



public interest
ADVOCACY CENTRE

In Poor Health:

Health care in Australian
immigration detention



About the Public Interest Advocacy Centre

The Public Interest Advocacy Centre (PIAC) is an independent, non-profit legal centre based in Sydney.

Established in 1982, PIAC works for a fair, just and democratic society, removing barriers to justice and fairness experienced by vulnerable and disadvantaged people. We ensure basic rights are enjoyed across the community through legal assistance and strategic litigation, public policy development, communication and training.

Our work addresses issues such as:

- homelessness (through the Homeless Persons' Legal Service);
- access for people with disability to basic services like public transport, education and online services;
- Indigenous disadvantage (through our Indigenous Justice Project and Indigenous Child Protection Project);
- discrimination against people with mental health conditions;
- access to energy and water for low-income and vulnerable consumers (the Energy and Water Consumers Advocacy Program);
- the exercise of police power;
- the rights of people in detention, including the right to proper medical care (including the Asylum Seeker Health Rights Project); and
- government accountability, including freedom of information.

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The Public Interest Advocacy Centre office is located on the land of the Gadigal of the Eora Nation.

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Introduction

Australia's treatment of asylum-seekers and others who enter or remain in the country without a valid visa is the subject of sustained controversy.

This report should not be controversial.

It calls for health care to be provided to people in immigration detention in Australia at the same standard as is available in the Australian community: fair and humane treatment for people who are especially vulnerable, and consistent with our fundamental duty of care to those we detain.

This report's recommendations show how this can be done.

Marco¹ is an asylum seeker. He was held in immigration detention from his arrival in June 2011. Shortly after he was first detained, Marco began to develop mental health issues. Within the first six months of detention, he experienced symptoms of depression and anxiety. During this time, he attempted suicide and self-harmed. Several medical practitioners attributed his mental health deterioration to his detention environment.

In January 2012, Marco tried to hang himself and was admitted to hospital for treatment. Medical professionals determined he had several diagnoses including anxiety disorder, adjustment disorder, ongoing post-traumatic stress disorder and depression. Following this suicide attempt, a CT scan identified a protruding disc in his neck with nerve root compression, requiring surgery.

Marco has never received the recommended neck surgery. He suffers from chronic neck pain which still remains unresolved today – it has also exacerbated his depression.

During the course of his immigration detention, Marco was routinely transferred between hospitals and detention facilities on Christmas Island, in Darwin, Brisbane, Perth and Sydney, as well as several psychiatric facilities. This disruption further aggravated his mental health conditions and resulted in discontinuity of care and delays in progressing through public health system waiting-lists.

Despite his well-known health problems, during transfers between facilities and to medical appointments, he was often handcuffed, including on one occasion for many hours in the back of a van. On another occasion, the distress and discomfort caused by the handcuffing led Marco to refuse to go to the emergency department following an intentional drug overdose because he was told he would be handcuffed.

After being released from hospital, Marco continued to have ongoing suicidal ideation and self-harmed on several occasions.

In late 2016, after several years in immigration detention centres, Marco was released into community detention and was subsequently placed on a bridging visa. He continues to experience significant complex physical and mental health issues arising from his time in immigration detention and his inability to access adequate health care.

This client is one of 24 retained by the Public Interest Advocacy Centre (PIAC) as part of our Asylum Seeker Health Rights (ASHR) Project. There are approximately 1,800 people currently in immigration detention across Australia.

¹ Pseudonyms have been used in the case studies included in this report.

Unfortunately, as the case studies included in this report make clear, the Australian government is failing to provide people in immigration detention with access to the medical care and treatment they need. This is despite the fact the government owes a clear, common law duty of care to people it detains.

However, this duty is not reflected in the legislation which governs the treatment of people in detention: the *Migration Act 1958* (Cth) (Migration Act) and the *Migration Regulations 1994* (Cth) (Migration Regulations). These laws do not include a guaranteed right to reasonable medical care and treatment. This 'legislative vacuum' stands in stark contrast to the laws of Australian states and territories which ensure people in correctional custody, do have such a right.

The Australian government must take urgent action to address this serious gap by providing for a minimum health standard in the Migration Regulations. These amendments must be supported by further practical steps to implement this substantive right to health care, as well as increased oversight including by the National Preventive Mechanism under the *Optional Protocol to the Convention Against Torture* (OPCAT).

These concrete steps will reduce the suffering of people in immigration detention.

Recommendations

PIAC makes the following recommendations for reform:

1. **Amend the Migration Regulations** by inserting a new provision to require a minimum standard of healthcare (the Minimum Standard of Healthcare) as follows:

Every held and community detainee has the right to –

- (a) access reasonable and culturally appropriate medical care and treatment necessary for the preservation of health at a standard equivalent to that available in the Australian community including:
 - i. if the detainee has an intellectual disability or is experiencing a mental health condition, such special care and treatment as a medical officer considers necessary or desirable in the circumstances including, for people in held detention, treatment outside of detention with the Minister's approval;
 - ii. dental treatment necessary for the preservation of oral health;
 - iii. with the approval of a medical officer but at the detainee's own expense, a private registered medical practitioner, dentist, physiotherapist or chiropractor chosen by the detainee;
 - (b) as far as practicable, no exposure to risks of infection; and
 - (c) conditions in detention that promote the health and wellbeing of the detainee.
2. Ensure that any **2019 contractual renewal** with International Health and Medical Services (IHMS) or any other health provider appointed to deliver services to immigration and community detainees, explicitly requires compliance with the Minimum Standard of Healthcare.
 3. **Conduct an audit** of existing departmental policies to ensure that they fully reflect the Minimum Standard of Healthcare.
 4. **Develop and roll-out training** to ensure the Minimum Standard of Healthcare is delivered.
 5. **Provide antiviral therapy** to all held and community immigration detainees living with **hepatitis C**.
 6. **Adopt** the *Human rights standards for immigration detention* developed by the Australian Human Rights Commission in the operations of held and community detention.
 7. **Appoint** a chief medical officer to the Department of Home Affairs (the Department).
 8. **Provide transparency** around the **role, functions and composition** of the Independent Health Advice Panel (IHAP), appointed by the Department of Home Affairs.

Depending on IHAP's role, functions and composition, **ensure** that:

 - a. IHAP is legitimately independent and capable of providing robust oversight functions;
 - b. IHAP is comprised of members of the medical profession with expertise in areas including **general practice, mental health, torture/trauma, men's health, women's health, paediatrics, public health, infectious diseases, chronic pain, obstetrics, midwifery, nursing, oral health and allied health**.
 - c. IHAP's mandate covers **agreed timelines** for the Commonwealth government to **respond to recommendations** arising from the advisory body's findings and to report to Parliament and relevant Ministers.
 9. If IHAP is not the appropriate body to meet the criteria outlined in Recommendation 8, **establish an independent health advisory body** to oversee the provision of medical care in the Australian immigration detention network that does meet the criteria outlined in Recommendation 8.
 10. **Appoint** a National Preventative Mechanism to implement Australia's obligations under the Optional Protocol on the Convention against Torture.
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Project background

Under Australian law, all non-citizens in Australia without a valid visa are detained, either in held detention (that is, detained in immigration detention centres) or community detention.

The ASHR Project was launched in September 2016 to address serious concerns about the lack of adequate health care in Australia's immigration detention system.

While much public attention in recent years has, understandably, focused on concerns about the regime of offshore detention on Manus Island and Nauru, PIAC has worked to ensure that basic human rights are being met in Australia's onshore detention network, both for those in held detention and those in community detention.

While PIAC does not support the approach of mandatory immigration detention and maintains grave concerns about the time for which people are detained, the focus of this report is on ensuring people in immigration detention have access to the medical care and treatment they need, at a standard consistent with the Australian community.

Methodology

This project is driven by the evidence uncovered through our case work with individual clients and supported by the findings of previous inquiries.

Given PIAC's litigation expertise, we have worked on a number of cases that have sought to obtain for clients the care they need and to develop the law to afford greater protections for immigration and community detainees.

Our case work has required us to closely and methodically consider our clients' stories and particularly their records, including extensive medical records. This has helped us identify current policies and patterns of practice that PIAC believes breach the rights of detainees and require systemic change.

This report demonstrates significant failures by the Commonwealth government to provide reasonable medical care to those being held in immigration detention centres and in community detention.

Throughout the ASHR Project, we have maintained strong relationships with our colleagues in the immigration sector and we acknowledge their support. We work with immigration lawyers; migration agents; corporate law firms undertaking work for asylum seekers; members of the medical profession; immigration detention advocates; community agencies and other social support groups who provide services to asylum seekers and immigration and community detainees.

We continue to accept case referrals through these channels which help us to assess the most prevalent issues on the ground. We also work with our colleagues in the sector to share information and workshop ideas to ensure that the ASHR Project both meets our clients' needs and complements existing advocacy strategies.

Clients

In the first 18 months of the ASHR Project, PIAC has been referred approximately 60 people for assistance. After initial screening, we prioritised the engagement of 24 clients based on particular high needs, urgency and capacity to illustrate systemic flaws in the provision of health care to asylum seekers.

All but one of our current clients were held in immigration detention centres at the time they were first retained by PIAC. Over the course of time, many clients have been referred into community detention or released on bridging visas while their substantive asylum applications are being decided.

Working with detained asylum seekers provides us with the unique opportunity to obtain real-time, first-hand accounts of the conditions of immigration and community detention; policies around the daily running of facilities and differences between practices and procedures at various centres; as well as insights into the Department and its subcontractors' decision-making processes.

Our clients' instructions provide an invaluable contribution to informing our understanding of the workings of Australia's immigration detention system.

The anonymised case studies cited in this report have been included with the permission of the clients' involved. PIAC gratefully acknowledges the people in immigration detention who have kindly, and courageously, allowed us to raise these issues on their behalf, and to seek better health care for all people in held and community detention.



Who, where and for how long are people being detained?

The ASHR Project focusses on the treatment of those detained in Australia's onshore immigration detention system, not those held on Nauru or Manus Island.

Who is in immigration detention?

Australian law requires that all non-citizens in Australia without a valid visa, including those seeking asylum as refugees, are to be held in immigration detention.²

This detention comprises two different types:

Held detention – that is, being physically detained in an immigration detention centre; and

Community detention – people in community detention live in the community under a 'residence determination' but remain detained for the purposes of the operation of Australia's migration laws and are designated a fixed-address by the Minister.³ Community detainees are not permitted to engage in any paid work or to study; are not permitted to obtain a Medicare card; have restricted access to medical care; and can be subjected to a range of other conditions,⁴ including curfews.⁵ Community detention can also be revoked by the Minister at any time if they think it is in the public interest to do so.⁶

Where are people being held?

As at 28 February 2018, the largest immigration detention population – onshore or offshore – is at Villawood Immigration Detention Centre (Villawood IDC) in New South Wales.⁷ At the time of writing this report, the Villawood IDC holds close to 500 immigration detainees at the facility – 452 men and 42 women.⁸

The government holds immigration detainees in other secure facilities on the Australian mainland and on Christmas Island as follows:⁹

Facility	State/Operative law	Population of men	Population of women
Villawood IDC	New South Wales	452	42
Christmas Island Immigration Detention Centre (Christmas Island IDC)	Western Australia	333	0
Yongah Hill Immigration Detention Centre (Yongah Hill IDC)	Western Australia	220	0
Maribyrnong Immigration Detention Centre (MIDC)	Victoria	93	11

² *Migration Act 1958* (Cth) s 189.

³ *Ibid* ss 5, 197AB.

⁴ *Ibid* s 197AB.

⁵ Refugee Council of Australia, *Australia's Detention Policies* (17 May 2016) <<https://www.refugeecouncil.org.au/getfacts/seekingsafety/asylum/detention/key-facts/>>.

⁶ *Migration Act 1958* (Cth) s 197AD.

⁷ Department of Home Affairs, 'Immigration Detention and Community Statistics Summary 28 February 2018' (Report, Department of Home Affairs, 2018) 4.

⁸ *Ibid*.

⁹ *Ibid*.

Facility	State/Operative law	Population of men	Population of women
Melbourne Immigration Transit (MITA)	Victoria	62	5
Brisbane Immigration Transit Accommodation (BITA)	Queensland	48	13
Adelaide Immigration Transit Accommodation (AITA)	South Australia	22	<5
Perth Immigration Detention Centre (PIDC)	Western Australia	21	6

The Christmas Island IDC is expected to close in June 2018 and immigration detainees housed at that facility at the time are expected to be transferred to Yongah Hill IDC.¹⁰

There are a further 132 men, 137 women and 173 children in community detention in Australia.¹¹

How long are people being detained?

Immigration detainees are currently held in secure facilities for an average of 426 days.¹² The greatest proportion of the immigration detention population – 19.6% – spend more than 730 days in Australian facilities.¹³

Australia is an outlier internationally in this respect, with the average length of stay for an immigration detainee far exceeding that experienced in other countries. For example, according to the Global Detention Project, in the United States the average immigration detention period is 30 days, in Canada it is 25 days and in France 10 days.¹⁴

In 2016, the *ABC* reported that the time asylum seekers spent in Australian immigration detention had hit an all-time high, noting that the period of detention for those in both onshore and offshore centres ‘has blown out... with a steady increase since May [2015].’¹⁵

10 Paul Farrell, ‘Peter Dutton’s New Super Department Is Facing Unprecedented Government Scrutiny’, *Buzzfeed News* (online), 12 March 2018, <https://www.buzzfeed.com/paulfarrell/peter-duttons-new-super-department-is-facing-unprecedented?utm_term=.aiz1LKq7W3#.tbjvnlexO2>.

11 Department of Home Affairs, n 3, 4. These are people under residence determination, which remains part of immigration detention, and is distinct from people living in the community on Bridging Visas, who are no longer detained.

12 Department of Home Affairs, n 3, 11.

13 *Ibid.*

14 Inga Ting and Conrad Walters, ‘Asylum Seekers’ Time in Detention Soars’, *Sydney Morning Herald* (online), 2 May 2014, <<https://www.smh.com.au/politics/federal/asylum-seekers-time-in-detention-soars-20140503-zr3eg.html>>.

15 Stephanie Anderson, ‘Immigration Detention Times on Nauru and Manus Island Blow Out to 450-day Average under Liberals’, *ABC News* (online), 13 January 2016, <<http://www.abc.net.au/news/2016-01-13/immigration-detention-times-blow-out-to-almost-450-days/7085264>>.

The mental and physical impact of prolonged detention

The figures regarding Australian immigration detainees' average length of stay in facilities is particularly alarming given the well-established medical evidence that long-term, indefinite immigration detention, causes physical and mental harm.

According to Griffith University research published in 2011:

There is a significant body of research which addresses the relationship between detention of those seeking asylum in Australia and various dimensions of mental and physical health and wellbeing...

Despite frequent discussion of the considerable health issues experienced by individuals in long-term detention appearing in the popular press, academic and medical publications and expert reports, it was not until the 2005 Palmer Enquiry into the circumstances of the detention of long-term Australian resident Cornelia Rau (Palmer 2005) that the [then] Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) acknowledged the need to address this problem.¹⁶

In *Seeking asylum in Australia: immigration detention, human rights and mental health care*, the authors of the University of South Australia's 2013 paper noted as follows:

A recent systematic review of the studies investigating the impact of immigration detention on the mental health of children, adolescents and adults identifies high levels of mental health problems in detainees. This review reflects a considerable body of scientific research that has consistently demonstrated high rates of mental disorder in detained asylum seekers...

Research has focussed on the impact of experiences in detention on vulnerable groups of asylum seekers, and also on modelling the factors contributing to better or worse outcomes. Factors such as length of time in detention, negative experiences and traumatic exposure, inability to communicate freely in a language most familiar to the detainee and the process of establishing refugee claims, all compound the asylum-seeking experience. Time in detention correlated with severity of distress.¹⁷

Also in 2013, the Commonwealth Ombudsman published its findings: *Suicide and self-harm in the immigration detention network*.¹⁸ The Commonwealth Ombudsman confirmed that the international and Australian medical evidence demonstrated that immigration detention in a closed environment for longer than six months had a 'significant, negative impact' on mental health.¹⁹

The Commonwealth Ombudsman relied upon data released in 2010 – commissioned by the Department – which found that persons detained for longer periods reportedly had a 'significantly larger number of both mental and physical health problems'.²⁰ Specifically, 'people detained for more than 24 months had rates of new mental illness 3.6 times higher than for those who were released within three months'.²¹

More recently, it was reported that IHMS data identified 14.9% of immigration detainees held in onshore facilities were in 'severe mental distress'.²² With average detention times at a near-record level, IHMS 'has warned the government that detainees' mental health is deteriorating dramatically the longer they are incarcerated'.²³

16 Melissa Bull et al, 'Sickness in the System of Long-term Immigration Detention' (2011) 26 *Journal of Refugee Studies* 47, 47-48.

17 Louise Newman, Nicholas Proctor and Michael Dudley, 'Seeking Asylum in Australia: Immigration Detention, Human Rights and Mental Health Care' (2013) 21(4) *Australas Psychiatry* 315, 318.

18 Commonwealth Ombudsman, *Suicide and Self-harm in the Immigration Detention Network*, Report No 2 (2013) 59.

19 See, eg, Peter Hallas et al, 'Length of Stay in Asylum Centres and Mental Health in Asylum Seekers: a Retrospective Study from Denmark', (2007) 7(1) *BMC Public Health* 288; Allen S Keller et al, 'Mental Health of Detained Asylum Seekers' (2003) 362 *The Lancet* 1721; Zachary Steel et al, 'Impact of Immigration Detention and Temporary Protection on the Mental Health of Refugees' (2006) 188 *The British Journal of Psychiatry* 58; Nicholas G Procter et al, 'Refugee and Asylum Seeker Self Harm with Implications for Transition to Employment Participation – a Review' (2011) 16(3) *Suicidology* 30.

20 Commonwealth Ombudsman, above n 14, 60.

21 Ibid.

22 Ben Doherty and Nick Evershed, 'Immigration Detainees Four Times More Likely to Suffer Severe Mental Distress', *The Guardian* (online), 19 January 2016, <<https://www.theguardian.com/australia-news/2016/jan/19/immigration-detainees-400-percent-more-likely-to-suffer-severe-mental-distress>>.

23 Ibid.

Detention map



Who provides health care in Australia's onshore immigration detention system?

The Department of Home Affairs is responsible for immigration and border policy and the processing of visa applications.²⁴ The Department manages the Australian immigration detention network through its operational enforcement arm, the Australian Border Force (ABF).²⁵ According to the Department:

The work of the Australian Border Force in immigration detention is guided by the Detention Services Manual which contains detention policies and procedures.

The ABF is active in the management of immigration detention facilities, and directs day-to-day operations by working with service providers to protect the welfare and dignity of detainees while maintaining the integrity of immigration detention.²⁶

Health care services – to detainees in held and community detention – are delivered and facilitated by IHMS, a subsidiary of International SOS.²⁷ IHMS has delivered services in immigration and community detention since 2004; the most recent contract was entered into on 11 December 2014.²⁸

The current contract is valued at \$438 million over a five-year period for immigration detention facilities and community detention, expiring on 10 December 2019. The contract includes an option to extend its term to 2023.²⁹

In its report, *Delivery of Health Services in Onshore Immigration Detention* (ANAO Report), the Australian National Audit Office (ANAO) described the provision of medical care to immigration and community detainees as follows:

Held detention

Primary health care, including nurse and general practitioner consultations, is provided at clinics located within the detention facilities. Most detainees receive prescribed medication at set medication distribution times. Mental health, dental and optical consultations are also to be provided within detention facilities. Access to external specialists, hospitals and other allied health services, is facilitated by IHMS referral arrangements.

Detainee access to health services in facilities is structured according to set procedures. Detainees are required to submit a written request to see a nurse or doctor. Consultation hours are generally from 9am to 5pm, Monday to Friday. Outside of these hours, IHMS operates a telephone nursing service that detention centre officers can access on a detainee's behalf. Emergency services attend detention facilities outside consultation hours when necessary.

Community detention

Detainees living in the community are assigned a medical practice and pharmacy in their local area by IHMS. They are required to arrange their own appointments. IHMS operates a cashless health care card system for community detainees to obtain medical services and medication. IHMS also manages referrals to secondary and tertiary health care providers.³⁰

²⁴ Department of Home Affairs, *Role of the Australian Border Force* <<https://www.homeaffairs.gov.au/about/immigration-detention-in-australia/abf-role>>.

²⁵ Ibid.

²⁶ Ibid.

²⁷ Auditor-General, Australian National Audit Office, *Delivery of Health Services in Onshore Immigration Detention Department of Immigration and Border Protection*, Report No 13 (2016-2017), 15 - 16.

²⁸ Ibid 16.

²⁹ Ibid.

³⁰ Ibid.

Australia's duty of care to immigration detainees

The Department has a duty of care to prevent any reasonably foreseeable harm to immigration detainees and is responsible for providing a range of services to them, including health care.³¹ This duty arises because people in immigration detention (like prisoners) are held against their will and are particularly vulnerable.

This obligation is not in dispute. As noted by the Commonwealth Ombudsman in 2013:

- 4.1 ...This duty of care is based on the legal obligation that everybody has: to take reasonable care to avoid acting in ways that are reasonably foreseeable as likely to harm others. A person breaches their duty of care if they act without taking reasonable care, and thereby causes harm that was reasonably foreseeable to another person. In legal terms, a person who has acted in this way has committed the common law tort of negligence...
- 4.4 The department, acting for the Commonwealth, has a very high level of control over detainees in closed detention facilities. It uses its coercive powers to hold those detainees against their will, determines the conditions and length of time of their detention, and is responsible for providing all of their needs...
- 4.6 Because the department has a high level of control over particularly vulnerable people, its duty of care to detainees is therefore a high one. It is not enough for the department to avoid acting in ways that directly cause harm to detainees. It also has a positive duty to take action to prevent harm from occurring.³²

Liability under Australia's common law

The Australian government's non-delegable duty of care owed to immigration detainees, including in relation to providing adequate health services, is well-established under the common law. For example, in *Behrooz v Secretary, Department of Immigration & Multicultural & Indigenous Affairs*,³³ Gleeson CJ noted:

Harsh conditions of detention may violate the civil rights of an alien. An alien does not stand outside the protection of the civil and criminal law. If an officer in a detention centre assaults a detainee, the officer will be liable to prosecution, or damages. **If those who manage a detention centre fail to comply with their duty of care, they may be liable in tort.**³⁴

A number of other cases have considered the duty of care owed to those in immigration detention and have identified failures to discharge that duty.

– *Mastipour v Secretary, Department of Immigration & Multicultural & Indigenous Affairs (Mastipour)*³⁵

The applicant suffered mental illness as a result of his placement in solitary confinement at two immigration detention facilities and the removal of his young daughter to Iran without his knowledge (among other factors).

In the interlocutory application, the subject of the Full Federal Court's decision, the applicant indicated that he sought a transfer from solitary confinement at Baxter Immigration Detention Centre (Baxter) to either Villawood IDC or Maribyrnong IDC, where mental health services were more readily available. The Minister refused the transfer request and offered for him to either return to the general population in Baxter or a transfer to the Port Hedland Immigration Detention Centre (Port Hedland).

The Full Federal Court upheld the primary judge's decision and awarded interlocutory relief in favour of the applicant restraining the Secretary from either detaining him at Baxter or transferring him to Port Hedland.

³¹ Auditor-General, Australian National Audit Office, n 23, 15; Department of Immigration and Border Protection, *Detention Services Manual, Chapter 1: Legislative and Principles Overview – Services Delivery Values*, 7.

³² Commonwealth Ombudsman, n 14, 27.

³³ (2004) 208 ALR 271.

³⁴ *Ibid* [21] (emphasis added).

³⁵ [2004] FCAFC 93.

On the issue of the duty of care owed to the applicant, the primary judge concluded as follows:

There is at the least a clearly arguable case that the Secretary owes to the applicant a duty to take reasonable care for his safety whilst he is in immigration detention. The Secretary did not contend to the contrary. A sufficiently close analogy is with the duty of care owed by those responsible for prisons towards those imprisoned: *Howard v Jarvis* [1958] HCA 19; (1958) 98 CLR 177; *Kirkham v Chief Constable of the Greater Manchester Police* [1989] EWCA Civ 3; [1990] 2 QB 283; *Hall v Whatmore* [1961] VicRp 35; [1961] VR 225; *Dixon v Western Australia & Lees* [1974] WAR 65.

In my view, there is also a serious question to be tried that the present form of detention of the applicant, if it were to continue in the circumstances, may involve a breach of the duty to take reasonable care for the applicant's safety. I do not intend to convey that placing the applicant (or another person in immigration detention) in the Management Unit at Baxter per se constitutes a breach of the duty of care. I do not have to decide that. But the applicant has been in the Management Unit for some two months, and the medical evidence indicates that his continued detention there is likely to cause him damage. There are no countervailing circumstances put forward by the Secretary to warrant his continued detention in the Management Unit.³⁶

– ***S v Secretary, Department of Immigration and Multicultural and Indigenous Affairs (S v Secretary)***³⁷

The applicants, S and M, had both been in immigration detention in various parts of Australia for approximately five years. At the time of the proceedings, they were held in Baxter and had both been diagnosed by psychiatrists as living with Major Depressive Disorder.

The object of their respective applications was to compel their assessment for admission to a mental health facility under the *Mental Health Act 1993 (SA)*. Shortly before the Federal Court delivered its judgment, the Commonwealth government transferred both applicants to mental health facilities.

Finn J noted:

While the scheme of the Migration Act levels the processes of detaining and holding in detention to detaining or holding by “an officer”, the context and structure of the Act in my view makes plain that, whosoever the officer in a given case, the detaining and holding is both on behalf of the Commonwealth and by the Commonwealth. “Officers” provide the Commonwealth’s medium for the purposes of the Act. It is for this reason I consider that the **Commonwealth has correctly conceded in this matter that it owes a non-delegable duty of care to the applicants because of its particular “relationship” with [immigration] detainees**: see *Kondis v State Transport Authority* (1984) 154 CLR 672 at 687.³⁸

Specifically, as to medical care, Finn J held:

This case is one of first impression and for that reason it is necessary to approach the standard required of the Commonwealth with some caution. This said, I am nonetheless satisfied that the minimum properly to be expected of the Commonwealth in virtue of its relationship with detainees in an immigration detention centre such as Baxter is that it ensure that **reasonable care is taken of the detainees who, by reason of their detention cannot care for themselves**: cf *Spicer v Williamson* 132 SE 291 (1926) at 293. **This necessitates that the Commonwealth ensures that a level of medical care is made available which is reasonably designed to meet their health care needs including psychiatric care**: see e.g. *Brooks v Home Office* (1999) 48 BMLR 109 at 114; cf also, although in a setting affected by constitutional considerations, *Bowring v Goodwin* [1977] USCA4 272; 551 F 2d 44 (1977) at 47. Where, as here, the Commonwealth contracts out the provision of services to detainees it is obliged to see that “care is taken”: cf *Kondis*, at 686; and that the requisite level of medical care is provided and with reasonable care and skill.³⁹

³⁶ *Mastipour v Secretary Department of Immigration and Multiculturalism and Indigenous Affairs*.

³⁷ [2005] FCA 549.

³⁸ *Ibid* [199] (emphasis added).

³⁹ *Ibid* [212] (emphasis added).

– ***SBEG v Commonwealth of Australia***⁴⁰

The appellant had a history of psychiatric illness. While in immigration detention he self-harmed, including an unsuccessful attempt to hang himself. Expert medical opinion was to the effect that, as a result of the circumstances of his detention, his mental health had been adversely affected.

The Full Federal Court held:

It is well-established that a gaoler owes a duty of care under the common law to exercise reasonable care for the safety of a person held in custody: *Howard v Jarvis* [1958] HCA 19; (1958) 98 CLR 177 at 183; *Behrooz v Secretary of the Department of Immigration and Multicultural and Indigenous Affairs* [2004] HCA 36; (2004) 219 CLR 486 at [174].

But that obligation is not a guarantee of the safety of the detainee; ***it is an obligation of reasonable care to avoid harm to the detainee whether that harm be inflicted by a third person or by the detainee himself or herself.*** The risk of harm to the detainee is not the only matter to be considered in assessing whether reasonable care has been exercised: a consideration which must be addressed is the need to ensure effective detention in accordance with the law.⁴¹

– ***MZYR v Secretary, Department of Immigration and Citizenship***⁴²

The applicant was detained at MITA. He lived with a neuro-developmental disorder with associated intellectual impairment. During the course of his detention, specialist psychiatric services were not made available to deal with his intellectual disability.

Gordon J noted:

...what then are the obligations of the Commonwealth to the applicant? ***It was not disputed that: The Commonwealth owes a duty of care to a person held in immigration detention to provide the person with the level of medical care which is reasonably designed to meet their health care needs, including psychiatric care:*** *S v Secretary, Department of Immigration and Multicultural and Indigenous Affairs* [2005] FCA 549; (2005) 143 FCR at [218].⁴³

40 [2012] FCAFC 18.

41 *Ibid* [19] (emphasis added).

42 [2012] FCA 694.

43 *Ibid* [20] (emphasis added).

Gordon J also noted:

The Commonwealth is in a position of control. ***Detainees cannot reasonably be expected to safeguard themselves from danger especially detainees with mental health needs which are known to the Commonwealth.***⁴⁴

– AS v Minister for Immigration and Border Protection & Anor⁴⁵

The case was a group proceeding brought on behalf of all persons who were detained on Christmas Island between 27 August 2011 and 26 August 2014, and who, it was alleged, suffered injury as a result of the failure of the defendants to provide them, or their parents, with reasonable health care.

The defendants accepted that the second defendant, the Commonwealth of Australia, owed a non-delegable duty of care to provide reasonable health care to persons who were held in detention on Christmas Island pursuant to the Migration Act. The defendants did not concede that the first defendant, the Minister, was subject to a similar duty of care, but accepted that it was arguable.⁴⁶

The above cases confirm not only that Australia owes a non-delegable duty of care to people in held and community detention, but also demonstrate a history of failure to fulfil this duty.



⁴⁴ Ibid [55] (emphasis added).

⁴⁵ [2014] VSC 593.

⁴⁶ Ibid [24].

A ‘legislative vacuum’ around health care for people in detention

Despite the settled common law position that the Australian government owes a duty of care to provide adequate health services to immigration detainees, this is not reflected in the current legislative framework which applies in this area.

Section 273 of the Migration Act confers power on the Minister to make regulations regarding the day-to-day running of facilities as follows:

– Detention centres

- (1) The Minister may, on behalf of the Commonwealth, cause detention centres to be established and maintained.
- (2) The regulations may make provision in relation to the operation and regulation of detention centres.
- (3) Without limiting the generality of subsection (2), regulations under that subsection may deal with the following matters:
 - (a) the conduct and supervision of detainees;
 - (b) the powers of persons performing functions in connection with the supervision of detainees.
- (4) In this section:

“detention centre “ means a centre for the detention of persons whose detention is authorised under this Act.

However, the Migration Regulations are silent on the ‘operation and regulation of detention centres’ with respect to the provision of reasonable medical care.

Regulation 5.35 concerns the medical treatment of immigration detainees but in the context of the Secretary’s power to take certain steps in instances where ‘there will be a serious risk’ to the immigration detainee’s ‘life or health’.

The regulation does not address the standard or quality of medical care more generally.

– Regulation 5.35 provides as follows:

- (1) In this regulation:

“detainee” means a person held at a detention centre in detention under the Act.

“medical treatment “ includes:

 - (a) the administration of nourishment and fluids; and
 - (b) treatment in a hospital.
- (2) The Secretary may authorise medical treatment to be given to a detainee if:
 - (a) the Secretary, acting in person and on the written advice of:
 - i. a Commonwealth Medical Officer; or
 - ii. another registered medical practitioner;

forms the opinion that:

 - iii. that detainee needs medical treatment; and
 - iv. if medical treatment is not given to that detainee, there will be a serious risk to his or her life or health; and
 - (b) that detainee fails to give, refuses to give, or is not reasonably capable of giving, consent to the medical treatment.
- (3) An authorisation by the Secretary under subregulation (2) is authority for the use of reasonable force (including the reasonable use of restraint and sedatives) for the purpose of giving medical treatment to a detainee.

- (4) A detainee to whom medical treatment is given under an authorisation under subregulation (2) is taken for all purposes to have consented to the treatment.
- (5) Medical treatment that is given under an authorisation under subregulation (2) must be given by, or in the presence of, a registered medical practitioner.
- (6) Nothing in this regulation authorises the Secretary to require a registered medical practitioner to act in a way contrary to the ethical, moral or religious convictions of that medical practitioner.

Criticism by the courts

The courts have noted with concern the lack of legislative guidelines around the ‘operation and regulation of detention centres’ notwithstanding the Minister’s power to enact such provisions under the Migration Regulations.

In *Mastipour*, Selway J noted:

What is surprising is that there are virtually no provisions, either in the Act or in the Migration Regulations which purport to regulate the manner and conditions of that detention.⁴⁷

Finn J was more critical in *Mastipour*:

The present **legislative vacuum** is, in my view, potentially unfair both to those involved in the conduct of detention centres and to the detainees. Selway J has illustrated why this is so. I need hardly add that this state of affairs is not conducive to ordered and principled public administration.⁴⁸

Finn J also held in *S v Secretary*: ‘I note in passing that judges of this Court criticised the Commonwealth’s failure to make regulations for detention centres under this section... That deficiency remains unrectified’.⁴⁹

47 [2003] FCAFC 93, [8].

48 *Ibid* [2] (emphasis added).

49 [2005] FCA 549, [198].

Inadequate health care in the Australian immigration detention system

This legislative vacuum is reflected in practice with a lack of reasonable health care being provided in Australia's immigration detention system.

This has been found over many years by organisations such as the ANAO and the Australian Human Rights Commission (AHRC) and confirmed by the Parliamentary Joint Committee of Public Accounts and Audit.

Our recent case work confirms that these serious problems are ongoing. The ASHR Project highlights the lack of reasonable medical care being provided in Australia's immigration detention system and the urgent need for reform.

ANAO Report

On 1 September 2016, the ANAO published its findings in relation to its audit of the Department's administration of health services in onshore immigration detention.⁵⁰ The ANAO concluded:

The department's administration of health services in onshore immigration detention has been improved by the strengthening of contractual arrangements with the selected provider of health services. The current contract, which was developed by the department based on a strategic analysis of shortcomings that had arisen under earlier contracts, includes: mechanisms to control the risk of over-servicing and uncontrolled cost escalation; clearly defined deliverables; and a performance monitoring regime containing provisions for the application of penalties and incentives. However, to be able to give assurance that contract objectives are being achieved, there is further scope for the department to improve its administration of health service delivery, primarily through strengthening arrangements for monitoring:

- the quality of the health services that are being delivered; and
- key areas of health service delivery risk (such as services to detainees with mental health conditions).⁵¹

The report outlined a number of critical areas of concern relevant to the ASHR Project.

ANAO finding – Inadequate departmental oversight of IHMS

The audit criticised the Department's monitoring of the performance of IHMS.⁵² As at March 2016, the Department was not effectively monitoring eight of 17 performance criteria.⁵³ The remaining measures were 'not being effectively monitored' by the Department, with methodologies that were partially or not implemented at all.⁵⁴

In particular, the key measure to assess the quality of primary health care was yet to be monitored '**15 months after** the contract was signed [emphasis added]'.⁵⁵ The ANAO found that the limited focus on measuring the quality of service delivery and significant delays in finalising measurement and verification activities undermined the assurance that the Department obtained in relation to the achievement of contractual objectives.

⁵⁰ Auditor-General, Australian National Audit Office, *Delivery of Health Services in Onshore Immigration Detention*, Report 13 of 2016-17.

⁵¹ Ibid 8.

⁵² Ibid 9.

⁵³ Ibid 8-9.

⁵⁴ Ibid.

⁵⁵ Ibid.

Further, the ANAO concluded there were aspects of the delivery of health services in detention where existing monitoring arrangements 'did not provide a sufficient level of assurance' to the Department that services were being delivered as intended.⁵⁶ Those aspects related most notably to **community detention, mental health care, medication management and timely and clinically appropriate access to health service**.⁵⁷

ANAO finding – Insufficient care for many detainees at risk of self-harm

The ANAO identified serious deficiencies in the delivery of care to detainees at risk of self-harm.

The Department's policy framework for health care in immigration detention, including the *Detention Health Framework and the Detention Services Manual*, recognises that people who enter immigration detention have a higher prevalence of risk factors for mental illness than those in the general population.⁵⁸

The *Psychological Support Program for the Prevention of Self-Harm and Suicide* is the Department's principal mechanism to treat the risk of suicide and self-harm in immigration detention. It is designed to deliver a clinically recommended approach for the identification and support of detainees assessed as being at risk of self-harm and suicide.⁵⁹

The ANAO found:

3.23 The data obtained from the contractor by the ANAO indicates that, between 1 February and 9 November 2015, 327 detainees were placed under supportive monitoring and engagement...239 detainees were assessed as high imminent risk on at least one occasion, representing a total of 407 instances of placement at that risk level. Of these instances, 47 per cent were placed at this risk level for longer than 72 hours and seven per cent more than one month. This analysis indicates that the clinically recommended approach set out in the *Psychological Support Program for the Prevention of Self-Harm and Suicide* **was not being followed for a large number of detainees** [emphasis added].

3.24 The program also requires detainees on high imminent risk to be clinically reviewed every 24 hours at a minimum. On average, for the period 1 February to 9 November 2015, detainees on high imminent risk received a clinical review every three days. Further, there were discrepancies between detainees, with the majority of detainees reviewed less frequently than prescribed under the program... and with some detainees reviewed very infrequently (once or twice every fortnight).⁶⁰

ANAO finding – Cost-cutting at the expense of quality of care

The ANAO Report noted at [2.2] that in December 2013, when planning for the re-tendering of the health service contract, the Commonwealth government indicated its expectation that the total costs and the cost per detainee would be lower in the new contract. To achieve this objective, the Department implemented a number of strategies including at [2.2]:

a focus on fixed pricing — the new contracts required the service provider to determine a fixed fee to cover all services and activities necessary to meet the health care needs of detainees. Any additional service requests would only be used in exceptional circumstances. This approach was aimed at reducing the risk of 'over-servicing'...⁶¹

⁵⁶ Ibid 9.

⁵⁷ Ibid (emphasis added).

⁵⁸ Ibid 40.

⁵⁹ Ibid.

⁶⁰ Ibid 41.

⁶¹ Ibid 19.

The ANAO Report was critical of the Department's cost-cutting approach at [2.15]. The ANAO highlighted that the Department did not undertake a structured assessment of the risks to the achievement of the objectives set for the new health service delivery contract, 'in particular those relating to the model proposed to reduce the overall cost of the contract'.⁶² The ANAO noted that the inherent risk of underservicing by the contractor – 'where the provider **prioritises commercial profitability over the delivery of services to adequate quantity and quality** – received less focus. This was despite issues relating to under-servicing arising under the previous contract,⁶³ suggesting a need for independent oversight, an issue discussed later in this report.

Parliamentary Joint Committee of Public Accounts and Audit

Having considered the ANAO Report, the Parliamentary Joint Committee of Public Accounts and Audit (Parliamentary Committee) conducted an inquiry on 25 November 2016.⁶⁴ It concluded that action to address areas for improvement identified by the ANAO was required, and requested the Department report back on measures it would take to address the concerns raised in the ANAO report, including:

- the implementation of appropriate performance monitoring of the contractor;
- the implementation of a risk-based remediation plan;
- progress on finalising key performance documents, including the Departmental Medical Audit Tool and the Health Policy and Procedures Manual; and
- the outcomes of any targeted audits it would undertake to assess IHMS's policies and procedures against the relevant clinical benchmarks.⁶⁵

The published ANAO Report included the Department and IHMS's respective responses to the audit in the appendices. The Department stated that it 'agreed' to the recommendations made by the ANAO and that it had 'work underway to continue to improve' its administration of these services.⁶⁶

However, as demonstrated by the case studies below, inadequate provision of health care to people in immigration detention is a persistent problem, continuing into 2018.

⁶² Ibid 25.

⁶³ Ibid (emphasis added). See also Sophie Scott, 'Government Told Doctors to Cut Health Care Costs for Refugees in Onshore Detention Centres: Report', *ABC News* (online), 2 September 2016, <<http://www.abc.net.au/news/2016-09-02/government-told-doctors-to-cut-health-costs-for-refugees/7807034>>.

⁶⁴ Joint Committee of Public Accounts and Audit, Parliament of Australia, *Commonwealth Procurement Inquiry based on Auditor-General's reports 1, 13 and 16* (2016-17) (2017).

⁶⁵ Ibid 36.

⁶⁶ Ibid 3.

ASHR Project cases demonstrate ongoing issues

Of the approximately 60 referrals we have received to date, the ASHR Project has prioritised 24 cases based on particular high needs, urgency and capacity of potential cases to deliver broader healthcare reform for the immigration detention system more generally.

In doing so, we have identified a number of patterns affecting especially vulnerable populations:

- routine denial of antiviral therapy for detainees living with hepatitis C;
- failure to properly physically and psychologically treat suicidal asylum seekers following unsuccessful attempts at life, after which new injuries are sustained; and
- misuse and overuse of handcuffs and mechanical restraints, particularly when transferring detained mentally ill asylum seekers to external appointments or between facilities.

Each of these issues is illustrated by the case studies provided throughout this report.

Overuse of handcuffs

Hozan is an asylum seeker who arrived in Australia in 2013. He has been subject to a number of transfers between detention centres and medical transfers and remains currently detained in Christmas Island IDC.

Hozan has a long history of detention, having been detained in a refugee camp overseas for over a decade as a young child where he was subject to handcuffing, beatings and serious sexual abuse by a prison guard. He reports that the Australian immigration detention environment is particularly re-triggering for him.

During his first psychiatric consultation with the IHMS, it was determined that Hozan had complex post-traumatic stress disorder, chronic stress and was experiencing grief. While in detention, Hozan has had several self-harm incidents. He was later diagnosed with prolonged detention syndrome and depression. In addition to Hozan's mental health conditions, he also lives with hepatitis C, has respiratory problems and chronic knee pain.

Hozan experiences significant stress and anxiety from the regular use of handcuffing on him by detention guards. For example, Hozan was handcuffed while on a flight to Christmas Island and became highly agitated. An officer on board further restrained him. As a result, Hozan became more anxious and had a seizure. A few months later, Hozan experienced rigid muscles and excessive sputum production after being handcuffed for a transfer. On another occasion, he suffered a pre-flight anxiety attack due to being required to wear handcuffs prior to and during the flight.

Hozan has refused to attend specialist medical appointments due to having to be handcuffed. He reported to a nurse at the detention facility that he felt being cuffed was not good for his mental health. On another occasion, after being handcuffed, Hozan banged his head against a wall. Bruising from the use of handcuffs was also reported. He later stated that the handcuffing reminded him of his incarceration in Iraq as a child.

While IHMS supports Hozan not being handcuffed during transfers to medical appointments, officers continue to use handcuffs when transferring him for medical appointments.

Lack of access to hepatitis C cures for detainees

There are an estimated 200,000 people in Australia living with hepatitis C. Untreated infection can lead to life-threatening illnesses: liver failure and liver cancer. Every year, around 800 Australians living with hepatitis C die from the infection.⁶⁷

As of March 2016, new generation direct acting antiviral (DAA) medications – curative drugs – became available on the Pharmaceutical Benefit Scheme (PBS).⁶⁸ Patients are prescribed a combination of the DAAs depending on the genotype (strain) of their infection and the severity, if any, of liver cirrhosis in each case. A course of treatment is usually prescribed for 12 weeks which may be increased depending on the patient's level of liver cirrhosis.

There are six genotypes of hepatitis C. The cure rate with DAA therapy is approximately 95% or above and 90% for patients with liver cirrhosis.⁶⁹

Australian community standard of care

According to the *Australian recommendations for the management of hepatitis C virus infection: a consensus statement* (Gastroenterology of Australia Guidelines) at page 12:

All people living with HCV infection should be considered for treatment, except those with limited life expectancy (<12 months) due to non-liver related or non-HCV-related comorbidities.⁷⁰

DAAs are available on the PBS for all people living with hepatitis C over the age of 18 and who have a Medicare card.⁷¹ There are no restrictions applied to persons who inject drugs or prisoners. To the contrary, both groups are considered priority populations and the federal government has guaranteed the new medicines will be funded for them.

According to *Recommendations for the management of hepatitis C virus infection among people who inject drugs*⁷² developed by the International Network on Hepatitis Care in Substance Users in 2015, treatment for hepatitis C through DAAs is cost effective and feasible. These recommendations are based on studies which demonstrate that 'curing hepatitis C among people who inject drugs, even with new expensive HCV therapies, is more cost-effective than delaying treatment until infection progresses to more advanced liver disease'.⁷³

Significantly, the PBS listing allows antiviral therapy to be prescribed by a general practitioner (GP) experienced in the treatment of chronic hepatitis C infection, or in consultation with a gastroenterologist, hepatologist or infectious diseases physician experienced in treating chronic hepatitis C infection.⁷⁴

Once GPs gain experience in treating patients, they may prescribe independently. The Pharmaceutical Benefits Advisory Committee recently expanded the criteria for prescribing the antiviral therapy through the PBS General Schedule to include authorised nurse practitioners experienced in the treatment of chronic hepatitis C infection. 'This initiative will increase the timely, affordable and equitable access to treatment in Australia.'⁷⁵

67 Hon. Greg Hunt, Minister for Health, 'New drug to help over 200,000 Australians', (Media Release, 28 July 2017) <[http://www.health.gov.au/internet/ministers/publishing.nsf/Content/2E17C3188C40073ECA25816B000E1BFF/\\$File/GH072.pdf](http://www.health.gov.au/internet/ministers/publishing.nsf/Content/2E17C3188C40073ECA25816B000E1BFF/$File/GH072.pdf)>.

68 Ibid.

69 Hepatitis Australia, *Treatment for Hep C* (9 January 2017) <<https://www.hepatitisaustralia.com/hepatitis-c-facts/treatment-for-hep-c>>.

70 Gastroenterological Society of Australia, *Australian recommendations for the management of hepatitis C virus infection: a consensus statement* (August 2017) <<https://www.asid.net.au/documents/item/1208>>.

71 International Health and Medical Services, *Department of Immigration and Border Protection Immigration Detention Health Report January – March 2016 Quarter 1* (2016) 37 <<https://www.homeaffairs.gov.au/AccessandAccountability/Documents/FOI/FA160800237-documents-released.pdf>>.

72 Jason Grebely et al, 'Recommendations for the Management of Hepatitis C Virus Infection Among People who Inject Drugs' (2015) 26 *International Journal of Drug Policy* 1028.

73 Kirby Institute, *New Recommendations for Treating Hepatitis C in People Who Inject Drugs* (22 October 2015) <<https://kirby.unsw.edu.au/news/new-recommendations-treating-hepatitis-c-people-who-inject-drugs>>.

74 Ibid.

75 Ibid.

Transmission of hepatitis C in detained environments generally

Prison populations in Australia have a high prevalence of hepatitis C infection, estimated at 30%, which reflects the close relationship between injecting drug use, hepatitis C infection and incarceration.⁷⁶

According to the Gastroenterology of Australia Guidelines, 'incarceration presents a unique opportunity for HCV therapy due to improved direct access to health care and stable accommodation'.⁷⁷

Likewise, the roll-out of the DAAs in immigration detention centres would appropriately:

- provide curative treatment before an immigration and community detainee is released; and
- reduce and control transmission rates of a potentially life-threatening communicable disease in a secure setting.

The public position of the Commonwealth government and IHMS on antiviral medication for immigration detainees living with hepatitis C

In March 2016, in its Department of Immigration and Border Protection, *Immigration Detention Health Report*, IHMS reported as follows:

On March 1, new hepatitis C drug regimens became available on the PBS to the average Australian Medicare card holder. **These drug regimens will also be offered to detainees in the network as detainees are provided with the equivalent access to new treatments and procedures as members of the Australian community** [emphasis added].⁷⁸

That report also noted 155 new diagnoses of the hepatitis C infection in immigration detention for the period July 2015 to March 2016.⁷⁹ Our understanding is that this is the most recent data currently publicly available.

In June 2016, in its Department of Immigration and Border Protection, *Immigration Detention Health Report*, April-June 2016, Quarter 2, IHMS reported:

Treatment for hepatitis C continues to be made available to those in need according to PBS guidelines. **DIBP has funded this treatment to ensure that Detainees have equivalent access to these drugs as the Australian public** [emphasis added].⁸⁰

On 28 July 2017, federal Health Minister Hunt reiterated the federal government's to 'eliminate' hepatitis C in Australia by 2030.⁸¹

⁷⁶ Ibid.

⁷⁷ Ibid.

⁷⁸ International Health and Medical Services, *Immigration Detention Health Report, January to March 2016*, 37.

⁷⁹ Ibid 36.

⁸⁰ International Health and Medical Services, *Department of Immigration and Border Protection Immigration Detention Health Report April - June 2016 Quarter 2 (2016)* 39 < <https://www.homeaffairs.gov.au/AccessandAccountability/Documents/FOI/fa170101034-documents-released.pdf>>.

⁸¹ Hon. Greg Hunt, Minister for Health, above n 49.

PIAC clients

We act for eight clients who did not initially receive antiviral therapy in immigration or community detention.

Of those clients, four ultimately did receive antiviral therapy in immigration or community detention – one through IHMS, the second funded through compassionate support provided by a pharmaceutical company and the third and fourth, due to PIAC's advocacy efforts.

Despite the national roll-out of the treatment, the experiences of our clients demonstrate that the provision of antiviral therapy to immigration and community detainees living with hepatitis C occurs on an ad hoc basis and more often, not at all.

This approach is entirely inconsistent with the Commonwealth government and IHMS's public position; recommendations of the medical profession; and the Australian community standard for the treatment of hepatitis C.

Client 1

Nadim is an asylum seeker, living with hepatitis C.

He arrived in Australia in November 2013 and was detained at the Christmas Island IDC. Nadim was later transferred to an offshore processing centre. Shortly thereafter, he was transferred back to an onshore immigration detention centre because he was living with a communicable disease.

In October 2014, Nadim attended a liver clinic at a local hospital. IHMS noted that a fibroscan had been undertaken and that he met the criteria for hepatitis C antiviral therapy. However, Nadim did not receive the therapy.

A report by the Commonwealth Ombudsman to the Minister stated:

The Ombudsman notes with concern the Government's duty of care to detainees and the serious risk to mental and physical health prolonged detention may pose. Without an assessment of [Nadim's] claims to determine if he is found to engage Australia's protection obligations, it appears likely that he will remain in restricted detention for an indefinite period.

The Ombudsman notes with concern that [Nadim] was transferred to Australia to receive medical treatment, but in November 2015 IHMS advised that [Nadim] had been waiting for more than 12 months for a course of treatment for hepatitis C to be confirmed by the liver clinic.

It was later confirmed that Nadim had liver cirrhosis.

IHMS subsequently reported to the Commonwealth Ombudsman that Nadim was reviewed at the local hospital on 15 March 2016 and was to 'be considered for hepatitis C medication...currently waiting for an appointment...for further management of this condition'.

However, Nadim still did not receive the medication.

IHMS further wrote to the Department as follows:

Please find below request for approval for hepatitis C medication, which is upon the recommendation of the... hepatology team. I can confirm that his treatment would be wholly in keeping with Australian community standard.

Despite this further recommendation, Nadim still did not receive the therapy.

In March 2018, PIAC commenced litigation in the Federal Court seeking access to the antiviral therapy for Nadim.

In April 2018, Nadim was provided with antiviral medication.

Client 2

Anas is an asylum seeker living with hepatitis C.

He has been held in immigration detention facilities since he arrived in Australia in 2013, almost five years and ongoing.

Anas has evidence of chronic liver damage, with persisting elevations of liver enzymes first noted in late 2013.

Despite IHMS referring him to a local hospital in May 2015 to get antiviral therapy, he did not receive the treatment.

IHMS subsequently advised PIAC as follows:

...unfortunately... [Anas] is not eligible for the PBS subsidy (as he is not eligible for Medicare) which complicates matters as the Department has to therefore make a decision to fund the full private cost of this medication on a case by case basis. IHMS has submitted an approval request for this cost to the Department for its consideration.

IHMS later confirmed to PIAC that it had submitted an approval request to the Department for the antiviral therapy for Anas. Despite this, Anas still did not receive the medication.

In February 2018, PIAC issued a Letter of Demand to the Commonwealth government seeking antiviral therapy for Anas and enclosing two medical reports on the need for the treatment, one from a leading specialist.

Just prior to commencing litigation in the Federal Court, the ABF agreed to provide Anas with antiviral therapy in March 2018.

Client 3

Bijan was held in immigration detention for over four and a half years, after which he was released on a bridging visa.

Hepatitis C was first detected in his induction pathology in April 2013.

In March 2016, while Bijan was in community detention, he attended the local hospital for hepatitis C care. The clinical records note as follows:

PBS approval was achieved on 1 March 2016 for the new direct acting antiviral medications for chronic hepatitis C infection. However, as...[Bijan] is in community detention and is a non-Medicare card holder he does not appear to qualify for this treatment. We will enquire through Immigration Services as to whether they would be prepared to fund his treatment.

Still in community detention, in June 2016, Bijan again attended the local hospital. On that occasion, the clinical records noted as follows:

I have explained to... [Bijan] that whilst it is clearly desirable that we treat him as soon as possible the new HCV antivirals are not available via Immigration Services. We have made applications (IPA) to both the drug company and... [local hospital] for access to this treatment on compassionate grounds and I am very hopeful that we will be successful.

Now re-detained in a secure facility, on 8 July 2016, IHMS noted 'Patient also says he is currently awaiting the commencement of certain medication for his condition...I suspect that this may be the antiviral medication for chronic hepatitis C infection...'

On 3 August 2016, (after Bijan was re-detained) the local hospital reported:

We are still awaiting confirmation for compassionate access of sofosbuvir and daclatasvir [antiviral therapy] with genotype 3 hepatitis C. As soon as we get that then we can bring him back into clinic and treat him with that. He does have ongoing pain in the right upper quadrant with what sounds like chronic cholecystitis. Unfortunately, the surgeons on review thought he was too high risk to have his gallbladder taken out so this will have to be managed conservatively for the time being, unless he gets a significant improvement of his liver function after treatment of his hepatitis C but we will be in touch when we get the medication to treat him.

In approximately mid-October 2016, the pharmaceutical company approved the provision of the antiviral medication for Bijan on compassionate grounds.

The standard of health care in Australia's immigration detention system

In 2006, an Immigration Health Advisory Group (IHAG) was established by the Department to provide expert advice on detention health services.⁸² IHAG was devised in response to the 2005 Commonwealth Ombudsman's *Inquiry into the circumstances of the Vivian Alvarez Matter* and the 2005 *Inquiry into the circumstances of the immigration detention of Cornelia Rau*.⁸³

IHAG was comprised of experts in psychiatry, psychology, public health, dentistry, nursing, general practice as well as refugee advocates and the Commonwealth Ombudsman, which had observer status.

In 2006, the Department via IHAG sought the Royal Australian College of General Practitioners' (RACGP) assistance to develop the *RACGP Standards for health services in Australian immigration detention centres* (RACGP Immigration Detention Standards). The purpose of the RACGP Immigration Detention Standards was for self-assessment for quality improvement or for collaboration with other services to assess one another.⁸⁴

At the time of publication, RACGP stated that the RACGP Immigration Detention Standards 'mirror the principles of safety and quality underpinning the RACGP Standards for general practices'.⁸⁵ In particular, the RACGP noted that the Department:

...has a duty of care toward those whom it detains. A primary responsibility is to protect the health of people in immigration detention and, when health care is required, to provide health care services that are timely, appropriate and effective. **The quality of care in immigration detention should be consistent with the quality of health service provision in the general Australian community** [emphasis added].⁸⁶

However, in 2013, IHAG was unexpectedly disbanded – effective immediately – by the incoming government and was replaced by the Australian Defence Force's medical expert, Doctor Paul Alexander. The government was heavily criticised for its decision.⁸⁷ For example, the Australian Medical Association's (AMA) President responded that he was 'shocked by the sudden announcement' and stated that the:

Government and the Department now have a major challenge in understanding and dealing with complex health conditions in difficult circumstances without the benefit of the expert advice of the highly qualified and respected IHAG members.⁸⁸

The AMA called on the Australian government to establish a 'truly independent' medical panel to oversee and report regularly on the health services available to asylum seekers in immigration detention facilities, both onshore and offshore.⁸⁹ The AMA proposed that the panel report regularly to the Parliament, the Prime Minister, and relevant Ministers.⁹⁰

In its 2015 policy position, *Health care of asylum seekers and refugees*, the AMA further stated at [21]:

82 Parliament of Australia, *Inquiry into the Migration Amendment (Health Care for Asylum Seekers) Bill 2012*, 7 December 2012, 9 <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Completed_inquiries/2010-13/migrationhealthcare2012/report/c02>.

83 Ibid 10.

84 Royal Australian College of General Practitioners (RACGP), *Standards for Health Services in Australian Immigration Detention Centres* (RACGP, 2007) 7.

85 Ibid 1.

86 Ibid 2.

87 Anna Henderson and Lucy Carter, 'Abbott Says Criticism Over Axing of Immigration Health Advisory Group is 'Complete Beat-up'', *ABC News* (online), 16 December 2013, <<http://www.abc.net.au/news/2013-12-16/coalition-disbands-immigration-health-advisory-group/5158084>>.

88 Australian Medical Association, 'AMA Shocked by Disbanding of Immigration Health Advisory Group (IHAG)' (Media Release, 16 December 2013) <<https://ama.com.au/media/ama-shocked-disbanding-immigration-health-advisory-group-ihag>>.

89 Ibid.

90 Ibid.

Health and medical services in immigration detention centres should only be provided by organisations, in facilities accredited to Australian standards, that have the full capacity to provide an appropriate range of health and medical care to all detainees as needed, **and according to best practice standards in health care delivery (as would apply in the general community)**. Adherence to these standards should be guaranteed through a process of ongoing monitoring of detainees' health by an independent statutory body of clinical experts with powers to acquire information and investigate conditions in centres as it determines [emphasis added].⁹¹

As far as PIAC is aware, IHAG – as it was then comprised and operated – has not been reinstated by subsequent governments.

IHMS's standard of care for medical care in immigration detention

IHMS's current stated position is that it is contracted by the Commonwealth government to provide health services within the Australian immigration detention network, 'to a standard of care **broadly comparable** to that available to the general Australian community under the public health system [emphasis added]'.⁹² This would appear to be a lesser standard than that in the RACGP Immigration Detention Standards and recommended by the AMA.

As for community detention, IHMS further provides that:

IHMS manages the healthcare of people in community detention through its network of community providers. People in community detention have the choice of a designated GP clinic, which is responsible for referring them to further services as required, **consistent with Australian public health standards** and waiting times [emphasis added].⁹³

The Department's position: 'broadly comparable'

The Department has adopted the same position as IHMS, publishing on its current website that under the contract, IHMS provides health care services for detainees that are 'broadly comparable to those available to the Australian community'.⁹⁴

On the one hand, the Department and IHMS's policy statements accept that the relevant standard of medical care required in immigration detention is that which is commensurate with the standard in the Australian community. However, the language of 'broadly comparable' appears designed to allow for departure from that standard.

It also appears to be lower than the standard of care which was previously imposed, via contract, on IHMS. A March 2012 Joint Select Committee Inquiry into Australia's Immigration Detention Network described that:

IHMS is required to provide health services to detainees at the same standard available in the general Australian community.⁹⁵

91 Australian Medical Association, *Health Care of Asylum Seekers and Refugees – 2011. Revised 2015* <<https://ama.com.au/position-statement/health-care-asylum-seekers-and-refugees-2011-revised-2015>>.

92 International Health and Medical Services, *Sites Onshore* <<http://www.ihms.com.au/onshore.php>>.

93 Ibid.

94 Department of Home Affairs, *Role of our service providers International Health and Medical Services* <<https://www.homeaffairs.gov.au/about/immigration-detention-in-australia/service-providers-role>>.

95 Joint Select Committee on Australia's Immigration Detention Network, Parliament of Australia, *Final Report* (2012) 6 [1.22].

This apparent relaxation of the Commonwealth government's duties to provide reasonable care to immigration detainees, confirms the pressing need to enact legislative reform which sets a clear minimum standard.

Human rights standards for medical care

In 2013, the AHRC published Human Rights Standards for Australian immigration detention centres.⁹⁶

Based on the AHRC's periodic inspections of facilities and the complaints it received and inquiries it conducted into conditions of immigration detention, the Human Rights Standards were intended to set out 'benchmarks for the humane treatment of people held in immigration detention...'.⁹⁷

They also incorporated the position at international law, namely that people detained by governments have the same right to health care as other people in the community.

For example, Article 12.1 of the *International Covenant on Economic, Social and Cultural Rights* states that 'The States Parties to the present Covenant recognise the right of *everyone* to the enjoyment of the highest attainable standard of physical and mental health' [emphasis added].

Meanwhile the *Human Rights' Basic Principles for the Treatment of Prisoners* provides that 'Prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation' (Principle 9), with people in immigration detention analogous to prisoners in this context.

The Human Rights Standards cover a range of conditions for immigration detention including security and facility management, transport and removal, complaints procedures, arrival and induction, food, clothing, religion, education and activities.

Section 14 of the Human Rights Standards considers medical care and treatment in detail as follows:

- 14.1 Adequate health care;
- 14.2 Provision of medical treatment;
- 14.3 Equipment;
- 14.4 Out-of-hours service;
- 14.5 Health screening on arrival and continuous monitoring;
- 14.6 Transfers;
- 14.7 Pharmacy and safe distribution of medications;
- 14.8 Consent to, or refusal of, treatment;
- 14.9 Women and girls;
- 14.10 Children's health;
- 14.11 Hygiene and public health;
- 14.12 Contagious and notifiable diseases;
- 14.13 Continuity of care;
- 14.14 Second medical opinions;
- 14.15 Specialists and medical aids;
- 14.16 Health records and confidentiality;

⁹⁶ Australian Human Rights Commission, *Human Rights Standards for Immigration Detention* (2013) <https://www.humanrights.gov.au/sites/default/files/document/publication/HR_standards_immigration_detention%20%284%29.pdf>.

⁹⁷ *Ibid* 6.

- 14.17 Sexual health;
- 14.18 Substance abuse;
- 14.19 Notification of death, illness, injury;
- 14.20 Mental health treatment and care;
- 14.21 Survivors of torture and trauma;
- 14.22 Counselling; and
- 14.23 Staff training in mental health.⁹⁸

PIAC endorses the Human Rights Standards with respect to the provision of medical care and treatment in immigration and community detention which is underpinned by the international human rights law framework.

In particular, we note the following standard for medical treatment and care:

Medical treatment and care is provided:

- **to a standard commensurate with that provided in the Australian community;**
- **in a manner which is culturally appropriate;**
- **which recognises the specific needs of detainees as displaced persons who may have experienced trauma;**
and
- **which respects the inherent dignity of the human person** [emphasis added].

Each detainee is provided, free of charge, with remedial medical treatment and care, dental, ophthalmological and mental health care, as determined by the Department in consultation with its nominated health advisors.

Preventative health care measures are undertaken where necessary, as determined by the Department in consultation with its nominated health advisors. This includes age-appropriate immunisation, oral health education and drug and alcohol programs.

Detention authorities must provide detainees with access to services of community non-government organisations that provide expert services such as torture and trauma counselling.

Each detainee is informed in a language and in words and formats they can understand about the health care services available in immigration detention; the health issues that may affect them; and about health promotion, including oral health care, and control of communicable disease.

Detention authorities consult health staff when devising meals schedules, services and programs that may impact on the health of detainees.

Health staff have the requisite qualifications, memberships or recognition to practice and undergo regular training, including training in issues specific to the populations within immigration detention facilities.⁹⁹

⁹⁸ Ibid 2.

⁹⁹ Ibid section 14.1.

Lessons from Australian prisons

The move to enact legislation to ensure people in immigration detention are provided with an appropriate standard of health care should be uncontroversial. Such an approach is consistent with our treatment of prisoners.

The obligation of the gaoler to provide a level of care that is commensurate with the Australian community is well-developed at common law and enshrined in State and Territory legislation.

Existing good practice

There are several legislative models from Australian correctional settings that provide helpful guidance. We note in particular:

– *Corrections Act 1986 (Vic)*

Section 47 – Prisoners rights

(1) Every prisoner has the following rights —

...

(f) the right to have access to **reasonable medical care and treatment necessary for the preservation of health** including, with the approval of the principal medical officer but at the prisoner's own expense, a private registered medical practitioner, dentist, physiotherapist or chiropractor chosen by the prisoner.

(g) if intellectually disabled or mentally ill, the right to have **reasonable access** within the prison or, with the Governor's approval outside a prison to **such special care and treatment** as the medical officer considers necessary or desirable in the circumstances.

(h) the right to have access to **reasonable dental treatment** necessary for the preservation of dental health [emphasis added].

– *Corrections Management Act 2007 (ACT)*

53. Health care

(1) The director-general must ensure that —

(a) detainees have a standard of health care **equivalent to that available to other people in the ACT**; and

(b) arrangements are made to ensure the provision of appropriate health services for detainees; and

(c) conditions in detention promote the health and wellbeing of detainees; and

(d) as far as practicable, detainees are not exposed to risks of infection.

(2) In particular, the director-general must ensure that detainees have access to —

(a) regular health checks; and

(b) timely treatment where necessary, particularly in urgent circumstances; and

(c) hospital care where necessary; and

(d) as far as practicable —

- i. specialist health services from health practitioners; and
- ii. necessary health care programs, including rehabilitation programs [emphasis added].

– **Correctional Services Act 2014 (NT)**

Division 4 – Health care for prisoners

82. Commissioner to arrange health care

- (1) The Commissioner must arrange for the provision of appropriate health care for prisoners.
- (2) The Commissioner must ensure that prisoners are provided with access to health care that is **comparable with that available to persons in the general community** in the same part of the Territory [emphasis added].

Proposed provision for Migration Regulations

We suggest a hybrid model of the relevant features of the Corrections Act 1986 (Vic) and the Corrections Management Act 2007 (ACT) as the basis for the Proposed Legislative Amendment to the Migration Regulations.

Recommendations:

1. Amend the Migration Regulations by inserting a new provision to require a minimum standard of healthcare (the Minimum Standard of Healthcare) as follows:

Every held and community detainee has the right to –

(a) access reasonable and culturally appropriate medical care and treatment necessary for the preservation of health at a standard equivalent to that available in the Australian community including:

- i. if the detainee has an intellectual disability or is experiencing a mental health condition, such special care and treatment as a medical officer considers necessary or desirable in the circumstances including, for people in held detention, treatment outside of detention with the Minister’s approval;**
- ii. dental treatment necessary for the preservation of oral health;**
- iii. with the approval of a medical officer but at the detainee’s own expense, a private registered medical practitioner, dentist, physiotherapist or chiropractor chosen by the detainee;**

(b) as far as practicable, no exposure to risks of infection; and

(c) conditions in detention that promote the health and wellbeing of the detainee.

Implementation

While a legislative amendment of this kind is essential, it will not be sufficient to ensure that people in held and community detention receive the same standard of care that is currently provided to members of the Australian community.

It must be implemented alongside a range of complementary measures, including incorporating this standard of care in contracts with the organisations delivering health services to held and community detainees (currently IHMS, but due for renewal in 2019).

An audit of existing policies should also be undertaken to ensure the delivery of this standard of care, as well as the development and roll-out of training to both Departmental and contractor employees and workers to fulfil their obligations under the Migration Regulations.

In the case of detainees living with hepatitis C, delivering the same standard of care to people in held and community detention will mean providing universal access to antiviral therapy.

Finally, while the proposed amendment to the Migrations Regulations sets out the minimum standard of care that is to be provided, it does not fully address how health care is delivered in practice. Therefore, PIAC suggests that the Human Rights Standards developed by the AHRC and described above, should be adopted on a policy level to guide the operation of the immigration detention system.

Recommendations:

2. Ensure that any **2019 contractual renewal** with International Health and Medical Services (IHMS) or any other health provider appointed to deliver services to immigration and community detainees, explicitly requires compliance with the Minimum Standard of Healthcare.
 3. **Conduct an audit** of existing policies to ensure that they fully reflect the Minimum Standard of Healthcare.
 4. **Develop and roll-out training** to ensure the Minimum Standard of Healthcare is delivered.
 5. **Provide antiviral therapy** to all held and community immigration detainees living with **hepatitis C**.
 6. **Adopt** the *Human rights standards for immigration detention* (Human Rights Standards) developed by the Australian Human Rights Commission in the operations of held and community detention.
-

Oversight mechanisms, including OPCAT

The delivery of the Minimum Standard of Healthcare identified above will still need to be subject to appropriate oversight, both internally and from organisations outside the Department, such as the AHRC and Commonwealth Ombudsman.

Independent Health Advice Panel

In January 2016, the Health Services and Policy Division was created within the Department.¹⁰⁰ According to the ANAO Report, the new division is responsible for the Department's health functions, including health service delivery in detention.¹⁰¹ Also at the time, it was noted that the position of the Assistant Secretary, Detention Health Services Branch, was filled by a clinically qualified officer in February 2016.¹⁰² Yet, it does not appear that the Health Services and Policy Division or the Detention Health Services Branch perform any oversight functions.

However, according to the Department's current website, part of its internal oversight program includes IHAP.¹⁰³ Members of IHAP are appointed by the Department's chief medical officer.¹⁰⁴ IHAP 'monitors health services and provides advice on improvements, to the Department'.¹⁰⁵

Very little information is publicly-available about the role, functions and composition of IHAP. PIAC is aware that in September 2017, the Department's chief medical officer, Dr John Brayley, resigned.¹⁰⁶ As at October 2017, SBS reported that the role had been temporarily filled as follows:

The immigration department has appointed a non-doctor to advise it on the health issues of asylum seekers and refugees.

Its first assistant secretary Elizabeth Hampton has replaced Dr John Brayley as chief medical officer in an acting capacity.

... [D]epartment secretary Michael Pezzullo revealed the arrangement during a Senate estimates hearing in Canberra on Monday.

Mr Pezzullo insisted Ms Hampton receives expert advice from a panel of 12 medical practitioners...

Unless there was a threat to life or permanent physical impairment, any chronic, acute medical conditions could be treated locally with supplemented medical services, Mr Pezzullo said...

The department is considering how to fill the chief medical officer position in the context of the new home affairs department being established in mid-2018.¹⁰⁷

According to the Australian Public Service website, applications for the position of the Department's chief medical officer closed on 31 January 2018.¹⁰⁸ On 5 April 2018, it was reported that the position of chief medical officer remained unfilled.¹⁰⁹

100 Auditor-General, Australian National Audit Office, *Delivery of Health Services in Onshore Immigration Detention*, Report 13 of 2016-17, p 51 [3.56].

101 Ibid.

102 Ibid.

103 Department of Home Affairs, *Oversight and assurance* <<https://www.homeaffairs.gov.au/about/immigration-detention-in-australia/oversight-and-assurance>>.

104 Ibid.

105 Ibid.

106 Paul Farrell, 'Peter Dutton Is Being Asked to Explain Why He Just Lost His Chief Medical Officer', *Buzzfeed News* (online), 15 September 2015, <https://www.buzzfeed.com/paulfarrell/peter-dutton-is-being-asked-to-explain-why-he-just-lost-his?utm_term=.rlkEDO32M#.cmY9yn7JV>.

107 SBS News, 'Non-Doctor Fills Immigration Medical Post', *SBS News* (online), 23 October 2017, <<https://www.sbs.com.au/news/non-doctor-fills-immigration-medical-post>>.

108 Australian Government, *Home Affairs*, Australian Public Service Jobs, 15 December 2017, <<https://www.apsjobs.gov.au/SearchedNoticesView.aspx?Notices=10717855%3A1&mn=SESSearch>>.

109 Paul Hayes, 'Department of Home Affairs needs doctor as Chief Medical Officer: RACGP President', *newsGP* (online), 5 April 2018 <<https://www.racgp.org.au/newsGP/Professional/Department-of-Home-Affairs-urgently-needs-doctor-f>>. See also: Max Chalmers, 'Dutton's Department Leaves Vital Medical Positions Vacant', *Crikey* (online), 26 February 2018 <<https://www.crikey.com.au/2018/02/26/a-mysterious-departure-at-the-immigration-department/>>.

Recommendations:

7. **Appoint** a chief medical officer to the Department.

8. **Provide transparency** around the **role, functions and composition** of the Department-appointed Independent Health Advice Panel (IHAP), appointed by the Department of Home Affairs.

Depending on IHAP's role, functions and composition, **ensure** that:

- a. IHAP is legitimately independent and capable of providing robust oversight functions;
- b. IHAP is comprised of members of the medical profession with expertise in areas including **general practice, mental health, torture/trauma, men's health, women's health, paediatrics, public health, infectious diseases, chronic pain, obstetrics, midwifery, nursing, oral health and allied health**.
- c. IHAP's mandate covers **agreed timelines** for the Commonwealth government to **respond to recommendations** arising from the advisory body's findings and to report to Parliament and relevant Ministers.

9. If IHAP is not the appropriate body to meet the criteria outlined in Recommendation 8, **establish an independent health advisory body** to oversee the provision of medical care in the Australian immigration detention network that does meet the criteria outlined in Recommendation 8.

External review

The Department also works with the AHRC, Commonwealth Ombudsman and the Minister's Council on Asylum Seekers and Detention, to provide regular access to immigration detention facilities for monitoring purposes. Specifically, the Department states that:

The members of MCASD [Minister's Council on Asylum Seekers and Detention] are drawn from the community and appointed by the Minister, for their expertise. The Council gives independent advice to the Minister about policies, processes, services and programmes relating to asylum seekers and immigration detention. MCASD conducts regular meetings at immigration detention facilities with detainees and members of the community and reports back to the Minister and the Department.

The Commonwealth Ombudsman undertakes regular oversight inspections of immigration detention facilities and provides feedback to the Department about any areas of concern they identify as well as providing suggested improvements.

The Australian Human Rights Commission investigates and resolves complaints about alleged breaches of human rights in immigration detention. If a complaint is not resolved, the President of the Australian Human Rights Commission may decide to hold a public hearing to ascertain whether a breach of human rights has occurred. Should the President be satisfied that a breach of human rights has occurred, it will be reported to the Federal Attorney-General. In this report, the President can make recommendations about how to resolve the issues raised. This report is tabled in Parliament.¹¹⁰

The Australian Red Cross also visits immigration detention facilities. It monitors the conditions of detention and the treatment of people within the Australian immigration detention network.¹¹¹

¹¹⁰ Department of Home Affairs website, 'Oversight and assurance', <<https://www.homeaffairs.gov.au/about/immigration-detention-in-australia/oversight-and-assurance>>.
¹¹¹ *ibid*.

Australian Human Rights Commission reports

The AHRC currently exercises reporting oversight functions with respect to onshore immigration detention facilities.

Most recently, on 20 December 2017, the AHRC released its reports on the inspections it conducted at the Villawood IDC and Yongah Hill IDC.¹¹² Among its conclusions, the AHRC noted where improvements had been made to the facilities but also reported the following:

- In the Villawood IDC’s high-security Blaxland compound, the AHRC remained concerned that conditions did not meet the standards required by international human rights law;
- Many of the people interviewed by the AHRC at the Villawood IDC reported they had been mechanically restrained when being escorted outside the facility, such as when attending medical appointments or court hearings. The AHRC was concerned that the use of restraints may have been disproportionate in some cases; and
- In both facilities, the AHRC continued to document concerns about the negative impacts of detention on mental health, especially on people detained for prolonged periods.¹¹³

Reports earlier in 2017, about the Melbourne Immigration Transit Accommodation¹¹⁴ and the Maribyrnong Immigration Detention Centre¹¹⁵ raised similar issues, including about the use of restraints. In its Maribyrnong Report, the AHRC noted:

The Commission was particularly concerned by reports that mechanical restraints were at times left on while the person was receiving medical treatment or undergoing diagnostic tests (such as x-rays). In some cases, restraints were reportedly used in circumstances where there appeared to be a limited risk of escape or harm to others. For example, some people indicated that they had been restrained even when receiving treatment in mobile clinics that remained parked inside the perimeter fence of the MIDC.¹¹⁶

The AHRC has also called for independent oversight of the provision of health services in immigration detention. In its Yongah Hill Report, it recommended that:

The Australian Government should establish and resource an independent body to monitor the provision of physical and mental health services in immigration detention.¹¹⁷

¹¹² Australian Human Rights Commission, ‘Commission Releases Villawood and Yongah Hill Inspection Reports’ (Media Release, 20 December 2017) <https://www.humanrights.gov.au/news/stories/commission-releases-villawood-and-yongah-hill-inspection-reports?utm_content=bufferdda3c&utm_medium=social&utm_source=twitter.com&utm_campaign=buffer>.

¹¹³ *Ibid.*

¹¹⁴ Australian Human Rights Commission, *Inspection of Melbourne Immigration Transit Accommodation: Report, 9-10 March 2017*, <<https://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/inspection-melbourne-immigration-transit>>.

¹¹⁵ Australian Human Rights Commission, *Inspection of Maribyrnong Immigration Detention Centre: Report, 7-8 March 2017*, <<https://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/inspection-maribyrnong-immigration-detention>>.

¹¹⁶ *Ibid.* 15.

¹¹⁷ Australian Human Rights Commission, *Inspection of Yongah Hill Immigration Detention Centre: Report, 16-18 May 2017*, <<https://www.humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/inspection-yongah-hill-immigration-detention>>.

OPCAT

On 15 December 2017, the Commonwealth government announced it was ratifying the Optional Protocol to the Convention against Torture.¹¹⁸

OPCAT requires the Australian government to establish an independent watchdog, known as a National Preventive Mechanism, which has power to conduct regular and random inspections of all places of detention in Australia including prisons, immigration detention centres, juvenile detention centres and held psychiatric facilities.¹¹⁹

Ratification of OPCAT also means that the Commonwealth government is required to facilitate periodic monitoring visits by the United Nations Subcommittee on Prevention of Torture.

Failure to provide reasonable medical care has long-been recognised as grounds that may give rise to 'torture, and other cruel, inhuman or degrading treatment'.¹²⁰

PIAC strongly recommends the Commonwealth government establish a National Preventative Mechanism to ensure Australia's obligations under OPCAT are met.

Recommendations:

10. **Appoint** a National Preventative Mechanism to implement Australia's obligations under the Optional Protocol on the Convention against Torture.

¹¹⁸ Ministers for Foreign Affairs, the Hon Julie Bishop MP and Attorney-General, Senator the Hon George Brandis QC, 'Ratification of OPCAT caps year of significant human rights achievements for Turnbull Government' (Media Release, 15 December 2017), <https://foreignminister.gov.au/releases/Pages/2017/jb_mr_171215b.aspx>

¹¹⁹ *Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment*, adopted on 18 December 2002 at the fifty-seventh session of the General Assembly of the United Nations by resolution A/RES/57/199, entered into force on 22 June 2006, art 17, and art 20(c) which requires that National Preventive Mechanisms be provided with 'access to all places of detention and their installations and facilities.'

¹²⁰ See Human Rights Committee, *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, 44th sess, UN Doc HRI/GEN/1/Rev.1 (27 May 2008); Manfred Nowak, 'What Practices Constitute Torture?' (2006) 28 *Human Rights Quarterly* 821; Manfred Nowak and Elizabeth McArthur, *The United Nations Convention Against Torture: A Commentary* (Oxford University Press, 2008) 553.

Conclusion

The case studies featured in this report confirm people in held and community detention are not receiving the same standard of health care that is provided to Australian community members. The failure to provide this care has real, often tragic, consequences.

The Australian government is not fulfilling its common law duty of care to people in immigration detention, many of whom have already experienced high levels of trauma prior to arriving in Australia, trauma that is then compounded by long-term, indefinite detention and sub-standard conditions of confinement.

The absence of legislation which guarantees these vulnerable people a right to health care commensurate with that available to the Australian community is a gap that must be filled, as a matter of priority. This report proposes such an amendment, based on the existing rights of people in custody in Victoria and the ACT.

Such legislation needs to be complemented by action to ensure people in held and community detention actually receive its benefits. This includes:

- including this standard of care in the 2019 contractual renewal with IHMS or other health providers appointed to deliver services to immigration detainees;
- auditing existing policies;
- developing and rolling-out training to those delivering these services;
- providing antiviral therapy to all held and community detainees living with hepatitis C; and
- appointing a chief medical officer to the Department.

This system also needs to be subject to appropriate oversight, including providing transparency around the role, functions and composition of the Independent Health Advice Panel, potentially establishing an additional independent health advisory body and appointing a National Preventative Mechanism to implement Australia's obligations under the Optional Protocol to the Convention against Torture.

These steps are critical for the Australian government to properly discharge its obligations to people who are in its care. This change should not be controversial, but it is urgent and long overdue.

Glossary/Abbreviations

ABF	Australian Border Force
The Act	Migration Act 1958
AHRC	Australian Human Rights Commission
AMA	Australian Medical Association
ANAO	Australian National Audit Office
ASHR	Asylum Seeker Health Rights Project
PBS	Pharmaceutical Benefits Scheme
Community detention	Community detention refers to people seeking asylum who are permitted to live in the community (at a designated location) but remain subject to other restrictions of detention. This is distinct from Bridging Visas.
DAA	Direct Acting Antiviral (medications used to treat hepatitis C)
The Department	Department of Home Affairs
DIBP	Department of Immigration and Border Protection (now part of the Department of Home Affairs)
GP	General Practitioner
HCV	Hepatitis C Virus
Held detention	Held detention refers to people seeking asylum who are physically detained inside Immigration Detention Centres
IDC	Immigration Detention Centre
IHAG	Independent Health Advisory Group
IHAP	Independent Health Advice Panel
IHMS	International Health and Medical Services
MCASD	Minister's Council on Asylum Seekers and Detention
The Minister	The Minister for Home Affairs
OPCAT	Optional Protocol to the Convention Against Torture
PIAC	Public Interest Advocacy Centre
RACGP	Royal Australian College of General Practitioners
The Regulations	Migration Regulations 1994

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