Public Interest Advocacy Centre

HEALTHCARE DENIED: MEDEVAC AND THE LONG WAIT FOR ESSENTIAL MEDICAL TREATMENT IN AUSTRALIAN IMMIGRATION DETENTION

December 2021

ABOUT THE PUBLIC INTEREST ADVOCACY CENTRE

The Public Interest Advocacy Centre (PIAC) is leading social justice law and policy centre. Established in 1982, we are an independent, non-profit organisation that works with people and communities who are marginalised and facing disadvantage.

PIAC builds a fairer, stronger society by helping to change laws, policies and practices that cause injustice and inequality. Our work combines:

- legal advice and representation, specialising in test cases and strategic casework;
- research, analysis and policy development; and
- advocacy for systems change and public interest outcomes.

Our priorities include:

- Reducing homelessness, through the Homeless Persons' Legal Service
- Access for people with disability to basic services like public transport, financial services, media and digital technologies
- Justice for First Nations people
- Access to sustainable and affordable energy and water (the Energy and Water Consumers' Advocacy Program)
- Fair use of police powers
- Rights of people in detention, including equal access to health care for asylum seekers (the Asylum Seeker Health Rights Project)
- Improving outcomes for people under the National Disability Insurance Scheme
- Truth-telling and government accountability
- Climate change and social justice.

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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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I. INTRODUCTION

This report examines the treatment and provision of health care for people brought to Australia into immigration detention as part of the Medevac scheme.

Under the Medevac scheme, refugee and asylum seekers were transferred to Australia from Nauru and Papua New Guinea to obtain medical treatment that was not available in those places.

The scheme required two independent doctors to determine that the temporary transfer was necessary. The Minister had 72 hours to decide whether to approve the transfer and could refuse it if he reasonably believed the transfer was not necessary or would threaten Australia's security. The law was intended to streamline the transfer process and confer decision-making to specialist medical practitioners rather than relying upon the discretion of Department of Home Affairs (**Department**) officials.

This report reveals that a concerning number of people in the Medevac cohort experienced serious problems in accessing necessary care once they arrived in Australia.

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The law operated for eight months – from 1 March 2019,[1] until its repeal on 4 December 2019.[2] Approximately 192 refugees and asylum seekers were transferred to Australia under the scheme.[3] All of the people in the Medevac cohort were detained in onshore immigration detention facilities upon arrival, despite many living in the community offshore having been determined to be refugees.[4] Some of our clients continue to be detained awaiting care.

Despite the scheme's intentions, this report reveals that a concerning number of people in the Medevac cohort experienced serious problems in accessing necessary care once they arrived in Australia.

The Commonwealth government owes a non-delegable duty of care to people it holds in detention. But the experiences of our clients in the Medevac cohort show that:

1. The decision to detain the Medevac cohort in onshore facilities significantly exacerbated and/or continues to exacerbate the health conditions for which they were transferred; and
2. People in immigration detention are not receiving access to necessary health care. Many of the significant systemic problems identified in our 2018 report ***In Poor Health*** have not been addressed by the Commonwealth government.

Our findings from working with clients in the Medevac cohort once again highlight the need for urgent reform to ensure people in immigration detention receive health care equivalent to the Australian community standard.

We have urgent concerns in relation to:

- delays in people receiving treatment by relevant agencies;
- relevant agencies failing to implement recommended treatment plans, for example, not providing access to a dental specialist despite referrals being made
- poor communication between agencies involved in providing health care and to people in detention; and
- poor detention conditions leading to worsening physical and mental health, including:
  - the use of 'temporary' hotels purportedly repurposed for immigration detention for long and indefinite periods; and
  - lack of access to adequate fresh air, sunlight, activities and visitors.

Health issues for people in the detained Medevac cohort further deteriorated in 2020/1 because of COVID-19, and the detrimental impacts of closed environments. In addition to the direct impact of COVID-19 outbreaks in immigration detention, the increased pressure on Australia's health system has led to further delays in access to medical consultations and treatment.

Measures to manage the risk of COVID-19 outbreaks in immigration detention have also led to restrictions, including isolation, limits on freedom of movement, socialising, activities and visits, all of which are critical to health and well-being in detention.

The report makes recommendations to improve the quality, timeliness and oversight of healthcare in Australian immigration detention. Implementing these recommendations will alleviate current suffering as well prevent future harm.

A central recommendation is to address the current 'legislative vacuum' that exists in relation to conditions of detention. The Commonwealth Government should immediately amend the *Migration Regulations 1994* (Cth) (**Migration Regulations**) to expressly provide for access to health care in immigration detention equivalent to the Australian community standard. This is an essential step in improving health outcomes for people who languish in Australian onshore immigration detention facilities.

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1 *Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019* (Cth).

2 *Migration Amendment (Repairing Medical Transfers) Act 2019* (Cth).

3 Refugee Council of Australia, *Offshore Processing Statistics* (Report, 4 October 2020); Senate Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, *AE20-216 - Medical Transferees* (Answer to Question on Notice No 216, 2 March 2020).

4 See, eg, Michael Green, 'Playing Games With Us': The Medevac Men Languishing in Hotel Detention', *The Guardian* (online, 15 December 2020) <https://www.theguardian.com/australia-news/2020/dec/15/playing-games-with-us-the-medevac-men-languishing-in-hotel-detention-for-almost-two-years>; Yara Murray-Atfield, 'Medevac Detainees Have Been Freed After Years in Australia's Immigration Detention System. Here's Why, And What May Happen Next', *ABC News* (online, 21 January 2021) <https://www.abc.net.au/news/2021-01-21/medevac-detainees-have-been-freed-from-melbourne-hotel/13077296>; Ella Archibald-Binge and Raveen Hunjan, 'While Dozens of Medevac Detainees Were Released From Detention, Others Have Been Left Behind', *ABC News* (online, 18 February 2021) <https://www.abc.net.au/news/2021-02-18/medevac-detainees-released-detention-asylum-seekers-left-behind/13164230>; Sara Dehm and Claire Loughnan, 'Scores of Medevac Refugees Have Been Released From Detention. Their Freedom, Though, Remains Tenuous', *The Conversation* (online, 22 March 2021) <https://theconversation.com/scores-of-medevac-refugees-have-been-released-from-detention-their-freedom-though-remains-tenuous-156952>; Tom Stayner, ' "They are Human Beings": Released Medevac Detainees Call for 'Permanent' Resettlement Option for Refugees', *SBS News* (online, 25 February 2021) <https://www.sbs.com.au/news/they-are-human-beings-released-medevac-detainees-call-for-permanent-resettlement-option-for-refugees/b28d96a4-c999-4a23-9e90-5b935a67c60b>.

2. RECOMMENDATIONS

PIAC makes the following recommendations for reform:

1. ***Immediately transfer any remaining members of the Medevac cohort out of closed immigration detention centres into the community.***
2. ***Prioritise and expedite access to medical treatment and/or assessment for people in the Medevac cohort through the public health system.***
3. ***Amend the Migration Regulations by inserting a new provision to require a minimum standard of healthcare (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.*
4. ***Ensure that the 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.***
5. ***Conduct an audit of existing departmental, operational and training policies to ensure that they fully reflect the Minimum Standard of Healthcare.***
6. ***Conduct a comprehensive review of the mental health care provided in immigration detention led by psychiatrists and specialists experienced in developing plans that reflect the unique and complex needs of the population.***
7. ***Improve the provision of quality and timely dental care to all immigration detainees.***
8. ***Immediately provide all staff working in facilities and people in immigration detention with access to COVID-19 vaccinations.***
9. ***Ensure that restraints for medical transfers in immigration detention, including handcuffing, are only used as a matter of last resort and if used, are only done so when clinically approved by a medical team.***
10. ***Ensure that the Commonwealth government fulfils Australia's obligations under the Optional Protocol on the Convention against Torture.***

3. BACKGROUND

3.1. METHODOLOGY

PIAC'S ASYLUM SEEKER HEALTH RIGHTS (ASHR) PROJECT

PIAC launched its ASHR project in September 2016 to address serious concerns about the lack of adequate health care in Australia's onshore immigration detention system.

PIAC does not support Australia's system of mandatory immigration detention. This system holds people for excessive and indefinite periods of time and causes harm to physical and mental health. We maintain that it is a system that is cruel and unnecessary.

It is also a system that is implemented in a way that causes harm, including by failing to ensure people in detention have access to an adequate standard of health and medical care. The focus of the ASHR project and this report is therefore ensuring people in immigration detention have access to the medical care and treatment they need, at a standard consistent with the Australian community. The ASHR project runs strategic litigation, files complaints with agencies and oversight bodies, makes submissions, engages with decision-makers and uses the media to protect these basic human rights of asylum seekers and refugees.

Throughout the ASHR Project, we have worked closely with colleagues in the immigration sector and we acknowledge their support. We work with immigration lawyers; specialist legal groups; corporate law firms undertaking work for asylum seekers; 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 client referrals through this network which helps us identify prevalent and emerging issues. We also work with colleagues in the sector to share information and workshop ideas to ensure the ASHR project both meets our clients' needs and complements the work of others.

3.2. IN POOR HEALTH

This report follows our 2018 report, *In Poor Health: Health care in Australian immigration detention*, and updates the recommendations for reform we made in that report. *In Poor Health* highlighted cases of asylum seekers with serious, chronic diseases and injuries suffering indefinitely without access to treatment.

In Poor Health identified that the Australian government is failing to provide people in immigration detention with access to the medical care and treatment they need. The failure to provide healthcare is not commensurate with Australian community standards. This is despite the fact the government owes a clear, common law duty of care to people it detains. Notwithstanding this duty, PIAC's analysis revealed that the legislation which governs the treatment of people in detention does not include a guaranteed right to reasonable medical care and treatment. This is in stark contrast to the rights of people in Australian prisons: State and Territory laws provide explicit rights to health care for prisoners.

The central recommendation of *In Poor Health* was accordingly that the Commonwealth government urgently amend the *Migration Regulations* to guarantee a minimum standard of health care, equivalent to that available in the Australian community, for people in immigration detention.

The failure to provide healthcare is not commensurate with Australian community standards.

3.3. PIAC'S MEDEVAC CASEWORK

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

Our case work has required us to closely and methodically consider our clients' experiences, particularly as evidenced by their records, including extensive medical records. We have worked closely with medical professionals to assess this evidence. This process has identified current policies and patterns of practice that PIAC believes breach the rights of detainees and require systemic change.

We acted or continue to act for 13 clients in the Medevac cohort, for whom we have advocated with the Department and IHMS to ensure access to necessary health and medical care. We are aware of at least 25 others in the cohort who raised complaints about lack of access to medical treatment that were assisted by other organisations, or for whom we provided information and referrals.

Based on the clients we have worked with, the enquiries we have received, and our work with the sector, we have seen a failure to provide timely medical assessment and treatment for people with serious physical and mental health conditions. We have also seen the worsening physical and mental health of our clients caused by their ongoing detention.

4. WHO ARE THE PEOPLE IN THE MEDEVAC COHORT?

4.I. WHAT WAS THE MEDEVAC SCHEME?

Under the *Migration Act 1958* (Cth) (**Migration Act**), all asylum seekers transferred to regional processing countries are 'transitory persons'. The Department has the power to transfer a transitory person from another country to Australia for a 'temporary purpose' (s198B).

The Migration Act does not define the 'temporary purposes' for which asylum seekers may be transferred offshore from regional processing countries, but one primary purpose is for medical treatment for a condition which cannot be adequately treated offshore.

Asylum seekers who are transferred to Australia for medical treatment or another temporary purpose generally are not granted a visa authorising their entry. Accordingly, they are held in detention, pursuant to ss 189 and 196 of the Migration Act. This may be in onshore detention centres, community detention or 'alternative places of detention', such as hotels.

Prior to the Medevac scheme, there was a growing number of cases in which the Department rejected recommendations by doctors that people be transferred from offshore processing to Australia for specialist medical treatment. As a result, over 50 cases were lodged in the Federal Court on behalf of refugees and asylum seekers who required urgent medical treatment. These cases sought, and successfully obtained, urgent interlocutory injunctions to force the Australian government to transfer those in need of treatment (and in some cases their family members) to places where they could receive urgent care. As a result of these cases, hundreds of people were evacuated from offshore processing to Australia.[5]

In the wake of these cases and escalating concerns about conditions on Nauru, in February 2019, the *Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019* (Cth) was passed, amending the *Migration Act 1958* (Cth) to allow independent doctors to recommend that refugees and asylum seekers be transferred to Australia for much needed medical treatment.

This was a change from the previous system, where transfer decisions rested in the hands of officers of the Department.

5 Kaldor Centre 'Medical transfers from offshore processing to Australia', (Web Page) https://kaldorcentre.unsw.edu.au/publication/medevac-law-medical-transfers-offshore-detention-australia.

Under the Medevac law, if two doctors recommended that a person be transferred to Australia for medical treatment, the Minister was required to approve or refuse the transfer within 72 hours of receiving that recommendation. A transfer could be refused on character and/or national security grounds, or (in the case of adults only) on medical grounds. Any transfers refused by the Minister on medical grounds were referred to an eight-person medical panel – the Independent Health Advice Panel (**IHAP**) – which had 72 hours to review the case and make a recommendation for or against transfer. If IHAP recommended transfer, the Minister retained power to refuse the transfer on security or character grounds, but otherwise had 24 hours to approve the transfer.

The Medevac process was significant because it created a process – based on medical expertise – to deliver health care to sick people in need, rather than a bureaucratic, delayed and often litigated process. Before Medevac, refugees and asylum seekers in offshore detention who required urgent health care were waiting for an average of two years for medical transfer to Australia for treatment.[6] The Medevac scheme provided a thorough, transparent and independent process, which minimised the political interference that could delay urgent medical treatment for asylum seekers and refugees.

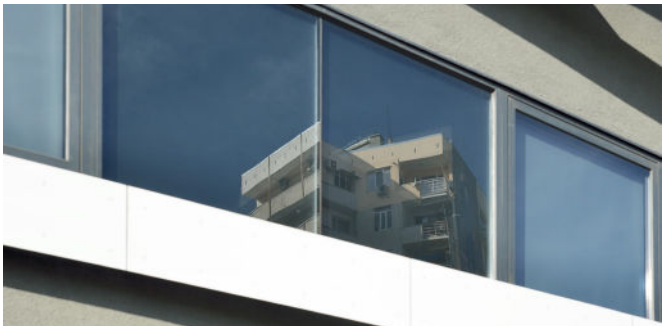
Dr Sara Townend coordinated the medical professionals providing opinions under the scheme. Dr Townend commented at the time:

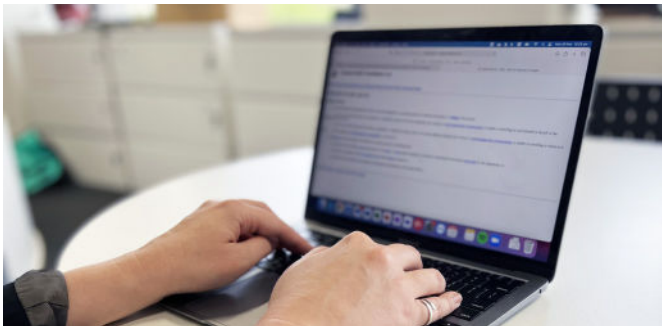
> It's important that there is an equitable system with medical need as its focus. Doctors are best placed to assess the nature of health needs for patients and what treatment the patient will require.
>
> In the past, medical requests for transfer have been diluted by bureaucratic obstruction and political agendas.[7]

The Medevac law was repealed on 4 December 2019. The repealed law is set out below.

6 Asylum Seeker Resource Centre, 'Medevac Process Explained', (Web Page) <https://asrc.org.au/medevac-process-explained/>.

7 Human Rights Law Centre, 'Medical evacuation response group established for urgent medical transfers from Manus and Nauru', (Web Page) https://www.hrlc.org.au/news/2019/3/7/medical-evacuation-response-group-established-for-urgent-medical-transfers-from-manus-and-nauru.





MEDEVAC LEGISLATION (NOW REPEALED)

198E Minister's approval to bring relevant transitory persons to Australia

1. If 2 or more treating doctors for a transitory person who is in a regional processing country have notified the Secretary that the person is a relevant transitory person, the Secretary must notify the Minister as soon as practicable.
2. A transitory person is a relevant transitory person if:
   a. the person:
      i. is in a regional processing country on the day this section commences; or
      ii. is born in a regional processing country; and
   b. in the opinion of a treating doctor for the person:
      i. the person requires medical or psychiatric assessment or treatment; and
      ii. the person is not receiving appropriate medical or psychiatric assessment or treatment in the regional processing country; and
      iii. it is necessary to remove the person from a regional processing country for appropriate medical or psychiatric assessment or treatment.
3. After being notified by the Secretary that a person is a relevant transitory person, the Minister must approve, or refuse to approve, the person's transfer to Australia.

3.A. The Minister must make a decision under subsection (3):
   a. as soon as practicable after being notified; and
   b. no later than 72 hours after being notified.

4. The Minister must approve the person's transfer to Australia unless:
   a. the Minister reasonably believes that it is not necessary to remove the person from a regional processing country for appropriate medical or psychiatric assessment or treatment; or
   b. the Minister reasonably suspects that the transfer of the person to Australia would be prejudicial to security within the meaning of the *Australian Security Intelligence Organisation Act 1979*, including because an adverse security assessment in respect of the person is in force under that Act; or
   c. the Minister knows that the person has a substantial criminal record (as defined by subsection 501(7) as in force at the commencement of this section) and the Minister reasonably believes the person would expose the Australian community to a serious risk of criminal conduct.

4.A. Within 72 hours of the Minister being notified under subsection (1), ASIO should advise the Minister if the transfer of the person to Australia may be prejudicial to security within the meaning of the *Australian Security Intelligence Organisation Act 1979* (including because an adverse security assessment in respect of the person is in force under that Act) and if that threat cannot be mitigated.

5. If the Minister does not make a decision under subsection (3) within the time required by subsection (3A), the Minister is, at the end of the time, taken to have approved the person's transfer under subsection (3).
6. The Minister's powers under this section may only be exercised by the Minister personally.
7. A medical practitioner is a treating doctor for a transitory person if the medical practitioner:
   a. is registered or licensed to provide medical or psychiatric services in a regional processing country or in Australia; and
   b. has assessed the transitory person either remotely or in person.
   c. The regulations may prescribe processes to be complied with in relation to the exercise of the Minister's powers under this section.

4.2. WHAT WAS MERG?

The Medical Evacuation Response Group (**MERG**) comprised specialists in the Medevac process, including doctors, caseworkers, counsellors and lawyers. MERG created a referral process that allowed people on Nauru and Manus Island to be triaged by medical professionals and supported by caseworkers. Where the patient required medical care that was not available on the islands, MERG could recommend medical transfers.[8]

MERG included the following organisations, who worked directly with medical professionals: Refugee Council of Australia, Asylum Seeker Resource Centre, Human Rights Law Centre, Refugee Legal, National Justice Project, Asylum Seekers Centre, Refugee Advice & Casework Service and Amnesty International Australia.[9]

4.3. WHO WAS TRANSFERRED TO AUSTRALIA?

Approximately 192 refugees and asylum seekers were transferred to Australia under the Medevac law. As at 11 September 2019 (two months before the Medevac law was repealed), only 15 cases had been refused by the Minister, six of which were overturned by IHAP.[10]

All people transferred were initially detained at onshore immigration detention centres in Brisbane and Melbourne. The Australian Human Rights Commission (**AHRC**) condemned the use of these hotels and motels as detention centres, after inspecting conditions at two hotels in Melbourne and Brisbane that had been designated as alternative places of detention (**APODs**), where some of the Medevac cohort were detained. The Australian Human Rights Commissioner remarked that the Commission 'generally considers that motels are not appropriate places of detention, given their lack of dedicated facilities and restrictions on freedom of movement and access to open space.'[11] More specifically, the AHRC found through their inspections that:

> The conditions of detention at the Melbourne and Brisbane hotel APODs are inadequate. They are extremely restrictive and lack sufficient outdoor space and facilities for exercise, recreation and activities. Such restrictive conditions and lack of access to these essential amenities appeared to be contributing to a decline in the physical and mental wellbeing of those detained in the hotel APODs.[12]

One individual at the Melbourne APOD told the AHRC that there is 'no fresh air and you can't see the sun.' Others commented that they felt 'locked in' and stated that they were not allowed to open any windows to let in fresh air.[13] Former independent MP Kerryn Phelps reflected this sentiment, stating, 'Once they were transferred to Australia, the government continued the cruelty by locking these people up in hotel rooms with no fresh air, no access to sunshine and the outdoors.'[14]

Ismail Hussein, from Somalia, was a Medevac transferee detained at the Mantra Hotel in Melbourne. He described the conditions as 'more difficult than what we experienced in Manus Island. Maybe one hour of gym – that's the only time that I am not in my room. The rest of the day, I'm lying on my bed or sitting on the chair.'[15]

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8 Refugee Council of Australia, 'Medical Evacuation Response Group Established for Urgent Medical Transfers from Manus and Nauru', *Medical Evacuation Response Group* (Web Page, 1 March 2019) <https://www.refugeecouncil.org.au/medical-evacuation-response-group/>.

9 Ibid.

10 Dana McCauley, 'Independent Doctors Backed Most Medevac Transfer Refusals', *The Sydney Morning Herald* (online, 11 September 2019) <https://www.smh.com.au/politics/federal/independent-doctors-backed-most-medevac-transfer-refusals-20190911-p52qba.html>.

11 Bianca Hall and Noel Towell, 'Not appropriate": Watchdog Unhappy After Inspecting Melbourne's Medevac Motel', *The Sydney Morning Herald* (online, 19 December 2019) <https://www.smh.com.au/politics/federal/not-appropriate-watchdog-unhappy-after-inspecting-melbourne-s-medevac-motel-20191219-p53ll7.html>; Australian Human Rights Commission, *Inspections of Australia's immigration detention facilities 2019* (Report, December 2020) 84.

12 Australian Human Rights Commission, (n 11) 83, 84.

13 Ibid 81.

14 Ella Archibald-Binge and Raveen Hunjan, 'While Dozens of Medevac Detainees Were Released From Detention, Others Have Been Left Behind', *ABC News* (online, 18 February 2021) <https://www.abc.net.au/news/2021-02-18/medevac-detainees-released-detention-asylum-seekers-left-behind/13164230>.
Ella Archibald-Binge and Raveen Hunjan, 'While Dozens of Medevac Detainees Were Released From Detention, Others Have Been Left Behind', *ABC News* (online, 18 February 2021) <https://www.abc.net.au/news/2021-02-18/medevac-detainees-released-detention-asylum-seekers-left-behind/13164230>.

15 Michael Green, 'Playing Games With Us': The Medevac Men Languishing in Hotel Detention', *The Guardian* (online, 15 December 2020) <https://www.theguardian.com/australia-news/2020/dec/15/playing-games-with-us-the-medevac-men-languishing-in-hotel-detention-for-almost-two-years>.

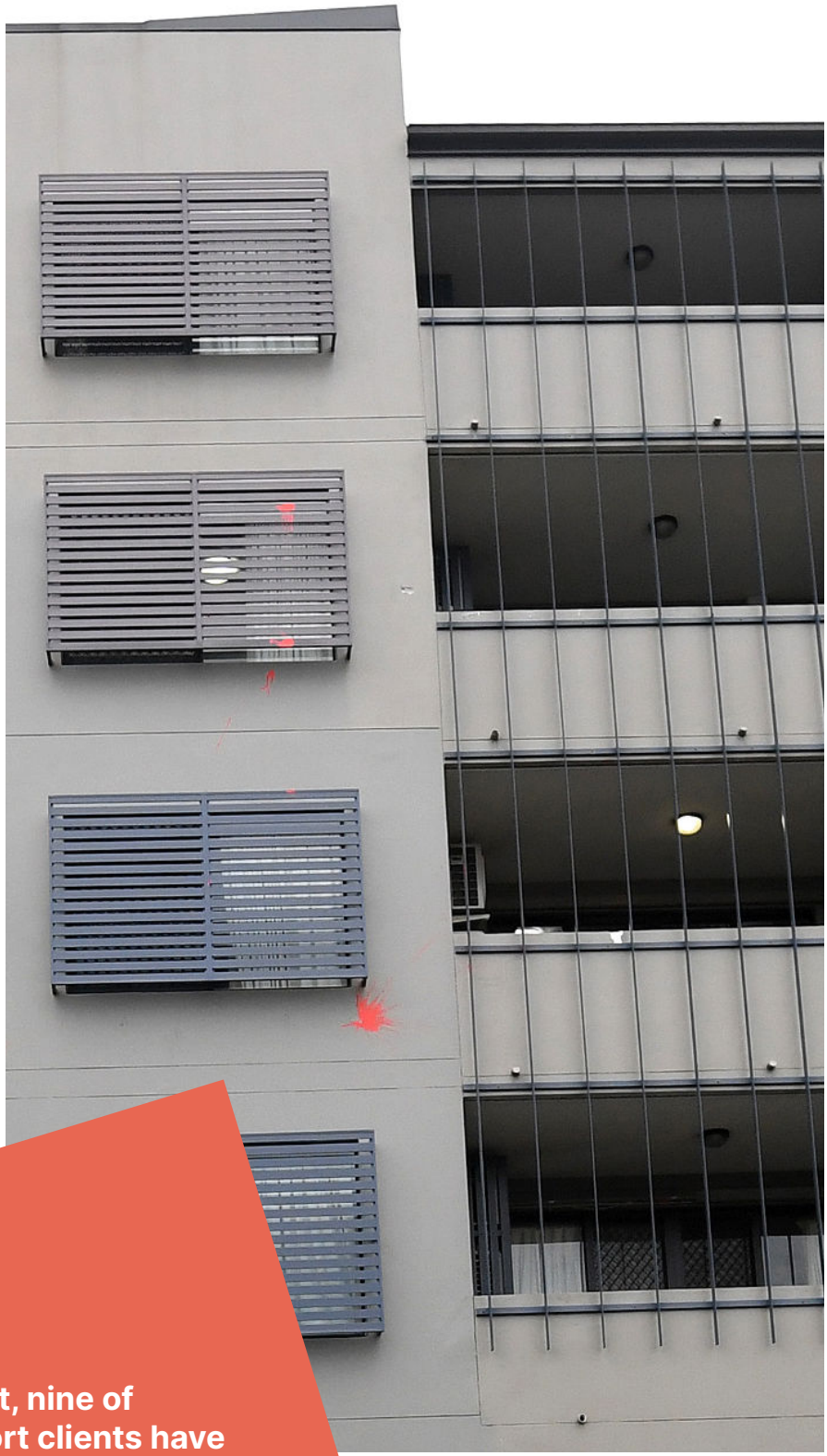
Of the people from the Medevac cohorts that remain detained, some are still on waiting lists to receive treatment for the health conditions that triggered their transfer to Australia.

As of the date of this report, nine of thirteen our Medevac cohort clients have been released into the community. Once in the community, our clients have generally accessed the treatment they need in a timely and appropriate way.

The AHRC interviewed 69 people in the Medevac cohort and most reported delays in accessing the medical treatment for which they were transferred. Most said they had not yet seen the relevant specialist or received treatment (often surgery or other significant treatment), despite being in Australia for up to six months and in some cases a year.[16]

It is particularly concerning that for our Medevac cohort clients that remain detained, they are experiencing new or deteriorating mental health issues caused by their ongoing indefinite detention in Australia.

16 Australian Human Rights Commission, (n 11) 41.



As of the date of this report, nine of thirteen our Medevac cohort clients have been released into the community. Once in the community, our clients have generally accessed the treatment they need in a timely and appropriate way.

4.4. WHAT DOES THE COMMONWEALTH GOVERNMENT PLAN TO DO FOR THE PEOPLE TRANSFERRED?

Following the repeal of the Medevac law, if a person in offshore processing needs to be transferred to Australia for medical treatment, the provisions in the *Migration Act* authorising 'transitory persons' to be transferred to Australia for a temporary purpose apply. Where the need for treatment is urgent and the government does not authorise a transfer, litigation seeking a court ordered transfer may be commenced.

Regarding the future for the Medevac cohort in Australia, the Commonwealth government has said:

> Persons who arrived in Australia illegally by boat will not be settled permanently in Australia. Transitory persons in Australia have migration options and are engaging with these options: Transitory persons may resettle in the United States or settle in PNG (Papua New Guinea). Transitory persons can return home voluntarily or to a country to which they have a right of entry, and will receive financial assistance to re-establish their lives. Transitory persons can independently explore migration options.[17]

17 Senate Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, *BE20-318 - Offshore Detention Costs - Budget Expenditure* (Answer to Question on Notice No 318, 6 November 2020).


Refugees
Refugee Action Network Newcastle
Let them Land

CASE STUDY: AMIR*

Amir's mental health significantly deteriorated during his detention. Since his transfer to Australia for medical treatment, an IHMS psychiatrist assessed and diagnosed Amir with Reactive Depression (Situational Disorder) and at high risk of suicide.

Amir is 34 years old and was born and raised in Basra Province, Iraq. Amir fled Iraq and was detained on Christmas Island in September 2013 before his transfer to detention on Manus Island. Amir was determined to be a refugee under Papua New Guinea's refugee status determination process in April 2016 and lived in the community for three years.

Amir was transferred from Manus Island to Australia for medical assessment and treatment for numerous physical and mental health conditions on 25 July 2019. He was detained at the Melbourne Immigration Transit Accommodation (**MITA**) centre for over two years.

Amir experienced lengthy delays in accessing medical treatment for his long-term physical health conditions. Amir remained in need of assessment and treatment for a serious haemorrhoid condition that caused him significant pain and discomfort, epigastric pain, heart palpitations, and right knee pain.

Amir's mental health significantly deteriorated during his detention. Since his transfer to Australia for medical treatment, an IHMS psychiatrist assessed and diagnosed Amir with Reactive Depression (Situational Disorder) and at high risk of suicide.

In January 2020, IHMS referred him for counselling with Foundation House (the Victorian Foundation for Survivors of Torture), identifying a range of symptoms including torture and trauma related symptoms and depression related symptoms.

In September 2020, following twelve assessment and counselling sessions between May-September 2020, the counsellor reported that 'there had been little improvement in his mental state, that progress is unlikely while he remains in held detention and that his psychological level of functioning will continue to deteriorate in this context'.

By June 2021, Amir had been identified by psychiatrists as being at high risk of suicide for almost two years, with his mental health continuing to deteriorate as a result of ongoing detention. Clinical notes record Amir having self-harmed, and having gone on a hunger strike and refusing food and water.

In August 2021, Amir was finally released into the community and is now accessing appropriate health care services. Amir's experience shows that Commonwealth government not only failed to provide him with adequate medical treatment, which had been the purpose of this transfer to Australia, but also that the impact of further periods of detention caused further harm to his mental health.

** Name changed to protect our client's privacy.*

5. ACCESS TO HEALTH CARE IN IMMIGRATION DETENTION

5.1. ABOUT ONSHORE IMMIGRATION DETENTION

At 31 August 2021, there were 1440 people in immigration detention facilities, and 560 people in community detention.

The average period of time for which people were held in detention facilities was 696 days.[18] Over 80 per cent of people had been held in detention facilities for more than three months. Over half had been detained for more than a year.

In 2020–21, the average number of people in held immigration detention was 1514. This is an increase of 100 people (7.1 per cent) from 2019–20,[19] despite repeated calls to reduce numbers in overcrowded facilities, given the risk of infection with COVID-19.

5.2. WHAT HEALTHCARE IS AVAILABLE?

The AHRC's 2019 inspections of Australia's immigration detention facilities provides an updated snapshot of access to healthcare in immigration detention.[20]

International Health and Medical Services (**IHMS**) is contracted by the Department to provide primary and mental health care services in Australia's immigration detention facilities. The IHMS health service in each facility is nurse-led, with some having specialisations in areas such as mental health. Where in-house health care is not available, IHMS staff can refer immigration detainees to external providers (such as psychiatrists or torture and trauma counsellors). IHMS staff at all facilities advised that waiting times for appointments vary depending on the assessment of priority, as well as the capacity of a particular clinic or service.[21]

Dental care in immigration detention is delivered by external providers. Detainees interviewed by AHRC reported delays in accessing dental care. For example, a significant number of people at Yongah Hill Immigration Detention Centre reported waiting over two months to see the dentist, and in a few cases over a year.[22]

During interviews with the AHRC, many people reported concerns about their mental health. This included experiencing depression, anxiety, stress, difficulties sleeping, problems with concentration and/or memory and lack of motivation. Many people felt the mental health care provided was of limited effectiveness given their ongoing detention and uncertain future. Others expressed concern that mental health is not taken seriously enough. For example, one person said, 'You need to be extreme or threatening self-harm for any action to be taken. People are given tablets and sent away.'[23]

18 Department of Home Affairs, *Immigration Detention and Community Statistics Summary* (Report, 31 August 2021).

19 Department of Home Affairs, *2020-2021 Annual Report* (Report, 30 June 2021), 154.

20 Australian Human Rights Commission, (n 11).

21 Ibid 38.

22 Ibid 44.

23 Ibid 50.

The AHRC recommended that the Department should commission a group of independent mental health experts to conduct a comprehensive review of the mental health care provided in immigration detention, including whether current practices are in line with medical advice and Australia's human rights obligations; the impacts of current practices on people in immigration detention; and alternative options for monitoring and engagement.[24] The Department agreed with this recommendation 'in principle'. As of the date of publication, no such review has been conducted.

Despite the apparent availability of healthcare for people in immigration detention, PIAC remains concerned that, in practice, people are still not getting the care they need.

For example, a number of immigration detainees living with hepatitis C continue to be denied access to treatment in accordance with Australian community standards. This is despite the fact that the Department of Home Affairs has stated its commitment to provide antiviral medication to all immigration detainees living with Hepatitis C.

As at 31 March 2021, 27 people in immigration detention had been diagnosed with active Hepatitis C, however fewer than five people were receiving treatment.[25] PIAC has twice been required to bring Federal Court proceedings to secure access for clients to curative medication for this life-threatening disease.

Part of this issue is that our key recommendation from our *In Poor Health* report remains outstanding. The Commonwealth government is still yet to amend the *Migration Regulations* to guarantee a minimum standard of health care, equivalent to that available in the Australian community, for people in immigration detention. The lack of a legislative guarantee means that there are limited legal protections to ensure the provision of healthcare in immigration detention. This is problematic given, in reality, many people are not getting the treatment they need. As this report details, the experiences of people in the Medevac cohort also suggest an ongoing failure to provide timely access to medical care, as does the Government's response to the risks of COVID-19 in immigration detention.

24 Letter from Department of Home Affairs to Australian Human Rights Commission, 30 November 2020, 2 <https://humanrights.gov.au/sites/default/files/att_a_-_home_affairs_response_-_ahrc_2019_idc_inspection_report_-_ohr-20-00262_0.pdf>.

25 Senate Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, *BE21-463* (Answer to Question on Notice No 463, 24-25 May 2021); Senate Standing Committee on Legal and Constitutional Affairs, Parliament of Australia, *BE21-464* (Answer to Question on Notice No 464, 24-25 May 2021)

5.3. HANDCUFFING IN IMMIGRATION DETENTION

Our work with people in immigration detention demonstrates that the overuse of handcuffs is a significant barrier to people receiving medical treatment.

People in immigration detention, regardless of their security profile, are routinely handcuffed during and in transit to medical appointments. These practices are particularly concerning given that many asylum seekers have a history of trauma and torture. In many instances, the use of force and restraints in immigration detention is arbitrary, yet the impact on our clients is severe.

In November 2020, PIAC filed landmark test case litigation in the Federal Court to challenge the lawfulness of restraints in immigration detention. Our client, Yasir, is living with severe mental illness and the use of handcuffs is particularly retraumatising for him. This has led to frequent disruption and delay to his medical care. The use of handcuffs causes Yasir to have seizures, which has prevented him from attending specialist appointments. It has also led to Yasir refusing medical attention to avoid being handcuffed. The case is ongoing. Janet Pelly, a detention rights advocate, noted:

> Following the launch of PIAC's Federal Court action, I was contacted about use of restraints on over 20 of the Medevac cohort. These reports were consistent across all sites where they were detained. They spoke of humiliation, being made to feel like a criminal and missing important appointments because they refused to be restrained for medical care.

6. RESPONSE TO COVID-19 IN IMMIGRATION DETENTION

COVID-19 poses heightened risks to people in all closed environments, including immigration detention facilities. People in immigration detention facilities live in close proximity with one another, in most cases sharing bedrooms, bathrooms and other enclosed communal spaces. This increases the risk of rapid person-to-person transmission in the immigration detention population.

To protect the health of people in immigration detention, including those working in and visiting places of detention, public health and infectious diseases experts, including the Australasian Society for Infectious Diseases (**ASID**) and the Australian College of Infection Prevention and Control (**ACIPC**), have recommended a significant reduction of the numbers of people in immigration detention, in addition to other risk mitigation strategies to prevent and manage an outbreak of COVID-19.[26]

In May 2020, PIAC filed a group complaint with the Commonwealth Ombudsman for 13 men in Australian immigration facilities who feared that an outbreak of COVID-19 could prove catastrophic for detainees, staff and the broader community.

The complaint called for an urgent inspection of immigration detention facilities and alternative places of detention, to examine the adequacy of conditions and measures being taken to mitigate and manage the dangers posed by COVID-19 to detainees and staff. The men who made the complaint were unable to follow public health advice and practice social distancing in crowded, shared facilities and have specific health conditions that increase their risk of serious harm in the event of an outbreak in detention.

The Commonwealth Ombudsman agreed to our call for an urgent investigation and inspections. Having conducted these inspections, the Ombudsman made a series of recommendations to the Commonwealth government to mitigate the risk of the transmission of COVID-19 in immigration detention. Importantly, this included recommending a reduction in the detention population.

Following PIAC's complaint, the Department of Home Affairs improved vulnerable detainee identification, outbreak management plans and safety procedures. Four of our 14 clients have since been released from detention and the Ombudsman has committed to continually monitor the issue and proposed regular meetings with PIAC to discuss observations.

Despite these steps, the number of people in closed immigration detention increased during the COVID-19 pandemic.[27]

In March 2020, there were 1,373 people in immigration detention facilities. By 28 February 2021, this number had increased to 1,527. On 31 August 2021 there remained 1,440 people in immigration detention facilities. This population increase has heightened the concentration of detainees, despite the health advice to significantly reduce the amount of people in detention.[28]

At the date of this report, the Commonwealth government has not publicly released information about its policies and procedures to mitigate the risk of COVID-19 in immigration detention or its plan for vaccine rollout for staff and detainees. Of further concern, the vaccine rollout has also been substantially delayed. By September 2021, only 17% of people in immigration detention had been fully vaccinated. At the end of October, this percentage was still only 55%.

26 Alice McBurney, Edward Santow and John Howell, *Management of COVID-19 Risks in Immigration Detention* (Review, June 2021) 15.

27 Ibid; Department of Home Affairs, *Immigration Detention and Community Statistics Summary* (Report, 31 July 2021).

28 Alice McBurney, Edward Santow and John Howell, *Management of COVID-19 Risks in Immigration Detention* (Review, June 2021) 15.

7. HEALTH RIGHTS AND AUSTRALIA'S DUTY OF CARE TO PEOPLE IN IMMIGRATION DETENTION

7.1. DOMESTIC LAW AND STANDARDS

AUSTRALIA'S DUTY OF CARE TO IMMIGRATION DETAINEES

The Commonwealth government 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.[29] This duty arises because people in immigration detention (like prisoners) are held against their will and 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.[30]

LIABILITY UNDER AUSTRALIA'S COMMON LAW

The Commonwealth 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*,[31] 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.***[32]

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.

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29 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; Department of Immigration and Border Protection, *Detention Services Manual, Chapter 1: Legislative and Principles Overview – Services Delivery Values* (at May 2015) 7.

30 Commonwealth Ombudsman, *Suicide and Self-harm in the Immigration Detention Network*, Report No 2 (2013) 59, 27.

31 (2004) 208 ALR 271.

32 Ibid [21] (emphasis added).

JUDICIAL COMMENTARY

Mastipour v Secretary, Department of Immigration & Multicultural & Indigenous Affairs (Mastipour)[33]

Mr Mastipour 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, Mr Mastipour 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 found in favour of the applicant, restraining the Secretary from either detaining him at Baxter or transferring him to Port Hedland.

On the issue of the duty of care owed to Mr Mastipour, 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.[34]

S v Secretary, Department of Immigration and Multicultural and Indigenous Affairs (S v Secretary)[35]

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 applications was to compel the Department to have them assessed 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 held that the Commonwealth 'owes a non-delegable duty of care to the applicants because of its particular "relationship" with [immigration] detainees.'[36]

Specifically, as to medical care, Finn J held 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 ensures 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 … [and]*** **that the requisite level of medical care is provided and with reasonable care and skill.**[37]

SBEG v Commonwealth of Australia[38]

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 that his mental health had been adversely affected as a result of the circumstances of his detention.

33 [2004] FCAFC 93.

34 *Mastipour v Secretary*, DIMIA [2003] FCA 952, [21]-[22].

35 [2005] FCA 549.

36 Ibid [199], citing *Kondis v State Transport Authority* (1984) 154 CLR 672 at [687].

37 Ibid [212] (emphasis added).

38 [2012] FCAFC 18.

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.***
>
> 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.[39]

MZYYR v Secretary, Department of Immigration and Citizenship[40]

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 the existence of a duty of care was not in dispute and this includes providing 'the level of medical care which is reasonably designed to meet their health care needs, including psychiatric care'.[41]

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.***[42]

AS v Minister for Immigration and Border Protection[43]

The plaintiff was a child who was an asylum seeker. She has been detained as an 'unlawful non-citizen' pursuant to s 189(3) of the *Migration Act 1958 (Cth)*. The proceedings were 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 Commonwealth accepted that it owes a non-delegable duty of care to provide reasonable healthcare to detainees, and conceded that the Minister also arguably owed a non-delegable duty of care in this regard.[44]

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.

LEGISLATIVE FRAMEWORK

Despite the Commonwealth's duty of care to provide adequate health services to immigration detainees, this is not reflected in the legislative framework.

Section 273 of the *Migration Act* confers power on the Minister to make regulations regarding the 'operation and regulation of detention centres'. The Migration Regulations are, however, silent on the issue of medical care.

Regulation 5.35 concerns the medical treatment of immigration detainees but only 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.

39 Ibid [19] (emphasis added).

40 [2012] FCA 694.

41 Ibid [20], citing *S v Secretary, Department of Immigration and Multicultural and Indigenous Affairs* [2005] FCA 549; (2005) 143 FCR at [218].

42 Ibid [55] (emphasis added).

43 [2014] VSC 593.

44 Ibid [24].

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.[45]

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.[46]

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.[47]

7.2. COMMONWEALTH LAW, IHMS AND DHA POLICIES

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

IHMS's stated position is that it is contracted by the Commonwealth government, represented by the Department of Home Affairs, 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].[48] This would appear to be a lesser standard than that in the RACGP Immigration Detention Standards and recommended by the AMA, set out below.

As for community detention, IHMS states:

> 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.[49]

On one hand, IHMS's policy statement accepts 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.[50]

This apparent relaxation of the Commonwealth government's duties to provide reasonable care to immigration detainees confirms the need for legislative reform to establish a clear minimum standard.

Royal Australian College of General Practitioners (RACGP) Standards

The RACPG have produced Standards for Health Services in Australian Immigration Detention Centres. These standards provide that the quality of care in immigration detention should be consistent with the quality of health service provision in the general Australian community.[51] Importantly, the Standards state that health practitioners contracted to work for third parties (including private health service providers) are not absolved from their professional and ethical responsibilities to their patients. As noted above, this is a clearer and stronger position than that adopted by IHMS.

45 [2003] FCAFC 93, [8].

46 Ibid [2] (emphasis added).

47 [2005] FCA 549, [198].

48 International Health and Medical Services, 'Sites Onshore' (Web page) <http://www.ihms.com.au/onshore.php>.

49 Ibid (emphasis added).

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

51 Royal Australian College of General Practitioners *'Standards for Health Services in Australian Immigration Detention Centres'* (June 2007) available https://www.racgp.org.au/FSDEDEV/media/documents/Running%20a%20practice/Practice%20standards/Health-services-in-Australian-immigration-detention-centres.pdf. We note the standards are currently being updated, however are yet to be publicly released.

7.3. INTERNATIONAL HUMAN RIGHTS LAWS AND STANDARDS

The right to health is fundamental and protected by an intersecting suite of international human rights treaties, interpretive instruments and national laws.[52] Both international human rights law and the Australian common law duty of care require the provision of health services to persons in detention. There are well-documented links between prolonged immigration detention and deterioration of mental health.[53]

International human rights standards set out that people who are detained in immigration detention must be provided with medical treatment and care in a manner which is culturally appropriate [and] which recognises the specific needs of detainees as displaced persons who may have experienced trauma which respects the inherent dignity of the human person.[54]

This must necessarily include that the detained person detainee is informed in a language and in words and formats they can understand about the health care services available in immigration detention; that preventative health care measures are undertaken where necessary; and that detention authorities must provide detainees with access to services of community non-government organisations that provide expert services such as torture and trauma counselling.

As a minimum standard, medical treatment and care must be provided to a standard commensurate with that provided in the Australian community.

Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT)

OPCAT is an international treaty designed to protect people who are detained and who are vulnerable to mistreatment or abuse in detention, including in immigration detention.

OPCAT requires signatory states to establish National Preventive Mechanisms (**NPM**): independent bodies tasked with conducting regular preventive visits to places of detention. It also requires that signatories accept visits from the United Nations Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (SPT).[55]

The Commonwealth government ratified OPCAT in December 2017 and elected to postpone its obligation to establish a NPM until January 2022.[56] As at the date of this report, the Commonwealth government has nominated the Office of the Commonwealth Ombudsman to be the NPM overseeing immigration detention.[57]

OPCAT is a critical accountability mechanism to ensure that people in immigration detention are able to access the healthcare they need. The Government must fulfil its obligations under OPCAT on an ongoing basis.

52 **Treaties**: International Covenant on Economic, Social and Cultural Rights, 12; Convention on the Rights of the Child, 24; Committee on the Elimination of Discrimination against Women, 12; Convention on the Rights of Persons with Disabilities, 14(2), 25.
Interpretive instruments: *Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, 24; Basic Principles for the Treatment of Prisoners, 9; Standard Minimum Rules for the Treatment of Prisoners, 22, 24, 25, 51; United Nations Rules for the Protection of Juveniles Deprived of their Liberty, 49, 51, 54; Detention Guidelines (Guidelines on the Applicable Criteria and Standards relating to the Detention of Asylum-Seekers and Alternatives to Detention) (UNHCR, 2012), 8 [48 (vi)]; Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, 1; (by analogy) World Health Organisation Guidelines on HIV Infection and AIDS in prisons [1], [53] and [54]; UN Committee on Economic Social and Cultural Rights, General Comment 14; European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment(2011) pp 38-47.*
National law: Common law duty of care and relevant legislative and other standards concerning health care, including accreditation.

53 See, eg, Médecins Sans Frontières, *Indefinite Despair: Mental Health Consequences on Nauru* (Report, 3 December 2018); Sundram, Suresh and Peter Ventevogel, 'The Mental Health of Refugees and Asylum Seekers on Manus Island' (2017) 390(10112) The Lancet 2534; Asylum Seeker Resource Centre, Submission No 56 to Senate Legal and Constitutional Affairs Legislation Committee, Migration Amendment *(Repairing Medical Transfers)* Bill 2019 (14 August 2019); Kaldor Centre for International Refugee Law, Submission No 53 to Senate Legal and Constitutional Affairs Legislation Committee, *Migration Amendment (Repairing Medical Transfers) Bill 2019* (16 August 2019); Martha von Werthern et al, 'The Impact of Immigration Detention on Mental Health: A Systematic Review' (2018) 18(1) *BMC Phyciatry* 382; Guy J Voffey et al, 'The Meaning and Mental Health Consequences of Long-Term Immigration Detention for People Seeking Asylum' (2010) 70(12) *Social Science & Medicine* 2070; Janette P Green and Kathy Eagar, 'The Health of People in Australian Immigration Detention Centres' (2010) 192(2) *Medical Journal of Australia* 65.

54 Australian Human Rights Commission, *Human Rights Standards for Immigration Detention* (Report, April 2013) 30.

55 Australian Human Rights Commission, *Implementing OPCAT in Australia*, (Report, 2020) 11.

56 Commonwealth Ombudsman, *Monitoring Immigration Detention* (Report, 2021) 4.

57 Commonwealth Ombundsman, '*Monitoring places of detention – OPCAT*' (Webpage) https://www.ombudsman.gov.au/what-we-do/monitoring-places-of-detention-opcat

8. COMMON HEALTH ISSUES FOR THE MEDEVAC COHORT

A significant proportion of our Medevac cohort clients reported multiple chronic or serious health conditions, often in addition to mental health or dental conditions. These included heart (1), knee (3), haemorrhoid (1), gastric/gastrointestinal (3) and urological (1) conditions, in addition to a hernia.

Many in this cohort waited for significant periods of time, often over 7 years, on Nauru and PNG for proper assessment and treatment of their health conditions prior to their transfer to Australia under the Medevac scheme. At the time of this report, some of our clients were still waiting to see the relevant specialist or receive treatment (often surgery or other significant treatment) despite being transferred to Australia for that specific purpose.

The failure to prioritise treatment and access to care for people in the Medevac cohort is further exacerbated by the fact that there are no clear IHMS guidelines or policies for them to access private healthcare, even when this has been offered to be funded either pro bono from medical providers or through assistance from advocate organisations.

Our research and our clients' experiences in the Medevac cohort reveal serious problems with the quality of health care in Australian immigration detention. These problems include:

- Significant delay in accessing the medical treatment for which they were transferred;
- Not getting the health care needed – including instances of specialist health care refused or denied;
- Inaccurate internal reporting on medical issues and apparent failures to follow through on recommendations in a timely manner;
- Failures to communicate medical issues and plan for treatment; and
- Inadequate continuity of care.

The excessive use of handcuffs also presents a barrier for people accessing healthcare, as set out above. This pervasive issue has impacted on the Medevac cohort. As detention rights advocate Janet Pelly explains:

> Almost everyone in this group has been medically evacuated with significant mental health issues, most often caused by torture and trauma. The use of restraints compounds this damage and derails treatment and recovery.

It is also clear that detention itself is leading to additional, and significant adverse health outcomes for people in the Medevac cohort. As noted above, the AHRC highlighted the deleterious impact of hotel detention, emphasising that:

> While APODs are generally to be used only for short periods, many people are currently detained in these facilities for long periods, with significant negative consequences for their health and wellbeing.[58]

There are also significant adverse effects of ongoing closed detention on existing health conditions, in particular mental health conditions.

58 Australian Human Rights Commission (n 11) 4.

8.I. MENTAL HEALTH

Mental health is a significant issue for all of our clients in the Medevac cohort. Many of our clients have significant backgrounds of trauma and torture, which was compounded by the ongoing effects of offshore and onshore immigration detention, and uncertainty concerning when, or if, they will be released into community detention or allowed to resettle.

These backgrounds of trauma and torture and uncertainty around length of detention have also been exacerbated by the stress and isolation of the COVID-19 pandemic, and the ensuing added delay in accessing appropriate mental health treatment, even for those in community detention. For example, between 2020-21 there were 195 instances of self-harm in onshore immigration detention centres.[59]

It is well recognised that asylum seekers and refugees are amongst the most vulnerable and marginalised people in the Australian community.[60] This cohort is especially vulnerable in the context of the migrant community, being twice as likely to experience common mental health disorders when compared to economic migrants, with complex and comorbid mental health disorders (such as PTSD) being disproportionately likely to be experienced within this group. These alarming rates of poor mental health are explained partially by experiences of torture and trauma, combined with displacement, and the experience of making a life-risking journey, followed by non-acceptance and exclusion.

It is also well-known that prolonged or indefinite detention worsens mental health conditions. It can also cause mental health conditions in people who previously did not have such conditions. This is again made worse by the fact that the types of mental health conditions experienced by asylum seekers are complex to treat and often unresponsive to primary interventions, meaning they require treatment not available in Australian immigration detention.

Rates of mental health disorders are highly correlated with length of detention – and treatment unlikely to be effective until key stressors are removed from the patient's life. While release from detention would ultimately remove the key stressor, given that detention is likely to continue for many of this cohort, all efforts should be made to ensure the best chance possible of successful recovery and treatment, particularly when this cohort was transferred to Australia for the explicit purpose of this treatment.

59 Department of Home Affairs, 2020-2021 *Annual Report* (Report, 30 June 2021) 120.

60 Royal Australian and New Zealand College of Psychiatrists (RANZCP), *The Provision of Mental Health Services for Asylum Seekers and Refugees* (Policy Statement No 46, September 2017) available ranzcp.org/news-policy/policy-and-advocacy/position-statements/mental-health-services-for-asylum-seekers-refugees.

CASE STUDY: SADIQ*

Two Australian doctors then assessed Sadiq's health issues, finding that he had been prescribed multiple medications with harmful and potentially life-threatening drug interactions.

Sadiq came to Australia by boat in 2013 and was detained on Manus Island and Nauru for 6 years. During this period, he developed a serious knee injury that prevented him from walking and weight bearing.

After three years of pain, Sadiq underwent surgery in Port Moresby, which revealed that years of lacking treatment had led to the cartilage in his knee almost completely wearing away. Post-operation, Sadiq suffered from a series of serious seizures over a period of eight months. The cause of these seizures was never identified in Port Moresby. Further, the operation on his knee failed to relieve him of any pain.

Two Australian doctors then assessed Sadiq's health issues, finding that he had been prescribed multiple medications with harmful and potentially life-threatening drug interactions. Both doctors concluded that Sadiq could not be safely treated in PNG.

Sadiq then was transported to Australia for medical treatment in June 2019. He shortly undertook an EEG, which was found to be within normal limits. No further investigation was conducted as to his seizures. Sadiq's knee pain also continued to worsen, and he was placed on the waiting list to see an orthopaedic specialist.

Whilst Sadiq waited over nine months for a specialist appointment, he developed serious mental health issues, including depression, PTSD symptoms and a severe anxiety surrounding being restrained. His anxiety was also accompanied by chest pain and heart palpitations. The doctors noted that his mental health symptoms were 'a result of his prolonged detention'.

By March 2020, Sadiq refused to be restrained in order to be taken out of detention to his specialist appointment. Sadiq objected to being touched and handcuffed by Serco security guards in public, stating that he 'is not a prisoner'.

Sadiq was finally able to see an orthopaedic specialist who found that his knee was inoperable due to the severe damage and prolonged lack of treatment. Sadiq's mental health spiralled again. By September 2020, he was suffering from advanced PTSD and Anxiety. He developed nightmares, insomnia and started having paranoid delusions.

Sadiq's story illustrates how detention can exacerbate both physical and mental health conditions. The failure to treat Sadiq's knee condition whilst offshore led to his permanent disability. This in turn led to a downturn in his mental health.

Sadiq was finally released into community detention in August 2021. Since being released, his mental health has improved significantly.

** Name changed to protect our client's privacy.*

8.2. DENTAL HEALTH

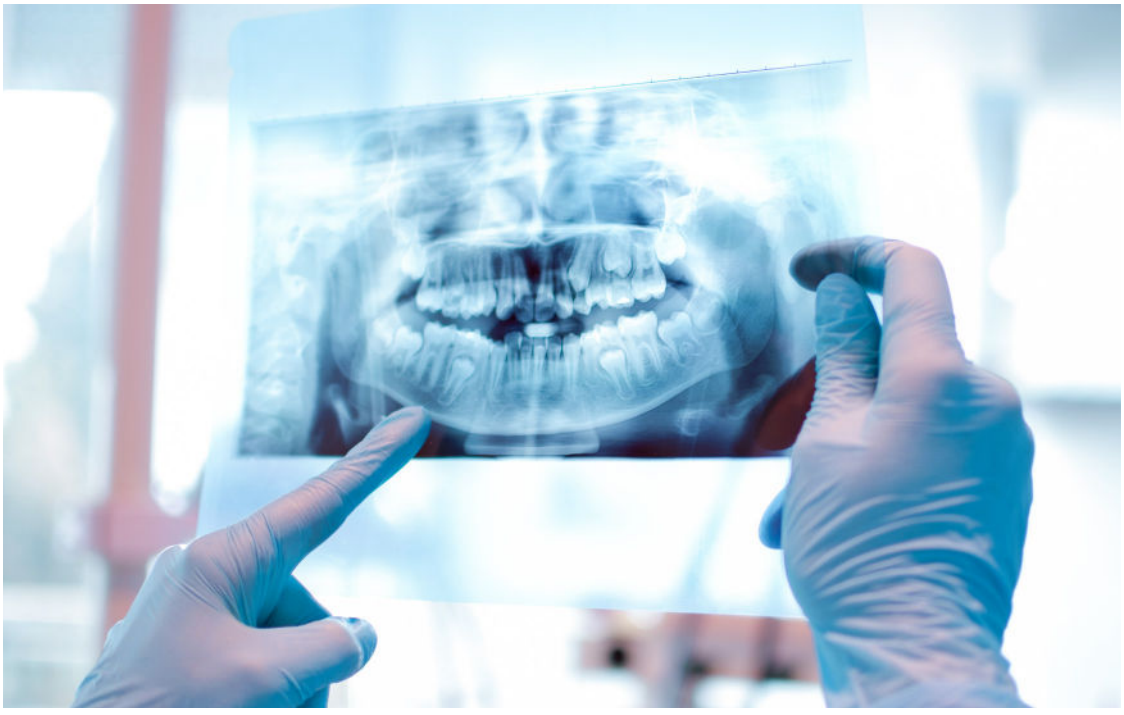
Dental health is another leading heath issue for many clients in the Medevac cohort. This is explained partly by low levels of access to nutrition, exposure to fluoride and dental care (including preventative dental care) in their countries of origin, and compounded by high rates of smoking, leading to high incidence of severe dental cavities, dental abscesses and gum disease.[61]

As with many chronic health issues experienced by people in this cohort, lack of access to treatment in offshore detention in PNG and Nauru has made dental issues which were once relatively easily and cheaply treatable into complex, difficult to treat, and expensive medical issues requiring specialist treatment. The treatment required frequently exceeds upper payment limits imposed by IHMS for dental healthcare. This has led to a focus on treatment of pain and dental extraction over longer-term and more sustainable treatments, and in turn a worsening ability to function (including being able to speak, eat or drink) for many within this cohort, impacting again on the worsening or creation of mental health conditions.

This short-term approach is partly explained by the fact that IHMS limit the availability of treatment options to those who have spent longer than two years in detention, and require Departmental approval for treatment options which exceed $2,000, with no clear policy or guidelines on the threshold required for submitting a detainee's dental treatment plan for Departmental approval. Furthermore, under IHMS policy, waiting times for assessment or treatment offshore on PNG or Nauru is not considered in accessing health care through the public health system.

Again, given that detention continues for some in this cohort, all efforts should be made to ensure the best chance possible of successful recovery through immediate treatment. This is particularly so when many in this cohort were transferred to Australia for the explicit purpose of dental treatment.

61 See Eileen Crespo, 'The Importance of Oral Health in Immigrant and Refugee Children' (2019) 6(9) *Children (Basel)* 102 available https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6770947/; Human Rights and Equal Opportunity Commission, *A Last Resort?, National Inquiry into Children in Immigration Detention* (Report, April 2004) ch 10 available https://humanrights.gov.au/our-work/10-physical-health-children-immigration-detention.



CASE STUDY: RASHID*

Over one year on, and over 21 months since his transfer to Australia for dental treatment, Rashid is yet to access this [treatment by a periodontist] and remains in pain with a deteriorating dental condition.

Rashid is 33 years old and was born and raised in Pakistan. He has been in the Australian immigration detention system for almost 8 years. Rashid fled Pakistan and he was detained on Christmas Island in July 2013 before his transfer to detention on Manus Island. Rashid was determined to be a refugee under Papua New Guinea's refugee status determination process in April 2016.

Rashid has a longstanding history of severe gum disease and dental pain in Papua New Guinea, including diagnosis with gingival recession (disorder) as early as 2015, and was transferred from Papua New Guinea for medical assessment and treatment for his dental condition on 13 November 2019. He has since been detained at Brisbane Immigration Transit Accommodation (**BITA**) and Kangaroo Point Central Hotel & Apartments.

Since his transfer to Australia, Rashid has attended dental examinations but he has not received treatment for his dental conditions. On 18 March 2020, a dentist examined Rashid's dental issues and noted gingival recession and periodontal disease. The dentist recommended that Rashid would benefit from treatment by a periodontist. The dentist also recommended an orthodontic referral.

Over one year on, and over 21 months since his transfer to Australia for dental treatment, Rashid is yet to access this and remains in pain with a deteriorating dental condition. After being told that the dental treatment he requires may not be provided in the public system and therefore may not be provided by IHMS, he has offered to self-fund private treatment (which could be possible with the funding support of advocates in the community), however IHMS has refused to allow him to self-fund private treatment.

If Rashid were in the community, he could take active steps to access the health services and treatment he requires for his dental condition.

** Name changed to protect our client's privacy.*

9. CONCLUSION

This report documents the failure to provide healthcare to Medevac refugees and asylum seekers who have been transferred to Australia. It exposes the Commonwealth government's poor treatment and inadequate provision of health care for people in Australian immigration detention.

The Commonwealth government should immediately transfer any remaining members of the Medevac cohort out of closed immigration detention centres into the community.

In addition, the Commonwealth government should ensure immediate and expedited access to medical treatment and/or assessment for all medical transferees from Nauru and PNG through the public health system. Where public waiting times do not allow for immediate treatment, the Commonwealth government should fund immediate access through the private system.

The case studies featured in this report confirm that people in held detention are not receiving the same standard of health care that is provided to Australian community members. As these experiences show, the failure to provide this care has serious consequences.

It is clear that the Commonwealth government is not fulfilling its duty of care to people in immigration detention, many of whom have already experienced high levels of trauma prior to arriving in Australia. This trauma is compounded by long-term, indefinite detention and sub-standard conditions of confinement.

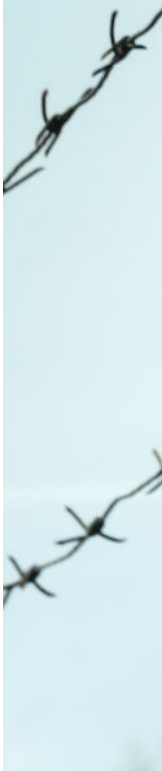
The absence of legislation to guarantee these vulnerable people a right to health care equivalent to that available to the Australian community, is a gap that must be filled, as a matter of priority.

This legislative change must be complemented by action to ensure that people in immigration detention actually receive the healthcare to which they are entitled. This includes:

- this standard of care in the contractual renewals with IHMS or other health providers appointed to deliver services to immigration detainees;
- auditing existing policies;
- mitigating the risks of COVID-19 by ensuring that all detainees and staff are vaccinated; and
- only using physical restraints such as handcuffs as a last resort.

This system also needs to be subject to appropriate oversight, and the Commonwealth government must fulfil its obligations under OPCAT.

These steps are critical for the Commonwealth government to properly fulfil its duty of care. As we observed in the *In Poor Health* report, these changes should not be controversial, but they are urgent and long overdue.



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