VRS, the median period in which young people were isolated for behavioural reasons at Port Phillip was six days, or approximately 144 hours. The inspection noted that the average period of isolation was considerably higher – 20 days, or approximately 485 hours.

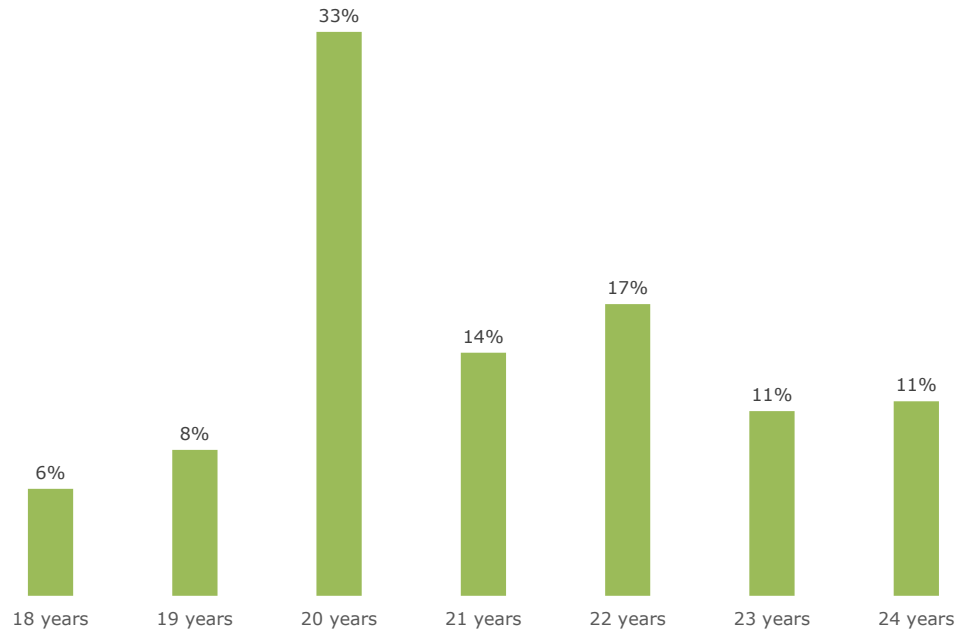
Figure 1: Excerpt from VRS Lockdown Register

20/05/2018	1700	[redacted]	TIME OUT/Psych issues	20/05/2018	18:00
21/05/2018	11:30	[redacted]	Safety concerns	22/05/2018	6:18
21/05/2018	16:30	[redacted]	Abuse\threats to staff	to Margoneet	########
21/05/2018	18:20	[redacted]	Safety Concerns		Formally separated
22/05/2018	18:50	[redacted]	Safety Concerns [redacted]	23/05/2018	6:16
22/05/2018	16:45	[redacted]	SAFETY CONCERNS	23/05/2018	13:15
23/05/2018	11:00	[redacted]	AGGRESSIVE BEHAVIOUR	24/05/2018	8:05
25/05/2018	11:50	[redacted]	TIME OUT/Psych issues	25/05/2018	16:00
25/05/2018	15:45	[redacted]	Verbaly Abusive/Intimidating	26/05/2018	14:45
27/05/2018	17:30	[redacted]	ASSAULT?? - PENDING CCTV REVIEW		Formally separated

Duration of VRS lockdowns concerning young people at Port Phillip



VRS lockdowns concerning young people at Port Phillip by age



Unit and facility-wide lockdowns

479. Under Port Phillip's *Operational Instruction 100: Prisoner Out of Cell Hours and Lockdowns*, Area or Duty Managers may authorise the lockdown of an accommodation unit for various reasons, including:

    - major operational incidents
    - searches
    - staff meetings
    - industrial action
    - to otherwise maintain the security, good order and management of the prison.

480. Prisoners are confined to their cells for the duration of a lockdown.

481. The inspection reviewed the entries made to Port Phillip's lockdown register over the 12-month reporting period and noted that there were approximately 4,000 reported lockdowns during this period.

482. Most unit lockdowns appeared to have been undertaken to allow separated prisoners their run-out time. Although these were mostly of a relatively short duration they were a source of frustration for some of the young people surveyed by the inspection.

483. The inspection noted that Port Phillip entered a four-hour facility-wide lockdown on most Wednesday afternoons to allow staff to undertake refresher training. Some of the young people surveyed expressed frustration at the frequency and length of these lockdowns.

484. From Port Phillip's records, it was not possible to determine the rate at which young people were affected by unit and facility-wide lockdowns at the facility.

Lockdowns are shithouse. Especially when it's not your fault. You can understand it when you've done something to deserve it.

– Young person

Withdrawal of privileges

485. Under the Corrections Regulations, prisoners are afforded privileges determined by the Secretary. As set out in the *Commissioner's Requirement 2.3.3: Disciplinary Process and Prisoner Privileges*, these include:

    - association with other prisoners at the same prison location who are subject to the same regime
    - access to full out-of-cell hours.

486. The Corrections Act provides that one or more of a prisoner's privileges may be withdrawn in circumstances where the prisoner has been found guilty of a prison offence. Under the Act, a prisoner's privileges may not be withdrawn for more than 30 days.

487. Section 54A of the Corrections Act provides that the Secretary may also withdraw a prisoner's privileges in circumstances where the prisoner is being investigated or has been charged or prosecuted for a prison offence.

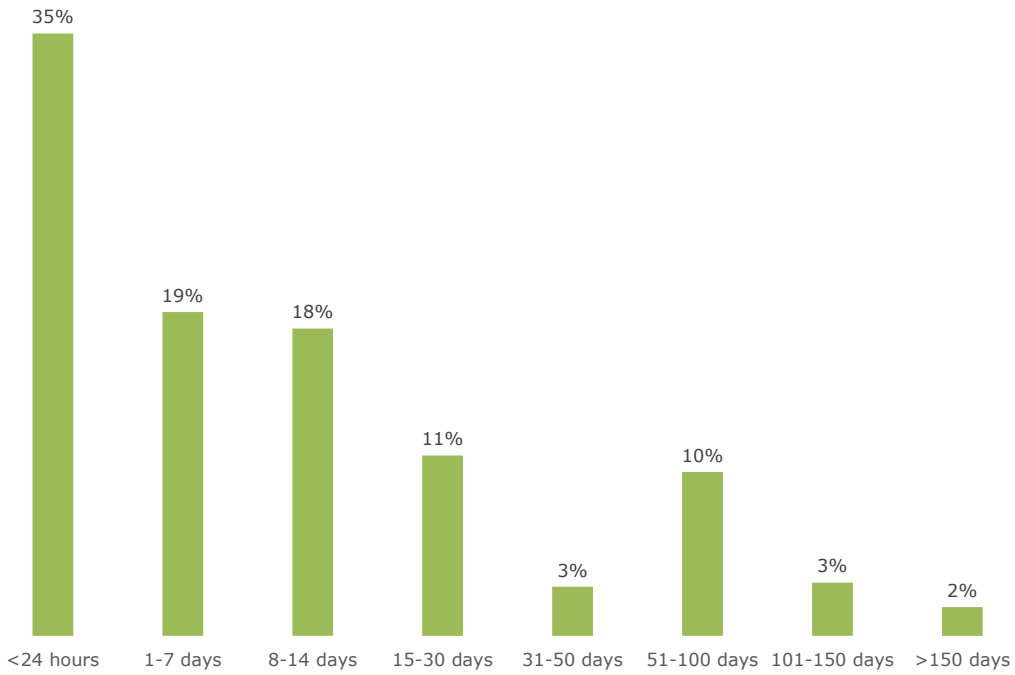
It's becoming the norm to just separate and sort it out later.

– Staff member

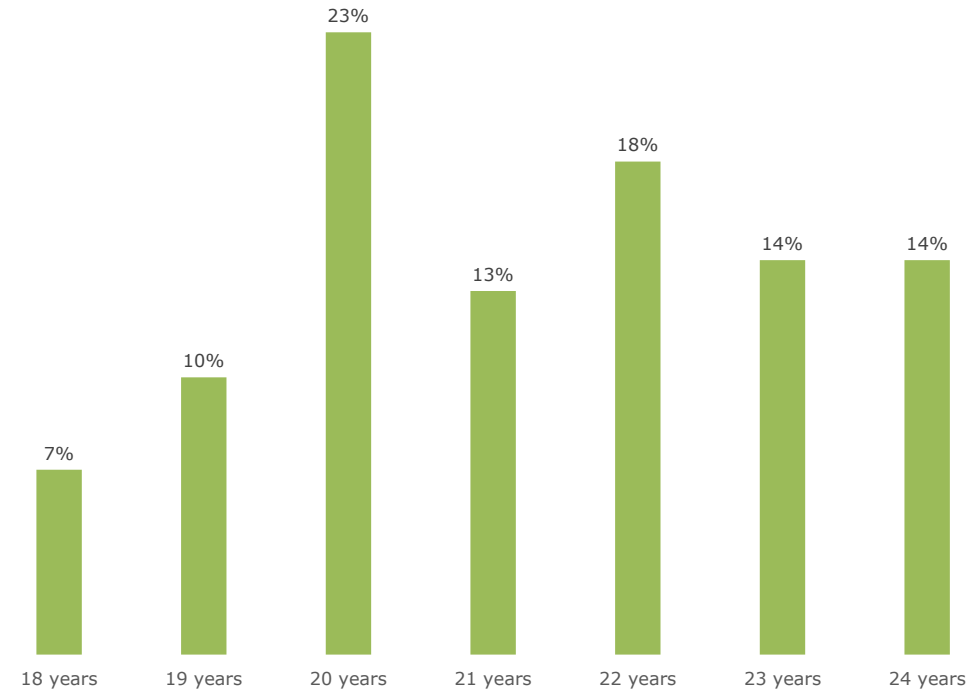
488. The terms of the Secretary's approval otherwise provide that the full list of privileges may not apply to prisoners who are classified to a management or high security unit or to an Intermediate Regime.

489. The inspection noted that none of the separation orders made in respect of young people within the previous 12 months appeared to result from a 'loss of privileges' determination. The inspection also did not identify any young people at Port Phillip who were subject to such a determination.

Periods in which young people were isolated at Port Phillip



Age at which young people were isolated at Port Phillip



Protective measures

Legislative protections against undue solitary confinement

490. The Corrections Act and Corrections Regulations currently allow for the solitary confinement of prisoners, including children and young people.

491. While the Regulations make the use of solitary confinement subject to certain safeguards, the legislative framework allows for the following practices, all of which are prohibited under relevant international human rights standards, and may be incompatible with the Human Rights Act:

- solitary confinement of children as a disciplinary measure[13]
- prolonged solitary confinement[14]
- solitary confinement that would exacerbate a prisoner's mental or physical disabilities[15]
- the use of solitary confinement other than in exceptional cases and other than as a last resort.[16]

492. Changes to the Corrections Regulations introduced in April 2019 also allow for the indefinite solitary confinement of all prisoners 'for the management, good order or security of the prison', a practice prohibited by the Mandela Rules.[17]

Separation

493. The Corrections Regulations make the use of separation subject to several safeguards:

- before separating a prisoner, staff must consider the medical and psychiatric condition of the prisoner
- since 28 April 2018, before separating a child under the age of 18, staff must consider the child's age, best interests and vulnerability, where it is 'reasonably practicable' to do so
- the amount of time that a prisoner may be separated is in some cases limited
- separation orders must be made or confirmed in writing
- prisoners must be advised of the reasons for the separation and provided with a copy of the order.

494. The inspection nevertheless considered that there were several shortcomings with this framework:

- The Corrections Act authorises the use of separation, including solitary confinement, as a punishment for misbehaviour.
- Staff are not required to regularly observe children, young people and other prisoners who are subject to separation, including solitary confinement.
- Prisons are not required to maintain a register of separations made under the Corrections Regulations.

13 Corrections Act, sections 53(4)(c) and 50(5)(b); Havana Rules, rule 67.

14 Mandela Rules, rule 43(1)(b).

15 Corrections Regulations, regulation 32(5)(a); Mandela Rules, rule 45(2).

16 Mandela Rules, rule 45(1).

17 Mandela Rules, rule 43(1)(a). Regulation 32(2) provides that '[t]he amount of time a prisoner may be separated from other prisoners must not be longer than is necessary to achieve the purposes set out in subregulation (1)(a) or (b).' The power to separate a prisoner 'for the management, good order or security of the prison' is established in subregulation (1)(c) and is exempt from this requirement.

495. The inspection also noted that recent changes to the Corrections Regulations appeared to lower the threshold for the making of a separation order, by introducing a subjective element to the criteria.

496. The inspection considered that the legislative and regulatory framework applicable to separation created a significant risk of solitary confinement, as well as significant risk of torture or cruel, inhuman or degrading treatment or punishment.

497. The Manual introduces some additional safeguards to the use of separation.

498. Under the Manual, both the Chief Practitioner and the Ombudsman must be notified when a child under the age of 18 is separated, and such separations must be reviewed at weekly intervals.

499. Also, a prisoner may initially be separated for a maximum of seven days; and once a separation order has been made at the local level, it must be forwarded to the Sentence Management Division of Corrections Victoria for endorsement. Separation resulting from a General Manager's disciplinary hearing is exempt from this requirement.

500. The Manual requires that the following information be included on a separation order:

- the prisoner's name, identification number, location and current accommodation
- a description of the situation leading to the separation
- the criteria under the Corrections Regulations said to form the basis for the separation
- the name and title of the member of staff approving the separation, together with their signature and the date and time of approval
- whether the prisoner was supplied with a copy of the order and, if not, the reasons why
- the name and title of the member of staff endorsing the separation, together with their signature and the date and time of endorsement.

501. A separation order must be completed in the following circumstances:

- to transfer a prisoner into a high security unit
- to transfer a prisoner into a management unit or cell
- to transfer a prisoner into a medical or psychiatric observation cell
- when separating a prisoner in a cell for management reasons, where the separation is expected to continue for longer than 24 hours.

502. Under the Manual, a separation order is not required in circumstances where a prisoner is confined to their own cell due to a lockdown or 'for a short period of time that doesn't significantly impact on their out of cell hours.'

503. Also, the Sentence Management Division must convene a Sentence Management Panel within eight days of a prisoner's separation.

504. The Sentence Management Panel – which consists of representatives of the Sentence Management Division and prison staff – is then responsible for reviewing the circumstances of the separation with input from the prisoner, with a view to either terminating the order or extending it for a further period.

505. If the Sentence Management Panel determines to terminate a separation order and classify the prisoner to an Intermediate Regime, the placement must then be reviewed every month at the local level, as well as on a quarterly basis by the Sentence Management Division.

506. Prisoners who are separated for more than 30 days are classified as 'long-term management', which must be approved by the Assistant Commissioner, Sentence Management Division, and reviewed at least once per month.

507. Long-term management prisoners are eligible to receive up to four hours of out-of-cell time per day, and those under the age of 18 must be reviewed at least weekly.

508. The inspection observed that there appeared to be little local oversight of separation orders made at Port Phillip.

509. In practice, most separation orders appeared to be made at the Unit Supervisor level. Of the 265 separation orders affecting young people that were reviewed by the inspection, just 15 per cent were endorsed by a member of staff at or above the Area or Duty Manager level.

510. The inspection observed that it was not uncommon for the same member of staff who approved the separation of the young person to then 'endorse' that separation on behalf of their supervisor. Just 10 per cent of all separation orders reviewed by the inspection were countersigned by a member of staff other than the original approving officer.

511. In response to the Ombudsman's draft report, DJCS wrote:

> All separation orders are discussed with an Operations Manager and approved by Corrections Victoria. Operations Managers generally approve verbally via phone which is why there is not a secondary signature.

512. The inspection identified one case where both the approval and endorsement of a separation order appeared to have been completed by a member of staff below the Supervisor level, in apparent contravention of the delegation made under Corrections Act.

513. All of the 265 separation orders reviewed by the inspection recorded that the young person had been provided with a copy of the order and given an explanation of the reasons for the separation. This contrasts with the experience of some of the young people surveyed by the inspection, who reported that they had not received a copy of the separation order when separated, even upon request.

I didn't get my separation order ... They said to FOI it ... That's not right.

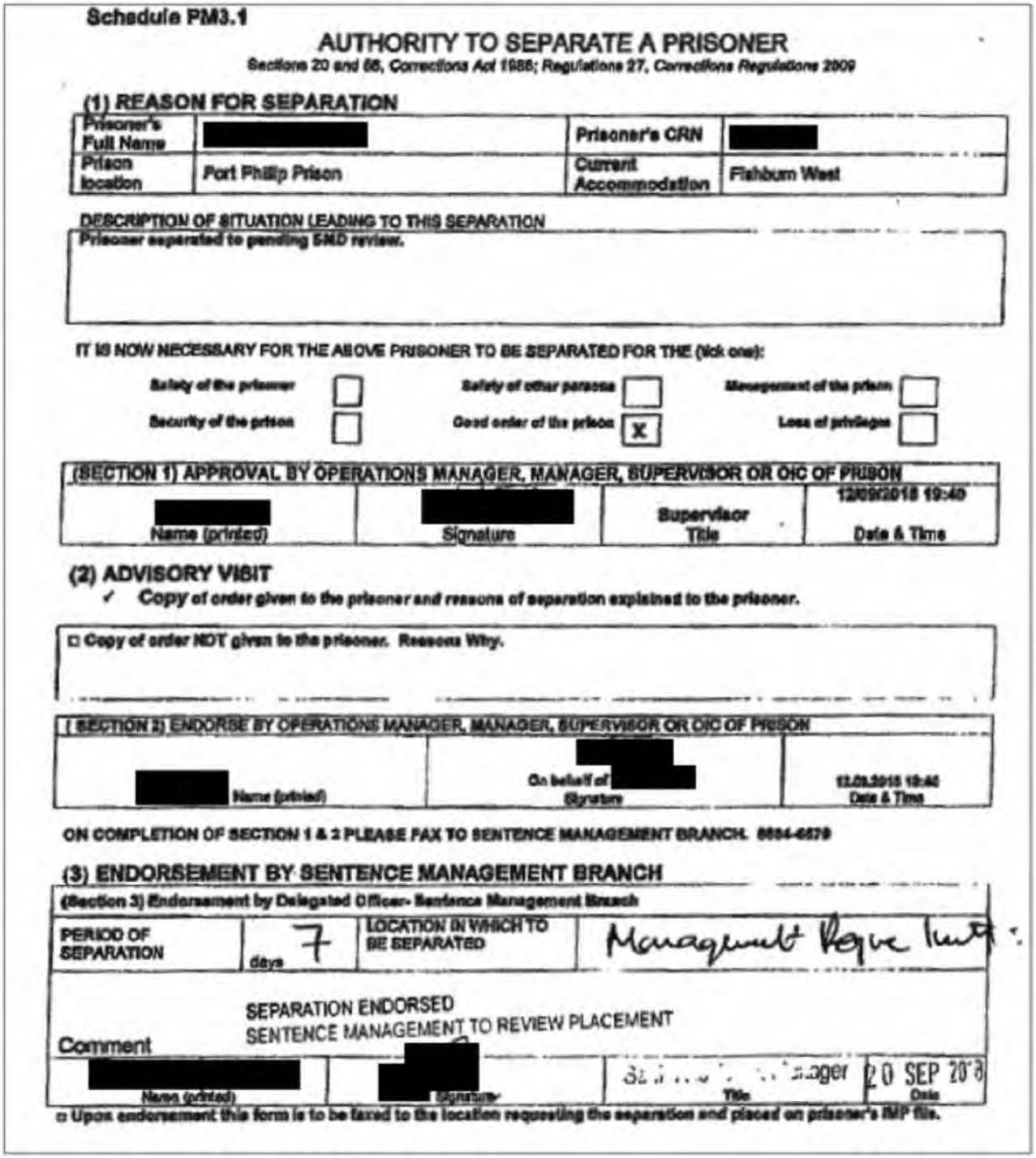
– Young person

514. In response to the draft report, DJCS acknowledged that it cannot be entirely sure that at a local level, separation orders are provided to prisoners on each and every occasion:

> The requirement to provide a copy of the order on each occasion will be reiterated to all prisons, as will the requirement to provide sufficient detail for the reason of the separation.

515. Several separation orders reviewed by the inspection did not adequately identify the circumstances giving rise to the young person's separation. One separation order merely stated that the young person had been separated 'pending SMD review', and several other orders stated that the young person had been separated on admission from another prison, with no further information recorded.

Figure 2: Separation order lacking detail; countersigned by same officer



Schedule PM3.1

AUTHORITY TO SEPARATE A PRISONER

Sections 20 and 66, Corrections Act 1986; Regulations 27, Corrections Regulations 2009

(1) REASON FOR SEPARATION

Prisoner's Full Name	[redacted]	Prisoner's CRN	[redacted]
Prison location	Port Phillip Prison	Current Accommodation	Fishburn West

DESCRIPTION OF SITUATION LEADING TO THIS SEPARATION

Prisoner seperated to pending SMD reviewr.

IT IS NOW NECESSARY FOR THE ABOVE PRISONER TO BE SEPARATED FOR THE (tick one):

Safety of the prisoner	☐	Safety of other persons	☐	Management of the prison	☐
Security of the prison	☐	Good order of the prison	X	Loss of privileges	☐

(SECTION 1) APPROVAL BY OPERATIONS MANAGER, MANAGER, SUPERVISOR OR OIC OF PRISON

[redacted] Name (printed)	[redacted] Signature	Supervisor Title	12/09/2018 19:40 Date & Time

(2) ADVISORY VISIT

✓ Copy of order given to the prisoner and reasons of separation explained to the prisoner.

☐ Copy of order NOT given to the prisoner. Reasons Why.

(SECTION 2) ENDORSE BY OPERATIONS MANAGER, MANAGER, SUPERVISOR OR OIC OF PRISON

[redacted] Name (printed)	On behalf of [redacted] Signature	12.09.2018 19:40 Date & Time

ON COMPLETION OF SECTION 1 & 2 PLEASE FAX TO SENTENCE MANAGEMENT BRANCH 8684-6879

(3) ENDORSEMENT BY SENTENCE MANAGEMENT BRANCH

(Section 3) Endorsement by Delegated Officer- Sentence Management Branch

PERIOD OF SEPARATION	7 days	LOCATION IN WHICH TO BE SEPARATED	Management Review Unit

Comment: SEPARATION ENDORSED
SENTENCE MANAGEMENT TO REVIEW PLACEMENT

[redacted] Name (printed)	[redacted] Signature	Manager Title	20 SEP 2018 Date

☐ Upon endorsement this form is to be faxed to the location requesting the separation and placed on prisoner's IMP file.

516. The inspection reviewed the case notes concerning a sample of 20 young people who were subject to a separation order or classified to an Intermediate Regime during the period of the inspection.

517. Of this sample:

- six cases appeared to involve a late review by either the Sentence Management Panel or the Local Case Management Review Committee
- six young people appeared to have been denied the opportunity to transition out of the Intermediate Regime at the earliest available opportunity, owing to local decisions not to review the young person's placement until after the date recommended by the Sentence Management Panel
- one young person subject to the Intermediate Regime was not due to have their placement reviewed for a period of approximately 120 days, in apparent contravention of Corrections Victoria policy.

518. The inspection considered that many placement decisions also appeared inconsistent or arbitrary. In several cases, good behaviour did not appear to result in the young person spending any less time in separation or on the Intermediate Regime.

519. In response to this observation, DJCS noted that a young person's removal from a restricted regime is often dependent on onward transfer which can take time, due to population demands and placement conflicts.

They [the Sentence Management Panel] have already made up their mind before they see you. it's another one week, two weeks' [separation].

– Young person

520. The inspection also identified several cases where the victim and perpetrator of an alleged assault received the same period of separation (see Jasper's story, on the next page).

521. Just 19 per cent of young people surveyed by the inspection reported that they usually felt 'heard and listened to' during separation review meetings.

522. The inspection observed that owing to an overall lack of meaningful human interaction, there was very little opportunity for young people in separation to demonstrate when they were ready to return to a normal regime.

If I had the cash I'd make a lot of changes; I'd introduce more structure and tell the prisoners what they need to do to get out of management.

– Young person

523. In response to this observation, DJCS advised that it is looking at options to manage Intermediate Regime prisoners in mainstream units (where there are no placement concerns) so as to maximise out of cell hours for both those prisoners, and others who cannot mix.

524. The inspection had mixed views about the separation review process. On the one hand, the process appeared consistent with the requirements of rule 45(1) of the Mandela Rules insofar as it increased the level of functional oversight of solitary confinement at Port Phillip.

525. On the other hand, it was noted that the division of responsibility between the prison and Corrections Victoria administration appeared to result in young people being separated for longer periods than was necessary. Although local staff were authorised to place a prisoner in separation, a classification decision by a Sentence Management Panel was ordinarily necessary to bring them out.

Kane

Twenty-three-year-old Kane became involved in a heated argument with a member of the prison's health team. After leaving the appointment, Kane told a correctional officer that he would be inclined to hit the health worker if he was ever booked to see them again.

The correctional officer reported Kane's conduct and, the next morning, Kane was separated and confined to his cell for 23 hours per day. That same day, the Sentence Management Division endorsed Kane's separation to last for an initial period of seven days. Kane's conduct was also separately referred to a disciplinary hearing.

Contrary to Corrections Victoria policy, Kane's separation was not reviewed by a Sentence Management Panel until 21 days later. At this time, the Panel noted that Kane's separation review had been delayed due to a 'miscommunication' with the prison.

The Sentence Management Panel acknowledged that Kane had remained incident free since his separation and determined to classify him to an Intermediate Regime. Kane spent another 38 days on the Intermediate Regime before he was reclassified to a mainstream unit. All up, Kane was isolated for a period of 59 days — about 1,416 hours.

Under the Corrections Regulations, Kane's separation ceased at expiration of the initial seven-day period. Kane's continued separation after this period was arguably unlawful.

Jasper

Twenty-two-year-old Jasper was subject to an Intermediate Regime at Port Phillip when he was assaulted by another prisoner.

Jasper received medical treatment and was then separated into a cell in another unit. The perpetrator was quickly identified and was also separated.

Four days later, Jasper's case was reviewed by a Sentence Management Panel. Although there was no evidence that Jasper had misbehaved while in separation, the Panel determined that Jasper's separation was to continue for a further nine days.

The Sentence Management Panel convened again nine days later and decided to reclassify Jasper back to the Intermediate Regime. The Panel recommended that Jasper spend a minimum of one month on this regime before he could be considered for clearance to a mainstream unit.

The perpetrator of the assault exited separation on the same day as Jasper. The Sentence Management Panel recommended that the perpetrator spend a minimum of one month on the Intermediate Regime, the same period as Jasper.

526. It was difficult to reconcile the separation review process with the requirement under the Corrections Regulations that a prisoner's separation be 'no longer than is necessary' to achieve the separation purpose.

527. In practice, young people at Port Phillip were separated until at least their next review date — which could be as much as a month away — whatever their behaviour in the interim. In addition to possibly being contrary to the Corrections Regulations, this practice appeared inconsistent with the requirement under rule 45(1) of the Mandela Rules that a prisoner's solitary confinement be for as short a time as possible.

528. On the whole, the inspection considered that local staff were not suitably empowered to facilitate prisoners to exit separation in a timely manner.

529. The inspection observed that owing to a lack of available accommodation, some young people remained in separation even after a decision had been made to reclassify them to a less restrictive regime. In one case reviewed by the inspection, a young person remained in separation for 56 days beyond the date in which he was reclassified to a mainstream regime.

530. The continued separation of young people in such circumstances appeared contrary to the Corrections Regulations, which provide that a prisoner's separation order ceases when their classification is determined by a Sentence Management Panel. The practice also arguably contravened the requirement under the Regulations that a prisoner's separation be no longer than necessary to achieve the purpose of the separation.

531. Although the Sentence Management Manual requires prisons to '[m]aintain a record of all separation orders completed at their location', there is currently no legislative requirement to record the details of a separation order in a centralised register established for that purpose.

532. The inspection was informed that Port Phillip did not maintain a register of all separations occurring at the facility.

533. Corrections Victoria maintains its own register of separations occurring in Victorian prisons; however this register does not record information such as the time and duration of each order, the authorising officer's details, or the frequency of staff supervision or observation of the prisoner.

534. The lack of a separation register made it difficult for Port Phillip to provide information concerning the number and duration of separation orders affecting children and young people at the facility.

535. To identify this information, it was necessary for the inspection to:

- manually review each separation order implemented at Port Phillip within the 12-month reporting period
- from this information, compile a register of the 265 separation orders
- consult with Corrections Victoria to identify the duration of each separation order and the time subsequently spent on the Intermediate Regime.

536. The inspection noted that without a separation register, Port Phillip was not readily able to:

- report on the rate and circumstances in which prisoners at the facility were being separated over time
- identify how often certain prisoners or groups of prisoners, including children and young people, were being separated at the facility
- compare the rate and circumstances of separation at the facility with other prisons in Victoria.

537. The inspection noted that Corrections Victoria would similarly be unable to readily identify the total time in which children, young people and other prisoners were separated at Port Phillip and compare this information with other prisons in Victoria.

538. The inspection considered that the absence of a separation register at Port Phillip significantly increased the risk of prisoners' ill-treatment.

Oliver

Twenty-three-year-old Oliver was one of ten individuals suspected to have been involved in the harassment and assault of two prisoners. All parties involved were placed in separation 'pending investigation' into the incidents. Oliver was transferred to Port Phillip's management unit, where he was placed on the handcuff regime.

Oliver's case was reviewed by a Sentence Management Panel six days later. Although Oliver denied knowledge of the alleged incidents, the Panel noted that the allegations were serious and that the matter had been referred to Victoria Police. The Panel determined that Oliver was to remain separated for a further 14 days. Oliver was also informed that Corrections Victoria was considering classifying him as a 'long-term management' prisoner. Oliver indicated that he accepted the Panel's decision, whilst still maintaining his innocence.

Oliver's case notes record that the Sentence Management Panel next discussed his separation fourteen days later, although no details of the Panel's discussion were recorded. The Panel determined that Oliver was to remain in the management unit for a further undisclosed period. Approximately eight days later, the Assistant Commissioner endorsed Oliver as a long-term management prisoner, '[g]iven the seriousness of the separating incident.'

The Sentence Management Panel met with Oliver the following week. By this time, Oliver had been separated for approximately one month. The panel notified Oliver of his long-term management status and informed him that his separation would be next be reviewed in a month's time.

The Sentence Management Panel met with Oliver one month later. The Panel noted that Oliver had been 'somewhat resistant' upon arrival in the management unit but that his behaviour had subsequently improved. The Panel also noted that Oliver had remained incident free and was no longer required to wear handcuffs when interacting with staff. Oliver told the Panel that he had not been contacted by police about the incidents leading to his separation. The Panel informed Oliver that his placement 'remained appropriate at this time, particularly given the ongoing [police] investigation' and his outstanding court proceedings.

Oliver remained incident free, and staff noted that he was consistently compliant and respectful in his interactions on the unit. During this period, police also resolved to refer the allegations leading to Oliver's separation back to Port Phillip for local action. Despite this, Oliver's separation was extended a further two times before he was eventually reclassified to an Intermediate Regime.

All up, Oliver spent a total of 147 consecutive days separated from other prisoners in the management unit — approximately 3,528 hours.

Trent

Twenty-four-year-old Trent was transferred to Port Phillip's management unit after he was found concealing a tablet of anti-depressant medication at another prison.

Trent's case was reviewed by a Sentence Management Panel after seven days. At this time, the Sentence Management Panel told Trent that he would have to remain in the management unit for a further seven days while the Panel considered the safest placement option. Trent expressed disappointment at this decision but said that he understood that it had been made for his own safety.

Trent's case was reviewed again after a further seven days. At this time, the Sentence Management Panel told Trent that he had been placed on the waiting list for a mainstream unit. The Panel then determined to re-classify Trent to a mainstream regime.

Trent remained in the management unit for another six days while he waited for a vacant bed in his new unit. Trent's continued separation during this period was arguably unlawful because he remained separated from other prisoners after his separation order had ceased.

Use of the Intermediate Regime

539. Corrections Victoria policy does not recognise classification to an Intermediate Regime as a form of separation within the meaning of the Corrections Act.

540. As such, use of the Intermediate Regime at Port Phillip is not made subject to the legislative and policy safeguards applicable to separation.

541. The inspection noted that prisoners subject to the Intermediate Regime were eligible to receive a maximum of three hours of out-of-cell time per day.

542. Some of the cases reviewed by the inspection showed that young people classified to the Intermediate Regime were receiving just one hour of 'separated' out-of-cell time per day.

543. The inspection considered that current use of the Intermediate Regime at Port Phillip was arguably contrary to law because the practice almost invariably entailed 'the separation of a prisoner from other prisoners' for significant periods of time without satisfaction of the requirements applicable to separation under the Corrections Regulations.

544. In response to the Ombudsman's draft report, DJCS commented:

> Intermediate Regime at Port Phillip is overseen by Corrections Victoria, and if the use of this regime is seen to be unlawful (which is disputed), this should be attributed to the department rather than G4S, which is considered to be within its contractual obligations in its application of the regime.

Geoff

Twenty-four-year-old Geoff occupied a triple-cell in one of Port Phillip's intermediate units.

One evening, staff observed that one of Geoff's cellmates had sustained injuries to his face. All three prisoners were removed from the cell and interviewed. No one was willing to identify the person responsible.

All three prisoners were placed in separation, 'pending investigation and placement review'. Staff also decided to refer the matter to a disciplinary hearing.

Geoff's separation was reviewed after five days. Geoff told the Sentence Management Panel that his cellmates had come into conflict over a movie; he denied having any involvement in the physical altercation. The Sentence Management Panel decided to place Geoff on the Intermediate Regime for a minimum of two months.

Geoff was taken to an intermediate unit, where he was initially confined to a cell for 23 hours per day. Geoff's behaviour during this period was largely exemplary; he remained incident free, he was polite and responsive when engaging with staff, and he eventually obtained employment as a unit billet. The conditions of Geoff's Intermediate Regime were later relaxed to permit him two hours of non-separated out-of-cell time per day. During this period, a disciplinary hearing also resolved to dismiss the allegation which led to Geoff's separation.

Although the allegation leading to his separation was dismissed, and notwithstanding his good behaviour, Geoff's classification to the Intermediate Regime was not reviewed until approximately two weeks after expiration of the two-month period recommended by the Sentence Management Panel. At this time, the local review committee noted Geoff's good behaviour and recommended that he be returned to a mainstream unit. Geoff was classified to a mainstream regime seven days later.

All up, Geoff spent 86 days confined to his cell for at least 22 hours per day – approximately 2,064 hours in total.

Lockdowns under the Violence Reduction Strategy

545. The inspection was informed that Port Phillip's Violence Reduction Strategy (VRS) was developed in recognition of the significant period in which prisoners are ordinarily isolated through the separation process, providing staff with the means to isolate prisoners for shorter periods of time in response to less significant incidents.

546. Port Phillip does not require that lockdowns under the VRS be the subject of a separation order. While recognising that this position appears consistent with the Manual that requires a separation order be completed, 'when separating a prisoner in a cell for management reasons where the separation is expected to continue for longer than 24 hours', the inspection was not convinced of the lawfulness of this approach.

547. The Corrections Regulations require that the 'separation of a prisoner from some or all other prisoners' be the subject of a separation order. The separation of a prisoner from others for less than one day is neither expressly nor implicitly exempt from this requirement.

We have far less separations than we would otherwise have [due to lockdowns under the Violence Reduction Strategy].

– Senior staff member

548. If lockdowns under the VRS do amount to separation, use of the practice appear to contravene the Corrections Regulations in several ways:

- Lockdowns under the Strategy can be initiated by staff below the Supervisor level, allowing for prisoners to be separated by persons who lack the requisite delegation.
- Lockdowns under the Strategy are not accompanied by a written separation order.
- Prisoners subject to lockdowns are not supplied with a written separation order, nor does the Strategy require that prisoners be advised of the reasons for separation.
- There is no requirement under the Strategy to consider the prisoner's medical and psychiatric condition prior to separation.

549. The inspection noted that lockdowns under the VRS were also not reviewed by Corrections Victoria, greatly reducing external oversight of the practice.

550. Port Phillip maintains a register of lockdowns made under the VRS which records the identity of the prisoner, the nature of the incident, the period in which the prisoner was confined to their cell and the staff members who authorised the lockdown.

551. The register also identifies when a prisoner's isolation under the Strategy is redesignated as 'separation'.

552. Prisoners may be isolated for a maximum of 23 hours under the VRS; and it is the responsibility of the Violence Reduction Coordinator to ensure that lockdowns approaching 23 hours' duration are 'ceased at the appropriate time'.

553. The inspection noted that seven per cent of all lockdowns affecting young people recorded on the register within the previous 12 months exceeded 23 hours' duration, in apparent contravention of the Strategy.

554. In addition, these lockdowns also appeared to deny the young person their right to at least one hour of fresh air per day, contrary to section 47(1)(a) of the Corrections Act and rule 23(1) of the Mandela Rules.

555. The inspection noted that many entries recorded on the VRS register also did not appear to explicitly raise an allegation of violence or aggressive behaviour on the part of the young person, in possible contravention of the policy.

Vittorio

Twenty-four-year-old Vittorio was accommodated in Port Phillip's intellectual disability unit.

During his time at Port Phillip, Vittorio was frequently isolated under the prison's Violence Reduction Strategy. Staff recorded various reasons for isolating Vittorio, including, 'Threats to staff', 'Disobeying direct order', Inappropriate unit behaviour' and 'Time out – for psych issues'.

Vittorio was isolated 32 times under the Strategy over a 10-month period. All up, Vittorio spent more than 342 hours – about 14 days – confined to his cell. These isolations were not the subject of a separation order, and consequently were not reviewed by Corrections Victoria.

On five occasions, Vittorio was isolated for more than 23 hours, exceeding the period allowed under the Violence Reduction Strategy, and contravening Vittorio's right to at least one hour of fresh air per day.

Unit and facility-wide lockdowns

556. Although the Corrections Act authorises prison staff to 'give any order to a prisoner [...] necessary for the security or good order of the prison or the safety or welfare of the prisoner or other persons' (section 23(1)), there is no provision which explicitly authorises the total or partial lockdown of a prison.

557. Regulation 32(1)(c) of the Corrections Regulations provides that a prisoner may be separated 'from some or all other prisoners [...] for the management, good order or security of the prison'; however, neither Port Phillip's Operational Instruction nor the Corrections Victoria Manual recognise a lockdown to be a form of isolation requiring a separation order.

558. The inspection considered that as in the case of lockdowns under the Violence Reduction Strategy, it is arguable that young people and others confined to their cells for the purposes of a unit or facility-wide lockdown were being separated within the meaning of the Corrections Regulations.

559. So, the lockdowns at Port Phillip likely contravened the Corrections Regulations because, among other reasons, prisoners were being separated without a written separation order made under the authority of the Secretary.

560. Although there is no legislative requirement to do so, the inspection noted that Port Phillip maintains a register of unit and facility-wide lockdowns, which records the date and duration of confinement, the number of prisoners affected and the nature or purpose of the lockdown.

Withdrawal of privileges

561. Under the Corrections Act, authorisation to withdraw a prisoner's privileges, including the ability to associate with other prisoners and access full out-of-cell hours, is subject to the following safeguards under section 53 of that Act:

    - Multiple privileges may only be withdrawn once the prisoner has been found guilty of, or admitted to, a prison offence at a disciplinary hearing.
    - Privileges cannot be withdrawn for more than 30 days.

562. Although authority to adjudicate a disciplinary hearing is vested in the Governor of a prison, the inspection observed that Port Phillip had delegated this function to staff at the Supervisor level.

563. The inspection noted that it is both Port Phillip and Corrections Victoria's policy that isolation resulting from the withdrawal of a prisoner's privileges must be accompanied by a written separation order, to be subsequently endorsed by Corrections Victoria.

564. As there were no separation orders affecting young people endorsed for this reason during the review period, the inspection is unable to meaningfully comment on the safeguards afforded to the practice.

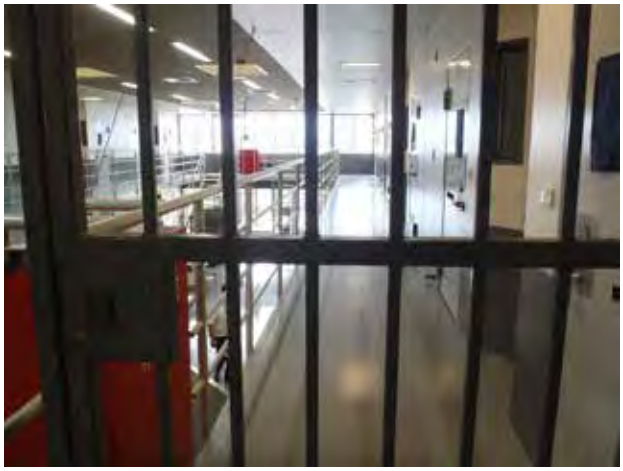
Material conditions

565. The inspection observed that Port Phillip was an austere environment.

566. The accommodation units were mostly kept to a reasonable standard of cleanliness, but common areas were drab. The prison grounds were sparse and monotonous.

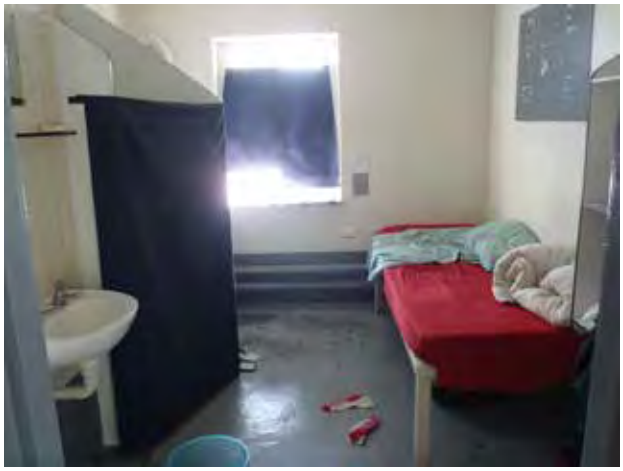
567. The exceptions were the two specialist units, Penhyn and Marlborough, where some effort had been made to provide a more enriching environment for prisoners. Marlborough Unit in particular was well decorated and included a small exterior garden area and horticultural facilities.

Unit interior (Borrowdale)



Prison grounds facing Penhyn Unit

Cell interior



Marlborough Unit exterior

Charlotte Unit

The walk to Charlotte Unit

Cell door slot

568. Conditions in Port Phillip's dedicated separation unit, Charlotte, were exceedingly bleak.

569. Prisoners in the unit who were confined to their cells for 23 hours per day, were escorted to and from their run-outs through a largely sterile common area lacking in natural light.

Once you get to the third day, it's like, 'fuck, I need to talk to someone.' You end up talking to the TV.

– Young person

570. Prisoners accommodated in the corridor area known as 'the spine' appeared to live a particularly impoverished existence.

571. One member of staff working in the unit described the 'Charlotte regime' as 'brutal'.

572. Staff working in the unit were polite and respectful in their interactions with the inspection. The inspection was nevertheless concerned to observe one prisoner being placed in a cell which appeared to be partially flooded. The inspection observed water on the floor of another unoccupied cell, which did not appear to be draining.

573. Some young people informed the inspection that they had been placed in cells in Charlotte Unit which contained faeces or other excreta from previous occupants.

574. Several young people described being required to clean out their cell on arrival to the unit, during the period reserved for their run-out. One said he had been required to spend a night in his cell before he was provided with cleaning products.

Charlotte is putrid; the day you land there you go to sleep. You clean the next day.

– Young person

575. The inspection noted that the placement of prisoners in unclean cells was contrary to the requirement in the Mandela Rules that '[a]ll parts of a prison regularly used by prisoners […] be properly maintained and kept scrupulously clean at all times', and also arguably breached the right of these prisoners under the Mandela Rules to be 'treated with the respect due to their inherent dignity and value as human beings' and to humane treatment when deprived of liberty under section 22 of the Human Rights Act.

Figure 3: Maximum allowances during separation under Corrections Victoria policy (PM5.1)

Incentive Based Regimes

	Loss of Privileges	Initial Separation	Incentive Regime 1	Incentive Regime 2	Incentive Regime 3
Regime Restrictions					
Out of cell hours	Maximum of 2 hours	Maximum of 2 hours	Maximum of 4 hours	Maximum of 6 hours	Maximum of 6 hours
Contact Visits	0	0	1/mth	1/mth	2/mth
Cubicle Visits	1/week (60mins)	1/week	1/week	2/wk	2/wk
Eligible to apply for Within Unit Run-out with other prisoners	2 prisoners (other LOP prisoners)	2 prisoners	2 prisoners	2 prisoners	2 prisoners
Access to special spends	No	No	No	No	Yes
Privileges (available incentives)					
Access to private monies	No	No	No	No	Yes
Access to non-essential canteen spend items	No	No	Yes	Yes	Yes
Number of telephone calls (other than legal, ombudsman and health services commissioner)	0	Maximum of 15/ week	Maximum of 20/ week	Maximum of 25/ week	Maximum of 35/ week
Access to in-cell electrical appliances	No	No	Limited	Yes	Yes
Access to TV (including Pay TV if avail)	No	Yes	Yes	Yes	Yes
Eligible to apply for Electronic Games	No	No	No	Yes	Yes
Eligible to apply for an In-Cell Computer	No	No	No	Yes	Yes
Access to approved hobby activities and items	No	No	No	Yes	Yes
Number of approved personal cell property points	50	50	50	75	100

576. The inspection was greatly concerned by the design and state of Charlotte Unit's run-out areas. These were little more than walled-in slabs of concrete with a steel mesh area opening to the sky. A handful of these areas contained aged exercise equipment. Some were kept entirely sparse, save for a toilet.

If you let yourself get into a really bad headspace, it's unbearable.

– Young person

577. The inspection's visiting expert from Her Majesty's Inspectorate of Prisons in the UK said that these were the worst such areas of this kind that he had observed in his many years of inspecting places of detention.

578. The inspection considered that Charlotte Unit run-out areas fell considerably short of the international human rights standards applicable to exercise and recreation in custodial settings.[18]

They just send you to another fucking room. The floor's concrete.

– Young person

579. Prisoners accommodated in the unit received visits on the unit, rather than in the prison's dedicated visiting area. The inspection observed that the unit's visiting rooms were similarly austere.

18 Mandela Rules, rule 23(2) ('[y]oung prisoners, and others of suitable age and physique, shall receive physical and recreational training during the period of exercise. To this end, space, installations and equipment should be provided.'). See Mandela Rules, rule 42; Havana Rules, rules 32 and 47.

580. The inspection heard that prisoners were sometimes released back into the community directly from Charlotte Unit.

581. The inspection considered that the conditions of Charlotte Unit, when coupled with the terms of the separation regime, created a significant risk of torture or cruel, inhuman or degrading treatment or punishment.

582. At the very least, the conditions appeared likely to contravene the obligation under rule 38(2) of the Mandela Rules to 'take the necessary measures to alleviate the potential detrimental effects' of solitary confinement upon prisoners.

583. Charlotte Unit appeared particularly ill-suited to accommodate vulnerable prisoners, including children and young people.

The good order of the prison takes precedence over the mental wellbeing of the prisoner.

– Staff member

Separation should be done more often and people with little knowledge of prisons should stay away. A stay in Charlotte is treated as a holiday/short break by prisoners.

– Staff member

In total I was put in the slot [Charlotte Unit] for nine months. I've never been the same since. A letterbox flap would drop outside, and I'd jump. Or it would be just the sounds; people walking around behind me … The day I was let out of here, they led me out of the slot in handcuffs to the front gate … I was on the bus in green pants, everyone was looking at me. I jumped off the bus early and started crying … I couldn't wait in the line at Centrelink with 100 other people. Do you know how hard that is, when the only person you've seen for the last nine months was yourself in the mirror?

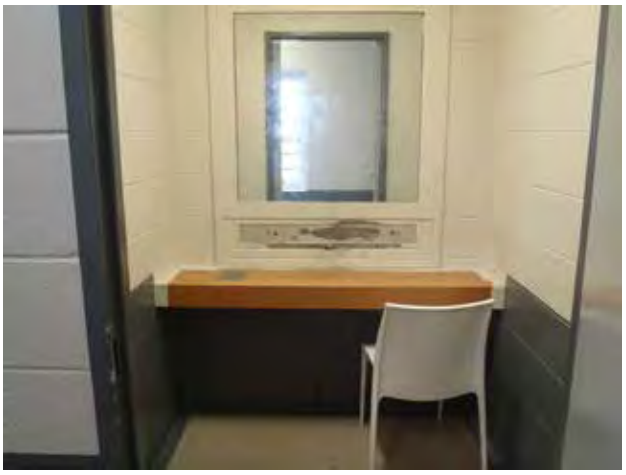
– Adult prisoner

Common area

Run-out area

'The Spine'

Non-contact visit area



Cell interior

Exercise equipment

Intermediate units

584. The conditions in Borrowdale Unit were also bleak. Prisoners spent their run-out times in small, cage-like areas, devoid of purposeful activity. As in the case of Charlotte Unit, the inspection considered that these areas were not in keeping with relevant international human rights standards or the Human Rights Act.

585. The material conditions of the other intermediate unit, Alexander South, were somewhat better. Prisoners in this unit were provided with a larger outdoor run-out area, albeit also sparsely equipped. The inspection was informed that the unit had previously been used to accommodate prisoners on mainstream regimes.

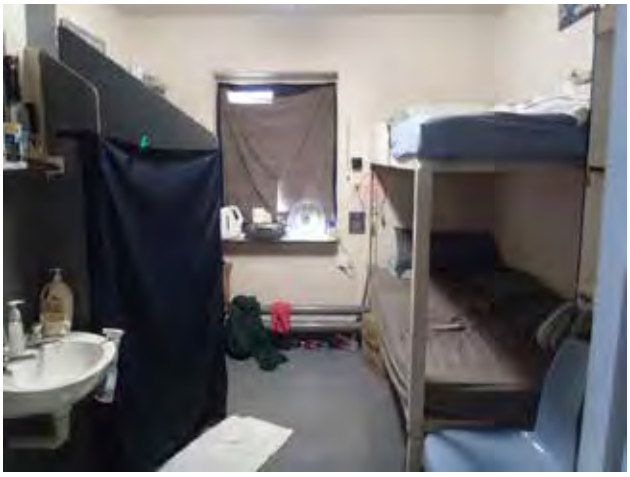
586. Some prisoners in the intermediate units were accommodated in shared cells. The inspection received mixed feedback from young people about these arrangements. Some appreciated having somebody to talk to, and others said that sharing a small area with another person for up to 23 hours a day was intolerable.

Unit interior (Borrowdale)

Run-out areas (Borrowdale)

Run-out area (Alexander South)

Double cell (Sirius)



Meaningful human contact

587. The central harmful feature of solitary confinement is that it reduces meaningful human contact to a level of social and psychological stimulus that many experience as insufficient to sustain health and wellbeing.

I like it [separation], but maybe I'm a bit institutionalised.

– Young person

588. It is well documented that the denial of meaningful human contact can lead to a range of psychological and sometimes physiological harm, including anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia, psychosis, self-harm and suicide.[19]

Isolation can breed paranoia. Separation can cause a prisoner to 'act out' in order to get the attention he is deprived of.

– Staff member

589. Meaningful human contact and access to purposeful activity have the added benefit of improving prisoners' chances of a successful return to the community when the time comes. International and national standards set minimum requirements around these activities.[20]

590. The Corrections Act also states that prisoners have the right under section 47 to:

- receive one visit for at least half an hour each week
- send and receive mail, subject to certain security measures
- take part in education programmes in prison.

591. Overall, the inspection was not satisfied that separated prisoners receive adequate meaningful human contact in terms of interaction with staff, contact with other prisoners and the outside world, and access to purposeful activity.

Interaction with staff

592. The inspection observed very little interaction between prison staff and separated prisoners, even at times when prisoners were out of their cell on a run-out.

If you're not on [suicide] watch, they don't really give a fuck, sometimes they forget about you [in Charlotte Unit].

– Young person

593. Despite this, 31 per cent of young people surveyed reported that they were 'always' able to speak to unit staff during separation and lockdowns. Another 37 per cent said they were 'sometimes' able to speak with unit staff during separation and lockdowns.

594. Thirty-eight per cent said that unit staff would ordinarily check on them regularly during periods of isolation; compared to 44 per cent who reported they did not.

19 Guidance document on the Nelson Mandela Rules page 105, referencing Grassian S, 'Psychiatric effects of solitary confinement', Journal of Law and Policy, Vol. 22, 2006, pp. 325-383; Craig Haney, 'Mental health issues in long-term solitary and supermax confinement', Crime & Delinquency, Vol. 49, No. 1, 2003, pp. 124-156; Sharon Shalev, 'A sourcebook on solitary confinement', Mannheim Centre for Criminology – London School of Economics, 2008; Interim report of the Special Rapporteur on torture, A/66/268, op. cit., note 231.

20 Nelson Mandela Rules, rules 23, 58-66, 96-108.

595. Almost half of the young people surveyed said that unit staff did not usually tell them what they had to do to get out of separation and onto a normal regime. The inspection did however observe some case notes of interactions between prisoners and staff where they discussed goals for maintaining appropriate behaviour.

They don't attend to me as much as they would if I wasn't locked down. Meals come cold, property comes when the time suits the officers. And we only get box visits.

– Young person

One supervisor here helps you. Everyone goes to him. It would be better if everyone helped.

– Young person on Intermediate Regime

Sometimes they check on you through the trap.

– Young person

596. Thirty-eight per cent of young people surveyed agreed with the statement, 'When I'm kept in a cell for a long time, unit staff usually ask me if I'm OK.' A similar proportion (40 per cent) disagreed with the statement.

597. Thirty-three per cent of young people surveyed said that unit staff would usually 'have a chat with me every day' during periods of isolation, compared to 50 per cent who reported that unit staff would not ordinarily do so.

598. Approximately 50 per cent of staff surveyed felt the prison did either 'Well' or 'Very well' at managing the following needs of young prisoners in separation:

- providing the prisoner with meaningful human contact
- preventing self-harm
- preventing suicide
- facilitating access to healthcare
- facilitating access to mental health care.

I understand why we're here. It all comes down to support from the officers [though]. I don't want to be treated special but just to get things done and what I need. Officers at other jails look through your case notes and do what they have to do, but not here.

– Young person on Intermediate Regime

599. However, comparatively fewer reported that the prison did either 'Well' or 'Very well' in terms of preparing the prisoner to return to a normal regime or the prisoner's ongoing rehabilitation.

It's not right to talk to them [unit staff] – it's not a good look.

– Young person

600. The inspection was told that effectively engaging with separated young people is particularly challenging for staff whose role it is to make arrangements for prisoners transitioning back into the community. Understandably, prisoners are reluctant to speak about their housing and other support arrangements through the trap in their cell door, as they are often required to do when planning for their release coincides with a period of separation.

Contact with other prisoners and the 'outside world'

601. All prisoners housed in Charlotte Unit or otherwise separated are subject to the 'Incentive Based Regime' as described in the Manual:

> ... all regimes include access to a minimum of one hour out of cell, one cubicle visit per week, access to reading materials, essential canteen items, professional visits, other programs, services and requirements based on the eligibility requirements that are authorised and administered elsewhere. This includes services such as medical services, programs and education where the offence or security issue does not constitute a reason for non-participation.

602. Prisoners on an 'initial separation' regime are eligible to receive one cubical visit per week, a maximum of 15 phone calls (excluding calls to lawyers or the Ombudsman) and eligible to apply for a run-out with two other prisoners. Prisoners are not eligible to any contact visits until they are on 'incentive regime 2', which may take months to achieve.

603. The prison may also suspend a prisoner's ability to make telephone calls (excluding legal calls or complaints to the Ombudsman) in certain circumstances, including as 'loss of privileges' following a disciplinary hearing.

604. In response to the Ombudsman's draft report, DJCS clarified that prisoners would only have 'phone access (personal calls) suspended if their offence relates to improper use of the phone system.'

605. Rule 43 of the Mandela Rules provide:

> Disciplinary sanctions or restrictive measures shall not include the prohibition of family contact. The means of family contact may only be restricted for a limited time period and as strictly required for the maintenance of security and order.

606. Restricting prisoners to cubical visits meets this standard, because it still allows for some contact. However, as noted in the Ombudsman's OPCAT-style inspection of the Dame Phyllis Frost Centre, suspending telephone calls arguably breaches the standard and is not a reasonable limitation on the right to protection of families and children pursuant to section 17 of the Human Rights Act.

607. To maintain relationships between parents and children, the General Manager may permit visits between a prisoner and the prisoner's children (up to the age of 16 years) during periods when the prisoner does not meet the conditions for participation in the Contact Visit Program. Just under a third (28 per cent) of young people surveyed said they were parents.

Separation makes it hard for me and the other guys to contact our kids. They go to school when we are locked down and we can't call them until after school.

– Young person

608. Thirty-eight per cent of young people surveyed said they were 'always' able to contact their family during periods of isolation; 33 per cent said they were 'sometimes' able to contact their family and eight per cent reported that they were 'never' able to contact their family during these periods.

609. Similarly, 38 per cent of young people surveyed reported that they were 'always' able to have visits with their family or friends during periods of isolation; 33 per cent said they were 'sometimes' able to have visits, and 10 per cent reported that they were 'never' able to have visits with their family or friends during periods of isolation.

610. Fifty-four per cent of young people surveyed reported that they were 'always' able to send and receive mail during periods of isolation; and 21 per cent said they were 'sometimes' able to.

22 hours [in a cell] for a week or two, then longer [out of my cell]. No visits, no phone calls, no contact. No letters, no phones, no Ombudsman. No TV for two weeks. Depends on the person to accept it.

– Young person

[Periods of isolation are] alright; I've got a lot of support from friends and family. I'm due to get out in a year.

– Young person

611. In response to the draft report, DJSC stated:

> Mail access, phone access, visits access are never restricted unless the offence relates to those specific areas. Ombudsman contact is never restricted.

Purposeful activity

612. Under its Operational Instructions, Port Phillip should operate a routine structured day where prisoners are engaged in work, programs and education. This routine must allow for specific prisoner groups including prisoners in maximum security or management units.

613. The inspection did not see any evidence of prisoners in separation engaging in purposeful activity. In effect, this can mean that there is little opportunity for prisoners to demonstrate good behaviour or exercise sound judgement.

614. The inspection was concerned by the lack of anything therapeutic for separated prisoners, and in Charlotte Unit, considered the unused communal dining space was a missed opportunity for positive interaction between prisoners and staff and dynamic security.

615. Despite this, staff surveyed had largely positive impressions of the conditions for young people in separation. Most respondents rated the quality of the following as either 'Good' or 'Very good':

- ability of prisoners to keep themselves clean
- access to clothing
- food
- access to request forms
- access to visits
- access to a telephone
- access to mail
- provision of legal resources
- quality of cell space

616. Approximately half of the staff surveyed felt the prison did either 'Well' or 'Very well' at providing young prisoners in separation with access to access to the chaplaincy, case management, in-prison complaints services and external complaints bodies.

617. Comparatively fewer gave a positive appraisal to the prison's ability to provide access to the following for young prisoners in separation:

- education
- vocational training
- prison industries
- programs
- reintegration programs
- orientation services.

618. Overall, staff employed in an operational capacity were much more likely to give a positive appraisal to the services received by young prisoners in separation than those employed in other areas of the prison.

619. In some cases, prisoners on an Intermediate Regime can have a billet job.

Asim

Twenty-four-year-old Asim spent 83 days in Borrowdale Unit on an Intermediate Regime. Local case notes record his interactions with staff during this time where they discussed his goals for maintaining positive behaviour.

Asim's good behaviour and positive attitude gained him a 7-day a week billet job.

Asim said he would like to move back into a mainstream unit one day; however, he feels comfortable in the unit with his billet job.

Self-isolation

620. Under the Corrections Act, prisoners are entitled to be in the open air for at least an hour each day, if the weather permits. For prisoners on separation, this is facilitated through a one-hour 'run-out'.

621. In response to the draft report, DJCS said that prisoners:

> can leave the cell regardless of the weather and it is up to the individual if they take their runout unless very extreme weather is present which would compromise safety or security.

Separated prisoners have no access to work as that is part of the separation.

– Staff member

622. Where prisoners are separated on mainstream units, their one-hour run-out results in the rest of the unit being locked down for that period. If there are multiple separated prisoners on the unit, it can be locked down for several hours. To minimise the impact of run-outs on other prisoners they often occur first thing in the morning.

623. The inspection was concerned to observe that young people separated on mainstream units would often refuse their run-outs due to pressure (or perceived pressure) from other prisoners and that they are offered early in the morning.

Unfortunately, I have been met in the past with negative attitudes when expressing concern regarding a prisoner's placement (in separation). With the support of my senior I have discussed placement concerns with the Health Services Manager, Prison Services Manager and Violence Reduction Managers.

– Staff member

624. Some staff reported strategies for dealing with young prisoners who refuse to take a run-out:

A lot of the fellas in the unit say don't do your run-out. It impacts on them.

– Young person

Sometimes I opt for leaving the door open for the hour of their run-out, even if they don't want it.

– Staff member

They are always offered the opportunity to have out-of-cell time, however some prisoners decline to accept the offer and wish to remain in their cell. If they repeatedly decline the offer, then discussion is held to encourage them to accept the offer.

– Staff member

Use of one hour 'run-out'

625. The overwhelming majority (85 per cent) of young people surveyed reported that they were ordinarily able to spend time outside as part of their out-of-cell time during separation.

626. Most (77 per cent) said they were usually able to exercise or work out during their out-of-cell time. This is consistent with the inspection's observations. Fewer prisoners (approximately 50 per cent) reported that they were ordinarily able to see and speak with other prisoners during their out-of-cell time, and almost one-third said they could not.

627. The inspection was told that prisoners also must use their one-hour run-out to clean their cell and wash their laundry. Often unit staff or other prisoners will have to finish a separated prisoner's laundry because the washing machine cycle is longer than an hour.

The separation orders [of other prisoners] can get in the way of other things we need to get done in the unit, they can get in the way sometimes.

– Young person

628. Although the incentive-based regimes described in the Sentence Management Manual provides that prisoners may be eligible for a maximum of two – six out-of-cell hours, depending on the regime, the inspection observed that it was rare for more than one hour to be offered. This was a significant point of frustration for the young people who spoke to the inspection.

[If I was the boss for a day] I'd make the time for a run-out two hours instead of one and a half ... But I understand there's rules.

– Young person

629. Overall, the inspection considered that the lack of meaningful human contact and purposeful activity, which, for the most part continued even during a prisoner's run-out, presented a significant risk of ill-treatment.

Prisoners are not in adequate accommodation units to facilitate lock down regimes and as a result are often encouraged not to take their 1 hour out of cell. Prisoners personal hygiene and mental health suffer as a result. Prisoners get abused and told not to take their run-outs and other prisoners threaten them when they do.

– Staff member

Health and wellbeing

630. Prisoners should receive the same standard of health care that is available in the community, according to both the Mandela Rules and the *Guiding Principles for Corrections in Australia* (2018).

631. The Corrections Act also states that prisoners have the right to access:

- reasonable medical care and treatment necessary for the preservation of health
- a private registered medical practitioner, dentist, physiotherapist or chiropractor chosen by the prisoner with the approval of the 'principal medical officer'. Access to these private services is at the prisoner's own expense.

Health consideration before ordering separation

632. Children and young people who have medical or psychiatric conditions are particularly vulnerable to the negative effects of solitary confinement.

633. As previously noted, before making an order to separate a prisoner, the Secretary must consider any medical and psychiatric conditions of the prisoner. This requirement is an important protective measure and is consistent with the Mandela Rules (rule 33), Havana Rules (rule 28) and the *Guiding Principles for Corrections in Australia*:

> Signs that a prisoner's physical or mental health has or will be injuriously affected by continued sanctions or segregation/ separation are recognised and considered, taking into account the safety of other prisoners and staff and the security and good order of the prison.

634. The inspection was not satisfied that this was occurring at Port Phillip. It was observed that:

- Port Phillip's Operational Instruction concerning the use of separation made no reference to the requirement, and the Manual was also largely silent as to the matter.
- Staff involved in the separation of prisoners did not refer to the requirement when discussing the separation procedure with the inspection.
- None of the separation records reviewed by the inspection made reference to the requirement.

635. In the clear majority of cases, staff did not document the extent to which, if at all, they had regard to a prisoner's medical or psychiatric condition before authorising separation.

636. According to rule 39(3) of the Mandela Rules, before disciplinary sanctions are imposed, consideration should be given as to whether and how a prisoner's mental illness or disability may have contributed to his conduct. This is also consistent with broader common law principles around sentencing[21] and is reflected in Port Phillip's 'Checklist for Disciplinary Officers'.

21 See *R v Verdins* (2007) 16 VR 269.

Figure 4: Extract from 'Checklist for Disciplinary Officers'

SPECIAL NEEDS CONSIDERATIONS	
At the time of the offence, did the prisoner have a **P Rating?** If yes list.....P3..... If the prisoner had a P1 or P2 rating, refer to health / psychiatric professional to assist in determining: If this could be a factor in the offence, has psychiatric advice been sought as to - • Whether the prisoner was responsible for his or her actions? • Whether an alternative to the disciplinary procedure is more appropriate (case management response)	Yes ☐
Does the prisoner have an **Intellectual disability?** If proceeding to a hearing, has an advocate for the prisoner been arranged? If this could be a factor in the offence, has specialist advice** been sought as to - • whether the prisoner was responsible for his or her actions? • Whether an alternative to the disciplinary procedure is more appropriate (case management response)	Yes ☐
Other (list):	Yes ☐ No ☐

Source: Port Phillip Prison

Rupert

Twenty-three-year-old Rupert is a young man with an intellectual disability living in Marlborough Unit at Port Phillip Prison. Rupert is described as a 'very low functioning prisoner.'

In early March 2019, Rupert was involved in an incident in Marlborough yard. Reports say that Rupert threw a rock at another prisoner, striking the other prisoner's wrist. According to Rupert, 'he was mouthing off at me, so I was walking through the garden to him and I tripped on a rock, so I picked it up and threw it at him.'

A 'code blue' was called, and Rupert was immediately separated. The incident report records that Rupert was to be charged for assaulting or threatening another prisoner. The other prisoner was seen by medical staff for a small laceration on his left wrist.

The disciplinary officer completed a checklist, however, the 'special needs considerations' section (set out above) was left blank.

Rupert was separated to a cell for 23 hours per day.

A Sentence Management Panel was convened on Rupert's seventh day in separation. According to the Panel's notes:

> In consideration of the length of time separated, incident free behaviour since his initial separation and in consultation with location management Rupert was advised that he would be cleared back to Marlborough Unit.

Rupert – continued

Five days later, Rupert was involved in a code purple and locked down under the Violence Reduction Strategy. Several hours later, Rupert was escorted to the St Paul's (Psycho-Social) Unit and placed in an observation cell on 'S2' – meaning that he was at significant but not immediate risk of suicide or self-harm and had to be observed by correctional staff at intervals of no greater than 30 minutes.

Rupert asked if he could have the TV turned on in his cell and was told that as a new arrival on S2, he could not.

Rupert's drawing

Access to health services while separated

637. The negative health impacts of solitary confinement are well documented and protective measures must exist to alleviate the potential detrimental effects. The role of health care staff is particularly important in this regard.

638. To this end, the European Committee for the Prevention of Torture (**CPT**) considers that medical personnel should never participate in any part of the decision-making process resulting in any type of solitary confinement, except where the measure is applied for medical reasons. The separation processes at Port Phillip appear to reflect this.

639. However, given the risks that practices related to solitary confinement pose to health and wellbeing, health care staff should be attentive to the situation of all separated prisoners. The CPT recommends that health care staff be informed of every separation and should visit the prisoner immediately after placement and thereafter, on a regular basis, at least once per day, and provide them with prompt medical assistance and treatment as required. This is consistent with the *Guiding Principles for Corrections in Australia*:

> prisoners who are segregated/separated have daily contact with **appropriate staff** [emphasis added] and their circumstances are reviewed on a regular basis.

640. Under Port Phillip's Operational Instruction 49, and to support prisoners placed in the 'Exclusion Placement Area' for loss of privileges, pending investigation or general management reasons, they must be seen by clinical services prior to their being removed from 'management observations', (observations once every 60 minutes). The clinical services team will meet with every prisoner within 48 hours of their placement and conduct a triage assessment to determine if the prisoner is 'distressed and requires further support' or is coping and can be removed from management observations.

641. In addition, the Operational Instructions state that the prison's 'psychiatric nurse will attend Charlotte Unit each Friday and conduct consults with the unit's 'Short Term' and 'Long Term' prisoners as needed.'

642. The inspection was concerned by a consultation it observed between a separated prisoner in Charlotte Unit and Forensicare staff, where the staff member attempted to engage with the prisoner through the closed cell door.

They just stick you in there [separation] and you have to buzz up for your meds. Otherwise they usually forget.

– Young person

643. Nineteen per cent of young people surveyed reported that they were 'never' able to see a psychologist or psychiatric nurse during separation. Twenty-nine per cent of respondents reported that they were 'sometimes' able to speak with a psychologist, and a similar proportion (31 per cent) reported that they were 'sometimes' able to speak to a psychiatric nurse during separation.

644. In both cases, less than one-fifth of young people surveyed reported that they were 'always' able to speak with a psychologist or psychiatric nurse (15 per cent and 19 per cent, respectively).

645. Twenty-seven per cent reported that they were 'never' able to speak with a doctor during separation; another twenty-three per cent reported that they were only 'sometimes' able to speak to a doctor. Twenty-three per cent said they were 'always' able to speak to a doctor.

The doctor takes three weeks to see me for a medical condition.

– Young person on Intermediate Regime

646. Twenty-seven per cent of young people surveyed reported that they were 'always' able to speak to a nurse during separation; 35 per cent were 'sometimes' able to, and 13 per cent were 'never' able to speak to a nurse during separation.

647. On the other hand, approximately one-half of staff surveyed felt the prison did either 'Well' or 'Very well' at providing young prisoners in separation with access to:

- in-prison health services
- access to health specialist
- mental health services
- suicide prevention and at-risk management
- services for prisoners in other forms of crisis.

648. In response to a survey question asking what action staff can take if they consider that a young prisoner's continued separation is not necessary or appropriate, one non-operational staff member felt there was little they could do, noting that 'the good order of the prison takes precedence over the mental wellbeing of the prisoner.'

Prisoners at risk of suicide or self-harm

649. Port Phillip's Operational Instruction 107 provides that in determining the intervention with an 'at risk' prisoner, consideration should be given to minimising the isolation of the prisoner and maximising their interaction with others, whilst maintaining the safety of all parties.

650. This is consistent with the *Guiding Principles for Corrections in Australia* that state prisoners identified as being at risk of suicide or self-harm are managed in the least restrictive manner.

651. Despite these principles, the inspection was concerned to observe that practices related to the treatment of prisoners at risk of suicide or self-harm may lead or amount to solitary confinement.

652. An 'at risk' prisoner is defined by Port Phillip as someone who has been identified as at risk of suicide or self-harm or exhibiting signs of deteriorating mental state. There are four categories of 'at risk':

    S1 – immediate risk of suicide or self-harm

    S2 – significant but not immediate risk of suicide or self-harm

    S3 – potential but not significant risk of suicide or self-harm

    S4 – not currently at risk but may have a history.

653. Forensicare and St Vincent's Correctional Health Services (St Vincent's) share clinical responsibility for providing 'at risk' services at Port Phillip. St Vincent's operates the services between 8am and 9pm, and Forensicare operates between 9pm and 8am. Forensicare maintains full clinical responsibility for prisoners under the 'St Paul's Psychological Program', even when classified as 'at risk'. Similarly, St Vincent's is responsible for prisoners in St Paul's Unit if their accommodation there is only for observation purposes.

654. In addition to utilising the 'at-risk' procedure, some staff reported positive strategies for engaging with young prisoners in separation who have self-harmed or who are at risk of self-harm, including:

- showing empathy
- identifying strengths and connections with family and friends
- speaking with respect and understanding
- trying to find out what can be done to help.

Observation of 'at risk' prisoners

655. Under Port Phillip's Operating Instructions, there are specific accommodation and observation requirements for 'at risk' prisoners, see Table 2 below.

656. Prisoners identified as being at immediate risk of suicide or self-harm are also restricted in their daily activities:

> they will not receive visits, unless otherwise deemed to be in their best interests, and they will not attend programs or work. They will generally only be allowed to attend medical appointments or other appointments specified in their Risk Management File.
>
> ...
>
> Generally, high-risk prisoners will not have telephone access – only in exceptional circumstances will they be given telephone access to their legal representative(s), which is to be determined by the General Manager, or Manager, Clinical and Integration Services, or a nominated delegate. If permitted to make a legal telephone call, the prisoner is to be closely monitored for the duration they are out of their cell to ensure their safety and to ensure they do not have close contact with any other prisoner.

657. The mental health expert on the inspection was concerned by the restrictions placed on S1 patients, noting that good mental health care will commonly incorporate and encourage visits and telephone contact with family and friends as these can be protective factors, and denying these supports may exacerbate a prisoner's mental illness. There were no young people on an S1 regime during the inspection.

Table 2: Accommodation and observation requirements for 'at risk' prisoners

	Immediate risk	Significant risk (S2)	Potential risk (S3)	History (S4)
Accommodation	Placement according to prisoner's needs: 'Muirhead' or observation cell; or, AAU (MAP) for male prisoners; or, secure psychiatric facility for male or female prisoners, where the prisoner meets the criteria for transfer.	Placement according to prisoner's needs: May be a 'Muirhead' or observation cell; or, single cell; or, shared cell under reasonable circumstances.	Placement according to prisoner's needs: single or shared cell.	Placement according to prisoner's needs: single or shared cell.
Observation	Interval of every four minutes.	Six times per hour on a random basis, but no more than 15 minutes apart.	As specified in the Risk Management Plan.	None.

658. The inspection was told that there are 18 'observation cells' at Port Phillip, including three located in St Paul's Unit.

659. During the inspection, the three observation cells in St Paul's were being used by prisoners who were not otherwise patients of that unit. This meant that the St Paul's patients were locked down to their cells for an additional three hours per day to allow each person on observation to be let out for their one hour run-out. The inspection noted the negative impact this had on patients' access to therapeutic programs and considered it was not in the best interests of supporting their recovery.

660. The inspection considered the regime for prisoners on observations for risk of suicide or self-harm was particularly severe. These prisoners were living in bare cells with CCTV and no possessions and, for the most part, were prevented from engaging in meaningful activity, only being able to leave their cell for one hour per day to exercise. In addition, the CCTV monitors were placed in full view of staff, prisoners and visitors, offering little dignity for the occupant of the observation cell while washing or using the toilet.

661. One prisoner told the inspection that 'you get reviewed every day when you're on constant obs, but if they don't like you they'll stick you on another day because even they know it's a punishment.'

662. The evidence supporting early intervention in life, illness and mental health is well documented in government reform strategies around the world. Given the high instance of mental illness in prisons, effective detection and proactive treatment for emerging issues, particularly for young people, is essential.

663. It is also well documented that practices that may lead or amount to solitary confinement are extremely harmful and can compound underlying mental health issues and causes of suicidal ideation. The risks are even greater when such practices are used on people identified as being at risk of suicide or self-harm.

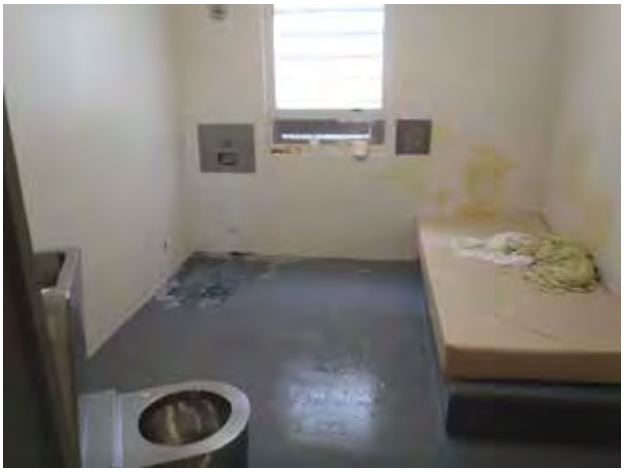
664. Beyond observations, the inspection saw little evidence of active treatment or therapeutic interventions for those at risk of suicide or self-harm. Oversight of decision making as to whether voluntary treatment in St Pauls had been considered or whether the criteria for compulsory treatment under the *Mental Health Act 2014* (Vic) had been met was also unclear.

665. The inspection was concerned that forms of isolation and observation were the primary strategies employed to respond to suicide risks, and noted that in a mental health setting, the use of such practices (being 'seclusion' under the Mental Health Act) is accompanied by safeguards and oversight provisions recognising human rights principles and mitigating the potential for ill-treatment.

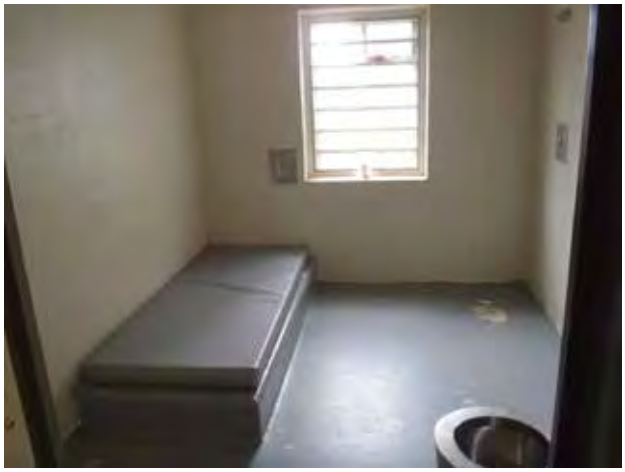
666. The mental health expert on the inspection was concerned to observe what appeared to be practices related to solitary confinement being used as an inappropriate and essentially punitive response to the mental health needs of suicidal prisoners.

667. It was not clear to the inspection why a person categorised as being at immediate or significant risk of suicide or self-harm (S1 or S2) would be subjected to isolation and observation for extended periods (possibly amounting to solitary confinement) rather than being moved to a mental health facility. Anyone at that level of risk could meet the criteria under the Mental Health Act, or alternatively warrant acute mental health treatment on a voluntary basis.

Observation cell in Charlotte Unit



Observation cell in Marlborough Unit



668. Pursuant to section 275 of the Mental Health Act, the Secretary may order that a prisoner be taken to a designated mental health service and detained and treated in that service. A Secure Treatment Order can only be made if the prisoner has been examined by a psychiatrist and the Secretary is satisfied on the psychiatrist's report (and any other evidence) that:

    - the person has mental illness
    - because the person has mental illness, the person needs immediate treatment to prevent:
        - serious deterioration in the person's mental or physical health
        - serious harm to the person or to another person
    - the immediate treatment will be provided to the person if the person is made subject to a Secure Treatment Order
    - there is no less restrictive means reasonably available to enable the person to receive the immediate treatment.

669. A Secure Treatment Order is also subject to a recommendation from 'the authorised psychiatrist' of relevant designated mental health service and that there are facilities or services available to treat the person.

670. This mechanism is not detailed in Port Phillip's Operating Instruction for 'at risk' prisoners, Forensicare's 'at risk referrals and assessments procedure' or St Vincent's 'risk assessment and observations policy'. A Commissioner's Requirement does, however, describe the procedure and key considerations in the administration of transfers on the basis on mental health. This is supported by the Corrections Victoria Sentence Management Manual.

Risk Management Plans

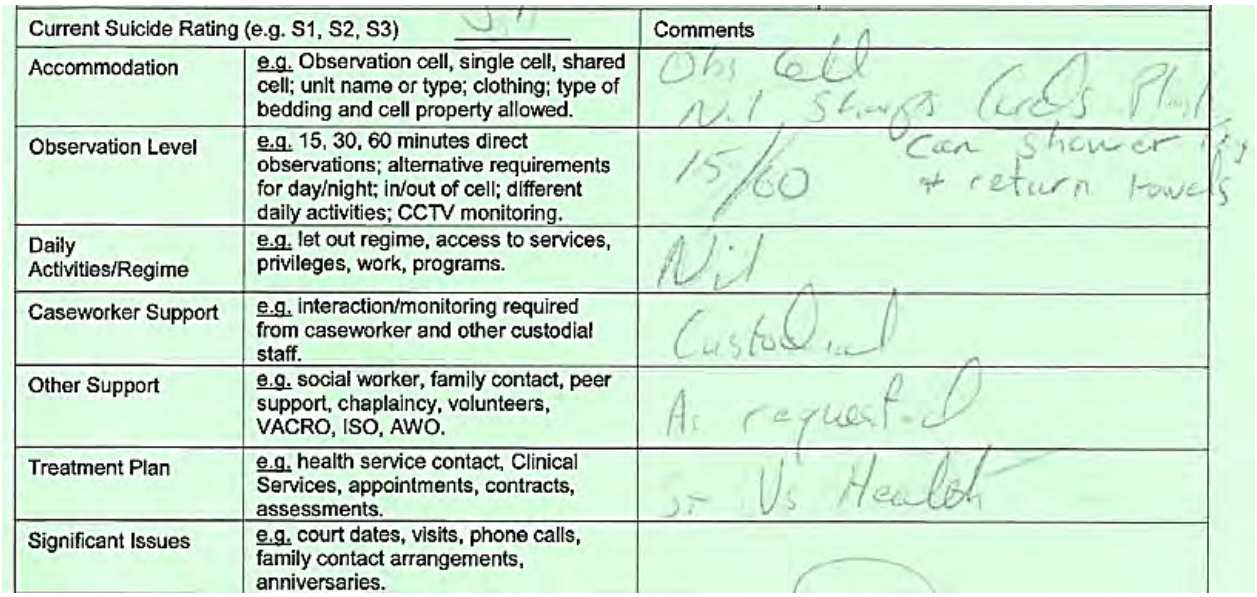
671. Where a prisoner is identified as being 'at risk', a Risk Management Plan is developed and endorsed by the Risk Review Team (**RRT**), comprised of the Manager, Clinical and Integration Services, Area and Duty Supervisors, clinical services staff, case workers and other staff. According to Operational Instruction 107, a Risk Management Plan will identify the:

    - level of risk
    - accommodation placement
    - level of observation and, where appropriate, differentiated observation specifications for:
        - day or night
        - cell or out-of-cell hours, and
        - different daily activities in which the prisoner may be involved
    - type and level of support to be provided (counselling, case worker, family, peer support, chaplaincy, culturally appropriate support)
    - treatment plan
    - daily activities
    - significant issues (e.g. court dates, visits etc)
    - type and level of interaction to be promoted (prisoner/peer support, volunteers, visitors, psychologist, case worker).

672. The inspection identified four young people who were separated for 'self-harm' in the last 12 months and obtained copies of relevant Risk Management Plans.

673. The Plans are a one-page template that appears to be completed by nursing staff and endorsed by the RRT Manager and Supervisor. The plans do not include any substantial information about the type and level of support to be provided, the treatment to be provided or the type and level of interaction to be promoted.

Figure 5: Extract of Risk Management Plan for prisoner at immediate risk of suicide or self-harm



Current Suicide Rating (e.g. S1, S2, S3)		Comments
Accommodation	e.g. Observation cell, single cell, shared cell; unit name or type; clothing; type of bedding and cell property allowed.	Obs cell N.I Stays (as) Pla
Observation Level	e.g. 15, 30, 60 minutes direct observations; alternative requirements for day/night; in/out of cell; different daily activities; CCTV monitoring.	15/60 Can shower + return towels
Daily Activities/Regime	e.g. let out regime, access to services, privileges, work, programs.	N.I
Caseworker Support	e.g. interaction/monitoring required from caseworker and other custodial staff.	Custodial
Other Support	e.g. social worker, family contact, peer support, chaplaincy, volunteers, VACRO, ISO, AWO.	As request-D
Treatment Plan	e.g. health service contact, Clinical Services, appointments, contracts, assessments.	St Vs Health
Significant Issues	e.g. court dates, visits, phone calls, family contact arrangements, anniversaries.	

674. The inspection observed an RRT meeting which occurs daily. The meeting was chaired by the Manager, Clinical and Integration Services and was attended by supervisors and clinical services staff. The RRT discussed each prisoner identified as being 'at risk' and on the recommendation of clinical staff decided whether a prisoner should move up or down on the S1-4 rating. The inspection noted that on some occasions, clinical staff were only able to speak to a prisoner through the cell door trap.

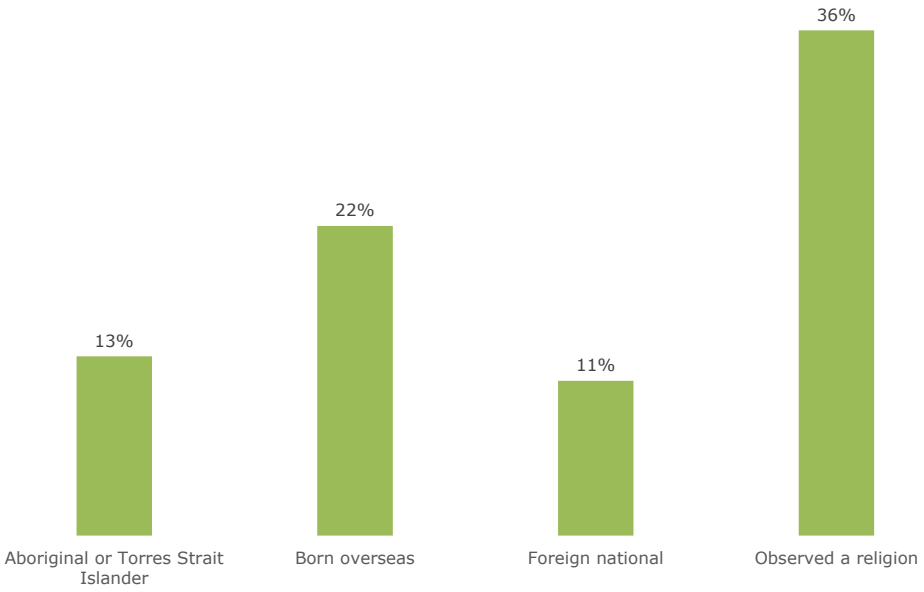
There are difficulties and barriers posed to obtaining appropriate healthcare and support for higher/complex needs offenders, such as those experiencing behavioural disturbance related to ABI/ID or mental health concerns. It can be difficult to obtain appropriate programs or treatment for such individuals, and it is stressful operating from a healthcare perspective within a rigid justice system which can leave you feeling a bit defeated about the prospects for change.

– Staff member

675. The inspection considered that the use of isolation without active treatment or therapeutic interventions for those at risk of suicide or self-harm posed a significant risk for ill-treatment to occur.

Diversity

Young people in Port Phillip demographics (25 Feb 2019)



676. Port Phillip accommodates a diverse cohort of young men from a range of cultural, linguistic and religious backgrounds, including a significant number of Aboriginal and Torres Strait Islander people.

677. There are also young people with a range of mental and physical health issues and disabilities.

678. Particular cohorts, including LGBTIQ+ people, are often more at risk within custodial environments. Prisons need to take account of these vulnerabilities when planning action to prevent cruel, inhuman and degrading treatment.

Aboriginal and Torres Strait Islander young people

679. Almost 30 years ago the *Royal Commission into Aboriginal Deaths in Custody* acknowledged the 'extreme anxiety suffered by Aboriginal prisoners committed to solitary confinement' and recommended that Corrective Services recognise that 'it is undesirable in the highest degree that an Aboriginal prisoner should be placed in segregation or isolated detention.' As quoted in the Royal Commission's final report, one Queensland Aboriginal prisoner described isolation from other Aboriginal prisoners as:

> the equivalent of total sensory deprivation for a white person. Murris always acknowledge other Murris, even strangers. There are social repercussions, people don't communicate. Even when fighting, we are still recognising others. Public displays of emotion are normal. Being forced to live internally is not normal. The Murri psyche is still there. If forced to internalise, our thoughts become ugly and we see no future.

680. In Victoria, the distinct cultural rights of Aboriginal persons are also recognised and protected by law in the Human Rights Act.

681. During the 12-month reporting period, 987 young people passed through Port Phillip, eight per cent of whom were of Aboriginal cultural background. In the same period, 265 young people were placed on a separation order, and 9 per cent were of Aboriginal cultural background.

682. Thirty-three per cent of young people surveyed who identified as Aboriginal stated that they were 'sometimes' able to speak with the Aboriginal Wellbeing Officer during separation or lockdowns, and 17 per cent said that they were 'always' able to speak with the Aboriginal Wellbeing Officer.

Normally the ALOs tell you what's going on ... We have the ALO, maybe [the younger prisoners] could have a youth liaison.

– Young person

[If I was the boss for a day] I'd have more cultural stuff for Aboriginals. More programs, more get-togethers for all the different cultures. It would make things much better and settle things down. Get everyone out.

– Young person

683. The overwhelming majority of staff surveyed felt that Port Phillip did either 'Well' or 'Very well' in facilitating young Aboriginal and Torres Strait Islander prisoners with access to the Aboriginal Wellbeing Officer (25 per cent and 44 per cent, respectively).

684. Far fewer, however, reported that the prison did 'Well' or 'Very well' at providing a culturally relevant diet to young Aboriginal and Torres Strait Islanders in separation (12 per cent and 19 per cent, respectively).

685. Approximately fifty per cent of staff surveyed reported that the prison did either 'Well' or 'Very well' at providing respect and recognition for the culture of young Aboriginal and Torres Strait Islanders in separation (16 per cent and 32 per cent, respectively).

Culturally and linguistically diverse communities

686. Almost fifty per cent of staff surveyed said the prison did either 'Well' or 'Very well' in providing a relevant diet to young people in separation from other culturally or religiously diverse groups (18 per cent and 29 per cent, respectively).

[If I was the boss for a day] I would get more programs going and get support from multicultural workers.

– Young person

687. More than half of staff surveyed also felt that the prison did either 'Well' or 'Very well' at providing respect and recognition for the culture of young people in separation from other culturally and linguistically diverse backgrounds (24 per cent and 29 per cent, respectively).

[If I was the boss for a day] I'd have more cultural activities, life skill programs.

– Young person

688. Interestingly, a majority of staff survey respondents reported that the prison did either 'OK', 'Well' or 'Very well' in facilitating access between the Multicultural Liaison Officer and young prisoners in separation from culturally and religiously diverse backgrounds. Notwithstanding this response, the inspection was informed that the prison did not employ a Multicultural Liaison Officer (or equivalent) during the inspection period.

Staff

689. While OPCAT inspections are primarily concerned with conditions and treatment for detainees, they also examine conditions for staff working in places of detention.

690. As rule 74 of the Mandela Rules provides, the proper administration of a prison depends on the 'integrity, humanity, professional capacity and personal suitability' of its staff.

691. The 690 or so staff at Port Phillip work in a challenging environment where they must balance the safety and security of the prison with upholding prisoners' dignity.

692. This section considers staff perceptions of practices related to solitary confinement, and the extent to which they are trained and empowered to utilise other management or de-escalation strategies to avoid the need to resort to separation.

Conception of role

693. The overwhelming majority of staff surveyed described the following aspects of their role as being 'Very important':

- keeping staff safe (87 per cent)
- ensuring prison security (85 per cent)
- helping the prison to run smoothly (79 per cent)
- being a positive role model (74 per cent)
- prisoner discipline (72 per cent)
- keeping prisoners safe (68 per cent)
- helping to protect the community (66 per cent).

694. This compares to staff surveyed reporting the following aspects of their role being either 'Somewhat important' or 'Not important':

- advocating for prisoners (43 per cent and 26 per cent, respectively)
- providing emotional support to prisoners (43 per cent and 15 per cent, respectively)
- assisting prisoners in rehabilitation (32 per cent and 7 per cent, respectively).

Effectiveness and effects of separation

695. The inspection spoke to some staff who showed concern for, and an understanding of, the harmful effects of solitary confinement. One staff member commented that 'placing a prisoner in separation can exacerbate mental health [issues] and risks to self or others if these concerns are underlying, and thus make things worse.'

Negative thinking patterns can escalate if the young person is ill-equipped to manage these. When separation is used regularly, this can impact on beliefs such as 'the world is against them', which perpetuates further violence. Or the prisoner can become desensitised to the experience of separation.

– Staff member

696. Some staff also told the inspection that in their experience, separation 'doesn't act as a deterrent for poor behaviour but contributes to further anger'.

I am not a supporter of long-term management ... as I think the prisoner's mental health deteriorates.

– Staff member

697. Just 26 per cent of staff surveyed said that separation was usually effective in helping a prisoner address the behaviour or risks that resulted in their placement in separation. Thirty-four per cent reported separation was 'somewhat' effective at achieving this outcome, whereas twelve per cent said it was not effective.

It's not ideal, but working in management for five years, I've seen it work.

– Staff member

698. The inspection also heard from several staff members who did not believe that separating a prisoner had any negative consequences.

They need discipline. Prisons in Victoria are a joke. The soft approach does not work. ... Prisoners over the age of 18 are adults, treat them like adults.

– Staff member

699. Forty-six per cent of staff surveyed said that in their experience, the long-term separation of a prisoner (more than 15 days) had both positive and negative consequences for the prisoner. Sixteen per cent considered that long-term separation did not have any consequences for the prisoner. Six per cent of respondents reported that long-term separation had exclusively positive consequences. Only seven per cent believed that long-term separation had exclusively negative consequences.

There are none [negative effects], provided that it is utilised and reviewed appropriately, which it is at PPP.

– Staff member

700. Survey respondents employed in an operational capacity were more likely to report that separation was effective at addressing the behaviour or risks.

Prisoners are never separated for too long.

– Staff member

Sometimes particularly young prisoners may be having issues with some of the older prisoners, so being locked down gives them a break away from the rest of the prisoners.

– Staff member

If a prisoner is separated due to safety concerns it gives him the opportunity to reflect on what he has done to end up in this situation whilst being kept safe from the person/s that he issues with.

– Staff member

Sometimes containment is necessary for the safety of the prisoner and others. If further support and intervention could be provided following the initial period of containment ... there would be an increased potential for the positive effects to last.

– Staff member

Staff training

701. Prisoners at Port Phillip are locked in their cells between noon and 4pm every three out of four Wednesdays of the month to accommodate staff training. During the twelve months before the inspection, on average, 63 staff attend training each week. Training topics include 'situational awareness', 'security awareness', 'CPR', 'cell searching' and 'disability management'. There are no specific sessions related to the particular needs of young prisoners, use of separation and other forms of isolation or responding to mental health issues.

702. Most staff surveyed reported feeling that they had been sufficiently trained in:

- de-escalation techniques
- suicide and self-harm prevention
- interpersonal skills
- cultural awareness
- engaging with young prisoners
- engaging with vulnerable prisoners
- use of restraints
- use of force.

703. However, less than half felt their training in engaging with prisoners with drug or mental health issues and training in the use of disciplinary processes was sufficient.

[These topics] are covered during [initial] training. I've had no updates on engaging with vulnerable or difficult prisoners or prisoners with mental health issues since.

– Staff member

704. Staff surveyed were least satisfied with their training in respect of engaging with prisoners with mental health issues; 38 per cent of respondents reported that their training in this area was insufficient.

705. Approximately one-quarter to one-third of staff surveyed felt they had been insufficiently trained in respect of the following:

- suicide/self-harm prevention
- engaging with young prisoners
- engaging with vulnerable prisoners
- engaging with prisoners with drug issues
- engaging with prisoners with mental health issues.

706. Staff who had been working at the prison for less than five years were more likely to report that their training was sufficient in all areas.

The training we receive is ongoing and we endeavour to sharpen people's skills to best equip them for dealing with volatile and unusual situations. Unfortunately, management also look to save money wherever possible, at the expense of training.

– Staff member

It would be good to debrief more after incidents, whether good or bad, and reflect on what could have been better handled or what worked well.

– Staff member

[Managing difficult behaviour] depends on the individual. Some respond to 'tough love'. Some require understanding with a mentoring approach. Some require threats of strong discipline. Others need conversation to pinpoint why the attitude is there in the first place. Sometimes you just need to say, 'talk to me'.

– Staff member

Chapter Three:

Inspection of Malmsbury Youth Justice Precinct

About Malmsbury Youth Justice Precinct

707. Malmsbury Youth Justice Precinct comprises two youth justice centres co-located in Malmsbury, approximately 95km north-west of Melbourne. The facility is one of two youth justice precincts operating in Victoria, predominantly accommodating male children and young people aged between 15 and 21 years.

708. Malmsbury is divided into 'secure' and 'senior' sites, with the combined capacity to accommodate approximately 139 children and young people. The facility receives both sentenced and remanded children and young people.

709. In response to the Ombudsman's draft report, the Department of Justice and Community Safety (**DJCS**) wrote:

> It is the practice of Youth Justice to consider accommodation capacity in terms of rooms, rather than bed capacity given the risks, needs and complexities of our young people. The approximate capacity is 123 rooms. Youth Justice does not include the Intensive Supervision Annexe in its count for operational capacity. This is a specialist unit.
>
> For the table provided [below] – Room capacity as followings:
>
> - Deakin, La Trobe Monash Unit: Accurate
> - Admissions: 15 rooms
> - Campaspe: 13 rooms
> - Coliban: 18 rooms
> - Lauriston: 18 rooms
> - Ulabara: 14 rooms

710. The secure site accommodates children and young people aged between 15 and 18 years and has three residential units (Deakin, Latrobe and Monash), three holding cells and a healthcare centre. Each residential unit has a dedicated 'isolation room'.

711. The senior site predominantly accommodates young people aged between 18 and 21 years who have been sentenced to a youth justice centre under Victoria's 'dual-track' sentencing system. Under the dual track system, young people aged between 18 and 20 years may be sentenced to detention in youth justice centre for up to four years. As the eligibility age corresponds with the day of sentencing, this can in practice result in a young person aged over 20 years being detained in a youth justice centre for the duration of their sentence.

712. The senior site comprises three secure units (Admissions, Ulabara and Coliban) and two open units (Campaspe and Lauriston), as well as educational, vocational and recreation spaces and a healthcare centre.

713. Two of the primary units at Malmsbury's senior site (Campaspe and Lauriston) are designated as 'open' units, meaning that children and young people accommodated in these units are ordinarily permitted to enter and exit the units and access other parts of the facility without escort.

714. Coliban Unit includes an area that is separate and apart from the rest of the unit, termed the 'Intensive Supervision Annexe' (ISA). Admissions and Ulabara Units are both equipped with isolation cells. Admissions Unit also has an observation cell.

715. Malmsbury is staffed and operated by the Department of Justice and Community Safety.

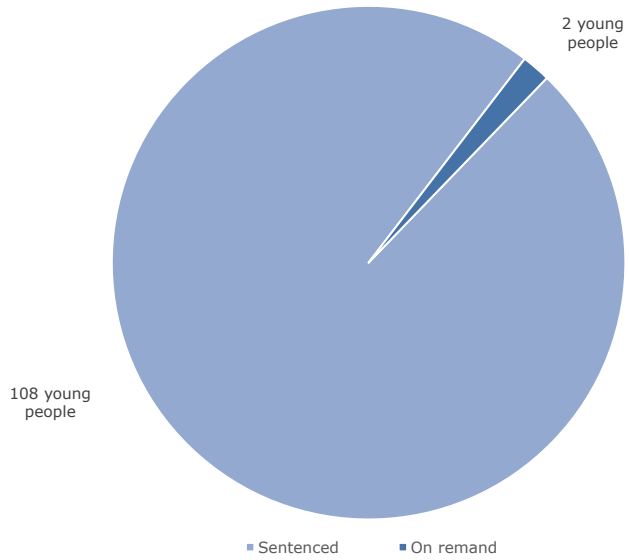
Table 3: Accommodation unit capacity

Accommodation units – secure site	Capacity
Deakin	15
Latrobe	15
Monash	15
Accommodation units – senior site	
Admissions	17
Campaspe	16
Coliban	20
Lauriston	21
Ulabara	16
ISA	4
Total capacity	**139**

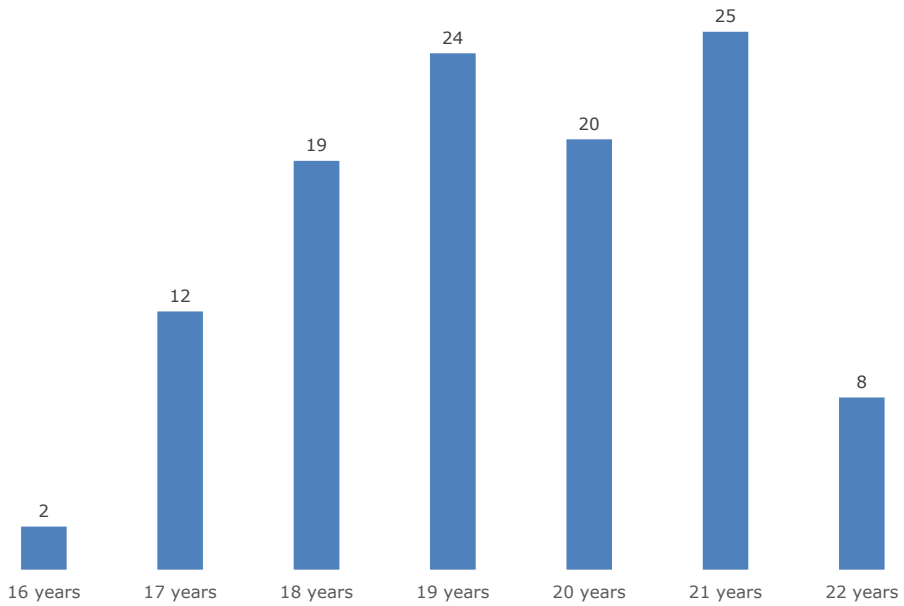
About the children and young people at Malmsbury

716. As at 28 February 2019, there was a total of 110 children and young people accommodated in Malmsbury.

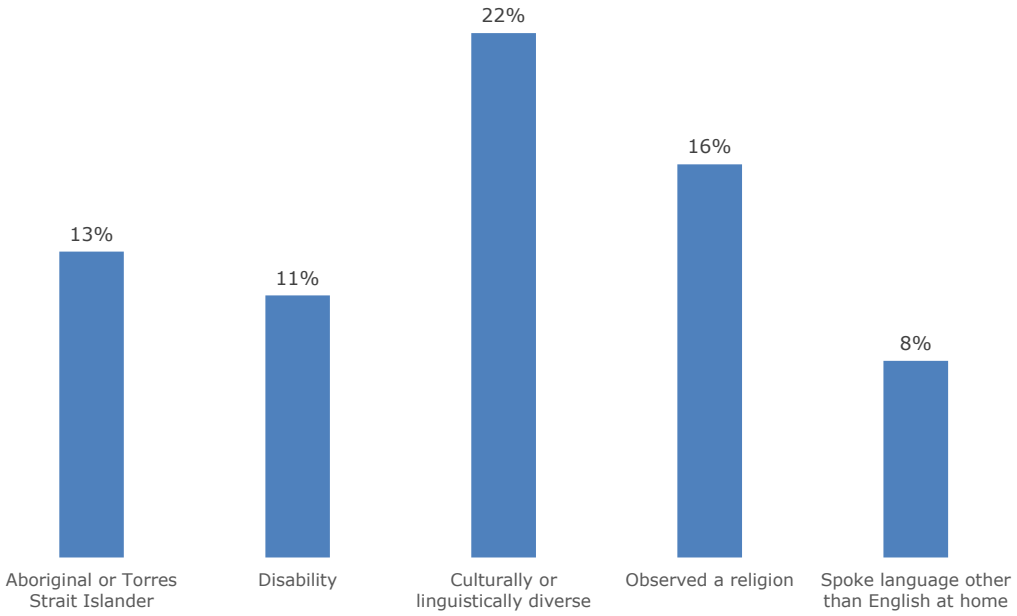
Young people in Malmsbury by status (28 Feb 2019)



Children and young people in Malmsbury by age (28 Feb 2019)



Children and young people in Malmsbury demographics (28 Feb 2019)



The inspection

717. On 28 February 2019, the Inspection Coordinator and other Ombudsman officers met with the then General Manager to advise him that the Ombudsman's OPCAT-style inspection would occur at Malmsbury the following month. They explained that the purpose of the inspection was preventive, rather than an investigation into specific allegations, discussed the practical arrangements and requested preliminary information.

718. The Ombudsman sought copies of relevant registers and other operational information for the period from 28 February 2018 to 28 February 2019 (the day inspection was announced). Unless stated otherwise, the graphs set out in this chapter were generated from data from this reporting period (**the 12-month reporting period**). Additional information was obtained during and after the inspection.

719. The inspection of Malmsbury was conducted over four days, from Wednesday 27 March to Saturday 30 March 2019.

720. Prior to the commencement of the inspection, DJCS requested to meet with representatives of the inspection. During this meeting, the Department advised that it had received intelligence which suggested that there could be significant unrest at the facility during the period of the inspection.

721. The Department requested that the inspection take place under an escort arrangement, wherein departmental representatives would accompany the inspection when moving around the facility.

722. The inspection agreed to trial a modified version of the proposed escort arrangements for the first day of the inspection. In doing so, the inspection noted that these arrangements did not reflect an OPCAT-style inspection.

723. The inspection met with the General Manager of Malmsbury on the first morning of the inspection and then attended a briefing on the facility. The inspection then provided a short briefing to the managers of the facility concerning the nature and purpose of the inspection.

724. In keeping with the trial arrangement, members of the inspection team were not issued with keys or swipe cards to the facility but were issued with duress alarms.

725. Malmsbury allocated an administration room to the team to use as a base throughout the inspection.

726. A list of children and young people accommodated in the facility and their locations was provided to the inspection and updated each morning.

727. At the commencement of the inspection there were a total of 109 children and young people accommodated in Malmsbury. Forty-three were accommodated at the secure site and 66 at the senior site.

728. The inspection observed that at there were three children aged 17 years accommodated at the senior site, and that there was also an increased remand population at the facility (23 individuals in total or 21 per cent). As at 28 February 2019 (the day the inspection was announced) there were only 2 people on remand at Malmsbury.

729. During the first afternoon, the inspection split up into groups and visited the different units across both sites, introducing themselves to the children and young people in the facility and describing the purpose of the inspection.

730. Departmental liaisons accompanied members of the inspection when moving between accommodation units at the facility but, as agreed, did not enter the units with the inspection.

731. At the end of the first day, as the inspection was preparing to leave, a facility-wide lockdown was initiated, and the inspection was strongly encouraged to leave the facility for its own safety. The team determined to leave at this time (in accordance with the existing schedule).

732. The following morning representatives of the inspection met with the General Manager and the Department's Executive Director of Youth Justice Operations, to receive a security briefing.

733. The inspection was informed that the previous day's lockdown had been initiated due to concerns about a possible escape attempt, and that Malmsbury remained in a state of lockdown at the time of the meeting. The Department raised the possibility of the inspection remaining offsite until at least the next day.

734. The inspection subsequently arranged to return to Malmsbury that afternoon, at which time it was expected that some of the children and young people would be allowed out of their bedrooms.

735. The inspection resumed that afternoon, and the team spent the remainder of the day and the days that followed visiting each unit to administer the survey with those who wished to participate. The inspection made paper surveys available to several interested young people but who remained confined to their bedrooms during the afternoon of the second day.

736. The inspection completed the survey with a total of 40 children and young people, an engagement rate of 37 per cent. Twenty-nine respondents completed the survey by tablet device and 11 respondents completed a paper survey.

737. During this period, the inspection also observed the activities around the precinct and spoke with staff and the children and young people about their experiences.

738. The staff survey was distributed by email at the end of the third day of the inspection. The inspection received 98 responses to the survey, an engagement rate of approximately 24 per cent.

739. On the final day of the inspection, the Inspection Coordinator and the Area Inspection Leads met with the General Manager to provide preliminary feedback about the inspection's observations.

The following sections

740. Throughout this chapter, the experiences of children and young people in some form of isolation are set out in case study narratives gathered from individuals' files. For privacy, the names in this report are not the real names of the individuals involved.

741. The sections set out the inspection's observations regarding the practices at Malmsbury which may lead or amount to the solitary confinement of children and young people. In doing so, the investigation identifies the risks that increase the potential for torture and other cruel, inhuman or degrading treatment at the facility, and protective measures that can help to reduce those risks.

Humane treatment

742. The inspection identified several practices at Malmsbury which had the potential to lead or amount to the solitary confinement of children and young people:

    - formal 'isolation' (including lockdowns) under the *Children, Youth and Families Act 2005* (Vic) (**CYF Act**)
    - 'separation' of children and young people in accordance with Separation Safety Management Plans
    - procedures known as 'time out' and 'quiet time'.

743. The inspection examined the legislative and policy frameworks applicable to each of these practices and sought to ascertain the rate and circumstances of their use at Malmsbury.

744. There appeared to be a high rate of isolation at Malmsbury, particularly through the use of formal isolation under the CYF Act, including lockdowns. However, it was unusual for children and young people to be isolated for extended periods of time through these mechanisms.

745. The inspection observed that Separation Safety Management Plans, although implemented relatively infrequently at Malmsbury, also appeared to result in the recurrent isolation of some vulnerable children and young people.

746. The inspection observed that although children and young people did not appear to be regularly kept in conditions akin to solitary confinement at Malmsbury, there was nevertheless a high rate of isolation at the facility, which was thought to increase the risk of ill-treatment.

747. In response to the Ombudsman's draft report, DJCS attributed some of this to staff shortages leading to lockdowns and added:

> The Department has been actively implementing a targeted recruitment campaign attracting youth justice custodial workers to work in the two Youth Justice Centres. As recommended in the Youth Justice Review, the Department is working on a Youth Justice Workforce strategy, which will include strategies addressing recruitment, retention and learning and development.

Isolation for behavioural reasons

748. Section 488 of the CYF Act empowers the officer in charge of a youth justice centre to authorise the isolation of a child or young person detained in the centre.

749. Isolation is defined in section 488(1) of the CYF Act as 'the placing of the person in a locked room separate from others and from the normal routine of the centre.'

750. Section 488(2) provides that a child or young person may only be isolated at a youth justice centre if:

    - all other reasonable steps have been taken to prevent the child or young person from harming themselves or any other person or from damaging property
    - the child or young person's behaviour presents an immediate threat to their safety or the safety of any other person or to property.

751. Pursuant to section 488(5), if a child or young person is isolated for any of the above reasons, they must be closely supervised and observed at intervals of no longer than 15 minutes.

752. The period of a child or young person's isolation must be approved by the Secretary of the DJCS (section 488(3)) and recorded in a register established for that purpose (section 488(6)).

753. Forty-five per cent of children and young people surveyed by the inspection reported that they had been isolated for misbehaviour while at Malmsbury.

754. The overwhelming majority of children and young people surveyed by the inspection attributed negative emotions to their experience of isolation (including lockdowns) at Malmsbury – 43 per cent reported that isolation made them feel 'Really bad' and a further 30 per cent reported that isolation made them feel 'Bad'.

[It makes me feel] angry, like I have no voice. [I feel] stuck and powerless.

– Young person

755. Survey respondents under the age of 19 years were more likely to report that isolation made them feel 'Really bad' than those aged 19 years and older (59 per cent and 27 per cent, respectively).

It doesn't really bother me because I don't normally interact with the other young people due to safety concerns.

– Young person

756. The inspection requested a copy of Malmsbury's Isolation Register for the 12-month reporting period and was provided with an electronic spreadsheet. A review of that data determined that there were a total of 1,214 isolations for behavioural reasons reported during this period. Of these, 26 per cent involved the child or young person being placed in a dedicated isolation room.

757. In response to the draft report, DJCS wrote:

> where safe to do so, young people are isolated within their bedroom (rather than a dedicated isolation room), as that provides them with a comfortable space, with their bed, television, and personal items.
>
> Where a young person is at risk of suicidal or self-harming behaviour, or is hampering staff to complete observations, they may be placed in a dedicated isolation room.

758. The inspection noted that children accommodated at the secure site were disproportionately placed in isolation; 60 per cent of all reported behavioural isolations took place at the secure site, despite children at this site accounting for just 40 per cent of the precinct's population.

759. In response to the draft report, DJCS noted that because the senior site is largely for 'dual track' young people with more settled behaviour, it is expected that there would be lower levels of behavioural isolation on that site.

760. The inspection observed that a small cohort of children and young people accounted for a significant proportion of all isolations. A review of the Isolation Register revealed that during the 12-month reporting period:

- 13 individuals were isolated more than 20 times, collectively accounting for 30 per cent of all isolations during the period
- one Aboriginal child, aged 16 years, was isolated 45 times over just four months
- one young person, aged 19 years, was isolated for a total cumulative period of seven days and 18 hours.

761. In response to the draft report, DJCS submitted that the Isolation Register in relation to the young person referred to above was recorded in error and that the 'young man was isolated for a total of 11 hours spread over three days, with two of these days being rotations of one hour in and one hour out of his bedroom.' The issue of data errors in the Isolation Register is discussed later.

762. The inspection compared the data with previous years and determined that while the rate of isolation for behavioural reasons appeared to have fallen considerably from 2016-17 levels, children and young people at Malmsbury were still being isolated at approximately four times the 2014-15 rate.

763. The CYF Act does not require a youth justice centre to advise a child or young person of the reasons for isolation. The Department's isolation policy (**Isolation Policy**) nevertheless requires staff at a youth justice centre to inform a child or young person that they are being placed in isolation and why they are being placed there, provided that it is 'appropriate to do so'.

764. Just 25 per cent of children and young people surveyed by the inspection agreed with the statement, 'When I'm kept in a room for a long time I usually know why I'm there'; whereas 68 per cent of survey respondents agreed with the statement, 'Sometimes I don't know the reason why I am kept alone by myself.'

I wasn't told why.

– Young person

765. Section 487(a) of the CYF Act expressly prohibits the use of isolation as a punishment. The inspection was accordingly concerned to note that 58 per cent of children and young people surveyed believed that they had been isolated at Malmsbury as a form of punishment.

766. The inspection noted that 59 per cent of behavioural isolations recorded over the 12-month reporting period were designated as 'immediate threat to safety (others).'

767. Relatively few young people surveyed reported that they had been isolated at Malmsbury for protection reasons or to prevent themselves from self-harming (10 per cent and five per cent, respectively).

768. This appeared consistent with the data analysed by the inspection, where approximately six per cent of all behavioural isolations were designated as being for the child or young person's own safety.

I have been [isolated] in a holding cell, in another unit, which was when we were doing baking and a staff member had said I couldn't take two things at once, but I had, and then he tried to take one off me. He took hold [of the item] but then he let go and fell back. He [called] a Code Blue. I said, 'What for?'; it was all just a misunderstanding. I was held in a holding cell for almost a day before I got to explain what had happened and got let out. The guy had exaggerated.

– Young person

769. The inspection reviewed a number of client files and identified several behavioural isolations which did not appear to meet the threshold required by section 488(2) of the CYF Act.

I'm afraid to be sent down to the holding cells for a week. You can be taken to the holding cells just for being angry.

– Young person

Yarran

Seventeen-year-old Yarran was accommodated at Malmsbury's secure site when he requested to speak to the manager of his unit.

A member of staff told Yarran that the manager was busy but would see him as soon as possible. Yarran replied, 'I want to see her now and I'm getting fucken angry'.

Yarran returned to his bedroom room, reclined in his bed, and started watching television. About 15 minutes later, members of Malmsbury's Safety and Emergency Response Team (SERT) arrived at the unit and escorted Yarran to an isolation cell. Staff recorded that Yarran was isolated because he presented an 'immediate threat' to the safety of others.

Although Yarran spent a total of two hours in the isolation cell, staff recorded that he was isolated for just 75 minutes on the register.

Yarran's isolation was arguably contrary to the CYF Act because when he was removed from his bedroom his behaviour did not appear to present an immediate threat to others.

Hashim

Staff received information that a makeshift weapon was in circulation at Malmsbury's senior site.

Eighteen-year-old Hashim was directed to remain away from his bedroom while his unit was searched. During this time, Hashim became frustrated and stated, 'there's a rat in this unit and it's going to stink our rooms out' and 'this is fucked', while gesturing towards another young person present. A member of staff perceived these comments to be 'indirect threats' towards the other young person.

The search of the unit did not locate a weapon. Hashim was then strip-searched (referred to as an 'unclothed search' in section 482A of the CYF Act) by staff, but no weapon was found in his possession.

Hashim was then placed in handcuffs and escorted to an isolation cell. Staff recorded that Hashim was isolated because he presented an 'immediate risk' to the safety of others. The justification for the use of handcuffs was recorded as 'suspicion of contraband'.

Staff recorded that Hashim was 'settled' but 'very upset' upon entry to the isolation cell. The observation notes reflect that Hashim remained calm and settled throughout the period of isolation. The notes record that during this period, Hashim made numerous requests to return to the unit. After three hours, Hashim was taken out of the isolation room and escorted to his bedroom. He was handcuffed during this process.

The following day, staff informed Hashim that they had found a prohibited item in his bedroom. Hashim informed staff that he had kept the object as a tool for vandalism. Hashim was advised that this was a 'breach of security' and that his behaviour posed a risk to others. Hashim was then handcuffed and moved to another unit.

770. Many of the young people surveyed by the inspection reported that they had been isolated at Malmsbury for a period of more than one day.

771. The inspection reviewed a number of client files and identified several incidents in which a child or young person appeared to have been isolated for longer than was strictly necessary. The inspection considered that this was a risk factor which increased the potential for ill-treatment at the facility.

Figure 6: Extract of observation notes, example of settled behaviour

Observation Time	Comments (what have you observed?) (eg. change of location, sleeping on left side with doona on, talking to others or self, asked for a drink, laughing, crying, watching TV, rocking, excessively restless, medication issued etc.)
5.20 PM	IN HOLDING CELL #2 - ESCORTED BY SERT. APPEARS SETTLED HOWEVER, TELLING STAFF THAT HE IS VERRY UPSET.
5.25PM	SITTING ON BENCH IN HOLDING CELL #2 TALKING TO STAFF THROUGH DOOR SAYING "I WONT CAUSE A CODE IF I GO BACK TO THE UNIT."
5.30 PM	LEANING AGAINST WINDOW TALKING TO STAFF. STILL ANNOYED HOWEVER APPEARS SETTLED
5.35 PM	SITING ON BENCH IN HOLDING CELL #2, SAID THAT HE IS SETTLED AND WANTS TO GO BACK TO THE UNIT
5.40 PM	SITTING ON BENCH, LEANING AGAINST WINDOW STARING AT FLOOR. TELLING STAFF THAT HE WANTS TO GO BACK TO THE UNIT. APPEARS SETTLED
5.45 PM	SITTING ON BENCH FACING ~~[illegible]~~ THE DOOR WANTING TO GO BACK TO THE UNIT. APPEARS SETTLED
5.50PM	SITTING ON BENCH ARMS CROSSED STARING AT THE FLOOR. RESPONDING TO STAFF, SAYING HE IS HUNGRY AND WANTS TO GO TO THE UNIT. APPEARS SETTLED
5.55PM	SITTING ON BENCH, HEAD AGAINST WALL, ARMS CROSSED, STARING AT FLOOR, ~~[illegible]~~ APPEARS SETTLE, VERRY HUNGRY AND WANTS TO GO BACK TO THE UNIT.
6.00PM	WALKING UP AND DOWN ROOM APPEARS SETTLED HOWEVER IS GETTING UPSET BECAUSE HE IS HUNGRY, WANTS TO GO BACK TO THE UNIT AND SAID HE DID NOTHING WRONG.
6.05 PM	WALKING UP AND DOWN ROOM. APPEARS SETTLED. TOLD STAFF THAT HE IS VERY HUNGRY AND WANTS TO GO BACK TO THE UNIT.

772. The inspection observed that the median recorded period of isolation for behavioural reasons at Malmsbury over the 12-month reporting period was approximately one hour. The average recorded period was somewhat higher — approximately two hours and twenty minutes.

773. The inspection noted that ten isolations in the register were recorded as having lasted for more than 12 hours. Four isolations were recorded as having lasted for more than 22 hours, potentially amounting to solitary confinement under accepted international definitions. One such incident involved a child aged 16 years, in possible contravention of the prohibition of the use of solitary confinement on children in rule 67 of the Havana Rules.

774. The longest reported isolation during this period was recorded as having lasted for 169 hours, although this appeared to be a significant outlier, and as noted above, DJCS submits that it was an error on the Isolation Register.

775. In response to the draft report, DJSC submitted that:

> A file review confirmed a number of data errors including 7pm – 8pm (one hour) being mistakenly recorded as 7am – 8pm (13 hours) and a short isolation on 28/02/2018 being mistakenly given an end date of 28/02/2019. The file reviews identified that none of these isolations were over 12 hours.

776. The inspection had already attributed the isolation recorded in the register as lasting 12-months to human error.

777. The data errors identified by DJCS in response to the draft report highlighted a flaw in the Isolation Register, which in the version initially provided to the inspection, did not capture the time and date isolation commenced and ended, as required by the CYF Regulations. It only included the calculated period of isolation.

778. On 13 August 2019, DJCS advised the Inspection Lead that a centralised Isolation Register, including the prescribed particulars set out in the CYF Regulations, can be generated from data on individual 'CRIS' files. The version of the register that was originally provided to the inspection was in a format consistent with reports provided to other oversight bodies and did not include some data fields.

779. Accordingly, DJCS provided an updated version of the Isolation Register including the time and date isolation commenced and the authorising officer's name and position.

780. The fact that DJCS can generate a centralised Isolation Register from data on individual files is likely to satisfy the requirements of section 488(6) of the CYF Act and the Regulations. Regular analysis of the centralised register will allow DJCS to track trends and systemic issues with the use of isolation across the entire precinct. Recording instances of isolation on individuals' files is also important to effectively monitor the standard of care, accommodation or treatment of children and young people.

781. A review of the revised Isolation Register over the same 12-month reporting period revealed that, as a result of the way in which isolation is recorded (starting and stopping with each run-out and overnight lockup), the register inevitably understates the effective period of isolation. For example, many instances of behavioural isolation on the secure site purported to end at 8pm, being the time of overnight lock-up. The practical effect of this is that children and young people in isolation at the time of overnight lock-up will spend an additional 13 hours in a locked room separate from others until the unit is unlocked at 9am the next morning.

782. In response to the draft report, DJCS acknowledged this practice:

> Usual practice is that operational lockdowns which include a 30 minute unit meeting at approximately 4.00pm and the overnight lockdown from approximately 8.00pm to 8.00am are not counted cumulatively within the isolation period. This is currently under review based on the cumulative impact of an isolation that commences prior to the overnight lockdown, and extending beyond operational unlock in the morning.

783. The inspection has not independently verified DJCS's submission that periods of isolation greater than 12-hours were recorded in error. In any event, when considering the cumulative period of isolation, the results are still concerning.

784. The revised Isolation Register demonstrates that during the 12-month reporting period 155 instances of behavioural isolation on the secure site (over 20 per cent) purported to end at 8pm, being the time of overnight lock-up. Therefore, when factoring in the cumulative impact of isolation, there were:

- two instances lasting between 18 and 19 hours
- four instances lasting between 17 and 18 hours
- ten instances lasting between 16 and 17 hours
- 22 instances lasting between 15 and 16 hours
- 56 instances lasting between 14 and 15 hours
- 61 instances lasting between 13 and 14 hours.

785. As isolation is defined in the CFY Act as 'the placing of the person in a locked room separate from others and from the normal routine of the centre', the practice of ceasing to record a period of isolation at overnight lock-up (8pm) is consistent with the Act. However, capturing the cumulative impact of isolation is important.

786. The inspection reviewed five years' worth of isolation data and noted that the median period of isolation for behavioural reasons appeared to have fallen somewhat from 2015-16 levels but had remained stable for two years.

787. Although under the Isolation Policy children and young people who are isolated for behavioural reasons in a youth justice centre must receive at least one hour of fresh air per day, 'where possible and weather permitting', 40 per cent of children and young people surveyed reported that they did not always receive at least one hour of fresh air per day when isolated.

788. Some who spoke with the inspection reported that during periods of isolation they were taken to other areas of the facility for access to fresh air. They said they were handcuffed and escorted by SERT officers when undertaking these movements.

789. The inspection observed two young people being moved about the facility in handcuffs on different occasions. Each was escorted by eight members of staff. Both individuals appeared compliant and neither appeared to present an immediate threat to the safety of others.

790. The inspection reviewed a number of files and noted that there appeared to be an almost routine use of restraints when children and young people were moved into and out of isolation at Malmsbury. The inspection noted that in such cases the use of force was commonly attributed to a 'high risk escort requirement'.

791. Section 487(b) of the CYF Act prohibits the use of force in a youth justice centre unless it is reasonable and:

- is necessary to prevent a child or young person from harming themselves or another person or from damaging property or
- is necessary for the security of the youth justice centre or
- is otherwise authorised at law.

Figure 7: Extract use of force form relating to isolation run-out

Name of young person	[redacted]			
Who initiated the force *Only one register per young person per incident needs to be completed*	Name [redacted]		Role SERT	
Is the young person Aboriginal or Torres Strait Islander?			Yes ☐	No ☑
Please describe what led to force being used?	H/R/E (Run outs)			
Was force used as a last resort?	Yes ☑		No ☐	
What alternative strategies were employed before restraining the young person?	Negotiation ☐	Diversion ☐	Immediate response required ☐	HRE – escort requirement ☑
	Sought assistance from colleagues ☐	Used existing rapport ☐		
Others, please describe				

Details of incident

Location Holding Cells	Date 4/02/19		Time 9:23	
Detail the type of restraint deployed *Tick all that apply*	Physical ☐	Handcuffs ☑	Baton ☐	OC spray ☐
Describe the technique used *Shoulder roll, arm bar etc*				
Did the event result in the young person being isolated?	Yes ☐	No ☐	Location: Visits	

Please email the completed form to osi@justice.vic.gov.au before the end of your shift

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792. Section 488(4) expressly authorises the use of reasonable force to place a child or young person in isolation at a youth justice centre.

793. The inspection identified many cases where the use of restraints to move a child or young person into or out of isolation did not appear reasonable. In those cases, the child or young person did not appear to have been given an opportunity to comply before restraints were used, and the decision to use restraints did not appear to have been informed by a contemporaneous risk assessment.

794. The inspection considered that the frequent use of restraints at Malmsbury was in possible violation of rule 48 of the Mandela Rules, which require instruments of restraint be used 'only when no lesser form of control would be effective to address the risks posed by unrestricted movement'.

795. Additionally, the routine use of restraints on children appeared contrary to rule 64 of the Havana Rules, which require that instruments of restraint and force only be used on children 'in exceptional cases, where all other control methods have been exhausted and failed'.

796. In response to the Ombudsman's draft report, DJCS advised that work is underway to re-establish risk-based decision making for the use of mechanical restraint for precinct movements rather than as standard practice.

Iain

Nineteen-year-old Iain was placed on a Separation Safety Management Plan after he was involved in a succession of incidents over the course of a week.

Iain's Separation Safety Management Plan stipulated that he was to be isolated in his bedroom for the duration of the day. Under the Plan, Iain was to be provided with a one-hour 'run-out' to another area of the facility after each hour of isolation.

Members of Malmsbury's SERT team attended Iain's bedroom in the morning to escort him to the run-out location. Iain refused to access his run-out because he did not wish to be handcuffed when moving to and from the area.

Iain asked a staff member, 'Why do I need to be cuffed? I wasn't cuffed yesterday.' The staff member replied, 'That's procedure Iain, when you're on a SSMP and you have your run-out, they have to handcuff you [...], it's just the way it goes'. Iain became frustrated and said, 'Fuck this. I'm gonna fuck this up. Fuck everyone up.'

Iain was later told that he would need to be handcuffed for future run-outs because of his statement that he would 'fuck everyone up'.

Lockdowns

797. Section 488(7) of the CYF Act provides that a child or young person may also be isolated 'in the interests of the security of the centre.' Isolations for this purpose are referred to as 'lockdowns' and are exempt from the legislative safeguards ordinarily applicable to isolation under the CYF Act.

798. Ninety per cent of children and young people surveyed reported that they had been isolated at Malmsbury due to a lockdown at the facility.

799. Data reviewed by the inspection established that there were a total of 13,653 reported lockdowns at Malmsbury during the 12-month reporting period.

800. In response to the draft report, DJCS considered that isolation under section 488(7) 'may be used in the best interests of security i.e. a shortage of staff, or a serious incident. This may include locking down a unit for a period of time or rotating small groups of young people out of their bedrooms.'

801. The frequent use of lockdowns and rotations in response to a shortage of staff is discussed elsewhere in this report, however, it is interesting to note that when the precursor to section 488(7) was explained in the memorandum to the *Children and Young Persons (Amendment) Bill 1992* (Vic), it was described as:

> a separate power to lock persons or children in their rooms to ensure that the security of the centre is maintained. This may be a routine procedure at night or may be used in an emergency.

802. It appears that staff shortage at Malmsbury is common place.

803. The inspection noted that staff at Malmsbury appeared to be in the habit of recording one incident for each child or young person affected by a lockdown, meaning that the actual number of lockdowns was likely considerably lower.

804. In response to the draft report, DJCS noted:

> While the CYFA does not require 488(7) isolations due to security to be recorded in an isolation register, it is a policy and practice requirement in youth justice. Please clarify in this paragraph that it is a practice requirement that any period of isolation including lockdown and rotation be recorded as an individual episode of isolation for each young person affected. If a unit of 15 young people in locked down for an hour, that is recorded as 15 x 1 hour isolations.

805. As in the case of isolations for behavioural reasons, children at the secure site were disproportionately affected by lockdowns at Malmsbury. Sixty-five per cent of all lockdowns within the 12-month reporting period occurred at the secure site of the facility.

806. Many staff members at the centre informed the inspection that the use of isolation at Malmsbury, particularly lockdowns, had significantly increased over recent years.

807. As Malmsbury commenced regularly recording lockdowns in its Isolation Register less than two years ago, it was not possible for the inspection to verify this information.

808. The inspection attributed the high rate of lockdowns at Malmsbury to what appeared to be a very low appetite for risk at the centre.

809. It was apparent that Malmsbury was under considerable external pressure to reduce the rate of unrest within the facility. This pressure appeared to manifest in greater reliance on restrictive practices, including the use of isolation and mechanical restraints.

810. Senior members of staff expressed concern at this approach, which they believed was counter-productive to the rehabilitative aims of the youth justice system. The inspection did not form the impression that these practices were being driven by management at the facility.

After people tried to escape and staff got injured on the secure site, the whole centre got locked down. My unit [on the senior site] was locked down Tuesday until Friday.

– Young person on the senior site

811. Communication regarding lockdowns at Malmsbury was a significant source of frustration for the children and young people who spoke with the inspection. Many said that they were not routinely informed of the reasons for lockdowns.

812. The inspection noted that approximately 40 per cent of all recorded lockdowns at Malmsbury within the 12-month reporting period were attributed to staff shortages at the facility.

813. Other lockdowns were attributed to staff meal breaks or to unrest within the facility. According to DJCS, 'sometimes due to staff shortages, a lockdown is required so that staff can be given the required break in their 12-hour shift.'

814. Several at the senior site told the inspection that they had been isolated due to incidents involving others at the secure site. Some said that they believed that the frequency of facility-wide lockdowns was contributing to further unrest within the facility.

A facility-wide lockdown

On the first day of the inspection, staff at Malmsbury received intelligence which suggested that there would be organised unrest at the facility during the evening. Staff believed that children and young people across both sites could become involved in the incident.

A facility-wide lockdown was called at approximately 5pm. All children and young people across both sites were directed to remain to their bedrooms.

The facility remained in a state of lockdown until approximately 12:30pm the following day, a period of 19 and a half hours. Children and young people were not permitted to exit their bedrooms during this period.

Once the lockdown ended, several units were placed on 'rotations', meaning that half of the children and young people accommodated in the unit were permitted to exit their bedrooms for one hour, before rotating with the other children and young people on the unit. This continued for the rest of the day. No one was permitted to exit the units during this period, and educational activities were largely halted.

The facility returned to a normal routine the next day. Many who spoke with the inspection said that they did not know the reason for the lockdown. They surmised that individuals had misbehaved elsewhere in the facility.

815. The inspection was concerned to observe that several children and young people described the facility-wide lockdowns at Malmsbury in terms of collective punishment.

It's just unfair. Not everyone should be locked down if one or two people do something wrong.

– Young person

Individual punishment tends to be everyone's punishment.

– Young person

We're put on lockdown due to other clients acting up. We are given no explanation, timeframes or anything to keep us occupied, meaning [we're] often struggling in these times.

– Young person on the senior site

816. According to data reviewed by the inspection, the median lockdown period at Malmsbury during the 12-month reporting period was approximately 40 minutes.

817. There were nevertheless many recorded lockdowns which lasted for two hours or more, and 43 lockdowns which reportedly lasted for more than six hours.

818. The inspection observed that the initial Isolation Register recorded 33 lockdowns as having lasted for more than 22 hours, potentially meeting the definition of solitary confinement under the Mandela Rules. The longest lockdown in that register was recorded as lasting for 171 hours – approximately one week.

819. In response to the draft report, DJCS submitted that there are errors in Isolation Register and that of the 33 lockdowns referred to above, the longest period of lockdown was three hours and 5 minutes.

820. As noted above, due to the data errors identified by DJCS in response to the draft report it is difficult for the inspection to rely on the information in the Isolation Register.

821. In any event, a review of the revised Isolation Register for the same 12-month reporting period identified 8,971 instances of lockdowns on the secure site. Of these, 439 (almost five per cent) purported to end at 8pm. When factoring in the cumulative impact of isolation, there was:

- one instance lasting between 21 and 22 hours
- 22 instances lasting between 16 and 17 hours
- 24 instances lasting between 15 and 16 hours
- 293 instances lasting between 14 and 15 hours
- 99 instances lasting between 13 and 14 hours.

Some time to yourself is good, but long lockdowns for more than a few hours or more than one day are too much.

– Young person

822. Although periods of lockdown are not required to be recorded in the Isolation Register, as in the case of behavioural isolation, capturing the cumulative impact of isolation is important.

823. Departmental policy does not expressly provide children and young people placed under lockdown with a daily minimum entitlement to fresh air.[22]

824. The inspection was nevertheless informed that children and young people subject to prolonged lockdowns at Malmsbury were ordinarily provided periods outside of their bedrooms.

22 Department of Justice and Community Safety, *Unit lockdowns*, 2017.

825. Children and young people who spoke with the inspection reported that they were permitted to exit their bedrooms for two one-hour periods per day during a significant lockdown which occurred during the previous week.

826. This notwithstanding, the inspection noted that access to time outside of the bedroom at Malmsbury did not necessarily involve access to fresh air.

827. The inspection observed that children and young people who were accommodated in the two open units on the senior site were not permitted time outside during lockdowns or rotations. Staff informed the inspection that this was because these units lacked an enclosed outdoor area for use during periods.

828. The inspection was concerned that this practice had the potential to deny these children and young people access to at least one hour of fresh air per day, as required under the Mandela Rules.[23]

829. The inspection was informed that unit staff were not permitted to open bedroom door traps in the absence of SERT during facility-wide lockdowns.

830. Several young people informed the inspection that staff were required to wait for SERT before handing them routine items during lockdowns or other periods of isolation.

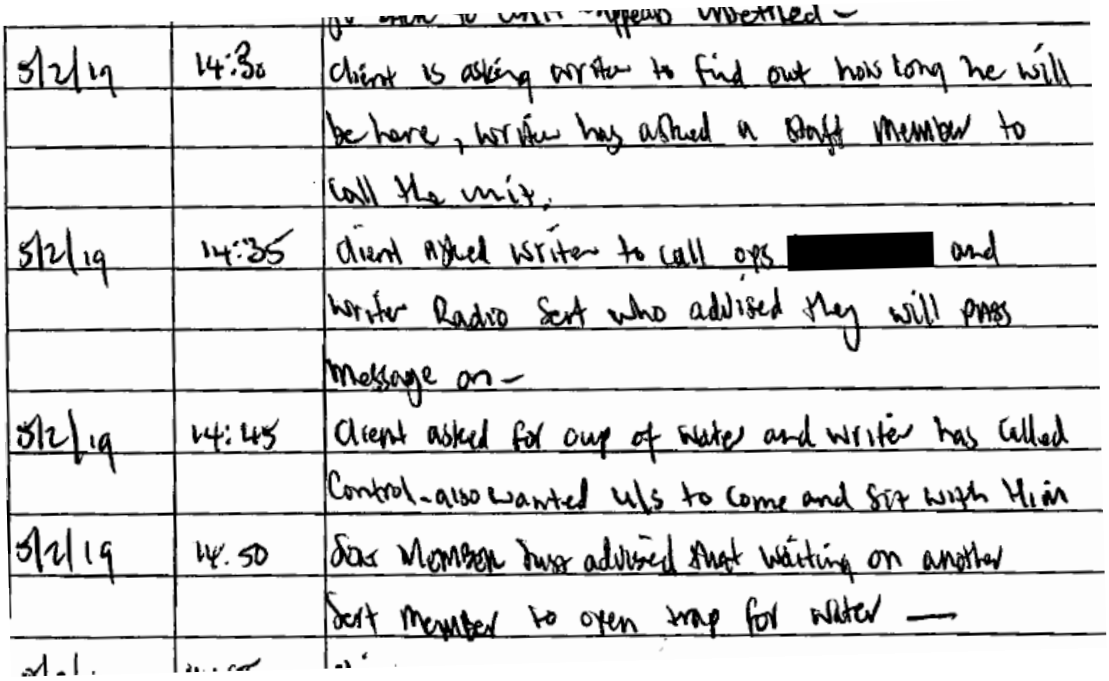
831. The inspection was of the view that absent a contemporaneous risk assessment, this procedure was not in keeping with the level of risk presented to staff.

832. In response to the draft report, DJCS wrote:

> Depending upon the circumstances of the lockdown, and the risk posed by the young person, there may be restrictions to opening the trap, due to spitting, throwing, or damage to the trap. This is considered on a case by case basis dependent upon the young person's behaviour.

833. DJCS's advice above is not consistent with the inspection's observations.

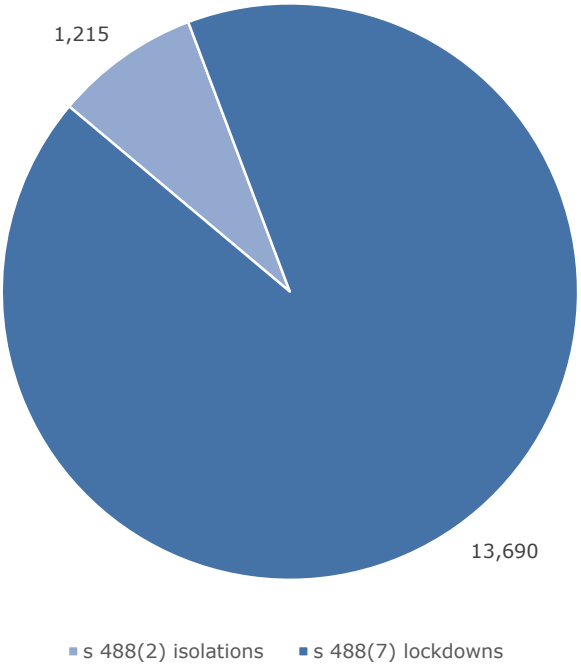
Figure 8: Extract observation form – request for water (holding cell)



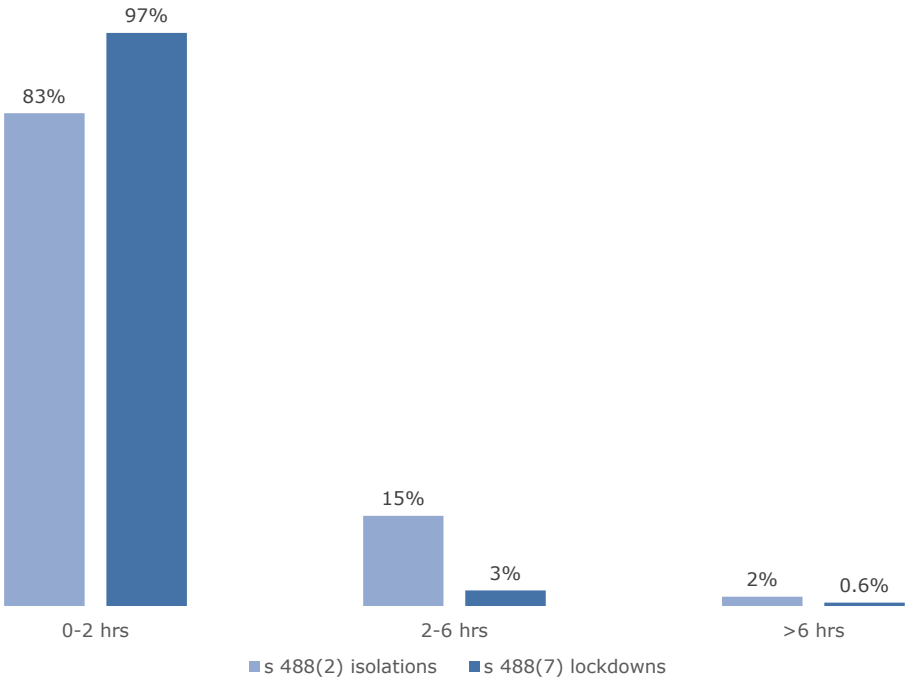
5/2/19	14:30	client is asking writer to find out how long he will be here, writer has asked a staff member to call the unit.
5/2/19	14:35	client asked writer to call ops [redacted] and writer Radio Sent who advised they will pass message on –
5/2/19	14:45	client asked for cup of water and writer has called Control – also wanted u/s to come and see with Main
5/2/19	14.50	Staff Member has advised that waiting on another Sect Member to open trap for water —

23 Mandela Rules, rule 23(1). Under the Havana Rules, children also have the right to 'a suitable amount of time for daily free exercise, in the open air whenever weather permits'.

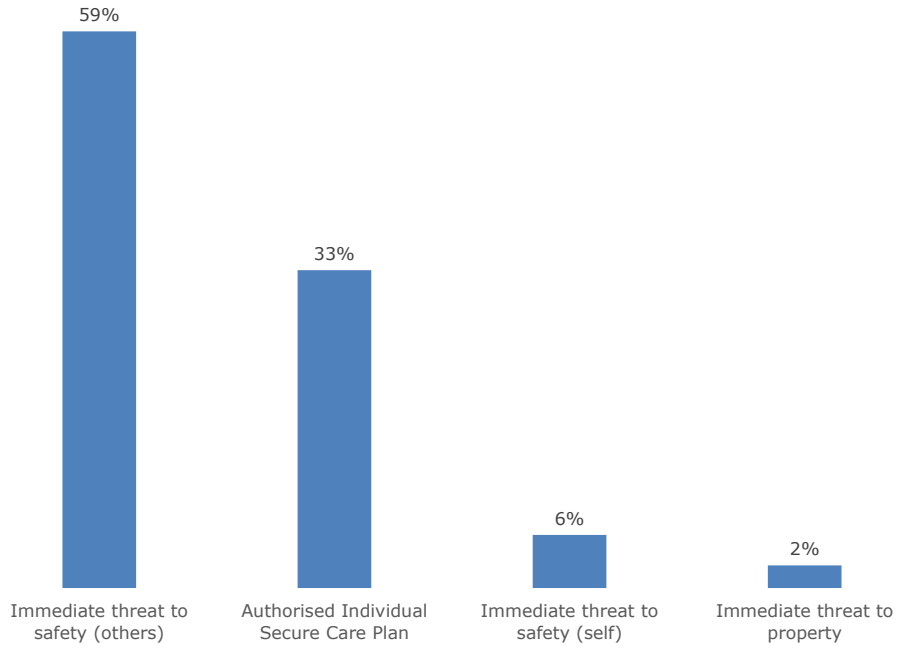
Instances of children and young people isolated at Malmsbury



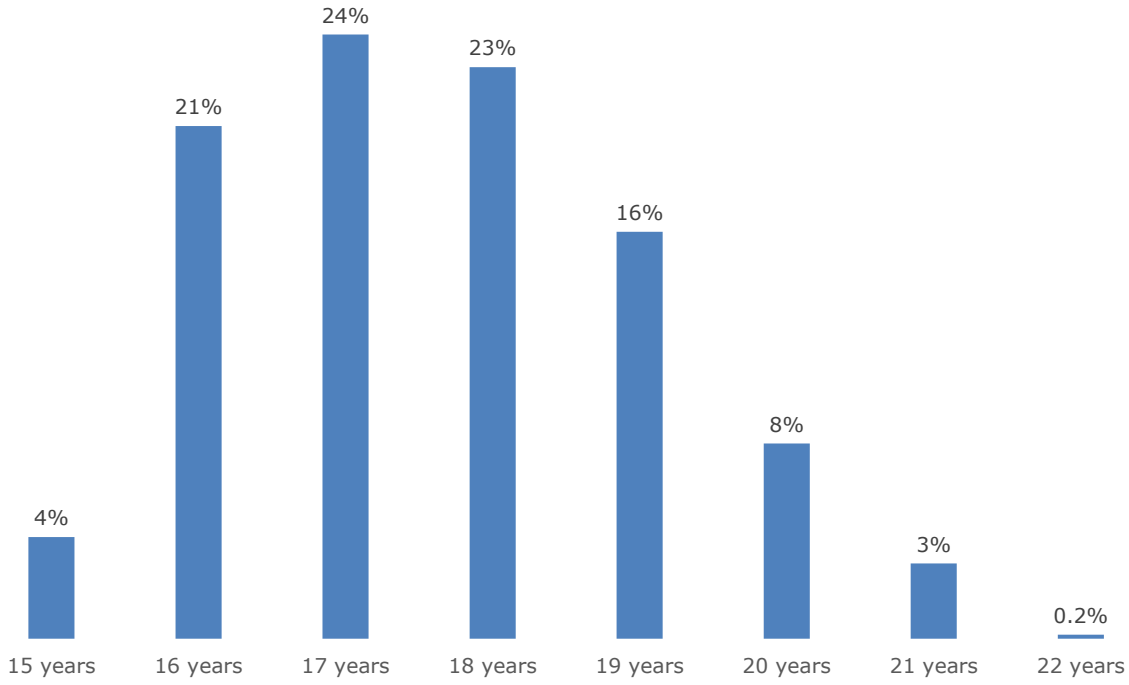
Length of isolation at Malmsbury



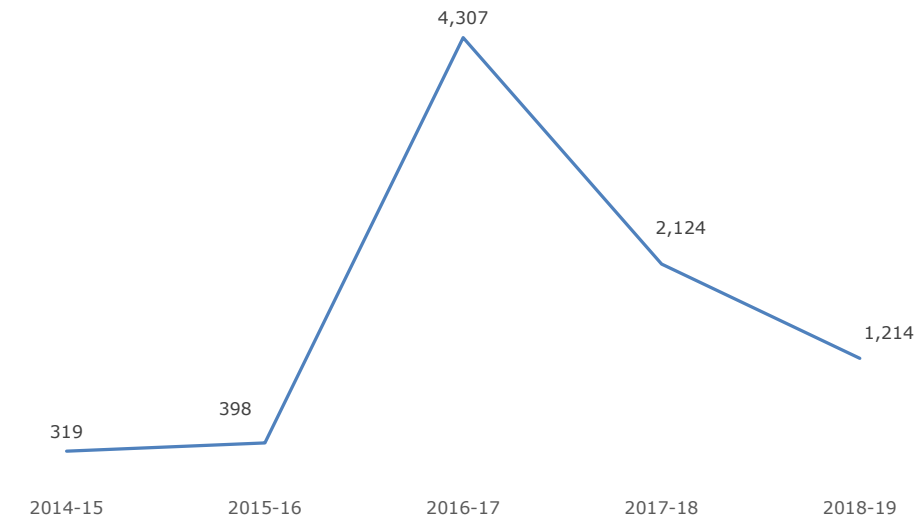
Isolation reasons, excluding lockdowns, at Malmsbury



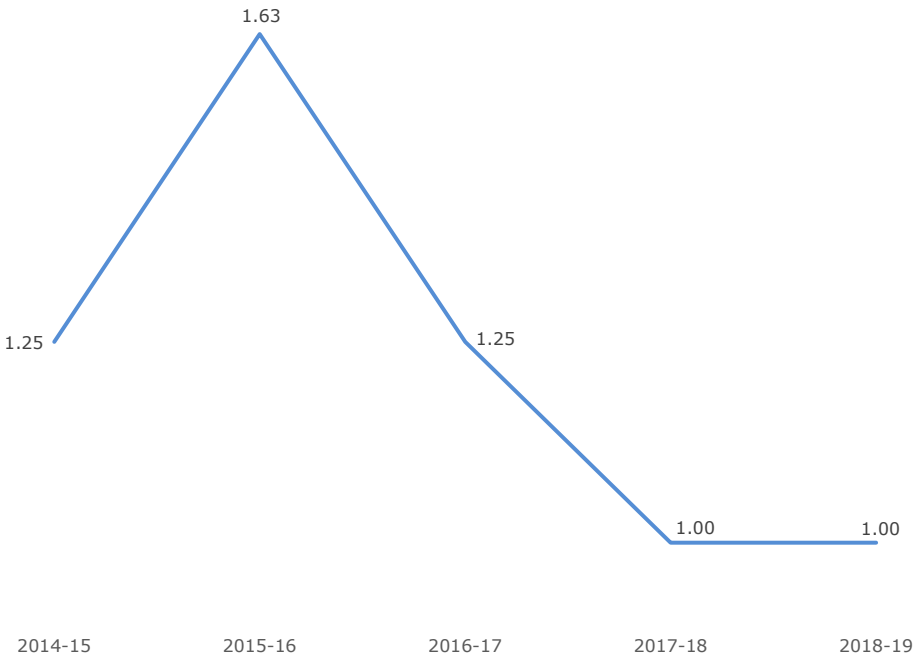
Isolations at Malmsbury by age, excluding lockdowns



Isolations at Malmsbury per year, excluding lockdowns



Median length of isolation at Malmsbury by year, excluding lockdowns (hours)



Separation under Separation Safety Management Plans

834. The Department's 'Separation of Young People' policy (**Separation Policy**) allows for a child or young person within a youth justice centre to be formally separated from their peers as a 'time limited response to incidents and extreme acts of aggression or other unsafe behaviour.'

835. Under the Separation Policy, separation entails:

- temporarily restricting the child or young person's movements and contact with peers
- developing a plan to assist the child or young person to change violent and maladaptive behaviours (a 'Separation Safety Management Plan').

836. According to the Separation Policy, separation may be used in circumstances where a child or young person has engaged in 'consistent or extreme violence or destructive behaviour that has continued despite all attempts to prevent it'.

837. The Separation Policy also provides that a child or young person may be separated for the purpose of providing 'intensive interventions, for example because of their vulnerability due to mental health or developmental disorders (such as Asperger's Syndrome)'. In such circumstances, separation is to be used 'to create a time limited safe place in which to support the young person to develop more adaptive behaviours that will allow for their long-term safety'.

838. The Separation Policy requires that a child or young person subject to a Separation Safety Management Plan must have access to at least one hour of fresh air per day, 'where possible and weather permitting'.

839. It is the position of the Department that the separation of a child or young person in accordance with a Separation Safety Management Plan does not amount to isolation under the CYF Act, 'as the young person continues to have access to education, programs and other aspects of the broader precinct and may not be confined to a locked room'.[24]

Figure 9: Extract of Separation Safety Management Plan

TIME	ACTIVITY
9am-10am	In his bedroom, access to education, reading material.
10am – 11am	In his bedroom, access to education, reading material.
11am - 12pm	Access to the Latrobe Unit Secure Yard.
12pm – 1pm	In his bedroom, access to education, reading material.
1pm – 2pm	In his bedroom, access to education, reading material.
2pm – 3pm	In his bedroom, access to education, reading material.
3pm – 4pm	Access to appropriate Parkville College area on secure site.
4pm – 4.30pm	In his bedroom, access to education, reading material.
4.30pm-5pm	Afternoon lockdown.
5pm – 6pm	In his bedroom, access to education, reading material.
6pm - 7pm	In his bedroom, access to education, reading material.
7pm-7.30pm	Access to the Latrobe Unit Secure Yard.
7.30pm - 8pm	In his bedroom, access to education, reading material.
8:00pm	Evening lockdown.

24 Department of Justice and Community Safety, *Separation of Young People.*

840. The inspection was informed that there were no children or young people subject to a Separation Safety Management Plan at Malmsbury during the period of the inspection.

841. Malmsbury's records reflect that 10 children and young people were subject to a Separation Safety Management Plan in the 12-month reporting period. The longest recorded duration of a Separation Safety Management Plan during this period was five days.

842. The inspection reviewed several Separation Safety Management Plans implemented at Malmsbury and noted that all appeared to include recurrent periods of isolation.

Time out and quiet time

843. The Isolation Policy provides that a child or young person at a youth justice centre may also be temporarily separated from his or her peers through the use of 'time out' and 'quiet time'.

844. Also under the Isolation Policy, a staff member in a youth justice centre may place a child or young person in 'time out' by directing the child or young person to 'remove themselves from a situation into an unlocked space, not a bedroom, to calm down or stop a particular negative behaviour.'

845. A child or young person subject to time out must be placed on observation and the time out must be formally recorded as a significant event.

846. A staff member in a youth justice centre may also facilitate a child or young person to undertake 'quiet time' by permitting the child or young person to return to their bedroom. The bedroom door may be locked during this period at the child or young person's request but must be unlocked 'as soon as the young person asks to be let out'.

847. A child or young person undertaking quiet time must be observed at least every 30 minutes. Requests for quiet time should be recorded and staff are directed to alert line management if they become concerned that a 'pattern of withdrawal' is developing.

848. The inspection did not observe the use of quiet time or time out. It was also unable to identify any incidents involving use of either practice on a review of client files.

849. It appeared that staff at Malmsbury were not well aware of the quiet time and time out policy. Several members of staff expressed confusion when asked about these practices.

What is 'quiet time'?

– Staff member

I have personally never seen a 'time out'.

– Staff member

We don't have time out.

– Staff member

'Time out' does apply to this facility.

– Staff member

Isolation may further exacerbate the situation. Perhaps we [could] ask the young person if they would like to go to their room to be alone for a while, rather than insisting on it.

– Staff member

Protective measures

Legislative protections against undue solitary confinement

850. The CYF Act currently allows for the solitary confinement of children and young people accommodated in a youth justice centre.

851. The CYF Act nevertheless makes the use of solitary confinement subject to some safeguards that are consistent with international human rights standards (rule 45 of the Mandela Rules and rule 67 the Havana Rules):

- Solitary confinement cannot be used against children as a disciplinary measure (section 487(a))
- Solitary confinement for behavioural reasons can only be used as a last resort (section 488(2)(a)).

852. The legislative framework nevertheless allows or fails to safeguard against several practices that are prohibited by the Mandela Rules:

- prolonged and indefinite solitary confinement (rule 43(1)(a) and (b))
- solitary confinement that would exacerbate a child or young person's mental or physical disability (rule 45(2))
- the use of solitary confinement other than in exceptional cases and as a last resort; for example, when it is 'in the interests of the security of the centre' (rule 45(1)).

853. The authority to isolate a child or young person due to an 'immediate threat […] to property', absent further qualification, is also arguably inconsistent with rule 45(1) above.

Isolation and lockdowns

854. The CYF Act makes the use of isolation for behavioural reasons subject to the following safeguards:

- All other reasonable steps must first be taken to prevent the child or young person from harming themselves or any other person or from damaging property.
- The period of isolation must be approved by the Secretary.
- The child or young person must be closely supervised and observed at intervals of no more than 15 minutes.
- Details of the isolation must be recorded in a register established for that purpose.

855. Under the CYF Regulations, the following information must be recorded in a youth justice centre's Isolation Register:

- the name of the child or young person isolated
- the time and date isolation commenced
- the reason why the child or young person was isolated
- the authorising officer's name and position
- the frequency of staff supervision and observation
- the time and date of release from isolation.

856. The inspection considered that there were several shortcomings with this legislative framework:

- The CYF Act does not require that a child or young person's isolation be terminated once the reason for isolation ceases, increasing the risk of prolonged or indefinite solitary confinement.

- A necessary element of isolation under the Act is that the child or young person be placed 'in a locked room', which potentially excludes situations where a child or young person is kept on their own for extended periods in other areas of a facility, such as Malmsbury's Intensive Supervision Annexe.
- The Act does not guarantee each child or young person a minimum period of fresh air per day.
- Staff are not required to inform children and young people of the reasons for isolation.
- Children and young people who are isolated 'in the interests of the security of the centre' are not required to be observed at regular intervals.
- Isolations 'in the interests of the security of the centre' are not required to be recorded in a register.

857. The Isolation Policy makes the use of isolation for behavioural reasons subject to some additional safeguards:

- A child or young person's isolation for behavioural reasons must cease 'when they no longer pose an immediate threat'.
- The child or young person must be initially observed at intervals of no more than five minutes.
- Staff supervising the isolation of a child or young person must certify that the child or young person has been provided with certain daily minimum entitlements.

Figure 10: Extract from 'Daily Entitlements Checklist'

Daily entitlements checklist when isolated to avoid immediate harm

This form is to be completed daily when a young person has been isolated **to avoid an immediate harm**. These young people must be checked during the isolation period to ensure the following entitlements are provided for them. The Unit Manager, or Night Manager after hours must endorse the form at the end of their shift and place it on CRIS as a case note attachment.

Young person's full name:		Date:	
Where young person is accommodated:		Reason for isolation:	

Entitlement	Requirement	Time/s provided	Staff member providing the entitlement (name and title) *Print full name*	Comment / detail re the item provided
Room is clean and hygienic	*The room has been cleaned and is appropriate for a young person to be placed in*			
Drinking water provided	*The young person has been given access to drinking water*			
Food provided	*The young person has been given access to meals and snacks*			
Seen by health service / medication given	*The young person has been given their medication at the appropriate times, and been offered access to health services*			

Source: Youth Justice

Table 4: Delegated authority to isolate a child or young person	
Period	**Position**
Up to two hours	Unit Manager or Duty Manager
Up to 12 hours	General Manager, Operations Manager or Senior Manager on Call
Up to 24 hours	Director Youth Justice Custodial Services
More than 24 hours	Executive Director Youth Justice Operations

858. Under the Isolation Policy, the Secretary's authority to isolate a child or young person has been delegated as above on Table 4.

859. Notwithstanding the above, the Isolation Policy requires that any isolation of an Aboriginal child or young person be authorised at the senior management level.

860. Further, the Director, Youth Custodial Services must be notified when a child or young person is placed in isolation for more than six hours and the Unit Manager or On Call Manager must be notified if a child or young person is placed in isolation more than once in any 24-hour period.

861. In addition to the data errors in the Isolation Register discussed above, the inspection was concerned that over 35 per cent of entries of behavioural isolation did not record the frequency of staff supervision or observation, contrary to regulation 32(e) of the CYF Regulations.

862. The inspection audited 15 incidents recorded in the Isolation Register against information in the child or young person's client file and noted:

- One entry appeared to record the date of the isolation incorrectly.
- Four entries appeared to misstate the duration of the isolation by more than 30 minutes.
- Four entries appeared to misstate the location of the isolation.
- One entry appeared to misstate the intervals of observation.
- Five entries appeared to misrepresent whether force was used in connection with the isolation.

863. In all cases reviewed, the inspection was unable to locate a completed 'daily entitlements checklist' in the child or young person's file, in apparent contravention of departmental policy.

864. In response to the draft report, DJCS advised:

> Youth Justice undertakes daily cross check of isolation registers with night reports and daily operation briefings to ensure that all isolations are recorded. Any records missing are highlighted to senior staff on a daily basis for rectification.
>
> A checklist is required for isolations in excess of two hours. As most isolations are under two hours, this may account for absence of checklists as referenced here.

865. The inspection noted that two incidents appeared to lack detailed descriptions in the child or young person's client file, making it difficult to evaluate the use of isolation.

Figure 11: Audit of Malmsbury Isolation Register

Register entry	Detailed description of incident in file	Date consistent	Entry and exit times consistent (+/- 15m)	Duration consistent (+/- 30m)	Location of isolation consistent	Observation intervals consistent	Use of force consistent
23261	✔	✔	✔	Could not be verified	✔	✔	✔
35321	✗	✔	✔	✔	✔	✗	✗
35431	✔	✔	✔	✗	✗	✔	✗
38423	✔	✔	✔	✔	✗	Could not be verified	✗
44969	✔	✔	✔	Could not be verified	✔	Could not be verified	✔
49704	✔	✔	✔	✔	✗	✔	Not recorded
52280	✔	✗	✔	✗	✔	✔	✔
52433	✔	✔	✔	Could not be verified	✔	Could not be verified	✗
52499	✔	✔	✔	✔	✔	Could not be verified	✔
53229	✔	✔	✔	✔	✔	✔	✔
58611	✔	✔	✔	Could not be verified	✔	✔	✔
59773	✔	✔	✔	✔	✗	Could not be verified	✗
59932	✔	✔	✔	✗	✔	✔	✔
54715 & 54717	✔	✔	✔	✗	✔	✔	✔
61170 & 61169	✗	✔	✔	Could not be verified	✔	Could not be verified	Not recorded

Remo

Eighteen-year-old Remo questioned the need to return to his bedroom during a unit lockdown.

Remo said to a member of staff, 'fuck you, why do we have to go to lockdown?' and 'fuck you I don't want to get searched.' Staff asked Remo to calm down, however Remo continued to tell members of staff to 'fuck off'.

Remo was then handcuffed and escorted to an isolation cell. Observation records show that Remo remained in the isolation cell for a period of 2 hours and 45 minutes, save for a four-minute period when he was taken to another area and searched. The observation records state that Remo appeared 'settled' upon entry to the isolation cell.

Staff recorded in the Isolation Register that Remo was isolated because he presented an immediate threat to the safety of others, however the observation form records the reason for observation as 'refused to be searched'.

Staff recorded on the Isolation Register that Remo was isolated for a period of 1 hour and 50 minutes, understating the period of isolation by about one hour. Staff did not record in the register that force was used to isolate Remo. The register entry also stated that Remo was isolated in his own room, rather than an isolation cell.

Malmsbury's Practice Leader subsequently reviewed the circumstances of the isolation and noted that Remo's ADHD made it difficult for him to manage changes in routine. The Practice Leader said that having to be searched 'likely lead to feelings of embarrassment and shame'. The Practice Leader said that Remo 'may have known that his actions would get him moved to a holding cell where, in the quieter environment, he would become less anxious.'

The Practice Leader recommended several measures through which staff could work with Remo to improve his behaviour.

866. The inspection also reviewed a sample of 15 isolations recorded in a child or young person's client file for inclusion in the Isolation Register. This review identified two isolations which did not appear to have been recorded in the Isolation Register, contrary to section 488(6) of the CYF Act.

867. The inspection noted that staff at Malmsbury appeared to be in the habit of recording periods of isolation as ending when the child or young person was escorted out of the room for fresh air or at commencement of the regular evening lockdown.

868. Although this practice may be in keeping with the definition of isolation under the CYF Act – essential elements of which include a 'locked room' and separation 'from the normal routine of the centre' – it risked presenting an incomplete picture of the total period in which a child or young person was effectively isolated from others.

Ben

Eighteen-year-old Ben had a history of self-harm and was escorted to an isolation cell after he was involved in a physical altercation with another young person in his unit.

Observation records show that Ben entered the isolation cell at 12:15pm and remained there until 8:10pm, a period of approximately eight hours. Ben was then returned to his bedroom, where he was 'locked down'. Ben was not permitted to leave his bedroom until approximately 10:00am the next morning. Ben was kept on his own, away from other young people, for a total period of 21 hours and 45 minutes.

The Isolation Register records that Ben was isolated three times over the two-day period: first for 260 minutes' duration, then for 180 minutes' duration, and then for 60 minutes' duration. The register records that Ben was also locked down for two intervals of 30 minutes' duration during this same period. According to the Isolation Register, Ben spent a total of nine hours and 20 minutes in isolation over the two-day period, significantly understating the total period of effective isolation.

Ben's file does not suggest that the Director, Youth Custodial Services was notified of Ben's isolation, which is a requirement when a child or young person is isolated for more than six consecutive hours.

869. The inspection also identified cases where a child or young person's isolation did not appear to have been authorised at the appropriate level.

Yousef

Seventeen-year-old Yousef was diagnosed with an acquired brain injury and a range of learning and behavioural disorders prior to his admission to Malmsbury.

One afternoon, Yousef asked a staff member whether he could go outside and throw dominos. Yousef was told that he could be escorted outside but could not take the dominos with him. Yousef threatened to 'kick off' if he wasn't let out. He then grabbed a bottle of BBQ sauce and squirted it around the unit lounge. When a worker attempted to take the bottle from him, Yousef raised his arm, passing the worker's chin. In response, a 'take-down' was initiated, and Yousef was pinned to the ground by three members of staff.

Yousef was handcuffed and escorted to his bedroom, where he was isolated for a period of approximately four and a half hours. Staff recorded that Yousef was isolated because he presented an 'immediate risk' to the safety of others. Staff incorrectly recorded that Yousef was isolated for two hours, significantly understating the period of isolation.

The register entry states that Yousef's isolation was authorised by the manager of Yousef's unit. Under the Department's Isolation Policy, Unit Managers can only authorise the isolation of a child or young person for up to two hours. Yousef's isolation arguably became unlawful at the two-hour mark because it was not authorised by a person with the requisite delegation.

870. Section 488(8) of the CYF Act exempts lockdowns from the legislative safeguards that are otherwise applicable to isolation.

871. The Department's 'Unit Lockdown' policy nevertheless requires that use of lockdowns be recorded in a register and that children and young people under lockdown be observed at frequent intervals.

872. The inspection noted that more than two-thirds of all lockdowns recorded in Malmsbury's Isolation Register over the previous two years did not identify the intervals at which the child or young person was observed. The inspection noted that observation records concerning lockdowns were rarely included on a child or young person's file.

873. In response to the Ombudsman's draft report, DJCS said 'Youth Justice will work to improve the practice of reviewing and uploading observation sheets within agreed timelines.'

874. The inspection noted 169 entries to the register did not record the identity of the officer who authorised the lockdown.

Separation under a Separation Safety Management Plan

875. The Department's Separation Policy does not recognise a child or young person's separation under a Separation Safety Management Plan as a form of isolation under the CYF Act, meaning that the legislative safeguards applicable to isolation are not considered to apply.

876. The Separation Policy nevertheless makes the use of separation subject to the following safeguards:

- Approval must first be obtained from the Director Youth Justice Custodial Services.
- The development of the Separation Safety Management Plan must be informed by a 'care team', comprised of the Unit Manager, a community-based youth justice worker, a member of the facility's health team and a teacher from Parkville College.
- There must be an 'exit plan' in place to facilitate the child or young person's reintegration to the normal routine of the facility.
- The Separation Safety Management Plan must be reviewed at least once every 72 hours.
- The child or young person must be supplied with a copy of the Separation Safety Management Plan once it has been developed.

877. Notwithstanding the policy position, each Separation Safety Management Plan reviewed by the inspection directed staff to consider whether the conditions of a child or young person's separation met the criteria for isolation under the CYF Act.

878. The inspection observed that periods in which children and young people were isolated at Malmsbury in accordance with Separation Safety Management Plans were only sporadically recorded in the facility's Isolation Register, notwithstanding apparent satisfaction of the criteria for isolation under the CYF Act.

879. The inspection noted that even when recording periods of isolation pursuant to a Separation Safety Management Plan in Malmsbury's Isolation Register, staff appeared uncertain as to the basis for the practice — 52 per cent of isolations pursuant to Separation Safety Management Plans were recorded as being for behavioural reasons, whereas 48 per cent were recorded as being for the security of the centre.

Justin

Nineteen-year-old Justin was separated from other young people at Malmsbury pursuant to a Secure Safety Management Plan for a period of two days.

Justin's Separation Safety Management Plan included a daily schedule, which stipulated that Justin was to remain in his bedroom for the duration of the day, subject to five one-hour 'rotations' to other areas of the facility, 'with no client interaction'.

The periods in which Justin was confined to his bedroom appeared to meet the definition of isolation under the CYF Act, because Justin was:

- placed in a locked room
- separated from others
- separated from the normal routine of the centre.

Staff did not record the periods in which Justin was confined to his bedroom in Malmsbury's Isolation Register.

Material conditions

880. The inspection had mixed impressions of Malmsbury's grounds and facilities. Although the centre appeared reasonably well-equipped, children and young people accommodated in the secure units were restricted in much of what they could access.

881. Across Malmsbury, there was evidence of the changing priorities within Victoria's youth justice system. At the time of the inspection, work was nearing completion on several new units at the rear of the facility.

882. Construction was also underway on a second perimeter fence around the secure site. Some members of staff expressed bewilderment at this measure; the inspection was informed that the existing perimeter fence had never been meaningfully breached.

883. In response to this observation, DJCS considered 'robust perimeter security provides the basis for additional freedom of movement internally'.

884. Two of the previously 'open' units on the senior site had also been fenced-off. These units had a distinctly more correctional atmosphere.

885. The inspection noted that the additional security restrictions at Malmsbury appeared to be having a significant impact upon the ability of children and young people to attend educational and other offerings. Coliban Unit in particular lacked a dedicated teaching room, and Parkville College staff were observed to be attempting lessons in a busy common area.

886. The inspection noted that the facility appeared to be in a reasonable state of cleanliness and repair, although some areas, such as the recently-refurbished Ulabara Unit, were in a better state than others.

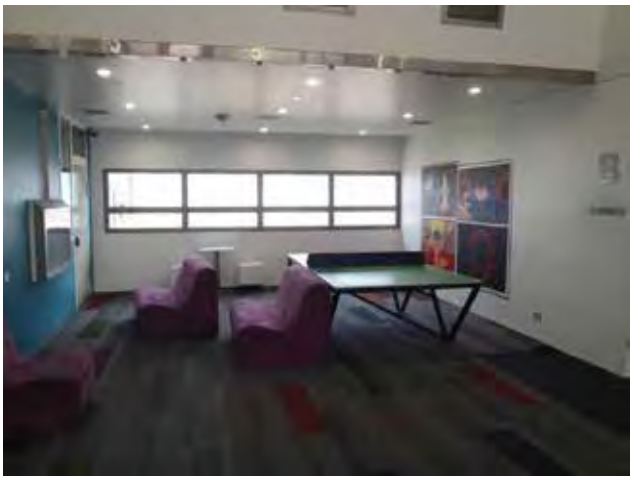
Common yard (Secure Site)

Common yard (Senior Site)

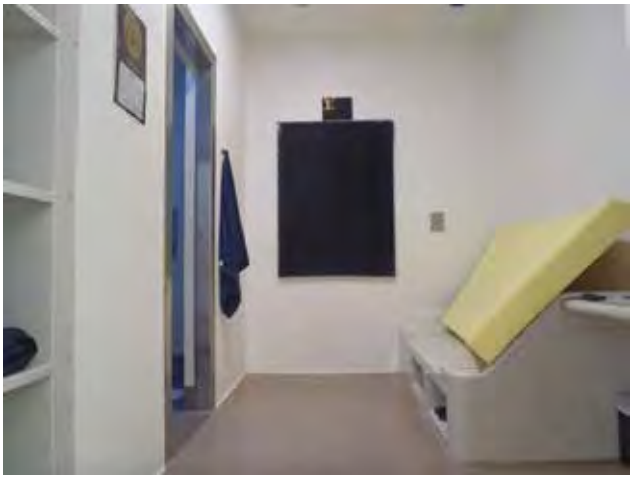
Coliban Unit exercise yard (Senior Site)

Admissions Unit corridor (Senior Site)

Monash Unit common room (Secure Site)



Occupied bedroom



Isolation cells

887. The inspection observed that Malmsbury had several dedicated and ad hoc isolation spaces.

888. There were dedicated isolation cells in each of the three units on the secure site. The secure site was also fitted with three holding cells, ostensibly for the reception of new arrivals, which were also used to isolate children from time to time.

889. At the senior site, Admissions Unit was fitted with one holding cell and one observation cell, both of which doubled as isolation spaces. Ulabara Unit was also fitted with two cells which could be used for isolation.

890. There were also four cells in the area designated as the Intensive Supervision Annexe, one of which was fitted for observation purposes.

891. Although the quality of Malmsbury's isolation cells varied, the inspection noted that none appeared to have been designed or fitted with a particularly therapeutic focus, and all maintained a distinctly correctional feel.

892. Noting the Mandela Rules seek to alleviate the potential detrimental effects of solitary confinement, the inspection considered that greater effort could be taken to soften the atmosphere of these areas.

Secure site

893. The dedicated isolation cells at the secure site were assessed as being in a reasonable state of cleanliness and repair.

894. The inspection noted that each cell included a mattress, toilet, attached washbasin and wall-mounted television. The inspection noted that the toilets in these cells lacked privacy screens and were in full view of staff observation windows.

895. The three holding cells at the secure site each contained a metal bench, toilet and washbasin. The inspection noted that the view of the toilet from the observation window was partially obscured by a privacy screen.

896. Although the holding cells appeared clean and well-maintained, they were not equipped with mattresses. The inspection did not consider these rooms to be suitable to accommodate children for any extended period.

897. The inspection was concerned to identify cases where children appeared to have been placed in isolation in these cells without access to bedding materials.

Timoti

Seventeen-year-old Timoti was required to return to his bedroom after he became involved in an altercation with another child accommodated in his unit.

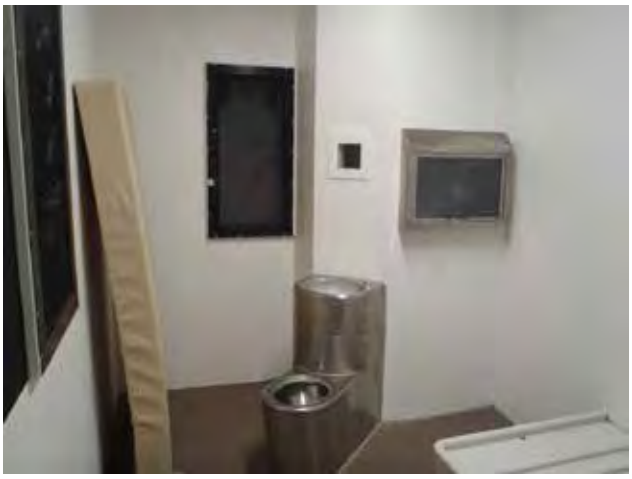
After approximately one hour in his bedroom, Timoti was informed that he was to be escorted to a holding cell for isolation. Timoti became agitated and damaged his bedroom, prompting a unit lockdown.

Timoti was removed from his bedroom, handcuffed and escorted to a holding cell. While isolated in the holding cell, Timoti made multiple attempts to self-harm. Staff radioed for assistance and arranged for Timoti to receive a health assessment. Timoti was later handcuffed and escorted to a Parkville College classroom for a fifteen-minute run-out. Timoti remained in the holding cell into the evening. As night approached, Timoti made numerous requests for a mattress. Staff observed that he was lying on the metal bench. Timoti's file does not record whether a mattress was ever provided to him.

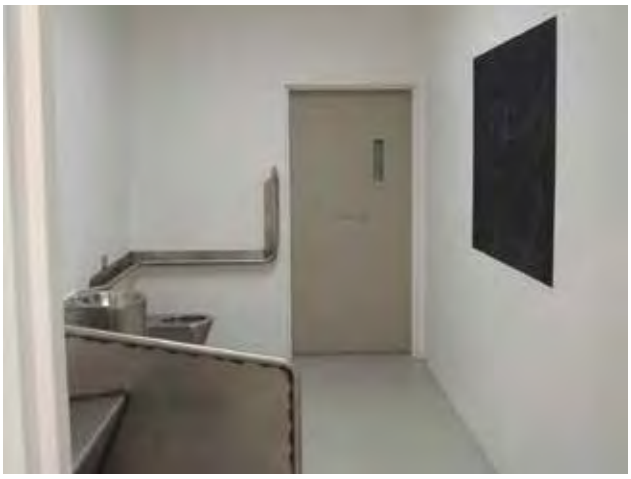
After a further period, Timoti asked staff for his anti-psychotic medication and, when this was not immediately provided, he made additional attempts to self-harm. Staff arranged for health services staff to attend to Timoti a second time and, after a period of quiet behaviour, he was transferred to a bedroom in another unit. All told, Timoti spent approximately eight hours in the holding cell.

At the time of the incident, Timoti had a behaviour support plan in place which recognised that confined spaces appeared to 'trigger a spiralling effect' in Timoti's behaviour. The behaviour support plan recommended that wherever possible, Timoti be allowed to de-escalate in an open area. Staff resolved to update the plan after the incident.

Isolation cell (secure site)



Holding cell (secure site)



Senior site

898. The holding cell in Admissions Unit was not clean when first inspected. The inspection was informed that the cell had recently been vacated by a young person. The cell was clean when inspected again later in the afternoon.

899. The holding cell was fitted with a mattress, toilet, washbasin and wall-mounted television. The inspection noted that the toilet lacked a privacy screen, an issue DJCS has acknowledged and will consider ways to address.

900. The holding cell was fitted with an outside-facing window. The blinds were drawn when the cell was inspected, with little natural light entering the room. Staff informed the inspection that the blinds were electric and could be raised or lowered at the request of the occupant. When asked to demonstrate this, staff informed the inspection that the controls did not appear to be working.

901. The observation cell in the Admissions Unit appeared to be in a reasonable state of cleanliness and repair. The cell was fitted with an outside-facing window, mattress and wall-mounted television. There was a toilet area separated by a partition, although the inspection noted that the toilet was still in view of the main observation window.

902. The inspection observed that the main isolation cell in Ulabara Unit appeared to have been recently refurbished alongside the rest of the unit. The cell was freshly painted and bore no signs of recent use.

903. The inspection noted that the cell was equipped with a private toilet area which could be monitored through a small, dedicated observation window. The cell was not equipped with a mattress at the time of the inspection. The cell lacked outside-facing windows and consequently received no natural light.

904. The inspection viewed another room in Ulabara Unit which appeared capable of being used as an isolation cell. Staff on the unit said that the room was used infrequently and that it was exceedingly rare for a child or young person to be placed in isolation there.

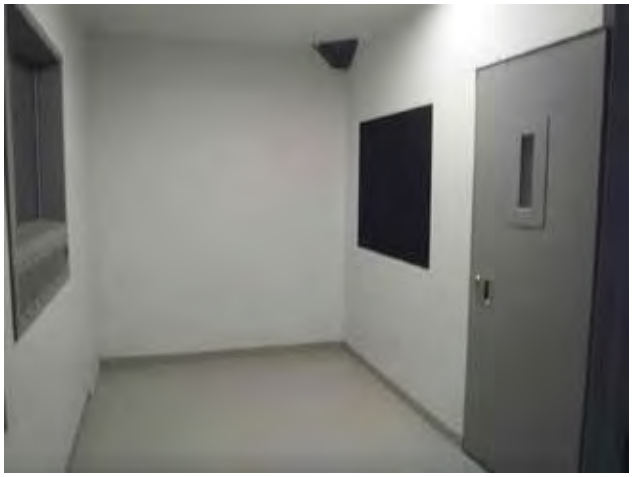
905. The inspection noted that the room lacked a toilet or washbasin. The inspection did not consider this area to be a suitable space to isolate a child or young person for any extended period.

906. The inspection considered that the lack of privacy screens around toilets in several of Malmsbury's isolation cells was incompatible with the right to privacy under section 13(a) of the Human Rights Act.

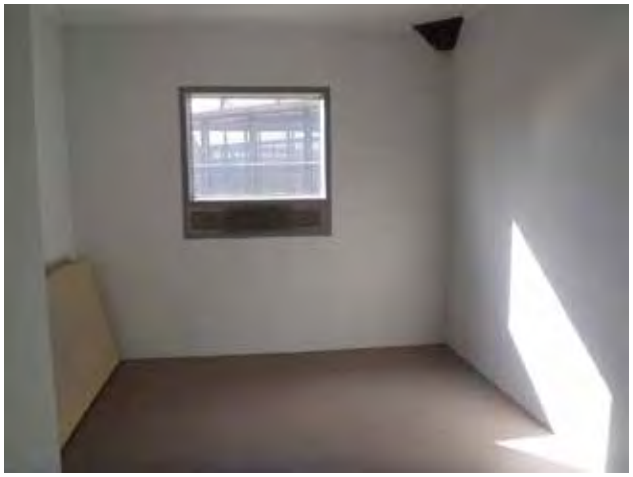
Admissions Unit holding cell

Ulabara Unit isolation cell 1

Admissions Unit observation cell



Ulabara Unit isolation cell 2



The Intensive Supervision Annexe

907. The Intensive Supervision Annexe (**ISA**) is situated at Malmsbury's senior site. It is comprised of three lockable bedrooms, one observation cell, a common area and an enclosed exercise yard.

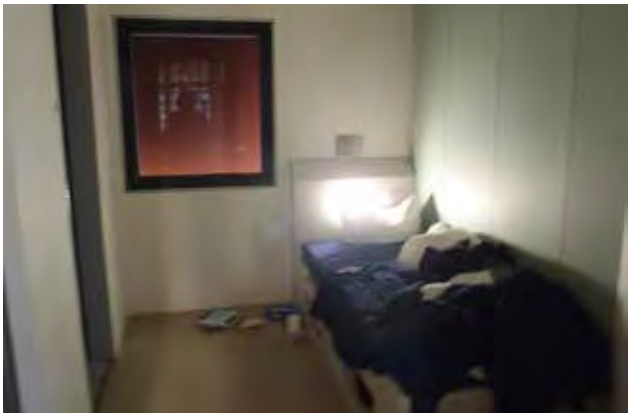
908. Although the ISA is ostensibly a self-contained unit, children and young people may be accommodated in the unit by themselves, with limited access to the normal routine of the facility.

909. The inspection noted that the ISA was used to accommodate a single child or young person on 32 non-consecutive days during the three months preceding the announcement of the inspection.

910. Cells in the ISA included a mattress, toilet, washbasin, wall-mounted television and were fitted with an outside-facing window with exterior blinds. Staff on the unit said that they were able to raise or lower the blinds manually from the outside of the facility at the request of the occupant. At time of the inspection all blinds were down and there was minimal natural light entering the cells.

911. The cells appeared well-worn and there were prominent etchings on windows and other surfaces. The inspection noted that two unoccupied cells had dirty floors. The unit as a whole felt very correctional and there appeared to be little therapeutic value in its design and fit-out.

ISA bedroom



ISA observation cell

ISA bedroom door trap

ISA observation window in bedroom door

Meaningful human contact

912. Meaningful human contact is an important protective measure to mitigate the harmful effects associated with practices such as isolation and lockdowns.

913. It is well documented that the denial of meaningful human contact can lead to a range of psychological and sometimes physiological harm, including anxiety, depression, anger, cognitive disturbances, perceptual distortions, paranoia, psychosis, self-harm and suicide.[25]

914. Meaningful human contact is particularly important for children and young people because crucial stages of social, psychological and neurological development can be interrupted or damaged as a result of isolation.[26]

Empathy is important when engaging with clients that are separated or isolated. Being attentive and ensuring their needs are met is usually the way staff work around young people who are separated or isolated.

– Staff member

915. Meaningful human contact and access to purposeful activity are also essential to the rehabilitative objective of youth justice to assist children and young people to assume socially constructive and productive roles on release.[27]

916. In accordance with these principles, under section 485(1) of the CYF Act, the Secretary may permit a temporary leave of absence for a child or young person from a youth justice facility to:

- seek or engage in employment
- attend an educational or training institution
- visit family, relatives or friends
- participate in sport, recreation or entertainment in the community
- attend a hospital or a medical, dental or psychiatric clinic
- attend a funeral.

917. Overall, the inspection saw positive examples of meaningful human contact between staff, children and young people at Malmsbury in the units. However, this was limited when a child or young person was isolated or locked down.

They [the staff] are really supportive and keep me as safe as they can. They play table tennis with me and stuff like that.

– Young Person observed to be self-isolating

25 Guidance document on the Nelson Mandela Rules page 105, referencing Grassian S, 'Psychiatric effects of solitary confinement', Journal of Law and Policy, Vol. 22, 2006, pp. 325-383; Craig Haney, 'Mental health issues in long-term solitary and supermax confinement', Crime & Delinquency, Vol. 49, No. 1, 2003, pp. 124-156; Sharon Shalev, 'A sourcebook on solitary confinement', Mannheim Centre for Criminology – London School of Economics, 2008; Interim report of the Special Rapporteur on torture, A/66/268, op. cit., note 231.

26 Commissioners and Guardians, Statement on conditions and treatment in youth justice detention (November 2017), 21 referencing Elizabeth Grant, Rohan Lulham and Bronwyn Naylor, 'The Use of Segregation for Children in Australian Youth Detention Systems: An Argument for Prohibition' (2017) 3 Advancing Corrections 117, 124-5; J Howell, M Lipsey and J Wilson, A handbook for evidence-based juvenile justice systems (London: Lexington Books, 2014) 95–99; Council of Juvenile Correctional Administrators, Administrators Toolkit; American Civil Liberties Union, Alone and Afraid 108 Laura Dimon, 'How solitary confinement hurts the teenage brain' (2014) The Atlantic < https://www.theatlantic.com/health/archive/2014/06/how-solitary-confinement-hurts-the-teenage-brain/373002/>

27 See generally The United Nations Standard Minimum Rules for the Administration of Juvenile Justice (the Beijing Rules), rule 26.

Interaction with staff

918. The inspection observed positive interactions between staff and young people when they are out in the exercise yards or on the unit. Some staff played basketball or table tennis with young people or otherwise engaged them in conversation.

919. However, when a young person is in isolation or a lockdown, there was very little interaction.

920. Forty-five per cent of young people surveyed said they were 'always' able to speak with unit staff and supervisors during isolation or lockdowns. Thirty-five per cent reported that they were 'sometimes' able to speak with staff.

I always try to keep them talking and ask them how they are doing and if they need anything. Sometimes they will talk and other times they won't. I don't push it. But I always let them know I'm here.

– Staff member

921. Comparatively, just 23 per cent of young people reported that they were 'always' able to speak with other workers such as their case manager, teachers or programs staff. Forty per cent said they were 'sometimes' able to speak with these persons and 20 per cent said they were 'never' able to speak to these persons.

922. The inspection noted that young people felt particularly frustrated about staff not telling them why a unit or the whole facility was put into lockdown. Some young people thought staff were 'left in the dark too' and just respond to whichever code was called.

923. Approximately 50 per cent of staff surveyed reported that Malmsbury did either 'Well' or 'Very well' at providing them with meaningful human contact to children and young people in isolation or lockdowns.

When a young person is separated or in isolation such as in the holding cells, I constantly engage with them. I do not take my eyes off them. I tell them they are not alone that 'I am here with you'. I once spent five solid hours with a young person at the holding cells. I did not leave his side. I spoke to him conversationally for the whole time I was there. He was ultimately being sent to [the adult system]. I kept reassuring him and talking to him as a child and as if I was his parent figure.

– Staff member

924. Survey respondents employed in an operational capacity were far more likely to report that Malmsbury did 'Very well' in managing the needs of young people in isolation than staff employed in other capacities.

925. Sixty per cent of young people surveyed said that when they were in isolation staff would usually ask them if they were 'OK'.

Some staff are alright; some staff look after you and make sure you're OK. Others just don't want to hear from you.

– Young person

926. Fifty-eight per cent of young people surveyed said that unit staff usually came when buzzed or called during isolation; however, almost one quarter (23 per cent) said they would not.

I get angry when I get hanged-up on when using the intercom. I have to buzz up five times to get an answer.

– Young person

Tamar

Twenty-year-old Tamar had poor social skills and a history of anxiety and substance abuse and would regularly self-isolate in his room at Malmsbury. Tamar felt unsafe and targeted by other young people in his unit. Case notes show that Tamar was prone to reveal details of his offending which resulted in him being ostracised and assaulted by other young people.

Tamar was a repeat victim of physical assaults and verbal abuse by other young people. In February 2019, Tamar was assaulted three times. Staff were aware that this 'bullying' led to Tamar's self-isolation, and to his fear that his parents would also be assaulted if they visited.

When Tamar was not self-isolating, he only wanted to go to 'safe' environments where he was 'highly supervised' and preferably while the rest of the unit were at the gym. Staff were aware that this behaviour posed a risk as it prevented Tamar from engaging in programs, exercising at the gym and interacting with other young people.

One morning, staff met with Tamar to encourage him to gradually increase his 'time on the floor' as his presence would assist in reducing targeting by other young people. Staff stated that they would regularly 'remove' Tamar from his room. Tamar protested. One hour later, Tamar threatened to self-harm. Over the subsequent 51 hours, the observation form showed Tamar intermittently self-isolating for a total of 46 hours. He spent this time alone in his bedroom, receiving meals from staff and refusing to leave.

Staff resolved to encourage Tamar to manage his fears and gain social competencies and confidence. They ensured a staff member was always with Tamar to provide safety and stability. Staff were also instructed to provide ongoing positive reinforcement and encourage Tamar's interests. At the start and end of each day, a staff member helped Tamar to reflect on what social behaviour works well for him.

Over the period that followed, Tamar began to engage in education programs and ate meals in the communal kitchen. Tamar started engaging in 'small interactions' with peers and participating in unit life. Although Tamar's social engagement with staff and some young people improved, the physical assaults and threats from other young people persisted.

Tamar continued to be fearful and case notes suggest that he would only leave his room if one-on-one contact with a staff member was guaranteed.

927. Forty-five per cent of young people said that unit staff made them feel 'OK' during periods of isolation, whereas 20 per cent of survey respondents said that unit staff made them feel 'Bad'. Ten per cent reported that unit staff made them feel 'Really bad' during these periods.

928. As illustrated in the case study above, the inspection noted that some staff will interact with young person who are self-isolating in an attempt to reengage them in a normal routine.

Contact with other young people and the outside world

929. Pursuant to section 482(2) of the CYF Act, children and young people detained in youth justice centres are entitled to receive visits from parents, relatives, legal practitioners and other persons. This is consistent with rule 59 of the Havana Rules that provides for adequate communication with the outside world as being integral to fair and humane treatment and essential for preparation to return to society.

930. Personal visits for sentenced young people occur mainly at weekends and public holidays; however, visits can be facilitated throughout the week due to special circumstances. Remanded young people are entitled to daily visits.

931. Forty per cent of young people surveyed reported that once isolated, they were still able to make contact with people outside Malmsbury; however, 45 per cent said they were not.

... My mother has been calling up to book a visit; they don't arrange it. It makes me angry and stressed out – family is pretty important to me.

Young person

932. Thirty-five per cent of those surveyed said they were 'sometimes' able to speak with their friends and other young people at Malmsbury when isolated, compared to 33 per cent who said they were 'never' able to.

933. Fifty per cent of young people surveyed said they were able to have visits from family and friends during isolation, whereas 35 per cent said they were not.

934. One young person told the inspection that his family had driven an hour to visit him, however, when they arrived, they were told that there were not enough staff to facilitate the visit.

935. One young person on the secure site told the inspection that he would normally call his mother three times per day, however, during the 'code aqua' the week before the inspection, he wasn't able to and no one from the facility spoke to the parents to let them know their children were OK.

When we get a code aqua [lockdown], we don't get phone calls.

– Young person

They should have put the boys on the code in lockdown [not us]. I wanted to talk to my parents on the phone. They wouldn't let us. That made me angry.

– Young person

936. Young people in one unit on the senior site, however, told the inspection that their unit staff had called parents to let them know that everyone was safe but there was a site lockdown which may prevent their children from using the phones for a while. This appears to be a good practice, however, it does not occur in each unit.

Purposeful activity

937. Education, vocational training and programs are important types of purposeful activity offered at Malmsbury.

938. Only approximately one in three staff surveyed rated young people's access to education and vocational training as either 'Good' or 'Very good', whereas 20 per cent, rated is as either 'Poor' or 'Very poor'.

939. Survey respondents employed in an operational capacity were far more likely to report that quality and access to services was 'Very good' for young people in isolation than staff employed in other capacities.

The common perception members of the public have is that young people who reoffend have done so despite rehabilitation programs. No such programs exist. The school is the only day to day program with a client development focus and is severely hampered in its ability to operate effectively and deliver evidence based high quality programs due to limitations placed on approved items, poor equipment and old classroom spaces in states of disrepair. These challenges are even more pronounced when the student is isolated/separated or locked down and therefore the student is not able to access the educational spaces, mix and learn with peers, or experience success in learning.

– Staff member

940. According to DJCS:

> Youth Justice Custodial Services utilises a fully structured day approach for young people, promoting their engagement in constructive activities and involvement in a predictable daily routine.
>
> The following applies to both the Secure and Senior centres, however there may be differences in the way that the routines are implemented, for example increased requirement for young people to be escorted between locations on the Secure Centre.
>
> Young people may mix with their peers from other units in classes and programs or when there is a particular cultural or other celebration. This is based on robust risk assessment processes.

[If I was the boss for a day] I'd engage all the young men in more productive programs and not make them feel isolated or without help.

– Young person

941. The inspection was concerned by the impact of lockdowns and 'rotations', on the provision of purposeful activity to children and young people at Malmsbury. The inspection was not satisfied that Malmsbury was providing a 'fully structured day' during the inspection or in the week preceding.

942. Documents from the Department describe a typical daily program for a young person as including:

> … compulsory involvement in education or vocational training with a total of six sessions. 09.30 – 10.20am, 10.30 – 11.20am, 11.30am – 12.30pm, 1.00pm – 1.50pm, 2.00 – 2.50pm and 3.00 – 3.50pm. There are four 10 minutes breaks and one 30-minute lunch break. The young men are returned to their unit for all breaks.

943. Education at Malmsbury is provided by Parkville College, a specialist Victorian Government school for students who are, or have been, detained in custody. Parkville College operates across seven campuses, including Parkville Youth Justice Precinct.

There are constant lockdowns due to understaffing. Due to lockdowns, it is hard to provide education to the young men.

– Staff member

944. During the inspection, most children and young people appeared to be in their units rather than in the education buildings. Parkville College teachers were seen on most units attempting to engage the children and young people. The inspection considered, however, that it would be challenging to deliver education appropriately in many units because of their design.

[It's stressful] not having access to students or having to teach on a unit. Rotations and lockdowns [lead to] student unrest.

– Teacher

945. One young person told the inspection that because of lockdowns unrelated to him, he had not been able to attend his hospitality course in Collingwood, for the last two weeks.

I've worked really hard to get here and to have these entitlements, and because of other people's behaviour I don't get to go to my hospitality class.

– Young person

946. The inspection was told that it is difficult for Parkville College teachers to deliver education to children and young people in the ISA and did not observe any education program being undertaken by young people in this Annex. Instead, the inspection observed young people in the ISA pacing the exercise area and occasionally engaging in conversations with staff.

947. The inspection was informed that ordinarily young people accommodated in the ISA would be on a Separation Safety Management Plan (SSMP) which should detail the educational/program, recreational, peer, cultural/spiritual and family/community supports to be provided.

948. During the inspection three young people were accommodated in the ISA. These young people were not on SSMPs and staff on the unit were uncertain when they would return to normal regime. The inspection considered that the use of the ISA without a tailored SSMP presented a risk to the child or young person being denied adequate meaningful human contact and purposeful activity.

Without measured & sweeping changes to the current system the chance of the young people at this facility to be rehabilitated is slim at best.

– Staff member

Self-isolation

949. The inspection also observed instances of 'self-isolation' where a young person would withdraw to their room and spend most of their time alone. Twenty-three per cent of young people surveyed said they would sometimes self-isolate to avoid others.

950. Although self-isolation is not 'isolation' within the meaning of the legislation, it presents a risk that needs be effectively managed by staff.

Kelvin

Twenty-year-old Kelvin self-isolated throughout his stay at Malmsbury. It was Kelvin's first time in detention. Although he was observed engaging well with peers and following staff directions, he spent most of his time by himself in his room.

From Kelvin's first week at Malmsbury he was recorded to be getting up late and spending his days in his room. He would only leave his room 'for a short time to have his meals'. When staff checked on Kelvin, he would report being fine and preferring to stay in his room. Staff told Kelvin that he needed to come into the unit and mix with peers. Kelvin said that he was doing this. However, he continued to self-isolate for the majority of each day.

Soon after, staff again told Kelvin that he could not stay in his room for his entire sentence. To this, Kelvin replied 'I will try'. A month after Kelvin's admission to Malmsbury, he was spending most of his day in his room. When he socialised, it was recorded that he was only pointing and nodding. Staff told Kelvin that he needed 'to talk with staff' so that they understood what he wanted them to do.

Health and wellbeing

951. Children and young people in youth detention should receive adequate preventive and remedial medical care, according to rule 49 of the Havana Rules. Similarly, the *Australasian Juvenile Justice Administrators: Juvenile Justice Standards* (2009) state that the health and wellbeing of a child or young person is paramount during periods of isolation or separation.

952. The CYF Act states that it is an offence for a person who has a duty of care in respect of a child to intentionally take action that results in, or appears likely to result in, the child suffering emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged (section 493(1)(a)(ii)).

953. The health services provided to children and young people at Malmsbury therefore form an important protective measure.

954. Since February 2019, Correct Care Australasia has provided healthcare at Malmsbury including a range of clinical services:

- primary medical and nursing services (general and mental health)
- dental and allied health services
- radiology and pathology referrals
- medication management, including pharmacotherapy
- health promotion, chronic disease management and immunisation and screening.

955. Specialist provider, Caraniche, provides psychological rehabilitation services including psychological assessment, a range of psychoeducation and criminogenic group programs and individual intervention to address the issues and behaviours that bring young people into the criminal justice system.

Health consideration before isolation

956. Children and young people who have medical or psychiatric conditions are particularly vulnerable to the negative effects of solitary confinement.

957. Unlike in the adult system, there is no requirement under the CYF Act for consideration to be given to a person's medical and psychiatric conditions before authorising isolation.

958. The inspection was concerned by this, particularly in cases such as the case study below where a young person with an intellectual disability and anxiety was isolated after becoming agitated because of lockdowns, despite staff being advised that 'being alone and the sound of silence' could trigger his anxiety and that he had a tendency to self-harm when isolated.

Jackson

At time of his admission to Malmsbury, staff were informed that sixteen-year-old Jackson had been diagnosed with an intellectual disability, anxiety and post-traumatic stress disorders. Jackson's behavioural support plan advised that 'being alone' and the 'sound of silence' could trigger Jackson's anxiety, and that he had a tendency to self-harm when placed in isolation.

Shortly after arrival at Malmsbury, Jackson was confined to his bedroom during a unit lockdown. The Aboriginal Liaison Officer visited Jackson and observed that he appeared upset. Jackson told the Aboriginal Liaison Officer that he had been led to believe that he would be allowed out of his room at 11am, however staff were now saying that they weren't sure when the lockdown would end. Jackson told the ALO that he was thinking about self-harming.

Jackson was subsequently transferred to an isolation cell for reasons that are not recorded in Jackson's file.

Staff observed that Jackson was 'heightened' and 'agitated' and was searching the room for implements with which to harm himself. Several hours later, a member of staff observed that Jackson was 'slamming' his head against the bench in the cell. The staff member asked Jackson to stop, but Jackson continued to hit his head against the bench. By the time help arrived, Jackson was unconscious and seizing.

Jackson subsequently regained consciousness during examination by paramedics. Jackson started to panic at the oxygen mask and refused to allow ambulance officers to administer a needle to his arm. At the recommendation of the paramedics, Jackson was conveyed to a hospital by ambulance for further examination. Jackson was handcuffed for the duration of the journey.

Health assessment upon isolation

959. Under the Department's Isolation Policy, 'when there are any specific health concerns', the unit supervisor is responsible to notify health services as soon as logistically possible after isolation commences. Health services staff are then to:

    - provide advice to the unit staff on any health issues or support needs they should be aware of while the young person is in isolation.
    - contribute to discussions and planning meetings regarding young people who have had repeated isolations, including assisting in the development of an Individual Behaviour Management Plan.

960. The inspection was not satisfied that routine health assessments are provided for all children and young people placed in isolation and considered this to be a significant risk factor that may lead to ill-treatment.

961. The inspection was told that when the general practitioner was called to the secure site to see a child or young person isolated in a holding cell, he would be accompanied by three members of SERT who would decide whether he could see the patient privately. The inspection was told that SERT officers remain present most of the time.

962. The inspection was also told that when nursing staff are called to a unit to conduct a mental health examination or risk assessment they may have to engage with the child or young person through the trap in the door if the full door isn't opened by SERT.

Figure 12: Case Notes, health assessment through trap door

On r/v through the trap with 3 sert present he was loud, angry and unable to self sooth. He was allowed to ventilate where he made flippant threats to assault staff and to kill himself or scratch up.

He was very slow to de escalate.
At his request I obtained a phone order; Dr [redacted] ordered Clonidine 100mcg and same given at 1800hrs with reasonable effect. [redacted] is already on this but is yet to be dispensed.

[redacted] soon settled with this and some positive attention from SERT; he accepted a meal and was progressing back to his baseline.

963. In response to the Ombudsman's draft report, DJCS wrote:

> Decisions regarding escort staff being present at medical, health and mental health consultation and treatment are made with regard to the safety of the young person and the staff involved. Consultations of a sensitive nature would not have escorting staff present.
>
> There may be times where health services staff consult with a young person through the trap, as an assessment has been made that it is not safe to open the door due to safety considerations. This could include where a young person is threatening to assault staff if the door is opened.
>
> Critical decision making by health services staff in relation to suicide and self-harm risk must occur after consultation with the young person face to face rather than through the trap.

964. Victorian legislation protects the right to privacy, such as between a patient and medical professional. The inspection considered that the routine presence of members of SERT during medical consultations without a contemporaneous risk assessment was neither appropriate nor necessary and may be incompatible with section 13 of the Human Rights Act.

Access to health care while in isolation

965. Approximately 50 per cent of staff surveyed reported that Malmsbury did either 'Well' or 'Very well' at facilitating young people's access to health and mental health care during periods of isolation.

966. This contrasts with just twenty per cent of young people reporting that once isolated, they were 'always' able to speak with medical staff such as a psychologist, psychiatric nurse, nurse or doctor. Thirty-three per cent of survey respondents reported that they were 'sometimes' able to speak with these persons. Twenty per cent of survey respondents reported that they were 'never' able to speak with such persons.

One person does something wrong and we all get punished. I had to wait an hour to get an asthma pump, and who's coming [with it]? It's not the doctor, it's SERT. SERT comes to stand around you.

– Young person

[This place] makes kids feel suicidal and shit.

– Young person

967. The inspection also reviewed case notes that demonstrated the impact isolation and lockdowns has on young people's access to health services. In the case note set out below, a young person, who was accommodated alone in the ISA, missed his scheduled health appointment because of an incident somewhere else at the facility. He was escorted from his unit to the neighbouring health building in handcuffs by SERT and unit staff.

968. In another case, a young person missed his psychology appointment because he was being held in a holding cell on the secure site.

Figure 13: Case Notes, health assessment through trap door

Case Note

Client:	[redacted]
Event Date & Time:	[redacted] 2:30 PM
Subject:	Rehabilitation Services- Individual session 2-brief attendance
Created by:	[redacted]

Details:

2:30 PM - 2:50PM:

The writer contacted the ISA unit at 1:00 PM to request [redacted] to be brought to health for his individual session which was scheduled for 2:00 PM. [redacted] had recently been residing at the [redacted] Unit however due to incidents occurring over the weekend; [redacted] was moved back to ISA.

At 2:30PM the writer contacted the ISA once more to enquire as to the status of the client's escort to health. The staff member stated that due to a code on centre, [redacted] was in queue for Control to approve the escort to health.

[redacted] arrived to the health building and was escorted by SERT and DJR staff members. He entered the consulting room and sat in the chair. [redacted] presented as fidgety and was unable to focus for longer periods. He often got out of this chair and became distracted by the noises outside the window.

Figure 14: Case Notes, health assessment through trap door

Case Note

Client:	[redacted]
Event Date & Time:	[redacted] 10:00 AM
Subject:	YHaRS Rehab Services - Unable to attend psychology appointment
Created by:	[redacted]

Details:

The writer contacted the Campaspe unit and asked for [redacted] to be sent to the health building for his scheduled counselling appointment. The writer was advised that [redacted] was being held in the holding cells on the secure side and it was unclear if or when he would be returned to the Campaspe unit. Next session booked for the week beginning 29th October 2018.

Children and young people at risk of suicide or self-harm

969. Malmsbury has a framework for the prevention of suicidal and self-harming behaviour which provides that it must be carried out in the least intrusive way possible to respect a child or young person's dignity, including when restrictive interventions such as restraints or isolation may be required to ensure safety.

970. The framework has three overarching zones, being 'proactive interventions' (green zone), 'active interventions' (orange zone) and 'reactive interventions' (red zone). Reactive interventions are designed to assist staff intervene in and respond to situations where a child or young person is actively self-harming or demonstrating behaviour indicated they are at an immediate risk of self-harm or suicide. Examples include calling a code, placing a child or young person in isolation or initiating a restraint. Under the framework, and consistent with the CYF Act and Human Rights Act, reactive interventions are only used as a last resort, and in response to an immediate harm.

971. The framework states that when a child or young person is isolated, the staff member responsible for their observation must engage with them verbally to show the child or young person that they are being supported and allow the staff member to monitor their mood and wellbeing.

[When a young person has self-harmed] I do not take my eyes off the young person. I engage constantly or suggest they may like to rest or lay down on the bench and be as comfortable as they can be in the situation. I sympathise with their circumstances. I do not add further harm or insult. I respect their vulnerability by my tone of voice, my angle towards them and by maintaining appropriate eye contact. I try to sit with them on this difficult journey. It is exhausting yet I feel proud and like I have done my duty of care at the end of it. I am strong towards them yet yield when I need to in order to allow them to express whatever feelings and emotions that may rise out of them. I try to keep them safe through my observation and my tone of voice.

– Staff member

A lot of [self-harming young people] I have found don't actually want to hurt themselves, they just want the constant attention of a staff member and someone to speak to. I always offer them this option and tell them that I can stay and chat with them and they don't need to self-harm for me to do so.

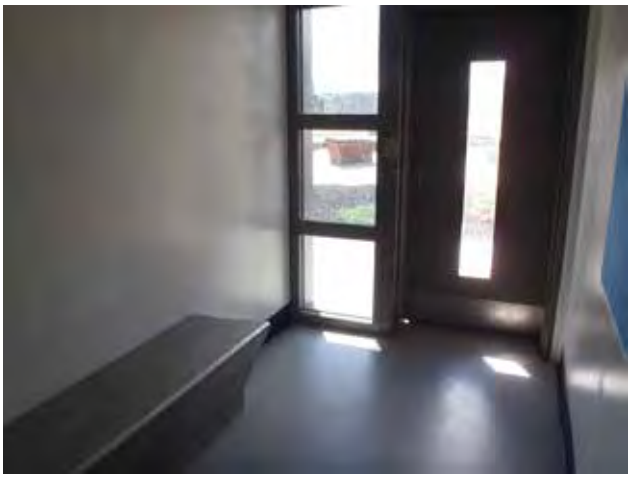
– Staff member

Observation of 'at risk' children and young people

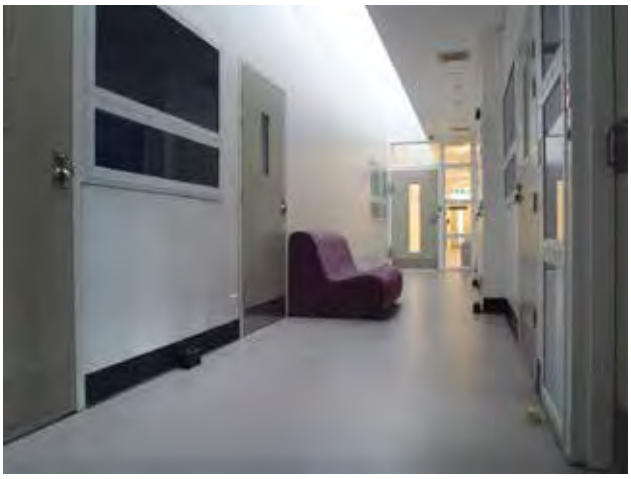
972. If a child or young person at Malmsbury is actively displaying suicidal or self-harming behaviours, they must not be left alone under any circumstances. They are put on a level of observation to reflect the identified level of risk. Observations are conducted by unit staff to note that the 'at risk' child or young person is present and safe and to provide them with 'appropriate interaction and emotional support.' The observation of children and young people at risk of suicide or self-harm are not medical observations.

973. When observation has been initiated because of concerns that a child or young person is at risk of suicide of self-harm, or because of a mental or physical health issue, a mental health worker will review the level of observation required twice per day. According to the framework for the prevention of suicidal and self-harming behaviour, a health service review of a child or young person on observation for being 'at risk' must occur face-to-face, not over the phone or through a door trap.

Health Unit waiting area (secure site)

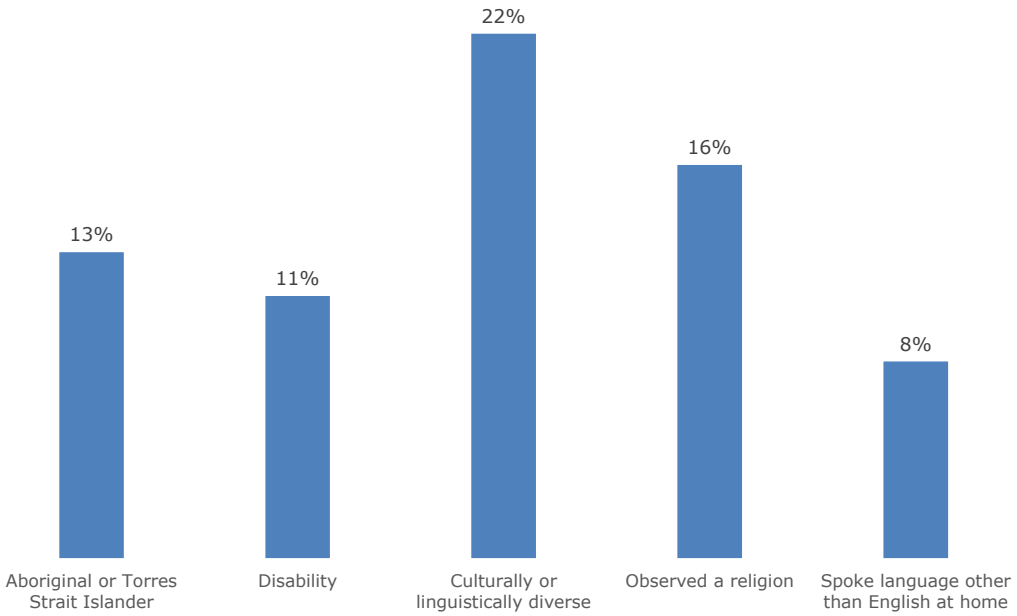


Health Unit (secure site)



Diversity

Children and young people in Malmsbury demographics (28 Feb 2019)



974. A diverse cohort of children and young people live at Malmsbury from a range of cultural, linguistic and religious backgrounds, including a significant number of Aboriginal and Torres Strait Islander people. There is also an increasing cohort of young people from African countries.

975. The negative effects of isolation are likely to be felt more severely for particular populations, and Malmsbury must take account of diverse vulnerabilities when planning action to prevent cruel, inhuman and degrading treatment.

Aboriginal and Torres Strait Islander young people

976. In the Commission for Children and Young People's inquiry into the use of isolation in the Victorian youth justice system, the Victorian Aboriginal Legal Service described the confinement of children and young people as 'completely adverse to the nature of Aboriginal and Torres Strait Islander cultural practices, and only serves to further contribute to the breakdown and decimation of cultural practices that began with the onset of colonisation'. The Commission commented that it is essential that 'periods of isolation of Koori children and young people are managed sensitively and with due recognition of the accrued harms they, and their families, have suffered'.

977. The inspection found that Aboriginal and Torres Strait Islander young people were overrepresented in isolation data. Approximately 14 per cent of the population at Malmsbury identified as Aboriginal and Torres Strait Islander. Despite this, these young people represented 20 per cent of the isolations under section 488(2) of the CYF Act reviewed over the 12-month reporting period. Although this disparity is smaller than it was when the Commission for Children and Young People reported in 2017, it is still not acceptable.[28]

28 The Commission for Children and Young People reported that in '2015 and 2016, 16 per cent of all children and young people in youth justice custody identified as Koori… At Malmsbury, 30 per cent of children and young people isolated were Koori'.

978. According to Malmsbury's Isolation Policy, when staff are considering placing a young Aboriginal person into isolation, they must contact the Aboriginal Support Worker as soon as logistically possible. In addition, all young Aboriginal people in isolation must be placed on constant observations.

979. Malmsbury's Isolation Register does not include a specific field to record whether an Aboriginal Support Worker was contacted. Of the 239 behavioural isolations of young Aboriginal people that occurred over the 12-month reporting period:

- Less than ten per cent record that an Aboriginal Liaison Officer was notified.
- Fifteen percent record that the health care team was notified.
- Fifty-eight per cent record that the young person was on 'constant' observation.
- Twenty-five per cent record that the young person was on 'close' observation.
- Seventeen per cent did not record the level of observation.

980. The inspection was told of an incident involving the isolation of a young Aboriginal person that occurred shortly before its visit to Malmsbury.

981. The inspection considered that the Isolation Register should include a specific field to record that an Aboriginal support officer was contacted upon isolation. DJSC agreed and advised this addition would made.

982. The inspection observed that the Aboriginal Liaison Officers are well respected within the facility and noted that their services are in high demand.

983. Twenty per cent of young people surveyed said that once isolated, they were 'always' able to speak with independent support persons such as the Independent Visitor, the Aboriginal Liaison Officer, the Cultural Support Officer or a religious leader of their faith. Thirty-three per cent reported that they were 'sometimes' able to speak with these people, whereas 15 per cent said they were 'never' able to.

[If I was the boss for a day] I'd have all Aboriginal fellas on their own unit.

– Young person

Aiden

In early 2019 Aiden was isolated for self-harming. On his release back into the unit, Aiden was assaulted by other young people.

Following the assault, staff considered placing Aiden into a holding cell for his protection.

The Aboriginal Liaison Officer was notified and negotiated a different approach.

Having familiarised themselves with Aiden's history, the Aboriginal Liaison Officer considered isolating him in the holding cell would be a trigger that could result in further attempts at self-harm.

Instead of being put in the holding cell, Aiden was accommodated back in his room with his possessions to help ensure he was supported and didn't feel like he was being punished for being the victim.

984. A majority of staff surveyed thought that Malmsbury did either 'Well' or 'Very well' at managing the following needs of Aboriginal and Torres Strait Islander young people in isolation or separation:

- respect for and recognition of their culture
- facilitating access to the Aboriginal Liaison Officer
- enabling them to participate in cultural activities.

985. Fewer, however, believed that Malmsbury did either 'Well' or 'Very well' at providing a culturally relevant diet to these young people. Approximately 15 per cent reported that Malmsbury did either 'Poorly' or 'Very poorly' at managing this need (10 per cent and five per cent, respectively), and a further 15 per cent were unsure.

Culturally and religiously diverse young people

986. Malmsbury's Isolation Policy does not appear to refer to any specific cultural or religious supports for other cohorts of young people.

987. As at 28 February 2019, twenty-five per cent of the population at Malmsbury identified as having African cultural backgrounds. Of the 268 behavioural isolations of young people of African cultural backgrounds that occurred over the 12-month reporting period:

- Eighty-two per cent were recorded as being of Sudanese cultural background.
- Nine percent record that the health care team was notified.
- Twenty-three per cent record that the young person was on 'constant' observation.
- Twenty-nine per cent record that the young person was on 'close' observation.
- Forty-nine per cent did not record the level of observation.

988. Relatively fewer staff surveyed believed that Malmsbury did either 'Well' or 'Very well' at managing the needs of other culturally and religiously diverse young people in isolation or separation when compared to Aboriginal and Torres Strait Islander young people, although sentiment was still largely positive.

989. Approximately 45 per cent of survey respondents felt that Malmsbury did either 'Well' or 'Very well' at respecting the culture or religion of young people in isolation or separation, including providing a culturally or religiously appropriate diet.

990. Approximately 50 per cent of survey respondents felt that Malmsbury did either 'Well' or 'Very well' at facilitating access to the Cultural Support Officer and enabling these young people to participate in religious and cultural activities.

[The staff here] don't treat me like other clients. I behave every day and I don't ask for much, but when I do [ask for something] they don't do it. I just get along with the Islander workers. It would be better if there were more Islander staff or staff of other nationalities. [We should do something for] Waitangi Day.

– Young person

991. The inspection received feedback from some young people that they felt culturally isolated at Malmsbury, which is a risk for self-isolation. For example, the inspection observed that there was no prayer space on the secure site and was told there were no options for mass worship for young people.

Staff

Sometimes it is difficult in our setting to show that we care for these young people because we have to be so conscious of implementing clear professional boundaries. But it is important to remember that these young people often just want to know that they're thought about and that people want them to be okay.

– Staff member

992. The inspection met many dedicated staff at Malmsbury, but also observed a culture that prioritised security over rehabilitation. As an example, the inspection saw compliant young people being moved around the facility in handcuffs and escorted by eight members of staff. As noted in the *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending* (2017):

> … SERT staff direct youth justice workers on techniques to manage behaviour, rather than youth justice workers seeking SERT support during serious or escalating incidents. This approach instigates a security response to every problem behaviour, rather than a rehabilitative response. While some behaviours necessarily warrant a security response, the presumption towards this approach is highly problematic and compromises rehabilitative outcomes. It does not support safe and secure custodial environments, or support community safety by teaching young people appropriate behaviours.

993. It would not be fair, however to attribute this culture solely to the facility's staff or management. External influences including 'tough on crime' rhetoric in politics and the press play a significant part.

994. Staff at Malmsbury told the inspection about the challenges of their role in balancing positive relationships and trust with young people and maintaining good order and security. For some, isolation was an important behaviour management technique.

Isolation is the only tool we've got and now you're going to take that away from us.

– Staff member

995. This section considers staff perceptions of practices related to solitary confinement and the extent to which they are trained and empowered to utilise other management or de-escalation strategies to avoid the need to resort to isolation.

Staff views on working at Malmsbury

996. Surveyed staff were asked to assign both their quality of working life and current level of work-related stress a rating between one and 10 (one being low, 10 being high). Approximately 50 per cent of respondents assigned the quality of their working life and their current level of work-related stress between a six and an eight on the scale out of 10, with other responses being relatively equally dispersed.

[The three most satisfying things about working at Malmsbury are] having a positive impact on young people's lives, colleague camaraderie and a sense of serving the community.

– Staff member

997. Sixty-two per cent reported that they either 'mostly' or 'always' felt safe in their working environment (40 per cent and 22 per cent, respectively), however, 22 per cent said they 'mostly' felt unsafe. Respondents employed in an operational capacity were more likely to report feeling unsafe than those employed in other capacities.

998. When asked to identify the most satisfying things about working at Malmsbury, a significant number referred to their interactions with young people and the quality of their working relationships with colleagues. Several referred to low staffing levels and a lack of personal safety as the most stressful things about working at Malmsbury.

[The three most satisfying things about working at Malmsbury are] engaging positively with young people, working with and learning from my team and making a difference in the outlook of young people in our care.

– Staff member

[The three most stressful things are] violence against staff, facility conditions and amenities and lack of options for the management of young people.

– Staff member

Conception of role

999. Staff surveyed considered the following aspects of their role as 'Very important':

- being a positive influence or role model (86 per cent)
- keeping staff safe (82 per cent)
- keeping young people safe (80 per cent)
- providing emotional support for young people (80 per cent)
- assisting young people in rehabilitation (74 per cent)
- ensuring security of the facility (73 per cent)
- advocating for young people (72 per cent)
- helping the facility run smoothly (68 per cent).

I love my job and hope that we are always improving ways that we can help the young people in our care to go on to lead productive and fulfilling lives. They deserve our utmost, our very best.

– Staff member

Challenging behaviour is to be expected, and every moment is a teaching moment for alternate behaviours. We're paid to be here, they are made to be here.

– Staff member

1000. Comparatively fewer rated 'helping to protect the community' (59 per cent) and 'maintaining discipline' (58 per cent) as 'Very important' aspects of their role.

Staff are just glorified babysitters and the young men learn nothing about how to rectify their offending behaviours.

– Staff member

I have been told by new recruits that they have been told by [Management] that YJW [Young Justice Workers] are not here to be 'social workers' which suggests they are here for security only.

– Staff member

Staff views on effectiveness and effects of isolation

1001. Staff views on the effectiveness of isolation were mixed. Thirty-eight per cent believed that a period in isolation or separation was usually effective in helping a young person address the behaviour or risks that resulted in the use of the practice. Ten per cent believed that the practice was not effective, and nine per cent reported that it made the problem worse.

It is easier to maintain and minimise a young person's behaviour when they are separated from others, because there can be workers focused just on them and ensuring their safety, whilst other workers continue to ensure the safety of other young people in different areas.

– Staff member

1002. Thirty-two per cent of staff surveyed said that in their experience, long-term isolation or separation (more than 15 days) had both positive and negative consequences for the young person. Twenty-eight per cent said long-term isolation or separation had exclusively negative consequences and sixteen per cent did not know.

Isolation in Youth Justice is severely misperceived. Isolation in Youth Justice is actually intensive support and supervision and should be re-named the same. Young people have constant support from various stakeholders and supervision if they are removed from an area for their safety or for the safety of others.

– Staff member

[It can] keep others safe, but it's not good for the young man in isolation.

– Staff member

[Isolation] allows the young person to assess their behaviour, to calm down and reflect on their actions or behaviours.

– Staff member

... It is an abject failure of our responsibility to support the social and emotional development of young people.

– Staff member

1003. Those employed in an operational capacity were considerably more likely to view isolation and separation as effective at helping a young person address their problem behaviours, and considerably less likely to view long-term isolation and separation as having exclusively negative effects on a young person.

There are NO positive effects. I believe in 'Time out' if the young men request it, giving them a chance to breath and process. I don't believe that isolation or separation helps any situation.

– Staff member

A lot of the time, the person's behaviour deteriorates after being kept in isolation.

– Staff member

It dehumanises the person. But when they are trying to bash someone, and staff numbers are low, what are you able to do in this environment?

– Staff member

Staff [currently lack] the ability to enforce consequences, for example when a staff member gets assaulted by a young person, [the young person] will be put in room for an hour or two instead of being put into the holding cells for a day or two.

– Staff member

Staff training

1004. The majority of staff surveyed reported that they had been sufficiently trained in the following areas:

- de-escalation techniques
- suicide and self-harm prevention
- interpersonal skills
- cultural awareness
- engaging with young people.

I believe training should be ongoing and not just a one-off experience. I believe we should be constantly reviewing our practice so that we may constantly be vigilant. Our role is to provide a safe and caring (as much as possible) environment for the young people in our care. We should minimise the use of force, including restraints where possible. Young people should be treated with the utmost care and respect at all times. This includes when things go wrong and occasionally staff and young people get hurt. We should always be repairing those rifts when they occur, so that healing may be complete in the moment and ongoing as further issues arise. We are guardians, loco parentis. I take my role seriously. I would not be here if I did not care.

– Staff member

The training that I received from the team was exceptional. [The trainers] were highly skilled in their job and hugely supportive. I absolutely loved the training and would gladly do refresher courses in the future.

– Staff member

1005. However, several staff felt they had not received sufficient training in engaging with young people with mental health issues and the use of disciplinary processes.

Training has been great however we are not mental health workers and not equipped to deal with some of the behaviours that clients exhibit.

– Staff member

Training was comprehensive and broad ranging. However ongoing training and refresher training is limited.

– Staff member

1006. In response to the Ombudsman's draft report, DJCS advised:

> After conducting a Skills and Learning Needs Analysis in late 2018, Youth Justice is developing a Learning and Development Strategy to improve training and skills for custodial staff. As part of this work the Department is looking at potential improvements to custodial pre-service training, including strengthening the mental health component.

1007. Those who had worked at Malmsbury for more than four years were more likely to report dissatisfaction with their level of training.

There's an overt focus of risk and management [by DJCS], rather than growth and development.

– Staff member

It's death by PowerPoint. We need more communication and less handcuff training. [Train us in] de-escalation.

– Staff member

Staffing levels and lockdowns

1008. The Commissioner for Children and Young People's *Same Four Walls* inquiry about the use of isolation, separation and lockdowns found:

> … most lockdowns (83 per cent at Parkville and 78 per cent at Malmsbury) were attributed to staff shortages, reflecting long-term problems with absenteeism and difficulties recruiting suitable employees. Some staff attributed these shortages to a lack of safety at work, inadequate remuneration, inexperience and the challenging nature of the job.

1009. The Commissioner considered the extensive use of lockdowns due to staff shortages to be entirely unacceptable and recommended that workforce planning and development be addressed as a matter of priority.

[One of the most stressful things is] at times, there are insufficient staffing numbers to allow us to operate and function effectively.

– Staff member

1010. The inspection noted that approximately 40 per cent of all recorded lockdowns at Malmsbury within the 12-month reporting period were attributed to staff shortages at the facility. While this is an improvement on the 78 per cent reported by the Commissioner, it is still unreasonably high.

The most common form of lockdown I have seen this year is rotations, when they are understaffed and so they cannot get adequate ratios to have all young people in a unit up at once. They are understaffed, struggle to retain staff, struggle to recruit, because they are drastically underpaid. I work for Parkville College, so I can objectively say that DJCS workers should be paid way, way more than they are.

– Teacher

1011. In addition to the impact on children and young people, lockdowns and rotations also contribute to stress on staff. Thirty-eight per cent of staff surveyed reported that lockdowns would occur at Malmsbury due to staff shortages 'Very often'.

1012. In response to this issue, DJCS advised:

> The Department has been actively implementing a targeted recruitment campaign attracting youth justice custodial workers to work in the two youth justice centres. As recommended in the Youth Justice Review, the department is working on a Youth Justice Workforce strategy, which will include strategies addressing recruitment, retention, and learning and development. Further work to address this issue is being driven by the Custodial Facilities Working Group which was established in April 2019. This Group comprises senior government and non-government youth justice experts and stakeholders who have been engaged to consider the key challenges facing the Youth Justice custodial system – including the workforce.

1013. Actively implementing a targeted recruitment campaign for youth justice custodial workers is positive; however, both DJCS, and DHHS before that have been on notice for years about the impact of lockdowns caused by staff shortages, including significant frustration among young people which can contribute to escalated behaviour, and reduced access to education, visits, fresh air and meaningful activity.

1014. As noted above, approximately 40 per cent of the 13,653 reported lockdowns at Malmsbury during the 12-month reporting period were attributed to staff shortages at the facility – almost 5,500.

Over the past ten years there has been a progressive deskilling and disempowering of frontline floor staff and health staff, with increasing reliance on the threat of force to maintain order. This creates a vicious cycle of staff dissatisfaction and poor client behaviour, leading to a more dangerous and unsettled environment, leading to more lockdowns, use of force.

– Staff member

Chapter Four:

Inspection of Secure Welfare Services

About Secure Welfare Services

1015. Secure Welfare Services comprises two secure out of home care services which provide accommodation to children at substantial and immediate risk of harm.

1016. Generally, Secure Welfare accommodates children aged between 10 and 17 years, however, children as young as eight may be placed there. The services operate at Ascot Vale and Maribyrnong, each approximately seven kilometres from Melbourne. The services commenced operation at their current sites in 1993 and 1999 and operated at different locations prior to that.

1017. Children are placed in Secure Welfare for their own care and protection, and the functions of the services are distinct from those of a prison or youth justice centre. Children are not sentenced or remanded to Secure Welfare and need had no interaction with the criminal justice system to be admitted.

1018. Under the CYF Act, a child may be placed in Secure Welfare:

- by the Secretary to the Department of Health and Human Services, if the child is under the parental responsibility or guardianship of the Secretary (section 173(2)(b))
- upon entering emergency care, pending the hearing of an interim accommodation order under the CYF Act (section 242(5)(b)
- by the Children's Court, as a condition of an interim accommodation order under the CYF Act (section 263(1)(e)).

1019. In all cases, a child may only be placed in Secure Welfare if they are at 'substantial and immediate risk of harm'.

1020. A child will ordinarily be accommodated at Secure Welfare for a maximum of 21 days, although provisions exist for the extension of this period by a further 21 days.

1021. The Ascot Vale and Maribyrnong services each accommodate a maximum of 10 child residents.

1022. Secure Welfare is staffed and operated by the Department of Health and Human Services (DHHS). The two services are jointly administered under a single organisational structure and share a General Manager.

About the children at Secure Welfare Services

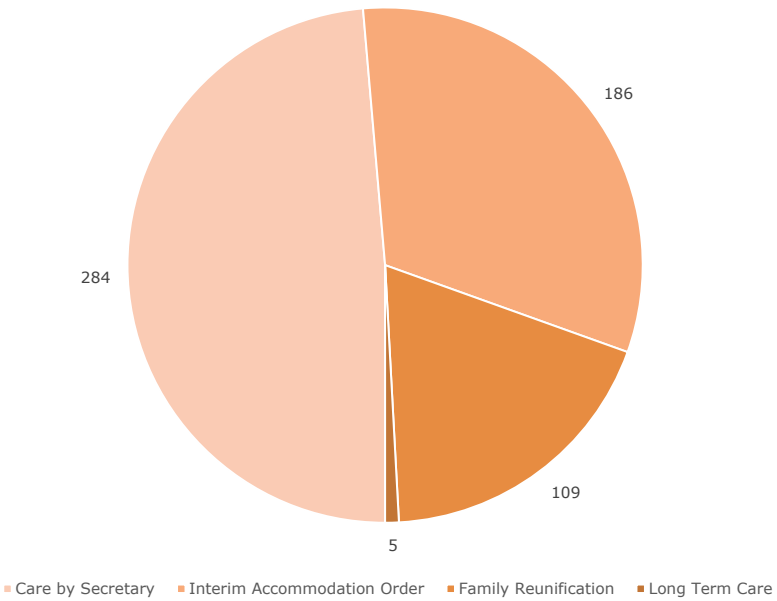
1023. There were 305 children admitted to Secure Welfare during the period between 1 April 2018 and 31 March 2019.

1024. Thirty-nine per cent of children were admitted more than once during this period, including 12 per cent who were admitted more than three times. The median duration of stay was 7 days.

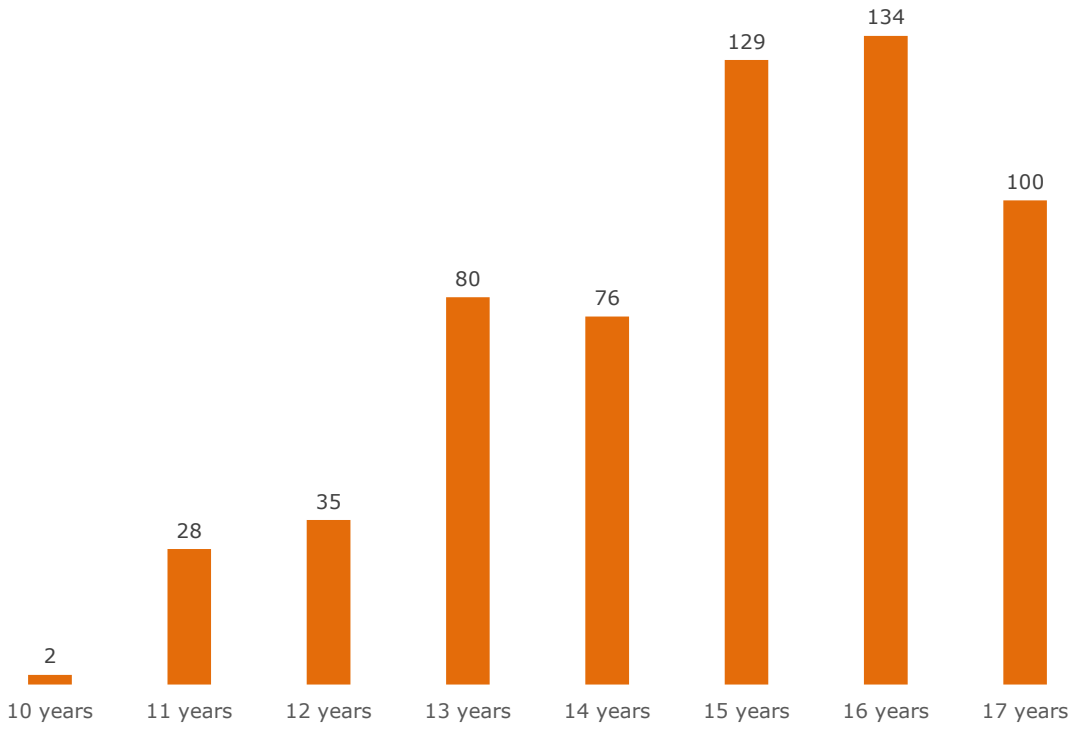
Table 5: Secure Welfare Services capacity

Accommodation units	Capacity
Ascot Value	10
Maribyrnong	10
Total capacity	**20**

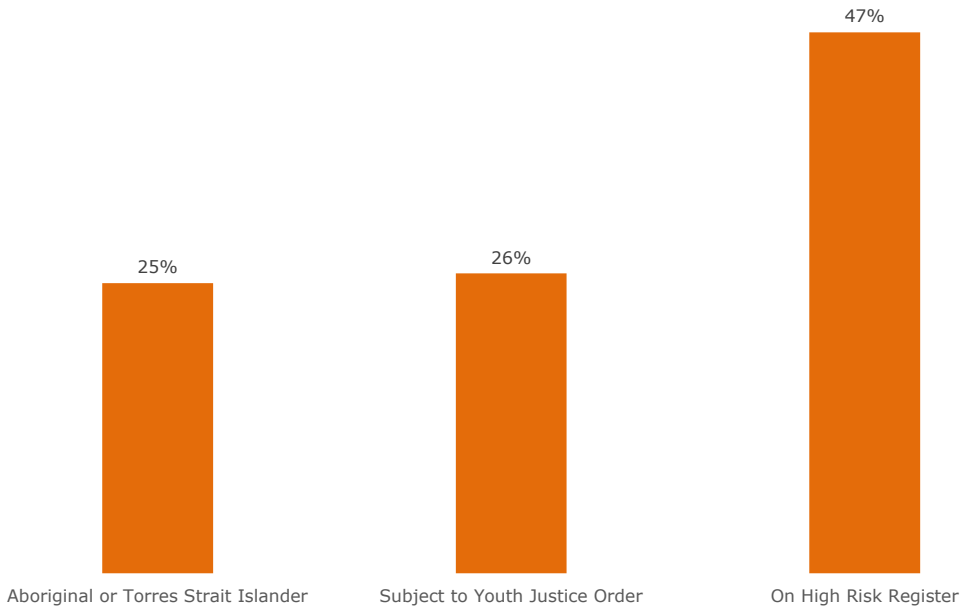
Children admitted to Secure Welfare Services by status



Children admitted to Secure Welfare Services by age



Children admitted to Secure Welfare Services demographics



The inspection

1025. On 1 March 2019, the Inspection Coordinator and other team members met with the Acting General Manager to advise him that the Ombudsman's OPCAT-style inspection would occur at the Secure Welfare Services the following month. They explained that the purpose of the inspection was preventive, rather than an investigation into specific allegations, discussed the practical arrangements and requested preliminary information.

1026. The Ombudsman sought copies of relevant registers and other operational information for the period from 26 February 2018 to 26 February 2019. Unless stated otherwise, the graphs set out in this chapter were generated from data from this reporting period (**the 12-month reporting period**). Additional information was obtained during and after the inspection.

1027. The inspection of Secure Welfare was conducted over three days, from Tuesday 2 April to Thursday 4 April 2019.

1028. On the first morning of the inspection, the inspection met with the General Manager and Operations Manager of Secure Welfare at the Ascot Vale service and received a briefing on the two services.

1029. Secure Welfare made swipe cards available to each member of the inspection, providing access to all areas of the services.

1030. The inspection then spilt up into two groups. One group visited the Maribyrnong service and the other remained at the Ascot Vale service.

1031. At commencement of the inspection there were a total of 11 children accommodated across the two services. Five were accommodated in the Ascot Vale service and six were accommodated in the Maribyrnong service.

1032. Secure Welfare provided each group with a briefing on the children present at the service, including their history of care and the reasons for their admission.

1033. During the first afternoon, the inspection introduced themselves to the children and staff present at both services and described the purpose of the inspection.

1034. The inspection spent the following two days observing and participating in the activities around the services in order to build a rapport with the children present. On the evening of the second day, members of the inspection also returned to each service to observe the night routine.

1035. Owing to the space available at the services, the Inspection Coordinator remained offsite, and the inspection returned to the office at the end of each day to debrief.

1036. The inspection completed the survey with five children, an engagement rate of 45 per cent.

1037. The staff survey was distributed by email at the end of the first day to both Secure Welfare Staff and Parkville College teachers (who sit within the Department of Education and Training, rather than DHHS). The inspection received 27 responses to the survey, an engagement rate of 33 per cent.

1038. On the final day of the inspection, members of the inspection met with the General Manager, Operations Manager and the Assistant Director of Secure Welfare to provide preliminary feedback about the inspection's observations.

The following sections

1039. Throughout this chapter, the experiences of children in some form of isolation are set out in case study narratives gathered from individual's files. For privacy, the names in this report are not the real names of the individuals involved.

1040. The sections set out the inspection's observations regarding Secure Welfare and, in particular, the practices at Secure Welfare which may lead or amount to the solitary confinement of children. In doing so, the investigation identifies the risks that increase the potential for torture and other cruel, inhuman or degrading treatment at the facility, and protective measures that can help to reduce those risks.

Humane treatment

1041. The inspection identified the following practices at Secure Welfare which had the potential to lead or amount to the solitary confinement of children:

- 'seclusion' under the CYF Act
- procedures known as 'time out' and 'quiet time'.

1042. The inspection observed that although children were sometimes isolated at Secure Welfare under these practices, there appeared to be no cases of isolation which resulted in solitary confinement within the recent history of the Ascot Vale and Maribyrnong services.

1043. The inspection noted that staff at Secure Welfare also appeared genuinely concerned with reducing the rate and duration in which children were isolated across both services.

1044. Overall, the inspection considered that there appeared to be a relatively low risk of ill-treatment arising from current use of isolation practices at Secure Welfare.

Seclusion

1045. Under section 72P(1) of the CYF Act, the Secretary of DHHS may authorise the 'seclusion' of a child resident placed in Secure Welfare.

1046. 'Seclusion' is defined in section 72A as 'the placing of a child in a locked room separate from others and from the normal routine of the secure welfare service'.

1047. Under section 72P(2), seclusion may only be authorised in circumstances where:

- all other reasonable steps have been taken to prevent the child from harming himself or herself or any other person or from damaging property
- the child's behaviour presents an immediate threat to his or her safety or the safety of any other person or to property.

1048. Further, the period of the seclusion must be approved by the Secretary pursuant to section 72P(3). A child placed in seclusion must be 'closely supervised and observed' at intervals of no longer than 15 minutes, and details of the seclusion must be recorded in a register established for the purpose.

1049. Section 72O of the CYF Act expressly prohibits the use of seclusion as a punishment.

1050. Under DHHS's Secure Welfare Practice Manual (**SWS Manual**), the power to place a child in seclusion has been delegated to senior staff at Secure Welfare and other Departmental officers.

1051. In response to the Ombudsman's draft report, DHHS described additional governance arrangements related to the use of seclusion:

> The Secure Welfare Services Performance Governance Group receives quarterly reports on rates of seclusion. The group includes senior representation from child protection, Care Services policy and Secure Welfare Services. The role of the group is to provide oversight of service performance and operational guidance.

1052. In accordance with the SWS Manual staff should consider developing or reviewing an Individual Behavioural Management Plan in circumstances where a child is placed in seclusion more than once in one day.

1053. The inspection noted that seclusion appeared to be used relatively infrequently at Secure Welfare, and for relatively short periods of time.

1054. None of the children who spoke with the inspection reported that they had been placed in seclusion at Secure Welfare. The inspection noted that several of these children had spent time at Secure Welfare on one or more past occasions.

1055. Staff informed the inspection that the use of the seclusion was relatively rare at Secure Welfare. Some members of staff said that they had never directly witnessed the use of the practice.

1056. The inspection reviewed the data concerning the use of seclusion at Secure Welfare over the 12-month reporting period and identified that there were 62 reported incidents of seclusion at Secure Welfare during this period — approximately five seclusions per month. Seventy-three per cent of seclusions occurred at Ascot Vale, and 27 per cent occurred at Maribyrnong.

1057. Staff informed the inspection that they believed that the use of seclusion and other restrictive practices had fallen over the previous five years.

1058. The inspection reviewed five years' worth of seclusion data and noted that the use of seclusion appeared to have fallen considerably over this period. This data reflected that there had been a 68 per cent decrease in reported use of the practice since the 2014-15 period.

1059. Staff attributed the fall in the use of seclusion to a concerted push from management to reduce the use of restrictive practices at Secure Welfare. Some staff believed that changes in hiring practices had also contributed to the reduction.

1060. The data reviewed by the inspection suggested that the use of seclusion was falling across both services.

1061. The CYF Act does not require a secure welfare service to advise a child of the reasons for seclusion. The SWS Manual nevertheless requires staff to inform children when they are being placed in seclusion and why they are being placed there, if it is 'appropriate to do so'.

1062. Staff informed the inspection that they would ordinarily explain to children that they were being placed in seclusion to assist them to regulate their behaviour, and that they would be permitted to exit seclusion as soon as this occurred.

1063. The inspection reviewed the data concerning the use of seclusion at Secure Welfare over the previous 12 months. This review established that of the seclusions reported at the Maribyrnong service during this period:

- 71 per cent were attributed to 'aggressive behaviour'
- 18 per cent were attributed to a physical assault to a member of staff or another adult
- six per cent were attributed to a threatened assault to a member of staff or another adult.

1064. The review established that of the seclusions reported at the Ascot Vale service during this same period:

- 49 per cent were attributed to a physical assault to a member of staff or another adult
- 24 per cent were attributed to 'aggressive behaviour'
- 15.6 per cent were attributed to a threatened assault to a member of staff or another adult.

1065. The review identified one incident in which a child's seclusion was attributed to 'attempted/threatened suicide' and one incident that was attributed to 'escape/attempted escape'.

Brenton

Fourteen-year-old Brenton had been staying at Secure Welfare for 10 days when he was involved in a verbal altercation with another child.

Brenton became agitated and walked into the art room, where he started to break the cupboards. A member of staff entered the art room and cleaned up the pieces of the broken cupboards to prevent Brenton from hurting himself or others.

Staff spoke with Brenton and attempted to de-escalate the situation. Brenton said to a staff member that he was going to stab the staff member in the throat. Brenton then retrieved a pencil from his pocket, walked towards the staff member and placed the pencil against the staff member's neck. Brenton was restrained by two staff members and escorted to the seclusion room.

Brenton spent the first 15 minutes in seclusion swearing and threatening to kill members of staff. After about 20 minutes, staff were able to speak to Brenton and, following a short discussion, Brenton was permitted to exit the seclusion room. In all, Brenton spent 35 minutes in seclusion.

An Aboriginal Liaison Officer checked-in with Brenton after the incident. Brenton also received a medical assessment and staff began preparing a Behaviour Support Plan for future reference.

1066. The inspection noted that children at Secure Welfare did not appear to be secluded for extended periods of time.

[When a child is in seclusion] I speak with them to learn what their concerns are which led to their behaviour and talk to them about how staff can support them to return to the unit and have their needs met. I explain that their safety and the safety of all clients and staff are paramount and we need to help them manage themselves safely. [I am] clear that once they are settled they will be let out. I speak in a calm and caring manner and show genuine concern for their wellbeing. For clients who are very heightened, they may need some quiet time without staff talking to them to help them settle. Regular checks must be maintained at all times.

– Staff member

1067. Staff informed the inspection that children in seclusion were closely monitored. Staff said that they would constantly attempt to engage with children in seclusion order to expedite their return to a normal routine. This information appeared corroborated by most of the client files reviewed by the inspection.

1068. Staff informed the inspection that they required contemporaneous authorisation from their Team Leader before they were permitted to extend a child's seclusion beyond a one-hour period.

I talk to the [child] outside the door, de-escalate, and keep the client in seclusion for the least amount of time. Once the client appears calm and ready to talk face to face, I'll enter the seclusion room with another staff member and talk about the reason why [they are] in seclusion and strategies and plan to prevent reoccurrence.

– Staff member

1069. A senior member of staff with the delegation to approve seclusions of more than one hour informed the inspection that he encouraged unit staff to telephone him when a child's seclusion was approaching 45 minutes duration. This worker said that he encouraged unit staff to do everything they could to bring an end to the seclusion before he would consider providing authorisation to exceed the one-hour limit.

1070. The inspection noted that during the 12-month reporting period:

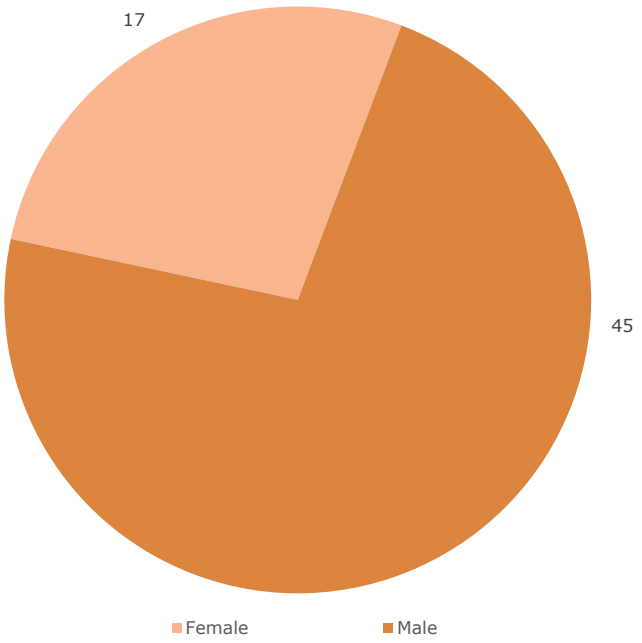
- there was a total of 34 reported seclusion hours across both services
- there were approximately nine reported hours of seclusion at Maribyrnong and 25 reported hours of seclusion at Ascot Vale
- at both services the median reported seclusion period was 30 minutes.

1071. The inspection noted that there were no reported seclusions which lasted longer than two hours at either service during this period. The longest reported seclusion at Maribyrnong lasted for one hour and five minutes and the longest reported seclusion at Ascot Vale lasted for one hour and 37 minutes.

1072. The inspection also reviewed the previous five years' of seclusion data and observed that while the average reported seclusion duration had approximately halved during this period, the median reported seclusion duration remained relatively stable across both services.

1073. The inspection noted that there were no reported seclusions at Secure Welfare during the previous five years capable of meeting the definition of solitary confinement.

Children admitted to Secure Welfare by gender



Jamal

Eleven-year-old Jamaal had been staying at Secure Welfare for six days when he attempted to take a cake from the pantry, contrary to the rules at the facility.

A member of staff retrieved the cake from Jamaal and explained that desserts were kept for supper in the evening.

Jamaal made another attempt to take food from the pantry later that same day. Staff spoke to Jamaal again, reinforcing their previous discussion. As Jamaal was being ushered out of the kitchen, he threw an item of food at the wall.

Jamaal started to verbally abuse and threaten staff, running from one corridor to the next. Two members of staff maintained clear communication with Jamaal during this time, whilst also supporting each other.

When Jamaal started to spit at staff, staff formed the view that he was unable to regulate his behaviour. A member of staff took hold of Jamaal's arm and escorted him into the art room. As Jamaal was being placed in the art room, he spat directly into the staff member's face.

The staff member maintained constant observation of Jamaal while he was secluded in the art room. After a short time, the staff member formed the view that Jamaal was no longer heightened and was permitted to leave the room. In all, Jamaal spent seven minutes in seclusion.

Jamaal's kitchen access was restricted for a short time, and he was closely observed for the remainder of the day.

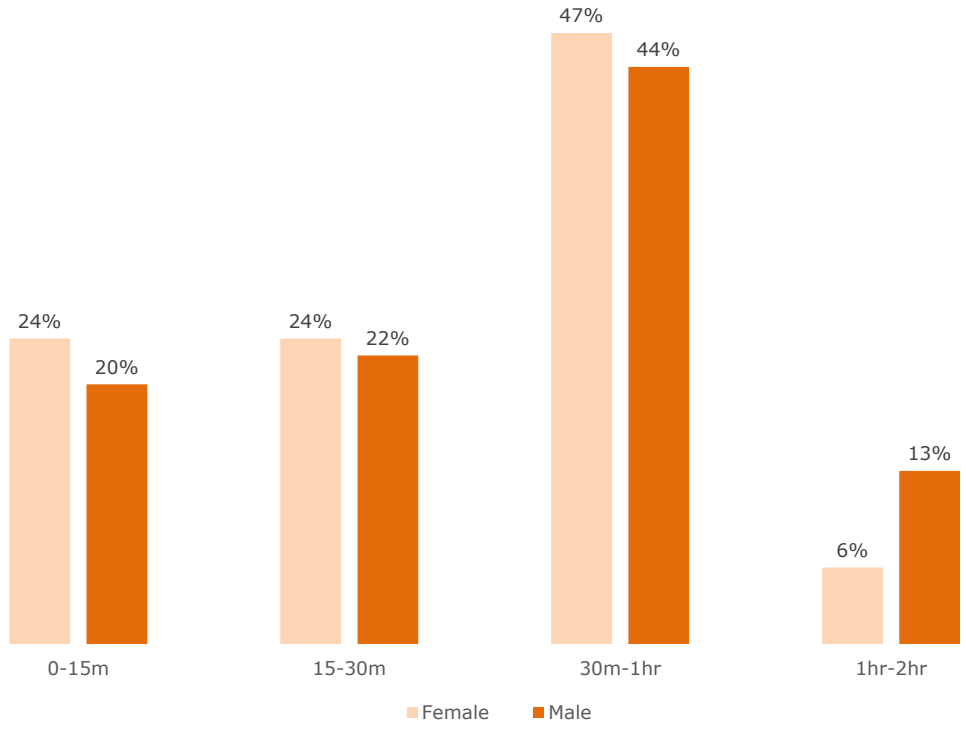
It is very hard for children with histories of trauma to manage emotions and they can easily move into 'fight' mode for reasons that are not always obvious to others (or themselves). Any period of seclusion will be stressful and must be kept to a minimum and time taken to help the young person learn how they can express their fears or frustrations without resorting to violence.

– Staff member

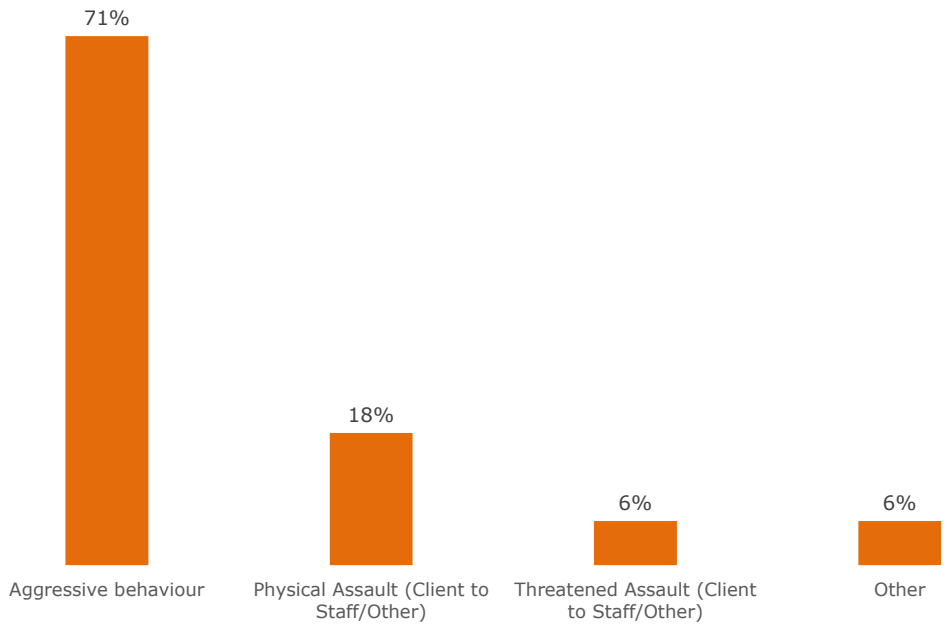
I hate it [being kept alone in a room for a long time] ... Even if you're playing up, you still need someone. Don't leave me alone, it makes me feel like shit.

– Child

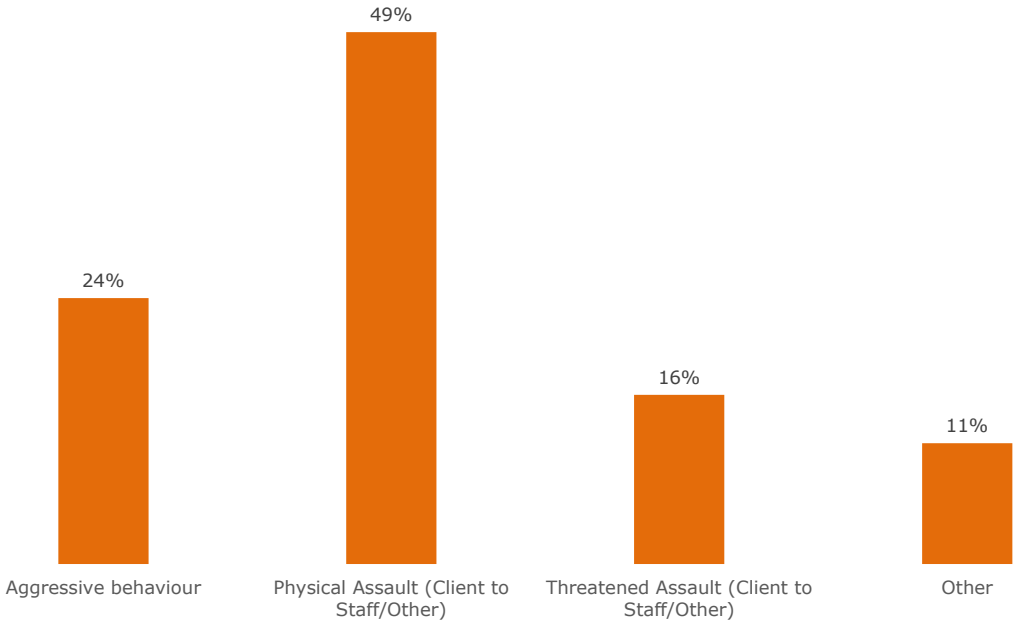
Length of seclusion at Secure Welfare Services



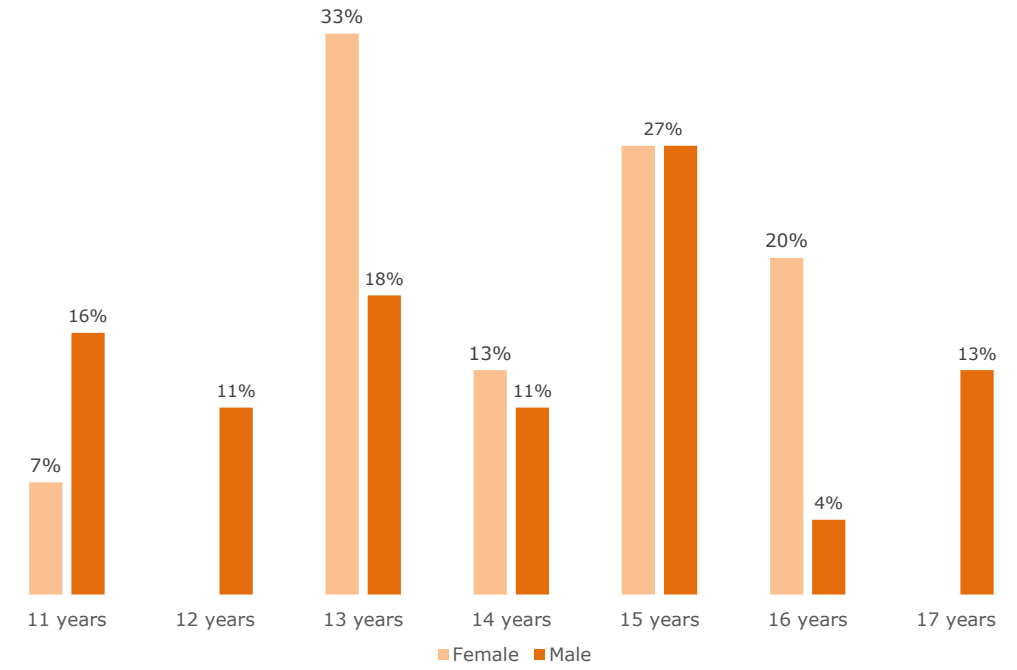
Reasons for seclusion – Maribyrnong service



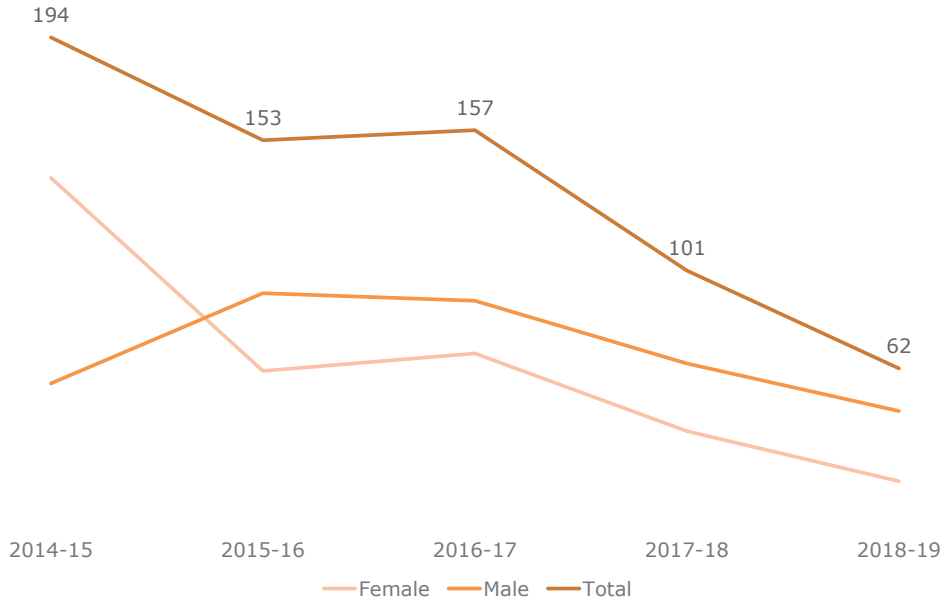
Reasons for seclusion – Ascot Vale service



Seclusions at Secure Welfare Services by age



Seclusions at Secure Welfare Services per year



1074. Under the SWS Manual, it is departmental policy that a child who is placed in seclusion for a 'prolonged period' must be provided with 'adequate fresh air'. The terms 'prolonged period' and 'adequate fresh air' are not defined in the Manual.

1075. The inspection observed that under current conditions, children at Secure Welfare were rarely secluded for more than one hour at a time.

1076. The inspection was informed that there were no mechanical restraints used or available at Secure Welfare. Staff informed the inspection that they were able to escort children to and from seclusion without the need for mechanical restraints.

1077. The inspection observed some children being transported by Victoria Police to Secure Welfare in handcuffs. Staff informed the inspection that they immediately request police remove a child's handcuffs on entry to the facility.

Ashley

On admission to Secure Welfare, fourteen-year-old Ashley was escorted by two police officers who had handcuffed Ashley's wrists. Staff asked police to remove Ashley's handcuffs immediately. Ashley then underwent a clothed, pat-down search and was offered a shower and some clean clothes.

Staff asked police why Ashley had been handcuffed for the two and a half hour journey to Secure Welfare. Police said Ashley had been aggressive at the police station.

Ashley seemed to settle in very quickly. Staff informed the inspection that this was not Ashley's first admission to Secure Welfare.

Time out and quiet time

1078. As in the youth justice system, a child accommodated at Secure Welfare may be temporarily separated from his or her peers through the use of 'time out' and 'quiet time'.

1079. Under the SWS Manual, the circumstances and requirements governing the use of 'time out' in a secure welfare service are largely the same as those in the youth justice system. In particular:

- The child may be directed to remove themselves from a situation into an unlocked space, other than a bedroom, to calm down or stop a particular negative behaviour.
- The child must be placed under observation.
- The incident must be recorded in the child's case notes.

1080. The circumstances and requirements governing the use of 'quiet time' are also largely the same as those in the youth justice system:

- At the child's request, staff may permit a child to return to their bedroom.
- The child must be observed at least every 30 minutes.
- Requests for quiet time should be recorded in the child's case notes, and staff should alert line management in the event that they become concerned that a 'pattern of withdrawal' is developing.[29]

1081. The inspection observed several incidents which arguably met the definition of 'time out' under the Department's policy. In those cases, a child was requested to move to another area of the facility following a verbal altercation with another child resident. In each case, the child was accompanied by a member of staff who continued to engage with the child, and there appeared to be little risk of prolonged isolation.

1082. One child who spoke with the inspection also reported that they had been subject to something akin to 'time out'.

If you do something wrong you have to go to your room. The doors don't lock but I have been told not to come out. This was only once. I didn't do anything wrong.

– Child

1083. The inspection did not observe the use of 'quiet time' at Secure Welfare. Staff informed the inspection that they attempted to maximise each child's time out of their bedroom. Staff said that they would make special accommodation for new admissions, who would sometimes require extended periods of rest.

29 In response to the draft report, the DHHS noted that bedroom doors at Secure Welfare cannot be locked, and that a child or young person is always able to exit their bedroom.

Protective measures

Legislative protections against undue solitary confinement

1084. The CYF Act currently allows for the solitary confinement of a child accommodated in a Secure Welfare Service; although, consistent with rule 67 of the Havana Rules, the use of solitary confinement as a disciplinary measure is expressly prohibited pursuant to section 72O of the CYF Act.

1085. The Mandela Rules do not apply to the treatment of children in child welfare facilities. The inspection nevertheless observed that the CYF Act allows for the use of several practices that are prohibited from use against prisoners under the Mandela Rules:

- prolonged and indefinite solitary confinement (rule 43(1)(a) and (b))
- solitary confinement that would exacerbate a child's physical or mental disability (rule 45(2)).

1086. It was otherwise noted that the CYF Act requires that seclusion be used as a last resort, consistent with the requirement applicable to the treatment of prisoners under the Mandela Rules.

Seclusion

1087. The CYF Act makes the use of seclusion subject to the following safeguards:

- All other reasonable steps must first be taken to prevent the child from harming themselves or any other person or from damaging property.
- The period of seclusion must be approved by the Secretary.
- The child or young person must be closely supervised and observed at intervals of no more than 15 minutes.
- Details of the isolation must be recorded in a register established for that purpose.

1088. Under the CYF Regulations, the following information must be recorded in a secure welfare service's Seclusion Register:

- the name of the child secluded
- the time and date seclusion commenced
- the reason why the child was secluded
- the name and position of the person who authorised the seclusion
- the frequency of staff supervision and observation
- the time and date the child was released from seclusion.

1089. The inspection identified several shortcomings with the legislative framework governing the use of seclusion:

- The CYF Act does not require that a child's seclusion be terminated once the reason for seclusion ceases, increasing the risk of prolonged or indefinite solitary confinement.
- A necessary element of seclusion under the CYF Act is that the child be placed 'in a locked room', which potentially excludes situations where a child or young person is kept on their own for extended periods in other areas of a secure welfare service.
- The CYF Act does not guarantee each child a minimum period of fresh air per day.
- Under the CYF Act, staff are not required to inform children of the reasons for seclusion.

1090. The SWS Manual makes seclusion subject to some additional safeguards:

- The child must be released from seclusion 'as soon as they have settled, are calm and are no longer an immediate threat to themselves or others.'

- The child must be observed at intervals of no more than five minutes.

1091. Departmental policy delegates the authority to seclude a child as follows on Table 6 below.

1092. Notwithstanding the above, the SWS Manual requires that any seclusion of an Aboriginal child be authorised by a person at or above the Unit Manager level.

1093. Also, the Director, Office of Professional Practice must be notified when a child is placed in seclusion for more than six hours and the Unit Manager or On Call Manager must be notified when a child is placed in seclusion more than once in any 24-hour period.

1094. The inspection reviewed a five-year extract from Secure Welfare's Seclusion Register and noted that although the majority of features appeared compliant with the CYF Regulations, staff at the Ascot Vale facility did not appear to be in the habit of recording the position of persons authorising seclusion for periods of less than one hour, contrary to regulation 22(d).

1095. The inspection audited 15 incidents recorded in the Seclusion Register against information in the child's client file and noted that:

- Three entries appeared to misstate the time that seclusion commenced or ended by more than 15 minutes.
- One entry appeared to misstate the duration of seclusion by more than 30 minutes.
- Two entries appeared to misstate the location of seclusion.
- Three entries appeared to misstate the intervals of observation.

1096. The inspection observed that some staff appeared to be in the habit of recording the location of the incident leading to seclusion instead of the room or area where the child was placed in seclusion.

1097. The inspection observed that each incident of seclusion was accompanied by an incident report and noted that descriptions of incidents leading to seclusion were detailed enough to facilitate scrutiny of the practice.

1098. The inspection reviewed a sample of 15 seclusions recorded in Secure Welfare's client files and confirmed that all were recorded in the Seclusion Register.

1099. The inspection nevertheless identified some incidents which arguably involved the use of seclusion that did not appear to have been recorded in the Seclusion Register.

1100. The inspection observed that unlike in the youth justice system, staff at Secure Welfare are not required to certify that children placed in seclusion have been provided with certain minimum entitlements. This was a factor which increased the risk of ill-treatment arising from the practice.

Table 6: Delegated authority to seclude a child

Period	Position
Up to one hours	Supervisor or Team Leader
Up to two hours	Unit Manager
Up to 12 hours	General Manager
Up to 24 hours	Director, Office of Professional Practice
More than 24 hours	Deputy Secretary, CFDO

Figure 15: Audit of Seclusion Register

Register entry	Detailed description in file	Date consistent	Entry and exit times consistent (+/- 15m)	Duration consistent (+/- 30m)	Location of isolation consistent	Observation intervals consistent	Use of force consistent
YWA027	✔	✔	✔	✔	✔	✔	✔
YWA014	✔	✔	Could not be verified	✔	✔	✔	✔
YMA024	✔	✔	✔	✔	✔	✔	✔
YMA010	✔	✔	✗	✔	✗	✔	✔
YMA050	✔	✔	✔	✔	✔	✔	✔
YMA051	✔	✔	✔	✔	✔	✔	✔
YMA016	✔	✔	✔	✔	✔	✔	✔
YMA041	✔	✔	✔	✔	✔	✔	✔
YMA081	✔	✔	✔	✔	✔	✔	✔
YWA006	✔	✔	✔	✔	✔	✗	✔
YWA005	✔	✔	✗	✔	✔	✗	✔
YWA022	✔	✔	✗	✗	✔	✗	✔
YWA020	✔	✔	✔	✔	✔	✔	✔
YMA039	✔	✔	✔	✔	✗	Could not be verified	✔
YWA009	✔	✔	✔	✔	✔	✔	✔

Eddy

Fourteen-year-old Eddy became unsettled during their stay at Secure Welfare, pacing up and down the corridor. Staff attempted to engage, however Eddy said, 'you can hang here, but I'm not talking, I'm just walking up and down the corridor until I get out.'

Staff tried different methods of engaging, but Eddy's behaviour started to deteriorate. After a little while, Eddy began to slam a door against the corridor wall, breaking a plastic viewing mirror.

Eddy then tied a blanket around their neck and attempted to loop the blanket around a door handle. During this time, staff kept Eddy under constant observation through the passage door and via CCTV. Eddy climbed onto a table and jumped off, but the blanket knot did not hold together. At this point, a member of staff managed to enter the corridor and close the programme room door, removing the hanging point.

Eddy remained enclosed in the corridor until a member of staff was able to safely enter and speak. Staff noted in the incident report that during this period Eddy was 'in seclusion based on the door being locked'. However, the incident was not recorded in Secure Welfare's Seclusion Register.

Mitchell

Fourteen-year-old Mitchell was making supper in the kitchen when another child pulled down his pants from behind.

Mitchell picked up a butter knife and lunged at the other child. Mitchell managed to grab hold of the other child from behind, holding the knife to the other child's throat. A member of staff took hold of Mitchell's hand and, after a brief struggle, managed to take possession of the knife.

Mitchell was escorted out of the kitchen and placed in the Xbox room. Later that evening, Mitchell was moved into the art room, where staff had decided he was to sleep that night. The incident report states that staff were directed to keep Mitchell in the art room until he exited Secure Welfare the next day. Staff recorded that Mitchell was to have 'NO other client contact' during this period.

Mitchell was arguably placed in seclusion because he appears to have been:

- placed in a locked room
- separated from others
- separated from the normal routine of the service.

Staff did not record the period in which Mitchell was confined to either room in Secure Welfare's Seclusion Register.

Material conditions

1101. The inspection observed that Secure Welfare's therapeutic ethos was in some ways undermined by the material conditions of the Ascot Vale and Maribyrnong facilities.

1102. The Ascot Vale service in particular was showing signs of having grown beyond its original design capacity. The facility was not purpose-built, and the inspection observed that staff sometimes struggled to keep on top of client dynamics due to idiosyncrasies in facility design.

1103. The Maribyrnong facility, although purpose-built, also appeared to be showing signs of age.

1104. The inspection observed that the decision to locate the two services at different sites led to certain administrative inefficiencies. Several members of staff said that they wished for a purpose-built, collocated facility.

1105. The inspection was disappointed to observe that there was little superficial difference between the bedrooms at the Ascot Vale service and those at Malmsbury, both in terms of design and state of upkeep. The bedrooms at the Maribyrnong service were comparatively better in terms of upkeep and fit-out, although could still be improved.

1106. Staff at the Ascot Vale service appeared to be struggling to keep on top of vandalism, and many areas of the facility appeared in need of a fresh coat of paint. There was an unfortunate correctional feel to the boys' living quarters.

1107. On the other hand, the inspection observed that outdoor areas at both services were spacious and well-maintained. Educational areas were also brightly decorated and appeared well looked-after.

Single bedroom (Ascot Vale)

Bathroom (Ascot Vale)

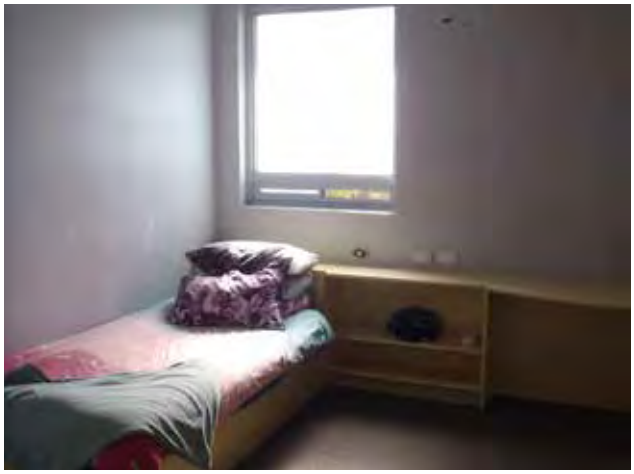
Xbox room (Ascot Vale)

Client phone (Maribyrnong)

Yard area (Ascot Vale)

Program space (Maribyrnong)

Single bedroom (Maribyrnong)



Yard area (Maribyrnong)

Seclusion rooms

1108. Both services were equipped with a dedicated seclusion room.

1109. The inspection considered that owing to design and fit-out, neither seclusion room was suitable to accommodate children for any extended period.

1110. The inspection observed that the seclusion room at the Ascot Vale service was a particularly claustrophobic environment. The room was small and undecorated. Owing to the floorplan of the facility, there was no outside-facing window, and natural light did not enter the area. The room was equipped with a mattress but was otherwise unfurnished.

1111. The seclusion room at the Maribyrnong service was made more tolerable by inclusion of an external window. There was otherwise little difference between the two seclusion rooms.

1112. Neither seclusion room was fitted with a toilet or washbasin. Staff informed the inspection that children who required use of the toilet when in seclusion would be permitted to temporarily exit the room and access a nearby bathroom. This was corroborated by some of the client files reviewed by the inspection.

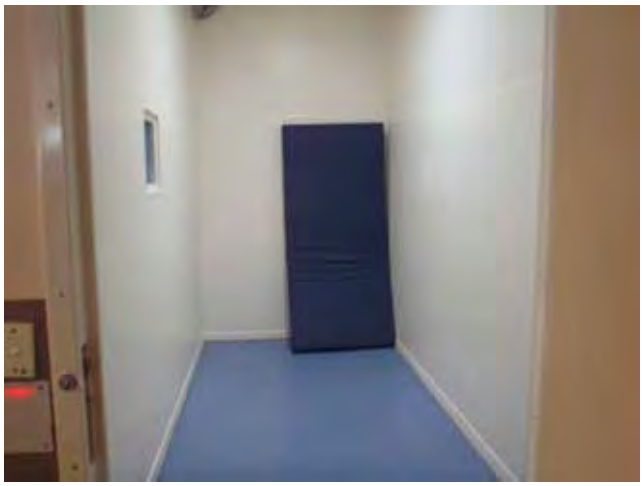
1113. The inspection nevertheless considered that the absence of toilet facilities in the seclusion rooms was a factor which increased the risk of ill-treatment at Secure Welfare. The inspection noted that under the Human Rights Act, all persons deprived of their liberty 'must be treated with humanity and with respect for the inherent dignity of the human person' and observed that the extended involuntary confinement of children in spaces without toilet facilities risked incompatibility with this obligation.

1114. The rooms lacked a therapeutic focus and the inspection considered that greater effort could be taken to soften the atmosphere of these areas.

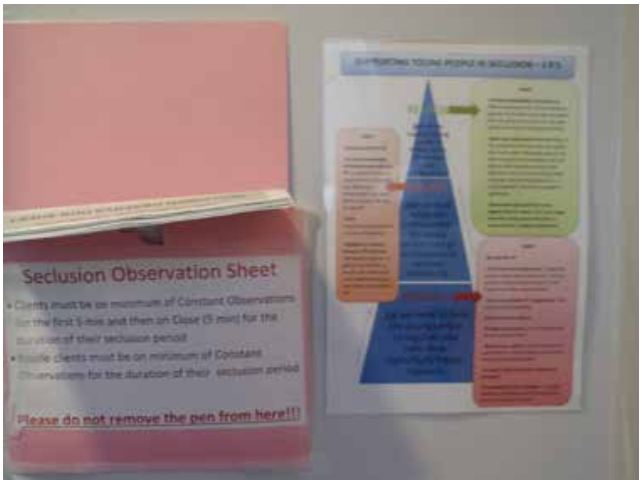
1115. Both seclusion rooms appeared to be in a reasonable state of cleanliness and upkeep when inspected.

1116. The inspection noted that information about assisting children in seclusion was made prominently available to staff outside the Maribyrnong seclusion room.

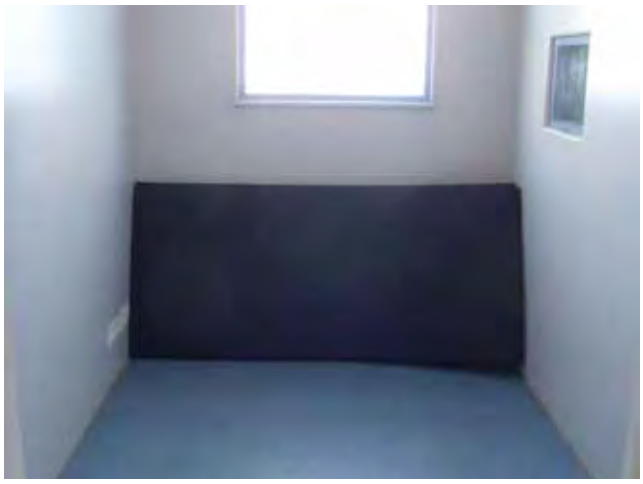
Seclusion room (Ascot Vale)



Seclusion forms and posters (Maribyrnong)

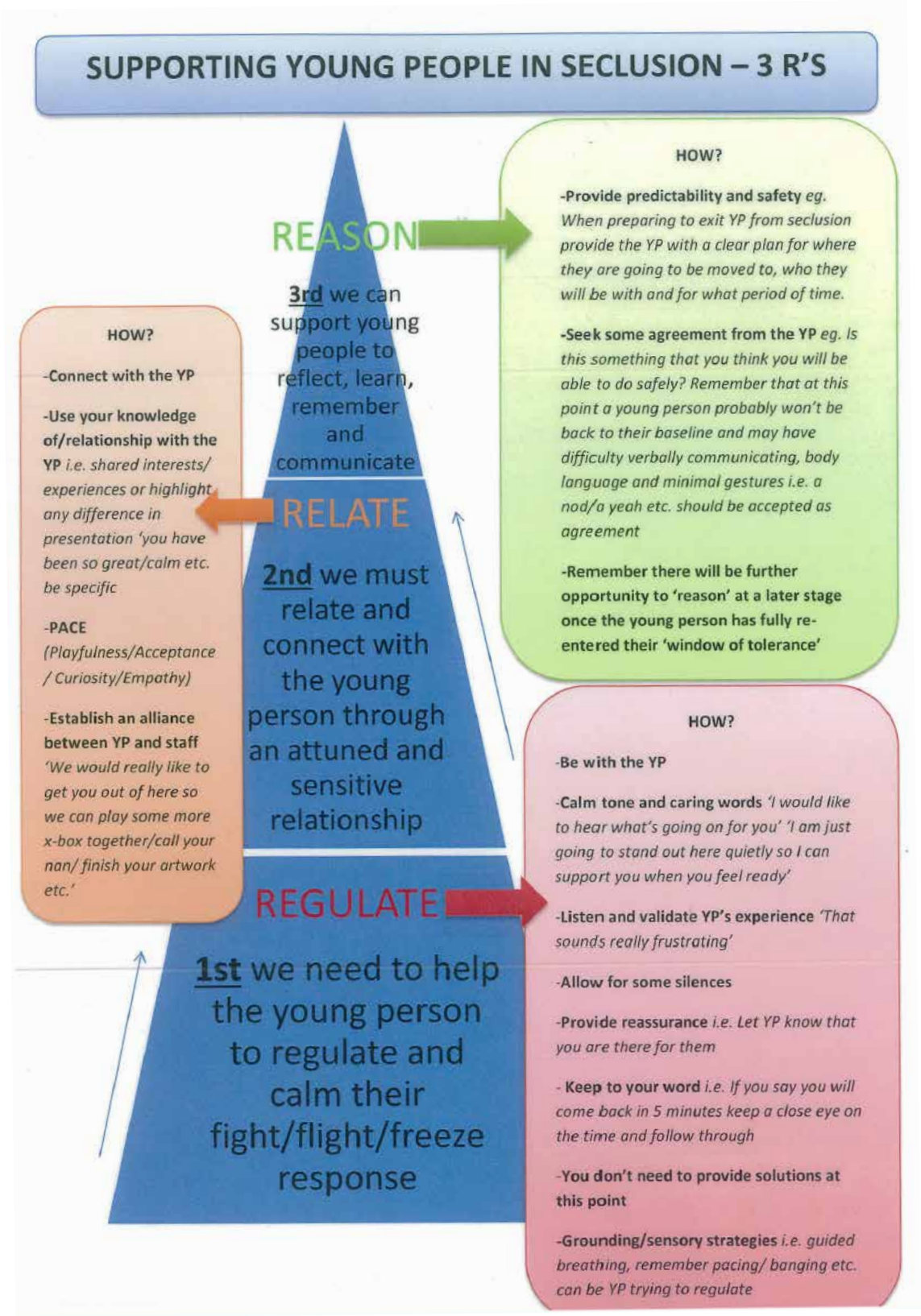


Seclusion room (Maribyrnong)



Seclusion room door (Ascot Vale)

Figure 16: Poster 'Supporting Young People in Seclusion



Source: Secure Welfare Services

Meaningful human contact

1117. The Secure Welfare Services are established by section 44 of the CYF Act 'to meet the needs of children requiring protection, care or accommodation.'

1118. A child's admission to Secure Welfare is likely to be precipitated by a significant crisis in their life. According to the SWS Manual, the aim of the service is to keep the child safe while a suitable case plan is established to reduce the risk of harm and return the child to the community as soon as possible.

1119. In terms of meeting the 'needs of children requiring protection', the inspection considered the positive interactions and meaningful human contact between with staff at Secure Welfare were important measures to protect against ill-treatment, and to some extent, reduced the potential negative impact of the facilities' material conditions.

Interaction with staff

1120. The inspection observed many positive relationships between children and staff during the inspection, including Secure Welfare staff and Parkville College teachers. Engagement was individualised to address particular challenges a child was encountering. For example, the inspection noted one child who had just arrived from police custody and staff were making him toasted sandwiches and milkshakes to settle in. Similarly, another child had a difficult visit with family, so staff engaged him in a cooking class.

1121. All staff, including day and night shift and teachers knew the children they were working with and were able to explain their unique circumstances to the inspection. The inspection was told that the rapport and trust developed was a useful tool to assist staff de-escalate situations without having to resort to the use of seclusion.

1122. On the Maribyrnong site, the children, staff and teachers prepared and ate lunch together at a big table while having group conversations, which appeared much like a supportive family dynamic.

The staff are really supportive here. They look out for me. Every time I leave, I feel healthier after being here.

– Child

1123. The inspection did however, observe more challenging interactions between children and Child Protection workers. One child was happily engaged in a group conversation with peers and staff until a Child Protection worker came into the yard to speak with them. The child anticipated the Child Protection worker would be delivering bad news and became upset and started to swear at the worker. Secure Welfare staff de-escalated the situation with calm conversation.

1124. The inspection was told that sometimes children are informed of decisions to extend their Secure Welfare placement over the telephone by their Child Protection workers. Secure Welfare staff described it as challenging when they are not informed of such decisions beforehand.

Contact with other young people and the outside world

1125. Under the SWS Manual, Secure Welfare is required to provide children with a 'meaningful structured day' that will:

- provide constructive engagement across the week
- drive participation and engagement across all activities
- provide activities that focus on 'life skills'
- reconnect young people to Education
- ensure access to family and community supports.

1126. Secure Welfare should operate a daily routine where children are engaged in programs and education during business hours, share meal times with staff and peers and a mix of activities and quiet 'downtime' are provided each day. According to the SWS Manual:

> Mealtimes should be a communal experience for all in the unit. Similarly, bedtime is also a critical time in the units. The period after dinner and before bedtime should be used to relax and wind down from the day's activities.

1127. Regular visits with key people in the children's lives is also recognised as important to maintain connections with family and others and maximise a child's support. Personal visits can occur each day of the week during set times.

1128. Children at both sites are also able to use a telephone to contact approved people. At Ascot Vale the phone is a cordless handset that may be used in quiet rooms across the facility with staff approval.

1129. At Maribyrnong, however, calls are forwarded from the staff office to a 'phonebooth' style handset in the unit corridor. The inspection considered that this arrangement did not offer enough privacy for the children to make personal calls to family or friends. In addition, on both sites, children would have to ask staff to dial out to oversight bodies, such as the Ombudsman.

1130. The inspection considered this presented an obstacle that may prevent children in the services from being able to complain about the standard of care, accommodation or treatment they are receiving.

1131. The inspection also observed staff encouraging positive relationships between children at the facilities. At the Maribyrnong site, as a reward for good behaviour, two young people who didn't normally share a room were allowed to watch a film together before going to bed.

1132. Both staff and children told the inspection that only three screens could be showing a movie at once and additional 'movie channels' would be good.

Client phone (Maribyrnong)

Purposeful activity

1133. As noted above, Secure Welfare is to provide a structured day including programs and education.

1134. Education at Secure Welfare is delivered by Parkville College. According to the College's website:

> In response to the diverse array of abilities, demographics, learning difficulties, length of stay and backgrounds, Parkville College teachers … have developed a flexible curriculum to meet students' varying needs and interests.
>
> At the Secure Welfare campuses, the Parkville College teachers focus on making the children and young people feel safe and secure within their environment. Parkville College follows a trauma informed practice approach, in which teachers are sensitive to a student's emotional state; they give space, offer choice and allow time for decision-making, with awareness and sensitivity to previous and ongoing trauma.

1135. The inspection observed Parkville College teachers delivering a mix of social and more structured education and noted the challenges engaging with a wide variety of children for a relatively short period of time. The education at the Maribyrnong site appeared to be more structured than at Ascot Vale, where the scheduled program started an hour late.

Some students do not attend classes or choose to stay in their rooms and therefore do not spend time outside.

– Teacher

1136. The inspection appreciated that flexibility would be important in the delivery of education at Secure Welfare, however, considered that at least at the Ascot Vale site, the physical space available would make it even more challenging.

Self-isolation

1137. The most significant risk factor faced by Secure Welfare in terms of access to meaningful human contact is posed by social or self-isolation.

1138. The inspection observed children on both sites who did not mix with others, either because of age (one young person was 11 years old, whereas others in the facility were aged 16 or 17) or disability.

1139. The inspection observed an annex at the Maribyrnong site that could be cordoned off from the rest of the facility. The annex had bedrooms, a program space and a private outdoor courtyard.

1140. Staff said that this area is sometimes used for particularly vulnerable children, who may be very young or present other challenging behaviours that may make it unsafe for them to mix with other children.

Health and wellbeing

1141. Compared with other children and young people in Victoria, those who are admitted to Secure Welfare have higher rates of mental health issues, behavioural disorders, substance-use problems and intellectual disability. According to the SWS Manual, they also commonly present with poor physical health, unmet medical needs and poor dental health.

1142. Accordingly, the health and wellbeing of children at Secure Welfare is a primary consideration in the facilities' operation.

1143. In addition, it is an offence under section 493(1)(a)(ii) of the CYF Act for a person who has a duty of care in respect of a child to intentionally take action that results in, or appears likely to result in, the child suffering emotional or psychological harm of such a kind that the child's emotional or intellectual development is, or is likely to be, significantly damaged.

1144. The health services at Secure Welfare include primary healthcare such as nursing and medical services provided by Youth Health and Rehabilitation Services and mental healthcare including Berry Street's 'Take Two' mental health services.

1145. Children receive a primary and mental health assessment on admission to Secure Welfare and a healthcare plan is developed. An exit summary is also prepared for a child's return to the community to inform child protection practitioners and other relevant services about the young person's health needs.

Health consideration before seclusion

1146. There is no requirement under the CYF Act for a health assessment to be conducted before a child is placed in seclusion. By contrast, when authorising similar isolation practices on adults, consideration is to be given to the person's medical and psychiatric conditions.

1147. Over the past three years, however, Secure Welfare has adopted a trauma-informed approach when considering interventions. The trauma-informed approach as described in the SWS Manual aims to provide an 'integrated and multi-disciplinary approach' to support children heal, recover from trauma and build pro-social skills.

1148. When a child is secluded and there are specific health concerns, staff are required to notify health services as soon as logistically possible after the seclusion commences. The inspection was told by some staff that in practice, health services will only attend a person in seclusion if there are immediate or obvious health concerns.

1149. When notified that a child has been secluded, health services provide advice to unit staff on any health issues or support needs they should be aware of and they contribute to discussions and planning meetings regarding young people who have had repeated seclusions, including assisting in the development of an Individual Behaviour Management Plan.

Access to health care while in seclusion

1150. Acknowledging the relatively short duration of seclusions at Secure Welfare, 42 per cent staff surveyed rated access to health services as either 'Good' or 'Very good'. Similarly, approximately 35 per cent rated access to mental health services and other services for children in crisis as either 'Good' or 'Very good'.

At SWS seclusion is only used for a very brief period of time and the young person is quickly reintegrated into the unit or a plan is developed that would not see them have any restrictions regarding, food, visits, access to health services etc.

– Staff member

1151. The inspection spoke with some health care staff who expressed surprise that nurses weren't routinely called every time a child was secluded.

1152. The inspection was also told that there were more children coming into Secure Welfare with intellectual disability. Accordingly, the inspection considered that Secure Welfare would benefit from staff with specific disability expertise.

1153. Just 27 per cent of staff surveyed rated 'access to disability supports' as either 'Good' or 'Very good' for children and young people in seclusion.

[One of the most stressful things about working at Secure Welfare is] when we are not trained in the disability sector and we get kids that need that attention.

– Staff member

Placing a child on 'observations'

1154. Children at Secure Welfare are subject to observations (an increased level of monitoring) when they are considered to be at increased risk of harm to themselves or others. Children are automatically placed on observation when they are:

- newly admitted
- at risk of self-harm or suicide
- in seclusion
- in seclusion or time out.

1155. Although a child in seclusion will automatically be on observations; requiring observations does not mean the child will necessarily be secluded.

Plans to avoid seclusion

1156. Each child at Secure Welfare should have a 'Therapeutic Plan' including behaviours and triggers, support needs, goals and timetabling. Plans are developed in conjunction with the child, Secure Welfare, significant people in the child's life from the community, professionals and other stakeholders. Therapeutic Plans provide staff with the tools and knowledge to create a safe environment and by identifying behavioural triggers and de-escalation techniques, can assist in avoiding the use of seclusion.

1157. The inspection observed that Therapeutic Plans had not been completed for at least three children present during the inspection period.

1158. In addition to Therapeutic Plans, the inspection was told that Behaviour Support Plans are developed if a child is secluded or has a history of being subject to seclusion or restraint, however, they are prepared by a staff member without directly engaging with the child. The inspection considered this is a flaw that could be easily rectified.

1159. Both therapeutic and behaviour support plans appear to be important tools to effectively manage the complex and individual needs of each child. It wasn't immediately clear to the inspection that the documents are actively read by operational staff. Despite this, staff were able to demonstrate their extensive knowledge of the children in their care and appropriate de-escalation strategies for each individual.

Diversity

1160. There were 305 children admitted to Secure Welfare during the 12-month reporting period. Meeting the diverse needs of these children, in a short period of time, presents a unique challenge for Secure Welfare.

1161. Interestingly, while only 23 per cent of the population live outside greater metropolitan Melbourne (according to the Australian Bureau of Statistics), 40 per cent of children admitted to Secure Welfare were from regional Victoria. This presents challenges in terms of maintaining community connections and support for children from regional areas during their stay in Ascot Vale or Maribyrnong.

Cultural supports

1162. The SWS Manual provides for Cultural Support Workers to be available to support young people from Aboriginal and culturally and linguistically diverse backgrounds:

> The Cultural Support Worker will help ensure that the young person's cultural or religious needs are accommodated. They will also assist staff in understanding the cultural context to some of the young people's behaviours and advice on culturally appropriate behaviours.
>
> Staff should be aware that some young people who come from Aboriginal or CALD backgrounds may have very limited connection, or may not want any connection, with their community. In these cases, staff should seek advice from the Cultural Support Worker, the child protection practitioner and the family if appropriate regarding the provision.

1163. When Secure Welfare staff are considering placing a young Aboriginal person in seclusion, they must contact the Aboriginal/Cultural Support Worker as soon as possible, who in turn, must attend the unit as soon as possible to assist in keeping the young person safe and to ensure that cultural support is provided.

1164. Twenty six per cent of children who passed through Secure Welfare during the 12-month reporting period were Aboriginal or Torres Strait Islander. Accordingly, Secure Welfare has an Aboriginal Support Worker to work across and move between the two sites. The Aboriginal Support Worker is well regarded by the children and staff who spoke with the inspection, and her services are in high demand.

1165. Sixty five per cent of staff surveyed considered that Secure Welfare did either 'Well' or 'Very well' at facilitating Aboriginal and Torres Strait Islander children and young people with access to the Aboriginal Support Worker (15 per cent and 50 per cent, respectively).

1166. Comparatively, just 31 per cent of staff surveyed felt that Secure Welfare did either 'Well' or 'Very well' at facilitating children and young people with access to a cultural support person (12 per cent and 19 per cent, respectively).

1167. The inspection heard anecdotal evidence of external cultural visits and supports being facilitated by Secure Welfare, and the increasingly multicultural demographics of the children being admitted to Secure Welfare will make this even more important into the future.

Staff

The people that work at Secure Welfare Services are incredibly caring and hard-working. All stakeholders have students' best interests at heart.

– Teacher

1168. The inspection encountered many dedicated and compassionate staff at Secure Welfare and observed positive engagement between staff and children. In relation to seclusion practices, the inspection noted that staff demonstrated:

- a good understanding of the risks and potential harm caused by the practice, and how to mitigate them
- a genuine commitment to developing a therapeutic environment
- a good understanding of de-escalation techniques and ways of stopping incidents rising to the point where seclusion is required.

1169. The inspection considered the staff culture at Secure Welfare was the single greatest protective measure the facility had against ill-treatment.

Staff views on working at Secure Welfare

1170. Survey respondents were asked to assign both their quality of working life and current level of work-related stress a rating between one and 10 (one being low, 10 being high). Responses were mixed as to the quality of working life at Secure Welfare Services, with most responses distributed relatively evenly between a five and a 10 on the scale.

1171. Forty six per cent of staff surveyed rated their current level of work-related stress as either a seven or an eight on the scale (27 per cent and 19 per cent, respectively). Thirty eight per cent rated their current level of work-related stress as between a one and a five on the scale. Very few, however, identified occupational safety as a cause for stress within the workplace.

[One of the most stressful things is] witnessing students escalating and having to be restrained in situations that could have been avoided had staff responded differently.

– Teacher

[The three most stressful things are] being unable to help a young person, not understanding their disability, and watching a young person detox off substances.

– Staff member

1172. Fifty per cent of staff surveyed 'almost always' felt safe in their working environment and a further 38 per cent 'mostly' felt safe. Eight per cent reported that they 'mostly' felt unsafe in their working environment.

1173. A sizeable proportion of staff surveyed identified their interactions with children and young people and their colleagues as being among the most satisfying things about working at Secure Welfare.

[The three most satisfying things about working at Secure Welfare Services are] meeting the young people and building relationships, working with staff who are like-minded, and having a positive influence on young people.

– Staff member

Conception of role

1174. An overwhelming majority of staff surveyed rated the following aspects of their role as 'Very important':

- keeping children and young people safe (92 per cent)
- providing emotional support to children and young people (92 per cent)
- advocating for children and young people (92 per cent)
- being a positive influence or role model (88 per cent)
- keeping staff safe (81 per cent)
- helping the facility to run smoothly (73 per cent).

We work with young people with significant trauma, putting them into a tiny little room isn't healthy for their mental health.

– Staff member

1175. Relatively fewer said that ensuring security of the facility (65 per cent) and maintaining discipline (42 per cent) were 'Very important' to their role. Nineteen per cent felt that 'maintaining discipline' and 'ensuring security of the facility' were not important to their role.

Seclusion gives the client time and space to self-regulate, keeping the young person, staff and other clients safe. When done properly, it provides an ability/opportunity to repair/build relationships between the young person and staff ... which may prevent further incidents and seclusion time.

– Staff member

Staff views on effectiveness and effects of isolation

Seclusion can cause significant harm to mental health and wellbeing, it weakens a child's connection to reality and their sense of self, it creates and exacerbates trauma, it incites or exacerbates suicidal ideation, it damages relationships with staff, and it breaks trust.

– Staff member

1176. Thirty one per cent of staff surveyed considered that seclusion was 'somewhat' effective in helping children and young people address the behaviour or risks that resulted in their placement in seclusion. Only 15 per cent thought that seclusion was usually effective, and 19 per cent believed it was not effective at helping children address the behaviour or risks.

It gives a client time to themselves to get out their anger and reflect on what occurred. Staff to work a plan with the client to prevent reoccurrence and strategies to manage their behaviour, instead of acting out and hurting other clients or staff.

– Staff member

If seclusion is offered as a choice and children are aware of how to use time alone for self-regulation as a regulation strategy, and understand it as such, then seclusion can be beneficial.

– Staff member

I don't think locking a child in a room helps anybody.

– Staff member

Staff training

1177. The overwhelming majority of staff surveyed felt they had sufficient training to engage with children and young people (85 per cent), engage with vulnerable children and young people (81 per cent), cultural awareness (81 per cent) and interpersonal skills (77 per cent).

1178. A not insignificant proportion, however, felt that they had not received sufficient training in child protection (42 per cent); engaging with children and young people with mental health issues (42 per cent); engaging with children and young people with drug issues (35 per cent); suicide and self-harm prevention (35 per cent) and de-escalation techniques (23 per cent).

Further training on mental health and autism, and ADHD would be useful.

– Staff member

1179. The inspection reviewed training materials delivered to Secure Welfare staff and noted they appeared to be trauma-informed and prioritised therapeutic care.

1180. The inspection noted that at least at Maribyrnong, within 24 hours of each instance of seclusion Secure Welfare staff participate in a 'debrief' to learn from the incident, and develop a behaviour management plan for the relevant child. This appeared to be a positive new initiative and should occur at both sites.

Chapter Five:

Solitary confinement across the three facilities

1181. It may surprise some that children and young people are kept in conditions akin to solitary confinement in a state as progressive as Victoria.

1182. As the inspection demonstrated, the rate, circumstances and periods of time in which children and young people are isolated in Victoria's places of detention differs dramatically between facilities and settings.

1183. We must be careful in drawing direct comparisons between Secure Welfare, Malmsbury and Port Phillip. Each facility operates according to a different model, with different levels of physical and organisational infrastructure, and particularly in the case of Secure Welfare, with different substantive aims.

1184. Any comparisons drawn from this report should, however, reinforce the need for specialised and tailored approaches for children as distinct from adults, and for different cohorts of children and young people.

1185. It should also be emphasised that there is no fixed or linear path between Secure Welfare, Malmsbury and Port Phillip. Children admitted to Secure Welfare may never come into contact with Victoria's justice system, and many children and young people accommodated in Malmsbury will not go on to spend time in an adult prison such as Port Phillip.

1186. Yet many of Victoria's most vulnerable children and young people will spend time in more than one of these facilities. The inspection team encountered several of these individuals: children compared life in Secure Welfare to their experience of different youth justice centres; young people in Malmsbury spoke of time spent in Port Phillip's Charlotte Unit; and young prisoners in Port Phillip reflected on the stark realities that faced them on arrival from Malmsbury.

Jake's journey

1187. The inspection demonstrated that although all were empowered to isolate a child or young person for various reasons, Secure Welfare, Malmsbury and Port Phillip each made very different use of the practice.

1188. Consider the hypothetical 17-year-old who spends time in each of the three facilities visited by the inspection. The data suggests that following an incident of misbehaviour, this child would most likely spend 30 minutes in isolation at Secure Welfare, one hour in isolation at Malmsbury, and six days in solitary confinement at Port Phillip. The relative likelihood of this child's isolation would also differ depending on the location.

1189. But this 17 year old need not be hypothetical, as Jake's journey illustrates. This case study narrative has been written following a review of Jake's files.

Jake

Jake never got to meet his birth father. He was raised in the care of his mother, who found it difficult to be a parent. Jake's childhood was marked by physical, verbal and emotional abuse and regular exposure to substance misuse and family violence.

From the age of five, Jake had to step up and take charge of his own care. As a result, Jake came to see himself as unworthy and unlovable and viewed the world as an unsafe place, where others could not be trusted. This made it difficult for Jake to accept positive, sensitive parental input, and he would often wake up angry. Jake was later diagnosed with ADHD, ODD and receptive and expressive language difficulties.

Jake entered State Care when he was 15 years old. By this time, Jake was regularly using marijuana and methamphetamine. Within less than a year, Jake was admitted to Secure Welfare.

Jake told a child psychologist that it felt good to be off drugs at Secure Welfare, and that he planned to make changes to his life when he was discharged. Jake talked about learning a trade; he was adamant that he did not want to end up in Parkville Youth Justice Precinct. The child psychologist observed that Jake was a sweet and engaging young man who cared deeply about his family and that with the right support, Jake would be able to lead a positive life.

Jake exited Secure Welfare, but it wasn't long before he came into conflict with staff at his residential care facility. Jake's placement was terminated, and he spent several months sleeping rough and staying in emergency accommodation. Jake was eventually picked up by police on an outstanding warrant and, owing to his accommodation instability, he was re-admitted to Secure Welfare.

Jake's experience of seclusion at Secure Welfare

Jake found his second stay at Secure Welfare to be harder. One morning, Jake became particularly upset, and he started to kick and pull at the sink in his bedroom. Staff successfully intervened, convincing Jake that his behaviour presented a risk to his own safety.

However, Jake later became heightened again, and was restrained when he attempted to damage an exterior door.

Jake – continued

A member of staff took hold of Jake's arm and escorted him to the seclusion room, where he was placed under constant observation. Staff made several attempts to speak with Jake, however Jake refused to engage, instead kicking at the walls and door and making various threats. After about 40 minutes, staff telephoned the Unit Manager and obtained approval to seclude Jake for more than one hour.

Staff arranged for a registered nurse to visit Jake, however Jake was still too heightened to engage. Jake continued to kick and shout for another half hour, before eventually retreating to the corner of the seclusion room and sitting down. Staff then entered the room and spoke with Jake, and Jake was permitted to exit seclusion. Jake spent approximately two hours in seclusion. He was not placed in seclusion again during his stay at Secure Welfare. Jake's situation in the community continued to deteriorate, and within months he was arrested and remanded to Parkville Youth Justice Precinct. Jake spent four of the next five months in Parkville, before he was transferred to a unit at Malmsbury's secure site.

Jake's experience of isolation at Malmsbury

Staff noted that Jake appeared settled and polite during his first week at Malmsbury. However, things took a turn on the morning of Jake's ninth day when, just as in Secure Welfare, Jake became upset and retreated to his bedroom, making threats to assault staff and damage property. Staff radioed for support, and members of Malmsbury's tactical response team (SERT), fitted with riot gear, congregated outside of Jake's bedroom door.

SERT officers attempted to speak with Jake through the door. Jake refused a 'surrender plan' and started to break items in his bedroom. Four members of SERT entered the room and restrained Jake. Jake was then handcuffed and escorted to an isolation cell. Jake began to settle down after approximately one hour in the isolation room. After a further 45 minutes, Jake spoke with the Unit Manager and was permitted to return to his bedroom. Although Jake remained settled, he was not allowed out of his bedroom for another three hours. In total, Jake spent approximately five hours in isolation.

Jake spent the next nine months moving between Malmsbury, Parkville and the Grevillea Unit of Barwon Prison. During this period, Jake was isolated at Malmsbury another 43 times. Jake received his first adult prison sentence shortly after his 19th birthday. Jake was taken to Port Phillip, where he was classified to the youth unit.

Jake's experience of separation at Port Phillip

A young person in Jake's unit received a bruise to the eye not long after Jake's arrival at the prison. Although the young person said that he was hearing voices and had self-harmed, staff were suspicious and arranged to review the previous day's CCTV footage. This footage depicted Jake and another young person entering a cell with the alleged victim. Jake and the other young person were then depicted exiting the cell, followed by the alleged victim, who was holding his eye.

Jake's alleged accomplice admitted to assaulting the victim when interviewed. Both Jake and the alleged victim declined to comment. The prison notified Victoria Police of the incident, and Jake then was escorted to a cell in another unit, where he was formally separated. Jake was confined to the cell for 23 hours per day and prohibited from speaking to other prisoners.

Jake – continued

Jake's separation was reviewed by a Sentence Management Panel after four days. Jake told the Sentence Management Panel that he did not know why he had been separated. Jake said that he had just been in the wrong place at the wrong time, that he knew the other prisoner, and that if he had wanted to assault him, he would have done it outside of the prison.

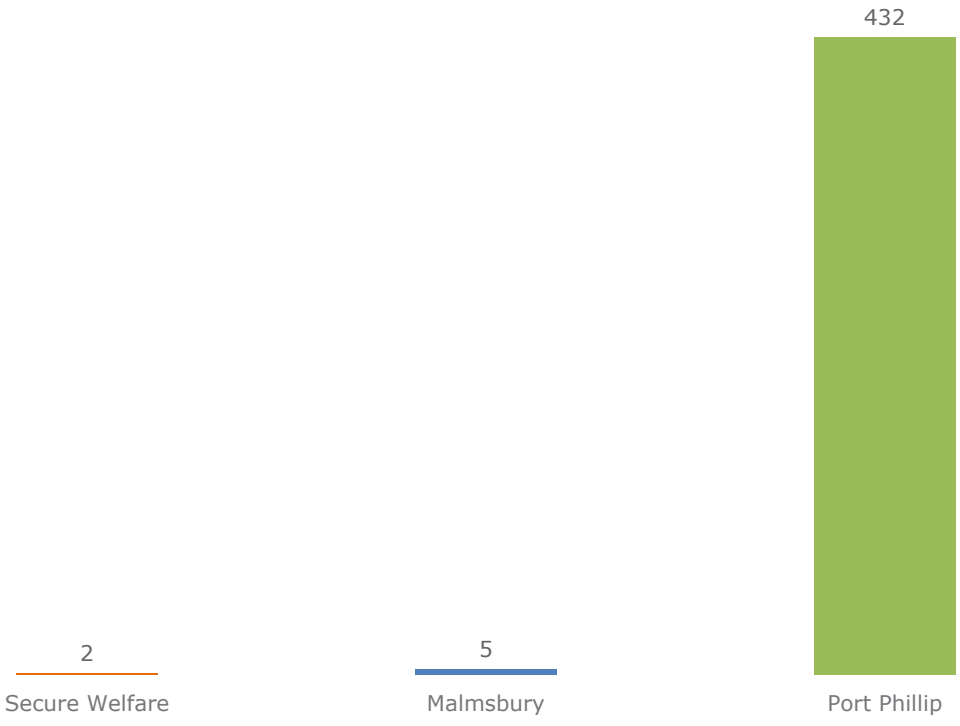
Although prison staff had noted that Jake was behaving himself, the Sentence Management Panel told Jake that he would be separated for a further seven days 'pending investigation' of the assault.

The Sentence Management Panel reviewed Jake's separation again seven days later. The Panel noted that Jake had remained 'incident-free' during his separation, and that information available suggested that Jake had not been directly involved in the alleged assault. The Panel decided that Jake would be cleared from the separation regime and transferred to another prison to serve out the rest of his sentence. Jake remained separated to his cell for another five days before he was transferred.

In total, Jake was confined to his cell for a period of 18 days, or approximately 432 hours.

In all, Jake's journey through isolation at Secure Welfare, Malmsbury and Port Phillip encompassed less than three years.

Numbers of hours Jake spent in isolation, per incident



Comparing the three facilities

1190. The inspection demonstrated that the legal and policy framework governing the use of isolation, although critically important, does not solely drive the use of the practice. The inspection was interested to observe that although subject to many of the same legal and policy safeguards, the rate and circumstances in which children and young people were isolated at Malmsbury and Secure Welfare diverged considerably.

1191. There was, fundamentally, a difference in ethos and motivation underpinning the work of staff at each of the three facilities. The inspection noted that there appeared to be a direct correlation between, on the one hand, the extent to which a facility prioritised a trauma-informed approach to managing the children and young people in its care and, on the other, the tendency of staff at the facility to recognise the harm caused by isolation and other restrictive practices.

1192. At one extreme, the comparatively therapeutic model implemented by Secure Welfare appeared reasonably successful in limiting the use of extended isolation at the Ascot Vale and Maribyrnong facilities. At the other end of the spectrum, the priority afforded to deterrence and considerations of 'good order' within Port Phillip appeared to make solitary confinement the preferred behaviour-management tool, rather than the exception to the norm.

1193. Although short-term isolation for periods of less than 20 minutes may sometimes assist a child or young person to regulate their behaviour,[30] extended isolation produces very different consequences.

1194. The inspection observed that the latter practice tended to take away a child or young person's ability to make regular, meaningful decisions about their behaviour and, consequently, made it harder for these individuals to develop and demonstrate sound judgement.

1195. The inspection was fortunate to meet staff at each facility who displayed a genuine concern for the wellbeing of the children and young people in their care. The inspection was interested to observe that greater reliance on the use of isolation within a facility did not appear to correspond with an increased sense of safety or lower levels of work-related stress amongst staff.

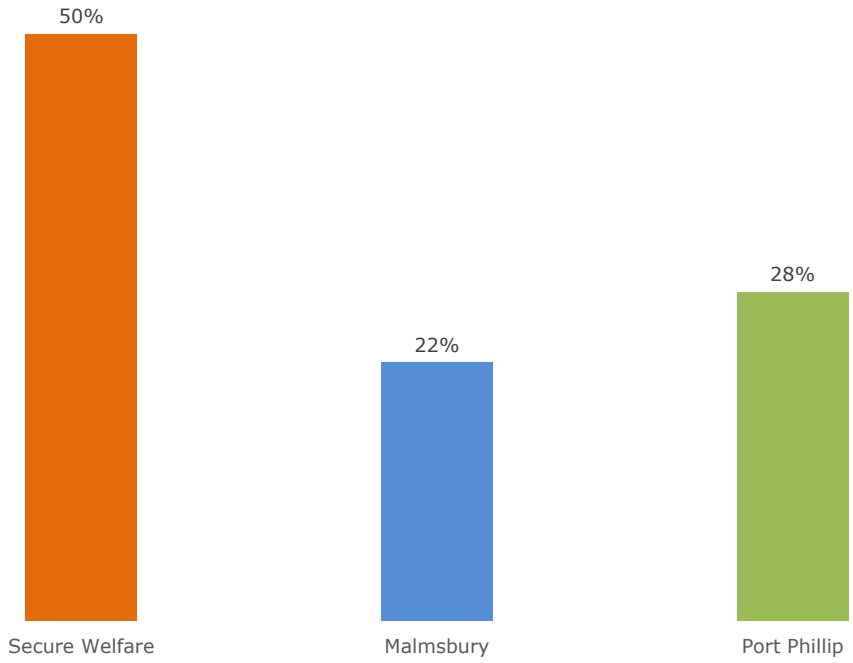
1196. Staffing levels and the physical dynamics of each environment no doubt also come into play. Yet the inspection team was not convinced that additional security measures were the only or best path towards a safer and more satisfied workforce.

1197. The most recent comprehensive review of Victoria's youth justice system (the Ogloff-Armytage Review) observed that as at approximately July 2017, investment in youth custodial supervision was approximately 20 times greater than the combined funds allocated to early intervention, diversion and restorative justice processes. The review observed that there was no data at that time to indicate that contact with the youth justice system led to a change in a child or young person's offending patterns.

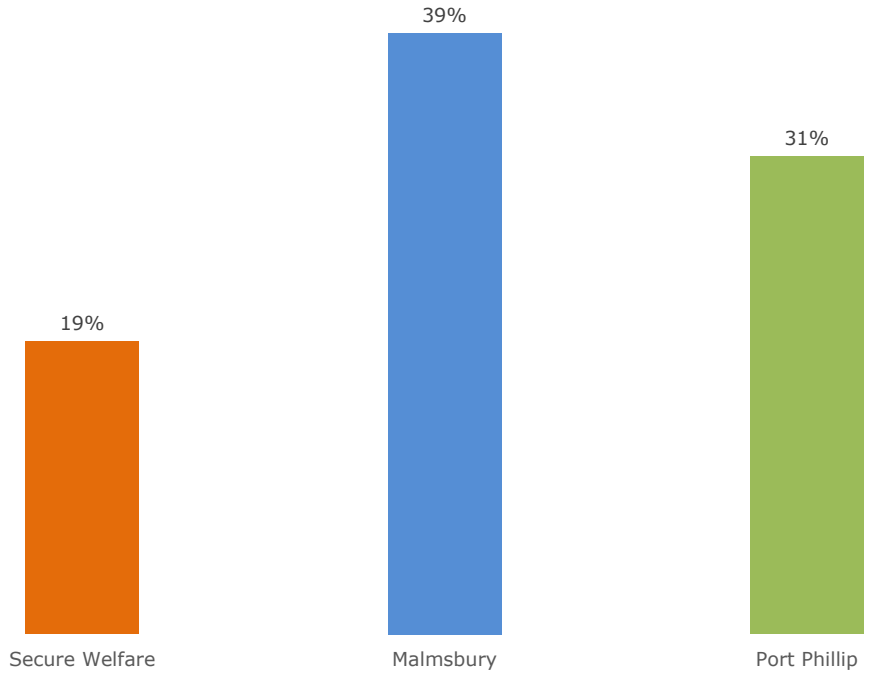
1198. Since that review, according to DJCS's 'Corporate Plan 2018-22', further funds have been allocated to expanding Malmsbury's secure bed capacity and fortifying the facility's security infrastructure. Work is also currently underway on a new, 224 bed high-security youth justice centre, to open in 2021, at an allocated cost of $288.7 million.

30 Children's Commissioner for England, *Research Report: Isolation and Solitary Confinement in the English Youth Justice Estate* (2014), 64.

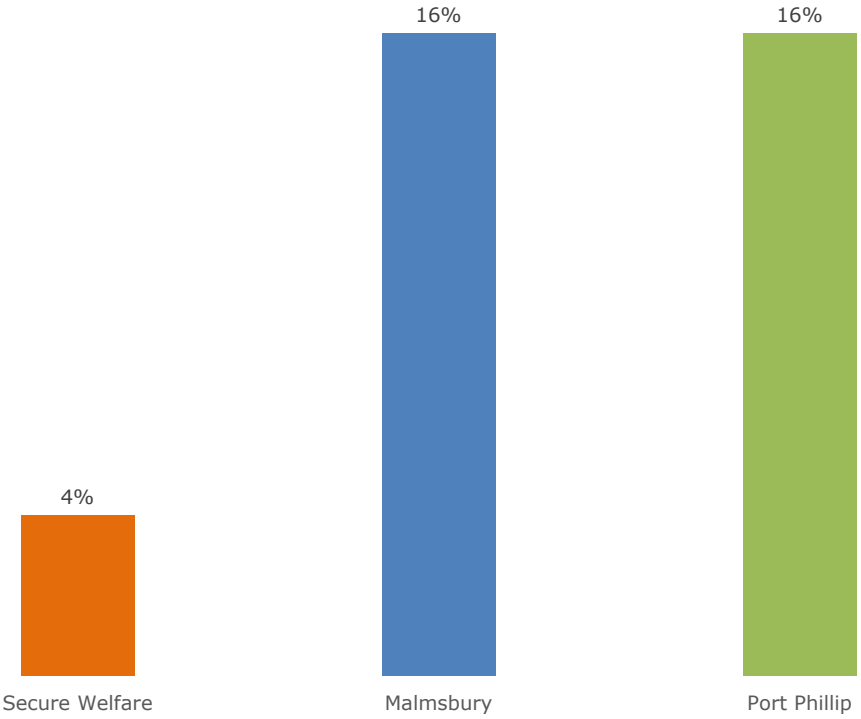
Percent of staff who reported that they 'almost always feel safe' in their working environment



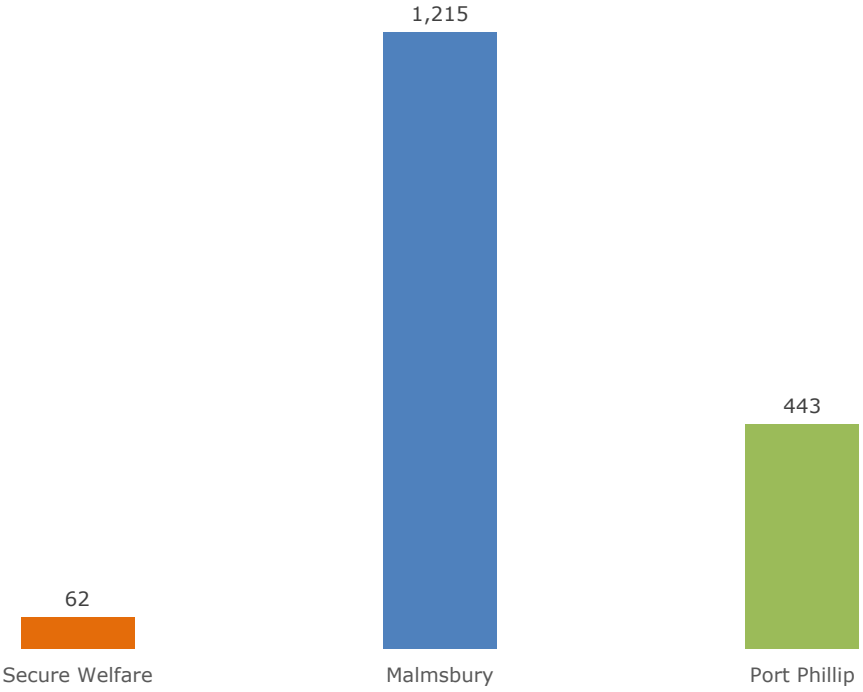
Percent of staff who reported very high levels of work-related stress (8/10 or above)



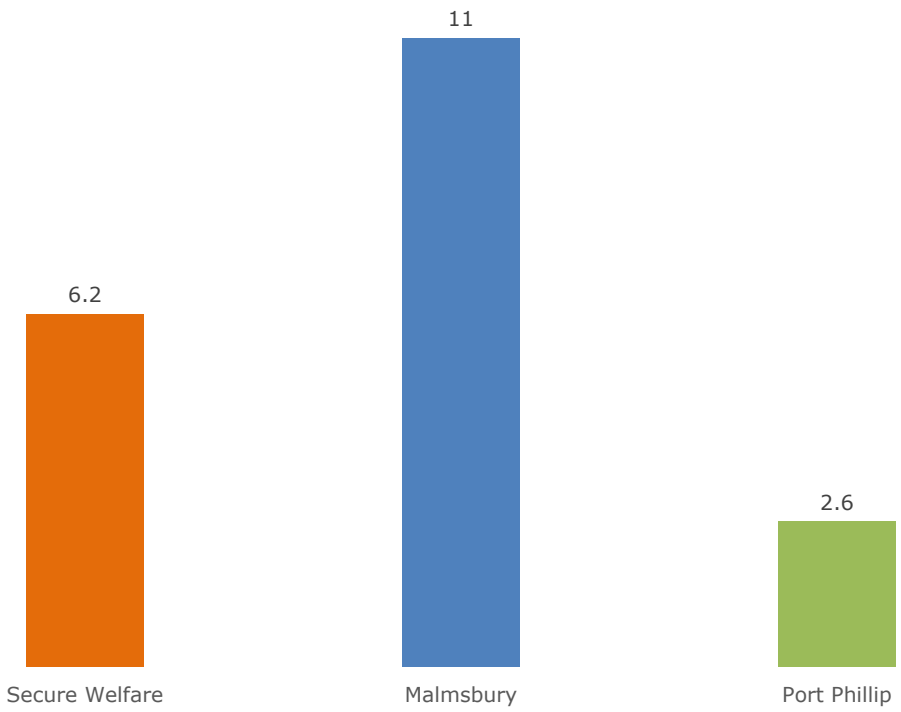
Percent of staff who reported a very low quality of work life (3/10 or below)



Isolations per facility, excluding lockdowns



Isolation rate per facility adjusted for population size, excluding lockdowns



Approximate isolation hours per day, excluding lockdowns, adjusted for population of 100 children and young people

Median isolation period per facility, excluding lockdowns

Chapter Six:

Conclusions and recommendations

Conclusions

1199. This investigation has used an OPCAT-style inspection to consider practices that may lead or amount to the solitary confinement of children and young people across three distinct closed environments in Victoria – an adult prison, a youth justice facility and an out of home care facility. It has explored the legal and policy frameworks of each, to identify factors that increase the risk of ill-treatment under local laws and international human rights standards, including the Mandela Rules and the Havana Rules. Importantly, the investigation engaged directly with detainees, staff and detaining authorities to understand the reasons and consequences that sit behind some of those practices.

1200. The different legislative mechanisms across the three closed environments give different names to practices that may lead or amount to solitary confinement. They include 'separation' in prison, 'isolation' in youth justice, and 'seclusion' in secure welfare. While in many of the cases the inspection observed the practices do not amount to solitary confinement, each has the potential to involve the physical isolation of individuals 'for 22 or more hours a day without meaningful human contact'– or solitary confinement as defined in the Mandela Rules.

1201. These are not the only practices that may lead or amount to solitary confinement. Lockdowns, which may be unit or facility-wide, can be made as a result of staff shortages as well as in response to challenging behaviour. Port Phillip's Violence Reduction Strategy, Malmsbury's Separation Safety Management Plans, the withdrawal of privileges and Port Phillip's Intermediate Regime, and the separation of people at risk of suicide or self-harm, pose similar risks.

1202. The evidence in this report, from detainees, staff and the facilities themselves, is both overwhelming and distressing. It is apparent that whatever name it is called, and for whatever reason, the practice of isolating children and young people is widespread in both prison and youth justice environments. It is equally apparent that the practice is seen as punitive even when that is not the intention; young people can be isolated both for acts of violence and for being the victim of an act of violence, and when used in response to challenging behaviour may exacerbate rather than improve the situation.

1203. The experience of Aboriginal youth is particularly distressing, not only the over-representation of these young people within the system, but against the backdrop of particularly challenging life circumstances including high rates of exposure to child protection, family violence, and loss of culture.

1204. Almost 30 years ago the *Royal Commission into Aboriginal Deaths in Custody* acknowledged the 'extreme anxiety suffered by Aboriginal prisoners committed to solitary confinement' and recommended that Corrective Services recognise that 'it is undesirable in the highest degree that an Aboriginal prisoner should be placed in segregation or isolated detention.' Despite this, the investigation observed at Malmsbury a disproportionate use of isolation involving Aboriginal young people.

1205. The evidence of staff across the three facilities is also telling, ranging from informed understanding of the impact of isolation (in Secure Welfare, supported by posters) to concerns about the practice but without the tools to respond in other ways, to outright denial that isolating young people may be a problem. In both the prison and youth justice environments the investigation's survey suggests a particular lack of understanding about the mental health impact of isolation on young people.

1206. The inspection observed that greater reliance on the use of isolation within a facility did not appear to correspond with an increased sense of safety or lower levels of work-related stress amongst staff.

1207. Specific observations for the three facilities inspected are set out below.

Port Phillip Prison

1208. The inspection found that at Port Phillip, a total of 265 separation orders had been issued on young people within the 12-month reporting period. Approximately 20 per cent were because the young person had assaulted someone and another 30 per cent were made pending investigation into a young person's involvement in an alleged assault. Another 30 per cent of separation orders concerning young people were made for reasons relating to the young person's own safety, namely they were the victim of an assault, they needed protection, or they had self-harmed.

1209. The inspection observed that with a median duration of 10 days, the use of separation at Port Phillip almost invariably amounted to solitary confinement under the accepted international definition. In almost a third of cases, the young person's separation was followed by a period on an Intermediate Regime. The median length of this placement was 49 days, and in many cases, the conditions also met the definition of solitary confinement.

1210. In the context of practices that may lead or amount to solitary confinement, the inspection observed several factors that increase the risk of ill-treatment at each of the facilities. The risks observed at Port Phillip include:

i. instances of young people being subject to 'prolonged solitary confinement' (greater than 15 days), contrary to rule 43(b) of the Mandela Rules and potentially incompatible with section 10(b) of the Human Rights Act

ii. young people remaining in separation despite their separation order ending, contrary to regulation 27(2) of the Corrections Regulations[31] and arguably incompatible with section 21(3) of the Human Rights Act

iii. that there was little difference between the separation and Intermediate Regimes, meaning that in many cases the Intermediate Regime was likely to amount to solitary confinement, and appeared to be 'separation' without satisfying the requirements of regulation 27 of the Regulations

iv. recent amendments to the Regulations authorise the indefinite solitary confinement of prisoners 'for the management, good order or security of the prison', without the requirement that the separation not be longer than is necessary to achieve that purpose, which is contrary to rule 43(a) of the Mandela Rules and arguably incompatible with section 10(a) of the Human Rights Act

v. the medical and psychiatric conditions of prisoners were not routinely considered before making separation orders, contrary to regulation 27(5) of the Regulations

vi. young people being separated on mainstream units, with unintended and unjust consequences for those people, others on the unit and staff

vii. the use of separation and observation without active treatment or therapeutic interventions for those at risk of suicide or self-harm

viii. the material conditions of Charlotte Unit, when coupled with the terms of a separation regime, appeared particularly ill-suited to accommodate vulnerable people, meaning that accommodating young people and those with mental health issues or disability may be incompatible with obligations under rule 38(2) of the Mandela Rules

ix. consideration as to whether and how a young person's mental illness or disability may have contributed to their conduct is not routinely given before disciplinary sanctions are imposed, contrary to rule 39(3) of the Mandela Rules and Port Phillip's Checklist for Disciplinary Officers

31 The regulations referred to above are the Corrections Regulations 2009, as in effect at the time of the inspection. In April 2019, the 2009 Regulations were replaced with the Corrections Regulations 2019. The regulation on 'separation' (now regulation 32) is largely the same as the earlier version (regulation 27).

x. that the Violence Reduction Strategy, while a positive initiative, had on occasion exceeded 23-hours, and does not have a clear basis under the Corrections Act or Regulations

xi. that the run-out areas in Charlotte and Borrowdale Units fall short of the international human rights standards applicable to exercise and recreation in custodial settings, namely rule 23(2) of the Mandela Rules

xii. the routine use of restraints under a 'handcuff regime', absent of any contemporaneous risk assessment, contrary to rules 48(1)(a) and (c) of the Mandela Rules.

Opinion – Port Phillip

1211. The practices outlined above at points i to v appear to have been taken contrary to law within the meaning of section 23(1)(a) of the Ombudsman Act, either by not meeting the existing legislative / regulatory requirements or because the practice may be incompatible with the Human Rights Act. The practices at points vi to ix appear to be unjust, oppressive and improperly discriminatory within the meaning of section 23(1)(b), and the practices at points x to xii appear to be wrong within the meaning of section 23(1)(g) of the Ombudsman Act.

Malmsbury Youth Justice Precinct

1212. At Malmsbury, there were 1,214 isolations for behavioural reasons within the 12-month reporting period. Almost 60 per cent of behavioural isolations were designated as 'immediate threat to safety (others)'. Only six per cent were for the child or young person's own safety. The median recorded period of isolation for behavioural reasons was approximately one hour, the average was somewhat higher – approximately two and a half hours.

1213. The inspection observed that the Isolation Register recorded four instances of isolation lasting more than 22 hours, potentially amounting to solitary confinement. DJCS suggested these were recorded in error. In any event, as a result of the way in which isolation is recorded (starting and stopping with each run-out and overnight lockup), the register inevitably understated the cumulative period of isolation.

1214. The inspection also found that there were 13,653 reported lockdowns at Malmsbury during the review period, with the median duration being less than an hour. Approximately 40 per cent of lockdowns at Malmsbury were attributed to staff shortages at the facility.

1215. The inspection attributed the high rate of lockdowns at Malmsbury to what appeared to be a very low appetite for risk at the youth justice centre. It was apparent that Malmsbury was under considerable external pressure to reduce the rate of unrest within the facility and that this pressure appeared to manifest in greater reliance on restrictive practices, including the use of isolation and mechanical restraints.

1216. The inspection also observed the significant frustration among young people caused by lockdowns and rotations at Malmsbury. It is not difficult to see how this frustration can contribute to escalated behaviour.

1217. The risks observed by the inspection at Malmsbury include:

i. instances of isolation not being used as a last resort or in response to an immediate threat, contrary to section 488(2) of the CYF Act

ii. instances of isolation lasting longer than was recorded in the Isolation Register, and longer than the relevant officer was delegated to approve under section 488(3) of the CFY Act

iii. instances of non-compliance of the Isolation Register with regulation 32 of the CYF Regulations

iv. the disproportionate use of behavioural isolation on Aboriginal and Torres Strait Islander young people, representing 14 per cent of the population but 20 per cent of behavioural isolations

v. the routine use of restraints without any contemporaneous risk assessment, contrary to rule 48 of the Mandela Rules, rule 64 of the Havana Rules and arguably incompatible with section 23(3) of the Human Rights Act

vi. the not unreasonable perception from young people that facility-wide lockdowns are a form of collective punishment, which is prohibited by rule 67 of the Havana Rules and section 487(a) of the CYF Act

vii. the routine use of SERT, including during medical consultations and to open cell door traps without a contemporaneous risk assessment

viii. multiple deficiencies of the Isolation Register in terms of recording the particulars of a young Aboriginal person's isolation.

Opinion – Malmsbury

1218. The practices outlined above at points i to iii appear to have been taken contrary to law within the meaning of section 23(1)(a) of the Ombudsman Act, either by not meeting the existing legislative / regulatory requirements or because the practice is incompatible with the Human Rights Act. The practices at points iv to vi appear to be unjust, oppressive and improperly discriminatory within the meaning of section 23(1)(b), and the practices at points vii and viii appear to be wrong within the meaning of section 23(1)(g) of the Ombudsman Act.

Secure Welfare Services

1219. At Secure Welfare there were 62 reported incidents of seclusion over the 12-month reporting period. Seventy-three per cent occurred at Ascot Vale, and 27 per cent occurred at Maribyrnong. Of the seclusions reported at Ascot Vale, almost half here attributed to a physical assault to a member of staff or another adult, and another quarter to 'aggressive behaviour'. At Maribyrnong, most seclusions (71 per cent) were attributed to 'aggressive behaviour' and 18 per cent to an actual physical assault. At both services the median reported seclusion period was 30 minutes.

1220. The risks observed by the inspection at Secure Welfare include:

i. instances where the conditions of a young person's detention in Secure Welfare met the definition of seclusion, however, it was not recorded on the Seclusion Register, contrary to section 72P(6) of the CYF Act

ii. instances of non-compliance of the Seclusion Register with the requirements of regulation 22 of the CYF Regulations

iii. the seclusion rooms at both sites not being fit for purpose, meaning that the confinement of children in those spaces may be incompatible with sections 17(2) and 22(1) of the Human Rights Act

iv. the arrangements for children to access the telephone not offering sufficient privacy and presenting an inappropriate obstacle to make complaints about the standard of care, accommodation or treatment they are receiving.

Opinion – Secure Welfare

1221. The practices outlined above at points i and ii appear to have been taken contrary to law within the meaning of section 23(1)(a) of the Ombudsman Act, because they have not met the existing legislative / regulatory requirements. The practices at points iii and iv appear to be wrong within the meaning of section 23(1)(g) of the Ombudsman Act.

The use of isolation practices across settings

1222. As should be clear from this report, isolation is not, invariably, solitary confinement. The use of solitary confinement on adults has been internationally condemned, except in exceptional circumstances and for as short a time as possible. The Mandela Rules also provide an absolute prohibition on 'prolonged' solitary confinement, being more than 15 days. Finally, it is widely accepted that solitary confinement of any duration on children is cruel, inhuman or degrading treatment; and would therefore be unlawful in Victoria pursuant to the Human Rights Act.

1223. OPCAT inspections are intended to be forward looking and preventive. While an NPM should identify practice that is incompatible with human rights or otherwise unjust, it is equally important to enter a dialogue with relevant authorities on measures for improvement – it is not enough, nor is it realistic, to simply say 'isolation is bad, don't do it.'

1224. A vast body of research confirms that young people, until around 25 years, are still developing physically, mentally, neurologically and socially, as a result of which solitary confinement poses a serious risk of long-term harm. It also means, however, that children and young people can be irrational, volatile and unable to self-regulate. It means that they may present behaviour that is more challenging and more extreme than many adults. The challenge is to effectively respond to such behaviours in a way that doesn't make it worse.

1225. Multiple studies confirm that the use of isolation in institutional settings is frequently harmful. As the literature observes, there is 'unequivocal evidence that solitary confinement has a profound impact on health and wellbeing, particularly for those with pre-existing mental health disorders, and that it may also actively cause mental illness.'[32] Owing to their stage of brain development and the effects of early trauma, children and young people are particularly susceptible to these adverse consequences.[33]

1226. Solitary confinement of children and young people is also counter-productive. It is known to be an 'ineffective therapeutic tool' which 'can make it impossible for juveniles to develop a healthy, functioning adult social identity'.[34] Worse still, solitary confinement has been shown to increase recidivism, making the community less safe.[35]

1227. It must also be acknowledged that mechanisms authorising separation or isolation are necessary and may be a reasonable and appropriate response to some situations. Prisons and youth justice facilities can be highly challenging and at times, dangerous places, both for detainees and staff.

1228. The evidence shows that children and young people in Victoria are isolated for a variety of reasons, yet those reasons do not then reflect the conditions or duration of the isolation. The case of the young person at Port Phillip who was the victim of an assault and received the same period of separation as the alleged perpetrator is an example of this.

1229. The evidence also suggests that the rate and duration of separation at Port Phillip and the rate of isolation at Malmsbury are too high. While legitimate reasons will always exist to isolate or separate, numerous studies in addition to the evidence in this report confirm that such practices can be counter-productive. In the youth justice context, for example, we have seen unrest causing lockdowns, causing more unrest, causing more lockdowns.

1230. The inspection observed that although subject to many of the same legal and policy safeguards, the rate and circumstances in which children and young people were isolated at Malmsbury and Secure Welfare diverged considerably.

1231. There was, fundamentally, a difference in ethos and motivation underpinning the work of staff at each of the three facilities. There appeared to be a direct correlation between, on the one hand, the extent to which a facility prioritised a trauma-informed approach to managing the children and young people in its care and, on the other, the tendency of staff at the facility to recognise the harm caused by isolation and other restrictive practices.

1232. At one extreme, the comparatively therapeutic model implemented by Secure Welfare appeared reasonably successful in limiting the use of extended isolation at the Ascot Vale and Maribyrnong facilities. At the other end of the spectrum, the priority afforded to deterrence and considerations of 'good order' within Port Phillip appeared to make solitary confinement the preferred behaviour-management tool, rather than the exception.

32 Sharon Shalev, *A Sourcebook on Solitary Confinement, Mannheim Centre for Criminology* (2008), 10.

33 American Academy of Child and Adolescent Psychiatry, Policy Statement: Solitary Confinement of Juvenile Offenders, available at <https://www.aacap.org/aacap/policy_statements/2012/solitary_confinement_of_juvenile_offenders.aspx> last accessed 13 June 2016.

34 Shira E. Gordon, 'Solitary Confinement, Public Safety and Recidivism, *University of Michigan Journal of Law Reform* (2014) Vol. 47(2), 502-503.

35 Ibid, 520-521.

1233. While the material conditions of all facilities tended to the bleak, the culture of the staff in dealing with comparably challenging behaviour presented strikingly divergent responses. The comparison also leads to the inescapable conclusion that while the youth justice system is far from perfect, and work is needed to bolster Secure Welfare, the adult prison system is particularly poorly equipped to deal with young people.

1234. If staff in these environments feel that separation or isolation are the only tools they have to respond to challenging behaviour, they are being set up to fail. It should be one of many, and one that is used only as a last resort and for the minimum time necessary. While this is plainly set out in legislation and acknowledged in official procedures, in prisons and youth justice facilities it does not translate into practice on the ground.

1235. There are lessons such systems can learn to ensure that when presented with challenging behaviours and situations, facilities are empowered to guarantee the safety and dignity of everyone – both detainees and staff, and by extension, the community more broadly.

1236. Such tools are known: including training of staff in de-escalation techniques, mental health and trauma-informed responses, and purpose-built infrastructure such as therapeutic spaces. They will take continued investment in both facilities and people, but should deliver far better returns than strengthened perimeter fencing.

1237. Correction legislation frequently refers to the 'security or good order' of a facility, a phrase often used as a justification for a myriad of actions and decisions. As Victoria moves to implement OPCAT, with its focus on prevention and dialogue to explore practical ways to mitigate risks of ill-treatment, we should ask ourselves: are we best served by a practice that promotes security over rehabilitation, and then provides neither?

Previous inquiries and recommendations

1238. Before setting out the Ombudsman's recommendations it is important to take stock of past inquiries, and acknowledge the significant body of previous work that has sought to address issues like those identified in the earlier chapters.

1239. The use of practices that may lead or amount to the solitary confinement of children and young people has been considered by a number of inquiries in Australia over the last two years alone, including:

- Commission for Children and Young People (Vic) – *The same four walls: Inquiry into the use of isolation, separation and lockdowns in the Victorian youth justice system* (March 2017)
- Office of the Inspector of Custodial Services (WA) – *Behaviour management practices at Banksia Hill Detention Centre* (June 2017)
- Armytage and Ogloff – *Youth Justice Review and Strategy: Meeting Needs and Reducing Offending* (Vic) (July 2017)
- *Royal Commission into the Detention and Protection of Children in the Northern Territory* (November 2017)
- Legal and Social Issues Committee of Parliament (Vic) – *Inquiry into youth justice centres in Victoria* (March 2018)
- Office of the Inspector of Custodial Services (WA) – *Directed Review of Allegations made by Amnesty International Australia about ill-treatment at Banksia Hill Detention Centre* (August 2018)
- Inspector of Custodial Services (NSW) – *Use of force, separation, segregation and confinement in NSW juvenile justice centres* (November 2018)
- Queensland Ombudsman – *The Brisbane Youth Detention Centre report* (March 2019).

1240. The findings of these inquiries largely reflect the observations in this inspection. Many have identified high rates of isolation; reliance on isolation practices as the primary tool to deal with challenging behaviour; disproportionate representation of Aboriginal and Torres Strait Islander people being isolated; concerns about the accuracy of relevant registers; deficiencies with the existing legislative and regulatory regimes and protective measures; and the significant impact of staff shortages. They also highlight the on-going cycle that is created when isolation practices increase, which fuels tension and instability, and in turn increases the likelihood of the practices needing to be used.

1241. The inquiries have also made a myriad of recommendations intended to address their concerns, including law reform, reviews and amendments to policy and practice, recruitment and investment in staff training and facility upgrades – to the point where it may appear that it has all been said before.

1242. The Commissioner for Children and Young People made 21 recommendations in her *Same Four Walls* inquiry, including that the:

- Victorian Government amend the CYF Act to:
  - clarify the purpose of isolation and the circumstances under which a young person can be isolated
  - ensure that all young people in youth justice centres have at least one hour of fresh air each day.
- Department of Justice (and Regulation, as it was at the time):
  - implement measures to improve Youth Justice compliance procedures for recording periods of isolation
  - review youth justice policy, practice and training to ensure isolation is not used as the primary behaviour management tool in the youth justice system
  - immediately review the youth justice staffing and recruitment model to ensure that sufficient, suitably trained staff are available to supervise children and young people to prevent frequent and extensive lockdowns.

1243. In March 2017, and in response to CCYP's inquiry, then Minister for Families and Children and Minister for Youth Affairs, the Hon Jenny Mikakos said:

> … The government accepts or accepts in principle all 21 recommendations in the report. …
>
> The government has not waited for this report to put in place the reforms needed for our youth justice system, including building modern, fit-for-purpose infrastructure, and we are getting on with addressing the longstanding issues relating to staffing…. Improved staff training is also being rolled out. We are acting to overhaul the separation safety management plans with new secure care plans that include a section that will be provided to young people to give them greater clarity, in accordance with one of the recommendations.
>
> Isolation is sometimes a necessary tool, and that is why it is legislated for in the act. The report shows that the common reasons it is used include physical assaults, aggressive behaviour altercations, verbal abuse and attempted escape. Isolation is used to de-escalate heightened behaviour and prevent a young person from harming them self, others or the facility, but it should not be overused and should only be used as a last resort.
>
> The report contains case studies that highlight the extreme complexity of the young people that are in our youth justice system. Whilst most instances of isolation occur in a young person's cell with full amenities and for short periods, the report shows compliance with proper authorisation and recording of isolation and separation needs significant improvement. The commission has directed all of its recommendations to the Department of Justice and Regulation in recognition that it will resume responsibility for youth justice from 3 April, and I will be making sure that all of these recommendations are in fact acted on.

1244. In August 2017, Minister Mikakos released the Ogloff-Armytage review and announced that the government had 'accepted or accepted in principle the review's 126 recommendations.' On releasing the report, the Minister committed:

> $50 million to address 42 priority recommendations, including a new custodial operating model; better risk and needs assessment tools by which to assess and rehabilitate young offenders, including the establishment of a classification and placement service for the first time; measures to improve workforce capability, including training of the same duration as Corrections Victoria staff; 21 additional safety and emergency response team staff; the biggest ever expansion of rehabilitation programs; and more resources to tackle Koori over-representation. Another 63 recommendations that do not require additional investment or legislative change are already underway.

1245. Most recently, in September 2018, the government responded to Parliament's Legal and Social Issues Committee *Inquiry into Youth Justice* and supported, or supported in principle, the inquiry's 39 recommendations. In relation to recommendations about isolation practices, the Government responded that substantial changes have been made in response to the CCYP report to the reporting of isolation, separation and lockdowns, with auditing and reporting on use on a daily basis, as well as to address issues of workplace culture, retention and staff training and development.

1246. In response to the draft report of this investigation, DJCS noted that one of the inspection's key observations of Malmsbury was that security was being prioritised over rehabilitation. Accordingly, DJSC reported:

- A new approach to case management was implemented in February this year. It includes the delivery of targeted assessment processes to determine young people's risk of reoffending, and comprehensive case planning, monitoring and review practices that deliver an integrated response to issues contributing to young peoples' reoffending behaviour.
- This new approach to case management is supported by the introduction of an expanded suite of Youth Offending Programs that have been redesigned and strengthened to target offending behaviour.
- The department is working closely with the Department of Education and Training to strengthen the delivery of education services to young people in custody.
- The department is working on enhancing the structured day in custody, and has engaged Youth Engagement Officers responsible for planning and timetabling structured day activities in custodial units and for ensuring young people have access to the variety of programs necessary to meet their individual needs.

1247. DJSC also described the 'whole-of-government' approach to crime prevention currently being developed that aims to:

> unify existing efforts across relevant portfolios and identify opportunities for improvement, collaboration and innovation. It will focus on prevention, early intervention and diversion, particularly with regards to overrepresented and vulnerable groups.
>
> ...
>
> A Youth Justice Strategy is also under development and will reflect the varied backgrounds and needs of children and young people in Youth Justice who are likely to exhibit multiple, overlapping vulnerabilities and complexities. It will have a strong focus on strengthened access, referrals and engagement with education and training, employment, housing and health and wellbeing support (including mental health, alcohol and drug, disability, Child Protection and family services).
>
> The Youth Justice Strategy will sit alongside the Aboriginal Youth Justice Strategy, which will continue to progress under the fourth phase of the Aboriginal Justice Agreement. The Aboriginal Youth Justice Strategy will have a particular focus on reducing Aboriginal overrepresentation in the Youth Justice system.
>
> The 2018-19 Budget provided $12.9 million for the Children's Court Youth Diversion Service.
>
> The 2019-20 Budget provided funding to continue the extension of the Youth Justice Community Support Service. This will fund extended service hours so that support can be provided to at-risk young people after-hours and on weekends.
>
> Two new evidence-based rehabilitation programs commenced in April 2019. Multi-Systemic Therapy and Family Functional Therapy work to improve family functioning, reduce substance abuse and address behavioural issues.

1248. As noted in Chapter Three, in relation to staffing challenges, DJCS advised:

> The Department has been actively implementing a targeted recruitment campaign attracting youth justice custodial workers to work in the two youth justice centres. As recommended in the Youth Justice Review, the department is working on a Youth Justice Workforce strategy, which will include strategies addressing recruitment, retention, and learning and development. Further work to address this issue is being driven by the Custodial Facilities Working Group which was established in April 2019. This Group comprises senior government and non-government youth justice experts and stakeholders who have been engaged to consider the key challenges facing the Youth Justice custodial system – including the workforce.

1249. The responses from the Victorian Government and relevant Departments to the various inquiries set out above describe some positive initiatives, particularly in relation to youth justice. However, it remains the case that this inspection, conducted in March and April 2019, observed that many of the issues identified in the Legal and Social Issues Committee's inquiry, the Ogloff-Armytage review and the Children's Commissioners report persist.

1250. Any future recommendations must be targeted and measurable.

Recommendations: Part Two

In addition to the recommendation made in Part One at paragraph 306, and in accordance with section 23(2) of the Ombudsman Act, the Ombudsman makes the following recommendations:

To the Victorian Government:

Recommendation 1

Recognising the significant harm caused by the practice, that it is not unreasonable for detaining authorities to provide meaningful human contact even when a person is isolated, and that separation and isolation do not invariably amount to 'solitary confinement', establish a legislative prohibition on 'solitary confinement', being the physical isolation of individuals for '22 or more hours a day without meaningful human contact.'

Recommendation 2

Recognising that young people until around 25 years are still developing and present a greater risk of irrational and volatile behaviour than the overall adult cohort, carry out a system-wide review of how young people are managed with a view to removing them from mainstream prisons to a dedicated facility.

Recommendation 3

Ensure that culturally supportive therapeutic spaces as an alternative to separation, isolation or seclusion rooms are established in prisons, youth justice centres and secure welfare services.

Recommendation 4

Take all necessary steps to address the following shortcomings of the legislative and regulatory framework applicable to separation:

- Neither the *Corrections Act 1986* (Vic) nor the *Corrections Regulations 2019* (Vic) prohibit the use of separation as a punishment.
- Prison staff are not required to regularly observe children, young people and other prisoners who are subject to separation.
- Prisons are not required to maintain a register of separations made under the *Corrections Regulations 2019* (Vic).
- Amendments to the *Corrections Regulations 2019* (Vic) introduced in April 2019 authorise separation 'for the management, good order or security of the prison', without the requirement that the separation not be longer than is necessary to achieve that purpose.

Recommendation 5

Recognising that new legislation for youth justice may be drafted, take all necessary steps to address the following shortcomings of the legislative and regulatory framework applicable to isolation and seclusion:

- The *Children Youth and Families Act 2005* (Vic) does not require that a child or young person's isolation or seclusion be terminated once the reason for isolation or seclusion ceases.
- A necessary element of isolation and seclusion under the *Children Youth and Families Act 2005* (Vic) is that the child or young person be placed 'in a locked room', which potentially excludes situations where a child or young person is kept on their own for extended periods in other areas of a facility, such as Malmsbury's Intensive Supervision Annexe and other areas of the Secure Welfare Services.
- The *Children Youth and Families Act 2005* (Vic) does not guarantee each child or young person a minimum period of fresh air per day.
- Staff are not required to inform children and young people of the reasons for isolation or seclusion.
- Children and young people who are isolated 'in the interests of the security of the centre' are not required to be observed at regular intervals.
- Isolations 'in the interests of the security of the centre' are not required to be recorded in the Isolation Register.
- Neither the Act nor the Regulations require proper consideration be given to the medical and psychiatric condition of a child or young person before isolating or secluding them.

Recommendation 6

Recognising that isolation under section 488(7) of the *Children Youth and Families Act 2005* (Vic) was intended to be used to maintain security in an emergency, and that it is now routinely used in response to staff shortage, take all necessary steps to enact a provision similar to that of section 58E of the *Corrections Act 1986* (Vic) allowing the Secretary to reduce the length of a sentence of imprisonment of a youth justice client on account of good behaviour while suffering disruption or deprivation, during an industrial dispute, emergency or in other circumstances.

To the Department of Justice and Community Safety (DJCS):

Recommendation 7

Ensure that principles and practices of trauma-informed behavioural management, including the impact on mental health, harmful effects of separation and isolation, and cultural awareness, are core elements in staff training across Corrections Victoria and Youth Justice, both to new staff and on an ongoing basis.

DJCS – Corrections Victoria:

Recommendation 8

Recognising the 'extreme anxiety suffered by Aboriginal prisoners committed to solitary confinement' as described in the *Royal Commission into Aboriginal Deaths in Custody*, ensure that detaining authorities are required to notify Aboriginal support workers of each instance of separation or isolation of Aboriginal or Torres Strait Islander peoples, and to give proper consideration to their cultural advice, including advice about relevant recent or upcoming sorry business and other sensitivities.

Recommendation 9

The Secretary should delegate her power under Regulation 32(7) of the *Corrections Regulations 2019* (Vic) to revoke a separation order at any time down to the same level of local prison officer authorised to order the separation of a prisoner.

Recommendation 10

Require each adult prison to establish and maintain a register of separations made under the *Corrections Regulations 2019* (Vic) including:

- the name of the person separated
- the time and date separation commenced
- the reason why the person was separated
- consideration of any risks to health and well-being
- the authorising officer's name and position
- the frequency of staff supervision and observation
- the time and date of release from separation
- whether the separated person identifies as Aboriginal or Torres Strait Islander, and if so whether an Aboriginal support officer was contacted upon separation.

Recommendation 11

Recognising that in other Victorian prisons people subject to an Intermediate Regime are eligible to receive up to six hours of out-of-cell time per day, and noting that the Intermediate Regime at Port Phillip is largely indistinguishable from a separation regime, amend policy and practice to increase the out-of-cell time on an Intermediate Regime.

Recommendation 12

Recognising the impact separating people in mainstream units at Port Phillip has on those people, others in the unit and staff, develop as a priority a strategy to reduce to zero the number of people separated in mainstream units.

Recommendation 13

Pursuant to section 41(c) of the *Charter of Human Rights and Responsibilities Act 2006* (Vic), request the Victorian Equal Opportunity and Human Rights Commission review Corrections Victoria's Management Regimes, Intermediate Regimes and other Violence Reduction Strategies, to determine their compatibility with human rights, and with a particular view to address the material conditions of Management Units (including run-out spaces) and measures to alleviate the potential detrimental effects that being accommodated in those units would have, especially for vulnerable people, including young people and those with disability or mental illness.

Recommendation 14

Amend policy and practice and immediately cease the routine use of restraints without a contemporaneous risk assessment.

Recommendation 15

Reconsider the detention conditions, namely isolation and observation, of people identified as being at risk of suicide or self-harm, particularly those on an 'S1' or 'S2' rating, with a view to ensure:

- active treatment and therapeutic interventions are provided
- staff record their consideration of whether to transfer a person to a designated mental health service pursuant to section 275 of the *Mental Health Act 2014* (Vic).

Recommendation 16

Remind staff of the importance, and requirement under the Corrections Regulations, for staff to give proper consideration to the medical and psychiatric condition of a person before separating them, and adequately record that assessment. For Aboriginal and Torres Strait Islander prisoners, this should include consideration of social and emotional wellbeing.

Recommendation 17

Ensure that before disciplinary sanctions are imposed, including issuing a separation order, proper consideration is given as to whether and how a prisoner's mental illness or disability may have contributed to their conduct, and that assessment is adequately recorded.

DJCS – Youth Justice:

Recommendation 18

Ensure Isolation Registers record whether an Aboriginal support officer was contacted upon isolation.

Recommendation 19

Amend policy and practice and ensure that the routine use of restraints without a contemporaneous risk assessment cease immediately.

Recommendation 20

Remind staff and ensure that behavioural isolations under section 488(2) of the *Children Youth and Families Act 2005* (Vic) are only authorised where all other reasonable steps had been taken and the relevant behaviour presents 'an immediate threat'. Details of the steps taken before resorting to isolation and assessment of the immediate threat should be adequately recorded in the Isolation Register.

Recommendation 21

Implement as a priority its plan to reduce to zero the number of lockdowns and rotations due to staff shortage at Malmsbury.

To the Department of Health and Human Services (DHHS):

Recommendation 22

Recognising that Secure Welfare's therapeutic ethos is to some extent undermined by the material conditions of the Ascot Vale and Maribyrnong facilities, the Department should consider options for replacing the facilities with a purpose-built facility.

DHHS – Secure Welfare Services:

Recommendation 23

The General Manager should remind staff and ensure that the prescribed particulars for all instances of seclusion are accurately recorded in the Seclusion Register as required by the *Children, Youth and Families Regulations 2017* (Vic).

Recommendation 24

The seclusion rooms at Ascot Vale and Maribyrnong should be replaced with dedicated therapeutic spaces. However, if they are to remain in use, the General Manager with assistance from the Department, should ensure they meet the relevant human rights standards and are, at a minimum, fitted with a toilet and washbasin.

Recommendation 25

The General Manager should, as a priority, improve the arrangements for children and young people to access the telephone at the Secure Welfare Services, including being able to privately make calls, including complaints.

Recommendation 26

The General Manager should ensure that outstanding maintenance repairs and necessary refurbishments are completed as soon as possible.

Responses to recommendations:

Department of Health and Human Services

On 26 August 2019, the Secretary of the Department of Health and Human Services advised that she accepts in full or accepts in principle each recommendation in Part Two of this report that relates to her department.

Recommendation 1

Accepted, where this recommendation relates to Secure Welfare Services.

Recommendation 3

Accepted in principle, where this recommendation relates to Secure Welfare Services.

Recommendation 5

Accepted [as it relates to Secure Welfare Services].

Recommendation 22

Accepted in principle.

Recommendation 23

Accepted.

Recommendation 24

Accepted in principle.

Recommendation 25

Accepted.

Recommendation 26

Accepted.

Department of Justice and Community Safety

On 30 August 2019, the Secretary of the Department of Justice and Community Safety advised that she accepts in full or accepts in principle each recommendation in Part Two of this report directed to her department. The Secretary's full response is set out on the following pages.

The Ombudsman looks forward to the Victorian Government's response to the recommendation in Part One, and recommendations 1 to 6 in Part Two of this report.

In accordance with section 25(2) of the Ombudsman Act, the Ombudsman will report to Parliament on the acceptance and implementation of her recommendations in due course.

Department of Justice and Community Safety

Secretary

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Our ref: CD/19/654945

Ms Deborah Glass
Victorian Ombudsman
Level 2, 570 Bourke Street
MELBOURNE VIC 3000

Dear Ms Glass

Thank you for your letter of 13 August 2019, in which you enclosed a copy of your draft report of your own motion investigation about practices which may lead to the 'solitary confinement' of children or young people in Victoria, and also for your email of 28 August 2019, in which you provided me with your final recommendations.

The findings of your report provide a basis for my department to continue the important reform work already underway. I am pleased to accept all of the recommendations directed toward the Department of Justice and Community Safety in Part Two of your report, with the exception of recommendations 12 and 14 which are accepted in principle to enable further consideration.

I note that the remaining recommendations are matters for the Victorian Government or other departments to consider. However, with regards to Recommendation 1 in Part One of your report, I can advise that the government is working through options for which body or bodies will fulfil Victoria's National Preventative Mechanism and inspection roles in relation to its ongoing obligations under OPCAT.

For Youth Justice, action is already underway to implement a number of the recommendations, including the development of a comprehensive Workforce Strategy to address recruitment and training needs, introduction of an Intensive Intervention Unit for complex young people, and re-establishing risk-based assessments for the use of mechanical restraints.

In addition, specific fields will be included in the isolation register to ensure that appropriate cultural support is provided, and that staff undertake necessary assessments of a young person's behaviour, before isolation is authorised. Other recommendations that go to legislative change will be considered as part of the development of the Youth Justice Act.

This work complements significant reforms recently implemented, including revised training guidelines and procedures for custodial staff on the use of isolation, daily audits to ensure compliance with legislation and operating procedures, and introduction of the Classification and Placement Unit, designed to determine the best placement option for young people in custody based on their assessed risk.

In the adult system, this includes a more sophisticated system to track state-wide separations in prisons, a system flag to identify young people in prisons, as well as system-wide strengthening of the consideration of needs of young people in adult custody.

Among a range of other initiatives, Corrections Victoria has also commenced discussions with Correctional Service Canada to provide advice on strategies undertaken in that jurisdiction to reduce the incidence of administrative segregation and the average length of stay in such separation. These discussions will inform consideration and advice about the efficacy of proposed designs for management units at the new Chisholm Road prison and the Dame Phyllis Frost Centre.

While I acknowledge the work that is already underway across Corrections and Youth Justice, I also acknowledge that we have further work ahead of us to ensure our most restrictive interventions such as restraint and isolation are used strictly in accordance with legislation and policy, used as a last resort, and used in such a way to limit the potential negative impact on the young people in our care.

Yours sincerely

Rebecca Falkingham
Secretary

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