Submission No 49

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Organisation: Anglican Community Services (trading as Anglicare)

Date Received: 26 November 2021

25 November 2021

BY EMAIL

The Hon Adam Searle MLC
Chair, Select Committee on the Coronial Jurisdiction in New South Wales
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Mr Searle

Submission No. 7 to the Select Committee on the Coronial Jurisdiction in New South Wales

I refer to the submission provided to the Select Committee on the Coronial Jurisdiction in New South Wales (**Committee**) by Associate Professor Laura Grenfell, Associate Professor Julie Debeljak and Dr Anita Mackay dated 25 June 2021 which has been published on the Committee's website (**Submission No. 7**).

As you would be aware, Anglican Community Services (**Anglicare**), the approved provider of the Newmarch House residential aged care service (**Newmarch House**), is currently party to the Coronial Investigation into the death of Catherine Adam & Ors (Case Number 2020/192802), which relates to the investigation of the death of 19 residents at Newmarch House (**Newmarch House Coronial**). The Newmarch House Coronial is scheduled to commence in July 2022.

Anglicare has recently been made aware of Submission No. 7 and the draft academic article that accompanies it. Anglicare is concerned that Submission No. 7 and the draft article contain numerous factual assertions about the COVID-19 outbreak at Newmarch House in 2020 that are unreferenced by the authors and are disputed by Anglicare. Further, many of the issues raised in the draft article will be the subject of consideration by the Deputy State Coroner in the Newmarch House Coronial.

Anglicare acknowledges and supports the right of the authors of Submission No. 7 to engage in academic debate and does not seek to stifle discussion of the issues raised in the draft article. However, Anglicare is concerned that readers of the draft article may infer that the facts that are asserted about Newmarch House are true, when in fact those matters are unreferenced by the authors and are disputed by Anglicare.

Consequently, Anglicare requests that the Committee please consider this letter and accept it as a submission, even though the deadline for filing submissions has now closed.

Anglicare would be grateful for this letter, the comments appearing at **Annexure A** and the annotated version of the draft article appearing at **Annexure B** of this letter be uploaded to the Committee's website along with the other submissions received by the Committee.

Anglicare does not wish to make any further submissions with respect to the issues being considered by the Committee, other than to respond to Submission No. 7.

Yours sincerely

Grant Millard
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Annexure A

Submission filed by A/Prof Laura Grenfell, A/Prof Julie Debeljak and Dr Anita Mackay on 25 June 2021			
	Page	**Statement**	**Anglicare's response**
1.	1	'*For example, the residents who died in Newmarch potentially had their right to liberty violated and were also arguably kept in solitary confinement.*'	Anglicare disputes that the residents who died during the COVID-19 outbreak at Newmarch House in 2020 had their right to liberty violated and/or were kept in solitary confinement.
Draft article titled '*Human Rights Accountability and Redress for Systems of Ill-treatment in Residential Aged-Care*' by A/Prof Laura Grenfell, A/Prof Julie Debeljak and Dr Anita Mackay			
	Page	**Statement**	**Anglicare's response**
2.	1	'*This article uses Newmarch as an illustration of the system-wide failure to protect the human rights* [sic] *residents in RACS.*'	Anglicare disputes that it failed to protect the human rights of residents at Newmarch House.
3.	1	*'This is protection that they are legally entitled to under the OPCAT, and which the events of Newmarch demonstrate is woefully lacking.*'	Anglicare disputes that events at Newmarch House during the COVID-19 outbreak in 2020 demonstrate that protections under OPCAT are woefully lacking.
4.	2	'*Ultimately eighteen residents died onsite after receiving compromised medical care.*'	Anglicare disputes that the residents who died during the COVID-19 outbreak in 2020 at Newmarch House received compromised medical care and notes that this issue is the subject of the Newmarch House Coronial.
5.	2-3	'*Further, complaints are being taken to various health-care complaints bodies, and the federal regulator, the Aged Care Quality and Safety Commission (ACQSC), which did not investigate the circumstances of the Newmarch House outbreak in the weeks that followed.*'	Anglicare denies that the ACQSC did not investigate the circumstances of the Newmarch House outbreak and notes that this issue is the subject of the Newmarch House Coronial.
6.	11	'*This position is increasingly difficult to justify, given examples like Newmarch where residents were prevented from leaving, . . .*'	Anglicare disputes that the residents of Newmarch House were prevented from leaving during the COVID-19 outbreak in 2020 and notes that this issue is the subject of the Newmarch House Coronial.
7.	16	'*Indeed, as the Four Corners report revealed, COVID-19-positive residents were not quarantined within the facility from COVID-19-negative residents.*'	Anglicare denies that COVID-19 positive residents were not quarantined within Newmarch House from COVID-19 negative residents and notes that this issue is the subject of the Newmarch House Coronial.

	Page	Statement	Anglicare's response
8.	16-17	*'COVID-19 negative residents were not able to leave the facility, but were instead isolated in their rooms.'*	Anglicare disputes that COVID-19 negative residents were not able to leave the facility.
9.	17	'*COVID-19 positive residents were not transferred to alternative facilities for quarantine or treatment, but were instead isolated in their rooms within the facility.*'	Anglicare denies that no COVID-19 positive residents were transferred to alternative facilities for treatment, noting that two of the residents who died during the COVID-19 outbreak at Newmarch House in 2020 died at Nepean Hospital and that a number of other COVID-19 positive residents were transferred to hospital during the outbreak and recovered. Anglicare also notes that this issue is the subject of the Newmarch House Coronial.
10.	17	'*No residents were allowed visitors and personal contact with staff was limited.*'	Anglicare denies that no residents were allowed visitors during the outbreak at Newmarch House in 2020 and notes that this issue is the subject of the Newmarch House Coronial.
11.	17	'*Initially some family members could speak to residents by telephone while seeing them through windows (depending on a resident's location within the facility). This became impossible when Anglicare covered the perimeter fence around the RACS.*'	Anglicare denies that window visits ceased once a perimeter fence was erected around Newmarch House and notes that this issue is the subject of the Newmarch House Coronial.
12.	17	'*When COVID-19 positive residents became extremely ill due to COVID-19, they could not leave the facility to access medical treatment in hospital, even when requested by family members, with one exception.*'	Anglicare disputes that COVID-19 positive residents could not leave Newmarch House to access medical treatment in hospital. Anglicare denies that only one COVID-19 resident was transferred to hospital during the outbreak at Newmarch House. Anglicare also notes that this issue is the subject of the Newmarch House Coronial.
13.	17	'*The NSW Government ordered Newmarch to adopt a 'hospital in the home' (HITH) approach to care, despite Newmarch not having necessary hospital equipment or qualified medical staff.*'	Anglicare disputes that the NSW Government ordered Newmarch House to adopt the HITH program and notes that this issue is the subject of the Newmarch House Coronial.
14.	18	'*Eighteen COVID-19 positive residents subsequently died at Newmarch, with one additional resident dying in hospital.*'	Anglicare denies that 18 COVID-19 positive residents died at Newmarch House but admits that 17 COVID-19 positive residents died at Newmarch House, while two COVID-19 positive residents died at Nepean Hospital.

	Page	Statement	Anglicare's response
15.	20	*'Newmarch residents were deprived of their liberty, by Anglicare in accordance with the state/federal governments' response to the pandemic.'*	Anglicare disputes that Newmarch residents were deprived of their right to liberty.
16.	21	*'Moreover, the COVID-19-negative residents suffered particular neglect in care because they were denied the same level of medical care as those under the HITH [Hospital in the Home] regime.'*	Anglicare disputes that COVID-19 negative residents suffered particular neglect in care because they were denied the same level of care as those under the HITH regime.
17.	21-22	*'Further, COVID-19-negative residents were subjected to the same isolation regime as COVID-19-positive residents, even though there was scope for what Anglicare CEO calls [sic] 'earlier liberalisation', suggesting the detention was arbitrary'.*	Anglicare denies that residents were arbitrarily detained at Newmarch House during the COVID-19 outbreak in 2020.
18.	22	*'Furthermore, the COVID-19-negative residents were not properly quarantined from the COVID-19-positive residents: the Independent Review cited evidence of 'inconsistent use of PPE' and 'imperfect [infection prevention and control] practices',[114] which meant that attempts to quarantine the two groups failed.'*	Anglicare disputes that the COVID-19 negative residents were not properly quarantined from the COVID-19 positive residents and notes that this issue is the subject of the Newmarch House Coronial.
19.	22	*'Accordingly, investigative mechanisms must consider the legal basis of the federal-state orders/regulations which prevented COVID-19 positive residents from leaving Newmarch and seeking medical care at properly equipped hospitals, . . .'*	Anglicare disputes that COVID-19 positive residents were prevented from leaving Newmarch House to receive medical care in hospital during the outbreak in 2020 and notes that this issue is the subject of the Newmarch House Coronial.
20.	23	*'The fact that Newmarch residents were deprived of their liberty by Anglicare, a non-state actor, does not absolve the federal government of its obligations under international law.[128]'*	Anglicare denies that the residents of Newmarch House were denied their right to liberty during the outbreak in 2020.

	Page	Statement	Anglicare's response
21.	25	'. . . *the Newmarch isolation should have been, first, based on an independent medical evaluation, evidence of which Anglicare ought provide*.'	Anglicare disputes that the decision to cohort residents and isolate them in their rooms during the outbreak at Newmarch House in 2020 was not based on medical advice. Anglicare confirms that it has provided evidence to the Deputy State Coroner about these decisions, and others, and notes that this issue is the subject of the Newmarch House Coronial.
22.	36	'*The NSW coronial inquest into the Newmarch deaths is a welcome opportunity for uncovering systems-level failure and future prevention measures. One preliminary question is whether the Newmarch deaths can be considered 'deaths in custody'*.'	Anglicare denies that the Deputy State Coroner is considering whether the deaths at Newmarch House were 'deaths in custody'.

Annexure B

Submission No. 7 containing Anglicare comments

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Submission No 7

INQUIRY INTO CORONIAL JURISDICTION IN NEW SOUTH WALES

Name: Associate Professor Laura Grenfell, Associate Professor Julie Debeljak, and Dr Anita Mackay

Date Received: 25 June 2021

Submitted via online form

Friday 25 June 2021

Dear The Hon. Adam Searle MLC
Chair, Select Committee on the Coronial Jurisdiction in New South Wales

Submission

We are pleased to have the opportunity to make a submission on your Committee's inquiry into the coronial jurisdiction in New South Wales (NSW). Our submission focuses on the following terms of reference:

> (a) the law, practice and operation of the Coroner's Court of NSW, including:
> (i) the scope and limits of its jurisdiction. [...]
> (iv) the outcomes of recommendations made, including the mechanisms for oversighting whether recommendations are implemented [...]
>
> (b) whether, having regard to coronial law, practice and operation in other Australian and relevant overseas jurisdictions, any changes to the coronial jurisdiction in New South Wales are desirable or necessary.

We have been conducting research into the treatment of residents at the Newmarch residential aged care service in Sydney during the COVID-19 outbreak in April-May 2020. Our research included detailed consideration to the upcoming inquest into the deaths of residents at Newmarch.

This research is likely to be of use to the Committee's inquiry for three reasons.

The first is that coronial inquests into deaths of residents in aged care facilities is under-developed and we recommend the Committee consider the importance of the coronial jurisdiction in this area. We have argued that there are sufficient grounds for the deaths in Newmarch to be considered 'deaths in custody' under s 23(1)(a) of the *Coroners Act 2009* (NSW), which would be a new approach. Moreover, we have identified the need to extend s 24 of the *Coroners Act 2009* (NSW), which currently applies to the death of a child or a disabled person, to an equally deserving vulnerable group – being residents in aged care facilities. Further, we argue in favour of adding 'deaths in care' to the list of reportable deaths in Division 1 of Part 3.2 or (preferably) as a new category of exclusive jurisdiction under Division 2 of Part 3.2 of the *Coroners Act 2009* (NSW).

The second is that our research has broader implications for the coronial jurisdiction because we argue that the human rights of the deceased person should be a central consideration. For example, the residents who died in Newmarch potentially had their right to liberty violated and were also arguably kept in solitary confinement. Under s 82 of the *Coroners Act 2009* (NSW), coroners already have a wide discretion regarding the focus of inquiries and recommendations, which we argue is sufficiently wide to include human rights considerations. Any amendments to the coroner's legislation could make the consideration of human rights an explicit consideration. Our research builds on the work of others who have

Anglicare disputes that the residents who died during the COVID-19 outbreak at Newmarch House in 2020 had their right to liberty violated and/or were kept in solitary confinement.

argued that human rights add significant value to the coronial jurisdiction (see, for example, Ian Freckelton and Simon McGregor, 'Coronial Law and Practice: A Human Rights Perspective' (2014) 21 *Journal of Law and Medicine* 584).

The third reason – which bridges both inquests into deaths in residential aged care and making human-rights a central consideration in inquests – is that Victoria provides a useful comparator for NSW reform due to the intersection between the *Coroners Act 2008* (Vic) and the *Charter of Human Rights and Responsibilities Act* 2006 (Vic). Although the adoption of human rights legislation in NSW is beyond the remit of your committee, there are other elements of the *Coroners Act 2008* (Vic) worthy of consideration. NSW should consider amending the *Coroners Act 2009* (NSW) along the lines of the Victorian legislative stipulation that recommendations may be made to 'any entity on any matter connected with a death' (s 72(2)), and that recommendations must be responded to in writing within 3 months (ss 72(3) and (4)). This would ensure that recommendations can be directed at residential aged care providers, as well as improving the response to coronial inquest recommendations more broadly.

All of these matters are discussed in detail in Part VI of the attached article, which is an advance version of an article that will be published in the *Monash University Law Review* in 2022 (see pages 33 - 42).

Yours faithfully

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This is a draft of an article that has been accepted for publication in Volume 47 of the *Monash University Law Review*. The post-refereed and fully-edited final and citable version of the article is forthcoming, and expected in 2022.

Human Rights Accountability and Redress for Systems of Ill-treatment in Residential Aged-Care

Laura Grenfell,* Anita Mackay,** Julie Debeljak***

ABSTRACT

Australia's handling of the COVID-19 pandemic in 2020 will require significant reflection, scrutiny and systems-based reform because there were avoidable deaths, particularly in residential aged-care services ('RACS'). The deaths in Newmarch House in Sydney in April-May 2020 made it the first RACS subjected to scrutiny by the media (an ABC investigation), and the Royal Commission into Aged Care Quality and Safety's COVID-19 focused hearings and report. It will also be the subject of a coronial inquest in 2021. This article uses Newmarch as an illustration of the system-wide failure to protect the human rights residents in RACS. It is argued that the current system of monitoring by the Aged Care Quality and Safety Commission is deficient and that reactive mechanisms, including Royal Commissions and inquests, have significant limitations. Australia should therefore follow in the steps of New Zealand and extend the Optional Protocol to the Convention Against Torture ('OPCAT') monitoring regime to RACS. This would provide residents of RACS deprived of their liberty with the same preventive protections afforded by the OPCAT to all Australians deprived of liberty. This is protection that they are legally entitled to under the OPCAT, and which the events of Newmarch demonstrate is woefully lacking.

Anglicare disputes that it failed to protect the human rights of residents at Newmarch House.

Anglicare disputes that events at Newmarch House during the COVID-19 outbreak in 2020 demonstrate that protections under OPCAT are woefully lacking.

KEY WORDS

human rights, aged care, OPCAT, Covid-19, Aged Care Quality and Safety Commission, Royal Commission into Aged Care Quality and Safety, coronial inquest

I INTRODUCTION

In Australia, deaths in residential aged-care services ('RACS') are treated as predictable, expected and explicable. Such deaths do not often trigger external and independent investigation and accountability processes, although deaths in similar settings of deprivation of liberty do. Despite the clear evidence that many RACS residents are prevented from leaving their facility, either via formal state-based orders,[1] by environmental constraints such as heavy doors or locked doors with keypads, or physical constraints such lack of mobility due to ill-health, the federal government has refused to accept that RACS can be places of detention.[2]

* Associate Professor, Adelaide Law School, The University of Adelaide. The authors are grateful for the research assistance of Jacqueline Giuffrida, funded by a La Trobe University *Transforming Human Societies Collaboration Grant*. The authors also acknowledge the ongoing leadership provided by Steven Caruana, coordinator of the Australia OPCAT Network.
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[1] See, eg, *Guardianship and Administration Act 1993* (SA) s 32 which provides for 'detention' orders for those under guardianship powers.

[2] Senate Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, *Supplementary Budget Estimates 2019-20* (Attorney General's Department) (LCC-SBE19-141-OPCAT-National Preventive Mechanism, 4 November 2019) in response to question asked by Senator Nick McKim the government stated:

This is a draft of an article that has been accepted for publication in Volume 47 of the *Monash University Law Review*. The post-refereed and fully-edited final and citable version of the article is forthcoming, and expected in 2022.

Denying 'detention' status to RACS means fewer external and independent oversight mechanisms are triggered. As Mitchell observes, 'deaths in RACS are not subject of the same level of accountability as other deaths in care'.[3] As with all persons being cared for in closed environments which are out of public sight, there are increased risks that detainees will be subject to human rights abuses. This is what the monitoring mechanisms under the *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* ('OPCAT')[4] are designed to address. Denying 'detention' status under OPCAT for some closed environments, such as RACS, is a missed opportunity to ameliorate the increased risk that residents of RACS will be subjected to such ill-treatment, or their right to life deprived, through independent investigation and external oversight. Given the similarity of the high risk with other places of detention, the lower level of accountability in RACS is not acceptable.

There is consensus that places of detention are at higher risk of an outbreak of an infectious disease, such as COVID-19, and that persons over 70-years old are at great risk of infection. Globally, the COVID-19 pandemic is having 'a disproportionate impact on older persons and has magnified existing violations of their rights'.[5] However, the pandemic has brought into focus the treatment of residents of RACS. For example, despite the lack of direct access to RACS, the media have spoken with families of residents and workers within residences, uncovering what could be characterised as violations of human rights, such as arbitrary deprivation of liberty and cruel, inhuman and degrading treatment.

In particular, the *ABC* Four Corners report into the treatment of residents at Sydney's Anglicare Newmarch House in April and May 2020 has raised many concerns that may constitute human rights violations.[6] Ultimately eighteen residents died onsite after receiving compromised medical care. Sadly, similar scenarios have occurred at other RACS. Accountability for this is being sought. Government accountability is the primary focus, at both federal and state levels: the *Aged Care Act 1997* (Cth) sits within the Commonwealth Department of Health, while states and territories shoulder responsibility for health generally and the operation of government-run RACS. Moreover, class actions against individuals RACs have reportedly been launched.[7] Further, complaints are being taken to various health-care complaints bodies,

Anglicare disputes that the residents who died during the COVID-19 outbreak in 2020 at Newmarch House received compromised medical care and notes that this issue is the subject of the Newmarch House Coronial.

Anglicare denies that the ACQSC did not investigate the circumstances of the Newmarch House outbreak and notes that this issue is the subject of the Newmarch House Coronial.

'aged care facilities do not fit within the concept of "places of detention" as set out in Article 4 of OPCAT and there is presently no proposal to include them in any list of primary places of detention'.

[3] Bill Mitchell, 'Identifying Institutional Elder Abuse in Australia through Coronial and Other Death Review Processes' (2018) 18 *Macquarie Law Journal* 35, 44.

[4] *Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 18 December 2002, 2375 UNTS 237 (entered into force 22 June 2006) ('*OPCAT*').

[5] Claudia Mahler, 'Older persons remain chronically invisible despite pandemic spotlight, says UN expert', *United Nations Human Rights Office of the High Commissioner* (News and Events, 1 October 2020) <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=26319&LangID=E>.

[6] 'Like the Plague', *Four Corners* (Australian Broadcasting Corporation, 22 June 2020).

[7] Sarah Curnow and Pat McGrath, 'Senior doctor says aged care still faces surge workforce shortage, as class action launched against Epping Gardens', *ABC News* (online), 19 August 2020 <http://www.abc net.au/news/2020-08-19/coronavirus-doctor-says-aged-care-surge-workforce-shortage/12569444>; Tony Zhang, 'Victorian aged care home hit with class action', *Lawyers Weekly* (Web Page,18 August 2020) <https://www.lawyersweekly.com.au/biglaw/29223-victorian-aged-care-home-hit-with-class-action>.

and the federal regulator, the Aged Care Quality and Safety Commission (ACQSC), which did not investigate the circumstances of the Newmarch House outbreak in the weeks that followed.[8]

In addition, two systems-level investigations have been initiated: the Royal Commission into Aged Care Quality and Safety (RCAC) has included hearings on the events at Newmarch, and the NSW Coroner has announced a coronial inquest into Newmarch.[9] Both of these investigative mechanisms may take a systems-level approach in their investigations, in formulating their recommendations, and securing accountability. Moreover, these mechanisms are independent from government and individual operators, and their lens includes the public interest. Further, both mechanisms have discretion to consider human rights and to make systems-level recommendations based on human rights standards. Furthermore, although both mechanisms are reactive in nature, their recommendations serve the important function of identifying prevention opportunities, so that human rights violations are not repeated in the future.

Prevention opportunities at the systems-level are crucial. Reactive, *ex-post facto* inquiry/investigative mechanisms, such as royal commissions and coronial investigations, may provide forward-looking prevention opportunities, but only after the cost of human rights violations. However, there are mechanisms designed to be *ex-ante*, proactive and prevention-focussed, such as the monitoring regime established by OPCAT, which Australia ratified in 2017. OPCAT monitoring focuses specifically on *preventing* torture, and cruel, inhuman and degrading treatment and punishment ('CIDTP'), as prohibited by numerous treaties which Australia has voluntarily ratified, including the *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* 1984 ('CAT').[10] Thus, OPCAT offers an independent system-level solution to proactively *prevent* ill-treatment in our aged-care facilities, which can operate in tandem with existing *reaction*-based inquiry and investigative mechanisms – if only RACS were included in the Australia-wide monitoring system currently being designed as part of the implementation of Australia's obligations under the CAT and OPCAT. As in all closed environments, rethinking systems to *prevent* human rights-denying treatment from occurring in the first place is preferable to *reacting* to the tragic consequences of such treatment, including premature and preventable deaths.

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[8] See Julie Power, 'Toothless: Staff at Aged Care Regulator claim they lack resources and power', 21 August 2020, *Sydney Morning Herald* (online), 21 August 2020 <https://www.smh.com.au/national/toothless-staff-at-aged-care-regulator-claim-they-lack-resources-and-power-20200819-p55nay.html>.

[9] The inquest was announced in June. Jenny Noyes, 'NSW Coroner will investigate Newmarch House deaths' *Sydney Morning Herald* (online), 3 June 2020 <https://www.smh.com.au/national/newmarch-families-want-inquiry-after-residents-cleared-of-covid-19-20200602-p54ynt html>. The other review mechanisms that will not be canvassed in the article are a government review and a Senate Committee inquiry: Senate Select Committee on COVID-19, Parliament of Australia, *Australian Government's response to the COVID-19 pandemic* (2020) <https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;db=COMMITTEES;id=committees%2Fcommsen%2Ff822c395-516a-4acb-92d3-5a5842292157%2F0001;query=Id%3A%22committees%2Fcommsen%2Ff822c395-516a-4acb-92d3-5a5842292157%2F0000%22>.

[10] *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, opened for signature 10 December 1984, 1465 UNTS 85 (entered into force 26 June 1987) ('*CAT*'); Article 1 of the OPCAT stipulates, 'The objective of the present Protocol is to establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment': *OPCAT* (n 4).

This article considers the treatment of residents at Newmarch House as an example of systems-level failure involving the entire RACS system, and it considers forms of accountability and redress. In particular, it analyses of some of the human rights concerns relating to the treatment of the Newmarch residents, and examines the systems-level investigations in response. Part II examines the rights context of residential aged-care in Australia. It explains how the federal government, through its Charter of Aged Care Rights and its Standards for RACS, is committed to a rights-framework which focusses on residents as 'consumers'. Both the Charter and the Standards use the language of 'dignity and respect', language which draws on international human rights principles and discourse.[11] It also explores how the federal regulator, the ACQSC, monitors compliance with these Standards, uncovering an approach which demonstrates little alignment with this rights-framework.

Part III analyses how New Zealand ('NZ') has complemented such regulatory monitoring with an independent, human rights-focussed approach to monitoring RACS. In NZ, OPCAT monitoring of RACS as places of detention began during COVID-19 in March and April 2020. Its August 2020 report provides guidance for Australia in bolstering its monitoring via a human rights-based approach to improving conditions in RACS.

Part IV scrutinises the treatment of residents at Newmarch against some of Australia's international human rights obligations. This Part focuses on the right not to be unlawfully and arbitrarily deprived of liberty by non-state institutions, and the standards which protect against the imposition of conditions that amount to solitary confinement which, in turn, protects against CIDTP.

Focus then turns to the mechanisms investigating Newmarch, namely the RCAC and the NSW Coroner. Part V analyses the RCAC's Interim Report and, in particular, the extent to which the RCAC's special hearings and report into Newmarch considered the human rights aspects of the treatment of residents. Part VI considers the forthcoming coronial investigation into the treatment and deaths of Newmarch residents, and whether human rights are likely to form part of the NSW Coroner's investigation and recommendations. When such investigative mechanisms perform their role in seeking system-level accountability and harm-prevention-based reform opportunities, they should methodically consider and apply human rights standards. This is particularly the case when investigating the residential aged-care sector, which has outwardly embraced a rights-framework by introducing rights-based Charters and Standards, and whose individual RACS can and do function as places of detention. Currently, such investigative mechanisms use human rights standards in an ad hoc fashion – whether human rights are considered and, if so, the depth of such consideration depends on the terms of reference (for Royal Commissions), the predisposition to human rights analysis of the commissioners and coroners (and their personnel), and the submissions received during their inquiry or investigation.[12] These investigative mechanisms are encouraged to formally embrace and embed human rights standards within their work.

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[11] See *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948) preamble [1], [5], art 1 (*UDHR*); *International Covenant on Civil and Political Rights*, opened for signature 16 December 1996, 999 UNTS 171 (entered into force 23 March 1976) preamble [1]-[2], art 10(1) (*ICCPR*); *International Covenant on Economic, Social and Cultural Rights,* opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) preamble [1]-[2], art 13 (*ICESCR*).

[12] This is unfortunately the case even in sub-national jurisdictions with human rights legislation (the ACT, Victoria, and Queensland), which impose an obligation on public authorities to act and decide compatibly with

Ultimately, the inadequacies in independent monitoring and investigations of places of detention for older Australians – namely, RACS – is highlighted by way of comparison to NZ's independent OPCAT monitoring. Specifically, the relevant inadequacies are the lack of *proactive* and *preventive* monitoring, and the absence of human rights as the focal point and yardstick for evaluating the treatment of persons who are out of public sight and deprived of their liberty. Accordingly, Australia should apply OPCAT monitoring to its RACS.

II RACS, ACQSC, AND MONITORING

The regulatory framework within in which RACS operate in Australia must be canvassed. Although the federal government has placed RACS within a rights-framework, the monitoring of RACS by the federal regulator has not been adequately aligned with a rights-framework.

A *Residential Aged-care*

Australia has just under 2650 RACS, operated by approximately 870 approved providers, which serve roughly a quarter of a million people.[13] The vast proportion of these RACS are privately run. By the age of 80, it is estimated that one in five older Australians will be living in RACS.[14]

In 2019, the federal government introduced a new set of Aged Care Quality Standards ('Standards') and a single Charter of Aged Care Rights ('Charter'), which came into effect in mid-2019.[15] These reforms were in part driven by the Oakden Inquiries. In 2017-2018, multiple aged-care inquiries were held into the abuse and neglect at the Oakden Older Persons Mental Health Service ('Oakden'), finding that federal and state regulatory mechanisms failed to protect residents from what can be characterised as human rights violations, particularly regarding the excessive, unnecessary and often unlawful use of restrictive practices which deprived residents of their dignity.[16]

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human rights: See *Human Rights Act 2004* (ACT) ss 40B-C ('*ACT HRA*'); *Charter of Human Rights and Responsibilities Act 2006* (Vic) ss 38-9 ('*Charter*'); *Human Rights Act 2019* (Qld) ss 58-9 ('*Qld HRA*').

[13] See the statistics relating to permanent, flexible and respite residential care in Australian Government, Department of Health (Cth), *2018-2019 Report on the Operation of the Aged Care Act 1997*, (Report, 2019) 44, 84.

[14] Michelle Brown, 'Aged Care Royal Commission hears number of Quality checks on Aged Homecare Providers has declined', *ABC News* (online, 2 September 2020) quoting Royal Commission into Aged Care Quality and Safety ('*RCAC*') Senior Counsel Assisting Peter Gray QC <https://www.abc net.au/news/2020-09-02/aged-care-royal-commission-hears-quality-checks-have-declined/12621568>.

[15] The Hon Ken Wyatt MP, 'Australia Signs Up for New Era of Aged Care Rights' (Media Release, Aged Care Quality and Safety Commission, 23 March 2019) <https://www.agedcarequality.gov.au/news-media/ministerial-media-release-australia-signs-new-era-aged-care-rights>; The former replaced four previous charters that covered various forms of aged care but under the new Charter, aged care providers had to provide each of their residents and care recipients a copy. The Charter is scheduled to the *User Rights Principles 2014* (Cth).

[16] A Groves et al, *The Oakden Report*, (2017) 97, 105-114; Kate Carnell and Ron Paterson, *Review of National Aged Care Quality Regulatory Processes* (October 2017) 105-106 (*Carnell-Paterson Review*). The fact that multiple inquiries were necessary indicates that there is an ongoing 'systems abuse' problem in our RACS. The sector is subject to limited scrutiny and accountability, and efforts by various actors to boost this scrutiny have suffered pushback. For example, the sector receives government subsidies of approximately $20bn annually. Legislative efforts to bring greater transparency to the financial side of this sector were thwarted in February 2020 when the Coalition, alongside Senator Hanson, voted down a Bill which would have required aged care providers to set out how they allocate taxpayer funding in terms of patient care. Currently there are no requirements for a set proportion of these subsidies to be spent on patient care or a set number of qualified staff: See Ben Butler and Melissa Davey, 'Millions for Aged Care investors, but homes lack nurses: where does

The new Charter amalgamates four previous charters and 'underpins' the Standards.[17] It comprises '14 protections'[18] for 'consumers' and 'users' of RACS. This includes a number of rights that directly align with Australia's treaty obligations, as shown in Table 1.

Table 1: Comparison of Charter of Aged Care Rights and Treaty Obligations

Charter (expressed as 'I have the right to…')	Treaty Obligations
1. safe and high-quality care and services	Art 6(1) *International Covenant on Civil and Political Rights* (ICCPR): 'Every human being has the inherent right to life'.[19] Art 9(1) ICCPR: 'Everyone has the right to … security of person'. Art 12(1) *International Covenant on Economic, Social and Cultural Rights* (ICESCR): 'The States Parties … recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.
2. be treated with dignity and respect	Art 10(1) ICCPR: 'All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person'. Preambles to ICESCR, ICCPR and CAT: 'Considering …recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world. Recognizing that these rights derive from the inherent dignity of the human person…' Preamble (25) *Covenant on the Rights of Persons with Disabilities* (CRPD): 'Convinced that a comprehensive and integral international convention to promote and protect the rights and dignity of persons with disabilities will make a significant contribution to redressing the profound social disadvantage of persons with disabilities and promote their participation in the civil, political, economic, social and cultural spheres with equal opportunities'.

$13bn in federal funding go?', *The Guardian* (online), 5 September 2020 <https://www.theguardian.com/australia-news/2020/sep/05/millions-for-aged-care-investors-but-homes-lack-nurses-where-does-13bn-in-federal-funding-go?CMP=Share_iOSApp_Other>.

[17] The Standards themselves are framed as 'consumer outcomes', for example, "I am treated with dignity and respect… I can make informed choices about my care and services and live the life I choose". This is then followed up with the 'Requirements' on RACS as 'organisations": (1)(3) The organisation demonstrates the following: (a) Each consumer is treated with dignity and respect ... (c) each consumer is supported to exercise choice and independence, including to make decision about their own care… .' The Standards are scheduled to the *Quality of Care Principles 2014* (Cth).

[18] Aged Care Quality and Safety Commission, 'Charter of Aged Care Rights', *Charter of Aged Care Rights Template for Signing*' (Web Page, 20 January 2020) <https://www.agedcarequality.gov.au/resources/charter-aged-care-rights-templates>.

[19] The prohibition of torture, and cruel, inhuman or degrading treatment under art 7 of the *ICCPR* may, on occasion, also be relevant here. For the purposes of this table, we have listed this right against the Charter protection to live without abuse or neglect.

4. live without abuse and neglect	Art 2(1) CAT: 'Each State Party shall … prevent acts of torture in any territory under its jurisdiction'. Art 16(1) CAT: 'Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment …' Art 6 ICCPR: (above) Art 7 ICCPR: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. In particular, no one shall be subjected without his free consent to medical or scientific experimentation'. Art 9(1) ICCPR (above). Art 15 CRPD: '(1) No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment….(2) States Parties shall … prevent persons with disabilities, on an equal basis with others, from being subjected to torture or cruel, inhuman or degrading treatment or punishment.' Art 11(1) ICESCR: 'The States Parties … recognize the right of everyone to an adequate standard of living for himself and his family, including adequate food, clothing and housing, and to the continuous improvement of living conditions….'
7. have control over and make choices about my care, and personal and social life, including where the choices involve personal risk; 8. have control over, and make decisions about, the personal aspects of my daily life, financial affairs and possessions;	Art 3(a) CRPD: 'The principles of the present Convention shall be: (a) Respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons.' Art 17(1) ICCPR: 'No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence…'.

It is expected that every RACS provider will ensure consumers have access to, and knowledge of, this Charter and an opportunity to 'co-sign it' with the provider.[20]

These reforms demonstrate the federal government's ongoing commitment to using a rights-framework for RACS, which focusses on residents as having 'user/consumer rights' in addition to their contractual rights. By employing the language of 'dignity and respect', the Standards and Charter reflect human rights principles and standards, but without formally incorporating the relevant international human rights obligations or providing for their enforceability.[21] While RACS operators must invite consumers to sign the Charter, it is a symbolic gesture

[20] This is a response to the Carnell-Paterson Report on Oakden, which highlighted that awareness of such consumer rights is 'low' among both providers and the public: *Carnell-Paterson Review* (n 16) ppviii, 105.
[21] Carnell and Paterson point out that unlike England and Ontario, Canada, Australia does not have specific laws and powers to protect consumers from neglect and abuse in the RACS context: *Carnell-Paterson Review* (n 16) 55.

because consumers have no means of enforcing operator/provider compliance with these rights. Enforcement of compliance is left to the federal regulator, the ACQSC.

In early 2019, the ACQSC was established as an all-in-one regulatory body, also largely because of the Oakden Inquiries. The Bill to establish the ACQSC was introduced into Parliament days before the RCAC was announced. According to the Federal Minister for Aged Care, '[t]he introduction of this Commission is … a direct response to the findings and recommendations of *Review of national aged care regulatory processes* undertaken by Kate Carnell and Ron Paterson', which focussed on Oakden.[22] Carnell and Paterson characterised Oakden as 'a sentinel case' that 'highlights areas for improvement in the regulatory system'.[23] One finding was that the disparate federal bodies for accreditation, compliance and complaints-handling failed to communicate with each other,[24] and were thus ineffective in preventing and identifying the 'abuse and neglect of basic human rights' at Oakden.[25]

One aspect of the ineffective monitoring which failed Oakden residents was the accreditation agency's practice of making announced visits. Announced visits effectively give RACS an opportunity to 'make a big effort for the site visits and thereafter return to their usual ways of working', a practice known as the 'pre-accreditation shuffle'.[26] As the multiple Oakden inquiries attested, particularly the Carnell and Paterson Review, making announced visits allowed even the highly troubled Oakden facility to receive a positive assessment and full accreditation despite the ongoing human rights abuse and neglect of residents.[27] Carnell and Paterson found that there was a widely shared view that 'announced visits are staged', and they 'recommend[ed] discontinuing planned accreditation visits and replacing them exclusively with unannounced visits'.[28] The post-Oakden reforms task ACQSC assessors with making predominantly unannounced onsite-visits to RACS, in addition to scheduled visits.

Even with the emphasis on unannounced visits, ACQSC assessors have 'one hand tied behind their back' according to a survey of assessors conducted pre-COVID-19 in early 2020.[29] When visiting RACS, whether announced or unannounced, assessors need to secure the consent of the occupiers to enter the premises.[30] Assessors are also hampered in gathering relevant information. For example, approved RACS providers are 'able to restrict or monitor access of assessors to documentation'.[31] Despite having legal powers to do so, in practice assessors reported being unable to compel RACS employees to answer questions, or to take photographs or video/audio recordings, during inspections.[32] The survey indicated that assessors feel

[22] Commonwealth, *Parliamentary Debates*, House of Representatives, 12 September 2018, 8715 (Ken Wyatt) referring to *Carnell-Paterson Review* (n 16).
[23] *Carnell-Paterson Review* (n 16) 50.
[24] Ibid vii, 49.
[25] Ibid 49, 106.
[26] Ibid 72, 128.
[27] Ibid 34-35; Senate Community Affairs References Committee, Parliament of Australia, *Inquiry into the Effectiveness of Aged Care Quality Assessment and Accreditation Framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and* practised, Interim Report (2018) 41.
[28] *Carnell-Paterson Review* (n 16) ix, xiii,128, 133.
[29] Community and Public Sector Union, *Submission to Royal Commission into Aged Care Quality and Safety*, 2 June 2020, 10 < https://www.cpsu.org.au/system/files/cpsu_submission_to_aged_care_royal_commission.pdf>.
[30] See *Aged Care Quality and Safety Commission Act 2018* (Cth) ss 68, 69.
[31] Community and Public Sector Union (n 29) 14.
[32] See Power (n 8); Community and Public Sector Union (n 29) 10, 14; See *Aged Care Quality and Safety Commission Act 2018* (Cth) s 70 (the Act) which says that an assessor *may* request a person to answer any

inadequately trained, and frequently have their assessments reversed by more senior ACQSC staff who did not participate in the onsite assessment.[33]

The ACQSC is not the independent oversight body recommended by Carnell and Paterson:[34]

> best-practice governance arrangements should separate the policy advice agency from the independent regulator or the body that administers the law. Making regulators independent from the changing agendas of governments generally increases consistency and transparency in the regulatory approach, and confidence in the regulator.[35]

The independence of the ACQSC has been questioned by some experts and advocacy bodies because it neither appears to be exercising its monitoring powers in full, nor immune from government influence.[36]

B *ACQSC's Monitoring of RACS During COVID-19*

The pandemic has tested the ACQSC, particularly in its role of ensuring residents'/consumers' safety by monitoring whether RACS are properly implementing the relevant infection control guidelines. For a period of three months from March 2020, the ACQSC stopped all *unannounced* visits.[37] Between events at Newmarch from March and the spread of COVID-19 into Victoria's RACS from July, there is evidence that the ACQSC was not proactive in making *announced* onsite-visits. For example, in late July 2020, in an *ABC* interview, Aged Care Quality and Safety Commissioner Janet Anderson said the ACQSC was 'working closely' with RACS. When questioned about how many *announced* onsite-visits the ACQSC had undertaken in Victoria since Newmarch, she explained that instead of announced visits, the ACQSC had required RACS to undertake self-assessment surveys and the ACQSA had detailed telephone conversations with each RACS.[38] This was in addition to the ACQSC writing to aged-care

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question or to produce any documents but a person is not required to comply with this request. Note, however, that under the search powers, specifically s 71(2)(d) of the Act, assessors may exercise 'the power to make any still or moving image or any recording of the premises or any thing on the premises'.

[33] Community and Public Sector Union (n 29) 4-5.

[34] *Carnell-Paterson Review* (n 16) vii, 76.

[35] Ibid 56.

[36] See, eg, Professor Joseph Ibrahim quoted in Clay Lucas, 'Federal aged care watchdog approved homes with worst COVID-19 outbreaks', *The Age* (Victoria) 8 September 2020; See also Combined Pensioners and Superannuants Association, *Submission to Royal Commission into Aged Care Quality and Safety: How the Aged Care Quality and Safety Commission was won* (Web Page,14 May 2020) <https://cpsa.org.au/publication/submission-to-the-royal-commission-into-aged-care-quality-and-safety-how-the-aged-care-quality-and-safety-commission-was-won/>; Combined Pensioners and Superannuants Association, *Submission to the Royal Commission into Aged Care Quality and Safety: System Governance*, (Web Page, July 2020) <https://cpsa.org.au/wp-content/uploads/2020/09/200713-System-governance-submission-to-ACRC.pdf>; See also Commonwealth, *RCAC*, 'Counsel Assisting's Final Submissions' [208]-[221] <https://agedcare.royalcommission.gov.au/sites/default/files/2020-10/RCD.9999.0541.0001_1.pdf>.

[37] Dana McCauley, 'Aged Care Regulator 'too late to act' in enforcing standards', *Sydney Morning Herald* (online) 31 August 2020 <https://www.smh.com.au/politics/federal/aged-care-regulator-too-late-to-act-in-enforcing-standards-20200831-p55qz9 html>.

[38] ABC, 'Staff around the country are moving to Victoria's Aged Care facilities', *AM*, 28 July 2020, ABC AM (Janet Anderson); In a media release of 9 July 2020, the Commissioner asserted that the Commission was 'conducting a site visit to any service identified as high risk where concerns are raised': Aged Care Quality and Safety Commission, 'Statement by Janet Anderson on response to COVID-19 situation in Victoria', (Media Release, 9 July 2020); The Commissioner also states that between mid-March and mid-August, 487 unannounced and short-notice visits were undertaken: Aged Care Quality and Safety Commission, 'Statement from Ms Janet Anderson PSM - Significant growth in regulatory activities relating to aged care in the context of COVID-19' (Media Release, 1 September 2020).

providers and requiring some RACS, predominantly those with multiple COVID-19 infections, to appoint and work with an independent advisor to ensure compliance with the ACQSC's quality standards. This approach to monitoring was based on medical advice.

Such an 'independent advisor' was appointed at Newmarch after 16 residents had already died. The ACQSC baffled some observers by nominating a former banker with limited experience in either overseeing residential aged-care or dealing with infectious disease control.[39] The operator, Anglicare, was to implement the independent adviser's recommendations, and report regularly to the ACQSC or risk losing its RACS licence.[40] In its Notice to Newmarch, the ACQSC indicated 'serious concerns' about compliance with particular Standards, including Standard 1(3a) which requires that 'each consumer is treated with dignity and respect', and Standard 1(3c) which requires that 'each consumer is supported to exercise choice and independence, including to (i) Make decisions about their own care'.[41]

Onsite-visits would have allowed ACQSC assessors to observe for themselves the system of infection controls at Newmarch, and whether the conditions and interactions between consumers and management meant that consumers were being 'treated with dignity and respect' and were able to exercise some autonomy. Crucially, the ACQSC assessors could have spoken directly with consumers/residents so they could have their voices heard. An onsite-visit would have ensured Anglicare's infection control protocols were independently reviewed and, if necessary, improved to ensure the safety, health and dignity of residents.

The ACQSC's approach to monitoring can be characterised as remote and ineffective. It offered RACS little incentive by the way of expertise, penalties or possible onsite-visits to motivate providers to ensure that residents/consumers were being treated with dignity and respect. The monitoring and oversight of the regulator did not adequately assist the prevention of the ill-treatment and premature death of residents of RACS through accidental transfer of COVID-19 due to poorly managed infection control. It raises the question of whether OPCAT-compliant independent and external monitoring based on international human rights standards would perform any better.

Australia's approach to monitoring RACS may be compared with NZ's approach. In NZ, government monitoring is coupled with monitoring undertaken by the Chief Ombudsman under NZ's OPCAT framework. It is the independent monitoring, undertaken by a body external to government, against human rights standards focused on the dignity of residents,

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[39] 'It's Taken 16 Deaths at Newmarch for an Independent Advisor to Step in…', *HelloCare* (Web Page, 8 May 2020) <https://hellocaremail.com.au/taken-16-deaths-newmarch-independent-advisor-step/>; Independent advisors are appointed under section 63U(3)(c) of the *Aged Care Quality and Commission Act 2018* (Cth) which provides: '(c) to appoint, within the period specified in the notice, an eligible adviser who has appropriate qualifications, skills or experience to assist the provider to comply with the provider's aged care responsibilities in relation to either or both of the following matters: (i) the care and services provided by the provider;(ii) the governance and business operations of the provider.' The Act provides no definition for 'appropriate qualifications, skills or experience'.

[40] See Aged Care Quality and Safety Commission, 'Newmarch House Notice to Agree', (Web Document, 6 May 2020) <https://www.agedcarequality.gov.au/sites/default/files/media/Newmarch%20House%20Notice%20to%20agree.pdf>.

[41] See Aged Care Quality and Safety Commission, 'The Aged Care Quality Standards (Quality Standards) are now in effect', *Quality Standards* (Web Page, 3 November 2020) <https://www.agedcarequality.gov.au/providers/standards>.

aimed at preventing violations and reforming practices where violations have occurred, that differentiates NZ's approach from that of Australia.

III RACS MONITORING LESSONS FROM NEW ZEALAND

OPCAT establishes a dual international and national system of human rights-based independent monitoring of places where people are deprived of their liberty. Being an optional protocol to the CAT, monitoring of places of detention by the international Sub-Committee on the Prevention of Torture ('SPT') and National Preventive Mechanisms ('NPMs') is aimed at assessing the treatment of detainees and their conditions of detention, and making recommendations with a view to strengthening the protection of detained persons against torture or other CIDTP.

At the national level, monitoring is performed by NPMs, who are empowered to make regular announced and unannounced onsite-visits to places of detention. The Australian government maintains that all RACS fall outside the scope of the OPCAT, arguing its initial focus will be on 'primary places of detention'. This position is increasingly difficult to justify, given examples like Newmarch where residents were prevented from leaving, and the abuses in RACS uncovered by the Oakden Inquiries.[42] The benefits of extending OPCAT monitoring to RACS are demonstrated by analysing the report of NZ's first OPCAT visit to RACS, which occurred during NZ's COVID-19 lockdown.

Anglicare disputes that the residents of Newmarch House were prevented from leaving during the COVID-19 outbreak in 2020 and notes that this issue is the subject of the Newmarch House Coronial.

A *NZ OPCAT Monitoring of RACS*

New Zealand ratified the OPCAT in 2007. Its NPM consists of four pre-existing independent investigative/monitoring bodies and a co-ordinating NPM.[43] The aged-care facilities visited as part of NZ's OPCAT monitoring programme were characterised as places 'where people are not free to leave at will'.[44] This included 'privately run care facilities where there are dementia units and where people, often the elderly, are detained because of their vulnerability'.[45] The Committee Against Torture (treaty-monitoring body under CAT) confirmed that aged care facilities can be places of torture and CIDTP, stating that 'each State party should prohibit, prevent and redress torture and ill-treatment in all contexts of custody or control, for example,

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[42] The Australian Government has decided that the NPM will initially focus only on 'primary places of detention': Senator George Brandis, 'Torture Convention - the Australian Government OPCAT announcement', *Human Right Law Centre* (Web Page, 9 February 2017) <www hrlc.org.au/bulletin-content/2017/2/22/torture-convention-the-australian-government-opcat-announcement>; This decision was made before the Oakden inquiries illuminated the widespread problem of neglect and human rights abuse taking place in RACS. There is strong support among civil society and existing oversight bodies for a more expansive view: See Australia OPCAT Network, *The Implementation of OPCAT in Australia*, 'Submission by the Australia OPCAT Network to the Subcommittee on the Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT) and The United Nations Working Group on Arbitrary Detention (*WGAD*)', (Web Document, January 2020) 19-21 <https://www kaldorcentre.unsw.edu.au/sites/default/files/Implementation_of_OPCAT_in_Australia.pdf >.

[43] The Human Rights Commission of New Zealand is the co-ordinating NPM, and there are four designated bodies with monitoring roles: the Ombudsman, the Independent Police Conduct Authority, the Children's Commissioner and the Inspector of Service Penal Establishments of the Office of the Judge Advocate General.

[44] Peter Boshier, *OPCAT COVID-19 Report: Report on Inspections of Aged Care Facilities under the Crimes of Torture Act* 1989 (Office of the Ombudsman, NZ-NPM Report 2020, August 2020) at 5 ('*NZ-NPM Report 2020*').

[45] See 'Ombudsman's Office to take role in monitoring private aged care facilities/court cells', *NZ Ombudsman* (Media Release, 6 June 2018) <https://www.ombudsman.parliament.nz/news/ombudsmans-office-take-role-monitoring-private-aged-care-facilities-court-cells>.

in prisons, [and] institutions that engage in the care of children, *the aged*, the mentally ill or disabled'.[46]

Unlike the Australian Government's position that RACS 'do not fit within the concept of "places of detention" as set out in Article 4 of OPCAT',[47] NZ considers RACS as 'places of detention' where the state should exercise regulatory and oversight functions. Article 4(1) of OPCAT provides:

> Each State Party shall allow visits … to any place under its jurisdiction and control where persons *are or may be deprived* of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence (hereinafter referred to as places of detention).[48]

Like in Australia, RACS in NZ are funded to some degree by government and/or subject to regulations and government oversight, meeting OPCAT's first criteria of being under the government's jurisdiction and control.[49] Like in Australia, they meet the second and third criteria, which are whether the 'persons are or may be deprived of their liberty' (for example through environmental restraints, such as keypads requiring codes)[50], and whether this deprivation is 'either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence'. On this third criteria, the SPT has stated that this 'relates to a situation in which the State exercises, or might be expected to exercise a regulatory function'.[51]

In March-April 2020, NZ RACS suffered five COVID-19 clusters. While Australia's response to COVID-19 manifested in a dramatic decrease in onsite-visits by the ACQSC, the situation was reverse in NZ: it accelerated the extension of OPCAT monitoring into RACS.[52] The extension of monitoring of RACS was announced in 2018,[53] and was to commence in 2021. However, in April 2020, the NZ Chief Ombudsman, the relevant NPM for inspecting

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[46] Committee Against Torture, *General Comment No 2: Implementation of Article 2 by States Parties* CAT/C/GC/2 (24 January 2008) para 4 ('*General Comment No 2*') (emphasis added).
[47] Senate Standing Committee on Legal and Constitutional Affairs (n 2).
[48] *OPCAT* (n 4) art 4(1) (emphasis added).
[49] Michael J V White, *He Ara Tika, A Pathway Forward: The scope and role of the Optional Protocol to the Convention against Torture (OPCAT) in relation to Aged care and disability residences and facilities* (New Zealand Human Right Commission, June 2016) 30-31.
[50] It is always a matter of fact whether a facility deprives or may deprive a person of their liberty - the NPM must decide this on a case-by-case basis. Note that Art 4 of the OPCAT says 'may be deprived'. This implies that the NPM simply needs to suspect that persons in a particular RACS may be deprived of their liberty. Not all those persons who are deprived of their liberty are under formal orders, such as guardianship orders. Deprivation of liberty need not be total. In *Public Advocate v C, B*, the SA Supreme Court held that even though the RACS resident, Mr C, was able to exit the locked ward for excursions with his son, 'those occasions could not change his status as a detained person whilst he was in the locked ward': *Public Advocate v C, B* [2019] SASCFC 58, [72].
[51] Subcommittee on the Prevention of Torture, 'Response to the NZ Human Rights Commission's request for interpretative guidance on Art 4.2 of the OPCAT' (2015) quoted in *He Ara Tika* (n 49) 47.
[52] In June 2018, the NZ Minister of Justice gazetted new responsibilities for the NZ Ombudsman under its OPCAT mandate to include 'the treatment of persons detained … in health and disability places of detention including within privately run aged care facilities'. See 'Designation of National Preventive Mechanisms', *New Zealand Gazette* (Departmental Notice Number 2018-go2603, 6 June 2018) <https://gazette.govt.nz/notice/id/2018-go2603>.
[53] See NZ Ombudsman (n 45); 'OPCAT inspections to include people held securely in privately-run aged care facilities', *NZ Ombudsman* (Fact Sheet, March 2020) < https://www.ombudsman.parliament.nz/sites/default/files/2020-03/agedcare-factsheet-agedcaremonitoring.pdf>.

residential aged care ('NZ-NPM'), publicly signalled that RACS monitoring needed to commence immediately.[54] NZ's Government responded by ensuring that the NPMs were designated 'essential services' under NZ's COVID-19 regulations, which permitted the NZ-NPM inspectors to undertake onsite-visit to places of detention during the lockdown.

Given that onsite-visits occurred during NZ's lockdown between April-May 2020, careful planning was required to minimise the risk that the inspection team itself would endanger residents and breach infection protocols. The NZ-NPM's team of three inspectors were mindful of the 'do no harm principle' when, wearing full Person Protective Equipment ('PPE'), they visited six RACS (including privately-run facilities) each for two hours. During these truncated visits, the inspectors did not utilise the full range of the NPM's powers, which enable inspectors to have full and unimpeded access to places of detention, including the opportunity to have private interviews with detainees and others, and to collect relevant information and data.[55]

While the visits were temporally brief, they were preceded by significant preparation. The remote preparation allowed the onsite-visits to be 'targeted physical on-site inspections focussed on COVID 19 issues', with an emphasis on residents' rights:

> the preventive purpose of these inspections is to provide independent assurance that the treatment and conditions in these facilities are appropriate, and to provide recommendations for improvement. The focus of these inspections is human rights based.[56]

The preparation included the development of a *Statement of Principles*, explaining the principles guiding the NZ-NPM inspections.[57] This Statement is based on international human rights legal standards, including that:

> Any restrictive measures taken against detained people to prevent the spread of COVID-19 should be proportionate, lawful, accountable, necessary, and non-discriminatory. The measures must respect human dignity, be of limited duration, and regularly reviewed. (Principle 5).

The Report resulting from the onsite-visits details the criteria used for the inspections.[58] These criteria were divided into five categories: (a)'health and safety'; (b) 'contact with the outside

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[54] 'Upcoming OPCAT inspection by Chief Ombudsman's team', *NZ Ombudsman* (Web Document, April 2020) <https://www.ombudsman.parliament nz/sites/default/files/2020-04/Upcoming%20OPCAT%20inspection%20by%20Chief%20Ombudsman%E2%80%99s%20team.pdf>.

[55] Section 34 of the *Crimes of Torture Act 1989* (NZ) provides: 'Where a National Preventive Mechanism has powers in relation to the exercise of any functions under any other Act, the National Preventive Mechanism has, in relation to the exercise of its functions under this Part, the same powers'; See also *Ombudsman Act 1975* (NZ) s19; Furthermore, section 30(1) of the *Crimes of Torture Act 1989* (NZ) provides: 'For the purposes of this Act, every person must permit a National Preventive Mechanism to interview, without witnesses, either personally or through an interpreter, (a) any person in a place of detention for which it is designated: (b) any other person who the National Preventive Mechanism believes may be able to provide relevant information.'

[56] *NZ-NPM Report 2020* (n 44) 5.

[57] NZ Zealand Chief Ombudsman, 'OPCAT inspections and visits during COVID-19 pandemic – update and Statement of Principles'(Statement, 9 April 2020) <https://www.ombudsman.parliament nz/sites/default/files/2020-04/OPCAT%20inspections%20and%20visits%20during%20COVID-19%20pandemic%20%E2%80%93%20update%20and%20Statement%20of%20Principles_0.pdf>.

[58] *NZ-NPM Report 2020* (n 44) Appendix 2, 27. It notes that the criteria should not be understood as 'a checklist or a set of rules', but as a non-exhaustive 'guide for consideration' of the issues that 'could be relevant to the … examination of treatment and conditions'.

world'; (c) 'dignity and respect'; (d) 'protective measures'; and (e) 'staffing'. Two examples of criteria relating to 'health and safety' are:

> Appropriate plans and policies for the management of suspected or confirmed cases of COVID-19, including access to medical care off-site, if needed. People in detention with suspected or confirmed cases of COVID-19 should be able to access urgent, specialised healthcare without fuss.
>
> Rationing of health responses and allocation decisions are guided by human rights standards, based on clinical status and do not discriminate based on any other selection criteria, such as age, gender, ethnicity and disability.[59]

Given the lockdown situation, the NZ-NPM opted to announce the visits in advance, with one facility initially objecting to the entry of the inspection team. In fact, when the NZ-NPM announced its plan to bring forward its visits to RACS, it faced resistance from the aged-care sector. For example, the NZ Aged Care Association ('NZACA'), which represents over 90% of NZ providers of aged-care, wrote directly to the Prime Minister requesting suspension of inspections.[60] The NZ-NPM reiterated its rationale for the visits, explaining that where extraordinary measures are being implemented to address extraordinary health challenges, these 'measures must not have an unnecessary or disproportionate impact on peoples' rights'.[61] Under OPCAT, the NZ Government is obliged to ensure that its NPMs are both functionally and financially independent,[62] which meant that the NZ Government was not able to interfere with the proposed RACS inspection timetable.

B *NZ-NPM OPCAT Monitoring Outcomes*

The aim of the RACS inspections was not to 'name and shame' individual RACS, but 'to give insight into how the sector was managing as a whole'.[63] Consequently, the inspected RACS are not named in the Report, although the NZ-NPM followed up its visits by communicating specific recommendations to the visited RACS and providing opportunity for comments. This contrasts with the general practice to name institutions in NPM reports, with the aim of advocating specific reforms in light of problematic treatment.

The Report sets out the NZ-NPM's findings, recommendations and suggestions at a system-level, ensuring that the practices and approaches of all NZ RACS – the six visited and the hundreds not visited – would benefit from the recommendations aimed at preventing and lowering the risk of neglect and abuse in this ongoing emergency situation. In terms of findings, for example, the Report noted that '[a]ll Facilities were able to provide policies and plans on infection control and had taken steps to protect residents', that 'a "bubble" strategy was applied in all Facilities', and that decisions about testing considered the rights of residents.[64] The Report noted that '[c]ontact with the outside world is an essential safeguard against ill-treatment', with the expectation being '[w]here visiting regimes are restricted' that 'sufficient

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[59] *NZ-NPM Report 2020* (n 44), Appendix 2, 27.
[60] Ibid 7; Unfortunately NZACA has not made the letter publicly available via its website.
[61] *NZ-NPM Report 2020* (n 44) 8.
[62] See *OPCAT* (n 4) Art 18(1) which provides: 'The States Parties shall guarantee the functional independence of the national preventive mechanisms as well as the independence of their personnel.' See also the *Guidelines on National Preventive Mechanisms* of the Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment, Basic Principle 12, which states: 'The NPM should enjoy complete financial and operational autonomy when carrying out its functions under the Optional Protocol.'
[63] *NZ-NPM Report 2020* (n 44) 7.
[64] Ibid 2.

alternative methods for residents to maintain contact with the outside world is facilitated and encouraged', with RACS generally doing 'a good job' of this.[65] Regarding dignity, 'warm interactions between staff and residents', and 'a commitment by Facilities to ensuring minimal disruption to the residents' day-to-day experience', were reported.[66]

Twenty-one suggestions were made, including that

- '[t]he Facility considers the size and integrity of its "bubble", and is clear and consistent in its "bubble" management';
- '[c]onsideration is given to ensuring residents are able to access safe and timely medical assistance';
- '[t]he particular needs of residents, including disability related needs, be taken into account when planning or implementing infection control practices'; and
- 'alternative ways of managing medically isolated residents' bathroom needs' be investigated.[67]

Regarding protective measures, suggestions included that

- '[r]esidents are supported to express their concerns and make complaints';
- '[f]eedback and comments boxes are … in places accessible to residents, that residents are made aware of how to use these, and are freely encourage and able to do so'; and
- '[a]dequate systems are put in place to ensure complaints are documented and appropriately responded to.'[68]

Of the four recommendations, only one related to infection control: that '[t]he Facilities clearly defines the composition of its "bubble"', and that PPE be used 'consistently' for people not in the "bubble".[69]

As an independent, systems-level mechanism, OPCAT monitoring has the potential to serve parliament, the government, sector-specific oversight agencies (such as ACQSA), and the public by communicating potential preventable problems facing persons who are out-of-sight, cannot leave of their own will, and cannot be visited by relatives. The NZ-NPM observes:

> My impartial monitoring of these places provides Parliament and the New Zealand public with reassurance about two areas in particular – that the facilities were doing all they could to prevent the virus spreading to those most at risk and that steps were being taken to ensure the basic human rights of residents were protected.[70]

This reassurance that persons deprived of their liberty are being treated fairly and that their rights are being respected is critical, especially given the ongoing impact on RACS of the pandemic. The OPCAT monitoring complements other independent reviews and government monitoring, but appears to be the only monitoring which includes onsite-visits.[71]

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[65] Ibid14.
[66] Ibid15.
[67] Ibid 21.
[68] Ibid 22.
[69] Ibid 20.
[70] Ibid 8.
[71] One example is NZ's *Independent Review of COVID 19 Clusters in RACFs,* which was primarily focussed on hearing the voices of RACS staff and management in relation to their experience of the COVID clusters.

This is a draft of an article that has been accepted for publication in Volume 47 of the *Monash University Law Review*. The post-refereed and fully-edited final and citable version of the article is forthcoming, and expected in 2022.

In Australia, there is no independent body with OPCAT-compliant powers to undertake onsite-visits, or a focus on preventing torture, or CIDTP. Nor is there a mechanism for ensuring that any restrictions on residents' rights are 'proportionate, lawful, accountable, necessary, and non-discriminatory'.[72] The body that externally monitors RACS, the ACQSC, is not empowered by substantive human rights standards, is not adequately independent from the government (as demonstrated by the survey of inspectors), and fails to utilise its most potent powers (of onsite-visits and unlimited access to residents and information) at arguably the most critical moment required of it. The ACQSC does not place the voices of affected people at the forefront, and its monitoring approach is focussed on certification criteria and compliance with inadequate standards. This is not to say that the ACQSC does not serve useful purposes; however, it is to say that the ACQSC, and its lip-service to rights, is not of equivalence to OPCAT-compliant monitoring. The Australian Government recognises the necessity of OPCAT-compliant monitoring for 'primary places of detention'. The necessity for OPCAT-compliant monitoring in RACS is surely demonstrated by the treatment uncovered in the Oakden Inquiries, the challenges of caring for aging persons exposed through COVID-19, and the benefits derived for NZ's facilities through its OPCAT-driven response to COVID-19.

IV RESIDENTS' TREATMENT AT NEWMARCH

Part IV explores the treatment of the residents of Newmarch in April-May 2020. The measures state and federal agencies imposed on Newmarch residents in this period are analysed to establish whether these measures would meet the NZ-NPM benchmarks – benchmarks founded on the text of and jurisprudence under the ICCPR and the CRPD, being treaties ratified by Australia. While the ICCPR applies to all persons, the CRPD applies to persons with disabilities and this definition covers many residents in RACS, particularly persons with dementia[73] and persons who are frail and lack mobility.

A *Events at Newmarch*

The initial response to two COVID-19 diagnoses on 11-12 April 2020 at Newmarch[74] was to confine *all* residents to their individual rooms 24/7.[75] Indeed, as the Four Corners report revealed, COVID-19-positive residents were *not* quarantined *within* the facility from COVID-19-negative residents. COVID-19-negative residents were *not* able to leave the facility, but

Anglicare denies that COVID-19 positive residents were not quarantined within Newmarch House from COVID-19 negative residents and notes that this issue is the subject of the Newmarch House Coronial.

Anglicare disputes that COVID-19 negative residents were not able to leave the facility.

Published very speedily, in May 2020, three months before the OPCAT Report, this report makes no mention of residents' rights and its authors were unable to interview any residents or to visit onsite. The Report indicates that it was one of a number of reviews: Ministry of Health, 'Independent Review of COVID-19 Clusters in Aged Residential Care Facilities', (online, 29 May 2020) 10 <https://www health.govt.nz/system/files/documents/publications/independent-review-covid-19-clusters-aged-residential-care-facilities-may20.pdf>.

[72] See NZ Chief Ombudsman (n 57) 2.

[73] See the definition at Art 1 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) (*CRPD*); See also Linda Steele et al, 'Ending Confinement and Segregation: Barriers to realising human rights in the everyday lives of people living with dementia in residential aged care', (2020) online *Australian Journal of Human Rights* 1 <https://www.tandfonline.com/doi/full/10.1080/1323238X.2020.1773671>; Linda Steele et al, 'Human Rights and the Confinement of People Living with Dementia in Care Homes' (2020) 22(1) *Health and Human Rights Journal* 7.

[74] A Newmarch staff member late on 11 April 2020 and a Newmarch resident on 12 April 2020; Commonwealth, *RCAC*, '*Statement of Grant William Millard*' (CEO Anglicare) (24 July 2020) [32]; Evidence to Senate Select Committee on COVID-19, Parliament of Australia, Canberra, 26 May 2020 (Senator Keneally);

[75] *Statement of Grant William Millard* (n 74) [44].

This is a draft of an article that has been accepted for publication in Volume 47 of the *Monash University Law Review*. The post-refereed and fully-edited final and citable version of the article is forthcoming, and expected in 2022.

Anglicare denies that no residents were allowed visitors during the outbreak at Newmarch House in 2020 and notes that this issue is the subject of the Newmarch House Coronial.

Anglicare denies that window visits ceased once a perimeter fence was erected around Newmarch House and notes that this issue is the subject of an the Newmarch House Coronial.

Anglicare denies that no COVID-19 positive residents were transferred to alternative facilities for treatment, noting that two of the residents who died during the COVID-19 outbreak at Newmarch House in 2020 died at Nepean Hospital and that a number of other COVID-19 positive residents were transferred to hospital during the outbreak and recovered. Anglicare also notes that this issue is the subject of the Newmarch House Coronial.

Anglicare disputes that COVID-19 positive residents could not leave Newmarch House to access medical treatment in hospital. Anglicare denies that only one COVID-19 resident was transferred to hospital during the outbreak at Newmarch House. Anglicare also notes that this issue is the subject of the Newmarch House Coronial.

Anglicare disputes that the NSW Government ordered Newmarch House to adopt the HITH program and notes that this issue is the subject of the Newmarch House Coronial.

were instead isolated in their rooms. COVID-19-positive residents were *not* transferred to alternative facilities for quarantine or treatment, but were instead isolated in their rooms within the facility.

No residents were allowed visitors[76] and personal contact with staff was limited. Initially some family members could speak to residents by telephone while seeing them through windows (depending on a resident's location within the facility).[77] This became impossible when Anglicare covered the perimeter fence around the RACS.[78] Telephone contact remained a possibility, although this was challenging for residents with dementia, and many contact attempts were unsuccessful because of the significantly increased workload of the staff members. The intense isolation experienced by Newmarch residents impacted on their physical, mental and psychological well-being.[79]

When COVID-19-positive residents became extremely ill due to COVID-19, they could *not* leave the facility to access medical treatment in hospital, even when requested by family members, with one exception. One family member indicated that Anglicare informed them that leaving Newmarch was not an option for residents due to a public health order, and that the resident could face a hefty fine and prison term if they did leave.[80] Other family members indicated that they did not want the resident transferred, but the independent review found that 'many relatives later felt they had not been given enough information to make a genuine choice'.[81]

The NSW Government ordered Newmarch to adopt a 'hospital in the home' ('HITH') approach to care, despite Newmarch not having necessary hospital equipment or qualified medical staff.[82] The *ABC's* interviews with family members of residents uncovered neglect of residents during this period. One resident fell over and waited 2 hours for assistance after pressing the

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[76] This applied from 24 March 2020 in all Anglicare run aged care facilities and was required by *Public Health (COVID-19 Residential Aged Care Facilities) Order 2020*: *Statement of Grant William Millard* (n 74); See also Lyn Gilbert and Alan Lily, *Newmarch House COVID-19 Outbreak [April-June 2020) Independent Review* (Final Report) (20 August 2020) 10 ('*Independent Review*').

[77] This commenced from 28 April 2020: *Statement of Grant William Millard* (n 74) [64].

[78] 'Like the Plague' (n 6).

[79] ABS News, 'Newmarch House resident dies after recovering from coronavirus, NSW hits record testing rate' (Blog Post, 9 May 2020) < https://www.abc.net.au/news/2020-05-09/nsw-coronavirus-newmarch-house-death-after-covid-19-recovery/12230504>.

[80] 'Like the Plague' (n 6). This may have been a misinterpretation of the Public Health Order by Anglicare. The Order imposes penalties for people other than residents entering and remaining in a residential aged care facility, rather than residents leaving: *Public Health (COVID-19 Aged Care Facilities) Order 2020* (NSW) (made under the *Public Health Act 2010* (NSW) on 24 March 2020). However, the NSW 'guidance' website (which does not refer to fines or imprisonment) does note that 'External excursions for residents should be prohibited': NSW Health, *COVID-19 (Coronavirus) – Guidance for residential aged care facilities* (Web Page, 22 November 2020) <https://www health nsw.gov.au/Infectious/covid-19/Pages/residential-aged-care.aspx>; Prima facie going to hospital for medical care should not be classified as an 'excursion'.

[81] Gilbert and Lily (n 76) 20. Lack of communication with family members was a focus of the independent review: see14-16.

[82] *Statement of Grant William Millard* (n 74) [53]; Commonwealth, *RCAC*, 'Transcript of Proceedings' (Head of Infectious Diseases, Nepean Hospital) (11 August 2020) 8524-25. This decision was reviewed by the independent reviewers who concluded that for HITH 'success depends on adequate patient support in the home setting, which was not available at Newmarch House, in the early weeks of the COVID-19 outbreak': Gilbert and Lily (n 76) 30.

'emergency buzzer'.[83] Another resident was severely dehydrated and waited 1.5 days before being provided with the intravenous fluids that a medical practitioner ordered.[84]

According to an Independent Review of Newmarch, commenced 8-weeks after the first COVID-19 positive diagnosis, the HITH approach 'led to shortfalls in hospital-standard care for some residents with COVID-19 and neglect of or delays in routine care of many others'.[85] The HITH classification did not trigger additional nursing support, or a consistent supply to the RACS of intravenous fluids or antibiotics.[86] The lack of care impacted on residents in multiple ways, including 'weight loss, dehydration, pressures sores, increases in urinary tract and skin infections and general deconditioning'.[87] The review also noted 'a lack of adequate provision for medical care of the residents who remained COVID-19 free' because they were not part of the HITH regime.[88]

Eighteen COVID-19-positive residents subsequently died at Newmarch, with one additional resident dying in hospital.[89] During this time, the number of new COVID-19 infections in NSW was relatively low,[90] and there was no evidence that hospitals were overflowing.[91] This represents a 46% mortality rate of COVID-19-positive residents at Newmarch.[92]

Anglicare denies that 18 COVID-19 positive residents died at Newmarch House but admits that 17 COVID-19 positive residents died at Newmarch House, while two COVID-19 positive residents died at Nepean Hospital.

Arguably, transferring COVID-19-positive residents to properly equipped and staffed hospitals would have improved their access to adequate medical care and potentially lessened the risk of death. The right of access to adequate healthcare was recognised by Council for the Ageing Australia ('COTA'):

> As a matter of basic human and legal rights COTA believes that every resident of every aged care home has the right to transfer to hospital if they need it and that is their preference

[83] 'Like the Plague' (n 6); Also reported in Matilda Boseley, 'Coronavirus NSW: government sends support staff to Newmarch House aged care home' *The Guardian* (online 23 April 2020) <https://www.theguardian.com/world/2020/apr/22/staff-shortage-strikes-coronavirus-stricken-newmarch-house-aged-care-home>.

[84] 'Like the Plague' (n 6).

[85] Gilbert and Lily (n 76) 20. Much like the independent review of the COVID 19 clusters in NZ, terms of reference for the review did not include human rights standards and the reviewers for the Newmarch report did not conduct direct interviews with residents but relied on interviews with family members for the 'resident perspective'. Only one reviewer was able to undertake a 'brief site visit': at 7.

[86] Ibid 28.

[87] Ibid 27; see also 21-22.

[88] Ibid 19.

[89] This resident's family members went to the media and, through persistence, were able to get the resident transferred. 'Nicole Fahey inundated the media with her story and early the next morning, Ann Fahey was transferred to Nepean Hospital. The family was shocked by the contrast in conditions': 'Like the Plague' (n 6); Commonwealth, *RCAC*, 'Transcript of Proceedings' (P Rozen QC, Counsel Assisting) (10 August 2020) 8378.

[90] See the daily statistics of the NSW Health Department at <https://www health nsw.gov.au/news/Pages/20200504_00.aspx>. During this period, the numbers were rarely in the double digits.

[91] There was an outbreak at another RACS in Sydney and '13 of the 16 residents who were tested positive were sent to hospital. Of the remaining three, one did not want to go to hospital and was palliated at the home. The remaining two recovered': Commonwealth, *RCAC*, 'Transcript of Proceedings' (P Rozen QC, Counsel Assisting), (10 August 2020) 8376.

[92] Gilbert and Lily (n 76) 8.

> … Older Australians have identical rights to access the same quality of healthcare as every other Australian.[93]

Transfer to hospitals would also have alleviated the need for the majority of COVID-19-negative residents to isolate in their rooms. Anglicare recognised this in evidence to the RCAC:

> I believe that if we would have been able to transfer out COVID-positive residents earlier, we might have had an earlier liberalisation of what was, really, extremely difficult for our residents to go through being isolated in their rooms with the doors closed.[94]

The COVID-19 pandemic has highlighted many ongoing problems with our system of RACS which go beyond the parameters of this article. This article focuses on whether, from a human rights perspective, the public health measures imposed on Newmarch and other RACS were 'proportionate, lawful, accountable, necessary, and non-discriminatory' and whether the measures could be said to 'respect human dignity, be of limited duration, and regularly reviewed' – being the NZ-NPM's OPCAT monitoring criteria.

But beyond OPCAT, under various treaties Australia has ratified (e.g. the ICCPR) Australia has obligations to investigate potential human rights violations. The duty to investigate is part of the obligation of State Parties, under Article 2(3) of the ICCPR, to ensure that victims of human rights violations have effective remedies.[95] According to the treaty-monitoring body under the ICCPR, the Human Rights Committee ('HRC'):

> Administrative mechanisms are particularly required to give effect to the general obligation to investigate allegations of violations promptly, thoroughly and effectively through independent and impartial bodies. … A failure by a State Party to investigate allegations of violations could in and of itself give rise to a separate breach of the Covenant. Cessation of an ongoing violation is an essential element of the right to an effective remedy.[96]

The substantive provisions of the ICCPR are read in conjunction with Article 2. For example, under the art 6 right to life, States Parties are required to undertake an investigation into all deaths where the State is involved, and these investigations 'must always be independent, impartial, prompt, thorough, effective, credible and transparent'.[97] Similarly, under the art 7 right to freedom from torture and CIDTP, States Parties have specific procedural obligations to ensure that 'competent authorities' investigate complaints of ill-treatment 'promptly and

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[93] COTA, '4 Corners report into Newmarch House demonstrates lessons from which all aged care providers and governments must learn' (Media Release, 23 June 2020) <https://www.cota.org.au/wp-content/uploads/2020/06/COTA_2006_MR_4-Corners_Newmarch_House.pdf>.

[94] Commonwealth, *RCAC*, 'Transcript of Proceedings', (Grant Millard) (11 August 2020) 8490.

[95] Article 2 (3) provides 'Each State Party to the present Covenant undertakes: (a) To ensure that any person whose rights or freedoms as herein recognized are violated shall have an effective remedy, notwithstanding that the violation has been committed by persons acting in an official capacity; (b) To ensure that any person claiming such a remedy shall have his right thereto determined by competent judicial, administrative or legislative authorities, or by any other competent authority provided for by the legal system of the State, and to develop the possibilities of judicial remedy; (c) To ensure that the competent authorities shall enforce such remedies when granted.'

[96] Human Rights Committee, *General Comment No 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, 80th sess, UN Doc CCPR/C/21/Rev.1/Add. 13 (26 May 2004) ('*General Comment No 31*') para 15.

[97] Human Rights Committee, *General Comment No 36: Article 6 of the ICCPR on the right to life,* 124th sess, UN Doc CCPR/C/GC/36 (30 October 2018) ('*General Comment No 36*') para 28.

impartially … so as to make the remedy effective'.[98] Accordingly, whether RACS come within the OPCAT purview or not, Australia has a positive legal duty to prevent and investigate human rights abuses.

This Part focuses on the deprivation of liberty and the medical isolation experienced by the Newmarch residents,[99] whilst acknowledging that Newmarch raises many other human rights issues, such as the residents' right to access adequate medical care, which require further investigation.

B *Deprivation of Liberty*

Anglicare disputes that Newmarch residents were deprived of their right to liberty.

Newmarch residents were deprived of their liberty by Anglicare in accordance with the state/federal governments' response to the pandemic. Deprivation of liberty, *per se*, is not a rights violation. Rather, art 9(1) of the ICCPR, which guarantees the right to liberty and security of the person, prohibits 'arbitrary' detention and deprivations of liberty that are not 'in accordance with procedures as are established by law'. Article 9(4) guarantees that anyone who is deprived of their liberty shall have the right to challenge the lawfulness of their detention before a court, and the court can order their release if the detention is not lawful. Article 14 of the CRPD is in similar terms. [100] The ICCPR and CRPD are the hard-law instantiations of arts 3 and 9 of the *Universal Declaration of Human Rights*.[101]

The focal point for human rights within the United Nations system is the Human Rights Council ('HR Council'). A special procedure of the HR Council, the Working Group on Arbitrary Detention ('WGAD'), noted that there is an absolute prohibition of *arbitrary* deprivation of liberty under customary international law.[102] The WGAD stated that this prohibition extends to 'public health emergency measures … introduced to combat the [COVID-19] pandemic' and to 'health-care settings'.[103] Moreover, WGAD confirmed that 'the deprivation of liberty is not only a question of legal definition but also a question of fact; therefore if the person concerned is not at liberty to leave a premise, that person is to be regarded as deprived of his or her liberty.'[104] Indeed, the WGAD refer to mandatory quarantining, concluding that where 'the quarantined person may not leave for any reason, [this] is a measure of de facto deprivation of liberty.' Furthermore, it stated that '[a]rbitrary detention can never be justified, whether it be for any reason related to national emergency, maintaining public security or health'.[105]

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[98] Human Rights Committee, *General Comment No 20: Article 7 (Prohibition of Torture, or other Cruel, Inhuman or Degrading Treatment or Punishment*, 44th sess, UN Doc HRI/GEN/1/Rev.1 (10 March 1992) ('*General Comment No 20*') para 14.

[99] These are the two themes from submissions to the Royal Commission: Commonwealth, *RCAC*, 'Transcript of Proceedings', (P Rozen QC, Counsel Assisting) (10 August 2020) 8365.

[100] United Nations, International Human Rights Instruments, *Compilation of General Comments and General Recommendation Adopted by Human Rights Treaty Bodies*, HRI/GEN/1/Rev.9 (vol I) ('*Compilation of General Comments*') 210 para 8. See also El Hadji Malick Sow, Chair-Rapporteur, *Report on Working Group on Arbitrary Detention*, UN Doc A/HRC/22/44 (24 December 2012).

[101] Article 9 of the UDHR states that '[n]o one shall be subjected to arbitrary arrest, detention or exile'.

[102] El Hadji Malick Sow, Chair-Rapporteur, *Report on Working Group on Arbitrary Detention*, UN Doc A/HRC/22/44 (24 December 2012) [42]-[43] and *WGAD*, *Deliberation No 11 on prevention of arbitrary deprivation of liberty in the context of public health emergencies* (8 May 2020) [5].

[103] *WGAD*, *Deliberation No 11 on prevention of arbitrary deprivation of liberty in the context of public health emergencies* (8 May 2020) paras 5, 7.

[104] Ibid para 8.

[105] Ibid para 5.

Unpacking the requirements of art 9(1) of the ICCPR: first, it prohibits 'arbitrary' detention. Detention that is authorised under domestic law may nonetheless be arbitrary: 'arbitrariness is not equated with "against the law"'.[106] According to the HR Council and the WGAD, "arbitrary" 'must be interpreted more broadly to include elements of inappropriateness, injustice, lack of predictability and due process of law, as well as elements of reasonableness, necessity and proportionality'.[107] Thus, even where federal/state orders/regulations provide a formal legal basis for the deprivation of liberty, those orders/regulations may not satisfy the requisite qualitative aspects – 'arbitrariness' is a matter of substance. Moreover, detention may become 'arbitrary' where a State fails to periodically review an ongoing detention to ensure it continues to be justified,[108] where it is imposed beyond the time required to combat any emergency,[109] and 'if the manner in which the detainees are treated does not relate to the purpose for which they are ostensibly being detained.'[110] Furthermore, in formulating the legal measures, States should consider alternative measures – including the least intrusive means of protecting public health – to avoid arbitrariness.

Regarding the necessity and proportionality of deprivations of liberty, the WGAD has identified persons over 60-years and persons with disabilities as vulnerable in the context of COVID-19, concluding that 'States should refrain from holding such individuals in places of deprivation of liberty where the risk to their physical and mental integrity and life is heightened.'[111] Regarding equality and non-discrimination, WGAD advised that when States enact measures in public health emergencies which lead to the deprivation of liberty, they must take into account the disparate impact upon groups who are vulnerable and already experience disadvantage, including persons with disabilities (such as dementia) and older persons, and ensure those measures respect the principle of equality and non-discrimination.[112] In considering the CRPD, detention of persons with disabilities based on 'medical necessity' is considered unlawful and arbitrary.[113]

Anglicare disputes that COVID-19 negative residents suffered particular neglect in care because they were denied the same level of care as those under the HITH regime.

In investigating the arbitrariness of the detention of Newmarch residents, available alternatives matter, such that the HITH detention measures must be questioned in light of the capacity of the NSW hospitals; as does non-discrimination, highlighting the disparity with other COVID-19-positive persons in the general community who could choose to be transferred to properly staffed and equipped hospitals if gravely ill. Moreover, the COVID-19-negative residents suffered particular neglect in care because they were denied the same level of medical care as those under the HITH regime. Was it appropriate and just to equally prevent COVID-19-negative residents from leaving the RACS, even to access adequate medical care? Further, COVID-19-negative residents were subjected to the same isolation regime as COVID-19-

Anglicare denies that residents were arbitrarily detained at Newmarch House during the COVID-19 outbreak in 2020.

[106] Human Rights Committee, *General Comment No 35 – Article 9 (Liberty and Security of Person)*, 112th sess, UN Doc CCPR/C/GC/35 (16 December 2014) para 12 ('*General Comment No 35*').
[107] Ibid; See also *WGAD*, *Deliberation No 11* (n 103) paras, 10, 11.
[108] *General Comment No 35,* UN Doc CCPR/C/GC/35 (n 106) para 12.
[109] 'When placing individual under quarantine measures, States must ensure that such measures are not arbitrary. The time limit for placement in mandatory quarantine must be clearly specific in law and strictly adhered to in practice.': *WGAD*, *Deliberation 11* (n 103) para 8.
[110] *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 106) para 14.
[111] *WGAD*, *Deliberation 11* (n 103) para 15.
[112] Ibid paras 26, 27.
[113] Special Rapporteur, *Report on the rights of persons with disabilities* UN Doc A/HRC/40/54 (11 January 2019) paras 58, 65; The CRPD provides at Article 14 that 'the existence of a disability shall in no case justify a deprivation of liberty'. Some tension exists between various UN treaty bodies as to whether the deprivation of liberty can be justified: at paras 57-62.

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positive residents, even though there was scope for what Anglicare CEO calls 'earlier liberalisation', suggesting the detention was arbitrary. Was the deprivation of liberty of 'limited duration, and regularly reviewed'? Furthermore, the COVID-19-negative residents were not properly quarantined from the COVID-19-positive residents: the Independent Review cited evidence of 'inconsistent use of PPE' and 'imperfect [infection prevention and control] practices',[114] which meant that attempts to quarantine the two groups failed. Inappropriateness of treatment is a factor in arbitrariness. More broadly, the failure of the ACQSC to undertake onsite-visits to Newmarch to assess the effectiveness of the infection control training or compliance, and its failure to appoint a specialist in infection control as the independent expert to Newmarch, must be examined.

Anglicare disputes that the COVID-19 negative residents were not properly quarantined from the COVID-19 positive residents and notes that this issue is the subject of the Newmarch House Coronial.

Second, under art 9(1), a deprivation of liberty without legal authorization is unlawful, with the HRC describing "unlawful deprivation of liberty" as a 'deprivation of liberty that is not imposed on such grounds and in accordance with such procedure as are established by law'.[115] Moreover, there is a qualitative aspect to this: 'Any substantive grounds for arrest or detention must be prescribed by law and should be defined with sufficient precision to avoid overly broad or arbitrary interpretation or application.'[116] Further, such legal authorisation 'must be accompanied by procedures that prevent arbitrary detention.'[117]

Anglicare disputes that COVID-19 positive residents were prevented from leaving Newmarch House to receive medical care in hospital during the outbreak in 2020 and notes that this issue is the subject of the Newmarch House Coronial.

Accordingly, investigative mechanisms must consider the *legal* basis of the federal-state orders/regulations which prevented COVID-19-positive residents from leaving Newmarch and seeking medical care at properly equipped hospitals, or which prevented COVID-19-negative residents from leaving Newmarch to reside in another RACS, or to find private accommodation. Investigators must also consider the precision of such orders/regulations, and what procedures were available for Newmarch residents to challenge the lawfulness of their detention. Establishing the answers to these questions is beyond the scope of this article – suffice to say, it will require close analysis of the federal and state regulations, their interaction, and the regulations as amended from time to time. Nevertheless, this investigation is necessary because any deprivation of liberty that lacks a lawful basis is unlawful and considered a violation of Australia's human rights obligations.[118]

The lack of a lawful basis for detention has been considered before. It is acknowledged that if persons are not at liberty to leave a premise, they are being deprived of their liberty and subject to detention.[119] In 2016, the Senate Community Affairs References Committee ('Senate Committee') confirmed that RACS are places of 'detention' and possibly 'unlawful' detention.[120] Based on evidence presented, the Senate Committee concluded with concern that 'indefinite detention of people with cognitive or psychiatric impairment is a significant problem within the aged care context… It is also clear this detention is often informal,

[114] Gilbert and Lily (n 76) 19, 24.
[115] See *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 106) para11; See also Human Right Committee, *Views: Communication No 702/1996*, UN Doc CCPR/C/60/D/702/1996 (26 April 1996) [5.5] ('*McLawrence v Jamaica*'): "the principle of legality is violated if an individual is arrested or detained on grounds which are not clearly established in domestic legislation".
[116] *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 106) para 22.
[117] Ibid para 14.
[118] Ibid para 11.
[119] *Antunovich v Dawson* (2010) 30 VR 355.
[120] Community Affairs References Committee, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (November 2016) [8.69].

unregulated and unlawful.'[121] That *unlawful* detention of RACS residents occurs in non-pandemic times has been confirmed by the courts.[122] Such false imprisonment can lead to substantial damages claims against the State.[123] This is regardless of the conditions of detention, and whether the person was able to leave the premise occasionally.[124]

Third, we must consider art 9(4) of the ICCPR, which provides a person deprived of their liberty with the right to challenge the lawfulness of this deprivation. This enshrines the common law writ of *habeas corpus*.[125] The WGAD has confirmed that this principle applies to persons deprived of their liberty under mandatory quarantine laws during a pandemic.[126]

Although access to the courts to challenge the lawfulness of their detention was not formally prevented, the residents isolated at Newmarch were not practically able to exercise this right. Beyond COVID-19, one must query whether RACS residents are well-placed to exercise this right. Whether limited by physical, cognitive or financial means, a *habeas corpus* application is beyond most residents, which is confirmed by the infrequency of such challenges reaching the courts.[127]

Anglicare denies that the residents of Newmarch House were denied their right to liberty during the outbreak in 2020.

The fact that Newmarch residents were deprived of their liberty by Anglicare, a non-state actor, does not absolve the federal government of its obligations under international law.[128] According to the HRC, under art 9 '[s]tates parties have the duty to take appropriate measures to protect the right to liberty of person against deprivation by third parties. ... They must also protect individuals against wrongful deprivation of liberty by lawful organizations, such as employers, schools and hospitals.'[129] Moreover, States have a due diligence obligation to prevent non-States actors 'horizontally' violating rights, which gives rise to the legal obligations on States to investigate human rights violations by private entities, such as private RACS.[130]

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[121] Ibid.

[122] *SA Public Advocate v C, B* [2019] SASCFC (24 May 2019). See also *Skyllas v Retirement Care Australia (Preston) Pty Ltd* [2006] VSC 409.

[123] See the English landmark case of *P (by his litigation friend the Official Solicitor) v Cheshire West and Chester Council and another* [2014] UKSC 19 ('*Cheshire West*'). See Esther Erlings, 'False Imprisonment in Locked Wards: *The Public Advocate v C, B*' (2019) 21 *Flinders Law Journal* 109.

[124] Ibid.

[125] *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 106) para 39; El Hadji Malick Sow, (n 102) paras 59-64.

[126] *WGAD, Deliberation No 11* (n 103) para19.

[127] *Compilation of General Comments*, HRI/GEN/1/Rev. 9 (vol 1) (n 127) para 8; See also El Hadji Malick Sow (n 102).

[128] The Federal Government has international legal personality and only the Federal Government can enter into binding international obligations under the *Australian Constitution* s 51(xix) and 61 (see *Koowarta v Bjelke-Petersen* (1982) 153 CLR 168; also *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 282). From an international law perspective, it is the Federal Government that is held to account for violations of human rights within Australia, even if those violations are committed by sub-national jurisdictions, such as States or Territories (see e.g. *ICCPR*, art 50). The operation of international law in a federation is well-illustrated by Australia's first individual communication before the HRC: see Human Right Committee, *Views: Communication No 488/1992,* 50th sess, UN Doc CCPR/C/WG/44/D/488/1992 (31 March 1994) ('*Toonen v Australia')*.

[129] *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 106) para 7; See also, paras 44-52.

[130] *General Comment No 36*, UN Doc CCPR/C/GC/36 (n 97) para 21.

C *Medical Isolation and Solitary Confinement*

Another matter for investigation is whether the Newmarch residents were subjected to isolation that constituted solitary confinement. Under the ICCPR, CAT and CRPD, 'prolonged' solitary confinement can amount to torture, and CIDTP.[131]

The term 'solitary confinement' is typically used in a prison context. Under international law, solitary confinement is regulated by the Mandela Rules, which apply to prisons specifically.[132] While not technically applicable to RACS, they help us understand when 'isolation' may become 'solitary confinement'. Under the Mandela Rules, 22 hours or more per day of isolation constitutes solitary confinement. 'Prolonged' solitary confinement refers to solitary confinement for a period of more than 15 consecutive days.[133] Residents at Newmarch were confined to their individual rooms for 24 hours per day for several weeks, thereby being subjected to 'prolonged' solitary confinement.

The Mandela Rules highlight the key feature of solitary confinement: being the absence of 'meaningful human contact'.[134] The 'meaningful human contact' standard was applied by the NZ-NPM in assessing whether isolation was a health or disciplinary measure.[135] The Istanbul Statement provides examples of 'meaningful human contact':

> This can be done in a number of ways, such as raising the level of prison staff-prisoner contact, allowing access to social activities with other prisoners, allowing more visits, and allowing and arranging in-depth talks with psychologists, psychiatrists, religious prison personnel, and volunteers from the local community.[136]

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[131] See the *ICCPR* (arts 7, 10), *CRPD* (art 15) and the *CAT*. See *General Comment No 20*, UN Doc CCPR/C/GC/1992/20 (n 98) para 6.

[132] For further discussion of solitary confinement in prisons see Anita Mackay, 'The Relevance of the United Nations Mandela Rules for Australian Prisons' (2017) 42(4) *Alternative Law Journal* 279.

[133] The Mandela Rules stipulate that 'solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days': *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)* GA Res 70/175, UN GAOR, 70th sess, Agenda Item 106, UN Doc A/RES/70/175 (17 December 2015) rr 44, 45 ('*Mandela Rules*'). While this definition was introduced by the Mandela Rules in 2015, it is taken from the Istanbul Statement that was finalised in 2007. Therefore 22 hours or more per day is a long accepted international definition of solitary confinement. For a discussion of the development of the definition see Manfred Nowak, 'Global Perspectives on Solitary Confinement – Practices and Reforms Worldwide' in Jules Lobel and Peter Scharff Smith (eds), *Solitary Confinement. Effects, Practices, and Pathways Toward Reform* (Oxford University Press, 2020).

[134] Pursuant to the definition of solitary confinement found in the *Mandela Rules* r 44, 'For the purpose of these rules, solitary confinement shall refer to the confinement of prisoners for 22 hours or more a day without meaningful human contact. Prolonged solitary confinement shall refer to solitary confinement for a time period in excess of 15 consecutive days'.

[135] *NZ-NPM Report 2020* (n 44)14-15, Criteria, Appendix 2, 27.

[136] Symposium, 'The Istanbul Statement on the Use and Effects of Solitary Confinement' (2007) 18(1) *Torture* 63, 65 ('*Istanbul Statement*'). The Istanbul Statement is an expert statement on the use an effects of solitary confinement. It was created in response to the increased use of strict and frequently prolonged use of solitary confinement in prison systems across the world. It was adopted on 9 December 2007 at the International Psychological Trauma Symposium in Istanbul: 'The Istanbul Statement on the Use and Effects of Solitary Confinement', (2008) 18(1), *Torture*, 63. It was provided to the United Nations General Assembly as an Annex to a report by the United Nations Special Rapporteur on Torture in 2008: Manfred Nowak, *Report of the UN Special Rapporteur on Torture* (28 July 2008) UN Doc A/ 63/175, 18 ff. and Annex (22 ff.). For further discussion about the Istanbul Statement see Nowak (n 133).

These examples involve person-to-person communication, rather than telephone- or internet-based communication. Arguably, the limited telephone contact between Newmarch residents and their family members would not constitute 'meaningful human contact'.

The NZ-NPM suggests that 'isolation' is a health measure, but that in certain circumstances it may become 'solitary confinement', which is a disciplinary measure. The NZ-NPM Report states that '[m]edical isolation should be prevented from taking the form of disciplinary solitary confinement; medical isolation must be on the basis of an independent medical evaluation, proportionate, limited in time and subject to procedural safeguards'.[137] Part of this assessment is whether the RACS ensured residents had an '[a]ppropriate amount of time out of the room in which they sleep' and whether it ensured their '[a]bility to have meaningful human contact'.[138]

Anglicare disputes that the decision to cohort residents and isolate them in their rooms during the outbreak at Newmarch House in 2020 was not based on medical advice. Anglicare confirms that it has provided evidence to the Deputy State Coroner about these decisions, and others, and notes that this issue is the subject of the Newmarch House Coronial.

Focussing on the NZ-NPM's criteria for medical isolation, the Newmarch isolation should have been, first, based on an independent medical evaluation, evidence of which Anglicare ought to provide. Second, whether the isolation was proportionate requires an assessment of whether it was reasonable and necessary to isolate COVID-19-negative residents. Third, the period of isolation for residents was limited in time, but it was a 'prolonged' period, particularly for the COVID-19-negative residents. Fourth, the availability and effectiveness of review of the isolation of residents is key to assessing the adequacy of procedural safeguards. Arguably, alternative and less-intrusive measures could have been arranged for COVID-19-negative residents. For example, residents could have been given access to outdoor gardens and courtyards, and given meaningful activity. Moreover, visits by family members with COVID-19-negative residents, with appropriate safeguards, could have been allowed.[139]

Could some measures have lessened the harmful impact of the ongoing quarantine situation on resident's physical and mental health?[140] After all, it is the harmful and adverse effects of solitary confinement we seek to avoid, as articulated in the Istanbul Statement:

> Research suggests that between one third and as many as 90 per cent of prisoners experience adverse symptoms in solitary confinement. A long list of symptoms ranging from insomnia and confusion to hallucinations and psychosis has been documented. Negative health effects can occur after only a few days in solitary confinement, and the health risks rise with each additional day spent in such conditions.[141]

In Australia, there is some confusion within government as to whether torture and CIDTP can occur in privately-run RACS. In late 2019, the Australian Government advised a parliamentary committee inquiry that '[s]uch a situation [of torture] seems unlikely to arise, as approved [aged care] providers are generally private entities. Aged care services are not staffed by persons acting in an official capacity'.[142] As the Parliamentary Joint Committee on Human Rights

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[137] *NZ-NPM Report 2020* (n 44) 27.
[138] These are two of the 'health and safety' criteria developed by the NZ Ombudsman for their OPCAT Covid-19 Inspections: *NZ-NPM Report 2020* (n 44) 27.
[139] There is a precedent for this. The RCAC heard that another RACS in Sydney had a concierge to manage visits (including screening them). They provided training to visitors in using PPE, enabling visits to continue even when there is an outbreak: Commonwealth, *RCAC*, 'Transcript of Proceedings' (Dr Steven Judd) (11 August 2020) 8578, 8553.
[140] ABC News (n 79).
[141] *Istanbul Statement* (n 136) 65.
[142] Parliamentary Joint Committee on Human Rights, Commonwealth Parliament, *Inquiry Report – Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019*, (2019) 48.

explained, this view disregards art 2(1) of CAT, which requires State Parties to take 'effective legislative, administrative, judicial or other measures to *prevent* acts of torture in any territory under its jurisdiction'.[143] Moreover, the definition of torture in art 1 of CAT acknowledges that torture is not limited to acts taken by persons in an official capacity, with the definition including acts 'with the consent or acquiescence of a public official or other person acting in an official capacity'. Indeed, since 1992, the HRC has recognised that State Parties must protect against all art 7 acts 'whether inflicted by people acting in their official capacity, outside their official capacity, or in a *private capacity*.'[144] Further, as discussed above, the Committee Against Torture extends State's responsibilities to 'institutions that engage in *the care of ... the aged* … where the failure of the State to intervene encourages and enhances the danger of *privately inflicted harm*'.[145] Furthermore, State Parties are required to exercise due diligence in this regard and a failure to do so is a breach of CAT.[146] It is disappointing that when the stakes are high –the prevention of torture no less – that the Australian Government fails to acknowledge fundamental elements of its legal responsibilities.

Investigative mechanisms, such as the RCAC and the Coroner, must question whether the Newmarch residents were subjected to human rights violations, such as arbitrary detention, and torture or other ill-treatment arising from prolonged solitary confinement. Part V considers whether the RCAC can use human rights standards in its inquiries into aged care.

V ROYAL COMMISSION INTO AGED CARE (RCAC)

Royal Commissions are established to investigate systemic failings, to restore public trust and to help solve complex policy problems. According to Prasser and Tracey, 'many a royal commission has helped to … frame new public policy'.[147] One strength of investigation by Royal Commissions, besides their flexible and extensive powers to investigate,[148] is the discretion they have to frame the issues under investigation. The RCAC provides an opportunity for human rights standards to be employed in a rigorous manner in seeking public accountability at the systems-level.

The RCAC was established by Letters Patent on 6 December 2018 following the events at the Oakden, which the Prime Minister referred to as the 'Oakden tragedy'.[149] The RCAC's brief is to examine aged-care nationally, including 'the causes of any systemic failures'.[150] Like the

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[143] Ibid (emphasis added).
[144] *General Comment No 20*, UN Doc HRI/GEN/1/Rev.1 (n 98) para 2 (emphasis added).
[145] *General Comment No 2*, CAT/C/GC/2 (n 46) para 15 (emphasis added).
[146] Ibid para 18.
[147] Scott Prasser and Helen Tracey, 'Public Inquiries – living up to their potential' in Scott Prasser and Helen Tracey (eds), *Royal Commissions and Public Inquiries – Practice and Potential* (Connor Court Publishing, 2014) 372.
[148] For a summary of both the powers under the *Royal Commissions Act 1902* (Cth) and a discussion of an example of how flexible these powers are see: Taylah Cramp and Anita Mackay, 'Protecting Victims and Vulnerable Witnesses Participating in Royal Commissions: Lessons from the 2016–2017 Royal Commission into the Protection and Detention of Children in the Northern Territory' (2019) 29(1) *Journal of Judicial Administration* 3.
[149] Prime Minister, Minister for Health, Minister for Senior Australians and Aged Care 'Royal Commission into Aged Care Quality and Safety' (Media Release,16 Sep 2018).
[150] Paragraph (a) in the terms of reference is: 'the quality of aged care services provided to Australians, the extent to which those services meet the needs of the people accessing them, the extent of substandard care being provided, including mistreatment and all forms of abuse, *the causes of any systemic failures*, and any actions that should be taken in response': Commonwealth, *RCAC, Letters Patent–6 December 2018* (2018) (emphasis added).

Oakden Inquiries, the Letters Patent setting out its Terms of Reference do not explicitly refer to human rights. However, some matters included align with human rights, including the need to examine:

- 'the extent of substandard care being provided, including mistreatment and all forms of abuse';
- 'how to ensure that aged care services are person-centred'; and
- 'all aspects of the quality and safety of aged care services, including but not limited to the following: (i) dignity; (ii) choice and control […] (viii) positive behaviour supports to reduce or eliminate the use of restrictive practices'.[151]

By contrast, the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability ('DRC'), established shortly after in April 2019, explicitly refers to the human rights of people with disabilities and Australia's obligations under the CRPD.[152] The DRC released an interim report that makes it clear that the Commissioners are taking a human-rights based approach, with particular emphasis on the CRPD.[153] Of relevance, for the DRC to fulfil its terms of reference, it should consider the CRPD rights of those persons with disabilities living in RACS, which is estimated to be half of the RACS population. The DRC could fill a critical rights-gap if the RCAC fails to address these rights.[154]

Two aspects of the RCAC's approach to date will be examined here: first, the Interim Report released in October 2019; and, second, the hearings held in August 2020 dedicated to the COVID-19 outbreaks in RACS in Sydney, including Newmarch, and the subsequent Special Report tabled on 30 September 2020. Of value, the Interim Report highlights the systemic failures in accountability across the sector. So too, the COVID-19 hearings provided a much-needed public examination of what occurred in RACS, ensuring a measure of accountability for those responsible for the treatment of the residents.

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[151] Commonwealth, *RCAC*, *Letters Patent-6 December 2018* (2018) <https://agedcare royalcommission.gov.au/publications/letters-patent-6-december-2018>.

[152] 'RECOGNISING that people with disability are: equal citizens and have the right to the full and equal enjoyment of all human rights and fundamental freedoms, including respect for their inherent dignity and individual autonomy […] AND Australia has international obligations to take appropriate legislative, administrative and other measures to promote the human rights of people with disability, including to protect people with disability from all forms of exploitation, violence and abuse under the Convention on the Rights of Persons with Disabilities': Commonwealth, Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (*DRC*), *Commonwealth Letters Patent* (4 April 2019) <https://disability royalcommission.gov.au/publications/commonwealth-letters-patent>.

[153] Commonwealth, *DRC*, *Interim Report* (October 2020) xi, 96, 342-343. The October 2020 Interim Report follows an issues paper: Commonwealth, *DRC*, *Rights and Attitudes Issues Paper* (28 April 2020), and commissioned a research report on the CPPD: Rosemary Kayess and Therese Sands, *Convention on the Rights of Persons with Disabilities: Shining a light on Social Transformation* (UNSW Social Policy Research Centre, 2020).

[154] Note the Terms or Reference of the DRC seek to avoid overlap between the two royal commissions by providing: 'We further declare that you are not required by these Our Letters Patent to inquire, or to continue to inquire, into a particular matter to the extent that you are satisfied that the matter has been, is being, or will be, sufficiently and appropriately dealt with by the Royal Commission into Aged Care Quality and Safety, another inquiry or investigation, or a criminal or civil proceeding': Commonwealth, *DRC*, *Commonwealth Letters Patent* (4 April 2019); The DRC's interim report notes that the Commissions are seeking to avoid overlap and that the DRC's work will be 'informed by the findings and recommendations' in the RCAC's final report: Commonwealth, *DRC*, *Interim Report* (October 2020) 311; See also discussion of how copies of submissions are being shared between Commissions, with the consent of authors at 95.

A *The RCAC's Interim Report*

The title of RCAC's Interim Report – *Neglect* – and the title of its Foreword – 'A Shocking Tale of Neglect' – speak volumes.[155] The Interim Report is highly critical of the aged-care sector, and the Commissioners note that 'substandard care is much more widespread and more serious than we had anticipated'.[156] It examines systemic failures, identifying five 'systemic problems' that will be fully examined in the final report,[157] including 'minimis[ing] the voices of people receiving care and their loved ones'.[158] This systemic problem could be characterised as a human rights issue, with a focus on providing residents with effective avenues for raising concerns about their rights and care more generally.

In mid-2019, the Australian Human Rights Commission asked the RCAC to frame its investigations and findings via a human-rights based approach:

> [A] *human rights based approach to aged care* – that is, an approach where human rights norms and principles are integrated in the planning, provision and monitoring of services – *is fundamental to addressing systemic problems and improving aged care*.[159]

Despite this, the RCAC makes only passing references to human rights in its Interim Report. For example, it notes that '[m]any people receiving aged care services have their basic human rights denied'[160] and '[f]ailing to obtain informed consent where required by law ignores the rights of older Australians',[161] but it does not elaborate. The exception is the framing of younger people being accommodated in RACS as a 'human rights issue'.[162] Byrnes notes that this 'is the only section of the [Interim Report] that characterises its subject as a human rights problem and invokes human rights standards so explicitly and prominently'.[163] The Interim Report does not consider specific rights issues of other vulnerable groups within aged-care services, such as persons with disabilities, even though persons with dementia constitute approximately half the population of RACS.

Byrnes notes that 'it is striking how little explicit reference the [Interim R]eport makes to human rights even as it details and denounces a litany of human rights violations resulting from the failures of the system'.[164] Byrnes observes that '[i]n these reports, we see inconsistent and sporadic references to human rights, but more often to principles that do not use the language

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[155] Commonwealth, *RCAC*, *Interim Report* (2019) vol 1, 1 (*RCAC Interim Report*).
[156] Ibid vol 1, 5; 'Substandard care' is defined as:
- care (or complaints about care) which did not meet the relevant quality standards under the Quality of Care Principles 2014 and other obligations under the Aged Care Act; and
- care (or complaints about care) which, although meeting the relevant quality standards under the Quality of Care Principles and other obligations under the Aged Care Act, was not of a standard that would meet the high standards of quality and safety that the Australian community expects of aged care services: Commonwealth, Royal Commission into Aged Care Quality and Safety, *Interim Report* (2019) vol 2, 3.

[157] *RCAC Interim Report* (n 155), vol 1, 255-56.
[158] Ibid vol 1, 255.
[159] Australian Human Rights Commission, *A Human Rights Perspective on Aged Care: Submission to the Royal Commission into Aged Care Quality and Safety* (18 July 2019) 4 (emphasis added).
[160] *RCAC Interim Report* (n 155) vol 1, 12.
[161] Ibid vol 1, 208.
[162] See Ibid vol 1, 241-242.
[163] Andrew Byrnes, 'Human Rights Unbound: An Unrepentant call for a more complete application of human rights in relation to older persons – And beyond' (2020) 39(2) *Australasian Journal of Ageing* 91, 94.
[164] Ibid 92.

of human rights in any consistent or sustained manner, even though they may embody or be aligned with human rights values.'[165]

Significantly, the Interim Report examines the ongoing problems of isolation/solitary confinement and inadequate medical care in RACS with little reference to human rights. First, the Interim Report examines isolation/solitary confinement in the chapter on 'restrictive practices'.[166] Even though multiple governmental and parliamentary bodies have framed restrictive practices as potential human rights violations,[167] including the RCAC's own Background Paper on Restrictive Practices,[168] the Interim Report sidesteps such framing.[169]

Second, regarding inadequate medical care, the Interim Report highlights three areas that would benefit from a human-rights based analysis, which are: 'inadequate prevention and management of wounds, sometimes leading to septicaemia and death'; 'widespread overprescribing, often without clear consent, of drugs which sedate residents, rendering them drowsy and unresponsive to visiting family and removing their ability to interact with people'; and 'patchy and fragmented palliative care for residents who are dying, creating unnecessary distress for both the dying person and their family'.[170]

The RCAC may consider human rights protections in its final report.[171] If the Commissioners accept the final submissions of Counsel Assisting from October 2020, this is a definite possibility. Counsel Assisting set out a 'blueprint for the future' that includes 'legislation which establishes a rights-based approach'.[172] Recommendation 1 is that the *Aged Care Act 1997* (Cth) be replaced with 'a new Act', accompanied by detailed suggestions about what to include in the Act, including a list of rights.[173]. These rights include the protections discussed in this article: the rights to 'freedom from degrading or inhumane treatment, or any form of abuse', and 'liberty, freedom of movement, and freedom from restraint'.[174]

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[165] Ibid.

[166] The Commission gives the following definition of restrictive practices: 'restricting people with wrist restraints, abdominal and pelvic straps, vests, bed rails or deep recliner chairs, confining a person to their room or a section of a facility, or sedating them with particular medication': *RCAC Interim Report* (n 155) vol 1, 194.

[167] See for example the webpage of the NDIS Quality and Safeguards Commission, which states: 'It is now recognised that restrictive practices can present serious human rights infringements': NDIS Quality and Safeguards Commission, *Regulated Restrictive Practices* (Web Page) <https://www ndiscommission.gov.au/regulated-restrictive-practices#02>; See the Parliamentary Joint Committee on Human Rights, *Inquiry Report, Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (13 November 2019); Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws*, Report No 124 (2014) 247-48; Commonwealth, *DRC*, *Restrictive Practices Issues Paper* (26 May 2020) 2.

[168] The RCAC's background paper on restrictive practices contains less than a page about human rights: Commonwealth, *RCAC*, *Restrictive practices in residential aged care in Australia-Background Paper* 4 (May 2019) 20-21. This may be contrasted with the issues paper on restrictive practices issued by the DRC, which refers to 'How we will look at restrictive practices. A human rights-based approach' upfront on page 2: Commonwealth, *DRC*, *Restrictive Practices Issues Paper* (26 May 2020).

[169] This is consistent with what Byrnes refers to as 'the ambivalence of Australian institutions to embrace human rights as a standard of accountability': Byrnes (n 163) 91-92.

[170] *RCAC Interim Report* (n 155) vol 1, 6.

[171] Byrnes thinks it may be overly 'optimistic' to think this will be the case: Byrnes (n 163) 91, 94.

[172] Commonwealth, *RCAC*, 'Counsel Assisting's Final Submissions' 40.

[173] The recommendation is four pages long: Ibid 47-51.

[174] Ibid 51.

B *RCAC's COVID-19 Hearings and Report*

In August 2020, the RCAC conducted preliminary hearings into the handling of COVID-19 outbreaks in Sydney early in the pandemic, with a view to uncovering 'lessons that can be learnt for responding to future pandemics or infectious disease outbreaks'.[175] The Commissioners indicated that a full inquiry was not possible given the many other aspects of the RCAC's work.[176] Despite the limited timeframe, significant benefits arose from these hearings.

From a human rights perspective, one benefit[177] was the provision of some sought-after answers to the family members of residents who died, albeit preliminary answers[178] (the right to know the truth),[179] and an opportunity to hear from some RACS residents. Another key human rights benefit was public accountability. Counsel Assisting undertook a detailed public examination of persons with responsibility relating to the treatment of the Newmarch residents.[180] Counsel Assisting concluded by saying: '[a]ll residents are legally entitled to

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[175] Commonwealth, *RCAC*, *The response to COVID-19 in aged care* (Web Page) <https://agedcare royalcommission.gov.au/hearings-and-workshops/sydney-hearing-2>.

[176] Tony Pagone QC, *Statement from the Honourable Tony Pagone QC relating to the COVID-19 outbreak in aged care facilities* (Media Release, 30 July 2020) <https://agedcare.royalcommission.gov.au/news-and-media/statement-honourable-tony-pagone-qc-relating-covid-19-outbreak-aged-care-facilities-30-july-2020>.

[177] One key benefit was that the hearings were timed to ensure there was enough of a delay for witnesses to have reflected on what occurred and offer advice to other RACS providers facing possible outbreaks in the future. This reflection is evident in some of the evidence quoted in the preceding part. See section 4.1 (n 74, 75, 76, 77, 82, 89, 91, 94, 99).

[178] Answers came in the form of witness statements and other documentary evidence (now available on the Commission's website), and through the examination of witnesses during the hearings.

[179] See, eg, Principle 4. The Victims' Right to Know: 'Irrespective of any legal proceedings, victims and their families have the imprescriptible right to know the truth about the circumstances in which violations took place and, in the event of death or disappearance, the victims' fate.': Commission on Human Rights, *Updated Set of principles for the protection and promotion of human rights through action to combat impunity*, 61st sess, Provisional Agenda Item 17, UN Doc E/CN.4/2005/102/Add.1 (8 February 2005) <documents-dds-ny.un.org/doc/UNDOC/GEN/G05/109/00/PDF/G0510900.pdf?OpenElement>; See also Principle 5 regarding the obligation on states to take effective measures to create bodies such as commissions of inquiry to establish the facts.

[180] This included Anglicare's Chief Executive Officer and General Manager of Service Development and Practice Governance and the medical practitioner overseeing Newmarch's HITM approach. The CEO and the Head of Infectious Diseases, Nepean Hospital both gave evidence on 11 August 2020. Senior government officials also appeared, including the Secretary of the Commonwealth Department of Health and the Aged Care Quality and Safety Commissioner. Senior government officials gave evidence on 12 August 2020. The Commission's hearings were live-streamed, the transcripts are available on their website and there was extensive media coverage, which brought additional attention to the matters raised during the hearings. The coverage was across a wide variety of print media, e.g. Katharine Murphy and Elias Visontay, 'Federal government had no Covid-19 aged care plan, royal commission hears' *The Guardian* (Sydney) 10 August 2020; Julie Power, 'COVID-19 has exposed Australia's aged care sector's flaws, royal commission hears' *SMH* 10 (online), 10 August 2020 <https://www.smh.com.au/national/covid-19-has-exposed-australia-s-aged-care-sector-s-flaws-royal-commission-hears-20200810-p55k7p html>; Ursula Malone, 'Aged care home coronavirus response hurt by government disputes, royal commission hears' *ABC News* (online), 10 August 2020 <https://www.abc.net.au/news/2020-08-10/royal-commission-aged-care-examines-government-coronavirus-plan/12541246>; Jamie McKinnell 'Aged care sector 'not equipped' for coronavirus outbreaks, royal commission told' *ABC News* (online), 13 August 2020 <https://www.abc.net.au/news/2020-08-13/aged-care-sector-still-not-prepared-for-coronavirus/12555014>; Michelle Grattan, 'Federal departments had no specific COVID plan for aged care: royal commission counsel' *The Conversation* (online), 10 August 2020 < https://theconversation.com/federal-departments-had-no-specific-covid-plan-for-aged-care-royal-commission-counsel-144204>; Finbar O'Mallon ''None of this was unforeseeable': Aged care response slammed' *Financial*

quality care at all times. That doesn't change in an emergency. If anything, it becomes more important'.[181]

These benefits were, however, welcome collateral rather than generated by an explicit human rights focus. There were very few explicit references to 'rights' during these hearings, no reference to the Charter of Aged Rights, and the hearings were not framed by human rights.[182] There was no mention of Australia's international human rights law obligations, and there were no expert human rights witnesses called (contrasting starkly with the approach taken by the DRC[183]). In his opening statement to the RCAC, Counsel Assisting noted that 'equal access to the hospital system is the fundamental right of all Australians, young or old, and regardless of where they live…. To put it very directly, older people are not less deserving of hospital treatment because they are old. Such an approach is ageist'.[184] This is one of the few references to RACS residents having 'rights'.

The hearings addressed isolation in some detail. The RCAC heard from a Victorian RACS resident about the impact of visitor restrictions on residents' mental health.[185] This was an ideal opportunity to rigorously consider the lawfulness, reasonableness, proportionality and necessity of the measures imposed on residents; however, such human rights concerns were not examined. Human rights were only mentioned once in this context, by an expert witness, Professor Ibrahim, who was of the opinion that the RACS voluntary code for visiting should have been developed with the assistance of 'either human rights or resident advocates'.[186]

Following these hearings, the RCAC tabled a short Special Report[187] containing six recommendations, all of which were accepted by the Federal Government.[188] While the Special

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Review (online), 13 August 2020 <https://www.afr.com/policy/health-and-education/none-of-this-was-unforeseeable-aged-care-response-slammed-20200813-p55lf2>.

[181] Commonwealth, *RCAC*, 'Transcript of Proceedings' (P Rozen QC, Counsel Assisting) (13 August 2020) 8695.

[182] This may be contrasted with the DRC Covid-19 hearings in August 2020, where the opening statement by the Chair, Ronald Sackville AO QC, states that 'The starting point […] must be the terms of the Convention of the Rights of Persons with Disabilities (CRPD)' […] 'These are important obligations which Australia, under International law, must comply with', Commonwealth, *DRC*, *Opening Statement-Chair Ronald Sackville AO QC* (18 August 2020) 6-7; The opening statement went on to identify one of the four objectives of the hearings to be 'To examine the response of the Commonwealth to the risks to health, safety and wellbeing of people with disability, tested against its responsibilities under International law': at 7.

[183] See Covid-19 hearings in August 2020, which called two expert witnesses on human rights: Catalina Devandas Aguilar, United Nations Special Rapporteur on the Rights of Persons with Disabilities: Commonwealth, *DRC*, 'Transcript of Proceedings – Day 2' (19 August 2020) 180-191 and Rosemary Kayess, Vice Chairperson, United Nations Committee for the Rights of Persons with Disability: Commonwealth, *DRC*, 'Transcript of Proceedings – Day 1' (18 August 2020) 29-41. The RCAC could have called on the UN independent expert on the enjoyment of all human rights by older persons, Claudia Mahler, appointed May 2020, for evidence about the applicable international human rights law.

[184] Commonwealth, *RCAC*, 'Transcript of Proceedings' (P Rozen QC, Counsel Assisting) (10 August 2020) 8377.

[185] Commonwealth, *RCAC*, 'Transcript of Proceedings' (Merle Mitchell) (10 August 2020) 8403-8410.

[186] Commonwealth, *RCAC*, 'Transcript of Proceedings' (Professor Ibrahim) (12 August 2020) 8588. Professor Ibrahim also called for 'a human rights and a public advocacy group to be there to advocate for the residents because there is no one advocating for the residents': at 8578. This latter point was referred to by Counsel Assisting in closing comments: Commonwealth, RCAC, 'Transcript of Proceedings' (P Rozen QC, Counsel Assisting) (13 August 2020) 8695.

[187] Commonwealth, *RCAC*, *Aged care and COVID-19: a special report* (2020) ('*RCAC Covid Report*').

[188] The Hon Richard Colbeck, Minister for Aged Care and Senior Australians, Minister for Youth and Sport, 'Government welcomes Aged Care Royal Commission's COVID-19 report recommendations' (Media Release,

Report refers to a 'fundamental right of all Australians young or old' to 'equal access to the hospital system',[189] this again is one of few explicit references to 'rights'. Absent in the Special Report's analysis is any consideration of international human rights law or its guiding standards of lawfulness, reasonableness, proportionality and necessity.

The Special Report does focus on the experience of residents' isolation in RACS. It pays particular attention to 'visitors and quality of life',[190] and recognises the heavy restrictions imposed on residents, stating that RACS residents 'have endured restrictions for most of this year that go beyond those endured by the general community'.[191] However, isolation is not analysed in human rights terms, whether the focus be on arbitrary detention, the prohibition on CIDTP, or the rights to association and family. Moreover, the RCAC makes no specific preventive recommendation about this.[192] The RCAC's recommendation for a National Action Plan suggests that the Plan 'maximise the ability for people living in aged care homes to have visitors and to maintain their links with family, friends and the community'.[193] This recommendation is not framed via human rights standards: it provides no guarantee that RACS' residents will not continue to be subjected to solitary confinement; it does not call for reasonableness, proportionality and necessity to be considered in implementing the recommendation; and it does not recommend that measures restrictive of the ability be the least-intrusive so as to lessen the risk of harming RACS' residents.

The Special Report also recommended that the proposed National Action Plan be 'developed and supported by' a new permanent national Advisory Body with the following membership: 'members with expertise in the following: aged care; health care, including clinical geriatric care; infection control as it applies in a "home-like setting"; the operational requirements of a range of aged care settings; and the particular characteristics of the aged care workforce'.[194] As highlighted by Ibrahim, this recommendation does not include either resident representatives/advocates or human rights experts on the Advisory Body.[195] Moreover, there is no requirement for the Advisory Body to be independent of both government and RACS providers because it will report to the Australian Health Protection Principal Committee,[196] and that Committee is comprised of State and Territory Chief Health Officers, and chaired by the Australian Chief Medical Officer.[197] Like the ACQSC, this Advisory Body may not be, and may not be perceived to be, independent.

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1 October 2020) < https://www.health.gov.au/ministers/senator-the-hon-richard-colbeck/media/government-welcomes-aged-care-royal-commissions-covid-19-report-recommendations>.

[189] *RCAC Covid Report* (n 187), 21.

[190] Ibid 6.

[191] Ibid 7.

[192] Ibrahim has suggested that the Commission should have recommended a mandatory visitation code to replace the voluntary one: Joseph Ibrahim, 'Older Australians deserve more than the aged care royal commission's COVID-19 report delivers' *The Conversation* (online), 2 October 2020 <https://theconversation.com/older-australians-deserve-more-than-the-aged-care-royal-commissions-covid-19-report-delivers-147273>.

[193] *RCAC Covid Report* (n 187) 12 (Recommendation 4).

[194] Ibid 13.

[195] '[I]t's extremely disappointing the commission has not directed that senior nurses, family members and residents (ideally supported by human rights lawyers) be appointed to the group. The people who will be most affected by the decisions should be directly involved in making them': Ibrahim (n 192).

[196] *RCAC Covid Report* (n 187) 13.

[197] Ibid 11.

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VI CORONIAL INVESTIGATION

Unlike Royal Commissions, which are ad hoc inquiries, Coronial courts are permanent institutions, which means that the ongoing nature of their power to conduct inquests is not dependent on the support of the government of the day. Like Royal Commissions, however, their recommendations are not enforceable, such that momentum for governmental and parliamentary action can be reliant on effective public pressure and civil society advocacy campaigns.[198]

Like Royal Commissioners, Coroners are independent and enjoy wide discretion in the focus of their inquiries and recommendations they make,[199] which includes the discretion to frame their inquests and recommendations in the language of human rights and to focus on systems-level issues. Being inquisitorial rather than adversarial in nature, coronial inquests are described as 'resembling commissions of inquiry rather than criminal or civil litigation', with coroners 'control[ling] the agenda and the proceedings … assisted by a police advocate or counsel', with the freedom to 'choose which witnesses to call or not call' and the ability to 'give directions to police investigators as to the inquiries they need carried out.'[200]

Royal Commissions have influenced the modern development of coronial inquiries in Australia. This influence is evident from the developments in coronial inquiries since the 1987-1991 Royal Commission into Aboriginal Deaths in Custody, which encouraged coroners to take a systems-based approach to inquiries.[201] In this context, Watterson et al comment:

> It was concluded by the Royal Commission that Australian coronial systems should accord coroners the status and powers to enable comprehensive and coordinated investigations to take place. These investigations should lead to mandatory public hearings productive of findings and *recommendations that seek to prevent future deaths in similar circumstances*.
>
> The Royal Commission recommended an expansion of coronial inquiry … to a more comprehensive, modern inquest; *one that seeks to identify underlying factors, structures and practices contributing to avoidable deaths and to formulate constructive recommendations to reduce the incidence of further avoidable deaths*.[202]

In focusing on prevention and 'underlying factors, structures and practices', coronial investigations share much in common with the OPCAT NPMs, which make independent systems-based recommendations to parliament and government in order to prevent future human rights abuses.

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[198] This lack of enforceability fuels concerns that coronial recommendations are not implemented. To address this, commentators have suggested the establishment of a national scheme for monitoring implementation of recommendations: Rebecca Scott Bray and Greg Martin, 'Exploring Fatal Facts: Current Issues in Coronial Law, Policy and Practice' (2016) 12(2) *International Journal of Law in Context* 115, 135.

[199] See s 82 of the *Coroners Act 2009* (NSW): 'A coroner … may make such recommendations as the coroner … considers necessary or desirable to make in relation to any matter connected with the death, suspected death, fire or explosion with which an inquest or inquiry is concerned.'

[200] Judicial Commission of New South Wales, *Local Court Bench Book*, [44-180] <https://www.judcom nsw.gov.au/publications/benchbks/local/coronial_matters html>

[201] Commonwealth, Royal Commission into Aboriginal Deaths in Custody, *National Report*, vol 1, [4.7.4].

[202] Ray Watterson, Penny Brown and John McKenzie, 'Coronial Recommendations and the Prevention of Indigenous Death' (2008) 12(2) *Indigenous Law Bulletin* 4, 6 (emphasis added).

A *Coronial Inquest into Newmarch*

In early June 2020, the NSW Coroner announced a coronial inquest into the deaths at Newmarch.[203] The NSW coronial system serves various objectives. Under the *Coroners Act 2009* (NSW) ('*NSW Act*'), there is the traditional narrow objective of 'investigating certain kinds of deaths or suspected deaths in order to determine the identities of the deceased persons, the times and dates of their deaths and the manner and cause of their deaths'.[204] There is also the more modern objective of enabling 'coroners to make recommendations in relation to matters in connection with an inquest or inquiry (including recommendations concerning public health and safety and the investigation or review of matters by persons or bodies)'.[205] This is considered 'a critical function of a coroner.'[206]

Coronial jurisdiction to hold an inquest into a death or suspected death depends on a death being a 'reportable death', or occurring in circumstances where a medical practitioner cannot provide 'a certificate as the cause of death'.[207] "Reportable deaths" fall into two categories: those reportable 'by virtue of circumstance … or setting'.[208] Regarding *circumstance*, a "reportable death" under s 6(1) includes a death where the person died 'a violent or unnatural death' (sub-para (a)), 'a sudden death the cause of which is unknown' (sub-para (b)), 'under suspicious or unusual circumstances' (sub-para (c)), or 'in circumstances where the person's death was not the reasonably expected outcome of a health-related procedure' (sub-para (e)). Regarding *setting*, under s 23 'a senior coroner [the State Coroner or Deputy State Coroner] has jurisdiction to hold an inquest concerning the death of a person if it appears to the coroner that the person has died … while in the custody of a police officer or in other lawful custody'. Moreover, under s 24, a senior coroner has jurisdiction to hold an inquest concerning the death of a child and a disabled person in certain circumstances, presumably on the basis that they have a higher risk of vulnerability.[209]

There are qualitative differences between deaths reported due to *setting* and those reported due to *circumstance*. First, deaths reported due to *setting* must be investigated by a senior coroner, whereas the deaths reported due to *circumstance* can be investigated by a coroner. Second, an inquest is mandatory for, inter alia, deaths occurring in the s 23 *settings*, being those occurring in custody or in the course of police operations.[210] Other situations requiring mandatory inquests include homicides, where 'it has not been sufficiently disclosed whether the person has died, or where the person's identity, or date, place, manner and cause of the person's death has 'not been sufficiently disclosed'.[211]

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[203] Noyes (n 9).
[204] *Coroners Act 2009* (NSW) s 3(c).
[205] Ibid s 3(e).
[206] *Local Court Bench Book* (n 200) [44-100].
[207] *Coroners Act 2009* (NSW) s 21(1).
[208] Mitchell (n 3) 44.
[209] The circumstances includes where a child is in care *Coroners Act 2009* (NSW) s 24(1)(a), if the child or the sibling of a child were the subject of a report under Part 2 of Chapter 3 of the *Children and Young Persons (Care and Protection) Act 1998* in the three years preceding the death at s 24(1)(b) and (c), if the death of a child is due to abuse or neglect or under suspicious circumstances at s 24(1)(d), if the person was living in supported group accommodation or an assisted boarding house at s 24(1)(e), or a person with a disability receiving care allowing them to live independently in the community at s 24(1)(f).
[210] *Coroners Act 2009* (NSW) s 27(1)(b).
[211] Ibid s 27(1)(a), (c), (d).

Where an inquest is not mandatory, a coroner may decide not to hold an inquest into a death. In addition to dispensing with an inquest where investigations indicate that the deceased person died of natural causes under s 25(2), according to the Local Court Bench Book:

> If the identity of the deceased and the date, place, cause and manner of death are all clear, there is no particular issue of public health or safety to address, if there are no suspicious circumstances and no compelling request for an inquest has been made, a coroner will ordinarily dispense with an inquest. If, on the other hand, there are live questions about these issues, an inquest should be considered.[212]

It is estimated 'that in over 90% of cases, the holding of an inquest can be dispensed with because the answers to the questions are relatively clear and there are no general issues of public interest to pursue.'[213]

Interestingly, the *NSW Act* differs from its inter-state counterparts in that it carves out deaths of persons over 72 years of age where the person dies 'after sustaining an injury from an accident, being an accident that was attributable to the age of that person, contributed substantially to the death of the person and was not caused by an act of omission by any other person'.[214] This carve out only applies to "reportable deaths" under s 6(1)(a), being where the persons death was 'a violent or unnatural death'. In such a situation, a medical practitioner may provide a certificate as the cause of death, rendering the death no longer 'reportable' – but in all other s 6(1) scenarios, the deaths remain reportable.

In terms of findings, under s 81(1), coroners in NSW are to record 'whether the person died and, if so, (a) the person's identity, and (b) the date and place of the person's death, and (c) … the manner and cause of the person's death'. In addition, under s 82(1), a coroner 'may make such recommendations as the coroner … considers necessary or desirable to make in relation to any matter connected with the death…'.[215] This includes matters concerning 'public health and safety' and 'that a matter be investigated or reviewed by a specified person or body'.[216] This broad recommendation power allows coroners to consider a range of preventive measures to ensure deaths and ill-treatment are not repeated in the future, and offers scope for human rights considerations to be part of the coronial investigation, provided there is 'a connection between the recommendation and the death.'[217]

In terms of accountability for past behaviours and influencing future policy direction and legislative development, as mentioned earlier coroners cannot enforce their findings and recommendations, and cannot command a response to their reports. However, three mechanisms bolster the influence of coronial outputs in NSW. First, under s 37, the State Coroner must report annually to Parliament all deaths occurring in the s 23 *settings*, being those occurring in custody or in the course of police operations. Second, coroners can request a

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[212] *Local Court Bench Book* (n 200) [44-160].
[213] Ibid [44-100]. The Bench Book notes the following competing factors when deciding whether to hold an inquest at [44-160]): 'whether an inquest is likely to lead to recommendations that will assist with the prevention of future deaths of a similar kind. On the other hand, if remedial action has been taken so that an inquest will not result in useful recommendations, the argument for dispensing with an inquest becomes stronger.'
[214] *Coroners Act 2009* (NSW) s 38(2).
[215] *Coroners Act 2009* (NSW) s 82(1).
[216] Ibid ss 82(2)(a)-(b).
[217] *Local Court Bench Book* (n 200) [44-220].

response.[218] Third, the NSW Department of Premier and Cabinet has issued a protocol to all Ministers and public officials requiring them to acknowledge receiving coronial recommendations within 21 days of receipt, and to respond to the recommendations within three months (or provide progress reports every three months).[219] The Minister must provide an explanation where recommendations are not implemented.[220]

B *Newmarch Inquest as Deaths in Custody or Care*

Anglicare denies that the Deputy State Coroner is considering whether the deaths at Newmarch House were 'deaths in custody'.

The NSW coronial inquest into the Newmarch deaths is a welcome opportunity for uncovering systems-level failures and future prevention measures. One preliminary question is whether the Newmarch deaths can be considered 'deaths in custody'. This classification carries symbolic weight, given that 'deaths in custody' generally call for a higher level of accountability and independent scrutiny. As mentioned, in NSW a senior coroner 'has jurisdiction to hold an inquest concerning the death of a person if it appears to the coroner that the person has died … while in the custody of a police officer *or in other lawful custody*'.[221] Over the years, 'other lawful custody' has in practice included the death of a forensic patient,[222] and it has not been strictly limited to deaths in prison custody, police custody, juvenile detention or immigration detention.[223] However, according to the State Coroner's annual reports regarding s 23 deaths under s 37, the five-year period from 2015 to 2019 indicates that no deaths in RACS had been classified as a 'death in custody'.[224]

The other *setting* jurisdiction is also relevant to Newmarch. As mentioned above, under s 24, the *NSW Act* also offers higher-level coronial investigation in relation to the deaths of various groups of people placed in settings which can be characterised as vulnerable, such as children and disabled persons. Of the latter group, this applies only to persons who live in accommodation registered under the scheme created by the *NDIS Act* (Cth) – in other words, people *under* 65 years of age, which would exclude many residents of RACS.[225] This is

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[218] The power to request a response is contained in the State Coroner's Circular No 72, and referred to in the *Local Court Bench Book* (n 200) [44-220].

[219] *Local Court Bench Book* (n 200) [44-220]; The protocol requires the Minister to have recommendations reviewed, and prepare a report addressing 'the outcomes that will be achieved by implementing the recommendation', 'whether the implementation of the recommendation is the preferable option', 'if the recommendation is to be adopted, a plan for doing so', 'the time frame for implementation', and 'the cost of implementation' – with the expectation being 'that Ministers generally implement recommendations unless the recommendation is impracticable due to cost or other factors or the outcome can be achieved in another way.': at [44-220].

[220] *Local Court Bench Book* (n 200) [44-220].

[221] (emphasis added). Section 23 of the *Coroners Act 2009* (NSW) is entitled 'Jurisdiction concerning deaths in custody or as a result of police operations'. This means that non-police custody situations were envisaged and it would be up to the coroner to determine whether such situations might encompass that experienced by the Newmarch residents.

[222] NSW Office of the State Coroner, *Report of the NSW State Coroner into Deaths in Custody/Police Operations for the year 2019* (April 2020), 1.

[223] Ibid 8.

[224] Ibid; NSW Office of the State Coroner, *Report of the NSW State Coroner into Deaths in Custody/Police Operations for the year 2018* (April 2019); NSW Office of the State Coroner, *Report of the NSW State Coroner into Deaths in Custody/Police Operations for the year 2017* (April 2018); NSW Office of the State Coroner, *Report of the NSW State Coroner into Deaths in Custody/Police Operations for the year 2016* (April 2017); NSW Office of the State Coroner, *Report of the NSW State Coroner into Deaths in Custody/Police Operations for the year 2015* (April 2016).

[225] See *Coroners Act 2009* (NSW) s 24(1)(e). Persons 65 or older are not able to access the NDIS.

unfortunate, given Mitchell's assessment that '[o]lder persons living in RACS are vulnerable to abuse, and are more likely to have some degree of cognitive impairment and/or a disabling condition'[226] Despite this, Mitchell indicates that a death in a RACS is not a prescribed setting in any state or territory.[227]

There are also aspects of 'reportable deaths' which impact on coronial jurisdiction over deaths in RACS. First, health care related deaths are 'reportable deaths' across all jurisdictions.[228] However, Mitchell argues this has 'limited application to a death in an RACS because the focus of such investigations 'has centred on the criteria that the death was not a reasonably expected outcome.'[229]

Secondly, NSW is the only Australian jurisdiction where a 'death in care' is not listed as a 'reportable death'.[230] The inclusion of 'death in care' as a 'reportable death' ought to be sufficient to trigger coronial jurisdiction for a death in a RACS. However, Mitchell highlights that many jurisdictions use a 'narrow or constrained definition' for the term 'death in care' that excludes RACS.[231] For example, Mitchell highlights that the Queensland State Coroner's guidelines explicitly exclude deaths in RACS from 'death in care', meaning such deaths are not automatically reportable and are only reportable under another 'reportable' circumstance to attract coronial jurisdiction.[232]

Victoria has a broader approach to 'deaths in care'. Similarly to NSW, under s 4(2)(a) of the *Coroners Act 2008* (Vic) ('*Victorian Act*'), any 'unexpected, unnatural or violent' death or any death resulting 'directly or indirectly from an accident or injury' is a 'reportable death' and subject to coronial investigation. In terms of the 'unexpected' element, this means that if a person dies in a RACS and a medical practitioner *can explain* their death (and none of the other factors are relevant), there is no need for a coronial investigation; whereas, a coronial investigation will be needed where a medical practitioner *cannot explain* their death – that is, the medical practitioner cannot issue a death certificate because the cause of death is unknown.

In addition, the death of 'a person placed in custody or care' is also 'reportable' under s 4(2)(c) of the *Victorian Act*. Relevantly, s 3(1) defines 'person placed in custody or care' to include 'a person under the control, care or custody of the Secretary to the Department of Human Services

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[226] Mitchell (n 3) 36-37.
[227] Ibid 44.
[228] Sarah Middleton and Michael Buist, 'The Coronial Reporting of Medical-Setting Deaths: A Legal Analysis of the Variation in Australian Jurisdictions' [2014] 37 *Melbourne University Law Review* 699.
[229] See Mitchell (n 3) 44 citing Sarah Middleton and Michael Buist, 'The Coronial Reporting of Medical-Setting Deaths: A Legal Analysis of the Variation in Australian Jurisdictions' (2014) 37(3) *Melbourne University Law Review* 699, 713–14.
[230] See Mitchell (n 3) 35, 44, fn 95.
[231] Ibid; See, eg, Queensland Courts, *State Coroner's Guidelines* (2013) chpt 3, 20 which state: 'the death of an aged care resident per se is not reportable as a death in care (disability)': 'Resources and Legislation', *Queensland Courts* (Web Page, 2 December 2020) ('*State Coroner's Guidelines 2013*') <https://www.courts.qld.gov.au/courts/coroners-court/about-coroners-court/resources-and-legislation#state>; This extends to those NDIS participants living in RACS and young persons living in RACS: at 21-2. This is despite the following rationale: 'Coronial scrutiny of these deaths is warranted because the ability of these groups of people to make independent, informed decisions about their lives is subject to some form of intervention by the State. The significance of a death being reported as a death in care lies in the requirement under s 27(1)(a)(ii) of the Act for an inquest to be held when the circumstances of the death raise issues about the deceased person's care.': at 18.
[232] Mitchell (n 3) 44.

or the Secretary to the Department of Health.' This category ensures that deaths of persons held in care are 'reportable irrespective of the cause', and 'recognises the vulnerability of people in State care, the appropriateness of transparent and independent investigation of their death by the coroner, and implicitly invites appraisal of the relevance of their status and the adequacy of the care provided to them'.[233] From a human rights perspective, where the person is effectively deprived of their liberty, reliant on others for their care and well-being, and more vulnerable to ill-treatment, there is a public interest in ensuring independent and external supervision.

Under s 15 of the *Victorian Act*, a coronial investigation is mandatory for all 'reportable deaths' which, by force of ss 3 and 4, includes the deaths of persons who were 'under the control, care or custody of' the relevant departments, which in Victoria includes over 180 Public Sector RACS ('PSRACS').[234] For deaths in these PSRACS, the issue comes down to meaning of 'control, care or custody', which is a question of fact and degree. Considering the Newmarch facts in the context of the *Victorian Act*, the residents requiring the HITH level of care would arguably qualify as being in 'custody, control or care'. More generally, whether persons within PSRACS ought to be considered to be in the 'control, care or custody' of their care provider should turn on considerations similar to those of 'places of detention' under OPCAT, including whether the residents are able to freely leave the PSRACS (e.g. whether they are under guardianship orders which limit their liberty). The use of the OPCAT definition of detention may focus the minds of coroners, and those with the responsibility to report deaths to coroners,[235] to the particular vulnerability of persons in care, and for the potential characterisation of their treatment (poor quality of care or lack of provided care) to constitute torture or CIDTP, instead of 'failures in care'.[236] Moreover, the legal notion of 'care' must account for the factual and practical reality of the situation of the person in care, which is consistent with human rights standards which focus on both the legal and factual indicators of detention. As Mitchell notes, older persons living in RACS 'are often frailer and more dependent on others for care and support and all approved care recipients reflect high level needs.'[237]

The NSW Coroner's announcement of the Newmarch Inquest is noteworthy given that, according to Mitchell, coroners are 'disproportionately unlikely to hold inquests for … deaths among the elderly (65 years of older) … the odds of discretionary (non-mandated) inquests

[233] *Inquest into the Death of Donna Lavinia Narelle Vicky Faure* (Unreported, Coroners Court of Victoria, Coroner Paresa Antoniadis Spanos, 9 December 2010) [8].
[234] Like elsewhere in Australia, the Commonwealth Government is responsible for RACS in Victoria, but the services are provided by a range of providers, including public providers. In fact, the Victorian Government boasts that it 'plays a key role in residential aged care through its funding contribution and support for high quality care in public sector residential aged care services' (PSRACS): State Government of Victoria, 'Residential aged care services', *Victoria's Hub for Health Services & Business* (Web Page) <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care>; The Victorian Government also notes that, with over 180 PSRACS, 'the Victorian Government is the largest public provider of residential aged care in Australia', with most services being 'operated by public health services': State Government of Victoria, 'Residential aged care services', *Victoria's Hub for Health Services & Business* (Web Page) <https://www2.health.vic.gov.au/ageing-and-aged-care/residential-aged-care>; PSRACSs come under the Department of Human Services and Health, meaning that deaths in PSRACS are 'reportable deaths'.
[235] See, eg, *Coroners Act 2009* (NSW) ss 35-38; *Coroners Act 2008* (Vic) ss 10-13.
[236] This vague term was used in the Oakden inquiries: see *Carnell-Paterson Review* (n16) ppii, 4.
[237] Mitchell (n 3) 36-37. By 'approved care', Mitchell is referring to ss 21-22 of the *Aged Care Act 1997* (Cth), which sets out the eligibility criteria for receiving residential care.

declined with the aged of the decedents'.[238] The very low rate of inquests for deaths taking place in RACS might be attributed to coroners' distillation of the public interest to be attached to the allocation of their public resources: the public interest driving coroners is preventing avoidable deaths, and not necessarily on the rights of older persons in RACS who are unavoidably going to die anyway. Nevertheless, s 23(1)(a) of the *NSW Act* may offer sufficient scope for NSW's senior coroners to determine whether the deaths of RACS residents might be 'deaths in custody' because they are subject to 'other lawful custody' and thus requiring mandatory inquest. [239] This coronial determination might be based on the level of deprivation of liberty which the term 'custody' entails.[240] A coronial finding that the Newmarch deaths were 'deaths in custody' would support the expert calls for secure RACS to be considered 'places of detention' for OPCAT monitoring purposes.

C *Newmarch Inquest and Human Rights*

A pressing issue is whether the NSW Coroner will adopt human rights standards in conducting the Newmarch inquest. Coroners across Australia, much like Royal Commissioners, take an uneven approach to adopting human rights standards in conducting their investigations and inquests, and in making recommendations. For example, Freckelton and McGregor observe that in terms of coronial practice, 'the human rights perspective has received relatively scant attention in Australia'; and that 'this contrasts with the situation in some other parts of the world where it has become an important yardstick', such as England and Scotland.[241]

Freckelton and McGregor argue that coroners should embrace human rights law and they identify three ways in which human rights law can be beneficial for coronial practice:

> [First, it] has the potential to facilitate better informed and contextualised findings, comments and recommendations and it is likely to be consistent with the avowed obligations expressed within current coronial legislation and its interpretation ...
>
> [Second, it] is likely to lend greater weight to coronial recommendations directed toward reducing the risks of further such violations. …
>
> [And finally] it has the potential to enhance the efficacy of the recommendatory function of coroners which constitutes a considerable component of the contemporary relevance of the reinvigorated coronership that is evolving.[242]

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[238] Mitchell (n 3) 42. See also Joseph Ibrahim et al, 'Premature Deaths of Nursing Home Residents: an Epidemiological Analysis' (2017) (10) *Medical Journal of Australia* 442.

[239] Among Australian parliaments, South Australia's is an outlier in having expressly provided that the deaths of those persons under guardianship orders (i.e. under lawful custody) should not be framed as 'deaths in custody'. See section 76A of the *Guardianship and Administration Act 1993* (SA) which provides: 'The death or apparent death of a person from natural causes while subject to an order under section 32(1)(b) [guardianship orders] is, despite the definition of ***death in custody*** in section 3(1) of the *Coroners Act 2003*, not to be taken to be a death in custody for the purposes of section 21(1)(a) of that Act.

[240] *State Coroner's Guidelines 2013* (n 231).

[241] Ian Freckelton and Simon McGregor, 'Coronial Law and Practice: A Human Rights Perspective' (2014) 21 *Journal of Law and Medicine* 584, 584.

[242] Ibid 601; See also Jonathan Hunyor, 'Human Rights in Coronial Inquests' (2008) 12 *Indigenous Law Bulletin* 64.

In regard to the Newmarch inquest, it is hoped that the NSW Coroner pays heed to these compelling arguments by harnessing international human rights standards in rigorously investigating the actions and omissions of both the state and federal governments, including the relevant regulator, and in making recommendations to prevent further human rights abuses. In particular, the Coroner could consider the lawfulness, necessity and proportionality of the measures imposed on RACS residents which, in some cases, may have contributed or even led to their premature deaths.

D *Victorian Inquest into Covid-19 Deaths in RACS*

On 6 August 2020, the Victorian Coroner's Court announced that its State Coroner is undertaking an investigation into the death of five residents at St Basil's Home for the Aged at Fawkner (not a PSRACS).[243] The State Coroner confirmed that the scope of the inquiry may expand to other RACS, depending on the findings of the initial investigation.[244] St Basil's was severely impacted by the 'second wave' of COVID-19 in Victoria. St Basil's staff were quarantined on 22 July,[245] the residents were evacuated to hospitals on 31 July,[246] and by the date of the announcement of the coronial investigation there were 160 cases linked to St Basil's.[247] In terms of its jurisdiction under s 4(2)(a) of the *Victorian Act*, the death of older persons from COVID-19 is arguably not 'unexpected' – that is, it is expected that older people are more likely to die from COVID-19.[248] However, the deaths ought to be 'reportable' under the 'accidental' aspect of s 4(2)(a). The transmission of COVID-19 within St Basil's appears to be *accidental*, in the sense that infection control protocols were inadequate, such that there is a question about whether the RACS was a systemically unsafe place.[249]

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[243] Coroners Court of Victoria, 'Victorian State Coroner to investigate St Basil's aged care deaths (Media Release, 6 August 2020) <https://www.coronerscourt.vic.gov.au/victorian-state-coroner-investigate-st-basils-aged-care-deaths>.

[244] 'Victorian coroner to investigate deaths at St Basil's aged care home during coronavirus pandemic' *ABC News* (online at 6 August 2020) <https://www.abc net.au/news/2020-08-06/coroner-investigates-coronavirus-deaths-st-basils-aged-care-home/12529042?>.

[245] Chip Le Grande, 'Chief Health Officer was warned St Basil's order would jeopardise care', *The Age* (online at 31 July 2020) <https://www.theage.com.au/national/victoria/chief-health-officer-was-warned-st-basil-s-order-would-jeopardise-care-20200730-p55h2o.html>.

[246] 'Victorian coronavirus outbreaks in aged care homes swell as St Basil's in Melbourne evacuated' *ABC News* (online at 31 July 2020) <https://www.abc.net.au/news/2020-07-31/victorian-coronavirus-outbreaks-aged-care-homes-st-basils/12513668>.

[247] *ABC News* (n 244).

[248] See the Australia Government's Health Advice: Australian Government, Department of Health, *Advice for people at risk of coronavirus (COVID-19)* (Web Page, 22 October 2020) <https://www health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/advice-for-people-at-risk-of-coronavirus-covid-19>; The fatality rate for those persons over 80 years of age is over 20% in Australia, but it varies in different countries: see World Health Organisation, *Guidance on COVID-19 for the care of Older People and People Living in Long-term Care Facilities, other non-acute facilities and home care* (Web Page, 23 July 2020) 1 <https://iris.wpro.who.int/bitstream/handle/10665.1/14500/COVID-19-emergency-guidance-ageing-eng.pdf>.

[249] Various media statements from government and health care providers highlight the systemic failures in the planning and executive of infection control at St Basil's. A media release by the Department of Health, announcing a decision 'made cooperatively between the Commonwealth and Victoria officials' to relocate all St Basil's residents to hospitals, the Executive Officer of Vic is quoted as saying: 'The Response Centre's highest priority is keeping the aged care residents safe, minimising the spread of the virus, the safety of staff and saving lives. This is about ensuring high quality care for St Basil's residents during this challenging time': 'St Basil's aged care residents transferred to hospital', *Australian Government, Department of Health* (Media Release, 31

Of relevance to the use of human rights standards in coronial investigation is the operation of the *Charter of Human Rights and Responsibilities Act 2006* (Vic) ('*Charter*'). The *Victorian Act* designates the Coroners Court as an 'inquisitorial court',[250] and the Coroners Court is included in the definition of 'court' under the *Charter*. This means that the Coroners Court is a 'public authority' when acting in an administrative capacity under s 4(1)(j) of the *Charter*, and thus bound by s 38 of the *Charter*.[251] The Attorney-General confirmed that 'when exercising the majority of its powers, the Coroners Court will be acting in an administrative capacity and will therefore be bound as a public authority by the obligation in section 38 of the *Charter*.'[252] Section 38 makes it 'unlawful for a public authority to act in a way that is incompatible with a human rights' (the substantive obligation) 'or, in making a decision, to fail to give proper consideration to a relevant human right' (the procedural obligation).[253] Beyond the Coroners Court, the s 38 obligations may also apply to the RACS providers in this investigation, given that the definition of 'public authority' includes functional/'hybrid' public authorities, being 'an entity whose functions are or include functions of a public nature, when it is exercising those functions on behalf of the State or a public authority'.[254] Human rights considerations will therefore be part of the St Basil's coronial investigation in Victoria, and it should provide an interesting comparator to the Newmarch inquest.

Beyond the *Charter*, and in terms of accountability and influencing future behaviours, s 72(2) of the *Victorian Act* allows a coroner to make recommendations to 'any entity on any matter connected with a death'. Sections 72(3) and (4) then provide that any entity that receives such a recommendation 'must provide a written response' within 3 months, and the response 'must specify a statement of action (if any) that has, is or will be taken in relation to the recommendations'. Again, with differing obligations regarding responses to coronial recommendations in NSW and Victoria, it will be interesting to compare the responses by Newmarch and St Basil's to their respective coronial inquests.[255]

July 2020) <https://www.health.gov.au/news/st-basils-aged-care-residents-transferred-to-hospital-0>; As per the public statement from the Epworth, '[a] team of our clinical staff has been seconded to St Basil's to work with the St Basil's team to provide nursing care, guidance on the use of personal protective equipment, isolation principals and supporting the provision of ongoing safe care': 'Epworth steps in at St Basil's', *Epworth* (Web Page) <https://www.epworth.org.au/newsroom/epworth-steps-in-at-st-basils>.

[250] *Coroner Act 2008* (Vic) s 89(4).

[251] This is confirmed in the Statement of Compatibility attached to the Coroners Bill 2008: Victoria, *Parliamentary Debates*, Legislative Assembly, 9 October 2008, 4030 (Mr Hulls, Attorney-General).

[252] Scrutiny of Acts and Regulations Committee, Parliament of Victoria, *Alert Digest* (No 15 of 2008, 2 December 2008) 13.

[253] See generally, Alistair Pound and Kylie Evans, *Annotated Victorian Charter of Rights* (Thomson Reuters, 2nd ed, Pyrmont NSW, 2019) 297-310.

[254] *Charter 2006* (Vic) s 4(1)(c). Section 4(2) then outlines a list of inclusive factors for determining whether a function is a function of a public nature. The presence of one or more factors does not necessarily mean the function is of a 'public nature'. See also ss 4(4) and (5). In the British case of *YL v Birmingham City Council* [2008] 1 AC ('*YL*'), concerning the provision of services in a private care home, a majority of 3 judges held that the care home was not a public authority, whereas a minority of 2 judges found the care home was a public authority. Due to differences in the definition of 'public authority' between the *Charter* and the *Human Rights Act 1998* (UK), particularly the former's focus on a functional approach and the latter's focus on institutional approach, Bell J indicated that the minority opinion in *YL* is 'to be preferred' (*Metro West Housing Services Ltd v Sudi (Residential Tenancies)* [2009] VCAT 2025 [138]). See also Pound and Evans (n 253) [4.440 – 4.460].

[255] Ian Freckelton and David Ranson note that Victoria is the only jurisdiction that requires entities that are not part of the State to provide explicit responses to coronial recommendations: Ian Freckelton and David Ranson, 'Death Investigation and the Role of the Coroner' in Ian Freckelton and Kerry Petersen (eds) *Tensions and Traumas in Health Law* (Federation Press, 2017) 561, 583.

Arguably the current problem in Australian RACS is the 'under-reporting' of both ill-treatment and deaths.[256] However, if every death in a RACS is considered a 'death in custody' resulting in a mandatory coronial inquest, this would dramatically increase the workload of coronial services and arguably result in 'over-reporting'. Ultimately it is a policy call as to whether further resources should be allocated for coronial investigations – is there a public interest in over-reporting deaths in RACS so that no ill-treatment is missed, or only reporting deaths in RACS where other circumstance factors trigger a report and thereby potentially under-reporting? In this context, the OPCAT monitoring system for RACS is a more appealing alternative because it focuses resources on preventing systems of ill-treatment as a means of improving the quality of lives in RACS and avoiding unnecessary deprivations of life, rather than on prevention opportunities arising from individual death investigations. Moreover, OPCAT's monitoring is primarily driven by human rights considerations, whilst coronial investigation focuses on preventing avoidable deaths in the public interest, with human rights being one element of a Coroner's assessment of the public interest.

VII CONCLUSION

The Newmarch tragedy is yet another 'sentinel case',[257] coming too soon after Oakden. It highlights that residents of RACS reside in vulnerable settings – out-of-sight, often unable to leave, potentially isolated and neglected, not guaranteed to have meaningful contact with those outside, and possibly unable to independently seek proper medical assistance. It also underlines that during both pandemic and non-pandemic times, independent external monitoring of RACS is absent.

The NZ experience demonstrates how OPCAT-compliant monitoring ensures timely and independent monitoring, and the benefits of monitoring embedded in a human rights legal framework. Such monitoring is an essential safeguard in protecting residents of RACS from CIDTP. Such independent monitoring based on human rights standards is the best guarantee that residents of RACS will be treated with humanity and dignity, and assure family members and the broader community that, even when their loved ones are out-of-sight, they are treated with respect.

The monitoring of RACS must be at the systems-level, and be proactive and preventive in its focus. The Newmarch tragedy cannot be blamed on individual actors; attention should focus on the aged-care system as a whole, where standards of review are substandard and accountability is seriously lacking. As Ibrahim and Ranson argue, '[t]he benefit of examining the whole system is that it shifts our tendency from blaming failures on the staff and their work practices'.[258]

The residents, their families and the broader community want accountability for the human rights failures occurring in RACS. The final report of the RCAC and the NSW Coroner should take a systems-level approach in reporting on the failures in RACS, and should embrace human rights standards and analysis. Some older persons' advocacy bodies recognise the need for human rights standards to be part of this accountability framework: COTA is calling for the government's response to the COVID-19 crisis, 'at the structural or big picture level', to

[256] On the problem of under-reporting of institutional abuse of older persons, see Mitchell (n 3) 36.
[257] The description given to Oakden in the *Carnell-Paterson Review* (n 16) 50.
[258] Joseph Ibrahim and David Ranson, 'Neglect in Aged Care – A Role for the Justice System?' (2019) 27 *Journal of Law and Medicine* 254, 256.

'emphasis[e] human rights'.[259] Given the funding arrangements for such advocacy bodies means they are effectively beholden to government, this call should not be lightly dismissed.

Extending OPCAT monitoring of places of detention to Australian RACS, like in NZ, will ensure that this approach is taken. Like in NZ, identifying the specific RACS that prevent, or may prevent, residents from leaving at their will needs to be considered on a case by case basis. This would cover all locked units in RACS, but it would also cover those RACS with medium to high needs residents, where liberty is or may be limited or removed. The voices and needs of these residents are largely invisible: OPCAT monitoring will help ensure their treatment is the subject of greater scrutiny and accountability.

[259] COTA Australia, 'Lessons of the COVID-19 crisis for Aged Care Reform-Submission 1', Submission to the *RCAC* (July 2020) 5,19. See at <https://www.cota.org.au/wp-content/uploads/2020/08/COTA-Australia-ACRC-Submission-Lessons-from-COVID-19-Submission-1-Final.pdf>. The Grattan Institute has recently released two reports that argue for a rights-based approach to aged care: Stephen Duckett and and Hal Swerissen, *Rethinking Aged Care: Emphasising the rights of older Australians* (October 2020); Stephen Duckett, Anika Stobart and Hal Swerissen, *Reforming Aged Care: A Practical Plan for a Rights-based System* (November 2020).