HUMAN RIGHTS ACCOUNTABILITY FOR SYSTEMS OF ILL-TREATMENT IN RESIDENTIAL AGED CARE

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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 facilities ('RACFs'). The deaths in Newmarch House in Sydney in April – May 2020 made it the first RACF 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 2022. This article uses Newmarch House as an illustration of the regulatory and governmental system-wide failure to adequately protect the human rights of residents in RACFs. 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 the lead of New Zealand and extend the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment *('*OPCAT*') monitoring regime to RACFs. This would provide residents of RACFs deprived of their liberty with the same preventive protections afforded by the* OPCAT *to all Australians deprived of liberty. This is protection that such residents are legally entitled to under the* OPCAT.

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I INTRODUCTION

In Australia, deaths in residential aged care facilities ('RACFs') are treated as predictable, expected and explicable. Such deaths do not often automatically trigger external and independent investigation and accountability processes, although deaths in similar settings of deprivation of liberty do. Despite the clear evidence that many RACFs 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 as lack of mobility due to ill health, the federal government has refused to accept that RACFs can be places of detention.[2] Denying 'detention' status to RACFs means fewer external and independent oversight mechanisms are triggered. As Mitchell observes, 'deaths in RAC[F]s are not subject to 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 RACFs, is a missed opportunity to ameliorate the increased risk that residents of RACFs 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 RACFs 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.[5] Globally, the COVID-19 pandemic is having 'a

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* (Response, 4 February 2020) 2. In response to question asked by Senator Nick McKim, the government stated: '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 See special issue on 'COVID-19, Criminal Justice and Carceralism: Critical Reflections and Change' (2021) 33(1) *Current Issues in Criminal Justice* 1. See the Australian government's health advice: 'Advice for Groups at Greater Risk', *Australian Government Department of Health and Aged Care* (Web Page, 19 January 2022) <https://www.health.gov.au/health-alerts/covid-19/advice-for-groups-at-risk>; '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', *World Health Organisation* (Web Page, 23 March 2022) <https://apps.who.int/iris/handle/10665/331913>.

disproportionate impact on older persons and has magnified existing violations of their rights'.[6] Additionally, the pandemic has brought into focus the treatment of residents of RACFs. For example, despite the lack of direct access to RACFs, 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.[7] Ultimately 17 residents died onsite after 'shortfalls in hospital-standard care'.[8] Sadly, similar scenarios have occurred at other RACFs.[9] 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 broadly speaking, states and territories shoulder responsibility for health generally and the operation of state-run RACFs.[10] Moreover, class actions against individual RACFs have reportedly been launched.[11] Further, complaints are being taken to various healthcare complaints bodies, and the federal regulator, the Aged Care Quality and Safety Commission ('ACQSC'). In the weeks that followed, the ACQSC did not investigate the circumstances of the Newmarch House outbreak.[12]

6 Claudia Mahler, 'Older Persons Remain Chronically Invisible despite Pandemic Spotlight, Says UN Expert' (Press Release, United Nations, 30 September 2020) <https://www.ohchr.org/en/press-releases/2020/09/older-persons-remain-chronically-invisible-despite-pandemic-spotlight-says>.

7 'Like the Plague', *Four Corners* (Australian Broadcasting Corporation, 23 June 2020) <https://www.abc.net.au/4corners/like-the-plague/12383726>.

8 Lyn Gilbert and Alan Lilly, *Newmarch House COVID-19 Outbreak [April–June 2020]: Independent Review* (Final Report, 20 August 2020) 20, 5, 10. This claim may be examined by the Deputy State Coroner in the Coronial Investigation into the Death of Catherine Adam & Ors (Case Number 2020/192802), which relates to the investigation of the deaths of 19 residents at Newmarch House in 2020.

9 Such as the deaths in St Basil's Home for the Aged at Fawkner in Victoria, which will be discussed in Part VI(D).

10 In regard to residential aged care, Federal Parliament does not have direct legislative power, but it has various heads of power that enable it to regulate the aged care sector, including the social welfare power and the power to make grants to states: see *Australian Constitution* ss 51(xxiii)–(xxiiiA), 96.

11 See, eg, 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* (online, 18 August 2020) <https://www.lawyersweekly.com.au/biglaw/29223-victorian-aged-care-home-hit-with-class-action>.

12 See Julie Power, 'Toothless: Staff at Aged Care Regulator Claim They Lack Resources and Power', *The 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> ('Toothless').

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 New South Wales ('NSW') Coroner has announced a coronial inquest into Newmarch.[13] Both of these investigative mechanisms may take a systems-level approach in their investigations, in formulating their recommendations, and securing accountability.[14] 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.[15] 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.[16]

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-focused, 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* ('*CAT*').[17] Thus, *OPCAT* offers an independent system-level solution to proactively *prevent* ill-

13 Royal Commission into Aged Care Quality and Safety, 'COVID-19, Aged Care Accommodation the Focus of Sydney Hearings' (Media Release, 7 August 2020) <https://agedcare.royalcommission.gov.au/news-and-media/covid-19-aged-care-accommodation-focus-sydney-hearings>. The inquest was announced in June: Jenny Noyes, 'NSW Coroner Will Investigate Newmarch House Deaths', *The 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: Evidence to Senate Select Committee on COVID-19, Parliament of Australia, Canberra, 4 August 2020 <https://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;query=Id%3A%22committees%2Fcommsen%2Ff822c395-516a-4acb-92d3-5a5842292157%2F0001%22>.

14 For a comparison on coronial inquests and royal commissions in Victoria: see Anita Mackay and Jacob McCahon, 'Comparing Commissions, Inquests and Inquiries: Lessons from Processes Concerning Family Violence and Child Protection in Victoria' (2019) 45(3) *Monash University Law Review* 531.

15 In relation to coronial inquests: see Ian Freckelton and Simon McGregor, 'Coronial Law and Practice: A Human Rights Perspective' (2014) 21(3) *Journal of Law and Medicine* 584.

16 On the subject of implementation of royal commission recommendations: see Scott Prasser, *Royal Commissions and Public Inquiries in Australia* (LexisNexis, 2nd ed, 2021) chs 8–9.

17 *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 *OPCAT* (n 4) 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.'

treatment in our aged care facilities, which can operate in tandem with existing *reaction*-based inquiry and investigative mechanisms — if only RACFs 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.

This article considers the treatment of residents at Newmarch House as an example of systems-level failure involving the entire RACFs 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* ('*Charter*') and its *Aged Care Quality Standards* ('*Standards*') for RACFs, is committed to a rights-framework which focuses 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.[18] 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-focused approach to monitoring RACFs. In NZ, *OPCAT* monitoring of RACFs 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 RACFs.

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.

The focus of the article 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

18 See *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, UN Doc A/810 (10 December 1948) Preamble paras 1, 5, art 1 ('*UDHR*'); *International Covenant on Civil and Political Rights*, opened for signature 19 December 1966, 999 UNTS 171 (entered into force 23 March 1976) Preamble paras 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 paras 1–2, art 13 ('*ICESCR*').

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 RACFs 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.[19] These investigative mechanisms are encouraged to formally embrace and embed human rights standards within their work.

Ultimately, the inadequacies in independent monitoring and investigations of places of detention for older Australians — namely, RACFs — 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 RACFs.

II RACFS, ACQSC, AND MONITORING

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

A *Residential Aged Care*

Australia has around 2700 RACFs, operated by approximately 870 approved providers, which serve roughly a quarter of a million people.[20] The vast proportion

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

20 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, 27 November 2019) 44, 84.

of these RACFs are privately run. By the age of 80, it is estimated that one in five older Australians will be living in RACFs.[21]

At the international level, RACFs are being increasingly characterised as potentially 'segregated institutions' where older persons with disabilities are being 'regularly coerced' to reside.[22] Long-term care institutionalisation where 'staff exercise control over the person's daily life and make decisions about the person's care' is considered to be contrary to the right to live independently and be included in the community, as articulated in art 19 of the *Convention on the Rights of Persons with Disabilities* ('*CRPD*').[23]

In 2019, the federal government introduced a new set of *Standards* and a single *Charter*, which came into effect in mid-2019.[24] These reforms were in part driven by the Oakden inquiries. In 2017–18, 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

21 Michelle Brown, 'Aged Care Royal Commission Hears Number of Quality Checks on Aged Homecare Providers Has Declined', *ABC News* (online, 2 September 2020) <https://www.abc.net.au/news/2020-09-02/aged-care-royal-commission-hears-quality-checks-have-declined/12621568>, citing Transcript of Proceedings, *Royal Commission into Aged Care Quality and Safety* (31 August 2020) 8813.

22 Catalina Devandas-Aguilar, *Report of the Special Rapporteur on the Rights of Persons with Disabilities*, UN Doc A/74/186 (17 July 2019) 12 [32].

23 Ibid. On this point the UN Special Rapporteur argues that '[n]o older person with disabilities should be institutionalized for the purpose of care': at 18 [54]. *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 19 ('*CRPD*'). Regarding this emerging global shift away from institutionalised forms of care: see 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 ('Human Rights and the Confinement of People Living with Dementia'); 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) 26(2) *Australian Journal of Human Rights* 308 ('Ending Confinement').

24 Ken Wyatt, '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 latter replaced 'four previous charters that covered various forms of aged care'. However, under the new *Charter*, aged care providers have to provide each of their residents and care recipients a copy: 'Charter of Aged Care Rights', *Australian Government Aged Care Quality and Safety Commission* (Web Page, 6 May 2022) <https://www.agedcarequality.gov.au/consumers/consumer-rights>. The *Charter* is scheduled to the *User Rights Principles 2014* (Cth).

regarding the excessive, unnecessary and often unlawful use of restrictive practices which deprived residents of their dignity.[25]

The new *Charter* amalgamates four previous charters and 'underpins' the *Standards*.[26] It comprises '14 protections' for 'consumers' and 'users' of RACFs.[27] 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;'	Article 6(1) *International Covenant on Civil and Political Rights* ('*ICCPR*'): 'Every human being has the inherent right to life.'[28] Article 9(1) *ICCPR*: 'Everyone has the right to … security of person.' Article 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.'

25 Aaron Groves et al, *The Oakden Report* (Report, 10 April 2017) 97, 105–14; Kate Carnell and Ron Paterson, *Review of National Aged Care Quality Regulatory Processes* (Report, October 2017) 105–6 ('*Carnell-Paterson Review*'). The fact that multiple inquiries were necessary indicates that there is an ongoing 'systems abuse' problem in our RACFs. 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 $20 billion 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 $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>.

26 The *Standards* are scheduled to the *Quality of Care Principles 2014* (Cth). They 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': at sch 2(1)(1). This is then followed up with the requirements on RACFs as organisations: '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: (i) make decision about their own care …': at sch 2(1)(3)(a)–(c)(i).

27 'Charter of Aged Care Rights Template for Signing', *Australian Government Aged Care Quality and Safety Commission* (Web Page, 27 July 2021) <https://www.agedcarequality.gov.au/resources/charter-aged-care-rights-templates>.

28 The prohibition of torture, and cruel, inhuman or degrading treatment under art 7 of the *ICCPR* (n 18) 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.

	Article 25 *CRPD*: 'States Parties recognize that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.'
'2. be treated with dignity and respect;'	Article 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* and *ICCPR*: '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'.[29] Preamble para (y) *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'.
'4. live without abuse and neglect;'	Article 2(1) *CAT*: 'Each State Party shall … prevent acts of torture in any territory under its jurisdiction.' Article 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'. Article 6(1) *ICCPR*: (above). Article 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.' Article 9(1) *ICCPR*: (above). Article 15(1)–(2) *CRPD*: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment. … 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.' Article 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	Article 3 *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'. Article 17(1) *ICCPR*: 'No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence'.

29 *ICESCR* (n 18) Preamble paras 2–3; *ICCPR* (n 18) Preamble paras 2–3. Preamble paras 2–3 of *CAT* (n 17) also reflect these ideas.

aspects of my daily life, financial affairs and possessions;'	

It is expected that every RACFs provider will ensure consumers have access to, and knowledge of, this *Charter* and an opportunity to 'co-sign it' with the provider.[30]

These reforms demonstrate the federal government's ongoing commitment to using a framework for RACFs which focuses 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* also reflect human rights principles and standards, but without formally incorporating the relevant international human rights obligations or providing for their enforceability.[31] While RACFs operators must invite consumers to sign the *Charter*, it is a symbolic gesture 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 [C]ommission is … a direct response to the findings and recommendations of the *Review of national aged care regulatory processes* undertaken by Kate Carnell and Ron Paterson',[32] which focused on Oakden. Carnell and Paterson characterised Oakden as 'a sentinel case' that 'highlights areas for improvement in the regulatory system'.[33] One finding was that the disparate federal bodies for accreditation, compliance and complaints handling failed to communicate with each other,[34] and were thus ineffective in preventing and identifying the 'abuse and neglect of basic human rights' at Oakden.[35]

One aspect of the ineffective monitoring which failed Oakden residents was the accreditation agency's practice of making announced visits. Announced visits effectively give RACFs an opportunity to 'make a big effort for the site visit[s] and

30 This is a response to the Carnell and Paterson report on Oakden, which highlighted that awareness of such consumer rights is 'low' among both providers and the public: *Carnell-Paterson Review* (n 25) viii, 105.

31 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 RACFs context: *Carnell-Paterson Review* (n 25) 55.

32 Commonwealth, *Parliamentary Debates*, House of Representatives, 12 September 2018, 8715 (Ken Wyatt) (emphasis in original), citing *Carnell-Paterson Review* (n 25).

33 *Carnell-Paterson Review* (n 25) 50.

34 Ibid vii, 49, quoting BUPA, Submission to Department of Health, Parliament of Australia, *Review of National Aged Care Quality Regulatory Processes* (24 July 2017) 12–13.

35 *Carnell-Paterson Review* (n 25) 49, 106.

thereafter return to their usual ways of working', a practice known as the 'pre-accreditation shuffle'.[36] 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.[37] 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'.[38] The post-Oakden reforms task ACQSC assessors with making predominantly unannounced onsite visits to RACFs, in addition to scheduled visits.

Even with the emphasis on unannounced visits, ACQSC assessors have their 'hands tied behind [their] backs' according to a survey of assessors conducted pre-COVID-19 in early 2020.[39] When visiting RACFs, whether announced or unannounced, assessors need to secure the consent of the occupiers to enter the premises.[40] Assessors are also hampered in gathering relevant information. For example, approved RACFs providers are 'able to restrict or monitor access of assessors to documentation'.[41] Despite having legal powers to do so, in practice assessors reported being unable to compel RACFs employees to answer questions, or to take photographs or video/audio recordings, during inspections.[42] The survey indicated that assessors feel inadequately trained, and frequently have their assessments reversed by more senior ACQSC staff who did not participate in the onsite assessment.[43]

The ACQSC is not the independent oversight body recommended by Carnell and Paterson:[44]

36 Ibid 72, 128, quoting Submission to Department of Health, Parliament of Australia, *Review of National Aged Care Quality Regulatory Processes* <https://consultations.health.gov.au/aged-care-access-and-quality-acaq/review-of-national-aged-care-quality-regulatory-pr/consultation/view_respondent?_b_index=300&uuId=617437173>.

37 *Carnell-Paterson Review* (n 25) 34–5; Senate Community Affairs References Committee, Parliament of Australia, *Effectiveness of the Aged Care Quality Assessment and Accreditation Framework for Protecting Residents from Abuse and Poor Practices, and Ensuring Proper Clinical and Medical Care Standards Are Maintained and Practised* (Interim Report, February 2018) 41.

38 *Carnell-Paterson Review* (n 25) ix, xiii, 128, 133.

39 Community and Public Sector Union, Submission to Royal Commission into Aged Care Quality and Safety (June 2020) 10.

40 See *Aged Care Quality and Safety Commission Act 2018* (Cth) ss 68–9 ('*ACQSC Act*').

41 Community and Public Sector Union (n 39) 14.

42 See ibid 10, 14; Power, 'Toothless' (n 12). See also *ACQSC Act* (n 40) s 70 which says that an assessor *may* request a person to answer any question or to produce any documents, but a person is not required to comply with this request. Note, however, that under the search powers assessors may exercise 'the power to make any still or moving image or any recording of the premises or any thing on the premises': at s 71(2)(d).

43 Community and Public Sector Union (n 39) 4–5.

44 *Carnell-Paterson Review* (n 25) vii, 76.

> [B]est-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.[45]

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.[46]

B *ACQSC's Monitoring of RACFs during COVID-19*

The pandemic has tested the ACQSC, particularly in its role of ensuring residents'/consumers' safety by monitoring whether RACFs are properly implementing the relevant infection control guidelines. For a period of three months from March 2020, the ACQSC stopped all *unannounced* visits.[47] Between events at Newmarch from March and the spread of COVID-19 into Victoria's RACFs 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 RACFs.[48] 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 RACFs to undertake self-assessment surveys and the ACQSC had detailed telephone

45 Ibid 56, citing Productivity Commission, Commonwealth, *Caring for Older Australians* (Inquiry Report No 53, 28 June 2011) vol 1, lxxvi.

46 See, eg, Clay Lucas, 'Federal Aged Care Watchdog Approved Homes with Worst COVID-19 Outbreaks', *The Age* (online, 8 September 2020) <https://www.theage.com.au/politics/victoria/federal-aged-care-watchdog-approved-homes-with-worst-covid-19-outbreaks-20200907-p55t9k.html>, quoting Professor Joseph Ibrahim. See also 'Submission to the Royal Commission into Aged Care Quality and Safety: How the Aged Care Quality and Safety Commission Was Won', *Combined Pensioners & Superannuants Association* (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 & Superannuants Association, Submission to Royal Commission into Aged Care Quality and Safety (July 2020) 3 <https://cpsa.org.au/wp-content/uploads/2020/09/200713-System-governance-submission-to-ACRC.pdf>; Counsel Assisting, Submission to Royal Commission into Aged Care Quality and Safety (22 October 2020) 66–73 [208]–[221] <https://agedcare.royalcommission.gov.au/sites/default/files/2020-10/RCD.9999.0541.0001_1.pdf>.

47 Dana McCauley, 'Aged Care Regulator "Too Late to Act" in Enforcing Standards', *The 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>.

48 'Janet Anderson: Staff around the Country Are Moving to Victoria's Aged Care Facilities', *AM* (ABC, 28 July 2020) 0:00:20–0:00:40 ('Staff around the Country').

conversations with each RACF.[49] This was in addition to the ACQSC writing to aged care providers and requiring some RACFs, predominantly those with multiple COVID-19 infections, to appoint and work with an independent adviser to ensure compliance with the ACQSC's quality standards. In the interview, Anderson explained this approach was 'on a risk basis'.[50]

Such an 'independent adviser' 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.[51] The operator, Anglicare, was to implement the independent adviser's recommendations, and report regularly to the ACQSC or risk losing its RACFs licence.[52] In its notice to Newmarch, the ACQSC indicated 'serious concerns' about compliance with particular standards, including Standard 1(3)(a) which requires that 'each consumer is treated with dignity and respect', and Standard 1(3)(c) which requires that 'each consumer is supported to exercise choice and independence, including to: (i) Make decisions about their own care'.[53]

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.

49 Ibid 0:05:36. 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': Janet Anderson, 'Statement by Janet Anderson on Response to COVID-19 Situation in Victoria' (Media Release, Aged Care Quality and Safety Commission, 9 July 2020). The Commissioner also stated that between mid-March and mid-August, '487 unannounced and short-notice visits were undertaken': Janet Anderson, 'Significant Growth in Regulatory Activities Relating to Aged Care in the Context of COVID-19' (Media Release, Aged Care Quality and Safety Commission, 1 September 2020) 1.

50 'Staff around the Country' (n 48) 0:05:50.

51 HelloCare Editorial Team, '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 advisers are appointed under s 63U(3)(c) of the *ACQSC Act* (n 40) 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 *ACQSC Act* provides no definition for 'appropriate qualifications, skills or experience'.

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

53 Ibid.

The ACQSC's approach to monitoring can be characterised as remote and ineffective. It offered RACFs 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 RACFs 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 RACFs 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, aimed at preventing violations and reforming practices where violations have occurred, that differentiates NZ's approach from that of Australia.

III RACFS 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 RACFs fall outside the scope of the *OPCAT*, arguing its initial focus will be on '"primary" places of detention'.[54] This position is increasingly difficult to justify, given the abuses in RACFs uncovered by the Oakden inquiries.[55] The benefits of extending *OPCAT* monitoring to RACFs are demonstrated by analysing the report of NZ's first *OPCAT* visit to RACFs, which occurred during NZ's COVID-19 lockdown.

54 George Brandis, 'Torture Convention: The Australian Government OPCAT Announcement' (Speech, 22 February 2017) <www.hrlc.org.au/bulletin-content/2017/2/22/torture-convention-the-australian-government-opcat-announcement>.

55 This decision was made before the Oakden inquiries illuminated the widespread problem of neglect and human rights abuse taking place in RACFs. There is strong support among civil society and existing oversight bodies for a more expansive view: see Australia OPCAT Network, Submission to Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment and United Nations Working Group on Arbitrary Detention (January 2020) 19–21 <https://www.kaldorcentre.unsw.edu.au/sites/default/files/Implementation_of_OPCAT_in_Australia.pdf>.

A *NZ OPCAT Monitoring of RACFS*

New Zealand ratified the *OPCAT* in 2007. Its NPM consists of four pre-existing independent investigative/monitoring bodies and a coordinating NPM.[56] 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'.[57] This included 'privately run care facilities where there are dementia units and where people, often the elderly, are detained because of their vulnerability'.[58] 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, in prisons [and] institutions that engage in the care of children, *the aged*, the mentally ill or disabled …[59]

Unlike the Australian government's position that RACFs 'do not fit within the concept of "places of detention" as set out in Article 4 of *OPCAT*',[60] NZ considers RACFs 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).[61]

As in Australia, RACFs 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.[62] As in Australia, they meet

56 The Human Rights Commission of New Zealand is the co-ordinating NPM, and there are four designated bodies with monitoring roles: the Ombudsman, Independent Police Conduct Authority, Children's Commissioner and Inspector of Service Penal Establishments of the Office of the Judge Advocate General: 'Monitoring Places of Detention', *NZ Human Rights Commission* (Web Page, 2022) <https://www.hrc.co.nz/our-work/torture-and-detention/monitoring-places-detention/>.

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

58 Office of the Ombudsman, 'Ombudsman's Office to Take Role in Monitoring Private Aged Care Facilities / Court Cells' (Media Release, 6 June 2018) <https://www.ombudsman.parliament.nz/news/ombudsmans-office-take-role-monitoring-private-aged-care-facilities-court-cells> ('Ombudsman's Office to Take Role in Monitoring').

59 Committee Against Torture, *General Comment No 2: Implementation of Article 2 by States Parties*, UN Doc CAT/C/GC/2 (24 January 2008) 4 [15] (emphasis added) ('*General Comment No 2*').

60 *Supplementary Budget Estimates 2019–20* (n 2) 2.

61 *OPCAT* (n 4) art 4(1) (emphasis added).

62 Michael JV White, New Zealand Human Rights Commission, *He Ara Tika: A Pathway Forward* (Report, June 2016) 30–1.

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),[63] 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'.[64] On this third criteria, the SPT has stated that this 'relates to a situation in which the State either exercises, or might be expected to exercise a regulatory function'.[65]

In March to April 2020, NZ RACFs suffered five COVID-19 clusters.[66] 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 RACFs.[67] The extension of monitoring of RACFs was announced in 2018,[68] and was to commence in 2021.[69] However, in April 2020, the NZ Chief Ombudsman, the relevant NPM for inspecting residential aged care ('NZ-NPM'), publicly signalled that RACFs monitoring needed to commence immediately.[70] NZ's government responded by ensuring that the NPMs were designated 'essential services' under NZ's COVID-19 regulations, which

63 *OPCAT* (n 4) art 4(1). 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(1) of the *OPCAT* says 'may be deprived'. This implies that the NPM simply needs to suspect that persons in particular RACFs 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 Supreme Court of South Australia held that even though the RACFs 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': (2019) 133 SASR 353, 371 [72] (Kourakis CJ) ('*Public Advocate*').

64 *OPCAT* (n 4) art 4(1).

65 Committee Against Torture, *Ninth Annual Report of the Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc CAT/C/57/4 (22 March 2016) annex ('*Compilation of Advice Provided by the Subcommittee in Response to Requests from National Preventive Mechanisms*') 19 [3].

66 Tanya Jackways et al, *Independent Review of COVID-19 Clusters in Aged Residential Care Facilities* (Report, 29 May 2020) 4 <https://www.health.govt.nz/system/files/documents/publications/independent-review-covid-19-clusters-aged-residential-care-facilities-may20.pdf>.

67 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': New Zealand, *New Zealand Gazette*, No 2018-go2603, 6 June 2018 <https://gazette.govt.nz/notice/id/2018-go2603>.

68 See 'Ombudsman's Office to Take Role in Monitoring' (n 58); 'OPCAT Inspections to Include People Held Securely in Privately-Run Aged Care Facilities', *Office of the Ombudsman* (Fact Sheet, March 2020) <https://www.ombudsman.parliament.nz/sites/default/files/2020-03/aged care-factsheet-agedcaremonitoring.pdf>.

69 'OPCAT Inspections to Include People Held Securely in Privately-Run Aged Care Facilities' (n 68) 1.

70 'Upcoming OPCAT Inspection by Chief Ombudsman's Team', *Office of the Ombudsman* (Web Page, April 2020) <https://www.ombudsman.parliament.nz/sites/default/files/2020-04/Upcoming%20OPCAT%20inspection%20by%20Chief%20Ombudsman%E2%80%99s%20team.pdf>.

permitted the NZ-NPM inspectors to undertake onsite visits to places of detention during the lockdown.[71]

Given that onsite visits occurred during NZ's lockdown between April to 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'[72] when, wearing full personal protective equipment ('PPE'), they visited six RACFs (including privately-run facilities) each for two hours.[73] 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.[74]

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 focused on COVID-19 issues',[75] 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.[76]

The preparation included the development of a Statement of Principles, explaining the principles guiding the NZ-NPM inspections.[77] This Statement is based on

71 'Expectations for OPCAT COVID-19 Inspections', *Office of the Ombudsman* (Web Page, August 2021) 1 <https://www.ombudsman.parliament.nz/sites/default/files/2021-08/Expectations%20for%20OPCAT%20COVID-19%20inspections.pdf>.

72 'Upcoming OPCAT Inspection by Chief Ombudsman's Team' (n 70) 1.

73 *NZ-NPM Report 2020* (n 57) 10.

74 Ibid. 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 *Ombudsmen Act 1975* (NZ) s 19. Furthermore, s 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.

75 *NZ-NPM Report 2020* (n 57) 6.

76 Ibid 5.

77 'OPCAT Inspections and Visits during COVID-19 Pandemic: Update and Statement of Principles', *Office of the Ombudsman* (Web Page, 9 April 2020) <https://www.ombudsman.parliament.nz/sites/default/files/2020-04/OPCAT%20inspections%20and%20visits%20during

international human rights legal standards. This includes Principle 5, which provides that

> [a]ny 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].[78]

The report resulting from the onsite visits details the criteria used for the inspections.[79] These criteria were divided into five categories: (a) '[h]ealth and safety'; (b) '[c]ontact with the outside world'; (c) '[d]ignity and respect'; (d) '[p]rotective measures'; and (e) '[s]taffing'.[80] 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.[81]

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 RACFs, 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.[82] 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 people's rights'.[83] Under *OPCAT*, the NZ government is obliged to ensure that its NPMs

%20COVID-19%20pandemic%20%E2%80%93%20update%20and%20Statement%20of%20Principles_0.pdf> ('Statement of Principles').

78 Ibid 2.

79 *NZ-NPM Report 2020* (n 57) 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'.

80 Ibid 27–8.

81 Ibid 27.

82 Ibid 7. Unfortunately, NZACA has not made the letter publicly available via its website.

83 Ibid 8.

are both functionally and financially independent,[84] which meant that the NZ government was not able to interfere with the proposed RACFs inspection timetable.

B *NZ-NPM* OPCAT *Monitoring Outcomes*

The aim of the RACFs inspections was not to 'name and shame' individual RACFs, but 'to give insight into how the sector was managing as a whole'.[85] Consequently, the inspected RACFs are not named in the report, although the NZ-NPM followed up its visits by communicating specific recommendations to the visited RACFs and providing opportunity for comments.[86] 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 RACFs — 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',[87] that 'a "bubble" strategy was applied in all Facilities',[88] and that decisions about testing considered the rights of residents.[89] 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 alternative methods for residents to maintain contact with the outside world is facilitated and encouraged', with RACFs generally doing 'a good job' of this.[90] Regarding dignity, 'warm interactions between staff and residents' and 'a commitment by Facilities to ensuring minimal disruption to residents' day-to-day experience' were reported.[91]

Twenty-one suggestions were made, including that:

84 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 Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, *Guidelines on National Preventive Mechanisms*, UN Doc CAT/OP/12/5 (9 December 2010) 4 [12], which states: 'The NPM should enjoy complete financial and operational autonomy when carrying out its functions under the Optional Protocol.'

85 *NZ-NPM Report 2020* (n 57) 7.

86 Ibid 20–2.

87 Ibid 11.

88 Ibid 12.

89 Ibid 13.

90 Ibid 14.

91 Ibid 15.

- '[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 specific needs of residents, including disability related needs, be taken into account when planning or implementing infection control practices'; and
- 'ways of managing medically isolated residents' bathroom needs' be investigated.[92]

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 encouraged and able to do so'; and
- '[a]dequate systems are put in place to ensure complaints are documented and appropriately responded to'.[93]

Of the four recommendations, only one related to infection control: that '[t]he Facility clearly defines the composition of its "bubble"', and that PPE be used 'consistently' for people not in the 'bubble'.[94]

As an independent, systems-level mechanism, *OPCAT* monitoring has the potential to serve Parliament, the government, sector-specific oversight agencies (such as ACQSC), 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.[95]

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 RACFs of the pandemic. The *OPCAT* monitoring complements other

92 Ibid 21.

93 Ibid 22.

94 Ibid 20.

95 Ibid 8.

independent reviews and government monitoring, but appears to be the only monitoring which includes onsite visits.[96]

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'.[97] The body that externally monitors RACFs, 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 focused 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'.[98] The necessity for *OPCAT*-compliant monitoring in RACFs 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 to 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 RACFs, particularly persons with dementia[99] and persons who are frail and lack mobility.[100]

96 One example is NZ's independent review of COVID-19 Clusters in RACFs: Jackways et al (n 66) 10 <https://www.health.govt.nz/system/files/documents/publications/independent-review-covid-19-clusters-aged-residential-care-facilities-may20.pdf>. This report was primarily focused on hearing the voices of RACFs' staff and management in relation to their experience of the COVID clusters: at 10. Published very speedily in May 2020, three months before the *OPCAT* report, it 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: at 4.

97 See 'Statement of Principles' (n 77) 2.

98 Brandis (n 54).

99 See generally Steele et al, 'Ending Confinement' (n 23); Steele et al, 'Human Rights and the Confinement of People Living with Dementia' (n 23).

100 See the definition at *CRPD* (n 23) art 1.

A *Events at Newmarch*

The initial response to two COVID-19 diagnoses on 11–12 April 2020 at Newmarch[101] was to confine *all* residents to their individual rooms 24/7.[102] According to the Four Corners report:

- COVID-19-positive residents were *not* quarantined *within* the facility from COVID-19-negative residents;[103]
- COVID-19-negative residents were *not* able to leave the facility, but were instead isolated in their rooms;[104] and
- COVID-19-positive residents were *not* transferred to alternative facilities for quarantine or treatment but were instead isolated in their rooms within the facility.[105]

No residents were allowed visitors.[106] Initially some family members could speak to residents by telephone while seeing them through windows (depending on a resident's location within the facility).[107] Family members interviewed by Four Corners reported that window visits became more difficult when Anglicare covered the perimeter fence around the RACF.[108] Telephone contact remained a possibility, although this was challenging for residents with dementia, and many contact attempts were unsuccessful because of the significantly increased

101 A Newmarch staff member late on 11 April 2020 and a Newmarch resident on 12 April 2020: Grant William Millard, Statement to Royal Commission into Aged Care Quality and Safety (24 July 2020) 8 [32], 36; Evidence to Senate Select Committee on COVID-19, Parliament of Australia, Canberra, 26 May 2020, 4 (Janet Anderson).

102 Millard (n 101) 10 [44].

103 'Like the Plague' (n 7) 0:21:17–0:24:02; Gilbert and Lilly (n 8) 11, 20; Millard (n 101) 10 [49]. This claim may be examined by the Deputy State Coroner in 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 in 2020.

104 'Like the Plague' (n 7) 0:18:15–0:21:17; Gilbert and Lilly (n 8) 20; Transcript of Proceedings, *Royal Commission into Aged Care Quality and Safety* (11 August 2020) 8490 ('*11 August Transcript*'). This claim may be examined by the Deputy State Coroner in 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 in 2020.

105 'Like the Plague' (n 7) 0:00:15–0:02:48, 0:30:30–0:32:29; Gilbert and Lilly (n 8) 11. This claim may be examined by the Deputy State Coroner in 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 in 2020.

106 This applied from 24 March 2020. Anglicare understood it was required by the *Public Health (COVID-19 Residential Aged Care Facilities) Order 2020* (NSW): Millard (n 101) 12 [58], 24 [125]. See also Gilbert and Lilly (n 8) 10.

107 This commenced from 28 April 2020: Millard (n 101) 13 [64].

108 'Like the Plague' (n 7) 0:00:15–0:02:48.

workload of the staff members.[109] The intense isolation experienced by Newmarch residents impacted on their physical, mental and psychological wellbeing.[110]

It was reported that 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 few exceptions.[111] 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.[112] If so, this may have been a misreading of the relevant order.[113] 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'.[114]

Newmarch adopted a 'hospital in the home' ('HITH') approach to care, in line with an NSW Government policy and the recommendation of an infectious diseases expert from Nepean Hospital.[115] HITH is intended to be a voluntary programme which patients (or their substitute decision-makers) must consent to.[116] Anglicare may have sought this consent but, as explained above, some residents' families appear to question whether it was *informed* consent. The Independent Review cites

109 Ibid 0:03:24–0:04:08.

110 'Newmarch House Resident Dies after Recovering from Coronavirus, NSW Hits Record Testing Rate', *ABC News* (online, 9 May 2020) <https://www.abc.net.au/news/2020-05-09/nsw-coronavirus-newmarch-house-death-after-covid-19-recovery/12230504>.

111 'Like the Plague' (n 7) 0:18:15–0:21:17, 0:30:30–0:32:29; Gilbert and Lilly (n 8) 11. This claim may be examined by the Deputy State Coroner in 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 in 2020.

112 'Like the Plague' (n 7) 0:16:50–0:17:50.

113 The Order imposes penalties for people other than residents entering and remaining in a RACF, 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 '[e]xternal excursions for residents should be prohibited': 'COVID-19 (Coronavirus): Guidance for Residential Aged Care Facilities', *NSW Health* (Web Page, 29 June 2020) <https://www.health.nsw.gov.au/Infectious/covid-19/Pages/residential-aged-care.aspx>, archived at <https://web.archive.org/web/20200922222741/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'.

114 Gilbert and Lilly (n 8) 20. Lack of communication with family members was a focus of the independent review: at 14–16.

115 Ibid 10. See NSW Health, *Adult and Paediatric Hospital in the Home* (Guideline, 9 August 2018) <https://www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2018_020.pdf> ('*HITH Guideline*'). Also relevant is the Nepean Blue Mountains Local Health District, *Adult Hospital in the Home Policy* — this document is not publicly accessible. This claim may be examined by the Deputy State Coroner in 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 in 2020.

116 See *HITH Guideline* (n 115) 11, 13.

a general practitioner's evidence as follows: 'I did question that. I said, "So we are not giving them a choice?" And they said, "No, but we will be providing everything except ventilation."'[117]

On the other hand, the Independent Review also heard evidence from a Virtual Aged Care Service Specialist that the families were told that 'if they really needed to come to hospital we'll bring them to the hospital'.[118]

Anglicare adopted this HITH approach despite the scale of the outbreak and not having necessary hospital equipment, such as ventilators, or qualified medical staff.[119] The ABC's Four Corners interviews with family members of residents uncovered neglect of residents during this period. One resident fell over and waited two hours for assistance after pressing her buzzer.[120] Another resident was severely dehydrated and waited a day before being provided with the intravenous fluids that a medical practitioner ordered.[121]

According to an independent review of Newmarch, commenced eight 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'.[122] The HITH classification did not trigger additional nursing support, or a consistent supply to the RACFs of intravenous fluids or antibiotics.[123] 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'.[124] The review also noted 'a lack of adequate provision for medical care of the majority of residents who remained COVID-19 free' because they were not part of the HITH regime.[125]

117 Gilbert and Lilly (n 8) 20.

118 Ibid.

119 Millard (n 101) 11 [53]; *11 August Transcript* (n 104) 8524–5. 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 Lilly (n 8) 30.

120 'Like the Plague' (n 7) 0:10:00–0:10:19. 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>.

121 'Like the Plague' (n 7) 0:33:33–0:33:50.

122 Gilbert and Lilly (n 8) 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.

123 Ibid 28.

124 Ibid 27. See also at 21–2.

125 Ibid 19.

Seventeen COVID-19-positive residents subsequently died at Newmarch, with two additional residents dying in hospital.[126] During this time, the number of new COVID-19 infections in NSW was relatively low,[127] and there was no evidence that hospitals were overflowing.[128] This represents a 46% mortality rate of COVID-19-positive residents at Newmarch.[129]

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 COTA Australia:

> 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. … Older Australians have identical rights to access the same quality of healthcare as every other Australian.[130]

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.[131]

The COVID-19 pandemic has highlighted many ongoing problems with Australia's system of RACFs 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 RACFs were 'proportionate, lawful, accountable, necessary, and non-discriminatory' and whether the measures could

126 One 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 7) 0:28:24–0:28:38; Transcript of Proceedings, *Royal Commission into Aged Care Quality and Safety* (10 August 2020) 8378 ('*10 August Transcript*'); Gilbert and Lilly (n 8) 8.

127 See the daily statistics of the NSW Health Department: 'COVID-19 (Coronavirus) Statistics', *NSW Health* (Web Page, 4 May 2020) <https://www.health.nsw.gov.au/news/Pages/20200504_00.aspx>. During this period, the numbers were rarely in the double digits.

128 There was an outbreak at another RACF 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': *10 August Transcript* (n 126) 8376.

129 Gilbert and Lilly (n 8) 8.

130 COTA Australia, '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>.

131 *11 August Transcript* (n 104) 8490.

be said to 'respect human dignity, be of limited duration, and regularly reviewed' — being the NZ-NPM's *OPCAT* monitoring criteria.[132]

But beyond *OPCAT*, Australia has obligations to investigate potential human rights violations under various treaties Australia has ratified (eg the *ICCPR*). The duty to investigate is part of the obligation of states parties, under art 2(3) of the *ICCPR*, to ensure that victims of human rights violations have effective remedies.[133] 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.[134]

The substantive provisions of the *ICCPR* are read in conjunction with art 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'.[135] 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 impartially … so as to make the remedy effective'.[136] Accordingly, whether RACFs come within the *OPCAT* purview or not, Australia has a positive legal duty to prevent and investigate human rights abuses.

132 'Statement of Principles' (n 77) 2.

133 Article 2(3) of the *ICCPR* (n 18) 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.

134 Human Rights Committee, *General Comment No 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant*, UN Doc CCPR/C/21/Rev.1/Add.13 (26 May 2004) 6 [15] ('*General Comment No 31*').

135 Human Rights Committee, *General Comment No 36: Article 6*, UN Doc CCPR/C/GC/36 (3 September 2019) 6 [28] (citations omitted) ('*General Comment No 36*').

136 United Nations, *Human Rights Instruments: Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, UN Doc HRI/GEN/1/Rev.9 (27 May 2008) vol 1, 202 [14] ('*Compilation of General Comments*').

This Part focuses on the deprivation of liberty and the medical isolation experienced by the Newmarch residents,[137] whilst acknowledging that the Newmarch case raises many other human rights issues, such as the residents' right to access adequate medical care, which require further investigation.

B *Deprivation of Liberty*

It is necessary to consider whether Newmarch residents were deprived of their liberty due to 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 such procedure 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.[138] The *ICCPR* and *CRPD* are the hard-law instantiations of arts 3 and 9 of the *Universal Declaration of Human Rights*.[139]

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.[140] The WGAD stated that this prohibition extends to 'public health emergency measures … introduced to combat the [COVID-19] pandemic'[141] and to 'health-care settings'.[142] Moreover, the 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.[143]

137 Isolation was 'the strongest theme' from submissions to the Royal Commission: *10 August Transcript* (n 126) 8365.

138 *Compilation of General Comments*, UN Doc HRI/GEN/1/Rev.9 (n 136) vol 1, 179 [1]. See also El Hadji Malick Sow, *Report of the Working Group on Arbitrary Detention*, UN Doc A/HRC/22/44 (24 December 2012) ('*Sow Report*').

139 Article 3 of the *UDHR* (n 18) states that '[e]veryone has the right to life, liberty and the security of person'. Article 9 of the *UDHR* (n 18) states that '[n]o one shall be subjected to arbitrary arrest, detention or exile'.

140 *Sow Report*, UN Doc A/HRC/22/44 (n 138) 17–18 [42]–[43]; Human Rights Council, *Arbitrary Detention: Report of the Working Group on Arbitrary Detention*, UN Doc A/HRC/45/16 (24 July 2020) annex II ('*Deliberation No 11 on Prevention of Arbitrary Deprivation of Liberty in the Context of Public Health Emergencies*') 35 [5].

141 *Deliberation No 11 on Prevention of Arbitrary Deprivation of Liberty in the Context of Public Health Emergencies*, UN Doc A/HRC/45/16 (n 140) 35 [5].

142 Ibid 35 [7] (citations omitted).

143 Ibid 35 [8] (citations omitted).

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'.[144] 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'.[145]

Focusing on 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 to be equated with "against the law"'.[146] 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'.[147] 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,[148] where it is imposed beyond the time required to combat any emergency,[149] and 'if the manner in which the detainees are treated does not relate to the purpose for which they are ostensibly being detained'.[150] 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 '[s]tates 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'.[151] Regarding equality and non-discrimination, the WGAD advised that when states enact measures in public health emergencies which lead to the deprivation of liberty, they must take into

144 Ibid (citations omitted).

145 Ibid 35 [5].

146 Human Rights Committee, *General Comment No 35: Article 9 (Liberty and Security of Person)*, UN Doc CCPR/C/GC/35 (16 December 2014) 3 [12] ('*General Comment No 35*').

147 Ibid (citations omitted). See also *Deliberation No 11 on Prevention of Arbitrary Deprivation of Liberty in the Context of Public Health Emergencies*, UN Doc A/HRC/45/16 (n 140) 36 [10]–[11].

148 *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 146) 4 [12].

149 'When placing individuals under quarantine measures, States must ensure that such measures are not arbitrary. The time limit for placement in mandatory quarantine must be clearly specified in law and strictly adhered to in practice': *Deliberation No 11 on Prevention of Arbitrary Deprivation of Liberty in the Context of Public Health Emergencies*, UN Doc A/HRC/45/16 (n 140) 35 [8].

150 *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 146) 4 [14] (citations omitted).

151 *Deliberation No 11 on Prevention of Arbitrary Deprivation of Liberty in the Context of Public Health Emergencies*, UN Doc A/HRC/45/16 (n 140) 36 [15].

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.[152] In considering the *CRPD*, detention of persons with disabilities based on 'medical necessity' is considered unlawful and arbitrary.[153]

In investigating the arbitrariness of any possible 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.[154] Was it appropriate and just to equally prevent COVID-19-negative residents from leaving the RACFs, even to access adequate medical care? Further, COVID-19-negative residents were subjected to the same isolation regime as COVID-19-positive residents, even though there was scope for what the Anglicare CEO calls 'earlier liberalisation'.[155] When investigating arbitrariness, consideration should be given to whether the deprivation of liberty was of 'limited duration and regularly reviewed'.[156] Furthermore, the COVID-19-negative residents were not properly quarantined from the COVID-19-positive residents: an independent review cited evidence of 'inconsistent use of PPE'[157] and 'imperfect [infection prevention and control] practices',[158] which meant that attempts to quarantine the two groups failed.[159] 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.

Second, under art 9(1) of the *ICCPR*, a deprivation of liberty without legal authorisation is unlawful, with the HRC describing 'unlawful deprivation of liberty' as a 'deprivation of liberty that is not imposed on such grounds and in

152 Ibid 38 [26]–[27].

153 Human Rights Council, *Rights of Persons with Disabilities*, UN Doc A/HRC/40/54 (11 January 2019) 14 [58]. See also at 15 [65]. The *CRPD* (n 23) provides at art 14(b) 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: *Rights of Persons with Disabilities*, UN Doc A/HRC/40/54 (n 153) 13–14 [57]–[62].

154 See above nn 92, 96–102 and accompanying text in the body of the article.

155 *11 August Transcript* (n 104) 8490.

156 'Statement of Principles' (n 77) 2.

157 Gilbert and Lilly (n 8) 24.

158 Ibid 19.

159 This claim may be examined by the Deputy State Coroner in 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 in 2020.

accordance with such procedure as are established by law'.[160] 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.'[161] Further, such legal authorisation 'must be accompanied by procedures that prevent arbitrary detention'.[162]

Accordingly, investigative mechanisms must consider whether there were any federal-state orders/regulations which may have prevented COVID-19-positive residents from leaving Newmarch and seeking medical care at properly equipped hospitals, or which may have prevented COVID-19-negative residents from leaving Newmarch to reside in another RACF, 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 possible deprivation of liberty that lacks a lawful basis is unlawful and considered a violation of Australia's human rights obligations.[163]

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.[164] In 2016, the Senate Community Affairs References Committee ('Senate Committee') confirmed that RACFs are places of 'detention' and possibly 'unlawful' detention.[165] 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, unregulated and unlawful'.[166] That *unlawful* detention of RACFs'

160 *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 146) 3 [11]. See also Human Rights Committee, *Views: Communication No 702/1996*, UN Doc CCPR/C/60/D/702/1996 (29 September 1997) 9 [5.5] ('*McLawrence v Jamaica*'): '[T]he principle of legality is violated if an individual is arrested or detained on grounds which are not clearly established in domestic legislation'.

161 *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 146) 7 [22] (citations omitted).

162 Ibid 4 [14].

163 Ibid 3 [11].

164 *Antunovic v Dawson* (2010) 30 VR 355, 395–6 [192]–[202] (Bell J) ('*Antunovic*').

165 Senate Community Affairs References Committee, Parliament of Australia, *Indefinite Detention of People with Cognitive and Psychiatric Impairment in Australia* (Report, November 2016) 169 [8.69].

166 Ibid.

residents occurs in non-pandemic times has been confirmed by the courts.[167] Such false imprisonment can lead to substantial damages claims against the State.[168] This is regardless of the conditions of detention, and whether the person was able to leave the premise occasionally.[169]

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.[170] The WGAD has confirmed that this principle applies to persons deprived of their liberty under mandatory quarantine laws during a pandemic.[171]

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 RACFs' 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.[172]

167 *Public Advocate* (n 63) 371 [72] (Kourakis CJ). See also *Skyllas v Retirement Care Australia (Preston) Pty Ltd* [2006] VSC 409, [9] (Byrne J) ('*Skyllas*'). The former case relates to powers under the *Guardianship and Administration Act 1993* (SA), in particular s 32 which gives the South Australian Civil and Administrative Tribunal the power to authorise the detention of those under guardianship orders. On guardianship, the power to detain, and restrictions upon liberty in residential care, see Victorian Law Reform Commission, *Guardianship* (Final Report No 24, 2012) ch 15. See also Victorian Law Reform Commission, *Guardianship Final Report Background Paper: Legislative Schemes Regulating Deprivation of Liberty in Residential Care Settings* (Background Paper, 4 May 2012).

168 See the English landmark case of *Cheshire West v P* [2014] AC 896 ('*Cheshire West*'); Esther Erlings, 'False Imprisonment in Locked Wards: *The Public Advocate v C, B*' (2019) 21(1) *Flinders Law Journal* 109, 119.

169 *Cheshire West* (n 168) 912 [21] (Baroness Hale), citing *Ashingdale v United Kingdom* (1985) 93 Eur Court HR (ser A) 15 [42]; Erlings (n 168) 114–15.

170 *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 146) 12 [39], citing Human Rights Committee, *Views: Communication No 1342/2005*, UN Doc CCPR/C/89/D/1342/2005 (3 May 2007) 9 [7.4] ('*Gavrilin v Belarus*'); *Sow Report*, UN Doc A/HRC/22/44 (n 138) 21–2 [59]–[64].

171 *Deliberation No 11 on Prevention of Arbitrary Deprivation of Liberty in the Context of Public Health Emergencies*, UN Doc A/HRC/45/16 (n 140) 4 [19].

172 The number of such reported habeas corpus applications is few: see *Skyllas* (n 167); *Antunovic* (n 164); *Public Advocate* (n 63). On the barriers to legal redress, see Steele et al, 'Ending Confinement' (n 23) 311. See also *Sow Report*, UN Doc A/HRC/22/44 (n 138).

If non-state actors like RACFs deprive residents of their liberty, this does not absolve the federal government of its obligations under international law.[173] According to the HRC, under art 9 of the *ICCPR*:

> States 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.[174]

Moreover, states have a due diligence obligation to prevent non-state actors 'horizontally' violating rights, which gives rise to the legal obligations on states to investigate human rights violations by private entities, such as private RACFs.[175]

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.[176]

The term 'solitary confinement' is typically used in a prison context. Under international law, solitary confinement is regulated by the *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules)* ('*Mandela Rules*'), which apply to prisons specifically.[177] While not technically applicable to RACFs, 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

173 The federal government has international legal personality and only the federal government can enter into binding international obligations under the *Australian Constitution* ss 51(xxix), 61: see *Koowarta v Bjelke-Petersen* (1982) 153 CLR 168, 237–8 (Murphy J); *Minister for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 282 (Mason CJ and Deane J). 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, eg, *ICCPR* (n 18) art 50. The operation of international law in a federation is well-illustrated by Australia's first individual communication before the HRC: see Human Rights Committee, *Views: Communication No 488/1992*, UN Doc CCPR/C/50/D/488/1992 (4 April 1994) ('*Toonen v Australia*').

174 *General Comment No 35*, UN Doc CCPR/C/GC/35 (n 146) 2 [7] (citations omitted). See also at 14–16 [44]–[52].

175 *General Comment No 36*, UN Doc CCPR/C/GC/36 (n 135) 5 [21].

176 See *ICCPR* (n 18) arts 7, 10; *CRPD* (n 23) art 15; *CAT* (n 17); *Compilation of General Comments*, UN Doc HRI/GEN/1/Rev.9 (n 136) 200 [6].

177 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.

to solitary confinement for a period of more than 15 consecutive days.[178] 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'.[179] The 'meaningful human contact' standard was applied by the NZ-NPM in assessing whether isolation was a health or disciplinary measure.[180] The Istanbul Statement on the Use and Effects of Solitary Confinement ('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.[181]

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'.

178 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 Doc A/RES/70/175 (8 January 2016, adopted 17 December 2015) rr 44–5 ('*Mandela Rules*'). While this definition was introduced by the *Mandela Rules* in 2015, it is taken from The Istanbul Statement on the Use and Effects of Solitary Confinement 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, 2019) 43.

179 Pursuant to the definition of solitary confinement found in the *Mandela Rules*, UN Doc A/Res/70/175 (n 178) r 44, '[f]or 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'.

180 *NZ-NPM Report 2020* (n 57) 14–15, 27.

181 Symposium, 'The Istanbul Statement on the Use and Effects of Solitary Confinement' (2008) 18(1) *Journal on Rehabilitation of Torture Victims and Prevention of Torture* 63, 65 ('Istanbul Statement'). The Istanbul Statement is an expert statement on the use and 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: at 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, Special Rapporteur, *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/63/175 (28 July 2008) from 18 on and Annex (from 22 on). For further discussion about the Istanbul Statement: see Nowak, 'Global Perspectives on Solitary Confinement: Practices and Reforms Worldwide' (n 178).

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's 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'.[182] Part of this assessment is whether the RACFs 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'.[183]

Focussing on the NZ-NPM's criteria for medical isolation, any decision to isolate residents should, first, be based on an independent medical evaluation. Such evidence should be made publicly and contemporaneously available. Second, whether the isolation at Newmarch 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.[184]

Could some measures have lessened the harmful impact of the ongoing quarantine situation on residents' physical and mental health?[185] 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 onethird 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.[186]

182 *NZ-NPM Report 2020* (n 57) 27.

183 These are two of the 'health and safety' criteria developed by the NZ Chief Ombudsman for their *OPCAT* COVID-19 Inspections: ibid.

184 There is a precedent for this. The RCAC heard that another RACF 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: *11 August Transcript* (n 104) 8550, 8553.

185 'Newmarch House Resident Dies after Recovering from Coronavirus, NSW Hits Record Testing Rate' (n 110).

186 'Istanbul Statement' (n 181) 64.

In Australia, there is some confusion within the federal government as to whether torture and CIDTP can occur in privately-run RACFs. 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'.[187] As the Parliamentary Joint Committee on Human Rights explained, this view disregards art 2(1) of the *CAT*, which requires states parties to take "'effective legislative, administrative, judicial or other measures to *prevent* acts of torture in any territory under its jurisdiction'".[188] Moreover, the definition of torture in art 1 of the *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 states 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*'.[189] Further, as discussed above, the Committee Against Torture extends states' 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*'.[190] Furthermore, states parties are required to exercise due diligence in this regard and a failure to do so is a breach of the *CAT*.[191] 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

Royal commissions are established to investigate systemic failings, to restore public trust and to help solve complex policy problems. According to Prasser and Tracey, '[m]any a royal commission … has helped to … frame new public

187 Parliamentary Joint Committee on Human Rights, Parliament of Australia, *Quality of Care Amendment (Minimising the Use of Restraints) Principles 2019* (Inquiry Report, 13 November 2019) 48 ('*Quality of Care Amendment Principles*').

188 Ibid (emphasis in original), quoting *CAT* (n 17) art 2(1).

189 *Compilation of General Comments*, UN Doc HRI/GEN/1/Rev.9 (n 136) vol 1, 200 [2] (emphasis added).

190 *General Comment No 2*, UN Doc CAT/C/GC/2 (n 59) 4 [15] (emphasis added).

191 Ibid 5 [18].

policy'.[192] One strength of investigation by royal commissions, besides their flexible and extensive powers to investigate,[193] 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'.[194] The RCAC's brief is to examine aged care nationally, including 'the causes of any systemic failures'.[195] Like the 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'.[196]

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

192 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, 372.

193 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.

194 Prime Minister, Minister for Health and Minister for Senior Australians and Aged Care, 'Royal Commission into Aged Care Quality and Safety' (Media Release, 16 September 2018).

195 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 …

Royal Commission into Aged Care Quality and Safety (Letters Patent, 6 December 2018) 2 [a] (emphasis added) <https://agedcare.royalcommission.gov.au/publications/letters-patent-6-december-2018>.

196 Ibid 2 [a], [e], 3 [i]. The preamble to the terms of reference does state at 1–2:

> AND that some people residing in aged care facilities, including younger people, or otherwise receiving aged care services, have disabilities and Australia has undertaken relevant international obligations, including to take all appropriate legislative, administrative and other measures for the implementation of the rights of people with disabilities.

Australia's obligations under the *CRPD*.[197] 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*.[198] Of relevance, for the DRC to fulfil its terms of reference, it should consider the *CRPD* rights of those persons with disabilities living in RACFs, which is estimated to be half of the RACFs' population. The DRC could fill a critical rights-gap if the RCAC fails to address these rights.[199]

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 RACFs 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 RACFs, ensuring a measure of accountability for those responsible for the treatment of the residents.

197 *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Letters Patent, 4 April 2019) 1 <https://disability.royalcommission.gov.au/publications/commonwealth-letters-patent> ('Letters Patent, 4 April 2019'):

> 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.

198 *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Interim Report, October 2020) xi, 96, 342–3 ('*RCAC 2020 Interim Report*'). The October 2020 interim report follows an issues paper: *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: Rights and Attitudes* (Issues Paper, 28 April 2020). It also commissioned a research report on the *CRPD*: Rosemary Kayess and Therese Sands, *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: Convention on the Rights of Persons with Disabilities* (Research Report, September 2020).

199 Note the terms of 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.

Letters Patent, 4 April 2019 (n 197) 3. 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: *RCAC 2020 Interim Report* (n 198) 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' — speaks volumes.[200] 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'.[201] It examines systemic failures, identifying five 'systemic problems' that will be fully examined in the final report,[202] including 'minimis[ing] the voices of people receiving care and their loved ones'.[203] 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*.[204]

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'[205] and '[f]ailing to obtain informed consent where required by law ignores the rights of older Australians',[206] but it does not elaborate. The exception is the framing of younger people being accommodated in RACFs as a 'human rights issue'.[207] 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

200 *Royal Commission into Aged Care Quality and Safety* (Interim Report, 31 October 2019) vol 1, 1 ('*RCAC 2019 Interim Report*').

201 Ibid vol 1, 5. '[S]ubstandard care' is defined at vol 2, 3 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 1997* (Cth)]; 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 1997* (Cth)], was not of a standard that would meet the high standards of quality and safety that the Australian community expects of aged care services.

202 Ibid vol 1, 255–6.

203 Ibid vol 1, 255.

204 Australian Human Rights Commission, Submission to the Royal Commission into Aged Care Quality and Safety (18 July 2019) 4 [9] (emphasis added).

205 *RCAC 2019 Interim Report* (n 200) vol 1, 12.

206 Ibid vol 1, 208.

207 See ibid vol 1, 241–2.

prominently'.[208] 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 RACFs.

Byrnes notes that 'it is striking how little explicit reference the [interim report] makes to human rights even as it details and denounces a litany of human rights violations resulting from the failures of the system'.[209] 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 of human rights in any consistent or sustained manner, even though they may embody or be aligned with human rights values'.[210]

Significantly, the interim report examines the ongoing problems of isolation/solitary confinement and inadequate medical care in RACFs with little reference to human rights. First, the interim report examines isolation/solitary confinement in the chapter on 'restrictive practices'.[211] Even though multiple governmental and parliamentary bodies have framed restrictive practices as potential human rights violations,[212] including the RCAC's own background paper on restrictive practices,[213] the interim report sidesteps such framing.[214]

Second, regarding inadequate medical care, the interim report highlights three areas that would benefit from a human rights-based analysis, which are:

208 Andrew Byrnes, 'Human Rights Unbound: An Unrepentant Call for a More Complete Application of Human Rights in Relation to Older Persons' (2020) 39(2) *Australasian Journal on Ageing* 91, 94.

209 Ibid 92.

210 Ibid.

211 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 2019 Interim Report* (n 200) vol 1, 194.

212 See, eg, the webpage of the National Disability Insurance Scheme ('NDIS') Quality and Safeguards Commission, which states: 'It is now recognised that restrictive practices can present serious human rights infringements': 'Regulated Restrictive Practices', *NDIS Quality and Safeguards Commission* (Web Page) <https://www.ndiscommission.gov.au/regulated-restrictive-practices#02>; *Quality of Care Amendment Principles* (n 187); Australian Law Reform Commission, *Equality, Capacity and Disability in Commonwealth Laws* (Final Report, 29 August 2014) 247–8; *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability: Restrictive Practices* (Issues Paper, 26 May 2020) 2–3 ('*RCAC Issues Paper*').

213 The RCAC's background paper on restrictive practices contains less than a page about human rights: *Royal Commission into Aged Care Quality and Safety: Restrictive Practices in Residential Aged Care in Australia* (Background Paper No 4, May 2019) 20–1. This may be contrasted with the issues paper on restrictive practices issued by the DRC, which refers to '[h]ow we will look at restrictive practices: A human rights-based approach' upfront on page 2: *RCAC Issues Paper* (n 212) 2.

214 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 208) 92.

'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'.[215]

The RCAC may consider human rights protections in its final report.[216] 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'.[217] 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.[218] 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'.[219]

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'.[220] The Commissioners indicated that a full inquiry was not possible given the many other aspects of the RCAC's work.[221] Despite the limited timeframe, significant benefits arose from these hearings.

From a human rights perspective, one benefit[222] was the provision of some sought after answers to the family members of residents who died, albeit preliminary

215 *RCAC 2019 Interim Report* (n 200) vol 1, 6.

216 Byrnes thinks it may be overly 'optimistic' to think this will be the case: Byrnes (n 208) 94. See also at 91.

217 Peter Gray et al, Submission to Royal Commission into Aged Care Quality and Safety (Final Submission, 22 October 2020) 40.

218 The recommendation is four pages long: ibid 47–51.

219 Ibid 51.

220 'The Response to COVID-19 in Aged Care', *Royal Commission into Aged Care Quality and Safety* (Web Page) <https://agedcare.royalcommission.gov.au/hearings-and-workshops/sydney-hearing-2>.

221 Tony Pagone, '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>.

222 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 RACFs providers facing possible outbreaks in the future. This reflection is evident in some of the evidence quoted in the preceding part. See above Part IV(A) nn 101–2 , 106–7 , 119, 126, 128, 131, 137.

answers[223] (the right to know the truth),[224] and an opportunity to hear from some RACFs 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.[225] Counsel Assisting concluded by saying: 'All residents are legally entitled to quality care at all times. That doesn't change in emergency. If anything, it becomes more important.'[226]

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*, and the hearings were not

223 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.

224 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*, UN Doc E/CN.4/2005/102/Add.1 (8 February 2005) 7 <https://undocs.org/E/CN.4/2005/102/Add.1>. 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: at 7–8.

225 This included Anglicare's Chief Executive Officer and General Manager of Service Development and Practice Governance and the medical practitioner overseeing Newmarch's HITH approach. The Chief Executive Officer 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 livestreamed, 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 media: see, eg, Katharine Murphy and Elias Visontay, 'Federal Government Had No Covid-19 Aged Care Plan, Royal Commission Hears', *The Guardian* (online, 10 August 2020) <https://www.theguardian.com/australia-news/2020/aug/10/government-had-no-covid-19-aged-care-plan-inquiry-told-as-catastrophic-failure-alleged-over-st-basils>; Julie Power, 'COVID-19 Has Exposed Australia's Aged Care Sector's Flaws, Royal Commission Hears', *The Sydney Morning Herald* (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', *The Australian Financial Review* (online, 13 August 2020) <https://www.afr.com/policy/health-and-education/none-of-this-was-unforeseeable-aged-care-response-slammed-20200813-p55lf2>.

226 Transcript of Proceedings, *Royal Commission into Aged Care Quality and Safety* (13 August 2020) 8695 ('*13 August Transcript*').

framed by human rights.[227] 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)[228]. 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'.[229] This is one of the few references to RACFs residents having 'rights'.

The hearings addressed isolation in some detail. The RCAC heard from a Victorian RACF resident about the impact of visitor restrictions on residents' mental health.[230] 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 RACFs' voluntary code for visiting should have been developed with the assistance of 'either human rights or resident advocates'.[231]

227 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 '[t]he 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': Ronald Sackville, *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Opening Statement, 18 August 2020) 6–7. The opening statement went on to identify one of the four objectives of the hearings to be '[t]o 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.

228 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: Transcript of Proceedings, *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (19 August 2020) 180–91 and Rosemary Kayess, Vice Chairperson, United Nations Committee on the Rights of Persons with Disabilities: Transcript of Proceedings, *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Transcript of Proceedings, 18 August 2020) 29–41. The RCAC could have called on the United Nations 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.

229 *10 August Transcript* (n 126) 8377.

230 Ibid 8403–10.

231 Transcript of Proceedings, *Royal Commission into Aged Care Quality and Safety* (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: *13 August Transcript* (n 226) 8695.

Following these hearings, the RCAC tabled a short special report[232] containing six recommendations, all of which were accepted by the federal government.[233] While the special report refers to a 'fundamental right of all Australians young or old' to 'equal access to the hospital system',[234] 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 RACFs. It pays particular attention to '[v]isitors and quality of life',[235] and recognises the heavy restrictions imposed on residents, stating that RACFs residents 'have endured restrictions for most of this year that go beyond those endured by the general community'.[236] 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.[237] 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'.[238] This recommendation is not framed via human rights standards: it provides no guarantee that RACFs' 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 RACFs' 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;

232 *Royal Commission into Aged Care Quality and Safety* (Special Report, 30 September 2020) ('*RCAC Covid Report*').

233 Richard Colbeck, Minister for Senior Australians and Aged Care Services and Minister for Sport, 'Government Welcomes Aged Care Royal Commission's COVID-19 Report Recommendations' (Media Release, 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>.

234 *RCAC Covid Report* (n 232) 21.

235 Ibid 6.

236 Ibid 7.

237 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>.

238 *RCAC Covid Report* (n 232) 12 (Recommendation 4).

and the particular characteristics of the aged care workforce'.[239] As highlighted by Ibrahim, this recommendation does not include either resident representatives/advocates or human rights experts on the advisory body.[240] Moreover, there is no requirement for the advisory body to be independent of both government and RACFs providers because it will report to the Australian Health Protection Principal Committee,[241] and that Committee is comprised of state and territory Chief Health Officers, and chaired by the Australian Chief Medical Officer.[242] Like the ACQSC, this advisory body may not be, and may not be perceived to be, independent.

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.[243]

Like Royal Commissioners, coroners are independent and enjoy wide discretion in the focus of their inquiries and the recommendations they make,[244] 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' while being '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'.[245]

239 Ibid 12–13.

240 '[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 237).

241 *RCAC Covid Report* (n 232) 13.

242 Ibid 11.

243 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.

244 See s 82(1) of the *Coroners Act 2009* (NSW) ('*NSW Act*'):

> 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.

245 Judicial Commission of New South Wales, *Local Court Bench Book* (rev ed, 2020) [44-180].

Royal commissions have influenced the modern development of coronial inquiries in Australia. This influence is evident from the developments in coronial inquiries since the 1987–91 Royal Commission into Aboriginal Deaths in Custody, which encouraged coroners to take a systems-based approach to inquiries.[246] In this context, Watterson, Brown and McKenzie 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*.[247]

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.

A *Coronial Inquest into Newmarch*

In early June 2020, the NSW Coroner announced a coronial inquest into the deaths at Newmarch.[248] The NSW coronial system serves various objectives. Under the *Coroners Act 2009* (NSW) ('*NSW Act*'), there is the traditional narrow objective of 'investigat[ing] 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'.[249] 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)'.[250] This is considered 'a critical function of a coroner'.[251]

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

246 *Royal Commission into Aboriginal Deaths in Custody* (National Report, 15 April 1991) vol 1, [4.7.4].

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

248 Noyes (n 13).

249 *NSW Act* (n 244) s 3(c).

250 Ibid s 3(e).

251 *Local Court Bench Book* (n 245) [44-000].

practitioner cannot provide 'a certificate as the cause of death'.[252] 'Reportable deaths' fall into two categories: those reportable 'by virtue of circumstance … or setting'.[253] Regarding *circumstance*, a 'reportable death' under s 6(1) includes a death where the person died 'a violent or unnatural death' (para (a)), 'a sudden death the cause of which is unknown' (para (b)), 'under suspicious or unusual circumstances' (para (c)), or 'in circumstances where the person's death was not the reasonably expected outcome of a health-related procedure' (para (e)).[254] Regarding *setting*, under s 23 '[a] senior coroner [the State Coroner or Deputy State Coroner] has jurisdiction to hold an inquest concerning the death or suspected 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.[255]

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.[256] 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 the date, place, manner and cause of the person's death has 'not been sufficiently disclosed'.[257]

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.

252 *NSW Act* (n 244) s 21(1).

253 Mitchell (n 3) 44.

254 *NSW Act* (n 244) s 6(1).

255 The circumstances include where a child is in care: ibid s 24(1)(a), if the child or the sibling of a child were the subject of a report under pt 2 of ch 3 of the *Children and Young Persons (Care and Protection) Act 1998* (NSW) in the three years preceding the death: at ss 24(1)(b), (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).

256 *NSW Act* (n 244) s 27(1)(b).

257 Ibid ss 27(1)(a), (c), (d).

> If, on the other hand, there are live questions about these issues, an inquest should be considered.[258]

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'.[259]

Interestingly, the *NSW Act* differs from its interstate 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 or omission by any other person'.[260] 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'. This includes matters concerning 'public health and safety' and 'that a matter be investigated or reviewed by a specified person or body'.[261] 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'.[262]

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

258 *Local Court Bench Book* (n 245) [44-160].

259 Ibid [44-100]. The Bench Book notes the following competing factors when deciding whether to hold an inquest at [44-160]:

> [W]hether 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.

260 *NSW Act* (n 244) s 38(2).

261 Ibid ss 82(2)(a)–(b).

262 *Local Court Bench Book* (n 245) [44-220].

course of police operations. Second, coroners can request a response.[263] 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).[264] The Minister must provide an explanation where recommendations are not implemented.[265]

B *Newmarch Inquest as Deaths in Custody or Care*

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 deaths in RACFs should be considered 'deaths in custody', thereby triggering mandatory investigations under the coronial legislative framework. 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*'.[266] Over the years, 'other lawful custody' has in practice included the death of a forensic patient,[267] and it has not been strictly limited to deaths in prison custody, police custody, juvenile detention or immigration detention.[268] 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 RACFs had been classified as a 'death in custody'.[269]

263 The power to request a response is contained in the State Coroner's Circular No 72 and is referred to in the *Local Court Bench Book*: ibid.

264 Ibid. 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'.

265 Ibid.

266 *NSW Act* (n 244) s 23(1)(a) (emphasis added). This section is entitled '[j]urisdiction 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.

267 NSW Office of the State Coroner, *Report by the NSW State Coroner into Deaths in Custody/Police Operations for the Year 2019* (Report, 30 April 2020) 1.

268 Ibid 8.

269 Ibid; NSW Office of the State Coroner, *Report by the NSW State Coroner into Deaths in Custody/Police Operations for the Year 2018* (Report, 12 April 2019); NSW Office of the State Coroner, *Report by the NSW State Coroner into Deaths in Custody/Police Operations for the Year 2017* (Report, 2 April 2018); NSW Office of the State Coroner, *Report by the NSW State*