

11 June 2020

Our ref: LP: MC

The Hon. Anastacia Palaszczuk MP
Premier of Queensland
By email: [REDACTED]

The Hon. Yvette D'Ath MP
Attorney-General and Minister for Justice
Leader of the House
By email: [REDACTED]

The Hon. Mark Ryan MP
Minister for Police and Minister for Corrective Services
By email: [REDACTED]

Dear Premier, Attorney-General and Minister

Prisoners in solitary confinement

As you may be aware on 18 May 2020, the *Legal Perspectives on Solitary Confinement in Queensland* report was released. I have enclosed a copy of the report and it is available at the following link <https://law.uq.edu.au/files/55114/Solitary-Confinement-Report.pdf>.

The report is the product of a two year research project completed by the University of Queensland and the Prisoners' Legal Service. It provides empirical research pertaining to the experience of prisoners held in solitary confinement and includes a review of case law regarding the use of solitary confinement. A number of findings and recommendations for reform are made which are summarised in part below.

I write to advise that QLS supports the findings and recommendations in the report without reservation. QLS requests your urgent attention to this issue. We are concerned to ensure that all necessary safeguards are put in place to minimise the catastrophic effects on prisoners' wellbeing caused by solitary confinement. This is particularly crucial in light of COVID-19 and the related measures and restrictions understandably put in place in Queensland Corrections facilities in responding to the pandemic.

Key points

The report highlights that in Queensland, solitary confinement is the default position for managing difficult prisoners, some of whom have been held in isolation for more than a decade, notwithstanding the well-established evidence that placement in solitary confinement, even for short periods of time, can result in serious and long-lasting psychological harm.

Prisoners in solitary confinement

United Nations bodies have concluded that 'solitary confinement should only be used in exceptional cases: for as short a time as possible and as a last resort'.¹ However, the position in Queensland appears 'separate confinement' is the standard approach to managing prisoners' behavioural and mental health issues. This position remains unchecked due to inadequate legislative and procedural safeguards. These safeguards are needed to address the profound harm solitary confinement causes.²

The current use of solitary confinement infringes on the rights to:

- a) humane treatment when deprived of liberty,³
- b) protection from torture and cruel, inhuman or degrading treatment,⁴
- c) liberty and security of person,⁵
- d) life⁶ and
- e) privacy and reputation.⁷

The *Human Rights Act 2019* (Qld) requires human rights to be considered in all administrative decision-making. Any limitations on individual rights must be demonstratively justified and the least restrictive means of achieving the desired purpose should be applied. Solitary confinement as the "standard approach" does not satisfy these tests.

The recommendations

The following recommendations are made in the report:-

1. That Queensland Corrective Services eliminate the use of solitary confinement, or segregation by any name.
2. That the *Corrective Services Act 2006* (Qld) be amended to:
 - a) require that prisoners receive a comprehensive mental health evaluation by an external mental health professional within 24 hours of a decision to separate them from the general population;
 - b) mandate that no prisoner be held in solitary confinement within 60 days of their release date; and
 - c) require that correctional authorities apply to a court for authority to separate a prisoner from the general population for more than 48 hours.
3. That Queensland Corrective Services immediately commence a process for undertaking meaningful engagement with relevant non-government organisations about solitary confinement reform.

The Society supports unreservedly the recommendations made in the report as a minimum.

¹ *Legal perspectives on solitary confinement in Queensland*, p 7 citing International Psychological Trauma Symposium, The Istanbul Statement on the Use and Effects of Solitary Confinement (December 2007) 2 ('The Istanbul Statement'); The Nelson Mandela Rules, UN Doc A/RES/70/175, rule 45(1).

² *Legal perspectives on solitary confinement in Queensland*, p 13.

³ *Human Rights Act 2019* (Qld), s 30.

⁴ *Human Rights Act 2019* (Qld), s 17.

⁵ *Human Rights Act 2019* (Qld), s 29.

⁶ *Human Rights Act 2019* (Qld), s 16.

⁷ *Human Rights Act 2019* (Qld), s 25.

Prisoners in solitary confinement

The Society further suggests that amendments to the *Corrective Services Act 2006* (Qld) should be made to ensure consistency with other State legislation governing the confinement of persons against their wishes. The *Mental Health Act 2016* (Qld), in particular, provides for the seclusion of patients in very limited circumstances with strict controls to minimise the risk of the confinement creating greater harm to the person. The provisions for seclusion in the *Mental Health Act 2016* (Qld) provide for transparency (with a clear decision and record keeping pathway before and after using seclusion), accountability (by oversight of the Chief Psychiatrist), and respect for the person (with observation, medical care and reflection).

Some of the control measures that govern the use of seclusion in the *Mental Health Act 2016* (Qld) include the following:⁸

- Seclusion is a measure of last resort and only used if necessary to prevent imminent and serious risk of harm to patients and staff, and where other less restrictive interventions have been unsuccessful or are not feasible;
- Mechanical restraint cannot be used for a person in seclusion;
- Seclusion cannot be used for more than three (3) hours at a time, and cannot be used more than three (3) times in a 24 hour period;
- Persons in seclusion must remain under continuous observation and CCTV is not considered a sufficient measure for observation⁹;
- A 'reduction and elimination' plan (stepping the person down from their seclusion) must be completed for all persons who are, who are likely to be, in seclusion for nine (9) hours in a 24 hour period and, failing that being effective over a maximum of seven (7) days, the Chief Psychiatrist must be notified to have input into any ongoing plan;
- Records must be kept to explain the rationale for any seclusion, and why it was considered there was no alternative practicable way of protecting the person or others from harm, including the strategies that were used to prevent the need for seclusion;
- When the person is released, a medical doctor must review them and, if appropriate, conduct a physical examination;
- There must be a debrief between staff and the person afterwards to reflect on the reasons for the seclusion, where the person can explain how they felt, ask questions and discuss strategies to avoid the requirement for seclusion in future (with a support person if they wish)
- Records are to be made and kept about the effectiveness of the seclusion on the person

Action should be taken immediately to prevent the negative health outcomes that solitary confinement creates for the most vulnerable members of the prison population.

The Society considers it desirable for the *Corrective Services Act 2006* (Qld) to be brought into line with the *Mental Health Act 2016* (Qld) so that decision makers within corrective services

⁸ *Mental Health Act 2016* (Qld), Chapter 8, Part 3;

https://www.health.qld.gov.au/data/assets/pdf_file/0025/465163/cpp-seclusion.pdf

⁹ In this regard we note the Chief Psychiatrist Policy under the *Mental Health Act 2016* where paragraph 3.2 states, "observation of a patient in seclusion must be continuous or at intervals of no more than fifteen (15) minutes. This must be determined by the authorised doctor based on clinical assessment. CCTV is not a sufficient way to continuously observe a patient in seclusion."

Prisoners in solitary confinement

are enabled to act and make decisions compatibly with the *Human Rights Act 2019* (Qld) to the extent intended by that legislation.

We consider it most important that the steps as called for in the report are taken in order to improve wellbeing and behavioural outcomes for prisoners in solitary confinement, as well as prioritising legitimate, safe and workable alternatives to solitary confinement.

We have written in similar terms to your colleagues the Leader of the Opposition, Shadow Attorney-General and the Shadow Minister for Police and Counter Terrorism.

If you have any queries regarding the contents of this letter, please do not hesitate to contact, me, our Legal Policy team via policy@qls.com.au or by phone on (07) 3842 5930.

Yours faithfully

A large black rectangular redaction box covering the signature of Luke Murphy.

Luke Murphy
President



THE UNIVERSITY
OF QUEENSLAND
AUSTRALIA

CREATE CHANGE



JUSTICE BEHIND BARS



Legal perspectives on solitary confinement in Queensland

Tamara Walsh, Helen Blaber, Claudia Smith, Lucy Cornwell and Karen Blake.

With additional research assistance by **Elizabeth Aisi, James Mullins, Daniel Murphy, Melody Valentine and Cara Scarpato.**

Contents

ABBREVIATIONS	5
EXECUTIVE SUMMARY	6
1. SOLITARY CONFINEMENT: AN INTRODUCTION	9
1.1 What is solitary confinement?	9
1.2 International standards on the use of solitary confinement in prisons	10
1.3 The harmful effects of solitary confinement on prisoners: Literature that has been judicially noted	12
1.4 Vulnerable prisoners	13
1.5 Rationale for this research	13
2. SOLITARY CONFINEMENT IN QUEENSLAND: A LEGAL OVERVIEW	15
2.1 'Separate Confinement' under the Queensland Corrective Services Act	15
2.2 Conditions in Separate Confinement: Queensland's Legislative and Operational Requirements	16
2.2.1 Minimum legislative requirements for prisoners undergoing separate confinement	16
2.2.2 Review procedures	17
2.2.3 Custodial Operations and Prisoner Management (COPD)	19
3. REPORTED CASE LAW CONCERNING SOLITARY CONFINEMENT IN QUEENSLAND	25
3.1 Judicial review in Queensland	25
3.2 Sentencing decisions in Queensland	33
4. CORONER'S INQUEST FINDINGS IN AUSTRALIA	35
4.1 References to solitary confinement in coronial cases	35
4.2 Coroners' recommendations on solitary confinement	40

We are grateful to the artist, **Boneta Marie Mabo**, for providing us with permission to use her artwork. Thanks also to Human Rights Watch for providing us with permission to use their photographs.

5. THE EXPERIENCE OF PRISONERS IN SOLITARY CONFINEMENT IN QUEENSLAND	44
5.1 Overview of empirical research	44
5.2 Interviews with prisoners' lawyers and advocates	44
5.2.1 Methodology and participants	44
5.2.2 Prevalence of mental illness and disability	45
5.2.3 Lack of accountability, transparency and oversight	47
5.2.4 Solitary confinement as a 'downward spiral'	49
5.2.5 Lack of access to mental health treatment	50
5.2.6 Conclusions on the use of solitary confinement	51
5.3 File analysis: Prisoners in solitary confinement in Queensland 2016-2018	52
5.3.1 Methodology	52
5.3.2 Quantitative information	53
6. SOLITARY CONFINEMENT AND THE QUEENSLAND HUMAN RIGHTS ACT	61
6.1 Queensland's Human Rights Act	61
6.2 Humane Treatment when Deprived of Liberty	62
6.2.1 Interpretation of the right	62
6.2.2. Application to solitary confinement	63
6.3 Protection from Torture and Cruel, Inhuman or Degrading Treatment	64
6.3.1 Interpretation of the right	64
6.3.2 Application to solitary confinement	65
6.4 Life, Liberty and Security of Person	66
6.4.1 Interpretation of the rights	66
6.4.2 Application to solitary confinement	67
6.5 Privacy and Reputation	68
6.6 Limitations on rights	68
6.7 Implications of the Human Rights Act for the practice of solitary confinement	70

7. ALTERNATIVES TO SOLITARY CONFINEMENT	72
7.1 Alternative behavioural management strategies	72
7.1.1 United States of America	72
7.2 Mental Health Units or ‘therapeutic housing’ as an alternative to segregation	73
7.2.1 United Kingdom	73
7.2.2 Northern Ireland	73
7.2.3 United States of America	74
7.2.4 Canada	76
7.3 Limiting the use of solitary confinement	77
7.3.1 United States of America	77
7.3.2 Europe and the United Kingdom	78
7.3.3 Canada	79
7.3.4 Australia	79
7.4 Improving conditions in solitary confinement	80
7.4.1 Australia	80
7.4.2 United States of America	80
7.4.3 Canada	82
7.4.4 United Kingdom	82
7.4.5 Europe	83
7.4.6 New Zealand	83
7.5 ‘Step-down’ and reintegration programs	84
7.5.1 United States of America	84
7.6 Cost and benefits	86
8. FINDINGS AND RECOMMENDATIONS	88
8.1 Key findings	88
8.2 Recommendations	89

Abbreviations

ATSI: Aboriginal and Torres Strait Islander

BMR: Behaviour Management Regime (New Zealand)

CAPS: Clinical Alternative to Punitive Segregation (New York)

COPD: Custodial Operations Practice Directive (Queensland)

DU: Detention Unit

HSU: High Support Unit (Northern Ireland)

LGBTI: Lesbian, gay, bisexual, transgender and intersex

MSU: Maximum Security Unit

MSO: Maximum Security Order

OPCAT: Optional Protocol to the United Nations Convention Against Torture

PACE: Program to Accelerate Clinical Effectiveness (New York)

PBMS: Positive Behaviour Management System (New York)

QCS: Queensland Corrective Services

SIU: Structured Intervention Unit (Canada)

US: United States

UK: United Kingdom

UN: United Nations

WHO: World Health Organisation

Executive Summary

Solitary confinement occurs when a prisoner is locked down in their cell for at least 22 hours a day with very limited or no association with other prisoners.¹ There is often little or no access to natural light or fresh air, limited contact with staff, and reduced privileges such as televisions, visits and phone calls.²

Whilst the term ‘solitary confinement’ is generally not used in Australian legislation, many Australian prisoners are subjected to these conditions. In Australia, solitary confinement is referred to as segregation, separate confinement, isolation or non-association.

In Queensland, solitary confinement can occur under a safety order, under a maximum security order, or as a result of a breach of discipline. Since there is no limit to the number of consecutive safety orders or maximum security orders (MSO) that can be imposed, prisoners can be held in solitary confinement for prolonged periods of time – for months, or even many years.

Prisoners in solitary confinement experience profound social and sensory isolation. It is well-established that placement in solitary confinement, even if only for a few days, can result in serious psychological harm that in some circumstances is permanent.³ It is not uncommon for prisoners in solitary confinement to develop symptoms of psychosis including delusions, hallucinations and paranoia.⁴ They may also engage in seriously disordered behaviour such as ‘bronzing’ (spreading faeces), and acts of self-harm.⁵

The conditions in solitary confinement are so harsh that judges have reduced the length of prisoners’ sentences in recognition of this fact.⁶ Judges around the world have recognised the harms that solitary confinement causes, and have held that placing someone in solitary confinement can constitute a breach of human rights including the right to humane treatment whilst in detention, and the right to be free from inhuman and degrading treatment.⁷ Australian coroners have found solitary confinement conditions to be ‘deplorable’⁸ and external oversight to be ‘inadequate’.⁹ They have noted the lack of access to appropriate health care and mental health care, as well as the association between isolation and the development of symptoms of psychosis.¹⁰

In Queensland, the *Corrective Services Regulation 2017* (Qld) establishes some minimum requirements for prisoners subjected to solitary confinement. However, it is our understanding that some of these minimum requirements – such as the opportunity to exercise in the fresh air for at least two daylight hours a day¹¹ – are not always provided. The Custodial Operations Practice Directives (COPD) provide guidance to corrective services officers on how prisoners should be managed. Yet some of these guidelines – such as those outlining the stages of reintegration for maximum security prisoners – are not reflective of actual practice.

1. United Nations Office on Drugs and Crime, *The United Nations Standard Minimum Rules for the Treatment of Prisoners*, GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016, adopted 17 December 2015) rule 44 (‘The Nelson Mandela Rules’).

2. Human Rights Watch, *I Wanted Help Instead I Was Punished: Abuse and Neglect of Prisoners and Disabilities in Australia* (Report, 2018) 42-3 (‘I Wanted Help Instead I Was Punished’).

3. S. Grassian, ‘Psychiatric Effects of Solitary Confinement’ (2006) 22 *Washington University Journal of Law and Policy* 325, 332.

4. J. Mendez, Special Rapporteur, *Interim report of the Special Rapporteur of the Human Rights Council on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, UN Doc A/66/268 (5 August 2011) 17 [62]; *Ibid* 333-8.

5. Grassian (n 3) 351.

6. In Queensland, see *Callanan v Attendee X* [2013] QSC 340; *Callanan v Attendee Y* [2013] QSC 341; *Callanan v Attendee Z* [2014] 2 Qd R 11.

7. In Canada, see *British Columbia Civil Liberties Association v Canada (Attorney-General)* [2018] BCSC 62 (‘*BCCLA v Canada* [2018]’). In New Zealand, see *Taunoa v Attorney-General* [2008] 1 NZLR 429 (‘*Taunoa v A-G*’).

8. *Inquest into the Death of W* (Coroner’s Court of New South Wales, Deputy State Coroner Sharon Freund, 11 November 2015) 30 (‘*W*’).

9. *Inquest into the Death of LP* (Coroner’s Court of South Australia, Deputy State Coroner Anthony Ernest Schapel, 19 November 2010) 15 (‘*LP*’).

10. *W* (Coroner’s Court of New South Wales, Deputy State Coroner Sharon Freund, 11 November 2015) 23, 28; *Inquest into the Death of FJTF* (Coroner’s Court of New South Wales, Deputy State Coroner Teresa O’Sullivan, 13 July 2018) 25 (‘*FJTF*’).

11. *Corrective Services Regulation 2017* (Qld) reg 4(d) (‘*Corrective Services Regulation*’).

The lived experience of prisoners revealed in this report may well ‘shock community conscience.’¹² Professionals who work with prisoners provide graphic descriptions of the conditions within solitary confinement, and the impacts of isolation on individuals.

They report prisoners with serious mental health problems being placed in solitary confinement ‘for behaviour they can’t really control.’

They describe prisoners ‘doing things with their faeces’, routinely self-harming, and engaging in obsessive-compulsive behaviour as a ‘coping strategy.’

They note that prisoners in solitary confinement often become hypersensitive to noise, afraid of open spaces, and reluctant to be released from isolation.

They describe the profound loneliness and boredom experienced by prisoners, and the extreme sensory deprivation, including their complete removal from grass, air and colour.

United Nations (UN) bodies have concluded that ‘solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort’ and that solitary confinement for more than 15 days at a time should be prohibited.¹³ Instead, in Queensland, it is the default position for managing difficult prisoners, some of whom have been held in isolation for more than a decade.

Considering the length of time that some Queensland prisoners have been in solitary confinement, the serious nature of their crimes, and the extent to which their mental health has deteriorated, releasing these prisoners from solitary confinement may seem impossible. However, this investigation shows that there are myriad alternatives to solitary confinement that can effectively address the safety concerns that tend to result in a person’s placement in solitary confinement in the first place. International best practice demonstrates that alternative behaviour management strategies and the establishment of specialist mental health units can remove the need to place prisoners in solitary confinement. There are a range of methods adopted internationally to facilitate the effective reintegration of prisoners from prolonged solitary confinement, including through the use of step-down units and alternative behaviour management strategies.

Conditions in solitary confinement can also be substantially improved by increasing the amount of meaningful conversation that prisoners engage in, and the range of activities they can participate in.

Improvements to in-cell exercise and education programs, and in-cell work opportunities, could easily be implemented.

Technology can allow prisoners better access to music, audiobooks and audio-programs, and can even be used to simulate outdoor experiences.

¹² This is the legal threshold for ‘cruelty’; see *Attorney-General v Taunoa* [2006] 2 NZLR 457 [225] (‘A-G v Taunoa’); *Munoz v Alberta (Edmonton Remand Centre)* (2004) ABQB 769, [78] (‘Munoz’).

¹³ International Psychological Trauma Symposium, *The Istanbul Statement on the Use and Effects of Solitary Confinement* (December 2007) 2 (‘The Istanbul Statement’); *The Nelson Mandela Rules*, UN Doc A/RES/70/175 (n 1) rule 45(1).



© 2017 Daniel Soekov for Human Rights Watch

The recent passing of the *Human Rights Act 2019* (Qld), as well as Australia's ratification of the Optional Protocol to the Convention Against Torture (OPCAT), will require Queensland Corrective Services (QCS) to rethink its approach to solitary confinement. The harshness of the conditions under which prisoners are currently held engages a number of human rights including the right to humane treatment when deprived of liberty, the right to be free from cruel, inhuman and degrading treatment, the right to life, liberty and security of person, and the right not to have one's family life arbitrarily interfered with. Whilst we acknowledge that a transition away from the use of solitary confinement will take time, substantial reforms are necessary to avoid future litigation and end a practice that causes significant harm to vulnerable individuals.

RECOMMENDATIONS:

1. That Queensland Corrective Services eliminate the use of solitary confinement, or segregation by any name.
2. That the *Corrective Services Act 2006* (Qld) be amended to:
 - a. require that prisoners receive a comprehensive mental health evaluation by an external mental health professional within 24 hours of a decision to separate them from the general prison population;
 - b. mandate that no prisoner be held in solitary confinement within 60 days of their release date;
 - c. require that correctional authorities apply to a court for authority to separate a prisoner from the general prison population for more than 48 hours.
3. That Queensland Corrective Services immediately commence a process for undertaking meaningful engagement with relevant non-government organisations about solitary confinement reform.

1. Solitary confinement: an introduction

1.1 What is solitary confinement?

Solitary confinement is where a prisoner is locked down in their cell for at least 22 hours a day with very limited or no association with other prisoners.¹⁴ Prolonged solitary confinement is where a person has been held in those conditions for more than 15 days.¹⁵

Solitary confinement is associated with the following conditions of detention:¹⁶

- the cell is often located in a separate part of the prison;
- no windows, or windows may be small or partially covered, or there may be no natural light;
- lack of fresh air;
- ‘small and barren’ exercise yards;
- no, or very limited, association with other prisoners;
- limited contact with other people, including family, staff and lawyers;
- limited access to programs, including work and education;
- reduced privileges including visits, phone calls, television; and
- limited or special furniture, bedding and amenities.

Placing prisoners in solitary confinement has become an increasingly common response to the ‘protective’ needs of prisoners.¹⁷ At the end of 2018, QCS reported that around 130 prisoners were being held in prolonged separate confinement in Queensland prisons, which represents around 1.4% of the Queensland prisoner population.¹⁸

In Australia, the term ‘solitary confinement’ is rarely used – rather, solitary confinement conditions are referred to as ‘segregation’, ‘separate confinement’, ‘non-association’ or ‘isolation’.

Prisoners may be placed in solitary confinement for administrative reasons or punitive reasons. Administrative reasons include situations where the prisoner is ‘at risk’ of harming either themselves or others, or of disturbing the ‘security’ or ‘good order’ of the prison. Punitive reasons include situations where the prisoner has been charged with an offence or a breach of discipline within the prison. Some prisoners are held in solitary confinement by virtue of their classification status. For example in Queensland, all maximum security prisoners are held in what is effectively solitary confinement.

¹⁴ *The Nelson Mandela Rules*, UN Doc A/RES/70/175 (n 1) rule 44.

¹⁵ *Ibid.*

¹⁶ Mendez, UN Doc A/66/268 (n 4) 14 [48]; M. Groves, ‘Administrative Segregation of Prisoners: Powers, Principles of Review and Remedies’ (1996) 20(3) *Melbourne University Law Review* 639, 640-1; S. Shalev, ‘Solitary Confinement and Supermax Prisons: A Human Rights and Ethical Analysis’ (2011) 11(2)-(3) *Journal of Forensic Psychology Practice* 151, 154; S. Shalev, *A Sourcebook on Solitary Confinement* (Report, October 2008) 39.

¹⁷ Mendez, UN Doc A/66/268 (n 4) 8 [23].

¹⁸ V. Krulin and M. van de Berg, ‘QLS Uncovers Solitary Confinement Data’ (2019) 39(3) *Proctor* 33.

Solitary confinement has been referred to as a ‘prison within a prison’,¹⁹ and it is widely acknowledged that solitary confinement exacerbates the negative effects of imprisonment upon individuals. This is particularly the case where:²⁰

- it is for a prolonged period of time;
- it is indeterminate, in the sense that the prisoner does not know how long they will be in solitary confinement for;
- the prisoner has a mental illness; or
- the prisoner is young or pregnant.

Solitary confinement causes serious psychological harm. In fact, it has been found to induce symptoms of psychosis including hallucinations, paranoia and delusions.²¹ For people who have pre-existing mental health conditions, solitary confinement exacerbates their illness and significantly increases their risk of suicide and self-harm.²² While there are significant differences in the effects of solitary confinement upon different individuals, all will experience a degree of stupor, difficulties with thinking and concentration, obsessional thinking, agitation, irritability and difficulty tolerating external stimuli.

Releasing an individual from solitary confinement is likely to diminish their most acute mental health symptoms, however many prisoners, including those who did not become visibly unwell during their placement in solitary, will likely suffer permanent harm as a result of it.²³

In addition to its significant negative health impacts, solitary confinement is not consistent with, and indeed may undermine, the goals of good order and safety of a prison. Institutional and broader community safety are not achieved when the mental health of prisoners is adversely affected, particularly since research has shown that these effects are irreversible in some instances.²⁴ The more disordered and anti-social prisoners become, the less likely they will be able to reintegrate into the mainstream prison population, or the community upon release.

1.2 International standards on the use of solitary confinement in prisons

At international law, solitary confinement is defined as the confinement of prisoners to their cells for 22 hours a day or more, without meaningful human contact.²⁵

The Istanbul Statement on the Use and Effects of Solitary Confinement states that:²⁶

‘As a general principle solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort.’

According to the *Istanbul Statement*, it has been ‘convincingly documented’ that solitary confinement ‘may cause serious psychological and sometimes physiological ill effects’ including psychosis, and that these effects can occur within only days of isolation.²⁷

¹⁹ *Martineau v Matsqui Institution Disciplinary Board* [1980] 1 SCR 602, 622.

²⁰ Mendez, UN Doc A/66/268 (n 4) 16 [57], 18 [63], 18 [66], 19 [68]; *United Nations Rules for the Treatment of Women Prisoners and Non-custodial Measures for Women Offenders with Their Commentary*, GA Res 65/229, UN Doc A/RES/65/229 (16 March 2011, adopted 21 December 2010) rule 22 (*‘The Bangkok Rules’*).

²¹ Mendez, UN Doc A/66/268 (n 4) 17 [62]; Grassian (n 3) 333-8.

²² Mendez, UN Doc A/66/268 (n 4) 17 [62], 18 [63].

²³ Grassian (n 3) 332.

²⁴ Mendez, UN Doc A/66/268 (n 4) 18 [64].

²⁵ *The Istanbul Statement* (n 13) 2; *The Nelson Mandela Rules*, UN Doc A/RES/70/175 (n 1) rule 44.

²⁶ *The Istanbul Statement* (n 13) 5.

²⁷ *Ibid* 2.

The revised version of the *United Nations Standard Minimum Rules for the Treatment of Prisoners* (the Mandela Rules) adopted in 2015 also states that solitary confinement should only be used ‘in exceptional circumstances as a last resort for as short a time as possible’, and adds the requirement that it be ‘subject to independent review and only pursuant to the authorization by a competent authority.’²⁸

Further to this, the Mandela Rules explicitly **prohibit prolonged solitary confinement, that is solitary confinement for ‘a time period in excess of 15 consecutive days.’**²⁹ The Mandela Rules also prohibit the use of solitary confinement for people with mental and physical disabilities ‘when their conditions would be exacerbated by such measures.’³⁰ The Mandela Rules further state that prisoners who are subject to involuntary separation must be visited by health care personnel on a daily basis, and health care personnel must have the authority to review and recommend changes to the conditions of their confinement.³¹

The original version of the *United Nations Standard Minimum Rules for the Treatment of Prisoners*³² states that:

*‘the prison system shall not, except as incidental to justifiable segregation or the maintenance of discipline, aggravate the suffering inherent in such a situation.’*³³

Rule 58 states that imprisonment should be ‘used to ensure, so far as possible, that upon his return to society the offender is not only willing but able to lead a law-abiding and self-supporting life.’³⁴ This requires the individual treatment needs of each prisoner to be assessed, and appropriate forms of assistance, including education, to be delivered.³⁵ The Standard Minimum Rules also emphasise the importance of prisoners maintaining contact with family members,³⁶ receiving adequate medical and psychiatric care,³⁷ and participating in meaningful work.³⁸

In a 2011 report to the UN General Assembly, the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment, Juan Mendez, found that the reduction of social contact occasioned by solitary confinement conditions was ‘insufficient for the individual to remain in a reasonable state of mental health.’³⁹ Mendez reported that **solitary confinement can cause psychosis, as well as ‘severe exacerbation’ of pre-existing mental health disorders.**⁴⁰ Some of the adverse health effects that result from solitary confinement, he said, were observable within only seven days and the effects could be long-term or irreversible especially after a prolonged period.⁴¹ Mendez noted that:⁴²

‘Intolerance of social interaction after a period of solitary confinement is a handicap that often prevents individuals from successfully readjusting to life within the broader prison population and severely impairs their capacity to reintegrate into society when released from prison.’

28. *The Nelson Mandela Rules*, UN Doc A/RES/70/175 (n 1) rule 45. See also the Committee of Ministers, *European Prison Rules* (January 2006) rule 60.5 (*‘European Prison Rules’*), which state that solitary confinement ‘shall be imposed as a punishment only in exceptional cases and for a specified period of time, which shall be as short as possible.’

29. *The Nelson Mandela Rules*, UN Doc A/RES/70/175 (n 1) rules 43, 44.

30. *Ibid* rule 45.2.

31. *Ibid* rule 46.

32. Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.

33. *The Nelson Mandela Rules*, UN Doc A/RES/70/175 (n 1) rule 57.

34. *Ibid* rule 58.

35. *Ibid* rules 59, 63.

36. *Ibid* rules 61, 79.

37. *Ibid* rules 22, 82.

38. *Ibid* rules 71–6.

39. Mendez, UN Doc A/66/268 (n 4) 16 [54].

40. *Ibid* 18 [63].

41. *Ibid* 18 [64].

42. *Ibid* 18 [65].

Mendez concluded that solitary confinement was ‘contrary to one of the essential aims of the penitentiary system, which is to rehabilitate offenders and facilitate their reintegration into society’⁴³ and ultimately recommended that solitary confinement only be used ‘as a last resort where less restrictive means could not achieve the intended disciplinary goals.’⁴⁴

Mendez also noted the importance of prisoners in solitary confinement being permitted to inform their family and friends of their placement in solitary confinement within 18 hours,⁴⁵ and the Human Rights Committee has said that prisoners in solitary confinement should be monitored daily by medical staff.⁴⁶

1.3 The harmful effects of solitary confinement on prisoners: Literature that has been judicially noted

Case law in Australia and around the world has cited extensive literature demonstrating the harmful effects of solitary confinement on prisoners, particularly those who are exposed to prolonged periods of segregation.

In the Supreme Court of Queensland case of *Callanan v Attendee X*,⁴⁷ Applegarth J refers to the research of Sharon Shalev, who found that **‘all studies of prisoners’ held in solitary confinement for more than 10 days have demonstrated negative health effects.’**⁴⁸ Applegarth J also notes Shalev’s finding that solitary confinement increases a person’s risk of being admitted to hospital for psychiatric reasons by 20 times.⁴⁹

In the Canadian case of *Corporation of the Canadian Civil Liberties Association v Her Majesty the Queen*,⁵⁰ Marrocco J provides a thorough review of the available literature, highlighting the ‘deeply’ traumatising effect that solitary confinement has on prisoners. His Honour notes that prisoners who spend time in solitary confinement are **‘more likely to express suicidal thoughts, develop psychiatric symptoms including psychosis, paranoia, depersonalisation, panic attacks and impulsivity, and they are also less likely to respond to anti-psychotic medication.’**⁵¹ Marrocco J also cites research indicating that solitary confinement can lead to a ‘vicious cycle’ where the prisoner experiences an emotional breakdown, acts out as a result, and is then considered (and indeed rendered) less able to re-integrate into the mainstream prison population.⁵²

Most recently in *British Columbia Civil Liberties Association v Canada (Attorney-General)*,⁵³ Fitch J of the Court of Appeal for British Columbia concluded, based on existing research, that **‘social deprivation’ is ‘the source of the greatest psychological harm’ for prisoners in solitary confinement;** His Honour was of the view that less restrictive alternatives to solitary confinement could achieve the same objectives and that ‘prolonged exposure to segregation undermines the goals of enhancing institutional safety and security and promoting the successful reintegration of offenders into the community.’⁵⁴ His Honour also observed that there was a ‘real and sufficient causal connection between segregation and an increased risk of self-harm and suicide’ and that ‘the risk of harm is intensified in the case of mentally ill inmates.’⁵⁵

43 Ibid 22 [79].

44 Ibid 23 [91].

45 Ibid 10 [41].

46 UN Human Rights Committee, *Concluding Observations of the Human Rights Committee on Portugal*, UN Doc CCPR/CO/78/PRT (17 September 2003) 4 [16].

47 *Callanan v Attendee X* [2013] QSC 340, [34]–[38] (*‘Attendee X’*).

48 S. Shalev, *A Sourcebook on Solitary Confinement* (Report, October 2008) 21.

49 *Attendee X* [2013] QSC 340, [38].

50 *Corporation of the Canadian Civil Liberties Association v Her Majesty the Queen* [2017] ONSC 7491, [238] (*‘Corporation of CCLA v The Queen’*).

51 Ibid.

52 Ibid.

53 *British Columbia Civil Liberties Association v Canada (Attorney-General)* [2019] BCCA 228, [90] (*‘BCCLA v Canada (2019)’*).

54 Ibid.

55 Ibid.

1.4 Vulnerable prisoners

It is well established that solitary confinement has a particularly harmful impact on prisoners with mental illness. However, there are clear indications that other prisoners, such as those with cognitive impairment, Indigenous prisoners, LGBTI prisoners and women are also disproportionately impacted. Prisoners with psychosocial or cognitive disabilities have been found to be disproportionately represented in solitary confinement regimes in both Western Australia and Queensland,⁵⁶ and Indigenous women are more likely to be held in solitary confinement than non-Indigenous women in Queensland.⁵⁷ Internationally, research has shown that LGBTI prisoners are also more likely to experience solitary confinement.⁵⁸

Further, solitary confinement regimes must be recognised as an extension of a correctional system (its architecture, security procedures and healthcare processes) that has been designed for men. Solitary confinement regimes fail to respond to the reality that women are biologically different to men, are generally in custody for less serious offences than men, experience higher levels of disadvantage than men and do not react to social controls in the same ways as men.⁵⁹ Also, women are often placed in solitary confinement for different reasons than men.⁶⁰ In the United States (US), factors such as age, race and level of education have been identified as influencing the frequency with which women are placed in solitary confinement; in contrast, the strongest factor that characterised men's placement in solitary confinement was the type of criminal offence that led to incarceration.⁶¹ Women have also been found to be more susceptible to developing mental illness in solitary confinement, and they are at greater risk of self-harm, suicide and abuse by prison guards compared to women in the general prison population.⁶²

1.5 Rationale for this research

In this report, we will show that the risks that prolonged solitary confinement pose to prisoners are not being effectively acknowledged or managed in Queensland prisons. Many prisoners in Queensland are held in solitary confinement for extensive periods of time, often for months – sometimes for years.

It is of particular concern to us that some prisoners are released from prolonged periods of solitary confinement directly into the community.

We recognise that prison authorities rely on solitary confinement to manage some of the most complex and challenging situations that arise in custody. These include circumstances where a prisoner poses a danger to others or cannot be accommodated within the existing population due to concerns for their own safety. However, **the use of prolonged solitary confinement has become more than an interim measure for managing safety concerns.** Its increasing prevalence suggests it is the default position for controlling a chaotic environment that prison staff are neither equipped nor resourced to manage. It is used because of the **lack of safe and readily available alternatives**, not because it represents best practice for managing safety concerns in prison. It remains unchecked due to **inadequate legislative and procedural safeguards** which fail to address the profound harm it causes.

⁵⁶ Human Rights Watch (n 2) 42.

⁵⁷ Anti-Discrimination Commission Queensland, *Women in Prison 2019: A Human Rights Consultation Report* (Report, 2019) 67-9.

⁵⁸ Penal Reform International and Thailand Institute of Justice, *Global Prison Trends 2019* (Report, May 2019) 26.

⁵⁹ L. Bartels and A. Gaffney, *Good Practice in Women's Prisons: A Literature Review* (Background Paper, 2011) 12.

⁶⁰ H. Cerneka, "We Will Not Be Invisible": Women and Solitary Confinement in the U.S., (2017) 32(2) *Wisconsin Journal of Law, Gender and Society* 107, 113-123.

⁶¹ Ibid 117.

⁶² Ibid 124-5.

It is our view that if members of the community were aware of the intense suffering experienced by prisoners in solitary confinement, combined with the risk that they then pose to themselves and others upon their release, they would support reform.

We will show that there are many less restrictive alternatives that have been successfully trialled in other jurisdictions including:

- capping the amount of time a person can be held in solitary confinement;
- improving conditions within solitary confinement by increasing social contact and meaningful activity;
- implementing alternative behavioural management strategies;
- establishing step-down units; and
- enhancing mental health care, including by establishing mental health units.

At a bare minimum, it is critical that prisoners who are in solitary confinement have access to effective, independent review procedures; that the rules of procedural fairness are complied with in decision-making; and that prisoners in solitary confinement are visited regularly by external health care professionals who are required to report daily on their wellbeing and empowered to make recommendations for review of their conditions.

Strict time limits should also apply. International legal bodies support a maximum period of 15 days.⁶³ Solitary confinement in excess of this time frame is prohibited under international rules. In June 2019, the Canadian parliament passed legislation imposing this mandatory time limit.⁶⁴ It will be seen later in this report that many other jurisdictions have capped the amount of time that prisoners can spend in solitary confinement – indeed, some are aiming to abolish solitary confinement altogether.

SUMMARY:

Solitary confinement can cause psychotic symptoms after only a short period of time, and often exacerbates pre-existing mental health conditions. Certain other vulnerable groups of prisoners such as those with cognitive disabilities, women and LGBTI prisoners are particularly likely to experience its adverse effects.

Spending time in solitary confinement can make it less likely that a prisoner will be able to successfully reintegrate into the mainstream prison population, or function effectively upon release into the community.

UN bodies, and courts around the world, have insisted that solitary confinement should only be used:

- as a last resort;
 - where there is no less restrictive means available to achieve the desired objective;
 - for short periods of time;
 - where effective independent review is accessible; and
 - where sufficient monitoring of adverse psychological and physiological impacts exists.
-

⁶³ Mendez, UN Doc A/66/268 (n 4) 21 [76].

⁶⁴ *Corrections and Conditional Release Act*, SC 1992, c C-20, s 37.

2. Solitary confinement in Queensland: a legal overview

2.1 ‘Separate Confinement’ under the Queensland Corrective Services Act

According to the *Corrective Services Act 2006* (Qld), the purpose of corrective services is ‘community safety and crime prevention through humane containment, supervision and rehabilitation of offenders.’⁶⁵ The Act states that everyone has basic human entitlements and that persons who have had their entitlements diminished because of imprisonment should be safeguarded.⁶⁶ The Act also recognises the need to respect prisoners’ dignity, including those who have special needs because of their age, sex, cultural background or disability.⁶⁷

The term ‘solitary confinement’ is not used in the *Corrective Services Act 2006* (Qld). In fact, it is not used in any of the other Australian corrections Acts.⁶⁸ Other terms are used to denote solitary confinement conditions, including ‘segregation’, ‘isolation’ and ‘separate confinement’.

In Queensland, prisoners who are held in the maximum security unit (MSU) will be held in solitary confinement. In most cases, prisoners who are held in the detention unit (DU) will also be held in solitary confinement. Prisoners housed in other units (including in a medical unit or padded cell) may also be held in ‘separate confinement’ if they are subject to safety orders.

The *Corrective Services Act 2006* (Qld) defines ‘separate confinement’ to mean the separation of the prisoner from other prisoners.⁶⁹ There are three ways in which a prisoner can be held in separate confinement in Queensland. These are: as punishment for a breach of discipline (7 days); being placed on a safety order (1 month); and being placed on a maximum security order (MSO) (6 months).

Breach of discipline proceedings can be initiated against prisoners for a range of behaviours in prison including: contravening a lawful direction; possessing or concealing an unapproved object; using abusive, indecent, insulting, obscene, offensive or threatening language; acting in an indecent or offensive way; or wilfully damaging property or clothing.⁷⁰ Breach of discipline proceedings must be conducted before a prisoner can be found guilty of a breach of discipline and issued with a punishment. If an authorised officer is satisfied that the prisoner has ‘habitually’ committed minor breaches of discipline and has received a final warning, or has committed a major breach of discipline, the prisoner may be placed in separate confinement for a maximum period of seven days following the breach hearing.⁷¹

⁶⁵ *Corrective Services Act 2006* (Qld) s 3(1).

⁶⁶ *Ibid* s 3(2).

⁶⁷ *Ibid* s 3(3).

⁶⁸ *Crimes (Administration and Sentences) Act 1999* (NSW) s 10 (“segregated custody”); *Prisons Act 1981* (WA) s 43 (“separate confinement”); *Correctional Services Act 1982* (SA) s 36 (“separately and apart from all other prisoners”); *Corrections Regulation 2009* (Vic) reg 27 (“separate a prisoner from other prisoners”); *Correctional Services Act 2017* (NT) s 41 (“separate a prisoner from other prisoners”); *Corrections Management Act 2007* (ACT) s 88 (“segregation”, includes “separate confinement”).

⁶⁹ *Corrective Services Act 2006* (Qld) Schedule 4.

⁷⁰ *Corrective Services Regulation 2017* (Qld) reg 5.

⁷¹ *Corrective Services Act 2006* (Qld) ss 118, 121(2).

A safety order can be issued where the chief executive believes there is a risk of the prisoner harming or being harmed by someone else, or the safety order is necessary for the security or good order of the corrective services facility.⁷² A safety order can also be issued on the advice of a doctor or a psychologist where they believe there is a risk of the prisoner harming himself, herself or someone else.⁷³ During the period of the safety order, the prisoner may be accommodated separately from other prisoners.⁷⁴ In practice, prisoners can be separately confined on safety orders in the DU, a health unit or by being locked down in their cell. A safety order cannot exceed a period of one month, however consecutive orders can be made.⁷⁵

A MSO can be made if the chief executive reasonably believes that: there is a high risk of the prisoner escaping or attempting to escape; there is a high risk of the prisoner killing or seriously injuring other prisoners or other persons with whom the prisoner may come into contact; or, generally, the 'prisoner is a substantial threat to the security or good order' of the corrective services facility.⁷⁶ If the chief executive makes a MSU, the prisoner will be accommodated in a MSU⁷⁷ which, in practice, means that the prisoner will most often be held in separate confinement.⁷⁸ A MSO must not be for a period longer than six months,⁷⁹ however consecutive orders can be made.⁸⁰

Since the *Corrective Services Act 2006* (Qld) allows consecutive safety orders and MSOs to be made, prisoners can spend months or years in solitary confinement. **There is no limit to the number of consecutive orders that can be made.** It is important to note, however, that the rules of procedural fairness apply to these determinations. For example, the chief executive cannot make consecutive safety orders or consecutive MSOs in respect of a prisoner unless he/she considers any submission made by the prisoner.⁸¹ Also, when considering whether or not a prisoner has committed a breach of discipline, the deciding officer must tell the prisoner of any evidence supporting the allegation of the breach of discipline, and give the prisoner a reasonable opportunity to make submissions in their defence.⁸² Prisoners, therefore, benefit substantially from having legal and advocacy advice available to them when these decisions are being made.⁸³

2.2 Conditions in Separate Confinement: Queensland's Legislative and Operational Requirements

2.2.1 Minimum legislative requirements for prisoners undergoing separate confinement

The *Corrective Services Regulation 2017* (Qld) states that a prisoner undergoing separate confinement must be able to access reticulated water, and a toilet and shower facilities that, as far as practicable, are constructed in a way to prevent the prisoner from associating with other prisoners.⁸⁴ Prisoners in separate confinement must also be given the same type of mattress, sheets, blankets and pillow as other prisoners would have,⁸⁵ as well as clothing that

⁷² Ibid s 53(1). Also, if a corrective services officer believes that the prisoner is at risk of harming themselves or another, but a doctor or psychologist is not available to provide advice, the chief executive may issue a temporary safety order for no more than five days to allow for an assessment to be undertaken: s 58.

⁷³ Ibid s 53(1)(a).

⁷⁴ Ibid s 53(6).

⁷⁵ Ibid ss 53(2), 54. Note that if the order was made on the advice of a doctor or psychologist, consecutive orders can only be made on the advice of a doctor or psychologist.

⁷⁶ Ibid s 60(2).

⁷⁷ Ibid s 60(1); Queensland Corrective Services, *Custodial Operations Practice Directive - MSO Management* (17 December 2019) 5 ('COPD MSO').

⁷⁸ *Corrective Services Act 2006* (Qld) Schedule 4 (definition of 'Maximum Security Unit'). Maximum Security Unit is defined as 'a facility for the accommodation of prisoners at a prison that is designed and constructed so that— (a) prisoners accommodated in the facility are totally separated from all other prisoners at the prison; and (b) some or all of the prisoners accommodated in the facility can be totally separated from all other prisoners accommodated in the facility'. The legislation and procedures permit prisoners accommodated in the maximum security unit to have contact with each other without a physical barrier separating them where this is approved by the Chief Executive or delegate. See section 62(1)(a) and COPD MSO (n 77) 9. However, to our knowledge, prisoners in the maximum security unit are not currently provided physical association with each other.

⁷⁹ *Corrective Services Act 2006* (Qld) s 60(3).

⁸⁰ Ibid s 61.

⁸¹ Ibid ss 54(4)(b), 61(3)(b).

⁸² Ibid s 116(3). Note also that the prisoner must be provided with a copy of the details about the breach that will be kept in the register: *Corrective Services Regulation 2017* (Qld) reg 6.

⁸³ Although it should be noted that in respect of a breach of discipline a prisoner is not allowed any legal or other representation before the deciding officer; *Corrective Services Act 2006* (Qld) s 116(5).

⁸⁴ *Corrective Services Regulation 2017* (Qld) reg 4(1)(a).

⁸⁵ Ibid reg 4(1)(b).

is appropriate for the prevailing conditions.⁸⁶ They must be given the opportunity to exercise, in the fresh air, for at least two daylight hours a day, unless a doctor or nurse has advised that this would not be in the interests of the prisoner's health.⁸⁷ For prisoners who are under MSOs, the only privileges the prisoner may receive are those that can be enjoyed within the MSU, and the enjoyment of which may reasonably be expected not to pose a risk to the security or good order of the corrective services facility.⁸⁸

QCS' COPD provide further guidance on the conditions of detention for prisoners in separate confinement (see Part 2.2.3 below). The COPD permits the placement of prisoners in non-powered cells, which includes prisoners in separate confinement.⁸⁹ Non-powered cells contain no power points, which prevents access to items such as televisions, and sometimes there is no running water.⁹⁰

2.2.2 Review procedures

Mandatory review procedures apply in respect of safety orders and MSOs. For prisoners on safety orders, health assessments must be undertaken by a doctor or nurse as soon as practicable after the order is made, and subsequently at intervals of no more than seven days for the duration of the order.⁹¹ If the safety order was made on the advice of a doctor or psychologist, the chief executive must refer the order to another doctor or psychologist for a review within seven days or as soon as is practicable.⁹² The reviewing practitioner must make recommendations⁹³ for the chief executive's consideration⁹⁴ as to whether the safety order should be confirmed, amended or cancelled, however, the chief executive is not bound by their recommendations.⁹⁵

Prisoners on MSOs must receive a health examination by a doctor or nurse as soon as practicable after the order takes effect, at intervals of not more than 28 days (but only 'to the greatest practicable extent'), and as soon as practicable after the order ceases to have effect.⁹⁶

A prisoner subject to a safety order or a MSO may apply in writing to the chief executive for referral of the order to an official visitor for review.⁹⁷ An official visitor must recommend to the chief executive whether the order should be confirmed, amended or cancelled, however the **chief executive is not bound by the official visitor's recommendations**.⁹⁸ Further to this, an official visitor must review a safety order on a monthly basis if the period of the order is more than one month.⁹⁹ Official visitors may also review a MSO on their own initiative if the period of the order is more than three months and the order has not been reviewed within the last three months.¹⁰⁰

⁸⁶ Ibid reg 4(1)(c).

⁸⁷ Ibid reg 4(1)(d).

⁸⁸ *Corrective Services Act 2006* (Qld) s 62(2).

⁸⁹ Queensland Correctives Services, *Custodial Operations Practice Directives – Cell Allocation* (July 2018) 2 ('COPD CA').

⁹⁰ It is our understanding that, at times, water is turned off in cells, for example where there is a risk that the prisoner may flood their cell. When the water is turned off, the prisoner will only have access to running water if they ask an officer for assistance.

⁹¹ *Corrective Services Act 2006* (Qld) s 57. See also s 55.

⁹² Ibid s 55(2)(b).

⁹³ Ibid s 55(4).

⁹⁴ Ibid s 55(5).

⁹⁵ Ibid ss 55(6), 58(6).

⁹⁶ Ibid s 64.

⁹⁷ Ibid ss 57, 63. Note that prisoners subject to maximum security orders are limited as to the frequency of applications: s 63(2). As to official visitors generally, see ss 290-292.

⁹⁸ Ibid ss 56, 63(9), 63(10).

⁹⁹ Ibid s 56(4).

¹⁰⁰ Ibid s 63(6).



© 2017 Daniel Soekov for Human Rights Watch

Official visitors are appointed by the chief executive, and they are required to investigate any complaint made by a prisoner.¹⁰¹ They have the power to enter a corrective services facility at any time, interview a prisoner on request and inspect any document relating to a complaint they are investigating.¹⁰² Official visitors may make recommendations to the chief executive in response to complaints, but the chief executive is never bound by them and is not required to make an official response to them.¹⁰³

The official visitor regime has been criticised for lack of independence, performance and transparency with a recent review by the Crime and Corruption Commission concluding it does not provide adequate oversight over QCS.¹⁰⁴ In practice, official visitor considerations are often confined to whether the statutory criteria have been met to warrant the imposition of a safety order or MSO.

A prisoner's maximum security classification must be reviewed by the chief executive at six monthly intervals, and if a court order changes the prisoner's term of imprisonment.¹⁰⁵ A prisoner should not be subject to a MSO if they are under 18 years of age or female, however women can be subject to prolonged solitary confinement in other ways, for example by placing them on consecutive safety orders.¹⁰⁶ The *Corrective Services Regulation 2017* (Qld) states that if the chief executive knows or reasonably believes the prisoner has a mental health condition or intellectual disability, they must notify a health practitioner before making a MSO.¹⁰⁷ This notification has no legal effect – no approval or response is required from the health practitioner.

¹⁰¹ Ibid ss 285, 290.

¹⁰² Ibid s 291.

¹⁰³ Ibid s 290(6).

¹⁰⁴ Crime and Corruption Commission, *Taskforce Flaxton* (Final Report, December 2018) 49.

¹⁰⁵ *Corrective Services Act 2006* (Qld) s 13(1)(a), 12(1)(c). Note, however, that reviews do not occur if a prisoner is on remand.

¹⁰⁶ Ibid s 54; Queensland Corrective Services, *Custodial Operations Practice Directive – Classification and Placement* (July 2018) 4 ('COPD CP').

¹⁰⁷ *Corrective Services Regulation 2017* (Qld) reg 16. See also *COPD CP* (n 106) 4.

2.2.3 Custodial Operations and Prisoner Management

The COPD guides the management of both remand and sentenced prisoners. The Directives are broadly reflective of the statutory requirements of custodial operations.¹⁰⁸ Relevant Directives are summarised in the table below.

Table 2.1 Custodial Operations Practice Directives: description of procedures

Custodial Operations Practice Directives	Relevant procedural notes
1 Sentence Management - Classification and Placement	<ul style="list-style-type: none"> • Recognises the need to consider any medical conditions including mental health issues as a part of classification and placement considerations and requests. • Requires corrective service officers to act or make decisions in a way that is compatible with, and requires consideration of, human rights. • Requires consideration of the nature of the prisoner's offence and their escaping, committing further offences, and/or the risk to themselves or others when considering their security classification. • Recognises the need for additional considerations in the placement of transgender prisoners. • Allows female prisoners to be considered for low security classification and placement as a first option, where possible. • States that female prisoners should not be classified as maximum security prisoners. • Permits Aboriginal and Torres Strait Islander prisoners to be accommodated in a corrective services facility as close as practicable to their family. • Recognises the need for mothers and babies to be placed in low custody facilities. • Considers the presence of any cultural, health or linguistic factors that may impact on the prisoner's behaviour/ability to comply with Progression Plan requirements. • Notes prisoners with a psychiatric condition who are able to self-regulate, and those who have a health condition that has stabilised, may return to low security.
2 Prisoner Accommodation Management – Cell Allocation	<ul style="list-style-type: none"> • Requires corrective service officers to act or make decisions in a way that is compatible with, and requires consideration of, human rights including cultural rights, humane treatment, individual special needs and recognition and equality before the law. • States that when accommodating prisoners, consideration must be given to perpetrators of serious assaults involving significant and/or life threatening injuries; any immediate risk to self or others; any intervention requirements identified in the classification and placement of prisoners; and any at-risk observations or Self-Harm Episode History in line with the At-Risk Management Directive. • Notes that non-powered cells are to be used only where no other accommodation is available, or when it is necessary either to mitigate the risk posed by a prisoner or given the nature of an order to which an offender is subject. • Limits the use of shared cell arrangements for prisoners with a known physical and/or mental health issue, medical issue, disability and/or cognitive impairment, history of self-harm, and maximum security offenders. • Considers cultural rights, specifically cultural rights of Aboriginal and Torres Strait Islander peoples, human rights, family impact on visits bookings and the prisoner's individual needs for the suitability of shared cell arrangements • Allows for assessment for protection including where there are 'personal/psychological characteristics which are likely to make him/her a target of aggression or intimidation from others'. • Allows prisoners to make verbal or written requests for protection at any time. Prisoners can also request their protection status be withdrawn at any time. Reviews of protection status are to be undertaken yearly, except in respect of maximum security prisoners who require a review only when they are considered for re-integration.

¹⁰⁸ Queensland Corrective Services, 'Custodial Operations Practice Directives', *Queensland Government* (Web Page, 14 September 2018) <<https://corrections.qld.gov.au/documents/procedures/custodial-operations-practice-directives/>>.

3 Daily Operations – Prisoners of Concern

- Requires prisoners' special needs to be considered when making decisions about the appropriateness of unit accommodation. Defines 'special needs prisoners' to be those who because of condition or circumstance have reduced capacity to respond to what is being asked of them, including those with mental illness, intellectual disability, physical disabilities, illiteracy and drug or alcohol dependence.
 - Outlines the need for corrective service officers to ensure the prisoner is capable of understanding and responding to circumstances and directions communicated to them and/or aware of the consequences that may follow.
 - Notes that a special needs prisoner may require rephrasing and/or external assistance, for example assistance from an interpreter, to improve understanding of the instruction.
-

4 Daily Operations – Case Management

- Specifies the use of the pro-social model and structures by which prisoners can 'positively engage with their imprisonment and are encouraged to take responsibility for their own behaviour'.
 - Identifies the need to take a 'base line' assessment of what 'normal behaviour' is for that prisoner upon entry into a new unit or facility.
 - Requires that interactions be recorded in relation to compliance, behavioural changes, stress or harm incidents, internal work and/or skills obtained. These are noted as positive or negative, or 'inappropriate' where the prisoner is a sexual offender.
 - Case notes are required on an as needed basis with more intensive case notes required as determined by a manager to include 'event based case notes'. Event notes are required for safety orders, placement in DU, 'at-risk' observations, shared cell reviews, and review of protection status.
 - Intensive case notes required for deterioration in behaviour/emotional state, special phone calls, counselling records, professional visits, and induction processes.
 - Continuous supervision is required for 'At-Risk Prisoners' and case notes are required to reflect this. Reviews of the case notes are required to be undertaken at 'regular' intervals. Any negative patterns of behaviour identified in case note review should raise a 'Notification of Concern' and discussion with a senior psychologist.
-

5 At-Risk Management – At-Risk

- Stipulates corrective services officers act or make decisions in a way that is compatible with human rights and, if making a decision that would limit these rights, ensure that the limit is reasonable and proportionate in the circumstances.
- States that historical and static information about the prisoner may be used to inform the analysis of the risk including presentation, appearance, vulnerability/predatory behaviour, substance use, self-harm and/or violence.
- Recognises that some groups of prisoners, including Youthful prisoners, Aboriginal and Torres Strait Islander prisoners, those who identify as transgender, those on remand, prisoners with chronic physical pain or physical illness and those in custody for the first time, have higher rates of suicide than others and should be monitored in accordance with their risk.
- Further recognises there are certain periods throughout a custodial sentence that are considered higher risk than others.
- Identifies need to comply with the World Health Organisation (WHO) best practice for prisoner suicide intervention, including appropriate training programmes, screening procedures, communication procedures relating to high-risk prisoners for staff, sufficient provision of mental health services and attendance of mental health staff and implementation of a suicide debriefing strategy.
- Requires prisoner management processes to: be the least intrusive possible; attempt to reduce anxiety levels; and be therapeutic rather than punitive.
- Identifies that QCS has a duty of care to minimise risk of self-harm and suicide.
- Requires special needs training for Aboriginal and Torres Strait Islander people, females, youth, prisoners from culturally, linguistically and religiously diverse backgrounds and prisoners with medical or dietary requirements.
- Requires staff to maintain an awareness of the specific at-risk management issues pertaining to offenders with special needs including Aboriginal and Torres Strait Islander prisoners, females, youth, aged prisoners, transgender prisoners, prisoners from culturally and linguistically diverse backgrounds, intellectually disabled/cognitively impaired prisoners, prisoners with psychological/psychiatric disabilities or disorders and prisoners with a history of self-harm or attempted suicide.

- Immediate response requirement includes keeping the prisoner in a corrective services officer's line of sight at all times until an assessment/reassessment can be conducted.
 - Allows corrective services officers to consider additional peer-support or intervention including placing a prisoner with another non-suicidal prisoner or referral to a formal peer support program.
 - Allows for transfer to a secure facility.
 - Allows for transfer to the MSU.
 - Allows for **padded cells to be used as a last resort where all other options have been discounted for an 'imminent risk' event and must occur only for the minimum time necessary, considering the balance between the necessity of the placement and the prisoner's human rights.**
 - States that a Risk Assessment Team must be convened as soon as possible following 'implementation of initial response plan' to ensure safe management of each at-risk prisoner. The Risk Assessment Team must consist of a correctional supervisor, psychological services, and Aboriginal and Torres Strait Islander (where appropriate).
 - If a determination is made that the most appropriate method of conducting observations of an at-risk prisoner is separate confinement in a DU, safety unit or health centre, a safety order must be approved.
 - Specifies that regular observations must be undertaken at 15 or 30 minute intervals and these must be recorded.
 - States that prisoners with an elevated baseline risk (EBLR) of self-harm and/or suicide require specialised management to ensure ongoing effective management, and includes as a minimum: housing in a safe cell; continuous supervision; issuing of safer design clothing, bedding and towels; and an intensive management plan.
-

6 At-Risk Management – Safety Unit

- Requires officers to give proper consideration to human rights and to ensure they act or make decisions in a way that is compatible with human rights
 - Requires prisoners to be managed in the least restrictive environment necessary to ensure safety and security for themselves, other prisoners, staff and visitors.
 - States that prisoners must be on a safety order to be considered for admission to a safety unit. The prisoner must be assessed as an elevated risk and cannot be managed in a 'mainstream' unit. However, prisoners that are not considered to at-risk of suicide or harm may still be accommodated in a safety unit.
 - States that referral should be made by a psychologist or medical officer.
 - States that the receiving unit must be secured for the admission of the prisoner. An induction assessment/interview by a risk assessment team, psychologist or doctor must be undertaken on arrival.
 - Notes that prisoners in a safety unit must have least two hours of daylight per day.
 - Notes at-risk prisoners are to be issued suicide restraint clothing, bedding and towels depending on the risk level.
 - Requires a logbook to be kept for each safety unit which includes elements relating to significant events for prisoners and/or officers, periods of open air exercise for those in separate confinement, details of safety orders and attendance of health services staff. The logbook must also record any use of restraints on a prisoner and any health checks conducted on the prisoner if used to prevent them from harming themselves.
-

7 Prisoner Accommodation Management – Maximum Security Unit

- Requires officers to give proper consideration to human rights and to ensure they act or make decisions in a way that is compatible with human rights
- Requires a psychologist to undertake a comprehensive clinical assessment/interview with the prisoner upon reception to the MSU.
- Requires an examination by a doctor or a nurse as soon as practical after the order takes effect and at intervals of no more than 28 days for the duration of the order and as soon as practicable after the order ceases to have effect.
- Requires ongoing assessments of dynamic risk to be conducted.
- Requires consideration of prisoner entitlements, including two hours of daily exercise in fresh air and personal visits within the legislative requirements.
- Prisoners are permitted to purchase items from the MSU Prisoner Canteen Price List.

- Prisoners are required to consume meals in their cells.
 - Identifies the need for a management team to develop a management plan for prisoners placed on a MSO; review the effectiveness of the plan; authorise further assessments; and summarise prisoner progress towards reintegration.
 - **Requires the MSU to manage the prisoner's progression through four stages using a multi-disciplinary approach with sequentially increased privileges and activities.**
 - States that **reintegration into mainstream facility should be the goal of the management plan and should commence on a prisoner's arrival.**
 - Stages of reintegration are identified as:
 - Stage 1 – basic entitlements and no prisoner association.
 - Stage 2 – prisoner association limited to one other prisoner in the MSU during exercise.
 - Stage 3 – prisoner association limited to one other prisoner in the MSU during eating, employment, exercise and/or other programs.
 - Stage 4 – prisoner association with one or more prisoners in the MSU during eating, employment, exercise and/or programs, and planning for reintegration.
 - States that prisoners may progress or regress through the stages depending on behaviour.
 - States that a MSO must specify the extent to which a prisoner will have access to programs, education and counselling services consistent with assessed risks, needs and behaviour.
 - States that **there is to be no association between MSU prisoners during programs, until approved by the chief executive or delegate.**
 - Specifies that a prisoner subject to a MSO may be employed as a unit worker (except for those in Stage 1 of the progression pathway), subject to operational requirements and the prisoner's management plan.
 - States that unsatisfactory behaviour must be explained to prisoners to allow for behaviour modification to enable progression to the next stage.
 - Stipulates that **staff have a fundamental role in the supervision and interaction with prisoners for effective management of the progression in MSU and to maximise the amount of time spent in the unit communicating with them.**
 - Requires that Intensive Management Plans be developed and implemented prior to reintegration. The Intensive Management Plan aims to intervene and support the prisoner through mitigation of the behaviour/risk that resulted in the MSO. It is finalised when behavioural objectives are met.
 - States that **prisoners should not be accommodated in non-powered cells unless: there is no other appropriate accommodation available; the placement is necessary to mitigate risk; or the placement is a requirement of, or specified in, an order.** Decisions around placement in a non-powered cell must be documented and reviewed.
 - States that prisoners may be transferred to the DU in circumstances where prisoner safety or security of the MSU cannot be achieved in a normal cell.
-

8 Prisoner Accommodation Management – Detention Unit

- Requires officers to give proper consideration to human rights and to ensure they act or make decisions in a way that is compatible with human rights
- States that the DU provides for the accommodation of a prisoner who is undergoing a period of separate confinement where they are: found to have committed a breach of discipline and have been ordered to undergo a period of separate confinement; or subject to a safety order.
- Provides that the chief executive must ensure a prisoner is undergoing separate confinement can access reticulated water, a toilet and shower facilities that, as far as practicable, are constructed in a way to prevent the prisoner from associating with other prisoners; is given a mattress, sheets, blanket and pillow; given appropriate clothing; and is given the opportunity to exercise, in the fresh air, for at least two daylight hours per day.
- States that where the prisoner does not pose a risk to self or others, or to the safety or security of the DU, then a decision needs to be made regarding the prisoner's access and use of the exercise yard in accordance with the ordinary operation of the unit.
- Allows for **accommodation in a non-powered cell where no other appropriate accommodation is available; this is necessary to mitigate risk; or this is necessary given the nature of an order.** However, **privileges must be maintained where there is an absence of identified risk.**
- Requires officers to ensure: prisoners are given the opportunity to exercise; patrols are conducted during the shift; and prisoners' behaviour observations, and changes, are recorded.

- Requires any use of restraints to be reasonable in the circumstances, necessary, proportionate to the seriousness of the circumstances and logged. Any restriction should be to the lowest level possible whilst still ensuring the prisoner's opportunity to self-harm or harm others is limited to an acceptable level of risk and ensuring the safety of officers.
- Requires daily routine and privileges to be recorded by the chief superintendent, general manager of the facility.

9 Sentence Management – MSO Management

- Requires officers to give proper consideration to human rights and to ensure they act or make decisions in a way that is compatible with human rights
- The chief executive is required to notify a health practitioner before making a MSO if they know or reasonably believe that a prisoner has a mental health condition or intellectual disability, but an assessment is not required prior to placement in a MSU. The notification requirement is not required for placing a prisoner on maximum security classification.
- The general manager or deputy general manager must consult with State-wide manager, Serious Offenders Unit, before making an MSO referral, and provide a rationale for the referral.
- Requires the Sentence Management Services to inform the nominated Prison Mental Health Service contact person and senior psychologist when process a MSO referral for a prisoner who is or is reasonably believed to have a mental health condition or intellectual disability.
- A MSO can only be made for prisoners with a maximum security classification.
- Security classification decision requires consideration of legislative factors: risk of escape or attempting escape; risk and impact of a further offence on the community; risk posed by the prisoner to themselves, other prisoners and staff members.
- A maximum security prisoner may be placed on an MSU to manage the prisoner's individual risks and in consideration of relevant human rights if there is a: high risk of escape or attempting escape; high risk of the prisoner killing or seriously injuring others; or a substantial threat to security and good order of the facility.
- A MSO decision may be amended or repealed by the decision maker.
- A prisoner with a MSU classification may be placed in a MSU, a health centre, a detention unit or other accommodation area suitable to accommodate the prisoners' risks.
- A MSO authorises MSU placement for a period of no longer than six months.
- Prisoners must be provided with a copy of the MSO, along with explanations of the order prior to the placement of the prisoner in the MSU.
- A MSO should include directions about separation from, or association with, other prisoners in the MSU and privileges such as two ten minute phone calls per week, visits and access to private property. It may also include directions about the prisoner's access, within the MSU, to programs and services, including training and counselling.
- Access to privileges while subject to an MSO must be considered on a case-by-case basis, considering individual prisoner circumstances and relevant human rights.
- The chief executive or authorised delegate must review the maximum security classification of prisoners at intervals not exceeding six months.
- Review of a MSO can occur at the request of the prisoner or by an official visitor. An official visitor must review a MSO at a prisoner's request, if the order is for more than three months or if there has been no review in the previous three months.
- Prisoners on a MSO of three months or less can only request a review once, or twice in a six-month period if the MSO is more than three months.
- The chief executive is not bound by an official visitor's recommendations, but must consider the recommendations and confirm, amend or cancel the MSO.
- The chief executive may provide for the prisoner's reintegration into the mainstream prisoner population of the corrective services facility before the period of the MSO ends.
- The chief executive or delegate can make a consecutive MSO to take effect at the conclusion of an existing MSO only if the chief executive considers any submissions the prisoner makes. The prisoner must be notified not more than 28 days before the conclusion of the existing MSO. The prisoner may, within 14 days after receiving the written notice, make submissions to the chief executive anything relevant to the decision about making a further MSO.



© 2017 Daniel Soekov for Human Rights Watch

It is important to note that these Directives are not necessarily reflective of what occurs in practice. For example, it is our understanding that no prisoner has progressed to Stage 4 of the 'stages of reintegration' under the *Prisoner Accommodation Management – Maximum Security Unit* COPD.

SUMMARY

The *Corrective Services Act 2006* (Qld) allows for prisoners to be held separately from other prisoners, in 'separate confinement', where they:

- have committed a breach of discipline – for a maximum of seven days;
- are under a safety order – for a maximum of period of one month, but there is no limit to the number of consecutive orders that can be made;
- are subject to a MSO – for a maximum period of six months, but there is no limit to the number of consecutive orders that can be made.

Official visitors and medical personnel have responsibilities to review safety orders and MSOs, but the chief executive is not bound by any recommendations they make and there are significant concerns about their independence and effectiveness as an oversight mechanism.

Minimum standards provided by the *Corrective Services Regulation 2017* (Qld) and the COPD do not comply with best practice. For example, they allow for a prisoner to be placed in a non-powered cell without access to a television or running water. They also allow for situations where prisoners remain completely socially isolated.

3. Reported case law concerning solitary confinement in Queensland

3.1 Judicial review in Queensland

Reported **case law concerning the use of solitary confinement in Queensland is limited.**

We were able to locate only seven reported judgements in which solitary confinement was discussed at any length. In this section, we provide a summary of those cases. It will be seen that some prisoners have had **MSOs set aside where procedural fairness requirements have not been met.** In some cases, the fact that the prisoners were to spend their sentence in solitary confinement influenced the term of imprisonment imposed by the judge.

The majority of solitary confinement case law in Queensland relates to judicial review applications of decisions to place prisoners on MSOs. There is no available case law in Queensland relating to the placement of prisoners on safety orders. One explanation for why safety order decisions have not been subject to judicial review applications is that each decision only lasts for a maximum period of 28 days. This makes safety orders difficult to litigate from both a practical and administrative law perspective, as it is necessary to challenge the operative decision.

The **lack of judicial oversight in relation to safety order decisions** is concerning for several reasons. First, safety orders are typically used for the most vulnerable prisoners, including women and where the prisoner poses a risk of harm to themselves. Second, there is no limit on the number of consecutive safety orders that can be imposed to keep a prisoner in prolonged solitary confinement. Third, prisoners detained in solitary confinement on safety orders can be accommodated in a range of different environments, including by being locked down in a cell that is not specifically designed for segregation. This makes it more difficult for advocates and lawyers to identify if their clients are detained in solitary confinement on safety orders, in contrast to prisoners detained on MSOs who are in solitary confinement by virtue of their placement in a MSU.

Farr & Ors v Queensland Correctional Services Commission [1999] QSC 86

A number of plaintiffs argued that their 'special treatment' orders were unlawful because the orders were open-ended, the legislation did not allow the forfeiture of privileges solely for disciplinary reasons, and the legislation did not allow a special treatment order to be made as a form of punishment. Moynihan J found in their favour.

In this case, nine plaintiffs sought declarations that their incarceration within the MSU at the Woodford Correctional Centre was unlawful, and injunctions to give effect to the declarations sought.¹⁰⁹ Each plaintiff had been held in the MSU under a 'special treatment order' for extended periods of time. Indeed, the first plaintiff's order was expressed as continuing 'until further notice.'

¹⁰⁹ Note that the fourth and seventh plaintiffs were not parties to the motion in this appeal.

Section 39 of the *Corrective Services Act 1988* (Qld) (since repealed) gave the general manager of a prison power to order that a prisoner receive 'special treatment' for the 'security or good order of the prison' or for the safety of the prisoner. Such special treatment involved the segregation or partial segregation of the prisoner, as well as a forfeiture of privileges that could not practicably be received while being held under these conditions. The Act stated that a person could not receive special treatment for more than seven days without the approval of the commission,¹¹⁰ but no maximum time period was prescribed in the relevant provision. The Policy and Procedures Manual stated that placement in the MSU could be short-term with a view to 'stabilising disruptive behaviour', or long-term 'in situations where a prisoner is assessed as representing a high risk of escape'.¹¹¹ The Manual also suggested that prisoners held in the MSU could be made subject to management regimes such that their access to privileges was linked with 'behavioural goals'.¹¹²

Moynihan J made three key findings:

1. Section 39 **did not authorise 'open-ended' special treatment**. His Honour noted that the provision referred to 'a' or 'the period' of the order, which implied a 'specific portion of time'.¹¹³
2. The **'sole basis' on which any privileges could be denied** to a prisoner was that they that could not practicably be made available to them under special treatment – that is, removal of privileges that could practicably be made available to them was unlawful¹¹⁴ as was a 'graduated continuum of privileges for the promotion of positive behaviour'.¹¹⁵
3. A special treatment order could only be used 'based on security considerations' – that is, imposing a special treatment order **'as a means of imposing a penalty would be an improper purpose'**.¹¹⁶

Subsequent to this decision, a new provision, section 38A, was inserted into the 1988 Act allowing the chief executive to 'apply different arrangements for the management of prisoners of different classes' including prisoners subject to special treatment. Another new provision, section 43A, was added which allowed the chief executive to make a MSO in respect of a prisoner where the chief executive considered on reasonable grounds that 'there is a high risk the prisoner will escape or attempt to escape', 'there is a high risk the prisoner will inflict death or serious injury' on another person, or the prisoner 'is a substantial threat to prison security and good order'.¹¹⁷ Time limits on MSOs were also added to the Act. A new section 43B stated that the chief executive could make a MSO of no more than 28 days. Consecutive orders could be made but the chief executive was required to provide written notice to the prisoner no more than 28 days before the expiry of the existing order, and the prisoner was permitted to make submissions to the chief executive about 'anything relevant to the decision' within 14 days after receiving the written notice.

In the 2006 Act (the current Act), section 62(2) states that privileges received by prisoners in the MSU must be limited to those that can be enjoyed within the MSU and 'the enjoyment of which, in the circumstances of the order, may reasonably be expected not to pose a risk to the security or good order of the corrective services facility.' Section 62(3) states that a MSO may also include 'directions about the prisoner's access... to programs and services including training and counselling,' and section 62(1) confirms that a prisoner subject to a MSO may be separated from other prisoners. Section 60(2) substantially replicates section 43A of the 1988 Act, and section 61 replicates section 43B of the 1988 Act.

¹¹⁰ The commission is the Queensland Corrective Services Commission.

¹¹¹ *Farr & Ors v Queensland Correctional Services Commission* [1999] QSC 86, [5].

¹¹² *Ibid* [5].

¹¹³ *Ibid* [12].

¹¹⁴ *Ibid* [13].

¹¹⁵ *Ibid* [14].

¹¹⁶ *Ibid* [13].

¹¹⁷ See *Corrective Services Legislation Amendment Act 1999* (Qld) ss 6–7.

Kidd v Chief Executive, Department of Corrective Services [2001] 2 Qd R 393

When successive orders for segregation are made, the decision-maker 'should demonstrate that he has directed his mind to the currency of the risk' each time, taking into account all relevant information, including past behaviour and recent behaviour. Where the decision-maker is basing his/her decision on an allegation made by an informant, the rules of procedural fairness require the decision-maker to inform himself/herself that the information is reliable, and provide the prisoner with sufficient information about the allegation to enable them to respond.

Kidd was a 67 year old man serving a sentence of 11 years imprisonment. He was placed on a MSO at Woodford Correctional Centre under the new provisions inserted in 1999.

'Intelligence information' had been received by staff of the Arthur Gorrie Correctional Centre (where he had been accommodated prior to his transfer to Woodford) that he had been involved in a plan to escape with other prisoners. Consecutive MSOs were made in respect of him, based on the resulting 'security concerns'. The orders stated that whilst Kidd's behaviour was of an acceptable standard, this 'may not be necessarily sufficient to override the serious risk of escape that you would appear to present.'

Kidd, however, denied any involvement in an escape plan. He requested that an official visitor review his case, and she concluded that he should not be held in the MSU on this basis because there was nothing in his file that indicated a risk of escape, and the informant remained un-named. This report proved difficult for Kidd's counsel to obtain, and it was only obtained eventually through a freedom of information request. Representatives of QCS maintained that they had not seen the official visitor's report, however they said that further information related to the allegation could not be disclosed because this 'would reveal or would be likely to reveal the identity of police informants.'

The conditions under which Kidd was being held were outlined by White J:¹¹⁸

- association with other prisoners was limited to two hours a day, with one other prisoner at any one time;
- one non-contact visit per week of one hour duration;
- one telephone call of no more than 10 minutes duration each week;
- two hours out-of-cell exercise per day, to coincide with the periods of association.

¹¹⁸ *Kidd v Chief Executive, Department of Corrective Services* [2001] 2 Qd R 393, 398 [21].

White J concluded that an issue of procedural fairness arose in respect of the missing official visitor report. Her Honour acknowledged the interest in protecting the identity of informants, but remained concerned regarding the basis upon which the decisions were reached. Her Honour noted that there was no information indicating a continued risk of escape, Kidd had no history of escape or escape related offences, and he had not received any serious behavioural breaches.¹¹⁹ Her Honour noted that it was possible that the intelligence information was untrue, and there was no evidence that steps had been taken to verify the information received.¹²⁰ The rules of procedural fairness required that Kidd be provided with an opportunity to make submissions in respect of the allegations.¹²¹ Further, it seemed that since the official visitor's report was not on file and had been lost, it could not have been considered in the decision-making process as the Act required.¹²²

Her Honour concluded:¹²³

*'If s 43B... is to be anything more than legislative lip service to the concept of procedural fairness, **information adequate for a prisoner to respond must be given...** The delegate should **demonstrate that he has directed his mind to the currency of the risk** expressed in the maximum security order and, if he is satisfied on reasonable grounds that those risks continue as high risks, **he must explain, without revealing the source of his information, why that is so.** He must also demonstrate that he has satisfied himself that there is independent support for the information from the informant and that there is no risk that this is a case of "prison politics."*

Since this had not occurred here, White J ordered that the MSO be set aside and the matter be remitted for further consideration.

Abbott v Chief Executive, Department of Corrective Services [2000] QSC 492

There is a risk that subsequent orders may simply be 'rubber stamped' without adequate consideration as to the 'currency of the risk' posed. There must inevitably come a time when past behaviour and criminal history will no longer be able to 'dominate' the decision-making process.

The conditions of Abbott's detention were identical to those of Kidd. However, unlike Kidd, Abbott had a 'bad criminal history extending over a number of years' involving crimes of violence, and numerous escapes and attempted escapes from custody.¹²⁴ As a result, he had experienced extensive periods of solitary confinement. He was in solitary confinement continuously between March 1995 and August 1997, and then again between May 1998 and December 2000 when the matter was heard by the Supreme Court. He was 38 years old.

There was no failure to accord procedural fairness in this case. Abbott's solicitors had written letters on his behalf to the chief executive regarding the conditions under which he was held, including the denial of access to a computer and educational materials. 'Passing mention' was made in submissions on behalf of the applicant that the conditions under which he was being held were 'cruel and unusual' and contrary to article 7 of the 'International Covenant on Human Rights [sic]'.¹²⁵ It was also argued on Abbott's behalf that his past criminal behaviour could not be altered, and recent conduct should be looked at to determine whether the risk posed was still current, as per the findings of the court in *Kidd*.

¹¹⁹ Ibid[25]-[26].

¹²⁰ Ibid [27], [30].

¹²¹ Ibid [30].

¹²² Ibid [28].

¹²³ Ibid [31] (emphasis added).

¹²⁴ *Abbott v Chief Executive, Department of Corrective Services* [2000] QSC 492, [4] ('Abbott').

¹²⁵ Ibid [26]. Article 7 of the *International Covenant on Civil and Political Rights*, opened for signature 19 December 1996, 999 UNTS 171 (entered into force 23 March 1976) ('*International Covenant on Civil and Political Rights*') states that no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Williams J emphasised that the court ‘has no jurisdiction to review the actual merits of a decision’ and it will be **‘loathe to interfere with what are essentially operational matters within the prison system.’**¹²⁶ What the court is concerned with is ‘whether or not the correct procedures were followed in arriving at the decisions in question.’¹²⁷

In this case, His Honour concluded that there were ‘good grounds’ for concluding that there was a high risk that Abbott would escape or attempt to escape. However, His Honour noted consistently with the court’s findings in *Kidd* that:¹²⁸

‘A time must therefore arrive, if behaviour remains acceptable, when the past criminal history, including that of escape, will no longer be capable of reasonably dominating the decision-making process.’

Although not reaching this stage here, Williams J remained concerned that the renewal of MSOs ‘may become a “rubber stamp” exercise.’¹²⁹ His Honour noted, therefore, that:¹³⁰

‘[I]t is important that those persons responsible for making the decision properly evaluate the evidence available at the time of each renewal and articulate clear reasons justifying the renewal of such an order.’

His Honour went on to say:¹³¹

‘It is of some concern that there is similar wording used in providing reasons in this case and that of Kidd. To be proper the reasons must be directed at each separate individual and address the issues relevant to each individual.’

Regardless of these criticisms, no error was found and the application was dismissed.

McQueen v Chief Executive, Department of Corrective Services [2002] QSC 421

Discussion of ‘currency of the risk’ in the context of recent good behaviour

McQueen had been held in the MSU at Woodford Correctional Centre for a continuous period of almost four years. The official visitor had recommended graduated return to mainstream and noted that he appeared ‘settled, well-presented and well-mannered’. Regardless, his MSOs were continually renewed. The justification provided was that, despite his recent good behaviour, he had been convicted of a murder whilst in custody, so his ‘risk and threat’ remained current. The official visitor noted in her report that this was a source of distress to McQueen and instilled a sense of hopelessness in him.

¹²⁶ *Abbott* [2000] QSC 492, [27]–[28].

¹²⁷ *Ibid* [27].

¹²⁸ *Ibid* [31] (emphasis added).

¹²⁹ *Ibid* [32].

¹³⁰ *Ibid* (emphasis added).

¹³¹ *Ibid* (emphasis added).

Mullins J noted, citing *Kidd*, that when considering the ‘currency of the risk’, recent conduct was a matter of ‘critical importance.’¹³² Her Honour concluded that the reasons demonstrated that McQueen’s recent behaviour had been taken into account, and that it could not yet be said that his past history was no longer relevant to the assessment of his risk.¹³³ She did reiterate the comments of the court in *Abbott* that such a time would inevitably come, but that at this stage ‘the evidence was not all one way’ and no ‘undue weight’ had been placed on that incident.¹³⁴

Garland v Chief Executive, Department of Corrective Services [2004] QSC 450; [2006] QCA 568

The court will look to the specific terms of the enabling provision when determining whether an order for segregation has been lawfully made. A requirement that the decision-maker form a certain ‘belief on reasonable grounds’ before making the order is a jurisdictional fact, and ‘sufficient’ facts must exist to enable a reasonable person to come to the same conclusion.

Garland was a 33 year old Aboriginal man with an extensive criminal history both inside and outside of prison. He had spent much of his life in correctional facilities, and his offending behaviour commenced at age 11. At the time of the appeal, he had been sentenced to life imprisonment and had spent more than seven years in continuous solitary confinement, in either the MSU or the DU. The grounds for his segregation were that there was a high risk he would inflict death or serious injury on other prisoners or persons, and generally that he was a substantial threat to the security or good order of the facility. During his time in segregation, he had enrolled in education programs and had engaged in psychological interventions. The conditions of his confinement were the same as those of *Kidd* and *Abbott* above, however he was permitted to have access to a playstation, walkman, relaxation tape, his own computer, yoga instruction materials, painting materials and educational support. He was also permitted to access a separate study cell which housed his computer, books and materials. He was most often outside of his cell between the hours of 9-11am and 1-4pm.

Garland argued that the making of the MSOs was an improper exercise of power because the purpose of a MSO was for short-term enforcement of discipline, and his orders were simply being ‘rubber stamped’ each time. He also claimed that he was being subjected to ‘inhumane’ treatment contrary to section 3 of the Act which outlined that the purpose of corrective services was to be achieved through the ‘humane containment’ of offenders.

Two official visitor reports were available to the court. In one, the official visitor expressed the view that his solitary confinement ‘seems now to have reached its useful limits’ and indeed **‘may leave us with a permanently anti-social member of society.’**¹³⁵ A second official visitor report concluded that the order was presently justified but expressed the concern that Garland’s past ‘will never be just that – the past.’ Two psychologists’ reports were also available. One report noted that his risk of reoffending was ‘unacceptably high’ but that this did not mean he was ‘beyond treatment.’ The other noted that ‘assisting the applicant to remain positive and future oriented... continued to be a difficult task with his lengthening isolation from the general prison population.’¹³⁶ There was substantial evidence that the decision-maker had taken into account a ‘large body of material’ when reaching her decision to continue the MSO.

¹³² *McQueen v Chief Executive, Department of Corrective Services* [2002] QSC 421, [15].

¹³³ *Ibid* [23].

¹³⁴ *Ibid* [22], [25].

¹³⁵ *Garland v Chief Executive, Department of Corrective Services* [2004] QSC 450, [53] (*‘Garland No.1’*).

¹³⁶ *Ibid* [74].

White J emphasised that the jurisdiction of the court did not ‘go beyond the declaration and enforcing of the law which determines the limits and governs the exercise’ of the decision-maker’s power, and that ‘the court has no jurisdiction simply to cure administrative injustice or error.’¹³⁷ However, Her Honour noted that ‘reasonable grounds’ required ‘the existence of facts which are sufficient to induce that state of mind in a reasonable person.’¹³⁸ Her Honour concluded that there were ‘ample facts’ upon which to base a view that Garland was a substantial threat to the security and good order of the prison.¹³⁹ White J concluded that the decision-maker had balanced the security and good order of the prison against Garland’s interests, as required.¹⁴⁰ Recent material as well as old material had been considered and the purpose of continuing the order was a permissible one: to address the security risk that Garland posed. White J concluded that there was no improper exercise of power because there was **‘no legislative provision against containing a prisoner for a long period of time’** in a MSU, nor was there any ‘legislative limit’ set.¹⁴¹

With regard to the claim that his containment was ‘inhumane’, White J considered the *UN Standard Minimum Rules for the Treatment of Prisoners*¹⁴² but concluded that they had not been departed from.¹⁴³ Her Honour also made reference to the statement in the *Council of Europe Standard Minimum Rules*¹⁴⁴ for prisoners that ‘prolonged solitary confinement... must not be used.’ Yet, Her Honour dismissed this by saying that this rule referred to measures of discipline and punishment and did not apply to measures for the maintenance of security.¹⁴⁵ White J noted that his treatment was ‘directed to his reintegration’ and there was no suggestion that other rules or policies has been departed from.¹⁴⁶

Garland’s application was therefore dismissed. He appealed unsuccessfully to the Court of Appeal. The Court of Appeal agreed with White J that there was ‘ample evidence which could lead reasonably to the opinion that the appellant posed a substantial threat to the good order of the prison unless confined in the maximum security unit.’¹⁴⁷

Chesterman J summarised Garland’s main argument to be that his criminal past was ‘grossly over-emphasised’, and inadequate weight was given to his recent good behaviour.¹⁴⁸ His Honour noted that the section required the chief executive to believe on reasonable grounds that the prisoner was a substantial threat to the security and good order of the prison.¹⁴⁹ This belief was a jurisdictional fact, required before the order could be made, and therefore sufficient facts must exist to support this belief.¹⁵⁰ His Honour said:¹⁵¹

‘The applicant’s counsel made much of his difficult situation. He cannot be released from maximum security unless he shows that he has a capacity for self-control and voluntary good behaviour. But he cannot demonstrate those characteristics unless he is released from maximum security.’

The Court of Appeal concluded that White J’s conclusion was correct, and that no error in the decision-making process had occurred.¹⁵²

¹³⁷ Ibid [79].

¹³⁸ Ibid [83].

¹³⁹ Ibid.

¹⁴⁰ Ibid [88].

¹⁴¹ Ibid [93].

¹⁴² *The UN Standard Minimum Rules for the Treatment of Prisoners*, UN Doc A/RES/70/175 (n 1).

¹⁴³ *Garland No.1* [2004] QSC 450, [86].

¹⁴⁴ *European Prison Rules* (n 28) rule 60.5.

¹⁴⁵ *Garland No.1* [2004] QSC 450, [87].

¹⁴⁶ Ibid [86].

¹⁴⁷ *Garland v Chief Executive, Department of Corrective Services* [2006] QCA 568, [50] (*Garland No.2*).

¹⁴⁸ Ibid [34].

¹⁴⁹ Ibid [38].

¹⁵⁰ Ibid [42].

¹⁵¹ Ibid [47] (emphasis added).

¹⁵² Ibid [51].

With respect to the relevance of the section 3 reference to ‘humane containment’, Chesterman J (with whom Holmes JA agreed) held that the power to make a MSO (under section 47) was not subject to section 3.¹⁵³ Section 3, His Honour said, is a ‘statement of legislative purpose’ and ‘does not contain any restriction’ upon specific powers conferred by the Act.¹⁵⁴ Therefore, ‘if the statutory pre-conditions are satisfied the order may be made.’¹⁵⁵ McMurdo P was of the view that the chief executive, when making a MSO, should keep the purposes of corrective services in mind, as outlined in section 3. However, Her Honour concluded that it was open to White J to find that the order made was not inhumane because the order was lawfully made.¹⁵⁶

McLaren v Rallings & Ors [2015] 1 Qd R 438

Want of procedural fairness was found because the prisoner was not provided with sufficient detail of the allegations against him which formed the basis for the belief that he continued to pose a safety risk to other prisoners.

Consecutive MSOs had been made in respect of McLaren on the basis that he was continuing to demonstrate ‘aggressive, assaultive and threatening behaviour towards other prisoners.’ However, the contents of the ‘intelligence reports’ upon which this assessment was based were not revealed to McLaren because the documents were the subject of a public interest immunity claim.

Jackson J reiterated that when it comes to the management of correctional facilities, courts have been ‘loathe to interfere by way of judicial review, even where there may be power to do so.’¹⁵⁷ This is particularly the case where the restrictions imposed are ‘not inappropriately prolonged’, ‘not imposed for an indirect object of punishing individuals’, and if they ‘involve a bona fide and reasonable use of the power of management.’¹⁵⁸

However, the court followed previous cases in finding that McLaren was entitled to ‘sufficient information’ upon which to make a meaningful response.¹⁵⁹ This need not have required the informant to be identified to McLaren – he was entitled only to details sufficient to know the allegations against him.¹⁶⁰ Jackson J held that insufficient information was provided to McLaren to enable him to respond in ‘any meaningful way’.¹⁶¹ It would have been sufficient if McLaren had been told about the alleged incident ‘to some extent,’¹⁶² yet not even the ‘gist’ of the information was provided to McLaren.¹⁶³ Given that the consequence was for McLaren to be subject to consecutive orders substantially impacting upon his treatment in prison, Jackson J was scathing of the decision-maker’s silence:

‘The unfairness of it also hangs in the air, like a damp impenetrable fog, that may not be lifted, with the prisoner left unable to say anything in answer. The statutory right of the prisoner to make submissions... is reduced below even mere “lip service,” to the depth of a solemn farce.’¹⁶⁴

Further to this, the intelligence report had not been made available to the decision-maker, and Jackson J concluded that the evidence did not suggest that the information was ‘critically assessed.’¹⁶⁵

¹⁵³ Ibid [21].

¹⁵⁴ Ibid.

¹⁵⁵ Ibid.

¹⁵⁶ Ibid [3].

¹⁵⁷ *McLaren v Rallings & Ors* [2015] 1 Qd R 438, 449 [45].

¹⁵⁸ Ibid.

¹⁵⁹ Ibid [32].

¹⁶⁰ Ibid [33].

¹⁶¹ Ibid [48].

¹⁶² Ibid [52].

¹⁶³ Ibid [65].

¹⁶⁴ Ibid [53].

¹⁶⁵ Ibid [61]–[63].

The latest MSO was therefore invalidated.¹⁶⁶ The effect of this finding was not that McLaren be released from the MSU, merely that he be provided with information about the basis upon which he was being detained in the MSU so that he could make submissions in response.

3.2 Sentencing decisions in Queensland

R v Edmund [1994] QCA 496

Solitary confinement conditions in the women's DU.

In this case, the conditions of solitary confinement under which a 20 year old Aboriginal woman was held are described. This young woman, who had led a transient lifestyle and was raised by extended family after her parents' separation, was held for seven days in the DU at the Brisbane Women's Correctional Centre. During that time, she **had no privileges, no contact with other inmates, no fresh air, no exercise, no television and no books.** This punishment was imposed upon her in response to an assault she perpetrated against a prison officer. Whilst the seriousness of the offence was acknowledged by Davies JA, His Honour did note that there was some provocation of the offence, in that the officer had called her a 'little darkie.' Whilst Davies JA discusses the conditions under which the prisoner was held in the DU, His Honour does not explicitly state that this influenced his conclusion that the sentence of nine months imprisonment, cumulative upon the sentence she was serving, was manifestly excessive.

Callanan v Attendee X [2013] QSC 340; *Callanan v Attendee Y* [2013] QSC 341; *Callanan v Attendee Z* [2014] 2 Qd R 11

When determining the length of a prisoner's sentence, the conditions of their confinement is a relevant consideration. X, Y and Z were sentenced to lesser periods of imprisonment on the basis that their terms would be served in solitary confinement.

Attendees X, Y and Z had each committed the offence of contempt by refusing to take an oath and answer questions posed by the Crime and Misconduct Commission (as it then was). The *Crime and Misconduct Act 2001* (Qld) obliged His Honour to impose sentences of imprisonment, so the question for the court was what term of imprisonment should be imposed. In the cases of X and Y, submissions from both parties suggested that a period of five to six months was an appropriate term, taking into account comparable cases. In the case of Z, submissions from the applicant also suggested that a period of five to six months was appropriate.

However, Attendee's X, Y and Z were deemed to be members of a Criminal Motorcycle Gang (CMG), and at that time, CMG prisoners were automatically subject to certain management rules, including placement in solitary confinement. The conditions were:¹⁶⁷

- out-of-cell time restricted to at least two daylight hours a day;
- no visits from CMG members or affiliates, including family members;
- one non-contact personal visit of one hour duration per week;
- wearing the CMG uniform;
- no TV and no access to gymnasium facilities or the oval;
- seven personal calls per week of six minutes duration;
- all calls monitored by intelligence staff, other than calls to legal representatives.

Applegarth J noted that a **sentencing judge 'can make allowance for the fact that a person**

¹⁶⁶ Ibid [69]–[71].

¹⁶⁷ *Attendee X* [2013] QSC 340, [28]; *Callanan v Attendee Y* [2013] QSC 341, [28] ('Attendee Y'); *Callanan v Attendee Z* [2014] 2 Qd R 11, 16–8 [27] ('Attendee Z').

has spent part of their time in custody in unusually harsh circumstances'.¹⁶⁸ His Honour cited cases where being held for extended periods in a watch house, or a foreign jail, resulted in a shorter sentence.¹⁶⁹ His Honour noted that, in the absence of a statutory provision to the contrary, the court could similarly take into account the fact that the sentence would be served in solitary confinement when setting the term,¹⁷⁰ particularly in view of the **'large body of literature' evidencing the 'harms of solitary confinement.'**¹⁷¹ His Honour cited research that demonstrated that solitary confinement can cause or exacerbate mental illness and cause enduring psychological damage.¹⁷² His Honour noted that the negative effects of solitary confinement are observed within only a few days and that its use should therefore 'be kept to a minimum'.¹⁷³

Applegarth J said there was no 'arithmetic calculation' which could be used to convert a normal term of imprisonment to a term in solitary confinement.¹⁷⁴ In the cases of Attendees X and Y, His Honour concluded that instead of imposing a five month term, a period of four weeks should instead be ordered.¹⁷⁵ In the case of Attendee Z, His Honour concluded that instead of imposing a six month term, a period of six weeks should be ordered.¹⁷⁶ These conclusions were reached given the conditions under which these sentences would be served were 'extremely harsh'.¹⁷⁷ Importantly, His Honour also noted that the **'purposeful infliction of psychological harm by lengthy solitary confinement would be a cruel and degrading punishment.'**¹⁷⁸

SUMMARY

There is a limited amount of Australian case law that discusses solitary confinement, which suggests a general lack of judicial oversight of the use of, and conditions within, solitary confinement.

Some prisoners have had orders imposing solitary confinement conditions overturned in Queensland on the basis of a want of procedural fairness. Courts have held that prisoners must be provided with sufficient information regarding the reasons behind the order so that they have an opportunity to make submissions in response. There is a risk that consecutive orders will simply be 'rubber-stamped', so decision-makers must establish that they have turned their minds to all relevant information, and assessed the currency of the risk posed by the prisoner, before making a non-association order.

Judicial officers have taken notice of the appalling conditions under which prisoners in solitary confinement are held. The term of prisoners' sentences have been reduced on the basis of the harshness of these conditions.

168 *Attendee X* [2013] QSC 340, [25]; *Attendee Y* [2013] QSC 341, [25]; *Attendee Z* [2014] 2 Qd R 11, 16 [24].

169 *Attendee X* [2013] QSC 340, [25]; *Attendee Y* [2013] QSC 341, [25]; *Attendee Z* [2014] 2 Qd R 11, 16 [24].

170 *Attendee X* [2013] QSC 340, [24]–[25]; *Attendee Y* [2013] QSC 341, [24]–[25]; *Attendee Z* [2014] 2 Qd R 11, 16 [23]–[24]. His Honour noted that spending time in solitary confinement would not always result in a sentence reduction, for example, in situations where the person was held in solitary confinement because they had attempted to escape. *Attendee X* [2013] QSC 340, [26]; *Attendee Y* [2013] QSC 341, [26]; *Attendee Z* [2014] 2 Qd R 11, 16 [25] citing *R v Abbott* (unreported, Court of Appeal, CA No. 344 of 1998, 13 April 1999) as an example.

171 *Attendee X* [2013] QSC 340, [34]; *Attendee Y* [2013] QSC 341, [34]; *Attendee Z* [2014] 2 Qd R 11, 16 [33].

172 *Attendee X* [2013] QSC 340, [37]–[39]; *Attendee Y* [2013] QSC 341, [37]–[39]; *Attendee Z* [2014] 2 Qd R 11, 16 [36]–[39].

173 *Attendee X* [2013] QSC 340, [44]; *Attendee Y* [2013] QSC 341, [44]; *Attendee Z* [2014] 2 Qd R 11, 16 [43].

174 *Attendee X* [2013] QSC 340, [49]; *Attendee Y* [2013] QSC 341, [49]; *Attendee Z* [2014] 2 Qd R 11, 16 [47]. Although note that Bagaric et al have suggested an automatic sentence reduction by a factor of 0.5 days for every day spent under harsh conditions: see M. Bagaric, R. Edney and T. Alexander, '(Particularly) Burdensome Prison Time Should Reduce Imprisonment Length – And Not merely in Theory' (2014) 38(2) *Melbourne University Law Review* 409.

175 *Attendee X* [2013] QSC 340, [46], [55]; *Attendee Y* [2013] QSC 341, [46], [55].

176 *Attendee Z* [2014] 2 Qd R 11, 20–1 [45], 21–2 [53].

177 *Attendee X* [2013] QSC 340, [49]; *Attendee Y* [2013] QSC 341, [49]; *Attendee Z* [2014] 2 Qd R 11, 16 [47]. This was in addition to the four weeks they had already spent in the watch house, which was also 'more onerous than normal conditions': *Attendee X* [2013] QSC 340, [54], [56].

178 *Attendee X* [2013] QSC 340, [52]; *Attendee Y* [2013] QSC 341, [52]; *Attendee Z* [2014] 2 Qd R 11, 16 [50].

4. Coroner's Inquest findings in Australia

4.1 References to solitary confinement in coronial cases

Another source of reported case law that concerns the use of solitary confinement is coroners' inquest findings. In all Australian States and Territories, a death in custody must be the subject of an inquest by the coroner.¹⁷⁹

We used The University of Queensland's Deaths in Custody Project's online database¹⁸⁰ ('the UQ database') to search for **coronial reports that mentioned the terms:**

- solitary confinement;
- isolation;
- segregation;
- seclusion;
- separate confinement;
- non-association order;
- detention unit; and
- safe cell/padded cell.

We found 49 coroners' inquest findings that mentioned these terms within the UQ database across all of the States and Territories.¹⁸¹ Of these, two concerned police custody rather than prison so we excluded them from our inquiry, leaving us with a sample of 47 cases, 11 of which were Queensland cases. **Thirty four of these prisoners (72%) were found to have died as a result of suicide.**

Information about each deceased prisoner, the nature of any reference to solitary confinement conditions, and the nature of any reference to the prisoner's mental health status or cognitive impairment is presented in Table 4.1 below, along with their cause of death, gender and Aboriginal and Torres Strait Islander status.

¹⁷⁹ *Coroners Act 1997* (ACT) s 13(1)(i); *Coroners Act 2009* (NSW) s 23; *Coroners Act* (NT) s 15(1)(b); *Coroners Act 2003* (Qld) ss 8(3)(h), 11(7), 27(1)(a)(i); *Coroners Act 2003* (SA) ss 21(1)(a), 28; *Coroners Act 1995* (Tas) ss 19(4)(a), 24(1)(b); *Coroners Act 2008* (Vic) ss 4(2)(c), 11, 52(2)(b); *Coroners Act 1996* (WA) ss 17, 19.

¹⁸⁰ To access the UQ Deaths in Custody Project database, go to: <www.deaths-in-custody.project.uq.edu.au>.

¹⁸¹ The UQ database includes all Australian coroners' inquest findings that are publicly available online. See further T. Walsh and A. Counter, 'Deaths in Custody in Australia: A Quantitative Analysis of Coroners' Reports' (2019) 31(2) *Current Issues in Criminal Justice* 143.

Table 4.1: Coroners' findings in relation to deaths in custody where certain terms related to solitary confinement were mentioned

Prisoner's initials	State/Territory	Year of finding	Gender/ ATSI	Reference to solitary confinement	Reference to mental illness or cognitive impairment	Cause of death
DES	Qld	2006	M Unknown	Placed in the DU because he was believed to be involved in an assault on another prisoner. He was then transferred to another unit (5B) but due to his fears for his safety in that unit he was temporarily taken back to the DU before being transferred back to 5B where he was murdered less than 24 hours later.	Nil	Killed by another prisoner
MJA	Qld	2006	M Unknown	Placed in the MSU because of his alleged involvement in a riot.	Nil	Suicide by hanging
MWD	Qld	2006	M Unknown	Placed in the MSU due to his history of violent offending, including the murder of two prisoners.	Nil	Killed by another prisoner
JMD	Qld	2007	F Unknown	Placed in the crisis support unit for suicide prevention.	Yes, risk of self-harm and history of suicide attempts	Suicide by hanging
TJM	Qld	2010	M Unknown	Placed in the DU because he assaulted a corrective services officer.	Schizophrenia, acquired brain injury	Asphyxia whilst being restrained
GMC	Qld	2012	M ATSI	Placed in the DU for eight days following a complaint he made about being subject to racial discrimination. This led to investigations and a risk assessment was ordered, which required constant observation in the DU.	Yes, depression, possibly a significant personality disorder	Medical condition –ischemic stroke. He suffered three falls which caused swelling in the brain.
KLC	Qld	2014	M Unknown	Moved to the DU after being placed on a safety order because he was found in possession of a syringe. Was not to associate with other prisoners without the general manager's consent, but association had been permitted.	Nil	Killed by another prisoner
FJV	Qld	2015	M Unknown	Placed in the DU at his own request for some 'time out'.	Yes, mixed personality disorder, possible PTSD or an anxiety disorder	Suicide by hanging
SMO	Qld	2015	M Unknown	Placed in the DU on consecutive orders to manage violent and dangerous conduct towards prisoners and staff. Transferred to the MSU with safety orders maintained because of his role in the violent death of another prisoner. Died in the DU within the MSU.	Yes, history of self-harm, schizoaffective disorder, bipolar affective disorder, anti- social personality disorder, intellectual impairment	Suicide by hanging
GAM	Qld	2016	M ATSI	Placed in the safety unit after being discharged from hospital.	Nil	Medical condition -myocardial infarction due to or as a consequence of coronary artery disease
DBS	Qld	2017	M Unknown	Placed in the MSU for six months as punishment for his involvement in a major security incident (climbed onto the roof, damaged security cameras and air conditioning units).	History of suicidal ideation, reported depression	Suicide by hanging
IGB	ACT	1999	M Unknown	Placed in isolation in the remand centre as he was considered to be at risk of self-harm.	Yes, depression	Suicide by hanging
SF	ACT	2018	M ATSI	A segregation review conducted on 18 February 2016 revealed that S 'presented dressed neatly and appropriately,' and displayed 'appropriate' behaviour and 'good engagement'.	Nil	Overdose

Prisoner's initials	State/Territory	Year of finding	Gender/ATSI	Reference to solitary confinement	Reference to mental illness or cognitive impairment	Cause of death
GB	NSW	2014	M Unknown	Placed in a safe cell on suicide watch because he told another inmate he wanted to kill himself. Then placed in segregation as a disciplinary measure following an altercation with prison staff.	Yes, risk of self-harm	Suicide by hanging
MS	NSW	2014	M Not ATSI	Placed in a safe cell – assessed as being at risk of self-harm as a result of self-inflicted injuries.	Yes, risk of self-harm	Suicide by hanging
SLW	NSW	2015	M Unknown	Placed on a segregation order because he was moved to the High Risk Management Centre at Goulburn. Every new reception into the centre is placed on a segregation order while suitability for the program is assessed. Declared an Extreme High Security inmate.	Nil	Suicide by hanging
W	NSW	2015	M Not ATSI	Placed in a safe cell because he told a counsellor he would hang himself if he was sent back to the yard or his cell. Placed in a safe cell a second time after presenting with black eyes and bruises. He complained of stomach pain and asked medical staff not to return him to his cell block. He was put in a safe cell for observation overnight. He later requested protection and was approved for Special Management Area Placement. He was placed in segregation on protection due to this request.	Yes, risk of self-harm, psychosis	Suicide by hanging
MDJN	NSW	2016	M Not ATSI	Placed in a safe cell, and then a camera cell, due to threats of self-harm. Placed on a Protection Non-Association Order on account of having had violent interactions with other prisoners in the past.	Yes, noted acquired brain injury, major depressive disorder, schizophrenia, organic psychosis, persistent auditory hallucinations	Suicide using a razor
GW	NSW	2017	M Unknown	Placed in a cell on his own under observation whilst waiting to be transferred, and then placed in the acute area of the Mental Health Screening Unit.	Yes, paranoid ideations	Medical condition - cardiac arrhythmia
GR	NSW	2018	M Unknown	Placed in a safe cell after being verbally aggressive and self-harming. Placed in an observation cell at his own request due to suicide risk.	Yes, risk of self-harm	Suicide by asphyxia from neck compression
FJTF	NSW	2018	M Not ATSI	Often placed in segregation for prolonged periods of time as a result of repeated internal offences including violent assaults against prison officers and other inmates, and disruptive acts including setting fire to his cell and flooding his cell.	Yes, psychotic disorder, depression, PTSD, paranoid ideation, anti-social personality disorder	Suicide using a razor
MC	NSW	2018	M Unknown	Placed in a detox cell, the High Dependency Unit at the Mental Health Screening Unit, and then in a safe cell.	Yes, risk of self-harm, drug-induced psychosis, possible schizophrenia or schizoaffective disorder	Suicide by hanging
JJW	NT	2001	M (youth) ATSI	Placed in 'time out' because he refused to take out the bin when instructed to twice. This meant he was sent to his room and the door was locked.	Doctor's report stated it was likely the deceased suffered from depression and psychosis but this was not diagnosed while he was alive.	Suicide by hanging
DPIJ	NT	2012	M ATSI	Placed in a segregation cell due to non-compliance with directions.	Yes, risk of self-harm and history of suicide attempts	Suicide by hanging

Prisoner's initials	State/Territory	Year of finding	Gender/ATSI	Reference to solitary confinement	Reference to mental illness or cognitive impairment	Cause of death
NS	NT	2018	F ATSI	Placed in a padded cell for observation due to repeated self-harm upon reception into custody. She had been returned to custody after being taken to hospital, where she was found to be fit for custody. Placed in a restraint chair multiple times.	Yes, risk of self-harm, borderline personality disorder, PTSD, depression, history of multiple suicide attempts	Medical condition – morbid obesity, sleep apnoea, asthma, cardiovascular problems, Type 2 diabetes, hyperlipidaemia
CMA	SA	2003	M Unknown	Placed in single cell accommodation, which amounted to a regime of solitary confinement, as punishment for an incident with officers where he refused to remove two rings, which was contrary to prison policy. He was abusive towards officers.	Yes, risk of self-harm, depression, previous suicide attempt	Suicide by hanging
ML	SA	2003	F ATSI	Placed in a padded cell for a short period of time and then moved to an observation cell because she said she felt suicidal.	Yes, risk of self-harm, history of suicide attempts, depression	Suicide by hanging
ACS	SA	2005	M Unknown	Placed 'on canvas' ¹⁸² and subject to constant observation.	Yes, risk of self-harm, history of suicide attempts, depression	Suicide by hanging
IM	SA	2005	M Unknown	Placed 'on canvas' in an observation room in the infirmary.	Nil mental health but cognitive impairment from alcohol abuse	Suicide by hanging
DKW	SA	2006	M ATSI	Placed in unit 7 ¹⁸³ on a number of occasions.	Yes, chronic schizophrenia	Suicide by hanging
BMT	SA	2006	M Unknown	Placed 'on canvas' in unit 7 as he was at risk of self-harm.	Yes, risk of self-harm, chronic depression, anxiety, personality disorder	Suicide by hanging
TMG	SA	2006	M Unknown	Placed in unit 7 because he was distressed and considered to be at risk of suicide.	No diagnosis but prison doctor considered he may have an adjustment disorder and a possible personality disorder	Suicide by hanging
JT	SA	2007	M Unknown	Placed 'on canvas' in an observation cell as a precaution against self-harm.	Nil	Suicide by hanging
SS	SA	2008	M Unknown	Placed 'on canvas' in an observation cell due to threats of self-harm.	Yes, risk of self-harm	Suicide by fall
LP	SA	2010	F Unknown	Placed in a cell on her own, in effective solitary confinement, due to her 'uncontrollable' behaviour.	Disturbed behaviour, initially thought to be the manifestation of bipolar disorder, but later borderline personality disorder, delusional ideation	Medical condition (epilepsy)

¹⁸² A prisoner placed 'on canvas' wears a canvas smock and is provided with canvas bedding as a means of suicide prevention.

¹⁸³ Unit 7 is a 'separation unit', sometimes used as punishment, to enable prisoners to have 'time out' from other prisoners, and to enable constant observation of them.

Prisoner's initials	State/Territory	Year of finding	Gender/ ATSI	Reference to solitary confinement	Reference to mental illness or cognitive impairment	Cause of death
SRB	SA	2015	M Unknown	Placed in a padded cell due to an emotional outburst and suicidal thoughts.	Yes, risk of self-harm, depression, history of suicide attempts	Suicide by hanging
MWP	SA	2015	M Unknown	Under a mental health detention order before being taken into custody. Placed in an observation cell because he was showing signs of distress and had threatened self-harm.	Yes, risk of self-harm, anxiety	Suicide by hanging
HRJ	SA	2018	M Unknown	Placed in a padded cell because he was assessed as 'high need' and had engaged in self-harming activities.	Yes, risk of self-harm, anxiety	Suicide by hanging
NAP	Tas	2014	M Unknown	Placed in the crisis support unit to obtain a psychiatric assessment. Then placed in the Mersey Unit ¹⁸⁴ because he was considered to be at risk of self-harm.	Yes, risk of self-harm, depression	Suicide by hanging
RDG	Tas	2018	M Unknown	Placed in a secure, isolated room for security reasons (imprisoned for sexual offences) and because he had an infectious illness.	Nil	Medical condition – heart disease
ASO	Vic	2013	M Not ATSI	Placed in a Muirhead cell ¹⁸⁵ due to significant risk of suicide and self-harm.	Yes, risk of self-harm, history of suicide attempts	Suicide by hanging
JPH	Vic	2014	M Unknown	Secluded from the mainstream population and categorised as a 'management prisoner'. ¹⁸⁶ Placed in the protection unit and unit 13 ¹⁸⁷ for suicide and self-harm prevention.	Yes, risk of self-harm	Suicide by asphyxia
MN	Vic	2015	M Unknown	Placed in seclusion on two occasions due to high level arousal, agitation and threats of violence towards staff.	Yes, psychosis	Suicide by hanging
RKK	Vic	2015	M Unknown	Placed in a Muirhead cell.	Yes, risk of self-harm	Suicide by fall
RCB	WA	2013	M ATSI	Placed in punishment cells and the DU multiple times as a disciplinary measure in response to his use of insulting and threatening language towards prison officers.	Yes, paranoid ideation, depression	Medical condition - acute myocardial infarction in association with coronary atherosclerosis
MJK	WA	2014	M ATSI	Placed in a punishment cell after attempting suicide by hanging with a bed sheet. Later placed in a punishment cell after assaulting another prisoner.	Yes, risk of self-harm, cognitive impairment from head injury, paranoia and depression	Medical condition - ischaemic heart disease in association with coronary arteriosclerosis
JSB	WA	2016	M ATSI	Placed in a punishment cell for five days for assaulting another prisoner. Placed in a punishment cell on other occasions for bullying, stand-over and graffiti.	Yes, depression, potential psychosis, paranoia and hallucinations	Suicide by hanging

¹⁸⁴ The Mersey Unit is a special unit for high needs inmates, including those who are considered to be at risk of self-harm or suicide.

¹⁸⁵ The Muirhead cells are seclusion cells where prisoners are clothed in canvas and receive intensive monitoring by corrections officers and mental health staff.

¹⁸⁶ The purpose of management units is separation to manage risk and generally involves solitary confinement with longer lockdowns than other units.

¹⁸⁷ Unit 13 contains cells for suicide and self-harm risk prevention.



© 2017 Daniel Soekov for Human Rights Watch

4.2 Coroners' recommendations on solitary confinement

In four of these coroners reports, the use of solitary confinement was discussed in detail, and the coroners made recommendations concerning the use of solitary confinement in Australian prisons. Coroners in those cases noted in particular: **the deplorable conditions under which prisoners in solitary confinement are held; the impact that solitary confinement has on prisoners' mental health; the lack of access to specialist mental health treatment available to prisoners in solitary confinement; and the lack of external oversight of prisoners in solitary confinement.**

FJTF, New South Wales

Isolation causing psychosis; failure to respond to prisoner 'knock up' informing officers he had self-harmed

FJTF was 24 years of age and had a history of developing symptoms of psychosis after being placed in prolonged isolation. He had **spent many periods of time in prolonged isolation** in the preceding years as a result of violent interactions with other prisoners, as well as 'various acts of arson and other disruptive acts such as flooding.'¹⁸⁸

Five weeks prior to his death, FJTF was observed to have **increased psychotic and depressive symptoms** including thoughts of self-harm and suicide. He became convinced that corrections officers were trying to kill him, including by poisoning his food. He was transferred to a safe cell and observation cell at various times over the next few weeks due to his risk of suicide or self-harm. This culminated in him inflicting a **fatal wound to his wrist with a common razor**. On that day, he had been seen by a psychiatrist who had described him as 'sullen' and 'disengaged.'¹⁸⁹

The coroner described the conditions of his confinement.¹⁹⁰ He was completely segregated from other prisoners, and had no interactions with other prisoners at all.

¹⁸⁸ *FJTF* (Coroner's Court of New South Wales, Deputy State Coroner Teresa O'Sullivan, 13 July 2018) 9, [9].

¹⁸⁹ *Ibid* [27].

¹⁹⁰ *Ibid* [117].

He had some limited access to the ‘rear yard’ but was by himself at these times. He was able to make phone calls, but only whilst handcuffed and shackled and accompanied by a number of corrective services officers. He had ‘brief interactions’ with a mental health nurse, and sporadic consultations with psychiatrists. The coroner noted that at one time **‘he did not see any person, including a correctional services officer... for a period of at least 16 hours.’**¹⁹¹

The psychiatrists who did consult with him reported that his **mental illness was ‘not being adequately treated’ and was associated with having ‘limited human contact’**.¹⁹² They agreed that he required specialist mental health treatment in an appropriate facility, but due to the limited number of available beds, the decision was made not to refer him.¹⁹³ On this basis, the coroner recommended that a review be undertaken to determine whether or not the **number of mental health beds available** was sufficient to meet demand.¹⁹⁴ The coroner concluded that FJTF’s death could have been avoided had he been more closely monitored, or had access to specialist mental health treatment in an appropriate facility.

LP, South Australia

Insufficient external oversight; delay in mental health referral; deplorable cell conditions associated with prisoner’s mental illness

LP was 40 year old female who died in the Adelaide Women’s Prison from severe brain damage that resulted from cardiac arrest associated with an epileptic seizure.¹⁹⁵ LP had been diagnosed with bipolar disorder, but more recently was suspected to have borderline personality disorder. She had been kept separate from other prisoners in a single cell in ‘D Wing’ ‘in the interests of security or good order within the correctional institution’.¹⁹⁶ She had acted aggressively towards corrections officers and had kept prisoners awake with her yelling at night.

LP had been kept in effective solitary confinement for 17 days. During this time, she had exhibited **difficult and disordered behaviour**, which was believed to be related to her medical condition, possibly because she had not been regularly taking her required medication. The coroner described the conditions under which she was existing as ‘dreadful’.¹⁹⁷

*‘The environment in [LP’s] single cell had become **incompatible with hygienic living** insofar as it involved her urinating and defecating in her cell without using the lavatory provided. It had also involved [LP] **distributing urine and faeces within the cell** such that the cell became **uninhabitable**.’*¹⁹⁸

It was widely known amongst the staff that at one point LP **did not sleep for 72 hours**. On the day of the episode that resulted in her death, it had been determined that she should be sent to a secure psychiatric facility. She was being prepared to be moved when she began having a seizure. **Staff were reluctant to enter the cell**, and indeed they did not enter the cell for more than 10 minutes after her collapse. Further to this, it appeared that the **Minister may never have been informed of her placement in solitary confinement** in the first place, in breach of the requirements of the Act.¹⁹⁹

¹⁹¹ Ibid [117].

¹⁹² Ibid [118].

¹⁹³ Ibid [117].

¹⁹⁴ Ibid [132]. One of the psychiatrists who gave evidence estimated that between five and seven percent of the prison population were suffering from psychosis and required treatment in a specialist mental health facility: [118].

¹⁹⁵ LP (Coroner’s Court of South Australia, Deputy State Coroner Anthony Ernest Schapel, 19 November 2010) [1.1-1.2].

¹⁹⁶ Ibid [4.7].

¹⁹⁷ Ibid [4.8].

¹⁹⁸ Ibid [2.5].

¹⁹⁹ The coroner noted that ‘this would represent a highly undesirable state of affairs because it might mean that nobody in authority outside of the confines of the AWP would have known of Ms Parker’s predicament in any meaningful detail or would have been in a position to do anything in order to mitigate the adverse affects of her solitary confinement or to otherwise question the appropriateness of her custodial regime and the dreadful conditions under which she was living’: ibid [4.8].

The coroner was scathing of the treatment of LP by corrections officers. He **questioned why a mental health referral was not made sooner**, and why LP had been left in such appalling conditions for so long.²⁰⁰ He also questioned why it took 10 minutes for medical treatment to be provided to LP after her collapse, and recommended that corrections officers be directed to intervene immediately in the event of a prisoner's unconsciousness and unresponsiveness.²⁰¹ The coroner also recommended improved training and protocols relating to prisoners with epilepsy.²⁰²

Importantly, the coroner was of the view that existing protections for prisoners placed in solitary confinement were inadequate. He recommended that the decision to place a prisoner in solitary confinement should not be delegated to officers below the position of general manager.²⁰³ The coroner was of the view that a requirement to inform the Minister once of a prisoner's placement in solitary confinement provided a **'conspicuously inadequate framework for the humane oversight of prisoners'**²⁰⁴ and recommended that the legislation be amended to require both the Minister and the Department of Correctional Services to be 'regularly informed of the current circumstances' of a prisoner in solitary confinement.²⁰⁵

W, New South Wales

Inadequate handover; inadequate mental health monitoring

W was a 23 year old male. He was being held in the Ebenezer Unit of the John Morony Correctional Centre. He had been held in solitary confinement for 18 days, first because he had expressed suicidal ideation, and then for protection. Having **begun to show symptoms of psychotic illness**, he was placed in a 'one out' cell, which meant he was held in solitary confinement. He then became fearful for his safety, and was placed in 'protective custody.' The coroner noted that prisoners in a 'one out' cell due to a risk of suicide were held under the same conditions as prisoners in protective custody.²⁰⁶

This was his first presentation of psychosis, however there was some family history of schizophrenia. Since he was expressing suicidal thoughts, the decision was made not to prescribe anti-psychotic medication. However, the nurse expressed some concern regarding his wellbeing and expected that he would be seen by another nurse the following day. The decision not to medicate W was not criticised by the coroner, however the coroner did note that there had been insufficient handover between staff which meant that he 'fell through the cracks' and was not seen urgently by a practitioner the following day.²⁰⁷ He committed **suicide by hanging**.

MWD, Queensland

Inadequate supervision of maximum security prisoners subject to an 'approved association'

MWD was being held in the MSU at Sir David Longland Correctional Centre in Brisbane. He had murdered two fellow prisoners and was serving a life sentence. He had been in prison for 14 years, and in the MSU for many years prior to his death. He was effectively held in solitary confinement, however he had been permitted to associate with one other prisoner for two hours a day. This was supposed to be done in a 'very controlled and structured way' and was 'an essential element of his progress towards being re-integrated back into the general prison population.'²⁰⁸ During one of these association periods, the other prisoner (who had also been convicted of another prisoner's murder) violently attacked and killed MWD.

²⁰⁰ Ibid [7.9].

²⁰¹ Ibid [8.38], [8.45].

²⁰² Ibid [10.2].

²⁰³ Ibid [10.2].

²⁰⁴ Ibid [4.8].

²⁰⁵ Ibid [10.2].

²⁰⁶ W (Coroner's Court of New South Wales, Deputy State Coroner Sharon Freund, 11 November 2015) [66].

²⁰⁷ Ibid [96].

²⁰⁸ *Inquest into the Death of MWD* (Coroner's Court of Queensland, State Coroner Michael Barnes, 19 December 2006) 8 ('MWD').



© 2017 Daniel Soekov for Human Rights Watch

The coroner noted that prisoners associating with one another in the MSU were required to be closely supervised.²⁰⁹ They were to be observed by a corrective services officer from the 'MSU control room'. However, on this occasion, video footage showed that the **officer responsible for supervising the prisoners 'did not look at the monitor at all' for a full 32 minutes.**²¹⁰ The coroner was of the view that had the officer not 'totally failed to discharge his duty' there was a 'strong basis for suspecting that the death may have been avoided.'²¹¹ It also transpired that the prisoner who killed MWD had not been searched before he entered the exercise yard.²¹² The coroner recommended that disciplinary action be taken against the officers who failed to monitor and search the prisoners, and that an audit be undertaken to establish the level of officers' compliance with existing legislation, policies and procedures.²¹³

SUMMARY

Forty-seven deaths in custody cases in the UQ Deaths in Custody Database mention 'solitary confinement' or related terms. In four of these cases, coroners made recommendations concerning the use of solitary confinement.

Coroners have been scathing of solitary confinement conditions in Australian prisons. They have recommended that executive oversight of solitary confinement conditions be increased and enhanced, and that prisoners demonstrating serious psychiatric symptoms be transferred to secure mental health units without delay.

²⁰⁹ Ibid.

²¹⁰ Ibid.

²¹¹ Ibid.

²¹² Ibid 9.

²¹³ Ibid 9.

5. The experience of prisoners in solitary confinement in Queensland

5.1 Overview of empirical research

This section of the report presents the results of two empirical investigations:

1. focus group interviews with prisoners' lawyers and advocates in Brisbane; and
2. analysis of client files at a Queensland-based community legal centre that advocates on behalf of prisoners and their family members.

It is difficult for researchers to obtain contemporaneous accounts of prison conditions in Queensland. Section 132 of the *Corrective Services Act 2006* (Qld) states that a person must not interview a prisoner, or obtain a written or recorded statement from a prisoner, whether the prisoner is inside or outside a corrective services facility, without the chief executive's written approval. In practice, this provision restricts researchers' ability to obtain reliable, up to date accounts of prisoners' experiences.

It was necessary for us to develop a methodology that was compliant with this section. We decided to hold focus group interviews with prisoners' lawyers and advocates, and undertake a textual analysis of client files held by a community legal centre that advocates on behalf of prisoners in Queensland.

Ethical clearance for both investigations was obtained from the University of Queensland's Human Research Ethics Committee.²¹⁴

5.2 Interviews with prisoners' lawyers and advocates

5.2.1 Methodology and participants

Between May and July 2019, four focus groups with prisoners' lawyers and advocates were held in Brisbane.²¹⁵ Relevant organisations and individuals were invited by email to participate. All organisations that were invited to participate agreed to be interviewed. Interviews ran for between 60 and 90 minutes. They were audio-recorded and transcribed. Data analysis was undertaken using manual coding and NVIVO software.

A total of 18 people participated in the focus groups. Participants were assured that their identities and the names of their employers would remain anonymous, so no further information can be disclosed concerning them. However, it can be said that all participants have acted as lawyers or advocates for prisoners in Queensland.

The focus groups were semi-structured in nature, and the same discussion topics were explored in each interview. They were:

- the circumstances under which prisoners tend to be placed in solitary confinement;
- the impacts of solitary confinement on prisoners;
- whether or not there are any differential impacts of solitary confinement based on gender, age, disability, or Indigeneity;

²¹⁴ Approval numbers: #2018001646 and #2019001003.

²¹⁵ We did not attempt to obtain the chief executive's approval to interview prisoners because of the ethical concerns associated with interviewing vulnerable prisoners accommodated in solitary confinement: National Health and Medical Research Council, *National Statement on Ethical Conduct in Human Research*, 2018, 13–14, 68, 74, 75.

- monitoring and external review of solitary confinement placements; and
- alternatives to solitary confinement and recommendations for reform.

The focus group discussions crystallised around four key themes: the relationship between solitary confinement and mental illness; the lack of accountability and oversight of decisions to place prisoners in solitary confinement; the ‘downward spiral’ that solitary confinement creates in terms of prisoner management and rehabilitation; and the importance of responding therapeutically rather than punitively to ‘at-risk’ behaviours.

5.2.2 Prevalence of mental illness and disability

Participants said that most, if not all, of the prisoners they had worked with in solitary confinement suffered from mental illness. One participant said, ‘I don’t think I’ve ever had any dealings with anybody in the MSU who has not had a mental health issue.’ In effect, they said, people are being **‘punished for behaviour they can’t really control.’**

Participants said that the most common mental health concern they observed amongst their clients in solitary confinement was **psychosis**, particularly paranoid schizophrenia, often with a dual diagnosis of intellectual disability or acquired brain injury.

Participants said it was not uncommon for people in solitary confinement to develop mental health symptoms that they had not experienced before, such as hearing voices, hallucinating, and becoming paranoid, fixated and obsessive-compulsive. One participant said: ‘I’ve seen people who I’ve worked with, when they’ve just gone into solitary, and I’ve gone back to see them six weeks later, and they have been unrecognisable.’

Participants provided graphic examples of the kinds of **disordered behaviour** exhibited by people in solitary confinement. In one exchange, participants said:

‘Participant 1: There was that one guy who just punched the door of his cell all day, and whenever you went out to the MSU, you could just hear the noise of his fists pounding on metal.’

‘Participant 2: Yes, his cell was often – his wall was often covered in blood, so they wouldn’t actually take him out of his cell for legal appointments. I would go and I’d be locked in the air lock, and have to speak to him through a slot in the door.’

Another participant said: ‘I didn’t think he could get any worse. [When I first met him] he wasn’t throwing his faeces at people and trying to hang himself. Now, he is.’

‘Bronzing’, that is, **‘spreading your faeces’ was described by participants as being ‘common’ amongst people in solitary confinement.** One participant explained:

‘Really common for people in solitary to start doing things with their faeces. Smearing it on the walls, writing with it, throwing it at officers, mixing it into concoctions. I had never realised that was a thing until I first started working with people in solitary.’

Participants said that often their clients became so unwell that they were unable to take instructions from them. Indeed, one participant said they recently had a client in solitary confinement who could not be assessed for fitness ‘because [he/she] was presenting with such paranoid features’ at court. Others said that their clients could be under the influence of illicit drugs during a legal visit: ‘just because you’re locked up somewhere doesn’t mean you can’t get drugs.’

The level of **social and sensory deprivation** described by participants was extreme. Many participants referred to the fact that people in solitary confinement ‘don’t see the sky’ and cannot ‘stand on the grass’. They said, ‘you’re always on concrete in solitary’; even the exercise yard was described as concrete ‘with wire over the top, so it’s not really daylight.’ Participants described not ‘being able to put your feet on the ground’ as a ‘huge thing’ for people in solitary confinement.

Other comments that illustrated the level of social and sensory deprivation experienced by people in solitary confinement included:

- ‘Not even the officers would talk to him.’
- ‘He would ask for books and they wouldn’t be given to him.’
- ‘I have people who in the DU, MSU who **used to commit offences so they could come to court so that they could speak to people** – that was the only contact they would have, with their lawyers.’
- ‘He would... scream out to the other prisoners... because he was just so lonely.’
- ‘A lot of them talk through the shower drain.’
- ‘Can you give them a television? Can you give them a powered cell? Can you give them some colouring pencils? Can you give them something that they can do so they don’t go quite so crazy while they’re in this environment?’
- ‘He had literally nothing, and no pen.’
- ‘He just used to squeal all day long, this high pitched – did you hear him?’
- ‘[He/she hadn’t] seen the colour red for years... all they see is khaki and the officers’ uniforms and the colour of their walls, the colour of their clothing and the colour of their bed.’

Participants said that as a result of these conditions, people in solitary confinement often developed a ‘hypersensitivity to noise’, and a **fear of open spaces**. A number of participants said that prisoners held in solitary confinement for extended periods of time often **became institutionalised and did not want to come out again**. One participant said they had a client who did not even want to access the exercise yard anymore because it was ‘too big.’

Some participants felt that their **Indigenous clients ‘seemed’ to be ‘affected more’** than non-Indigenous clients. One participant suggested that this was because ‘you’re even more disconnected - because of the massive over-representation of Indigenous people in jail, at least if you’re in the mainstream population, you’re connected.’ Another participant said their Indigenous clients seemed to be particularly affected by their removal from nature, specifically the ‘air’ and the ‘birds’.

In one focus group, a participant said that they had a client who was heavily pregnant placed in solitary confinement, despite the fact that this is prohibited under international law.²¹⁶

216 The Bangkok Rules, UN Doc A/RES/65/229 (n 20) rule 22.

5.2.3 Lack of accountability, transparency and oversight

There was general concern expressed amongst participants regarding the ‘lack of oversight’ of people placed in solitary confinement. They said the only way lawyers find out that a client has been placed in solitary confinement is by going out to the unit to observe who is in there for themselves, or waiting for their client to contact them: ‘the onus is on the prisoner – or on us to find them.’

Participants explained that people in solitary confinement are **unable to easily access a phone**, so they may be in solitary confinement for a number of days before they are able to alert anyone of this. In some cases, they may need to be moved to another part of the prison to access the phone, in which case they will be accompanied by prison officers. The prison has to be ‘shut down’ to allow for this as it is ‘a cease movement’, and ‘they say that resources don’t allow it to happen regularly.’ As a result, contact with lawyers, and family members, is significantly reduced for those in solitary confinement.

Participants said that it was often **difficult to obtain a legal visit** with a client in solitary confinement, particularly those in the MSU. ‘Special permission’ is required, appointments are frequently cancelled, and prisoners are often in ‘lock down’ or otherwise cannot be moved for the purpose of the visit. Also, the MSU is ‘separate from the prison’ and visitors are often driven down to the unit by corrective services officers, which has ‘resource implications’ for corrective services staff. All of this, they said, results in ‘lengthy delays’; in one group, participants said that a week’s notice is often required for a legal visit to someone in solitary confinement.

Yet, visits from lawyers and advocates were considered by participants to be extremely important. Sadly, prisoners are often reliant on lawyers to protect their welfare. As one participant said, ‘many of my clients have no family or family involvement... and that means that there’s nobody advocating for their wellbeing.’ Legal visits were also important to ensure accountability; in one group, participants said that ‘the most effective way I have found to ever get somebody off a safety order is just to go and visit them.’ This, they said, ‘shows that quite often the safety orders aren’t really justified’ and prisoners are reliant upon lawyers to provide a check on decision-making.

Participants agreed that the **official visitor scheme** was designed to provide for accountability and transparency, but they felt that it was **‘completely ineffective.’** There were a number of reasons for this. First, prisoners are required to fill in a form to request a visit. This presents problems for prisoners who lack literacy skills, or who are not provided with the form upon request.

Secondly, participants felt that the official visitors generally ‘reinforce Corrective Services’ views,’ rather than providing independent oversight. One participant explained:

‘I don’t know that I’ve ever seen [an official visitor] recommend that the order be cancelled... I’ve even spoken to official visitors who have said to me, “I don’t feel that I can do anything else.” And they’ve acknowledged how traumatised they are by seeing the effects of solitary confinement on people. But they don’t think it’s their role to discuss that. Their role is to discuss whether the legislative criteria has been met. And they say yes.’

Participants also expressed doubts about the effectiveness of the role of the chief inspector,²¹⁷ given that the chief inspector is appointed by the chief executive, and their reports are not made publicly available.²¹⁸

Thirdly, participants noted that ‘not a lot changes’ even in the rare event that an official visitor recommends a variation to the conditions of the prisoner’s confinement, or in response to inspectors’ reports.

Participants in all groups emphasised that independent oversight of the use of solitary confinement was required, and participants in all groups agreed that ideally, this **oversight should be provided by the courts**. Judicial review was considered an important avenue for redress in certain situations, however the risk of a costs order discouraged some organisations from pursuing judicial review applications except in the most exceptional of circumstances. This, they said, meant that ‘unlawful’ practices often go unchallenged. In particular, participants said that it was common for prisoners on safety orders not to be provided with two hours out of their cells each day, yet this ‘just slips through and nobody notices.’

Participants felt that there should be judicial oversight of decisions to place a person in solitary confinement, or make consecutive maximum security or safety orders. Participants felt that ‘if whoever’s making these decisions is actually forced to stand by them in a public and transparent way, in a court, I think we’re actually going to start seeing different outcomes.’ Participants were of the view that **additional legislative criteria should need to be met to keep someone in solitary confinement for a prolonged period of time, and that the decision as to whether these criteria have been met should be made by a judge**.

In two of the groups, some of the participants suggested that decisions to place, or keep, prisoners in solitary confinement for prolonged periods of time could be made by a specially constituted panel of external experts. The benefits of a **decision-making panel**, they said, would be that there could be ‘case conferencing about what’s the best plan’ for each individual, and they could ‘link people in with support services’. However, most participants considered this to be inferior to judicial oversight, because courts are ‘public’, ‘independent’ and have greater ‘authority’. Some participants felt there was a risk that a panel could ‘become like a court without the accountability or transparency,’ and that a panel could simply ‘rubber-stamp’ decisions of corrective services officers. One participant said that judicial officers are best placed to balance the competing interests of community safety and rehabilitation based on legislative criteria.

Short of this ideal, participants made some suggestions that could easily be implemented within the current legislative framework. For example, in one of the groups, participants suggested that an ‘independent assessment’ should be required before a consecutive order is made, perhaps by an ‘external psych’, and that additional criteria should be met to justify extended periods of solitary confinement. Participants suggested that the official visitor program be modified so that it ‘actually operates externally with proper oversight’ perhaps by removing responsibility for appointing official visitors from the chief executive. One participant said that:

*what is required is ‘a system where you have **external people come in and review what’s going on – talk to the prisoner** in that circumstance, get their perspective of what’s happening’ because, ‘when you see the effect, it just becomes so clear that this isn’t right, this has to stop.’*

It was also suggested that there be ‘some accountability mechanisms to the Minister.’

217 *Corrective Services Act 2006* (Qld) s 296 establishes the role of chief inspector to coordinate the official visitor scheme and undertake inspections of prisons.

218 The most recent report of the chief inspector available on the Queensland Corrective Services website is from 2013: <https://corrections.qld.gov.au/documents/reviews-and-reports/healthy-prison-report/>.

5.2.4 Solitary confinement as a ‘downward spiral’

Participants said that once their clients had spent time in solitary confinement, they found it very **difficult to reintegrate** back into the general prison population and society more broadly. Solitary confinement was described by participants as a ‘downward spiral’, a ‘catch-22 situation’, a ‘repeating cycle’ and a ‘self-fulfilling prophecy’. There were many reasons for this.

First, prisoners are often placed in solitary confinement because they are considered a risk to those around them, but participants said that solitary confinement actually serves to **increase the risk they pose**. They said that once people are released from solitary confinement into mainstream, ‘they’re not there very long until they’re back in [solitary] because they haven’t got that ability to reintegrate.’ This means that their order is more likely to be continued, sometimes for very long periods of time. One participant described the dilemma that solitary confinement creates:

‘It can often be this catch-22 situation where you can’t demonstrate that you’re able to go back into the community because you’re not in the community, so you can’t demonstrate that you’re not a risk to other prisoners because you haven’t been around any prisoners to demonstrate that you’re not a risk to other prisoners. And the actual consequences of solitary confinement tend to increase those factors anyway, makes you less likely to be socially adapted, it makes you less likely to be able to regulate your emotions or it makes you more likely to feel like suicide or self-harm. So the actual period in solitary confinement, rather than addressing the issues that sent you to solitary confinement, that period in solitary confinement exacerbates those issues and makes a consecutive order more likely.’

Secondly, many prisoners are placed in solitary confinement as a result of their mental health problems, but solitary confinement **causes their mental health to deteriorate**. Solitary confinement was described as a ‘downward spiral’ by participants because ‘their mental health goes down, their ability to regulate their behaviour goes down.’ Participants said that prisoners’ behaviour deteriorates because they become more ‘unstable’ and ‘just don’t know how to cope.’ This means they receive ‘more write-ups’, and are charged with more in-prison offences, which in turn compromises their chances of getting out of solitary confinement or receiving parole. Participants noted the irony of charging a prisoner with offences that arise out of the conditions of their detention:

‘If you’re still charging someone after you’ve already put them in [solitary confinement] – like, for the peace and good order of the prison – it’s a joke, it’s a lie. Like, you have not addressed any of the underlying reasons that you say this person needs to be isolated [for]. Why don’t you try something different?’

Indeed, some participants said that their clients were **less likely to disclose suicidal thoughts** because they feared being placed in solitary confinement. One participant said that ironically, prisoners who felt suicidal benefitted from being in the general prison population because they had access to ‘people who can be a support group.’ They also tended to confide in their lawyers rather than the prison psychologists because the lawyer is ‘safe’ and will not ‘use it against’ them.

Thirdly, a goal of incarceration is rehabilitation in the interests of community safety, but solitary confinement does not provide prisoners with the treatment or skills that they need to live as productive citizens. Participants noted that some prisoners have a release date so it is possible for them to be **released directly from solitary confinement into the community**. One participant said:

'I've seen multiple people be released directly from prolonged solitary confinement into the community. And I tell you what, I don't want to be the person standing next to that guy at the train station.'

Participants said that when their clients were released into the community straight from solitary confinement, they generally came back into custody quickly, often on more serious charges (particularly sex offences) which they had not previously been charged with. Participants felt this was because they were 'even less equipped to go out into the real world' and had been rendered 'unable to cope in any other environment except that one.' Participants believed that this demonstrates 'it didn't do any good being in a maximum security unit.'

5.2.5 Lack of access to mental health treatment

Participants said that despite the fact that their clients in solitary confinement are generally very mentally unwell, they **do not have sufficient access to psychiatrists or psychologists**. In fact, participants said it was not uncommon for prisoners in some units to serve their entire sentence without seeing a psychiatrist. The level of mental health care available in the prisons was described as being 'substantially worse than what's available on the outside.' There was general agreement amongst participants that many of the prisoners in solitary confinement 'shouldn't really be in prison at all' – what they required instead was specialised mental health treatment.

Sometimes, prisoners in solitary confinement become so unwell that they are transferred to a secure mental health facility. Participants said that when this occurs, their clients become 'a different person.' One participant said: 'the changes are so dramatic... the change in the person's personality is just amazing, you often wonder why are they here?' However, once they are transferred back to the prison, 'it's as if they'd never gone to the [hospital].'

Participants felt that the improvement in their clients' health in hospital was a direct result of the increased social contact they had there. As one participant observed, 'you can't use seclusion as a punishment in mental health – it's only ever for therapeutic, what is considered to be therapeutic, or risk management reasons.' This meant, they said, that even people who had spent very long periods of time in solitary confinement in prison were very quickly transferred out of solitary confinement in hospital.

The problem is that there are **not enough beds in secure mental health facilities** to meet the demand coming from the prisons; participants said that many people are in solitary confinement in prisons because there are no available beds at secure mental health facilities. One participant remarked:

'Getting someone into secure in a hospital takes a long time because you have to have a bed. And a bed only becomes available when someone becomes well enough to leave secure. And so it becomes this issue of, well, who is the most likely to hurt someone or themselves?'

Participants agreed that most people in solitary confinement instead needed to be in a 'hospital-like environment' that was a 'mixture of a jail and a hospital' where there is both 'surveillance' and 'the treatment that's required.' Participants said that there should be 'a specialist treating team' and 'guards that were well informed and understood what each of these persons' needs were.' Alternatively, participants said that more beds were needed in secure mental health facilities, and that prisoners with serious mental health concerns should be 'transferred immediately to a hospital.'

5.2.6 Conclusions on the use of solitary confinement

In all of the focus groups, participants expressed the view that **solitary confinement should be 'abolished' because it 'serves no useful purpose' and 'the harm is so profound.'**

For prisoners who were at risk of suicide or self-harm, participants said there were alternatives to solitary confinement: '15 minute obs doesn't mean you have to be in solitary confinement.' For those who posed a risk to the safety of others, participants said adequate monitoring and supervision was required.

The consensus was that solitary confinement **should only be used in emergency situations** where there was no practicable alternative **for a maximum of 24 to 48 hours.**

Participants agreed that **prolonged detention in solitary confinement should not be permitted at all, or at least not without judicial scrutiny** or approval. In some groups, participants said that the maximum amount of time a person spends in solitary confinement should be seven days; others said 14 days. They agreed, however, that there should be a 'hard legal limit' set within the legislation. To ensure that prisoners are prepared for release, one participant suggested a section be added to the Act providing that **no prisoner be held in solitary confinement if they are within six months of their release date.**

If solitary confinement continued to be used, participants made a number of recommendations directed at improving the conditions. For example, they suggested that prisoners in solitary confinement be able to **access an outdoor area** during that day, where they could stand on grass and see the sky. Participants also emphasised how important it was for people in solitary confinement to have **more contact with people** – more visits, more telephone calls, more conversations with staff, more supervised association. Additional access to psychiatrists and psychologists was considered critical, with an **emphasis on therapeutic interventions and transitioning to mainstream** prior to release.

It was also suggested that official visitors be required to inform prisoners' lawyers if they are placed in solitary confinement.

In terms of the overarching ideology and culture of corrective services, there was general agreement amongst participants that the way 'risk' is conceptualised needed to be rethought. Participants criticised **the conflation of 'need' and 'risk.'** They said that the focus of corrective services officials was preventing a death in custody rather than working to reduce the risk the person posed to themselves and others. One participant said: 'they only care about their obligation to make sure this person doesn't either kill themselves in jail, or damage somebody else in jail, or get killed in jail.' Risk, they said, needs to be looked at 'as a holistic concept'. Instead of asking 'is this person a risk to the security and good order of the facility, now?' they said we should consider 'will you be a risk to the community, more of a risk, if we keep you here in solitary confinement?' and 'how can we reduce this person's risk to the security and order of the facility?'

5.3 File analysis: Prisoners in solitary confinement in Queensland 2016-2018

5.3.1 Methodology

An analysis of client files was undertaken to provide further information on the experiences of prisoners in solitary confinement in Queensland.

The files included in this analysis were sourced from one legal service that advocates on behalf of prisoners in Queensland. All files opened by the service between January 2016 and July 2019 that involved assisting prisoners with their placement in solitary confinement were included in the analysis, **a total of 30 files**.

Relevant information was extracted from client files and deidentified by staff members from the legal service. The deidentified information was then provided to the primary researcher (Walsh), fully anonymised, in an excel spreadsheet.

Extraction of the information from the files by staff members from the legal service was conducted in a manner consistent with their client agreements and confidentiality obligations. Information was considered relevant if it related to the client's placement in solitary confinement, or was demographic information. However, some information was excluded to ensure the researchers acted in compliance with section 132 of the *Corrective Services Act 2006* (Qld), including:

- any correspondence written by a prisoner;
- any statements made by prisoners; and
- any quotes from prisoners.

Legal files contain all documents and file notes that pertain to that client's legal matters. Therefore, the information included in the spreadsheet came from a variety of different sources including:

- file notes written by lawyers after a legal visit;
- sentencing remarks of judges presiding over the client's legal matters;
- reports from psychologists, psychiatrists and official visitors;
- correspondence sent by the legal service to the client;
- correspondence between the legal service and other parties, including corrective services officers, psychologists, psychiatrists;
- custodial case notes, statements of reasons and review documents.

A condition of ethical approval was that all individuals mentioned in the files remain anonymous. Therefore, no direct reference is made to the source of the information in this analysis. For example, no indication will be provided as to whether the information was sourced from a file note, or a psychological report, or correspondence.

The information in the spreadsheet was subjected to content analysis using Krippendorff's methods.²¹⁹ Thematic distinctions were made between each unit of text, and each unit was categorised based on the type of information it contained. Specifically, the units of text were divided into the following categories:

- demographic and descriptive information related to the prisoner;
- time spent in solitary confinement;
- reasons for placement in solitary confinement;
- behaviours exhibited by prisoners in solitary confinement;
- proposed justifications for behaviours exhibited by prisoners in solitary confinement;
- references to prisoners' suitability for reintegration into mainstream, or release into the community.

The qualitative data was then entered into NVIVO for coding and analysis.

5.3.2 Quantitative information

Some quantitative information was extracted from the files, including demographic information pertaining to each client such as age, gender, Indigenous status and diagnoses; the length of time the client had spent in solitary confinement, recently and in the past; and the reasons for their most recent placement in solitary confinement.

5.3.2.1 Age, gender and disability

Most of the clients (n=22) identified as male, and the remaining clients (n=8) identified as female.

Thirteen of the clients were of Aboriginal and Torres Strait Islander descent, including six of the eight females.

As at 1 July 2019, all of the clients were aged between 20 and 50 years. Seven were aged in their 20s; 16 were aged in their 30s; and seven were aged in their 40s.

Most of the clients (n=22) were noted in the file to have at least one psychiatric disorder, including seven of the eight female clients. Five clients were noted in the file to have a cognitive impairment. A history of childhood abuse, either sexual or physical, was noted in 16 of the files, and a further three clients were noted to have had a 'dysfunctional' childhood.

Of the psychiatric disorders noted on the clients' files, the most common were: Anti-Social Personality Disorder; Post-Traumatic Stress Disorder; and depression. Many clients also had a history of substance use. The frequency of each diagnosis is outlined in Table 5.1 below. Note that most clients presented with more than one diagnosis. Only the diagnoses with a frequency greater than two are included in the Table.

219 K. Krippendorff, *Content Analysis: An Introduction to its Methodology*, 2018.

Table 5.1 – Psychiatric and cognitive impairments noted on clients' files

Diagnosis	N
Anti-Social Personality Disorder	14
Post-Traumatic Stress Disorder (PTSD)	12
Depression	12
Substance misuse disorder/history of substance use	12
Chronic self-harm/previous suicide attempts	10
Borderline Personality Disorder (BPD)	9
Anxiety	9
Psychosis, including but not limited to schizophrenia	9
Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)	7
Cognitive impairment/intellectual disability	6
Autism Spectrum Disorder (ASD)	5
Psychopathology/Psychopathic Personality Disorder	4
Paranoia/Paranoid Personality Disorder	4
Developmental Trauma Disorder	3

In most of the files (n=28), there was at least one document that indicated that the client's mental health had deteriorated since they had been placed in solitary confinement. Often, the client was observed to exhibit symptoms of psychosis, including auditory and visual hallucinations, paranoia and delusions.

5.3.2.2 Placement in solitary confinement

Of the 30 clients whose files were included in this analysis, 21 had spent time in the DU; 14 had spent time in the MSU, and two had been held under solitary confinement conditions in other units. Often, they had spent time in more than one unit.

The reasons noted in the file for clients' most recent placement in solitary confinement are outlined in Table 5.2 below. It can be seen that the most common reasons for placement in solitary confinement were threats to staff and safety concerns. 'Safety concerns' refers to situations where the client was considered to be at risk of harm from other prisoners; that is, they were placed in solitary confinement for their own protection. Note that for some clients, there was more than one reason for their placement in solitary confinement.

Table 5.2 – Reason for client's most recent placement in solitary confinement

Reason for placement in solitary confinement	N
Threats of violence to staff	13
Safety concerns	8
Self-harming or other mental health concerns	8
Assaulted staff	7
Assaulted other prisoners	6
Produced or was in possession of a weapon	3
Positive drug test	3

The average length of clients' most recent consecutive period in solitary confinement, as at 1 July 2019,²²⁰ was 18 months. The length of the clients' most recent period in solitary confinement varied widely: the shortest period was one month, and the longest period was 114 months (9.5 years) (see Table 5.3 below). Female clients tended to spend less time in solitary confinement: the average length of their most recent consecutive period in solitary confinement was 3.1 months.

Table 5.3 – Length of clients' most recent consecutive period in solitary confinement, as at 1 July 2019

Length of most recent solitary confinement placement	N
1-2 months	10
3-6 months	8
7-9 months	4
10-12 months	3
More than 12 months	5

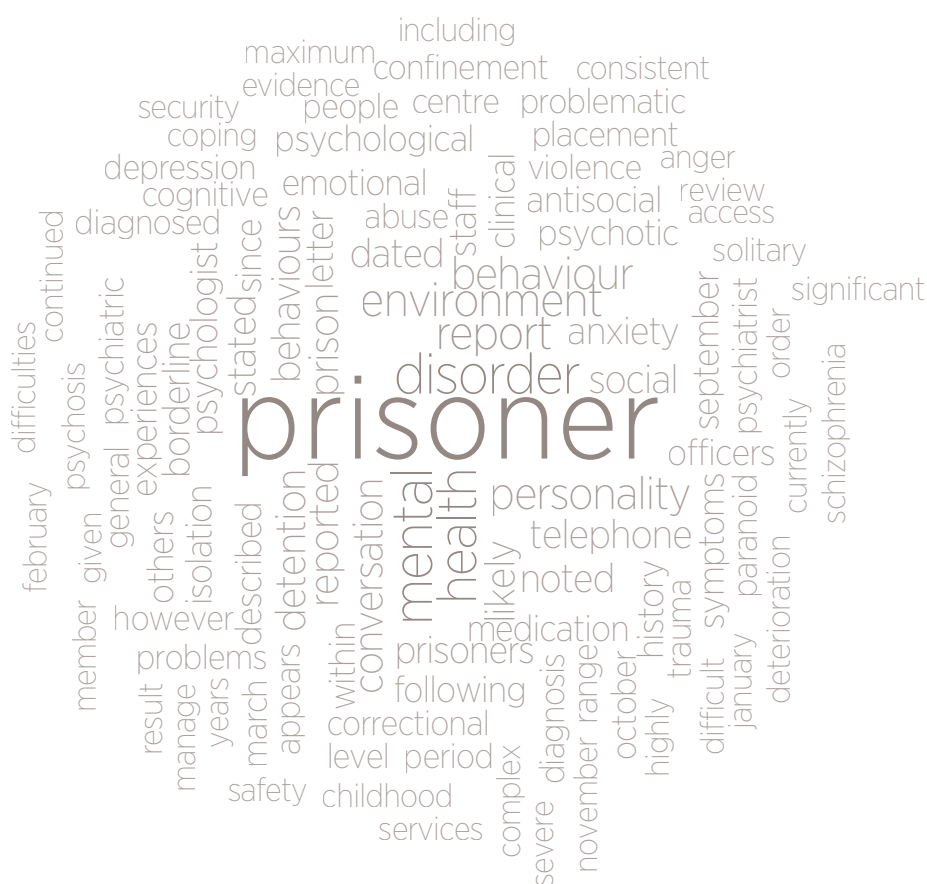
Of the 30 clients whose files were included in this analysis, 20 were noted to have experienced at least one period of solitary confinement prior to their most recent placement. Some prisoners had been released from solitary confinement, or from prison, but had subsequently returned to solitary confinement. For some of these clients, their most recent period in solitary confinement was not their longest. Information was also collected on prisoners' longest known consecutive placement in solitary confinement. This is presented in Table 5.4 below. It can be seen that seven clients (23%) had experienced solitary confinement placements of longer than 12 months. The longest known consecutive period in solitary confinement recorded in the 30 files was 150 months (12.5 years). The overall average was 21 months. The average for the female clients was 3.7 months.

²²⁰ Note that some clients were still in solitary confinement at this time.

Length of longest known period in solitary confinement	N
1-2 months	7
3-6 months	8
7-9 months	3
10-12 months	5
13-24 months	2
More than 24 months	5

The files contained detailed information regarding the circumstances, experiences and conditions of prisoners in solitary confinement. Documents within the files included opinions of lawyers, corrective services staff, judges, psychologists, psychiatrists and official visitors.

Figure 5.1: 100 most frequently used words of five letters or more, generated by NVIVO



5.3.3.1 Behaviours exhibited by clients in solitary confinement

The files contained evidence of seriously disturbed behaviours being exhibited by clients in solitary confinement. The documents contained the following descriptive quotes:

- ‘observed throwing water’
- ‘talking/arguing with himself’
- ‘talking/yelling to things that were not there’
- ‘spent most of the day without any clothing on’
- ‘began to speak in an unfamiliar voice with an accent’
- ‘standing in his cell and staring at the wall’
- ‘threw water and food at officers’
- ‘showered several times during the day’
- ‘manic outbursts of laughter’
- ‘appeared to lick the cell floor’
- ‘sitting on his bed with a towel over his head’
- ‘remained unusually expressionless... with a fixated stare’

In addition to numerous references to clients’ attempting suicide, there were many references to self-harming behaviours:

- ‘started punching the wall and he split his hands open’
- ‘swallowing... batteries’
- ‘bashing his head against walls’
- ‘cell lighting fixture was broken open and used for self-harming’

There were also many references to clients handling their own faeces:

- ‘smearing faeces on the wall’
- ‘excreting faeces on the floor’
- ‘mixed his faeces with water before painting... on the wall’
- ‘I noticed faeces on top of a torn page of a book in the middle of the floor of the cell’
- ‘injected himself with faeces and urine’

Professionals involved in the care and management of clients made a number of suggestions as to why clients in solitary confinement engaged in these behaviours. They said that the lack of activity and lack of social contact could cause prisoners to engage in certain ‘bizarre’ behaviours:

- ‘they were bored and had nothing else to do’
- ‘He is seeking sensory stimulation in an environment that lacks a range of stimuli’
- ‘he will attempt to get his needs met or regulate himself by external mechanism, and primarily through interactions with others, whether these be negative or positive interactions.’
- ‘Unless provided with alternative stimuli he will engage in maladaptive strategies in order to self soothe and distract’

Professionals noted that these behaviours were generally ‘maladaptive ways of getting a basic need for connection and safety met’:

- ‘The smearing of excrement appears to serve both a psychological function (ie. retaliation, sense of control over others) and is also likely a primitive response to negative ruminations within the restricted environment.’
- ‘He has become increasingly reliant on, and prepared to use, self-harm as a strategy for getting his needs met, punishing others and asserting control over his environment.’
- ‘This seemed to be his way of problem solving a difficult situation.’
- ‘... can create a cyclical pattern where prisoners act out to be placed on observations as a way to manage social isolation.’
- ‘he became increasingly agitated in the detention unit and wanted to get out... he grabbed the officer because he was angry.’
- ‘he had not self-harmed prior to his placement in separate confinement’

It was not uncommon for files to contain references to the fact that the ‘most problematic behaviours occur’ when clients are placed in an ‘unpowered cell.’ In non-powered cells, prisoners do not have access to a television, so they have very limited means of distracting or entertaining themselves. Some clients’ files referred to the fact that they did not have access to books, writing materials or any kind of stimulation at all.

5.3.3.2 Harder to reintegrate

Concerns are raised within many of the files that the client was becoming too ‘comfortable’ in solitary confinement and did not want to come out of their cell, even for exercise:

- ‘he [seems] comfortable in the MSU’
- ‘prison is too loud, chaotic, disorganised and things are much calmer and easier in the MSU’
- ‘he has no motivation to access his entitlement to exercise’
- ‘he is freaking out about being released from the MSU’

Throughout many of the clients’ files, there was evidence of professionals’ attempts to effectuate a transfer out of solitary confinement, or at least to improve the conditions under which they were living. These recommendations were often driven by a concern that the client was ‘likely to deteriorate further the longer [he/she] remains,’ and that this would make it more difficult to release them from isolation. Comments included:

- ‘This prisoner is **highly institutionalised** and demonstrates many of the symptoms associated with being housed in highly restrictive environments... sound sensitivity, hyperarousal, anxiety, panic attacks, obsessive thoughts content, communication issues, paranoia, violent fantasies, hopelessness, lethargy, reduced sleep and day sleeping.’
- ‘[his/her] capacity to tolerate psychological distress has deteriorated over the years, and [he/she] is becoming **increasingly reliant upon self-harm as a strategy to regulate [his/her] emotional state.**’
- ‘I would recommend that consideration be given to lifting [his] MSO, and efforts be made to identify a viable longer term strategy for managing his problematic behaviour within the regular prison context.’



© 2017 Daniel Soekov for Human Rights Watch

*'[his] placement in the MSU is hindering his ability to manage his behaviour and **only serves to deepen his behavioural issues** that resulted in his initial placement in the MSU.'*

In some of the files, there was an acknowledgement that isolation was **causing psychotic symptoms** in the client:

- 'I no longer see the MSU as facilitating meaningful rehabilitative progress in this prisoner. This progress is especially remiss with respect to the damage it has caused and will continue to cause his mental health and stability.'
- '[paranoia, delusions, depression] are problems that are a product of [his/her] environment and **unlikely to respond to any pharmacological or therapeutic approach** I can think of.'

'the sensory and social deprivation of the MSU provides fertile ground for his anxiety and pseudo-psychotic symptoms... He is likely to deteriorate further the longer he remains.'

5.3.3.3 What happens on release

In three of the files, there was a reference to the person being released from solitary confinement into the general prison population, despite the concerns raised about their well-being and the risk they posed. For two of these clients, their reintegration was a success. They were described as having ‘settled a little’, experiencing ‘an overall improvement in [his/her] mental health’ and exhibiting a ‘steady improvement in behaviour’. This is despite the fact that both of them had spent many months in solitary confinement. The other client was returned to solitary confinement within a ‘brief period’ after an assault on a staff member.

SUMMARY

Many prisoners in Queensland are subjected to extended periods of solitary confinement. Many experience solitary confinement for more than 12 months at a time.

Prisoners’ advocates report that most of their clients in solitary confinement have a mental illness, and that placement in solitary confinement can itself cause a prisoner to develop psychotic symptoms.

When placed in solitary confinement, prisoners often display disordered behaviours, particularly ‘bronzing’ (handling their faeces) and serious acts of self-harm. Information from legal files suggests that these behaviours are a coping strategy to deal with the high level of sensory and social deprivation they experience.

In addition to intense boredom and profound loneliness, prisoners in solitary confinement experience distress as a result of not being able to see the sky, walk on grass, or be in nature.

Lawyers and prisoners’ advocates are concerned about the lack of oversight of decisions to place prisoners in solitary confinement, as well as the making of consecutive orders. They recommend that solitary confinement be abolished, but if it remains, they suggest that a higher level of scrutiny be applied to decisions to place, and hold, prisoners in solitary confinement, and that this scrutiny be exercised by judges. They argue that a legal limit of no more than 14 days should be introduced for solitary confinement placements, and that prisoners in solitary confinement should be provided with access to nature, more social opportunities, and increased means of distraction to preserve their mental health.

6. Solitary confinement and the Queensland Human Rights Act

6.1 Queensland's Human Rights Act

In March 2019, the *Human Rights Act 2019* (Qld) was enacted.

This is Australia's third domestic human rights Act, following the *Human Rights Act 2004* (ACT) and the *Charter of Human Rights and Responsibilities Act 2006* (Vic). It includes similar rights to those in the ACT and Victorian Acts, and is substantially based on the *International Covenant on Civil and Political Rights*.²²¹ It recognises 'the inherent dignity and worth of all human beings'²²² and acknowledges the distinct cultural rights of Aboriginal and Torres Strait Islander peoples,²²³ including the right to self-determination.²²⁴

By virtue of ratifying several human rights based treaties, Australia has accepted international legal obligations.²²⁵ However, the treaties must be directly incorporated into domestic legislation to become a direct source of individual rights,²²⁶ so their capacity to influence law, policy and practice is limited. The *Human Rights Act 2019* (Qld) creates new legal obligations in respect of administrative decision-making and statutory interpretation in Queensland.

The included rights that are most relevant to the use of solitary confinement in Queensland prisons are:

- The right to humane treatment when deprived of liberty (section 30);
- The right to protection from torture, and cruel, inhuman or degrading treatment (section 17);
- The right to liberty and security of person (section 29);
- The right to life (section 16); and
- The right to privacy and reputation (section 25).

Of course, the manner in which these rights will be interpreted and applied is not yet known. Some guidance is offered by the Victorian and ACT case law, and international case law from courts in New Zealand, Canada, the United Kingdom (UK) and the European Court of Human Rights. These decisions are important because the *Human Rights Act 2019* (Qld) specifies that international law and the judgments of domestic, foreign and international courts and tribunals relevant to a human right may be considered in interpreting its statutory provisions.²²⁷ In this chapter, we examine how the new rights legislation in Queensland could influence – and perhaps operate to limit – the practice of solitary confinement.

²²¹ Explanatory Note, Human Rights Bill 2018 (Qld) 2.

²²² *Human Rights Act 2019* (Qld) Preamble para 1 ('Human Rights Act').

²²³ *Ibid* s 28(1).

²²⁴ *Ibid* Preamble para 6.

²²⁵ See for example *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 286–7; *Dietrich v The Queen* (1992) 177 CLR 292, 305–6.

²²⁶ *Chow Hung Ching v The King* (1948) 77 CLR 449, 478; *Minister of State for Immigration and Ethnic Affairs v Teoh* (1995) 183 CLR 273, 286–7.

²²⁷ *Human Rights Act 2019* (Qld) s 48(3).

6.2 Humane Treatment when Deprived of Liberty

Section 30(1) of the *Human Rights Act 2019* (Qld) states that: ‘All persons deprived of liberty must be treated with humanity and with respect for the inherent dignity of the human person.’ Human rights legislation in Victoria,²²⁸ the ACT²²⁹ and New Zealand²³⁰ includes the same provision.

6.2.1 Interpretation of the right

The case law on the right to be treated humanely when deprived of liberty does not always distinguish between ‘humanity’, ‘humane treatment’ and ‘dignity’. Judgments often refer to a breach of the provision in its entirety without considering the individual limbs.

In *Taunoa & Ors v The Attorney-General & Anor* (*‘Taunoa v A-G’*), the Supreme Court of New Zealand held that the right to humane treatment when deprived of liberty prohibits:

*‘conduct that lacks humanity but falls short of being cruel; which demeans the person, but not to an extent which is degrading; or which is clearly excessive in the circumstances, but not grossly so.’*²³¹

The treatment must be considered ‘unacceptable’ according to the standards of ‘civilised society’²³² but it need not be considered ‘outrageous’.²³³ Therefore, the threshold is less than what is necessary for ‘cruel’ treatment, which requires an additional ‘level of harshness’.²³⁴

In *Taunoa v A-G*, Elias CJ said that the requirement that prisoners be treated with humanity imposes a positive duty of humane treatment, and that treatment that falls ‘well below standards that befits a human being’ will deny such humanity.²³⁵ Her Honour referenced the dictionary definition of ‘humanity’ as ‘the quality, condition or fact of being human’,²³⁶ and said that **humanity will be denied by ‘a deprivation of basic human needs, including personal dignity and physical and mental integrity.’**²³⁷

In relation to the requirement to treat persons in detention with ‘dignity’, the Supreme Court of Victoria accepted in *Castles v Secretary to the Department of Justice* (*‘Castles’*) that prisoners should not be subjected to ‘hardship or constraint other than the hardship or constraint that results from the deprivation of liberty’ and that **access to health care is a ‘fundamental aspect of the right to dignity.’**²³⁸ The European Court of Human Rights has similarly held that the right to respect for human dignity requires the prevention of distress or hardship, ‘of an intensity exceeding the unavoidable level of suffering inherent in detention.’²³⁹ In *Taunoa v A-G*, the court observed that **the infliction of disproportionate, severe or arbitrary punishment is likely to ‘seriously diminish human dignity’.**²⁴⁰

Importantly, the right to humane treatment when deprived of liberty applies despite a person’s status as a prisoner and despite the nature of the person’s own behaviour in prison.²⁴¹ In *Castles*, Emerton J of the Victorian Supreme Court held that respecting the right **‘requires the provision of facilities, goods, services and conditions necessary for the realisation of the standard of health enjoyed by other members of the community.’**²⁴² Also, to establish a breach of this right, it is not necessary to prove intentional infliction of harm or conscious, reckless indifference to causing harm.²⁴³

²²⁸ *Charter of Human Rights and Responsibilities 2006* (Vic) s 22(1).

²²⁹ *Human Rights Act 2004* (ACT) s 19(1).

²³⁰ *New Zealand Bill of Rights Act 1990* (NZ) s 23(5).

²³¹ *Taunoa v A-G* [2008] 1 NZLR 429, 501 [177], 544 [340].

²³² *Ibid* 476 [94], 500 [170], 529 [285], 544 [339]–[340].

²³³ *Ibid* 500 [170], 529 [285], 544 [339]–[340].

²³⁴ *Ibid* 548 [362].

²³⁵ *Ibid* 448 [7], 477 [95].

²³⁶ *Ibid* 471 [79].

²³⁷ *Ibid* 471 [80].

²³⁸ *Castles v Secretary to the Department of Justice* (2010) 28 VR 141, 169 [108] (*‘Castles’*).

²³⁹ *Kudła v Poland* (European Court of Human Rights, Grand Chamber, Application No 30210/96, 26 October 2000) [94]; *Ilascu and Ors v Moldova and Russia* (European Court of Human Rights, Grand Chamber, Application No 48787/99, 8 July 2004) [428].

²⁴⁰ *Taunoa v A-G* [2008] 1 NZLR 429, 475 [91].

²⁴¹ *Ibid* 454 [27].

²⁴² *Castles* (2010) 28 VR 141, 173 [127].

²⁴³ *Vogel v Attorney-General* [2014] NZAR 67, [69] (*‘Vogel’*).

6.2.2. Application to solitary confinement

In *Taunoa v A-G*, the Supreme Court of New Zealand considered a 'Behaviour Management Regime' ('BMR') which subjected prisoners to a highly controlled environment.²⁴⁴ Under its most restrictive conditions, prisoners were locked down in their cells for 23 hours a day, prohibited from associating with other prisoners and prohibited from engaging in hobbies and cultural activities.²⁴⁵ The Supreme Court upheld the decision of the New Zealand Court of Appeal that the BMR breached the right to humane treatment when deprived of liberty.²⁴⁶

In evaluating the general conditions of the BMR, the Court of Appeal affirmed the trial judge's criticism of the fact that **windows were closed** for extended periods of time to prevent the use of 'string lines'. Considering the already restrictive conditions, this factor was deemed relevant because 'any loss of an attractive feature of their prison environment would be significant for them.'²⁴⁷ The court also emphasised the **lack of natural light**²⁴⁸ and noted that inadequate opportunities were provided to the prisoners for exercise.²⁴⁹ The court further noted the failure to launder prisoners' clothing and bedding each week,²⁵⁰ the **limited telephone access**,²⁵¹ and the failure to provide prisoners with modesty screens which resulted in a lack of reasonable privacy.²⁵² Justice McGrath described the regime as, 'deplorable, particularly because it involved persons who were especially vulnerable to mistreatment.'²⁵³

In *Certain Children v Minister for Families and Children & Ors (No 2)*,²⁵⁴ the Supreme Court of Victoria considered an executive order that provided for young offenders to be isolated in a maximum security unit of an adult prison after the youth detention centre became uninhabitable due to damage. Justice Dixon accepted medical evidence that this environment had a negative psychological impact on the young prisoners, 'demoralising and dehumanising' them.²⁵⁵ His Honour concluded that their rights were breached as a result of **extensive isolation which deprived them of fresh air, natural light, mental stimulation and privacy**.²⁵⁶

A lack of mental stimulation may in itself may amount to a breach of the right to be treated with humanity in detention. In *Toia v Auckland Prison*²⁵⁷ the New Zealand Court of Appeal accepted that the **right would be breached 'were a prisoner forced to vegetate.'** In *Murray v The Netherlands*,²⁵⁸ the European Court of Human Rights alluded to an obligation on the State to offer the possibility of prisoner rehabilitation to ensure human dignity. And in *Eastman v Chief Executive of the Department of Justice and Community Safety*, Refshauge J of the Supreme Court of the ACT concluded that 'opportunities for work, especially in the context of rehabilitation and access to medical treatment and facilities in a timely basis' formed 'part of' the right.²⁵⁹

The particular vulnerabilities of certain prisoners are relevant when determining whether the prisoner's right to humane treatment has been breached. In *Taunoa v A-G*, the fact that the psychiatric vulnerability of prisoners had not been adequately assessed prior to them being subjected to BMR, and that the subsequent monitoring of their mental health was inadequate, were relevant in finding a breach of the right.²⁶⁰

244 *A-G v Taunoa* [2006] 2 NZLR 457 [225], 462 [11].

245 *Ibid* 463 [12].

246 *Taunoa v A-G* [2008] 1 NZLR 429.

247 *A-G v Taunoa* [2006] 2 NZLR 457 [225], 480 [96]-[97].

248 *Ibid* 481 [103].

249 *Ibid* 482 [108].

250 *Ibid* 483 [115]-[118].

251 *Ibid* 486 [130].

252 *Ibid* 480 [95]. See also *Toia v Auckland Prison* [2015] NZCA 624, [66].

253 *Taunoa v A-G* [2008] 1 NZLR 429, 548 [362].

254 *Certain Children v Minister for Families and Children & Ors (No 2)* (2017) 52 VR 441, 566 [425] ('*Certain Children*').

255 *Certain Children* (2017) 52 VR 441, 566 [424].

256 *Ibid*.

257 *Toia v Auckland Prison* [2015] NZCA 624, [49] ('*Toia*').

258 *Murray v The Netherlands* (European Court of Human Rights, Grand Chamber, Application No 10511/10, 26 April 2016) [104].

259 *Eastman v Chief Executive of the Department of Justice and Community Safety* (2010) 172 ACTR 32, [111].

260 *Taunoa v A-G* [2008] 1 NZLR 429, 467 [67]; *A-G v Taunoa* [2006] 2 NZLR 457 [225], 478 [84]-[87].

In *R v Kent*, the Supreme Court of Victoria reasoned that:

*placing people 'in a custodial environment which is able to be foreseen as likely to result in their suffering a major psychiatric illness can hardly be said to be treating them with humanity.'*²⁶¹

In *John Alfred Vogel v Attorney-General*, holding a prisoner in confinement for a period that exceeded the statutory maximum, at the prisoner's own request, was deemed to breach the right to be treated with humanity.²⁶² This was because Department of Corrections had knowledge of Mr Vogel's mental health issues and this 'should have underlined the potentially harmful effects of an excessive period of cell confinement on his mental well-being.'²⁶³

6.3 Protection from Torture and Cruel, Inhuman or Degrading Treatment

Section 17 of the *Human Rights Act 2019* (Qld) states that a person must not be:

- a. subjected to torture; or
- b. treated or punished in a cruel, inhuman or degrading way; or
- c. subjected to medical or scientific experimentation or treatment without the person's full, free and informed consent.

The *Charter of Human Rights and Responsibilities 2006* (Vic)²⁶⁴ and the *Human Rights Act 2004* (ACT)²⁶⁵ also include this provision. Similar provisions exist in other jurisdictions:

- Section 9 of the *New Zealand Bill of Rights Act 1990* – this section does not refer to 'inhuman'; instead it prohibits 'disproportionately severe treatment or punishment.'
- Article 3 of the European Convention on Human Rights – this provision omits the word 'cruel'.
- Section 12 of the *Canadian Charter* – this section prohibits 'cruel and unusual treatment or punishment'.
- Article 7 of the *International Covenant on Civil and Political Rights*.

The *UN Convention Against Torture* provides that each State Party 'shall take effective legislative, administrative, judicial or other measures to prevent acts of torture in any territory under its jurisdiction.'²⁶⁶ Torture is defined as 'any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity.'²⁶⁷ **Australia ratified the Optional Protocol to the Convention Against Torture (OPCAT) in December 2017.**

6.3.1 Interpretation of the right

The New Zealand Supreme Court and the European Court of Human Rights have held that torture 'involves the *deliberate* infliction of severe physical or mental suffering for a particular purpose, such as obtaining information.'²⁶⁸ However, cruel, inhuman and degrading treatment does not require deliberate intent.²⁶⁹

²⁶¹ *R v Kent* [2009] VSC 375, [32].

²⁶² *John Alfred Vogel v Attorney-General* [2014] NZSC 5.

²⁶³ *Vogel* [2014] NZAR 67, 84 [72].

²⁶⁴ *Charter of Human Rights and Responsibilities 2006* (Vic) s 10.

²⁶⁵ *Human Rights Act 2004* (ACT) s 10.

²⁶⁶ *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment of Punishment*, opened for signature on 10 December 1984, 1465 UNTS 86 (entered into force 26 June 1987) art 2(1).

²⁶⁷ *Ibid* art 1.

²⁶⁸ *Taunoa v A-G* [2008] 1 NZLR 429, 500 [171] (emphasis added).

²⁶⁹ *Ibid* 472 [81], 475-6 [91]-[94], 519 [247].

The threshold for cruelty is treatment that would ‘shock community conscience’;²⁷⁰ ‘merely excessive or disproportionate treatment or punishment is not enough.’²⁷¹ In the Canadian case of *R v Ferguson*, McLachlin CJ indicated that the treatment would have to be ‘so disproportionate that Canadians would find it abhorrent or intolerable.’²⁷² Of course, whether or not the treatment would shock community conscience ‘cannot be divorced from the inmate’s background’ or the ‘institutional situation’.²⁷³

As noted above in respect of the right of persons in detention to be treated humanely, inhuman treatment refers to that which is ‘not fitting for human beings’²⁷⁴ or as McGrath J said in *Taunoa v A-G*, ‘treating a person as less than human.’²⁷⁵ The European Court of Human Rights appears to equate inhuman treatment with loss of human dignity. For treatment of an individual to be considered ‘inhuman’ or ‘degrading’, the individual must have suffered or been humiliated beyond ‘that inevitable element of suffering or humiliation connected with a given form of legitimate treatment or punishment.’²⁷⁶ For example, in *Mathew v The Netherlands*,²⁷⁷ the European Court of Human Rights suggested that the use of unnecessary physical force on a prisoner will diminish their human dignity.

Assessing whether or not treatment is ‘inhuman’ will require an assessment of how the individual applicant was personally affected.²⁷⁸ **When conditions of detention cause considerable mental suffering, human dignity is likely to be compromised.**²⁷⁹ Treatment has been deemed ‘inhuman’ because it was premeditated, lasted for consecutive hours and led to either bodily injury or **intense physical and mental deterioration.**²⁸⁰ The European Court of Human Rights has held that:

*‘complete sensory isolation, coupled with total social isolation, can destroy the personality and constitutes a form of inhuman treatment.’*²⁸¹

The European Court of Human Rights also stated that ‘a lack of appropriate medical care and, more generally, detention under inappropriate conditions of a person who is ill may in principle amount to treatment contrary to Article 3.’²⁸² In assessing whether a prisoner’s detention is compatible with their state of health, the European Court of Human Rights has considered the prisoner’s condition, the quality of care provided to them and, whether the prisoner should continue to be detained in light of their state of health to be relevant.²⁸³

Treatment will be considered ‘degrading’ if it arouses ‘feelings of fear, anguish and inferiority capable of humiliating and debasing.’²⁸⁴ Matters to be considered include whether the objective of the treatment ‘is to humiliate and debase the person concerned’ and whether, in consequence, **the individual’s personality has been adversely affected.**²⁸⁵

6.3.2 Application to solitary confinement

The UN General Assembly has noted that solitary confinement may amount to torture under the Convention Against Torture under certain circumstances, taking into account its strictness, duration and purpose.²⁸⁶

²⁷⁰ *A-G v Taunoa* [2006] 2 NZLR 457 [225], 503 [225]; *Munoz* (2004) ABQB 769, [78].

²⁷¹ *BCCLA v Canada* [2018] BCSC, [530].

²⁷² *R v Ferguson* [2008] 1 SCR 96, [14].

²⁷³ *Munoz* (2004) ABQB 769, [78].

²⁷⁴ *Taunoa v A-G* [2008] 1 NZLR 429, 471 [80].

²⁷⁵ *Ibid* 531 [297].

²⁷⁶ *Jalloh v Germany* (European Court of Human Rights, Grand Chamber, Application No 54810/00, 11 July 2006) [68]; *Enea v Italy* (European Court of Human Rights, Grand Chamber, Application No 74912/01, 17 September 2009) [56] (*Enea v Italy*). See also *T. Gómez de Voituret v Uruguay*, CCPR, Commc’n No. 109/1981, at 168, UN Doc A/39/40 (Apr. 10, 1984).

²⁷⁷ *Mathew v The Netherlands* (European Court of Human Rights, Application No 24919/03, 29 September 2005) [177] (*Mathew v Netherlands*).

²⁷⁸ *Lorse & Ors v The Netherlands* (European Court of Human Rights, Application No 52750/99, 4 February 2003) [65] (*Lorse v Netherlands*).

²⁷⁹ *Poltoratskiy v Ukraine* (European Court of Human Rights, Application No 38812/97, 29 April 2003) [146].

²⁸⁰ *Kalashnikov v Russia* (European Court of Human Rights, Application No 47095/99, 15 July 2002) [95].

²⁸¹ *Ahmad & Ors v The United Kingdom* (European Court of Human Rights, Application No 2402/07, 10 April 2012) [206].

²⁸² *Enea v Italy* (European Court of Human Rights, Grand Chamber, Application No 74912/01, 17 September 2009) [57].

²⁸³ *Keenan v United Kingdom* (European Court of Human Rights, Application No 27229/95, 3 April 2001) [116]; *Farbtuhs v Latvia* (European Court of Human Rights, Application No 4672/02, 2 December 2004) [53]; *Enea v Italy* (European Court of Human Rights, Application No 74912/01, 17 September 2009) [59].

²⁸⁴ *Kudla v Poland* (European Court of Human Rights, Grand Chamber, Application No 3021/96, 26 October 2000) [92] (*Kudla v Poland*).

²⁸⁵ *Raninen v Finland* (European Court of Human Rights, Application No 152/1996/771/972, 16 December 1997) [55]; *Kalashnikov v Russia* (European Court of Human Rights, Application No 47095/99, 15 July 2002) [95].

²⁸⁶ UN General Assembly, *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, GA Res 68/156, UN Doc A/RES/68/156 (adopted on 18 December 2013) [28].

The New Zealand Supreme Court has held that cell confinement in itself will not constitute a breach of section 9 of the New Zealand *Bill of Rights Act 1990*.²⁸⁷ In *Ramirez-Sanchez v France*,²⁸⁸ the European Court of Human Rights declared that, despite spending eight years in solitary confinement, there was no breach of the prisoner's rights under article 3 of the European Convention on Human Rights.

However, the placement of certain restrictions on prisoners for an extended period of time may amount to inhuman or degrading treatment if it meets the 'minimum threshold of severity'.²⁸⁹ There is no 'precise length of time' at which this threshold is reached,²⁹⁰ rather severity is relative and depends upon all circumstances including the reasons for segregation, treatment duration,²⁹¹ the general conditions, and the physical and mental impacts on the individual.²⁹²

The European Court of Human Rights has considered the following circumstances to be relevant:

- the presence of premeditation;²⁹³
- an intention 'to break the individual's resistance or will';²⁹⁴
- an intention 'to humiliate or debase' an individual or, if intention is absent, the fact the measure was **implemented in a manner which caused 'fear, anguish or feelings of inferiority'**;²⁹⁵
- whether there was proper justification for the imposed measure²⁹⁶ or whether it was arbitrary in nature;²⁹⁷ and
- whether the degree of distress or hardship exceeded a level that was unavoidable within the detention context.²⁹⁸

6.4 Life, Liberty and Security of Person

Section 16 of the *Human Rights Act 2019* (Qld) states that: 'Every person has the right to life and has the right not to be arbitrarily deprived of life.' Section 29(1) states that: 'Every person has the right to liberty and security.' Section 29(3) states that: 'A person must not be deprived of the person's liberty except on grounds, and in accordance with procedures, established by law.'

The New Zealand *Bill of Rights Act*,²⁹⁹ the *Canadian Charter*³⁰⁰ and European Convention on Human Rights³⁰¹ each contain parallel provisions.

6.4.1 Interpretation of the rights

An action will engage the right to life when it involves death or an increased risk of death.³⁰²

The right to security of the person serves to protect the psychological integrity of that person.³⁰³ This right will be breached by State interference with a person's psychological

²⁸⁷ *Vogel* [2014] NZAR 67, 83 [66].

²⁸⁸ *Ramirez-Sanchez v France* (European Court of Human Rights, Grand Chamber, Application No 59450/00, 4 July 2006) [146]. See also *Shahid v Scottish Ministers* [2016] AC 429, 449 [37]; *Lorse v The Netherlands* (European Court of Human Rights, Application No 52750/99, 4 February 2003) [77].

²⁸⁹ *Enea v Italy* (European Court of Human Rights, Grand Chamber, Application No 74912/01, 17 September 2009) [64].

²⁹⁰ *Enea v Italy* (European Court of Human Rights, Grand Chamber, Application No 74912/01, 17 September 2009) [64].

²⁹¹ *Wu v Attorney General of Canada* [2006] BCSC 44, [4]-[5]; *Bacon v Surrey Pretrial Services Centre (Warden)* [2010] BCSC 805, [327].

²⁹² *Kudla v Poland* (European Court of Human Rights, Grand Chamber, Application No 3021/96, 26 October 2000) [91]; *Enea v Italy* (European Court of Human Rights, Grand Chamber, Application No 74912/01, 17 September 2009) [55]; *BCCLA v Canada* [2018] BCSC 62, [531].

²⁹³ *Ireland v The United Kingdom* (European Court of Human Rights, Application No 5310/71, 18 January 1978) [167].

²⁹⁴ *Ilascu and Ors v Moldova and Russia* (European Court of Human Rights, Grand Chamber, Application No 48787/99, 8 July 2004) [446].

²⁹⁵ *Peers v Greece* (European Court of Human Rights, Application No 28524/95, 19 April 2001) [75]; *Jalloh v Germany* (European Court of Human Rights, Grand Chamber, Application No 54810/00, 11 July 2006) [82].

²⁹⁶ *Iwarczuk v Poland* (European Court of Human Rights, Fourth Section, Application No 25196/94, 15 November 2001) [58]; *Van der Ven v The Netherlands* (European Court of Human Rights, First Section, Application No 50901/99, 4 February 2003) [61]-[62].

²⁹⁷ *Yankov v Bulgaria* (European Court of Human Rights, Application No 39084/97, 11 December 2003) [117].

²⁹⁸ *Mathew v the Netherlands* (European Court of Human Rights, Application No 24919/03, 29 September 2005) [197]-[205].

²⁹⁹ *Bill of Rights Act 1990* (NZ) ss 8, 22.

³⁰⁰ *Canada Act 1982* (UK) c 11, Sch B Pt 1 s 7 ('*Canadian Charter of Rights and Freedoms*').

³⁰¹ *Convention for the Protection of Human Rights and Fundamental Freedoms*, opened for signature 4 November 1950, 213 UNTS 221 (entered into force 3 September 1953) arts 2, 5 ('*European Convention on Human Rights*').

³⁰² *Carter v Attorney General* [2015] 1 SCR 331, 367 [62].

³⁰³ *BCCLA v Canada* [2018] BCSC 62, [275].

integrity to a level ‘greater than ordinary stress or anxiety’ but need not reach the level of ‘nervous shock or psychiatric illness.’³⁰⁴

Section 29(7) of the *Human Rights Act 2019* (Qld) states that ‘A person deprived of liberty by arrest or detention is entitled to apply to a court for a declaration or order regarding the lawfulness of the person’s detention.’ If the court finds the detention is unlawful, then it must order the release of the person.³⁰⁵ Equivalent provisions in the New Zealand *Bill of Rights Act* and the *Canadian Charter* explicitly refer to the right to apply for a writ of *habeas corpus*.³⁰⁶ In Australia, it has been held that a writ of *habeas corpus* will not be available to transfer a person from one (more harsh form) of detention into another,³⁰⁷ however in Canada, *habeas corpus* has been used in this manner.³⁰⁸

6.4.2 Application to solitary confinement

The placement of a prisoner in solitary confinement constitutes a substantial deprivation of liberty.³⁰⁹ In *British Columbia Civil Liberties Association v Canada (Attorney-General)*³¹⁰ the State conceded that placing a prisoner in segregation deprives that prisoner of their ‘residual liberty interest’, engaging the right to liberty and security of person under section 7 of the *Canadian Charter*. The evidence presented to the court in that case established that segregation causes serious psychological suffering and the court held that mental health monitoring did not address its deleterious impacts.³¹¹ There was also evidence of a lack of confidentiality and privacy when prisoners engaged with psychologists, as well as limited interactions and inadequate assessments through cell doors.³¹² Overall, the Supreme Court of British Columbia held that the safeguards aimed at preventing psychiatric harm to segregated prisoners were inadequate.³¹³

The court also held that segregation increases the risk of self-harm and suicide among prisoners, and thus the right to life, liberty and security of person was engaged.³¹⁴ The court considered the case of Ashley Smith, a 19-year-old female who committed suicide while in a segregated cell.³¹⁵ The Office of the Correctional Investigator took the view that ‘Ms Smith would be alive today if she had not remained on segregation status and if she had received appropriate care.’³¹⁶ In that case, a sufficient causal connection between Ms Smith’s placement in segregation and her suicide was established.³¹⁷

In Canada, a prisoner deprived of residual liberty by way of transfer to a more restrictive setting may apply for a writ of *habeas corpus*.³¹⁸ Succeeding requires proof of an unlawful deprivation of liberty.³¹⁹ The question of what is unlawful turns on whether the decision adhered to requirements of procedural fairness and whether it was arbitrary.³²⁰ The applicants in *Hamm v Attorney General of Canada (Edmonton Institution)*³²¹ succeeded in their applications for a writ of *habeas corpus* and this ultimately resulted in their transfer from segregation back into the general population.

304 *New Brunswick (Minister of Health and Community Services) v G. (J.)* [1999] 3 SCR 46, [60]; *Corporation of CCLA v The Queen* [2017] ONSC 7491, [98]; *BCCLA v Canada* [2018] BCSC 62, [275].

305 *Human Rights Act 2019* (Qld) s 29(7)(b).

306 *Bill of Rights Act 1990* (NZ) s 23(1)(c); *Canadian Charter of Rights and Freedoms* s 10(c).

307 *Certain Children* (2017) 52 VR 441, 285–287.

308 *R v Miller* [1985] 2 SCR 613, 637; *Gogan v Attorney General of Canada* [2017] ABQB 609, [43]–[51]; *Munoz* (2004) ABQB 769, [63]; *May v Ferndale* [2005] 3 SCR 809, [74]; *Gogan v Attorney General of Canada* [2017] ABQB 609, [43]–[51].

309 *Corporation of the CCLA v The Queen* [2017] ONSC 7491, [86].

310 *BCCLA v Canada* [2018] BCSC 62, [261], [310].

311 *Ibid* [285].

312 *Ibid* [292].

313 *Ibid* [306].

314 *Ibid* [265], [274].

315 *Ibid* [270].

316 *Ibid* [270].

317 *Ibid* [271].

318 *R v Miller* [1985] 2 SCR 613, 637; *Gogan v Attorney General of Canada* [2017] ABQB 609, [43]–[51]; *Munoz* (2004) ABQB 769, [63]; *May v Ferndale* [2005] 3 SCR 809, [74]; *Gogan v Attorney General of Canada* [2017] ABQB 609, [43]–[51].

319 *May v Ferndale* [2005] 3 SCR 809, [74].

320 *R v Ross* [2011] 369 Sask R 146, [15]–[16].

321 *Hamm v Attorney General of Canada (Edmonton Institution)* (2016) 41 Alta LR (6th) 29.

The applicants had been placed in segregation for ‘investigation purposes’ following a tip-off from confidential informants that the applicants were planning to attack correctional officers. However, the court was not satisfied that the evidence relied upon was reliable and credible.³²² The court noted that **in light of the severe consequences of segregation, a high level of procedural fairness was required in the decision-making process.**³²³ Although the formalities behind the initial placement in segregation met the legislative requirements, the decision was deemed unreasonable.³²⁴ It was also held that procedural fairness was denied to the applicants at their segregation review because the prisoners were not informed of the reason for their segregation.³²⁵ The Court further noted that the prisoners’ mental health and Indigeneity contributed to the placement in solitary being unreasonable.³²⁶

6.5 Privacy and Reputation

Section 25(a) of the *Human Rights Act 2019* (Qld) states that: ‘A person has the right not to have the person’s privacy, family, home or correspondence unlawfully or arbitrarily interfered with.’ Similar rights are protected under the *Human Rights Act 2004* (ACT),³²⁷ the *Charter of Human Rights and Responsibilities 2006* (Vic),³²⁸ *International Covenant on Civil and Political Rights*,³²⁹ and the European Convention on Human Rights.³³⁰

By its nature, any lawful detention entails a limitation on private and family life.³³¹ Yet, in *AB v Secretary of State for Justice*³³² it was held by the European Court of Human Rights that the denial of contact with family members to a young prisoner, and their separation from other inmates, could engage this right. The European Court of Human Rights has also indicated that prison institutions **should assist prisoners in maintaining contact with family.**³³³

Any interference with this right will be justified if it is deemed to be necessary and proportionate having regard to the circumstances.³³⁴ For the interference to be considered necessary, it must relate to a pressing social need and remain proportionate to the aim pursued.³³⁵ One objective of segregation is to reduce the risk that the prisoner will form or associate with criminal organisations.³³⁶ In *Enea v Italy*, the European Court of Human Rights placed particular emphasis on this in its decision, and noted that family visits could present a risk that orders would be conveyed to the outside.³³⁷ On this basis, the court accepted that restricting visits was a legitimate and proportionate means of achieving the objective of reducing organised crime and did not go beyond what ‘was necessary in a democratic society in the interests of public safety and for the prevention of disorder and crime.’³³⁸ In this case, the court held that a fair balance had been struck between the prisoner’s rights and aims of the regime in question.³³⁹ In *Lorse v The Netherlands*, restricting contact with family to avoid the transfer of items which may assist an attempt to escape was also deemed reasonable in the circumstances.³⁴⁰

6.6 Limitations on rights

Section 13 of the *Human Rights Act 2019* (Qld) states that human rights may be subject to reasonable limits, but only those that can be ‘demonstrably justified in a free and democratic society based on human dignity, equality and freedom.’ In deciding whether a limit is

³²² Ibid [81].

³²³ Ibid [66].

³²⁴ Ibid [70].

³²⁵ Ibid [73].

³²⁶ Ibid [90].

³²⁷ *Human Rights Act 2004* (ACT) s12.

³²⁸ *Charter of Human Rights and Responsibilities 2006* (Vic) s13.

³²⁹ *International Covenant on Civil and Political Rights* art 17.

³³⁰ *European Convention on Human Rights* art 8.

³³¹ *Messina v Italy* (No. 2) (European Court of Human Rights, Application No 25498/94, 28 September 2000) [61].

³³² *AB v Secretary of State for Justice* [2019] EWCA 9, [55].

³³³ *Messina v Italy* (No. 2) (European Court of Human Rights, Application No 25498/94, 28 September 2000) [61].

³³⁴ *AB v Secretary of State for Justice* [2019] EWCA 9, [70], [161].

³³⁵ *McLeod v The United Kingdom* (European Court of Human Rights, Application No 24755/94, 23 September 1998) [52]; *Messina v Italy* (No. 2) (European Court of Human Rights, Application No 25498/94, 28 September 2000) [65].

³³⁶ *Enea v Italy* (European Court of Human Rights, Grand Chamber, Application No 74912/01, 17 September 2009) [125].

³³⁷ Ibid [126].

³³⁸ Ibid [131].

³³⁹ *Messina v Italy* (No. 2) (European Court of Human Rights, Application No 25498/94, 28 September 2000) [73].

³⁴⁰ *Lorse v The Netherlands* (European Court of Human Rights, Application No 52750/99, 4 February 2003) [86].

reasonable and justifiable, the following factors are considered relevant: the nature of the right, the nature of the purpose of the limitation, the relationship between the limitation and its purpose, the importance of the limitation and, whether there are any less restrictive means to achieve the purpose.³⁴¹

Section 1 of the *Canadian Charter* similarly permits, 'such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.'³⁴² To justify limiting rights, a law must be proportional to meeting a substantial objective.³⁴³ In *R v Oakes*,³⁴⁴ it was held that 'a law is proportionate if (a) the means adopted are rationally connected to that objective; (b) it is minimally impairing of the rights in question; and (c) there is proportionality between the deleterious and salutary effects of the law'.³⁴⁵

Of course, preserving the security of a correctional facility as well as the safety of its staff members and prisoners are 'pressing and substantial objectives'.³⁴⁶ In *Corporation of the Canadian Civil Liberties Association v Her Majesty The Queen*, the court was satisfied that segregating prisoners deemed a danger to the security of the facility, themselves or others was rationally connected to the objectives of segregation.³⁴⁷ However, to satisfy the minimal impairment requirement, the limit must be reasonably tailored to the objective behind justifying the limit.³⁴⁸ In *British Columbia Civil Liberties Association v Canada (Attorney-General)*,³⁴⁹ the British Columbia Court of Appeal held that the provisions of the *Corrections and Conditional Release Act* that effectively mandated isolation from all other inmates violated section 7 of the Canadian Charter because:

*'prolonged and indefinite segregation inflicts harm on inmates subject to it and ultimately undermines the goal of institutional security... [segregation] is so grossly disproportionate to the objectives of the provision that it offends the fundamental normal of a free and democratic society'*³⁵⁰

Segregation will be deemed unnecessary where an alternative, lesser form of restriction would serve the same purpose.³⁵¹ In *Razvyazkin v Russia*, the European Court of Human Rights cited the 21st General Report of the Committee for the Prevention of Torture ('The General Report'):³⁵²

'Given that solitary confinement is a serious restriction of a prisoner's rights which involves inherent risks to the prisoner, the level of actual or potential harm must be at least equally serious and uniquely capable of being addressed by this means. This is reflected, for example, in most countries having solitary confinement as a sanction only for the most serious disciplinary offences, but the principle must be respected in all uses of the measure. **The longer the measure is continued, the stronger must be the reason for it and the more must be done to ensure that it achieves its purpose.'**

341 *Human Rights Act 2019* (Qld) s 13(2).

342 *Canadian Charter of Rights and Freedoms* s 1.

343 *BCCLA v Canada* [2018] BCSC 62, [549].

344 *R v Oakes* [1986] 1 SCR 103.

345 *BCCLA v Canada* [2018] BCSC 62, [549].

346 *Corporation of the CCLA v The Queen* [2017] ONSC 7491, [159]–[160].

347 *Ibid* [161].

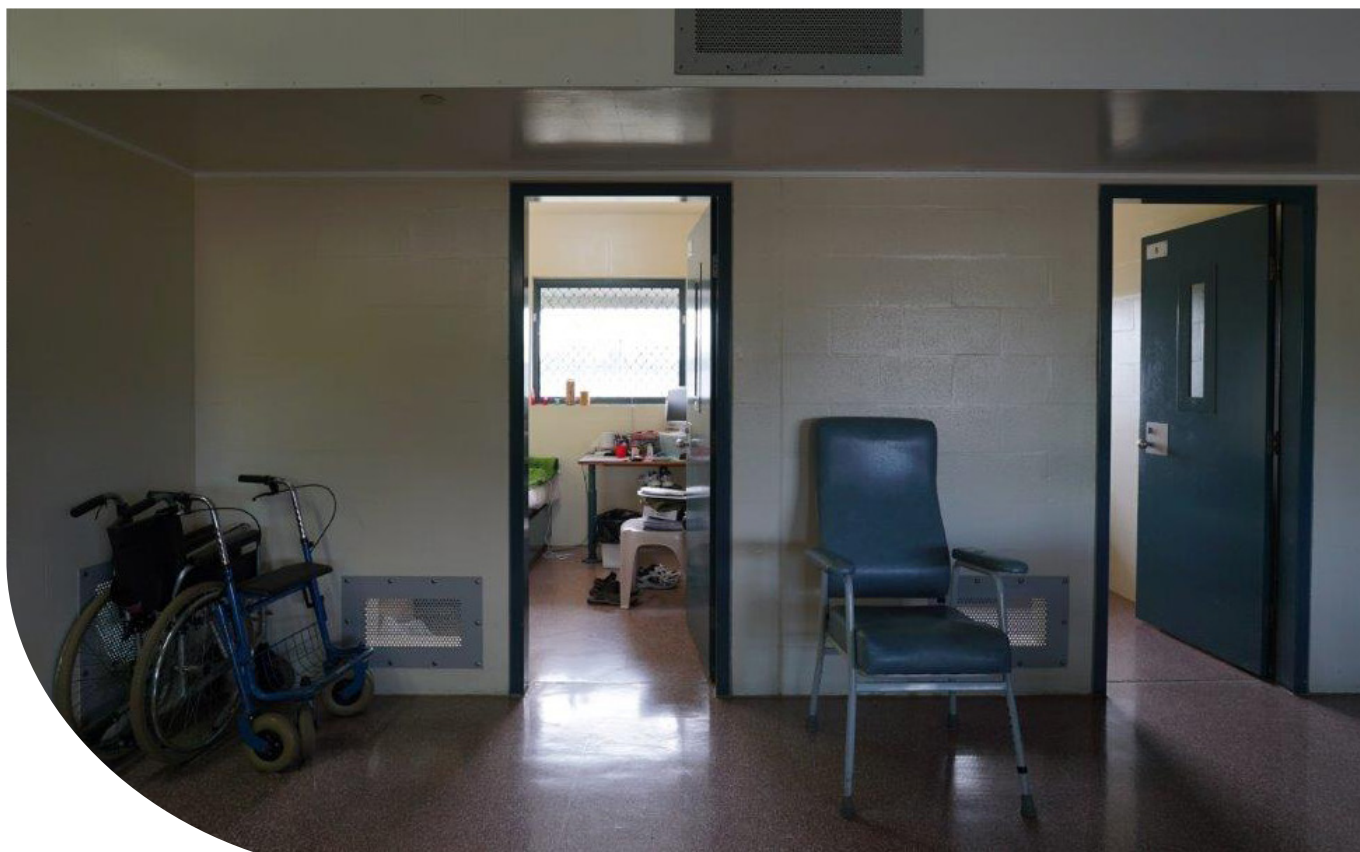
348 *BCCLA v Canada* [2018] BCSC 62, [555].

349 *BCCLA v Canada* [2019] BCCA 228, [165].

350 *Ibid* [167].

351 *BCCLA v Canada* [2018] BCSC 62, [557].

352 *Razvyazkin v Russia* (European Court of Human Rights, Application No 13579/09, 3 July 2012) [89].



© 2017 Daniel Soekov for Human Rights Watch

The General Report was also considered in *Shahid v Scottish Ministers*,³⁵³ a case concerning a prisoner segregated for 56 months for his own safety. The UK Supreme Court held that the prisoner's segregation was not proportionate because an appropriate management strategy was not devised expeditiously enough.³⁵⁴

The European Court of Human Rights has said that it is incumbent on the State to organise its prison system so as to ensure respect for the dignity of prisoners, regardless of logistical or financial difficulties;³⁵⁵ it has held that **'lack of resources cannot in principle justify prison conditions which are too poor as to reach the threshold of treatment** contrary to Article 3 of the Convention.'³⁵⁶ In *Certain Children v Minister for Families and Children & Ors (No 2)*, the resources available to the government were deemed relevant to the consideration of what reasonable limits on human rights may be justified, but in that case, the State failed to demonstrate, 'that resources were inadequate for the provision of less restrictive measures.'³⁵⁷

6.7 Implications of the Human Rights Act for the practice of solitary confinement

Acts or decisions made by Queensland public entities must now be compatible with human rights, and public entities must give proper consideration to human rights in making decisions.³⁵⁸ A finding of unlawfulness will not invalidate the decision,³⁵⁹ and a breach of the *Human Rights Act 2019* (Qld) will not give rise to a cause of action unless another cause of action also exists.³⁶⁰ If a prisoner applies for judicial review of a decision, they will also be able to allege a breach of human rights.³⁶¹ In addition to this, prisoners will be able to make a complaint to the Queensland Human Rights Commissioner, and the matter may then be dealt with by conciliation.³⁶²

³⁵³ *Shahid v Scottish Ministers* [2016] AC 429, 460-461 [85].

³⁵⁴ *Ibid* [86].

³⁵⁵ *Mursic v Croatia* (European Court of Human Rights, Application No 7334/13, 20 October 2016) [101].

³⁵⁶ *Poltoratskiy v Ukraine* (European Court of Human Rights, Application No 38812/97, 29 April 2003) [148].

³⁵⁷ *Certain Children* (2017) 52 VR 441, 581 [475].

³⁵⁸ *Human Rights Act 2019* (Qld) s 58(1).

³⁵⁹ Nor will it amount to an offence: *ibid* s 58(6).

³⁶⁰ *Ibid* ss 58(1)-(2).

³⁶¹ *Ibid* s 59.

³⁶² *Ibid* ss 64, 79.

QCS will need to demonstrate that there was no less restrictive alternative reasonably available to them to justify a decision to place a prisoner in solitary confinement.³⁶³ We argue in the next section of this report that there are many alternatives available to a placement in solitary confinement.

SUMMARY

The introduction of the *Human Rights Act 2019* (Qld) will have implications for the use of solitary confinement in Queensland. Four of the rights in the Act are particularly relevant:

1. Humane treatment when deprived of liberty (s 30(1)) – Solitary confinement regimes may breach this right if they result in extensive isolation, lack of mental stimulation, lack of natural light, and inadequate medical treatment.
2. Protection from torture and cruel, inhuman and degrading treatment (s 17) – Solitary confinement regimes may breach this right if they cause considerable mental suffering, intense physical or mental deterioration, destruction of a prisoner's personality, or denial of appropriate medical care.
3. Right to life (s 16) and liberty and security of person (s 29(1)) – Solitary confinement regimes increase the risk of self-harm and suicide and thereby engage the right to life. They also substantially limit a person's liberty. Due to the serious consequences for the prisoner, a high level of procedural fairness must be accorded when a decision is made to place someone in solitary confinement.
4. Right to privacy and reputation (s 25(a)) – Solitary confinement regimes should not arbitrarily restrict prisoners' contact with family members. Any such limitation should be proportionate to the aim sought to be achieved.

All human rights have limits, and protecting the safety and security of prison staff, other prisoners, and the community generally is a legitimate goal. However, any limitations on individual rights must be demonstrably justified in a free and democratic society, and the least restrictive means of achieving the desired purpose should be applied.

³⁶³ Ibid s 13(2)(d).

7. Alternatives to solitary confinement

Consistent with the position at international law, scholars agree that solitary confinement should only be imposed under ‘extraordinary circumstances to accomplish a legitimate penological goal for which there is literally no less-intrusive or less-dangerous alternative available to the person on whom it is imposed.’³⁶⁴ In principle, this position is reflected in Queensland legislation which only permits prolonged solitary confinement for administrative rather than punitive purposes, for example where a person poses a risk to themselves or to others if they remain in the mainstream prison population. As such, solitary confinement is often accepted as a necessary means by which to safely manage a large prison population. However, there are many alternatives to the use of solitary confinement which can achieve this objective without the significant negative health impacts and which arguably better promote the safety and security of correctional centres.

7.1 Alternative behavioural management strategies

Labrecque and Smith emphasise the importance of front end triaging of prisoners at risk of being placed in solitary confinement.³⁶⁵ They suggest that these prisoners should receive intensive ‘treatment interventions that seek to prevent the misconduct and other analogous antisocial behaviours that often precipitate initial placement into restrictive housing settings.’³⁶⁶

7.1.1 United States of America

A number of states in the US have attempted to replace a long-standing reliance on solitary confinement, particularly for disciplinary purposes, with alternative forms of behavioural management. Maine Department of Corrections previously utilised solitary confinement as a ‘default practice’.³⁶⁷ The Department revised its policy and now imposes disciplinary measures that can take place while prisoners are still housed in the general population; they include **‘confining prisoners to their own cells’, ‘removal of visitation privileges and prohibiting prisoners from attending work.’**³⁶⁸ The New York Department of Correction has implemented a Positive Behaviour Management System (PBMS) as an alternative to punitive strategies for young prisoners.³⁶⁹ The system aims to promote good behaviour and compliance by allowing prisoners, individually and within units, to be rewarded for displaying good behaviour.³⁷⁰ Under this system, punitive segregation has been eliminated as a punishment in favour of a **‘loss of earned privileges’.**³⁷¹ Colorado has also introduced **Immediate Accountability Resolution, where prisoners and staff members work together to develop an appropriate punishment to be served within the general prison population.**³⁷²

The Colorado Department of Corrections is increasingly using **‘de-escalation rooms’** for prisoners who may need or request time away from the general population, rather than immediately sending these prisoners to restrictive housing units.³⁷³

³⁶⁴ C. Haney, ‘Restricting the Use of Solitary Confinement’ (2018) 1 *Annual Review of Criminology* 285, 301.

³⁶⁵ R. Labrecque and P. Smith, ‘Reducing Institutional Disorder: Using the Inmate Risk Assessment for Segregation Placement to Triage Treatment Services at the Front End of Prison Sentences’ (2019) 65(1) *Crime & Delinquency* 3, 5.

³⁶⁶ Ibid.

³⁶⁷ D. Fathi, ‘United States: Turning the Corner on Solitary Confinement’ (2015) 4(1) *Canadian Journal of Human Rights* 167, 171–2.

³⁶⁸ Ibid.; American Civil Liberties Union of Maine, *Change is Possible: A Case Study of Solitary Confinement Reform in Maine* (Report, March 2018) 15.

³⁶⁹ New York City Department of Correction, ‘Efforts to Reform Punitive Segregation and Create Therapeutic Alternatives to Address Persistent Violence by Individuals in NYC Department of Correction Custody’, *New York City Department of Correction* (online, 2017) 4 <<https://www1.nyc.gov/assets/boc/downloads/pdf/Meetings/2017/July-11-2017/DOC-Report-on-Punitive-Segregation-Reforms-6-27-17.pdf>>.

³⁷⁰ Ibid.

³⁷¹ Ibid.

³⁷² Vera Institute of Justice, ‘Promising Practices: Alternatives for Nonviolent Infractions and Time Limits for Restrictive Housing’, *Safe Alternatives to Segregation* (online), <https://www.safealternativestosegregation.org/promising_practice/alternatives-for-nonviolent-infractions-and-time-limits-for-restrictive-housing/>.

³⁷³ R. Raemisch and K. Wasko, ‘Open the Door – Segregation Reforms in Colorado’, *Colorado Department of Corrections* (online, 2016) 8 <<https://drive.google.com/file/d/0B30yLi0IlyBRY2h2UDBC20Q5WIE/view>>.

Facilities within the Idaho Department of Corrections have also made use of **'calm down areas'**.³⁷⁴

Ohio Department of Rehabilitation and Corrections introduced 'Limited Privilege Housing' as an alternative disciplinary measure to be used for punitive segregation.³⁷⁵ It was introduced for prisoners who commit 'low-to-moderate severity rule violations'.³⁷⁶ While the Department acknowledges that a challenge of this new reform is finding a balance between conditions in limited privilege housing and restrictive housing, this alternative is designed to remove prisoners from the current environment as a sanction into a new environment where there remain opportunities for interaction, treatment and programming.³⁷⁷

7.2 Mental Health Units or 'therapeutic housing' as an alternative to segregation

7.2.1 United Kingdom

Her Majesty's Prison Grendon is the only correctional facility in the UK which operates using a democratic **therapeutic communities model**.³⁷⁸ Under this model, prisoners live in small communities and **share significant responsibilities with staff for their own treatment and practical operation of the facility**.³⁷⁹ The aim of this model is to assist prisoners in taking responsibility for their offending behaviour.³⁸⁰ Group therapy sessions are undertaken by prisoners at Grendon, and the facility also provides substantial out-of-cell time, educational and employment opportunities.³⁸¹ Most prisoners in Grendon's population are serving indeterminate or life sentences.³⁸² A significant achievement of the facility is that it does not have a solitary confinement unit, despite the fact that many of its residents have displayed disruptive behaviours in other correctional facilities and have histories of violent offending and mental health conditions.³⁸³ At the time of the 2017 Chief Inspector of Prisons Report, no prisoner had been segregated in their cell in the previous six months.³⁸⁴ Moreover, violent incidents are rare³⁸⁵ and prisoners who have been housed at Grendon are typically less likely to reoffend.³⁸⁶

7.2.2 Northern Ireland

Giblin et al describe a mental health unit that was set up in a prison as an alternative approach to placing unwell prisoners in solitary confinement.³⁸⁷ A 10 bed **'High Support Unit' (HSU) was established to treat prisoners with psychotic symptoms** and those with an immediate risk of self-harm. The HSU is **staffed by officers who have been specially trained** in suicide awareness, risk assessment and psychiatric screening. Nurses attend the unit every day, there is increased **access to psychiatrists and community mental health nurses**, and prisoners are reviewed by a multidisciplinary team each week. Establishment of the HSU led to a significant reduction in the use of isolation cells and enhanced continuity of care between secure mental health units and the prison. Importantly, this initiative was 'cost neutral' and involved only a 'reorganisation and redeployment' of existing staff.³⁸⁸

374 The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School, *Reforming Restrictive Housing: The 2018 ASCA-Liman Nationwide Survey of Time-in-Cell* (Report, October 2018) 70.

375 Ibid 12.

376 Ibid.

377 Ibid 13.

378 Her Majesty's Chief Inspector of Prisons, *Report on an Unannounced Inspection of HMP Grendon* (Report, May 2017) 5.

379 M. Brooks, 'Introduction to the Special Issue on "Fifty Years of HMP Grendon"' (2010) 49(5) *The Howard Journal* 425, 425.

380 Her Majesty's Chief Inspector of Prisons (n 378) 5.

381 Ibid.

382 Brooks (n 379) 425.

383 Her Majesty's Chief Inspector of Prisons (n 378) 22.

384 Ibid.

385 Ibid 11.

386 Ibid 7.

387 Y. Giblin et al, 'Reducing the Use of Seclusion for Mental Disorder in a Prison: Implementing a High Support Unit in a Prison Using Participant Action Research' (2012) 6(2) *International Journal of Mental Health Systems* 1, 3-4.

388 Ibid 5.

7.2.3 United States of America

As an alternative to solitary confinement for people with serious mental health needs, the Vera Institute of Justice recommended the use of secure therapeutic housing units which mirrored the general population as to time out-of-cell, privileges and programming.³⁸⁹ In 2013, the New York City Department of Correction, the second largest corrections system in the US, began establishing alternative housing for prisoners with mental illness³⁹⁰ and restricting the use of solitary confinement only to situations where other alternatives would threaten the security and safety of the facility.³⁹¹ The Department has introduced six alternative therapeutic housing units, which each target a specific population.³⁹² As a result, there has been a reduction in its punitive segregation population to two percent of the overall prison population, while four percent of the overall population is now housed in alternative settings.³⁹³ The main form of therapeutic housing implemented by the Department is the Clinical Alternative to Punitive Segregation (CAPS) unit.³⁹⁴ The CAPS unit is an alternative to punitive segregation for prisoners with serious mental illness who have committed infractions in custody.³⁹⁵ CAPS units are designed to provide clinical support to these prisoners with a **high ratio of 'specialty staff' to prisoners who coordinate therapeutic activities such as 'psychotherapy, creative art, nursing education groups, individual mental health and medical encounters and community meetings with patients, health and security staff'**.³⁹⁶ The unit employs a 'lock-out' approach, where prisoners are not subjected to long periods of isolation in cells; the **aim is to increase interaction** between all the prisoners housed in the unit as well as with staff.³⁹⁷ The unit has a **wide range of specialty staff**, including psychologists, psychiatrists, social workers, nurses and mental health staff.³⁹⁸

The Department has found that prisoners who are housed in this unit commit far less 'serious rule violations' than they did before they commenced the program.³⁹⁹ A small study undertaken a year after the opening of the CAPS unit found that incidents of self-harm were much lower for prisoners with serious mental illness when they were housed in the CAPS unit as compared with Restrictive Housing Units.⁴⁰⁰ The same result was found for prisoners who were housed both in the CAPS unit and in the Mental Health Assessment Unit for Infracted Inmates.⁴⁰¹ The CAPS unit was the setting found to have the lowest incidents of injury.⁴⁰² As a result, the CAPS model has been implemented in a number of existing mental health units in New York City prisons.⁴⁰³ This form of therapeutic housing is more costly than other forms of containment, however the Department has said that the costs 'may be offset by decreased rates of injury, self-harm, use of force and ultimately, litigation'.⁴⁰⁴

The New York Department of Correction has established a variety of other therapeutic housing units, including the Program to Accelerate Clinical Effectiveness (PACE).⁴⁰⁵ PACE was designed specifically as **'preventive care'** to provide clinical support to inmates with serious mental illness.⁴⁰⁶ **Multi-disciplinary therapy in group and individual settings** is provided, focused on providing additional support to inmates with mental health conditions to prevent the worsening of these conditions.⁴⁰⁷ Within PACE, participants receive the

389 Vera Institute of Justice, *Rethinking Restrictive Housing: Lessons from Five U.S. Jail and Prison Systems* (Report, May 2018) 34.

390 New York City Department of Correction (n 369) 1-2.

391 Ibid 2.

392 Ibid 3.

393 Ibid 2.

394 Ibid 3.

395 Ibid 2.

396 S. Glowa-Kollisch et al, 'From Punishment to Treatment: The "Clinical Alternative to Punitive Segregation" (CAPS) Program in New York City Jails' (2016) 13(2) *International Journal of Environmental Research and Public Health* 1, 3.

397 New York City Department of Correction (n 369) 2-3.

398 Ibid 3.

399 Ibid 7.

400 Glowa-Kollisch et al (n 396) 7.

401 Ibid 6.

402 Ibid 7.

403 Ibid 8.

404 Ibid.

405 New York City Department of Correction (n 369) 4.

406 Ibid.

407 Ibid.

standard amount of out-of-cell time per day.⁴⁰⁸ The Department has reported substantial decreases in use of force incidents and internal offences for prisoners housed in PACE.⁴⁰⁹ Two alternative housing units for young adults displaying repeated violent behaviour have also been created in New York, the Transitional Restorative Unit and the Secure Unit.⁴¹⁰ Both units provide rehabilitation programming and support teams to administer prisoners' behaviour management plans.⁴¹¹ Notably, both units operate while providing prisoners with the standard period of **fourteen hours of daily out-of-cell time**.⁴¹² The introduction of these specialty units in place of solitary confinement has resulted in decreases in violence.⁴¹³ The Department reported a 44 percent decrease in use of force incidents, as well as significant reductions in assaults between prisoners resulting in serious injury, and assaults on staff.⁴¹⁴

As part of its 2013 reforms, the Colorado Department of Corrections has also designed a number of therapeutic housing units for prisoners with serious mental illness.⁴¹⁵ The Department established three Residential Treatment Programs to provide clinical support for inmates with serious mental illness, with a heavy focus on group therapy as well as individual treatment.⁴¹⁶ **Inmates interact in groups at 'restraint tables'**, which are designed to provide both social and therapeutic opportunities while also ensuring safety of inmates and participating staff.⁴¹⁷ These units do not utilise solitary confinement and instead actively encourage out-of-cell time, though one key feature of the program is that **prisoners are not forced to engage in activities and are not punished for choosing to remain in their cells**.⁴¹⁸ Instead, therapies and activities such as **pet therapy, art therapy and 'de-escalation' rooms with calming music are used to encourage inmates to actively engage in activities**.⁴¹⁹ As a result of these changes, the Department has reported significant reductions in forced cell entries and prisoner assaults on staff.⁴²⁰

In 2016, South Carolina introduced a Behavioural Management Unit aimed at reducing reliance on long-term solitary confinement for prisoners with severe personality disorders.⁴²¹ The unit provides targeted programming to allow prisoners within this group to safely return to the general prison population or their community at the conclusion of their sentence. The unit's purpose is to remove prisoners who are consistently returning to solitary confinement based on behaviours expressed as part of their mental health conditions to another environment where treatment can be provided.

Other States, such as Nebraska, have introduced Protective Management Units, which house groups of prisoners in protective custody while providing conditions that are similar or the same to those offered in the general population.⁴²² This includes the provision of out-of-cell time, and employment, educational and programming opportunities.⁴²³

408 Ibid 5.

409 Ibid 7.

410 Ibid 5.

411 Ibid.

412 Ibid.

413 Ibid 6.

414 Ibid.

415 Raemisch and Wasko (n 373) 5.

416 Ibid 5-6.

417 Ibid 6.

418 Ibid.

419 Ibid.

420 Ibid 7.

421 The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 145.

422 D. Cloud, J. Kang-Brown and E. Vanko, *The Safe Alternatives to Segregation Initiative: Findings and Recommendations for the Nebraska Department of Correctional Services* (Report, November 2016) 58.

423 Ibid.

The Federal Bureau of Prisons has established a **Reintegration Housing Unit** at one of its facilities, which is specifically designed for protective custody prisoners who are unwilling to return to the general prison population.⁴²⁴ Prisoners in this unit take part in **programming which focuses on developing skills to re-enter the general population**.⁴²⁵ Prisoners are also able to participate in activities outside the unit which are still kept separate from the general population.⁴²⁶ The Federal Bureau also operates a Sex Offender Management Program, a program providing treatment while also allowing prisoners to live in the general population of prisons where a high number of prisoners are sex offenders.⁴²⁷

7.2.4 Canada

Over the past two years, Canada has reviewed its practice of solitary confinement.⁴²⁸ As noted above (at 6.4.2), laws governing the use of administrative segregation in federal prisons were found to violate the *Canadian Charter of Rights and Freedoms* in *British Columbia Civil Liberties Association v Canada (Attorney-General)*.⁴²⁹ The court suspended the administrative segregation laws for one year, giving the federal government an opportunity to legislate the use of solitary confinement in a way which complied with the Charter.⁴³⁰ The new legislation was passed in June 2019.⁴³¹

The new legislation provides for the establishment of Structured Intervention Units (SIUs) to replace all segregated housing (solitary confinement) in Canadian prisons, and it provides additional protections in respect of prisoners with mental illness.⁴³² **If a prisoner in a SIU begins refusing to interact with others, exhibiting self-injurious behaviour, showing signs of a drug overdose, or showing signs of emotional distress or behaviour that suggests they are in urgent need of mental health care, they must be referred for treatment.**⁴³³

A health care professional can recommend to the institutional head that the prisoner's conditions of confinement be altered and, **before the institutional head makes a decision on this, he or she must visit the prisoner.**⁴³⁴ If the institutional head decides to act against the recommendation of the health care professional, another health care professional must refer the matter to a committee, and the committee will determine whether the prisoners should remain in the SIU or not.⁴³⁵ Prisoners must receive a **mental health assessment within 24 hours** of their placement in the SIU, and must be **visited daily by a registered health care professional**.⁴³⁶

Since the legislative changes have only just been introduced they are yet to be evaluated, however advocates have expressed concern that they do not go far enough. Indeed, the Senate passed an amendment to the legislation requiring the immediate transfer of prisoners found to have 'disabling mental health issues' to a psychiatric hospital for treatment, however this amendment was rejected by the House of Commons.

424 US Department of Justice, *Report and Recommendations Concerning the Use of Restrictive Housing* (Report, January 2016) 24.

425 Ibid.

426 Ibid.

427 Ibid 24-5.

428 B. Vaze, 'Ongoing Advocacy for Prisoners' Rights in the Continued Administration of Solitary Confinement: *British Columbia Civil Liberties Association and John Howard Society of Canada v Canada (Attorney General)*' (2018) 197 *BC Studies* 135.

429 *BCCLA v Canada* [2018] BCSC 62.

430 Ibid [609]-[610].

431 *An Act to amend the Corrections and Conditional Release Act and another Act*, SC 2019, c C-20.

432 K. Harris, 'Liberals Move to End Solitary Confinement of Federal Prisoners', *CBC News* (Web Page, 16 October 2018) <<https://www.cbc.ca/news/politics/segregation-corrections-goodale-1.4602084>>.

433 *An Act to amend the Corrections and Conditional Release Act and another Act*, SC 2019, c C-20; *Corrections and Conditional Release Act*, SC 1992, c C-20, s 37.11.

434 *Corrections and Conditional Release Act*, SC 1992, c C-20, ss 37.2-37.3.

435 Ibid ss 37.31-37.32.

436 Ibid s 37.1(2)(b).

7.3 Limiting the use of solitary confinement

In many jurisdictions, legal limits on the amount of time that a person can spend in solitary confinement have been imposed, and minimum conditions of confinement have been established. Some jurisdictions have restricted solitary confinement placements to certain prisoners, for example, some have prohibited the use of solitary confinement for young people, people with mental illness, pregnant women, and women generally.

7.3.1 United States of America

In the US, the reform agenda has been largely focused on limiting the use of solitary confinement, referred to there as ‘restrictive housing’.⁴³⁷ In 2016, a report of the US Department of Justice recommended that correctional authorities place prisoners in ‘the least restrictive settings necessary’ and that any use of solitary confinement be for ‘no longer than the time necessary to achieve the purpose of the confinement’.⁴³⁸ It also recommended that pregnant women,⁴³⁹ young people under the age of 18 and inmates with serious mental illness should not be held in solitary confinement,⁴⁴⁰ and that solitary confinement should not be used as protective custody.⁴⁴¹ The Report made a number of recommendations for improving the conditions of prisoners in solitary confinement, including that authorities ‘seek ways to increase the minimum amount of time’ spent out-of-cell, and **increase opportunities for ‘recreation, education, clinically appropriate treatment therapies, skill-building, and social interaction with staff and other inmates’ and confidential psychological appointments whilst out-of-cell.**⁴⁴²

President Barack Obama adopted the recommendations of this report in full and in August 2016, the American Correctional Association approved detailed new standards for the use of solitary confinement implementing these recommendations.⁴⁴³

In 2018, the Association of State Correctional Administrators and Yale Law School conducted research to determine the extent to which these new standards were being implemented. In their *Time in Cell Report*, they note that 23 out of 39 jurisdictions surveyed had made alterations to their placement policies.⁴⁴⁴ Of these, 20 reported that mental health screening would influence placement decisions, 16 had **narrowed the behavioural infractions qualifying for time in solitary confinement**, 16 required **senior-level approval of solitary confinement decisions**, 14 conducted mental health screening prior to placement, and four conducted mental health screening following placement in solitary confinement.⁴⁴⁵ It was reported in 2017 that none of the jurisdictions surveyed had pregnant women in restrictive housing.⁴⁴⁶

A number of States now have **time restrictions on the use of solitary confinement**. For example, a maximum of 15 days applies in Colorado,⁴⁴⁷ 20 days in Washington,⁴⁴⁸ 30 days in New Mexico,⁴⁴⁹ and 45 days in Maine.⁴⁵⁰

437 ‘Restrictive housing’ is defined as “any type of detention that involves three basic elements: removal from the general inmate population, whether voluntary or involuntary; placement in a locked room or cell, whether alone or with another inmate; and inability to leave the room or cell for the vast majority of the day, typically 22 hours or more”: US Department of Justice (n 424) 3.

438 US Department of Justice (n 424) 1.

439 ‘Pregnant women’ is defined as those ‘who are post-partum, who recently had a miscarriage, or who recently had a terminated pregnancy’: Ibid 102.

440 Ibid 99, 101 and 102.

441 Ibid 97.

442 Ibid 99.

443 The Association of State Correctional Administrators, *Aiming to Reduce Time-In-Cell Report* (Report, November 2016) 2 <<https://assets.documentcloud.org/documents/3234404/Aiming-to-Reduce-Time-In-Cell-Correctional.pdf>>; American Correctional Association, *Restrictive Housing Expected Practices* (Report, January 2018) Standard 4-RH-0002, Standard 4-RH-0033, Standard 4-ALDF-RH-024 (7, 39, 43) <http://www.aca.org/aca_prod_imis/docs/Standards%20And%20Accreditation/%20RH%20Expected%20Practices-%201_2018.pdf>.

444 The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 60.

445 Ibid 60–61. Note that, as a result of the case of *Disability Law Center, Inc. v Massachusetts Department of Corrections, et al*, prisoners must be screened by a qualified professional prior to being placed in segregation (pg. 5), mental health rounds of the segregation unit (pg. 5), mental health evaluation by a professional during confinement (pg. 5) and similar requirements in other segregation housing (pg. 6 – 9): *Disability Law Center, Inc. v Massachusetts Department of Correction, et al., Civ. No. 07-10463 (D. Mass.) (Settlement Agreement)*.

446 The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 55.

447 Ibid 67.

448 A. Steinbuch, ‘The Movement away from Solitary Confinement in the United States’ (2014) 40(2) *New England Journal on Criminal and Civil Confinement* 499, 527.

449 US Department of Justice (n 424) 76.

450 Steinbuch (n 448) 528–529.

A number of states have limited or **prohibited the use of solitary confinement for vulnerable groups**. In 2015, the Colorado Department of Corrections implemented a policy preventing the use of restrictive housing for all female prisoners.⁴⁵¹ Some jurisdictions, such as Philadelphia, have severely limited the use of restrictive housing for prisoners with mental illness.⁴⁵² Colorado has gone as far as prohibiting solitary confinement for all prisoners with serious mental illness; instead, they divert these prisoners to mental health units or programs.⁴⁵³

The Colorado Department of Corrections is regarded as being at the forefront of solitary confinement reform in the US.⁴⁵⁴ From 2013, the Department introduced a policy **preventing any inmates housed in solitary confinement or maximum security units from being released directly into the community** at the end of their sentence.⁴⁵⁵ The Department also **abolished indeterminate orders** of solitary confinement.⁴⁵⁶ Under the new regime, prisoners must be informed of the reason for, and length of their placement in a solitary confinement unit.⁴⁵⁷ Solitary confinement or restrictive housing is only used for 'serious violations' and consecutive periods of solitary confinement are prohibited, so prisoners cannot be released and then immediately returned to solitary confinement after the fifteen-day limit is reached.⁴⁵⁸ Following these reforms, extensive waiting lists for two Colorado facilities dedicated to housing mentally ill prisoners were reduced so much so that there were vacant beds in both facilities.⁴⁵⁹

In 2015, the New York Department of Correction developed a 'tiered system' for managing internal offences in order to reduce reliance on solitary confinement.⁴⁶⁰ Prisoners who have committed non-violent internal offences can receive 'seven hours of out-of-cell time' per day.⁴⁶¹ Further, prisoners **must be granted 7 days of release from solitary confinement once they have served 30 consecutive days in solitary confinement**.⁴⁶² Prisoners **cannot be placed in solitary confinement for more than 60 days over a six-month period** unless an override is approved, and this only occurs when another person is in direct danger.⁴⁶³

A study in Mississippi found that by adopting new, objective criteria for placement in administrative segregation, and reviewing all prisoners currently in solitary confinement against these criteria, the number of prisoners in solitary confinement fell by 80 percent from 1000 to less than 150.⁴⁶⁴ Under the new criteria, prisoners can only be held in administrative segregation if they have committed serious infractions, are active 'high level' members of a gang, or have had prior escapes or escape attempts.

7.3.2 Europe and the United Kingdom

A number of countries in Europe have been viewed as models for good prison practice given their low rates of incarceration and sparing use of solitary confinement. The Vera Institute of Justice reports that in Germany, prisoners can only be held in solitary confinement for a maximum period of four weeks, while Norway permits the use of solitary confinement for a maximum of only two weeks.⁴⁶⁵ In Norway, **punitive solitary confinement was abolished** in 2001, although 'preventive solitary confinement' is still used.⁴⁶⁶ Prisoners may be 'partially

451 Raemisch and Wasko (n 3733) 7.

452 The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 5.

453 Ibid 67.

454 Steinbuch (n 448) 524.

455 US Department of Justice (n 424) 75; Raemisch and Wasko (n 373) 3.

456 Raemisch and Wasko (n 373) 3.

457 Ibid.

458 The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 67.

459 Ibid 68.

460 New York City Department of Correction (n 369) 2.

461 Ibid.

462 Ibid 3.

463 Ibid.

464 T. Kupers et al, 'Beyond Supermax Administrative Segregation: Mississippi's Experience Rethinking Prison Classification and Creating Alternative Mental Health Programs' (2009) 36(1) *Criminal Justice and Behaviour* 1037, 1041.

465 R. Subramanian and A. Shames, *Sentencing and prison practices in Germany and the Netherlands: Implications for the United States* (Report, October 2013) 13 <<https://www.vera.org/publications/sentencing-and-prison-practices-in-germany-and-the-netherlands-implications-for-the-united-states>>.

466 Dignity (Danish Institute Against Torture), *Solitary Confinement as a Disciplinary Sanction: Focus on Denmark* (Discussion Paper, April 2017) 1, 13 <https://dignity.dk/wp-content/uploads/Discussion_Paper_Solitary_Confinement-1.pdf> ('*Solitary Confinement as a Disciplinary Sanction*'); S. Shalev, 'Solitary Confinement: The View from Europe' (2015) 4(1) *Canadian Journal of Human Rights* 143, 155.

isolated for up to 24 hours' for disciplinary infractions.⁴⁶⁷ In Sweden, punitive solitary confinement ended in 1975.⁴⁶⁸ In Denmark, prisoners can be held in solitary confinement for up to four weeks.⁴⁶⁹ In England and Wales, solitary confinement for punitive reasons is restricted to twenty-eight days, and the maximum period in Ireland is sixty days.⁴⁷⁰

7.3.3 Canada

The new Canadian SIUs have been described by the government as enabling prisons to separate offenders from the mainstream prison population so they can 'receive **structured interventions and programming** tailored to address their specific risks, as well as their specific needs.'⁴⁷¹ The legislation states that the purpose of SIUs is to 'provide an appropriate living environment for an inmate who cannot be maintained in the mainstream prison population for security or other reasons' and to 'provide the inmate with an opportunity for **meaningful human contact** and an opportunity to participate in programs.'⁴⁷²

A prisoner can only spend a maximum of 15 days in a SIU within a 30 day period.⁴⁷³ An independent decision-maker, appointed by the Minister, must **review decisions to place a prisoner in the SIU** within five working days, and this independent decision-maker also has the **power to direct the removal** of a prisoner from the SIU.⁴⁷⁴

Despite these reforms, the SIUs have been criticised by advocates as failing to properly address the harmful impacts of segregation given their similarities to solitary confinement.⁴⁷⁵ Whilst the SIUs are intended to increase opportunities for meaningful human contact and provide more programming and health-care interventions, prisoners will still be isolated for 20 hours a day in 10-by-six-foot rooms with concrete walls and solid metal doors.⁴⁷⁶ The Senate passed a number of amendments to the legislation, including a clause limiting the amount of time a prisoner could spend in the SIU to 48 hours, unless a longer period of time was authorised by a Superior Court. However, this amendment was rejected by the House of Commons.

7.3.4 Australia

In *Callanan v Attendee X*, Applegarth J said that the use of solitary confinement 'should be kept to a minimum' because '[a]ny substantial period in solitary confinement carries a high risk of causing serious psychological damage' which may 'endure after his [sic] release.'⁴⁷⁷

Both the Royal Commission into the Protection and Detention of Children in the Northern Territory (the Royal Commission) and the Independent Inquiry into Youth Detention recommended the express prohibition of solitary confinement for young people, and recommended restrictions on the use of temporary segregation.⁴⁷⁸ Where segregation for the protection of another person or property is necessary, the Royal Commission specified it should only be used as last resort 'after all therapeutic alternatives have been attempted' and that its use should be closely monitored.⁴⁷⁹

467 Dignity (n 466) 13.

468 Ibid 14. Note, however, that 'violent prisoners' are occasionally placed in solitary cells: see K. Virk, 'ASAP Rocky: Sweden prison boss defends jail conditions', BBC (online, 10 July 2019), <<https://www.bbc.com/news/newsbeat-48934378>>.

469 Dignity (n 466) 1.

470 Shalev (n 466) 155.

471 Explanatory Note, Bill C-83: An Act to amend the Corrections and Conditional Release Act and another Act (Can); Harris (n 432).

472 Corrections and Conditional Release Act, SC 1992, c C-20, s 32(1).

473 Corrections and Conditional Release Act, SC 1992, c C-20, s 37.83(1).

474 Ibid ss 37.76, 37.83(3).

475 Standing Committee on Public Safety and National Security Canada, *Report on Bill C-83, An Act to Amend the Corrections and Conditional Release Act and another Act*, December 2019 (Report 28); Senator Kim Pate, 'Corrections bill lacks key provisions on judicial oversight' (2019) May Policy Options.

476 Canadian Senate, *Parliamentary Debates: First Session, Forty-second Parliament*, 2 May 2019, 1740-1750; A. Grace, 'The end of solitary confinement in Canada? Not exactly', *The Conversation* (online, 27 October 2019) <<https://theconversation.com/the-end-of-solitary-confinement-in-canada-not-exactly-124679>>.

477 *Attendee X* [2013] QSC 240, [51].

478 Royal Commission into the Detention and Protection of Children in the Northern Territory (Final Report, 17 November 2017) vol 2A, 332; K. McMillan and M. Davis, *Independent Review of Youth Detention Report* (Final Report, April 2017) 284, 286.

479 Royal Commission into the Detention and Protection of Children in the Northern Territory (n 478) 332-3.

It was also recommended that the decision to segregate a child be reviewed at least every two hours and that extendable periods in isolation beyond 24 hours be prohibited.⁴⁸⁰

7.4 Improving conditions in solitary confinement

A number of jurisdictions have increased services, resources and activities available to prisoners in solitary confinement units in order to mitigate the harmful effects of solitary confinement. Research clearly indicates that access to programs has positive benefits for prisoners, both in terms of increased well-being and improved behavioural outcomes.⁴⁸¹ The provision of **educational and therapeutic programs, as well as other daily activities**, are of even greater importance in solitary confinement settings where there is little opportunity for stimulation.⁴⁸²

7.4.1 Australia

In *Callanan v Attendee X*,⁴⁸³ Applegarth J said that it was important to ‘raise the level of meaningful social contacts for prisoners’ in solitary confinement. This could be done, His Honour said, by:⁴⁸⁴

‘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. Especially important are the possibilities for both maintaining and developing relations with the outside world... [and providing] meaningful in-cell and out-of-cell activities.’

7.4.2 United States of America

In their 2018 *Time in Cell Report*, the Association of State Correctional Administrators and Yale Law School reported that a number of federal prisons had sought to improve conditions in solitary confinement in response to the 2016 Department of Justice Report:⁴⁸⁵

- more than half reported that they had changed their monitoring processes, including frequency of reviews;
- around half reported **increased monitoring** of the mental health of those held in solitary confinement through access to mental health professionals;
- half had added more **structured time out-of-cell**, including programs, therapy and meals in social settings;
- around half had enhanced both **out-of-cell and in-cell learning opportunities**, including distance education and prison classes.

⁴⁸⁰ Ibid 333–4.

⁴⁸¹ Shalev (n 48) 44.

⁴⁸² Ibid 44–5.

⁴⁸³ *Attendee X* [2013] QSC 340, [51], [44].

⁴⁸⁴ Ibid [44].

⁴⁸⁵ The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 61–2.

The Maine Department of Corrections now allows prisoners in solitary confinement to access **recreational and educational resources such as televisions and books**.⁴⁸⁶ The Department has also increased opportunities for association in solitary confinement, with the introduction of activities such as **'group recreation and counselling sessions'**.⁴⁸⁷ There is also an incentive-based model for segregation units, where rewards are given for good behaviour.⁴⁸⁸ In Ohio, four prisoners considered to be the most dangerous in that state were granted greater interaction through allowance of **phone calls, visits and association** with one other prisoner.⁴⁸⁹ No serious safety incidents occurred following this shift in policy.

The **use of technology** for both recreational and therapeutic purposes has generated positive outcomes in solitary confinement settings. In 2008, Hamden County Jail and House of Correction in Massachusetts introduced **MP3 players for daily use in solitary confinement units**.⁴⁹⁰ Prisoners can earn access to MP3 players by displaying good behaviour.⁴⁹¹ The devices not only serve a recreational purpose, by providing resources such as audiobooks and music, but are also used to deliver treatment through various audio-programs on topics including parenting and substance misuse.⁴⁹² The rationale behind the reform was to provide prisoners in solitary confinement with cost-effective resources to prevent 'mental decompensation' and to provide educational content that does not require additional staffing.⁴⁹³ Staff specifically chose to implement devices with a **'one-piece headset unit', removing the potential dangers of headset chords**.⁴⁹⁴ Most prisoners in solitary confinement are able to use the MP3 players for approximately fifteen hours each week.⁴⁹⁵ The introduction of this resource resulted in reduced instances of violence and property damage.⁴⁹⁶

Technology has also been utilised to connect prisoners housed in solitary confinement to nature for therapeutic purposes. The creation of the **'Blue Room', designed to deliver nature imagery videos to prisoners housed in solitary confinement** in Oregon, was an initiative of University of Utah Biology Professor Nalini Nadkarni.⁴⁹⁷ In one of her studies, prisoners were provided with 38 video options, each containing various landscapes including **beaches, underwater scenes, scenes from space, forests and deserts** with an option for no noise, background sound or music.⁴⁹⁸ Prisoners were entitled to 45 minutes per day of time in the Blue Room for five days of the week.⁴⁹⁹ Over 80 percent of participants reported that access to nature imagery made their experience in solitary confinement 'easier'.⁵⁰⁰ Surveys also reported increased calmness, and improved relationships with, and understanding of, unit staff.⁵⁰¹ The study reported a 26 percent reduction in violent offences for the prisoners with access to the Blue Room.⁵⁰² Despite initial reluctance by some staff members towards the initiative, all staff reported prisoners to be calmer and less violent following time in the Blue Room.⁵⁰³ Staff started using the Blue Room as a preventive mechanism to minimise behavioural incidents, by prioritising inmates who displayed warning signs for violent or disruptive behaviour.⁵⁰⁴

486 American Civil Liberties Union of Maine (n 368) 13.

487 Ibid.

488 Ibid.

489 J. Lobel, 'The Liman Report and Alternatives to Prolonged Solitary Confinement' (2015-2016) 125 *Yale Law Reform Journal* 238, 243-4.

490 J. Evon and F. Olive, 'The Utilization of MP3 Players in Correctional Segregation Units' (2013) 74(6) *Corrections Today* 53, 53-4 <<https://search-proquestcom.ezproxy.library.uq.edu.au/docview/1312702081?accountid=14723>>.

491 Ibid 54.

492 Ibid 55.

493 Ibid 54.

494 Ibid.

495 Ibid 56.

496 Ibid 55.

497 Vera Institute of Justice, 'Promising Practices: The Blue Room', *Safe Alternatives to Segregation* (Web Page) <https://www.safealternativestosegregation.org/promising_practice/the-blue-room/>. The initiative was named in Time Magazine's Top 25 inventions for 2014: 'The 25 Best Inventions of 2014' TIME (Web Page, 20 November 2014) <<https://time.com/3594971/the-25-best-inventions-of-2014/>>.

498 N. Nadkarni et al, 'Impact of Nature Imagery on People in Severely Nature-Deprived Environments' (2017) 15(7) *Frontiers in Ecology and the Environment* 395, 397.

499 Ibid.

500 Ibid 398.

501 Ibid 399.

502 Ibid 400.

503 Ibid 399.

504 Ibid.

Following its success, the Blue Room has been adapted to other correctional facilities in Oregon, and to other units including detention units and administrative segregation units.⁵⁰⁵

North Dakota Department of Corrections has created a **timetable of structured activities** for prisoners in its Behavioural Intervention Unit, a segregation unit. Prisoners are provided with one recreational activity each weekend, and clinical staff oversee **weekly ‘leisure’ activities, such as ‘art projects, mindfulness practice, or a movie’** along with behavioural management sessions.⁵⁰⁶ Reform has also focused on improving relationships between correctional staff and prisoners. Correctional **officers engage in communication with prisoners twice a day, whether this is through conversation or ‘practice of a cognitive or behavioural skill’**.⁵⁰⁷ The Department reported improved behavioural outcomes as a result of these reforms.⁵⁰⁸

The Colorado Department of Corrections has begun placing **purpose-built restraint tables**, previously used in speciality mental health and clinical units, in restrictive housing maximum security units, with a view to increasing safe opportunities for out-of-cell time and interaction for prisoners who remain in solitary confinement.⁵⁰⁹ The ultimate goal is for prisoners to progress to a position where restraints are not required for safe association.⁵¹⁰ Washington Department of Corrections also uses restraints to create greater opportunities for safe interaction between inmates in solitary confinement. The Department has developed a number of purpose-built chairs for use in ‘congregate programming’, which allow violent and disruptive prisoners to engage in therapeutic education in a group setting, and to experience human contact while in solitary confinement units.⁵¹¹

7.4.3 Canada

Under the new Canadian legislation, prisoners in the SIU must have an opportunity to spend a minimum of four hours outside their cell, and an opportunity to interact for a minimum of two hours with others through activities (including programs, interventions and services aimed at their reintegration) and leisure time.⁵¹² Prisoners must receive a mental health assessment within 24 hours of their placement in the SIU, and must be **visited daily by a registered health care professional**.⁵¹³

7.4.4 United Kingdom

In the UK, prisoners who are regarded as particularly dangerous are isolated from the general population in small groups in ‘Close Supervision Centres’, rather than complete solitary confinement.⁵¹⁴ Approximately 60 of the most high-risk and dangerous prisoners throughout the UK are held in these centres.⁵¹⁵ Though concerns remain surrounding conditions in these centres, generally these prisoners are provided with greater levels of human interaction than is typically found in solitary confinement units, through the availability of **family visits, telephone access and in-person access to legal representatives**.⁵¹⁶ For example, prisoners are able to collect their own meals from the server, and they have **daily access to a health professional and chaplaincy services**.⁵¹⁷

⁵⁰⁵ Vera Institute of Justice (n 497).

⁵⁰⁶ The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 72-3.

⁵⁰⁷ Ibid 72.

⁵⁰⁸ Ibid 73.

⁵⁰⁹ Raemisch and Wasko (n 373) 12.

⁵¹⁰ The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 68.

⁵¹¹ D. Pacholke and S. Mullins, *More Than Emptying Beds: A Systems Approach to Segregation Reform* (Report, 2016) 7 <<https://www.bja.gov/publications/MorethanEmptyingBeds.pdf>>.

⁵¹² *Corrections and Conditional Release Act*, SC 1992, c C-20 s 36(1).

⁵¹³ Ibid s 37.1(2)(b).

⁵¹⁴ Her Majesty's Chief Inspector of Prisons, *Report on an Announced Thematic Inspection of the Close Supervision Centre System* (Report, March 2015) 5 <<https://www.justiceinspectorates.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2015/08/CSC-web-2015.pdf>>.

⁵¹⁵ Ibid.

⁵¹⁶ Ibid 22, 25; Shalev (n 466) 158.

⁵¹⁷ D. Johnner, ‘One is the Loneliest Number’: A Comparison of Solitary Confinement Practices in the United States and the United Kingdom’ (2019) 7(1) *Penn State Journal of Law and International Affairs* 229, 257.

In some centres, prisoners are given the opportunity to involve relatives and friends in their case management meetings and reviews, and inter-prison visits are sometimes made available.⁵¹⁸ Kitchens and appliances are sometimes provided to give prisoners the **opportunity to make their own meals**,⁵¹⁹ and recreational facilities are offered including **pool tables, craft rooms and board games during association time**.⁵²⁰

In the unit at Full Sutton Prison, **daily timetables are created for prisoners with a variety of available activities** and prisoners are permitted to **interact for seven hours per day**.⁵²¹ The prison employs a **physical education teacher to provide multiple exercise sessions** to prisoners each week,⁵²² and allows visits with relatives in open spaces with a meal.⁵²³ Prisoners are also provided with **employment opportunities, offered art therapy sessions and can do gardening as a recreational activity**.⁵²⁴ In Woodhill Prison, some prisoners are permitted to engage in **paid 'in-cell work'**.⁵²⁵ The Woodhill unit also **employs a full time teacher** and provides distance education to ensure that prisoners have meaningful opportunities for learning.⁵²⁶ In the unit at Lindholme Prison, prisoners are provided with **'distraction and activity packs'** and have **daily use of a telephone**.⁵²⁷

7.4.5 Europe

A 2018 Report by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment describes some examples of good practice in Europe.⁵²⁸ For example, in one Norwegian prison, a 'Resource Team' that includes an **'activity organiser'** was introduced for prisoners with mental health conditions.⁵²⁹ The Resource Team facilitates **weekly activities including outdoor exercise, education, cooking and employment opportunities**.⁵³⁰ Other units provide prisoners with association time and access to books.⁵³¹

One prison in the Netherlands provides a particularly good example of suitable **exercise facilities**. Many solitary confinement units provide only a simple cage with some gym equipment for exercise use.⁵³² In contrast, Vught Prison provides a **'running strip'**, varied gym equipment and allows prisoners to exercise in small groups.⁵³³

7.4.6 New Zealand

A 2017 report on solitary confinement practices in New Zealand noted that some facilities provide prisoners with a **'welcome pack', including illustrated instructions on operating procedures, daily timetables and complaints processes**.⁵³⁴ Sometimes, families of prisoners are also provided with this information.⁵³⁵ Activities available to prisoners in solitary confinement units range from gardening to eating meals at communal tables.⁵³⁶ Some facilities permit **painted walls, artworks or murals** to brighten rooms, as well as recreational resources including television, books and writing materials.⁵³⁷

⁵¹⁸ Her Majesty's Chief Inspector of Prisons, *Report on an Announced Thematic Follow-up Inspection of the Close Supervision Centre System* (Report, December 2017) 31. <<https://www.justiceinspectorates.gov.uk/hmiprisoners/wp-content/uploads/sites/4/2018/04/CSC-follow-up-web-2017.pdf>>.

⁵¹⁹ Ibid 37.

⁵²⁰ Ibid 30; Her Majesty's Chief Inspector of Prisons (n 514) 36.

⁵²¹ Her Majesty's Chief Inspector of Prisons (n 514) 36-7.

⁵²² Her Majesty's Chief Inspector of Prisons (n 518) 30.

⁵²³ Ibid 31.

⁵²⁴ Ibid 30; Independent Monitoring Board, *Annual Report of the Independent Monitoring Board at HMP Full Sutton* (Report, May 2019) 14 <<https://s3-eu-west-2.amazonaws.com/imib-prod-storage-locod6bqky0vo/uploads/2019/05/Full-Sutton-2018-final-publ-May-2019.pdf>>.

⁵²⁵ Her Majesty's Chief Inspector of Prisons (n 518) 30.

⁵²⁶ Ibid.

⁵²⁷ Her Majesty's Chief Inspector of Prisons (n 514) 22.

⁵²⁸ European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment, *Report to the Norwegian Government on the visit to Norway carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) from 28 May to 5 June 2018* (Report, January 2019) 34-6 <<https://rm.coe.int/1680909713>>.

⁵²⁹ Ibid 35-6.

⁵³⁰ Ibid 36.

⁵³¹ Ibid.

⁵³² Shalev (n 48) 39.

⁵³³ Ibid 44.

⁵³⁴ S. Shalev and New Zealand Human Rights Commission, *Thinking Outside the Box? A Review of Seclusion and Restraint Practices in New Zealand* (Report, 2017) 50 <http://solitaryconfinement.org/uploads/Thinking_Outside_The_Box_PRINT.pdf>.

⁵³⁵ Ibid.

⁵³⁶ Ibid 52.

⁵³⁷ Ibid 50, 52-3.

In some facilities, prisoners' beds in the general population are reserved for them.⁵³⁸ This ensures that solitary confinement is used only for short periods of time and prisoners' release into the general population is not delayed due to over-crowding.⁵³⁹

7.5 'Step-down' and reintegration programs

7.5.1 United States of America

Step-down and reintegration programs have been designed in the US to reintegrate prisoners from prolonged solitary confinement. The 2016 Department of Justice Report recommended the establishment of 'step-down units' to assist prisoners to 'demonstrate good conduct and positive institutional adjustment' by progressing them through a series of reintegration stages.⁵⁴⁰ An important feature of these 'step-down units' is that **social visits, legal visits and social correspondence are encouraged**. Access to other privileges, however, is determined in light of the prisoner's progress through the program.⁵⁴¹ The aim of 'step-down' programs is to 'facilitate the reintegration of the inmate into general population or the community' and a **multidisciplinary team approach** is taken 'that includes mental health, case management and security practitioners' as well as medical personnel where the person has a chronic illness or significant medical needs.⁵⁴²

The 2018 *Time in Cell Report* found that 27 jurisdictions in the US have begun implementing step-down and re-integration programs to facilitate inmates' transition from solitary confinement to the general prison population, and facilities have reported positive results in terms of decreased incidents of violence and recidivism.⁵⁴³ The report states that some programs involve '**progressive levels or phases with increasingly less-restrictive conditions**' and some are separate housing units.⁵⁴⁴ The step-down units allow for much more social contact between prisoners, and between prisoners and staff, however this is done in a closely controlled way. For example, many step-down units make use of physical restraints including **ankle restraints and restraint tables**.⁵⁴⁵ Out-of-cell time is progressively increased, as is access to privileges such as **electronic devices, games and email**. In-cell time is made more bearable through the use of **in-cell exercise programs, education, mindfulness, puzzle books, music and special programming**.⁵⁴⁶ **Job assignments and eating meals in the cafeteria** can also be earned.⁵⁴⁷ Prisoners have individualised behaviour management plans, and decisions regarding a prisoner's progress are made by a multidisciplinary team.⁵⁴⁸

Kupers et al describe a step-down unit in Mississippi for prisoners who had remained in solitary confinement for extended periods of time, often due to severe mental illness. Treatment focused on their strengths and ambitions and how these could act as protective factors against 'disorder'.⁵⁴⁹ Prisoners received **education on anger and anxiety** in groups, with the incentive of being able to spend progressively more time in an activity room that contained media equipment, a library and art materials. Group treatment was facilitated by the **use of ankle restraints which were secured to bolts in the floor. Prisoners sat proximate to one another, but could not physically reach each other**.⁵⁵⁰ Once prisoners progressed to the next stage of treatment, the restraints were removed. Prisoners remained in the step-down unit for three to six months, and could be readmitted if they experienced a

⁵³⁸ This practice has also been introduced by the Maine Department of Corrections in the USA: Ibid 50; American Civil Liberties Union of Maine (n 368) 16.

⁵³⁹ Shalev and New Zealand Human Rights Commission (n 534) 50.

⁵⁴⁰ US Department of Justice (n 424) 41.

⁵⁴¹ Ibid 76.

⁵⁴² The Association of State Correctional Administrators (n 443) Standard 4-RH-0032 (38).

⁵⁴³ The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 63, 126.

⁵⁴⁴ Ibid 63.

⁵⁴⁵ The Association of State Correctional Administrators and the Liman Center for Public Interest Law at Yale Law School, *Aiming to Reduce Time-In-Cell: Reports from Correctional Systems on the Number of Prisoners in Restricted Housing and on the Potential of Policy Changes to Bring About Reforms* (Report, November 2016) 62, 63.

⁵⁴⁶ Ibid 65, 68, 72-3.

⁵⁴⁷ Ibid 67.

⁵⁴⁸ Ibid 68.

⁵⁴⁹ Kupers et al (n 464) 1042.

⁵⁵⁰ Ibid 1043.

relapse after discharge. Kupers et al report that both serious violent incidents and the use of force against prisoners reduced once the reforms were introduced. Both prisoners and staff provided 'positive assessments' of the step-down unit and reported that it 'helped keep this group out of trouble'.⁵⁵¹

Alger Correctional Facility in Michigan has been operating a step-down program since 2009 and this program has since been implemented in other correctional facilities across the US.⁵⁵² It operates on an incentive model, where prisoners can access increasing rewards and privileges, such as **snacks, television, family telephone calls and finally, removal to the general population**.⁵⁵³ In order to progress, prisoners must demonstrate good behaviour and hygiene, but they can also progress by writing essays detailing the cause of their placement in solitary confinement and how this behaviour will be modified to prevent future infractions.⁵⁵⁴ Since a number of prisoners have progressed out of solitary confinement, one of the segregation units has been closed⁵⁵⁵ and the facility has reported decreases in both critical and minor offences.⁵⁵⁶

The Colorado Department of Corrections introduced two connected step-down programs which have been replicated in other correctional facilities due to their success.⁵⁵⁷ Close Custody Management Control Units are targeted at inmates seeking to return to the general population.⁵⁵⁸ The units provide increased opportunities for interaction, allowing prisoners a minimum of four hours of out-of-cell time each day, and association in groups of up to seven prisoners for social and recreational time.⁵⁵⁹ The Department also has Close Custody Transition Units for prisoners who have progressed from the Close Custody Management Control Units.⁵⁶⁰ Prisoners in this unit are afforded increased privileges, including a minimum of six hours of out-of-cell time each day where association is permitted with up to 16 other prisoners.⁵⁶¹ Both units provide educational and behavioural programs, such as the 'Thinking for a Change Program', a program the Department reports as successful in reducing recidivism.⁵⁶²

Washington State Department of Corrections has implemented an Incentive Transition Program, a nine-month program for prisoners in its restrictive housing units.⁵⁶³ The program also operates on a 'levels' system, where prisoners can progress through each level to earn privileges.⁵⁶⁴ An important component of the program is 'moral recognition theory' and behavioural strategies.⁵⁶⁵ The program has an impressive success rate; in 2016, it was reported that 107 of the 131 participants had not returned to restrictive housing following completion of the program.⁵⁶⁶

An important feature of step-down units is increased out-of-cell time. A pilot step-down program introduced in Massachusetts uses '**dorm style housing**' so that prisoners are not confined to their cells immediately before being reintegrated into the general population.⁵⁶⁷

⁵⁵¹ Ibid 1046.

⁵⁵² Maurice Chamamah, 'How to Get Out of Solitary – One Step at a Time', *The Marshall Project* (Web Page, 7 January 2016) <<https://www.themarshallproject.org/2016/01/07/how-to-get-out-of-solitary-one-step-at-a-time>>.

⁵⁵³ Ibid.

⁵⁵⁴ Ibid.

⁵⁵⁵ Ibid.

⁵⁵⁶ Ibid.

⁵⁵⁷ Raemisch and Wasko (n 373) 4.

⁵⁵⁸ Ibid.

⁵⁵⁹ Ibid.

⁵⁶⁰ Ibid.

⁵⁶¹ Ibid.

⁵⁶² Ibid 4-5.

⁵⁶³ Steinbuch (n 448) 527-8.

⁵⁶⁴ Ibid.

⁵⁶⁵ Ibid 527.

⁵⁶⁶ Ibid 528; US Department of Justice (n 424) 76.

⁵⁶⁷ The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 126.

The Louisiana Department of Public Safety and Corrections includes **peer mentors, specialising in areas such as addiction**, in their step-down process.⁵⁶⁸

Successful step-down programs have been established specifically for prisoners who have been held in long-term solitary confinement. States such as Washington have introduced ‘transition pods’ for maximum security prisoners, which prepare prisoners for return to the general population by gradually increasing interaction with staff and other prisoners without restraints.⁵⁶⁹ The New Mexico Corrections Department reformed its maximum security units into another step-down program, the Predatory Behaviour Management Program.⁵⁷⁰ The program reflects a shift towards only using long-term restrictive housing for prisoners who display predatory behaviour.⁵⁷¹ The program reinforces the overall goal of returning prisoners to the general population after they have successfully participated in programming and treatment.⁵⁷² Other states, such as New York, have established step-down programs designed for prisoners who are re-entering the community from solitary confinement units.⁵⁷³ Its step-down to the Community Program is available for prisoners who have been in solitary confinement for more than sixty days and will be released into the community in 45 to 60 days.⁵⁷⁴ The program provides programming to aid safe return to the community.⁵⁷⁵ Virginia Department of Corrections reports that the population of prisoners in the maximum security level of its restrictive housing units has been reduced from 511 in 2011 to 72 in October 2018 since the introduction of its step-down unit.⁵⁷⁶

Other step-down programs are targeted at prisoners with linkages to gangs. For example, New Mexico Corrections Department created the Restoration to Population Program, which allows prisoners to renounce their previous gang memberships.⁵⁷⁷ Once the renunciation is verified, prisoners can return to the general prison population.⁵⁷⁸ Within the Federal Bureau of Prisons, Security Threat Group Drop-Out Units have also been established to transition prisoners into the general population once gang membership is renounced.⁵⁷⁹

7.6 Cost and benefits

Restricting the use of solitary confinement is not only humane and consistent with international law – there are also significant economic benefits for correctional facilities.⁵⁸⁰ By imposing limits on the amount of time prisoners can be held in solitary confinement and implementing alternative behavioral management and housing strategies, states in the US have been able to entirely shut down notorious ‘supermax’ facilities.⁵⁸¹ For example, in 2013 the Illinois Department of Corrections permanently closed the state’s only supermax facility, Tamms Correctional Centre, where 25 percent of all prisoners were held in solitary confinement for over 10 years.⁵⁸² A briefing paper from the American Civil Liberties Union reports that this closure may save \$20 million annually.⁵⁸³ Similarly, in 2007 the Mississippi Department of Corrections was able to close a solitary confinement unit saving \$5.6 million annually.⁵⁸⁴

568 D. Cloud et al, *The Safe Alternatives to Segregation Initiative: Findings and Recommendations for the Louisiana Department of Public Safety and Corrections, and Progress Toward Implementation* (Report, May 2019) 13 <<https://www.vera.org/downloads/publications/safe-alternatives-segregation-initiative-findings-recommendations-ldps.pdf>>.

569 The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 126.

570 New Mexico Corrections Department, *Financial Year 2017 Annual Report* (Report, 2018) 17 <https://cd.nm.gov/wp-content/uploads/2019/05/2016-2017_Annual_Report.pdf>.

571 Ibid.

572 US Department of Justice (n 424) 76.

573 The Association of State Correctional Administrators and The Liman Center for Public Interest Law at Yale Law School (n 374) 128.

574 Ibid.

575 Ibid.

576 B. Kline, E. Vanko, and L. Digard, *The Safe Alternatives to Segregation Initiative: Findings and Recommendations for the Virginia Department of Corrections* (Report, December 2018) 10 <<https://www.vera.org/downloads/publications/segregation-findings-recommendations-virginia-dept-corrections.pdf>>.

577 US Department of Justice (n 424) 76.

578 Ibid.

579 Ibid 25.

580 Lobel (n 489) 245.

581 Steinbuch (n 448) 525-6.

582 Ibid.

583 American Civil Liberties Union, *The Dangerous Overuse of Solitary Confinement in the United States – American Civil Liberties Union* (Briefing Paper, August 2014) 13 <https://www.aclu.org/sites/default/files/assets/stop_solitary_briefing_paper_updated_august_2014.pdf>.

584 Steinbuch (n 448) 525.

Further to this, some states such as Maine have reported decreases in workers' compensation claims, as working conditions in prisons have improved as a result of restrictions on the use of solitary confinement and implementation of step-down programs.⁵⁸⁵ Resources can then be diverted to the provision of appropriate care and supervision.

SUMMARY

There are many alternatives to solitary confinement, even for prisoners with serious mental health difficulties, and those who need to be held in protective custody.

Many jurisdictions have established in-prison units that provide a therapeutic environment for prisoners with serious mental illness. It is important that unwell prisoners are triaged for treatment at the earliest possible stage so that preventative care can be delivered before their mental health deteriorates.

Many jurisdictions around the world have placed hard legal limits on the amount of time that someone can spend in solitary confinement, ranging from 15 to 45 days.

Many jurisdictions have improved conditions in solitary confinement units by:

- allowing prisoners to engage in meaningful in-cell activities by providing them with a television, books, MP3 player (for music, audiobooks and audio-programs), puzzle books, education resources, exercise programs, in-cell work, and art supplies;
- permitting prisoners to spend more time out of their cell for meals, programs, art projects, sports and other activities – purpose-built restraints can be used if this is necessary for the purpose of ensuring order and safety;
- providing prisoners with timetables, either daily or weekly, so their use of time is predictable and varied;
- providing and simulating outdoor experiences, including through the use of technology;
- increasing their contact with the outside world through telephone, email and visits;
- increasing the amount of meaningful contact prisoners have with staff, chaplains and medical personnel.

The development of step-down programs has enabled corrective services in many jurisdictions to increase prisoners' range of activities and out-of-cell time in a closely controlled, monitored and staged way. Prisoners' behaviour can be managed in many ways that do not require complete social isolation, such as reduction of privileges, periods of in-cell confinement, or time in 'calm down' or 'de-escalation' rooms.

585 M. Chammah, 'Stepping Down from Solitary Confinement', *The Atlantic* (Web Page, 7 January 2016) <<https://www.theatlantic.com/politics/archive/2016/01/solitary-confinement-reform/422565/>>.

8. Findings and recommendations

8.1 Key findings

The key findings of this research are:

- UN bodies have concluded that **‘solitary confinement should only be used in very exceptional cases**, for as short a time as possible and only as a last resort’ and that solitary confinement for more than 15 days at a time should be prohibited. However, research suggests that there is no ‘safe’ period of solitary confinement, and that enduring damage to prisoners’ mental health can be caused within days.
- Courts in New Zealand, Canada, the UK and the European Court of Human Rights have held that **solitary confinement conditions engage and may breach human rights** including the right to humane treatment when deprived of liberty, the right to be free from cruel, inhuman and degrading treatment, the right to life, liberty and security of person, and the right to be free from arbitrary interference with one’s family.
- **A number of jurisdictions have abolished the use of solitary confinement for vulnerable people and placed legal limits on the duration of solitary confinement for all prisoners.** Whilst legislation and practice directives in Queensland provide some minimum protections for prisoners in solitary confinement, there is a disconnect between the law, policy and practice. Further, the applicable laws and policies, and existing practices, are not consistent with international law, or international best practice.
- **Many prisoners in Queensland have experienced prolonged periods of solitary confinement, sometimes for years at a time.** The conditions in solitary confinement in Queensland prisons would shock community conscience. **Prisoners with serious mental health conditions receive inadequate and inappropriate care and treatment.** Prisoners are exposed to **extreme sensory and social isolation**. Prisoners’ mental health deteriorates substantially whilst in solitary confinement, and continues to deteriorate the longer they are exposed to these conditions.
- In a number of deaths in custody inquests, coroners have recommended that executive oversight of solitary confinement orders be increased, and that prisoners demonstrating serious psychiatric symptoms be **transferred to secure mental health units without delay**.
- It is more difficult to justify placing women in solitary confinement as their protective needs, and the degree of risk they pose to safety and good order, are different from men.
- Lawyers, advocates and professionals who work with prisoners in solitary confinement in Queensland often agree that prisoners should be removed from solitary confinement, and that the conditions they experience should be immediately improved to preserve their mental health and physical safety.
- **There are many alternatives to solitary confinement** for prisoners with serious mental health problems, and for prisoners who pose a threat to safety and good order. Alternative behaviour management strategies, step-down units, mental health units provide some best practice examples.

- **Conditions in solitary confinement could be immediately improved** by providing prisoners with more opportunities for meaningful communication and social interaction; improved access to mental health personnel; in-cell activities including education, exercise programs, employment, music, books; opportunities to interact with nature, see the sky, feel the grass; and carefully managed and monitored association with other prisoners assisted by the use of restraints where necessary.

8.2 Recommendations

The findings of this report demonstrate a clear and urgent need to eliminate the use of solitary confinement.

There are a range of steps that can be immediately taken to prevent the negative health outcomes that solitary confinement creates for the most vulnerable members of the prison population. Urgent action is required in recognition of the profound harm that solitary confinement causes and in order to achieve compliance with the *Human Rights Act 2019* (Qld).

We recognise that comprehensive and responsible reform of prolonged solitary confinement practices will take time. We acknowledge that there are people currently detained in prolonged solitary confinement who could not be immediately released from this environment without causing additional harm.

These recommendations have been drafted to achieve a balance between the need to implement urgent changes to policy and practice, and the importance of ensuring that legislative reform is both meaningful and responsible. Any legislative reform must involve proper consultation to safeguard against the creation of a different version of solitary confinement. It is also necessary for changes to be made to infrastructure to safely transition those prisoners who are currently being held in prolonged solitary confinement.

Therefore, in balancing these considerations, we recommend:

1. That QCS eliminate the use of solitary confinement, or segregation by any name.

In fulfilment of this objective, the following measures should be immediately undertaken by QCS:

- introduce a policy that prohibits the use of solitary confinement for prisoners with mental illness - all prisoners with mental health issues should be transferred out of prisons into community based, state health administered mental health services;
- introduce a policy that prohibits the use of solitary confinement for women;
- establish step-down programs for prisoners who are being held in prolonged solitary confinement with a view to commencing their reintegration within 12 months;
- improve conditions for prisoners currently in solitary confinement. This could include:
 - increasing in-cell mental stimulation through the provision of additional books, puzzles, televisions, movies, MP3 players, games, education and employment opportunities;
 - increasing prisoners' opportunities for in-cell physical activity by providing running strips, exercise programs and physical education;

- providing prisoners with access to nature by allowing them time outside, under the sun, standing on grass; and
- providing prisoners with opportunities to engage in appropriate self-soothing and self-regulation by having access to calm down rooms, Blue Rooms, music, yoga and relaxation programs.

2. That the *Corrective Services Act 2006* (Qld) be amended to:

- a. require that prisoners receive a comprehensive mental health evaluation by an external mental health professional within 24 hours of a decision to separate them from the general prison population;
- b. mandate that no prisoner be held in solitary confinement within 60 days of their release date;
- c. require that correctional authorities apply to a court for authority to separate a prisoner from the general prison population for more than 48 hours.

3. That QCS immediately commence a process for undertaking meaningful engagement with relevant non-government organisations about solitary confinement reform.

Suggestions for implementation include:

- establishing a steering group or advisory committee to inform policy and program development pertaining to solitary confinement, and the management of prisoners with serious mental illness;
- not limiting employees of non-government organisations' access to prisoners for the purposes of service delivery including psychiatric and psychological support, and legal services; and
- engaging in consultation regarding amendments to the *Corrective Services Act 2006* (Qld) to eliminate solitary confinement.



For more information,
please contact

Professor Tamara Walsh

E: t.walsh@law.uq.edu.au

W: law.uq.edu.au

A: Level 3, Forgan Smith Building (1)
The University of Queensland
St Lucia QLD 4072, Australia