UNTOLD DAMAGE

Workplace health and safety in immigration detention under the *Work, Health and Safety Act 2011* (Cth)
About us

The Australian Lawyers Alliance is a national association of lawyers, academics and other professionals, dedicated to protecting and promoting justice, freedom and the rights of the individual. We receive no government funding and are funded entirely by our members.

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Acknowledgements

Authors: Emily Mitchell and Anna Talbot.
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With thanks to Francesca Arciuli and Zoe Le Quesne for their assistance in research.
Emily Mitchell, Anna Talbot, Renée Harris, Francesca Arciuli and Zoe Le Quesne were employed by the Australian Lawyers Alliance when making their contributions to this Report.
Design: Tianli Zu.
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Disclaimer

The Australian Lawyers Alliance has made every effort to verify that the information within this Report is accurate. We have reviewed extensive documentation and consulted widely. The Report focuses primarily on the Work Health and Safety Act 2011 (Cth) and incidental legislation. Other legislation may be relevant to the facts described in this Report; the absence of reference to it is not to be interpreted as a comment on its relevance. The Report is believed to be correct at the time of publication. This is an area, however, where the law and facts move quickly. As such, it is possible that some of the information has become out of date or is no longer accurate. The Australian Lawyers Alliance accepts no liability whatsoever if that is the case.
‘The Department of Immigration and Border Protection’s position is that the Work, Health and Safety Act 2011 applies in full in the context of Manus Island Regional Processing Centre and that the Manus Island RPC satisfies the definition of ‘workplace’ for the purposes of the WHS Act.’
- Comcare Inspector Report into the death of Reza Barati, 2014

‘We would like to be absolutely clear: the government of Australia and the Department of Immigration and Border Protection have tolerated the physical and sexual assault of children, and the sexual harassment and assault of vulnerable women in the centre for more than 17 months.’
- Open Letter to the Australian People, 7 April 2015

‘The committee is very deeply concerned about a situation in which this level of reported misconduct can occur and, at least until brought to light by the Moss Review, apparently be accepted.’
Select Committee into the conditions and circumstances at the Nauru Regional Processing Centre

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<th>Description</th>
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<tbody>
<tr>
<td>AFP</td>
<td>Australian Federal Police</td>
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<tr>
<td>ANAO</td>
<td>Australian National Audit Office</td>
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<tr>
<td>CAT</td>
<td>Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</td>
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<tr>
<td>DIAC</td>
<td>Department of Immigration and Citizenship</td>
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<tr>
<td>DIBP</td>
<td>Department of Immigration and Border Protection</td>
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<tr>
<td>DIMA</td>
<td>Department of Immigration and Multicultural Affairs</td>
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<tr>
<td>FOI Act</td>
<td>Freedom of Information Act 1982 (Cth)</td>
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<tr>
<td>G4S</td>
<td>(formerly) Group 4 Securicor</td>
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<tr>
<td>IDF</td>
<td>Immigration detention facility</td>
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<td>IHMS</td>
<td>International Health and Medical Services</td>
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<tr>
<td>IMA</td>
<td>Illegal maritime arrival</td>
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<tr>
<td>ITA</td>
<td>Immigration transit accommodation</td>
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<tr>
<td>Manus Inquiry</td>
<td>Senate Legal and Constitutional Affairs References Committee, Inquiry into the incident at Manus Island from 16 to 18 February 2014</td>
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<td>MIRPC</td>
<td>Manus Island Regional Processing Centre</td>
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<td>Moss Review</td>
<td>Philip Moss, ‘Review into recent allegations relating to conditions and circumstances at the Regional Processing Centre in Nauru, Final Report’.</td>
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<tr>
<td>MOU</td>
<td>Memorandum of Understanding</td>
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<tr>
<td>Nauru Inquiry</td>
<td>Select Committee on the recent allegations relating to Conditions and Circumstances at the Nauru Regional Processing Centre, Inquiry into Recent Allegations relating to Conditions and Circumstances at the Regional Processing Centre in Nauru</td>
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<tr>
<td>NPF</td>
<td>Nauru Police Force</td>
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<td>OHS Act</td>
<td>Occupational Health and Safety Act 1991 (Cth)</td>
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<td>OPC</td>
<td>Offshore Processing Centre</td>
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<tr>
<td>OPCAT</td>
<td>Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment</td>
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<tr>
<td>PCBU</td>
<td>Person conducting a business or undertaking</td>
</tr>
<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
</tr>
<tr>
<td>RPC</td>
<td>Regional Processing Centre</td>
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<td>SCA</td>
<td>Save the Children</td>
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<td>SRC Act</td>
<td>Safety, Rehabilitation and Compensation Act 1988 (Cth)</td>
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<td>The Cornell Review</td>
<td>Robert Cornall AO, Review into the events of 16 - 18 February 2014 at the Manus Regional Processing Centre, May 2014</td>
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<tr>
<td>WHS Act</td>
<td>Work, Health and Safety Act 2011 (Cth)</td>
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Terminology

Language is important. Asylum seekers have been referred to as ‘illegals’, ‘migrants’ ‘unauthorised maritime arrivals’, and even an acronym: ‘IMA’. Each of these terms is designed to elicit a response from the reader, helping to dehumanise these humans.

In this Report, the term ‘detainee’ is used to refer to people who are detained in one of Australia’s immigration detention facilities. Where reference is made to that individual in the community, we use the phrase asylum seeker or refugee.

In terms of individuals employed to work in the detention facilities, the broad term of ‘worker’ is used to refer to all employees of the Commonwealth and all contractors. This reflects the term used in the Work Health and Safety Act 2011 (Cth) and operates as a reminder that these individuals are under obligations prescribed by law. Comcare inspectors are referred to as such, indicating the separate obligations and powers that these people have. Where the contractor or subcontractor company is referred to, the generic term ‘contractor’ is used, unless a specific contractor is being referred to.

The Department of Immigration and Border Protection (DIBP) has undergone numerous name changes over recent years. Where relevant the name that was being used at the time in question is used. The obligations and liabilities of the Department survive changes in name, however, and thus recommendations made refer to the current name. Similarly, obligations of the Minister survive, regardless of the name being used at the time.

The term ‘health’ throughout the report should be interpreted as referring to physical and psychological health, unless specified otherwise. In terms of psychological health, this term is used interchangeably with ‘mental health’. Terminology regarding sexual misconduct is complex. More detail regarding the concepts wrapped up in this phrase can be found in Chapter 6: sexual misconduct.

Executive summary

The federal regulator of Commonwealth workplaces, Comcare, has been the watchdog of immigration detention facilities in Australia and regional processing centres (‘RPCs’) in Nauru and Manus Island for many years.

The Work, Health and Safety Act 2011 (Cth) (‘WHS Act’) places a statutory duty of care upon the Department of Immigration and Border Protection (‘DIBP’) as the legal person conducting the business or undertaking (PCBU), to ensure the health and safety of workers and ‘other persons’ such as detainees. A duty of care also exists at common law.

This duty extends to identifying, eliminating or minimising risks to health and safety, and reporting ‘notifiable incidents’ (as defined in the WHS Act) to Comcare. Comcare in turn is obliged to investigate incidents and make recommendations to increase health and safety. It also has enforcement powers.

The Australian Lawyers Alliance (‘ALA’) applied under the Freedom of Information Act 1982 (Cth) to unearth details of what the DIBP has been reporting to Comcare from FY2013 - 2015.
This Report details both what was, and was not, reported to Comcare, and how these reports were investigated.

What we found

• Inconsistencies exist in the reporting of incidents by the DIBP and the investigation of incidents by Comcare.

• The phrase ‘arising out of the conduct of the business or undertaking’, the key phrase that underpins Comcare’s investigations, is unclear. This means that some injuries and incidents are not adequately investigated and opportunities to improve workplace health and safety are missed.

• Evidence suggests that prosecutions of the DIBP and/or relevant contractors may be appropriate for some breaches of legislation that have occurred in immigration detention.

• The DIBP and Comcare appear to seriously misunderstand the nature of some injuries and illnesses, meaning threats to workplace health and safety are not responded to. This is particularly the case in relation to sexual misconduct and mental health.

• Inadequate data collection means that health and safety for vulnerable groups does not receive adequate attention.

• A lack of basic necessities poses a risk to health and safety but there is no mechanism for Comcare to investigate this.

• There are obstacles to reporting threats to workplace health and safety, in relation to workers employed by contractors and responses to complaints by the DIBP. These obstacles have been exacerbated by the Border Force Act 2015 (Cth).

• Evidence provided by whistle-blowers and the DIBP itself to the parliamentary inquiries into Nauru and Manus Island indicates gross inconsistencies in the number of incidents reported, suggesting under-reporting of incidents to Comcare.

A duty of care exists

• The DIBP has asserted that it provides only a supporting role to the governments of Nauru and Papua New Guinea in relation to RPCs. This does not absolve the DIBP from its responsibilities under the WHS Act or other legislation and case law that provides for extraterritorial application. It is clear that the DIBP has accepted that it has a duty to ensure health and safety in RPCs under the WHS Act.

• The WHS Act has clear provisions regarding the duties binding the DIBP, including relevant penalties for failure to comply.
At a glance

From 1 July 2013 to 30 June 2015, the DIBP reported a total of 1,092 incidents to Comcare across all of its activities, which includes office workers, workers overseas, immigration detention facilities and RPCs.

This included approximately 198 incidents affecting workers, 800 incidents affecting asylum seekers, 4 incidents affecting members of the public, and 90 unspecified incidents.

Of the 1,092 reported incidents, 845 were characterised as not-notifiable and 247 were characterised as notifiable. Included in these figures were 87 dangerous incidents and 20 deaths. See Appendix 1 for a comprehensive table of incidents reported to Comcare by incident type.

Decisions made by the DIBP regarding what to report to Comcare do not appear to have been made consistently, due in part to confusion regarding reporting requirements under the WHS Act. Specifically, the interpretation of what constitutes a notifiable incident and what is considered to have arisen out of the conduct of the business or undertaking do not appear to be consistent across the incident reports that have been provided to the ALA. This indicates a need for further training of DIBP and Comcare workers in their duties under the WHS Act, as well as amendment of the Act to make provisions more relevant to Australian workplaces.

Comcare, in turn, appears to have made inconsistent assessments as to the types of cases it should be investigating as notifiable incidents. Comcare has advised that:

‘the duty lies in the first instance to determine whether an incident arises out of the conduct of the PCBU’s business or undertaking. This is a question of fact to be determined in each case.

Comcare’s current practice when receiving a notification from a PCBU is to evaluate whether the PCBU was required to notify Comcare of the incident under s38… The evaluation does not determine whether or how Comcare will respond to the incident.’

Comcare has largely failed to impose any penalties on the DIBP for lack of compliance with the WHS Act as far as the ALA is aware.

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4 Email from Comcare to the Australian Lawyers Alliance, received 11 April 2016.
Report overview

The structure of this Report is divided into two main components: Part One – The law and context, and Part Two – The investigation.

Part One – The law and context

Part One – The law and context, identifies the background regarding the Department of Immigration and Border Protection’s (the ‘DIBP’) control of immigration detention facilities and regional processing centres and identifies existing obligations under the Work, Health and Safety Act 2011 (Cth) (the ‘WHS Act’). Part One also provides an overview of Comcare’s monitoring of immigration detention facilities and regional processing centres, and examines Comcare Inspector Reports of the Manus and Nauru RPCs.

Chapter 1 explores the Work, Health and Safety Act 2011 (Cth) and the relevant provisions regarding a duty to ensure health and safety, duty to notify of notifiable incidents, and highlights the potential liability of the Commonwealth for breaches of this duty.

Chapter 2 investigates the common law obligations of the DIBP, considers the position of the DIBP regarding control in RPCs, and identifies that this position is inconsistent.

Chapter 3 considers the monitoring role undertaken by Comcare, including an overview of the DIBP’s liaison with Comcare over a period of years, and examines Comcare Inspector Reports of the Manus and Nauru RPCs that were released under the Freedom of Information Act 1982 (Cth).

Chapter 4 explores the chain of knowledge and incident reporting, including the DIBP’s arrangements with contractors regarding reporting to Comcare and allegations of concealment and conflict of interest.

Part Two – The investigation

Part Two – The investigation, explores what was reported to Comcare by the DIBP, and the picture this reveals regarding both conditions in detention and the inadequacies of the DIBP’s reporting policies. Part Two also identifies key incidents that were not reported by the DIBP, drawing upon media stories, submissions to parliamentary inquiries and Senate Estimates, and the Moss Review.

Chapter 5 investigates deaths that have occurred across the DIBP’s activities in FY2013 – FY2015, including inadequacy in the reporting of the death of Hamid Khazaei. Chapter 5 also examines the 20 fatalities that were reported, the deaths of infants, and the assessment of deaths as not-notifiable incidents.

Chapter 6 investigates sexual misconduct that has occurred in immigration detention facilities and RPCs. This includes identifying sexual assaults that were not reported to Comcare. The gap in reporting obligations, meaning the failure to routinely report serious sexual assaults and sexual abuse and serious sexual harassment is not routinely reported as a workplace health and safety issue, is examined.

Chapter 7 examines issues pertaining to vulnerable groups, including individuals who have engaged in self-harm, the possible physical manifestation of mental health problems, pregnant women and children.
Chapter 8 considers allegations that have been raised regarding under-reporting and concealment, and outlines relevant civil and criminal penalties which could be invoked. Concerns regarding the treatment of individuals who have revealed workplace health and safety concerns and the *Border Force Act 2015* (Cth) are explored.

Chapter 9 provides conclusions and summarises specific recommendations made throughout the Report.

**Recommendations**

**Independent body to investigate**

It would be appropriate for an independent body with enforceable powers to subpoena and examine witnesses and documents, to investigate the failures of the DIBP, contractors and Comcare to adequately discharge their obligations under the WHS Act in the immigration detention network, including RPCs on Nauru and Manus Island.

This investigation should be via an independent judicial inquiry or a Royal Commission. Issues to be investigated could include:

- the nature of the duty of care of the DIBP and its contractors to workers and detainees at all immigration detention facilities, including RPCs;
- the nature of the obligations of Comcare to monitor and investigate threats to work health and safety at all immigration detention facilities, including RPCs;
- the phrase ‘resulting from the conduct of the business or undertaking’ in the WHS Act, which underpins much of Comcare’s jurisdiction;
- any failure to identify, mitigate and eliminate risks to health and safety posed by sexual misconduct;
- any failure to identify, mitigate and eliminate risks to health and safety to vulnerable groups;
- any failure to identify, mitigate and eliminate risks to psychological health and safety, including self-harm incidents;
- any failure to identify, mitigate and eliminate risks to health and safety posed by contractors;
- any under-reporting and concealment of risks by contractors and DIBP officers;
- the adequacy of current provisions of the WHS Act to appropriately ensure workplace health and safety in immigration detention, given the unique risks that exist in those workplaces;
- steps that could be taken to identify, mitigate and eliminate risks to health and safety; and
- the appropriateness of prosecuting the DIBP, contractors or other parties.

It would be appropriate for an independent body with enforceable powers to subpoena and examine witnesses and documents, to investigate the failures of the DIBP, contractors and Comcare to adequately discharge their obligations under the WHS Act in the immigration detention network, including RPCs on Nauru and Manus Island.
Royal Commission into Institutional Responses to Child Sexual Abuse to inquire

The ALA believes that it would be appropriate for the Royal Commission into Institutional Responses to Child Sexual Abuse to investigate allegations of child sexual assault in all places of immigration detention, considering that responses of government institutions to allegations of child sexual abuse is likely to have taken place in Canberra.

Most of the data available to the ALA does not identify whether the individuals involved in any incidents were minors, although reports from other sources indicate that minors have suffered sexual misconduct.

The Commonwealth should review the WHS Act

Amendments to the WHS Act should be considered by the federal Parliament, via a committee process. In particular, ss 19, 35, 36, 37 and 38 should be amended to ensure that the following matters are appropriately recognised as relevant to health and safety:

- all deaths, regardless of the circumstances in which the death occurred;
- serious sexual assault, sexual abuse and serious sexual harassment;
- all assaults of children;
- bullying giving rise to a fear for safety;
- psychological injury;
- self-harm incidents;
- series of serious injuries or illnesses that could be related;
- any failure to identify, mitigate and eliminate risks to health and safety posed by contractors, including failure to report incidents to the DIBP or Comcare; and
- the individual’s age, sex and any other characteristics giving rise to vulnerability, with reporting requiring that these factors be identified.

These types of incidents should be required to be published in the relevant Commonwealth agency’s Annual Report.

The Commonwealth should ratify OPCAT and engage with UN human rights mechanisms

The Australian government should ratify the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). This would provide for more effective monitoring of detention environments in line with human rights standards.

As a party to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), Australia has already committed to refrain from acquiescing to the infliction of severe pain and suffering which amounts to torture or cruel, inhuman or degrading treatment or punishment. This obligation extends wherever Australian government officials operate. It is not
permisssible for acquiesce to torture or other cruel, inhuman or degrading treatment or punishment in foreign countries.

The government should also engage openly with all United Nations (UN) human rights mechanisms to ensure that health and safety standards in immigration detention are maintained, including implementing all recommendations from the CAT and facilitating visits by all UN Experts and implementing their recommendations regarding immigration detention in full.

**Comcare should review its interpretation of the WHS Act**

Comcare should review its interpretation of the WHS Act. A broad interpretation of the types of injuries, illnesses and incidents that it should investigate should be adopted. A broad interpretation of ‘the conduct of the business or undertaking’ should also be used. This is required to meet the objects of the WHS Act to enhance the health and safety of workplaces.

Comcare should also ensure that penalty provisions are enforced for failure to comply with duties under the WHS Act in relation to other persons, including prosecuting offences where relevant.

**Comcare should consider prosecution of the DIBP and/or relevant contractors**

Comcare should consider the appropriateness of prosecuting the DIBP and/or relevant contractors for relevant possible breaches of the WHS Act outlined in this Report. Offences that may have been committed include those directly relating to workplace health and safety, as well as concealing health and safety incidents.

Comcare should also consider what other further enforcement action should be undertaken in relation to any failure of the DIBP and/or relevant contractors to implement previous recommendations. This could include referring breaches of other legislation by the DIBP or other parties to the Australian Federal Police.

**The Commonwealths should remove of secrecy provisions of the Border Force Act**

The provisions of the Border Force Act 2015 (Cth) that prevent disclosure of health and safety concerns by any person who works in an immigration detention facility should be repealed in full. These provisions undermine the ability of the DIBP and Comcare to ensure that immigration detention is a safe place for workers and detainees.

**The Australian public should consider the implications of any failure to implement these recommendations**

In the event that the federal government does not implement the above recommendations, it would be appropriate for the Australian public to consider the implications regarding the government’s commitment to health and safety, and transparency in Commonwealth workplaces.
Part One – The law and context

The DIBP has a statutory duty of care to ensure the health and safety of workers and other persons in immigration detention facilities in Australia and regional processing centres (‘RPCs’) under the Work, Health and Safety Act 2011 (Cth) (‘WHS Act’).

Chapter 1 – The WHS Act

Overview

The Work, Health and Safety Act 2011 (Cth) (‘WHS Act’) governs workplace issues in every Commonwealth workplace, and makes provision regarding the health and safety of workers and ‘other persons’ in these workplaces.

The Commonwealth has a duty of care to both workers and asylum seekers under this statute. The WHS Act applies to all Australian immigration detention centres, including offshore facilities on Manus Island and Nauru.

Under the WHS Act, the person in control of the workplace is the ‘person conducting a business or undertaking’ (‘PCBU’), and certain duties attach to this role. These duties include the duty to ensure health and safety, and the duty to notify the regulator, Comcare, regarding notifiable incidents that occur in the Commonwealth workplace. Failure to adequately fulfil these duties can lead to fines or even criminal liability, including imprisonment.

1.1 WHS Act applies in Australian immigration detention centres

The WHS Act applies to the Commonwealth where it conducts a business or undertaking. The DIBP has confirmed that it is the person conducting the business or undertaking (PCBU) in relation to immigration detention facilities: it lists itself as the PCBU on incident reports to Comcare. The Commonwealth Ombudsman has also made this observation.5

As a PCBU, the DIBP has various obligations under the WHS Act to ensure the workplaces that it operates are safe for workers and others using those workplaces. It is not possible to contract out of the duties owed under the WHS Act under s272.

1.2 WHS Act applies in RPCs

All offences under the WHS Act are subject to extended geographical jurisdiction in line with s15.1 of the Criminal Code, according to s12F(3) of the WHS Act:

‘Section 15.1 of the Criminal Code (extended geographical jurisdiction—category A) applies to an offence against this Act.’

The relevant provision of the Criminal Code states (emphasis added):

‘15.1 Extended geographical jurisdiction – category A
(1) If a law of the Commonwealth provides that this section applies to a particular offence, a person does not commit the offence unless:

(a) the conduct constituting the alleged offence occurs:
   (i) wholly or partly in Australia; or
   (ii) wholly or partly on board an Australian aircraft or an Australian ship; or

(b) the conduct constituting the alleged offence occurs wholly outside Australia and a result of the conduct occurs:
   (i) wholly or partly in Australia; or
   (ii) wholly or partly on board an Australian aircraft or an Australian ship; or

(c) the conduct constituting the alleged offence occurs wholly outside Australia and:
   (i) at the time of the alleged offence, the person is an Australian citizen; or
   (ii) at the time of the alleged offence, the person is a body corporate incorporated by or under a law of the Commonwealth or of a State or Territory; or

(d) all of the following conditions are satisfied:
   (i) the alleged offence is an ancillary offence;
   (ii) the conduct constituting the alleged offence occurs wholly outside Australia;
   (iii) the conduct constituting the primary offence to which the ancillary offence relates, or a result of that conduct, occurs, or is intended by the person to occur, wholly or partly in Australia or wholly or partly on board an Australian aircraft or an Australian ship.’

This means that, even where the conduct constituting the alleged offence occurs wholly outside Australia, prosecution under the WHS Act is possible: see s15.1(1)(c) of the Criminal Code. Generally decisions made by DIBP officers affecting health and safety were made in Canberra, meaning territorial jurisdiction is not in issue. See 1.7 and 1.8 below for further detail regarding the liability of the Commonwealth under the WHS Act.

This interpretation has been acknowledged by the DIBP itself, as provided to the Select Committee examining the conditions and circumstances at Nauru RPC (the ‘Nauru Inquiry’):

‘Comcare, the WHS Act regulator, has published guidance material in relation to obligations that carry criminal offence penalties for proved or admitted noncompliance as follows:

‘The WHS Act and the WHS Regulations have extraterritorial application overseas under s12F(3) of the WHS Act, which is supported by s15.1 of the Criminal Code Act 1995 (“Criminal Code”). Therefore, offences against the WHS Act and/or the WHS Regulations committed by Australian citizen workers or a Commonwealth/Commonwealth Authorities/Non-Commonwealth Licensees outside Australia would be covered by the WHS Act and WHS Regulations, provided the relevant factors in s15.1 of the Criminal Code are met”.

Whether s15.1 of the Criminal Code (extended geographical jurisdiction – category A) applies depends upon the individual and unique circumstances of a particular matter and the conduct that constitutes the alleged offence having occurred or as a result of that alleged conduct.’

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Under s245 of the WHS Act, offences of the Commonwealth are to be subjected to penalties that apply to bodies corporate under the Act. As such, the ALA believes that the duty of care provisions detailed below apply to detention facilities wherever in the world they are located: in Australia, Nauru, Papua New Guinea or anywhere else. The ALA intends to provide a copy of this Report in full to Comcare, with a written request that a prosecution be brought.

1.3 Person conducting a business or undertaking

The WHS Act places the primary duty of care and various other duties and obligations on a ‘person conducting a business or undertaking’ (PCBU).

Prior to the WHS Act, which came into force on 1 January 2012, the Occupational Health and Safety Act 1991 (Cth) (‘OHS Act’) governed occupational health and safety in Commonwealth workplaces. Under the OHS Act, the main duty-holders under health and safety laws were ‘employers’: the entities that the law recognised as the ‘person’ in an employment relationship with an employee.\(^7\)

The harmonised work, health and safety laws enacted in 2011 used the term ‘person conducting a business or undertaking’ instead of ‘employer’ to more adequately reflect modern workplace arrangements.\(^8\)

Comcare clarifies the responsibilities of a PCBU as follows:

‘A PCBU retains overall responsibility for workplace health and safety, even if they contract out activities to others under their duty of care obligations. The WHS Act provides that a person can have more than one duty by virtue of being in more than one class of duty holder and that more than one person can concurrently owe the same duty.

If more than one person has a duty of care for same matter, then each person:

• retain responsibility for their duty in relation to the matter
• must discharge their duty to the extent the matter is within the person’s capacity to influence or control
• must consult, cooperate and coordinate activities with all other persons who have a duty in relation to the same matter.’\(^9\)

Comcare notes that:

‘The duty of a person conducting a business or undertaking is probably the most significant conceptual change from the majority of previous OHS Acts. For the public sector, it means that every activity is captured, both policy and operational. The WHS Act coverage extends beyond the traditional employer/employee relationship to include new and evolving work arrangements and extends a PCBUs duty of care to any person who is performing work directly for, or on behalf of, the PCBU.’\(^10\)

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\(^10\) Ibid.
1.4 Health and safety duties, offences and due diligence

A number of ‘health and safety’ duties exist under the WHS Act under ss19 to 29. Section 19 establishes a primary duty of care to ensure the health and safety of workers and other persons. A worker is defined broadly to include contractors, subcontractors and employees of labour hire companies, among others: s7. The phrase ‘other persons’ is not defined and could include asylum seekers or anyone else present in the workplace. Consideration of ‘health and safety’ within the Act is not limited to physical risks: s4 of the Act defines ‘health’ to mean physical and psychological health.

Section 19 goes on to specify how the duty to workers and other persons can be met, including by providing a work environment without risks to health and safety; provision and maintenance of safe systems of work; and provision of information, training, instruction or supervision that is necessary to protect all persons from risks to their health or safety arising from work carried out as a part of the conduct of the PCBU.

Failure to comply with those duties constitutes an offence under s30, giving rise to liability wherever in the world the failure takes place, in line with the Criminal Code as described above. Thus, if a duty towards a worker or a detainee in Nauru or Manus Island is not complied with, the Commonwealth and/or relevant contractors could possibly be prosecuted for a category three offence: s33.

If someone to whom a health and safety duty is owed is exposed to a risk of death or serious injury or illness as a result of such a failure, penalties increase as a category two offence: s32. Principles underpinning these duties can be found in ss 13 to 18, which provide additional guidance as to the nature of the duties that give rise to criminal liability. The existence of recklessness increases penalties further, constituting a category one offence: s31.

The regulator or the Department of Public Prosecutions can bring proceedings for offences under the Act: s230.

Section 17 assists in elucidating the health and safety duties imposed, including to eliminate risks to health and safety, or to minimise those risks if elimination is not reasonably practicable. The regulations make it clear that this obligation extends to reasonably foreseeable hazards: clause 34. Officers have a duty to exercise due diligence to ensure that the PCBU complies with its duties: s27. Due diligence is defined to include: understanding the nature of the operation and the hazards and risks associated with it; ensuring that appropriate resources and processes to eliminate or minimise risks to health and safety are available and used; ensuring that processes for receiving and considering information regarding incidents, hazards and risks and responds in a timely way; and having and implementing processes to comply with the duty or obligation. As such, if relevant information does not come to the attention of the DIBP, this is likely to point to a failure of due diligence. An officer of the PCBU can be found liable for an offence if they fail to exercise this duty, even if the PCBU itself is not liable: s27(4).

In addition to offences, there are also obligations that give rise to civil penalties.
The DIBP has a clear statutory duty to ensure that the health and safety of both workers and asylum seekers is not put at risk from work carried out as part of the conduct of the business of the undertaking.

1.5 Duty to notify of notifiable incident

The WHS Act imposes a duty on PCBUS to notify Comcare of ‘notifiable incidents’ under s38. The duty exists where notifiable incidents arise out of the conduct of the business or undertaking. Given that the DIBP is the PCBU, the DIBP must ensure that it immediately notifies Comcare after becoming aware of such an incident. Failure to do so attracts a penalty per incident; in the case of an individual - $10,000; in the case of a body corporate - $50,000. There is nothing in the legislation to suggest that this duty expires at Australia’s borders. Given that the DIBP is based within Australian territory, it would not be logical to restrict this duty to incidents that occur only in onshore detention facilities. Ultimately, the duties that can give rise to criminal liability requires Comcare be notified of all notifiable incidents that occur across all immigration detention facilities.

Under s35, a notifiable incident means:

(a) the death of a person; or
(b) a serious injury or illness of a person; or
(c) a dangerous incident.

The Explanatory Memorandum to the Work, Health and Safety Bill appears to clarify that the death of any person must be reported. The Explanatory Memorandum does not provide any limitation on its plain meaning, and also cites that:

‘All Australian work health and safety laws currently require all workplace deaths and certain workplace incidents, injuries and illnesses to be reported to a relevant authority’ (emphasis added).

Section 36 defines serious injury or illness of a person:

‘sensitive injury or illness’ of a person means an injury or illness requiring the person to have:
(a) immediate treatment as an inpatient in a hospital; or
(b) immediate treatment for:
(i) the amputation of any part of his or her body; or
(ii) a serious head injury; or
(iii) a serious eye injury; or
(iv) a serious burn; or
(v) the separation of his or her skin from an underlying tissue (such as degloving or scalping); or
(vi) a spinal injury; or
(vii) the loss of a bodily function; or
(viii) serious lacerations; or
(c) medical treatment within 48 hours of exposure to a substance; and includes any other injury or illness prescribed by the regulations but does not include an illness or injury of a prescribed kind’.

11 WHS Act 2011, s38(1)(a), (b).
12 Explanatory Memorandum to the Work, Health and Safety Bill, at 24 [95].
Section 37 defines a dangerous incident:

‘an incident in relation to a workplace that exposes a worker or any other person to a serious risk to a person’s health or safety emanating from an immediate or imminent exposure to:

a) an uncontrolled escape, spillage or leakage of a substance; or
b) an uncontrolled implosion, explosion or fire; or
c) an uncontrolled escape of gas or steam; or
d) an uncontrolled escape of a pressurised substance; or
e) electric shock; or
f) the fall or release from a height of any plant, substance or thing; or
g) the collapse, overturning, failure or malfunction of, or damage to, any plant that is required to be authorised for use in accordance with the regulations; or
h) the collapse or partial collapse of a structure; or
i) the collapse or failure of an excavation or of any shoring supporting an excavation; or
j) the inrush of water, mud or gas in workings, in an underground excavation or tunnel; or
k) the interruption of the main system of ventilation in an underground excavation or tunnel; or
l) any other event prescribed by the regulations;
m) but does not include an incident of a prescribed kind’ (emphasis added).

It is important to note that these definitions are not limited to workers. Each incident that occurs in relation to a ‘person’ (not only a worker) are required to be notified to the regulator.

1.5.1 The business of the DIBP

As discussed above, the obligations to report notifiable incidents to Comcare arise when those incidents arise out of the conduct of the business or undertaking: s38. As such, identifying the nature of the DIBP’s business or undertaking in immigration detention facilities will allow us to more clearly ascertain if an incident arose out of the relevant conduct. As will be seen in Part 2 below, inconsistencies in Comcare’s assessments as to whether particular incidents were notifiable or not indicate that clarifying the meaning of the phrase ‘conduct of the business or undertaking’ is important.

In its 2014-2015 Annual Report, the DIBP outlined the objectives of the programmes that it operates and the outcomes that those programmes were designed to achieve. The DIBP uses the term ‘illegal maritime arrival’ or ‘IMA’ to refer to detainees, asylum seekers and refugees.

It is encouraging to note that the health and safety of detainees, refugees, asylum seekers and workers at immigration detention facilities and in regional processing countries features heavily in the description of the objectives, deliverables and indicators identified in the Annual Report. This indicates that the DIBP understands its obligations under the WHS Act in this regard.

According to the DIBP, ‘[t]he Government considers mandatory immigration detention to be an essential component of strong border control. Immigration detention supports Australia’s well-managed migration system and is used to manage potential risks to the Australian community…'
It also supports the integrity of Australia’s visa programmes’. It also supports the integrity of Australia’s visa programmes’.13 ‘Immigration detention facilities (IDFs)... continued to accommodate IMAs while their immigration status is resolved. This ensures that health, identity and security risks to the community can be managed’.14 To this end, the DIBP has constructed a number of facilities in Nauru and Papua New Guinea, including the East Lorengau Refugee Transit Centre in Manus Island, which can accommodate up to 298 transferees with supporting amenity and water, power and waste water services’.15 It also ‘supported the construction of two 150-bed settlement accommodation facilities in Nauru for refugees’.16

The 2014-2015 Annual Report describes the objectives as follows:

- ‘Administer effective programmes and strategies that support the integrity of the Australian border and advance the objectives of Operation Sovereign Borders through:
  - Transfer of eligible IMAs to a Reginal Processing Centre (RPC)
  - Facilitation of a substantive immigration outcome for IMAs in a lawful, timely, fair and reasonable manner, including through departure from Australia.
  - Administer programmes and services in community and detention environments in Australia...’17

In relation to RPCs, the objectives identified are to:

“Administer arrangement that assist regional processing countries to implement the Memoranda of Understanding (MOUs) and Administrative Arrangements agreed with Australia, including building regional processing countries’ capabilities to:

- Manage IMAs transferred to a RPC
- Determine the refugee status of transferees
- Return and remove transferees
- Settle refugees.”18

Deliverables are included in the Annual Report to assess the extent to which these objectives are met. The deliverables include:

- Providing health and other support services of an adequate standard for detainees;19
- Maintaining immigration detention facilities to a standard that supports the health, safety and security of detainees;20
- Transferring eligible detainees to RPCs in a safe and timely manner;21
- Ensuring that immigration detention facilities meets operational requirements and are maintained to a standard that supports the health, safety and security of detainees and staff;22
- Providing services to detainees in immigration detention and in the community consistent with relevant laws and government standards;23

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14 Ibid, at 154.
15 Ibid, at 155 (references omitted).
16 Ibid, at 156.
17 Ibid, at 184.
18 Ibid, at 91.
19 Ibid, at 160, 164.
20 Ibid, at 164.
21 Ibid, at 185, 186.
22 Ibid, at 186.
23 Ibid, at 187.
• Building capacity in regional processing countries in line with the MOU and agreed administrative arrangements;\textsuperscript{24}

• Constructing and maintaining facilities that support regional processing countries to manage and accommodate transferees;\textsuperscript{25}

• Providing services that assist regional processing countries to manage the settlement of transferees found to be refugees which may include basic living allowances, language training, links to education and employment opportunities and health services.\textsuperscript{26}

These objectives and deliverables suggest that the business of the DIBP in immigration detention facilities is to detain detainees, providing all incidental health and safety support, to achieve broader departmental objectives. In terms of asylum seekers and refugees living in the community, including those living in the community in Nauru and Papua New Guinea, the business of the DIBP appears to be to support those individuals by providing them accommodation. They are also supported in the community by way of government payments and support in accessing employment opportunities and health and counselling services.

The fact that numerous facilities have been built to accommodate asylum seekers and refugees on Nauru and Manus Island and that support is provided following a determination that an asylum seeker is a refugee, indicates that the business of the DIBP extends beyond the release of detainees from detention. This ongoing responsibility will have ramifications for the types of incidents that should be reported to Comcare under s38 of the WHS Act.

1.6 Duty cannot be transferred

Duties under the WHS Act are not transferrable: s14. This makes the DIBP directly liable, even if alleged failures at the RPCs were due to the activities of a contractor. This liability was recognised by the Select Committee into the conditions and circumstances at Nauru:

\textsuperscript{1}Evidence revealed to the committee during its inquiry was put to the Department of Immigration and Border Protection for investigation and comment.

Although numerous allegations were made against staff of Wilson Security and the head contract holder Transfield Services, responsibility ultimately rests with the department. The committee believes that there must be a direct relationship between the department and the security service provider in order to facilitate stronger accountability and transparency, where at present the department can only deal directly with Transfield Services. The department has effectively outsourced its accountability to Transfield Services and through them, to Wilson Security, with no penalty for non-compliance\textsuperscript{27} (emphasis added).

While the Select Committee acknowledges that the DIBP has outsourced functions to Transfield Services, the DIBP cannot contract out of its accountability under the WHS Act, or its liability as a PCBU at law.

Section 272 of the WHS Act provides that:

\begin{itemize}
\item \textsuperscript{24} Ibid, at 192.
\item \textsuperscript{25} Ibid, at 192.
\item \textsuperscript{26} Ibid, at 195.
\item \textsuperscript{27} Nauru Inquiry Final Report, at 125 [5.34], accessed at: \url{http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Regional_processing_Nauru/Regional_processing_Nauru/Final_Report}. 
\end{itemize}
‘A term of any agreement or contract that purports to exclude, limit or modify the operation of this Act or any duty owed under this Act or to transfer to another person any duty owed under this Act is void.’

The Select Committee noted that:

‘It appears to the committee that the Regional Processing Centre on Nauru is not run well, nor are Wilson Security and Transfield Services properly accountable to the Commonwealth despite the significant investment in their services.

The committee has found that the Department of Immigration and Border Protection does not have full knowledge of incidents occurring on Nauru, owing to their inability to scrutinise their contracted service providers.’

If the DIBP does not or cannot effectively discharge its obligations due to contractual arrangements, it may face legal proceedings. The range of penalties under the Act include civil penalties, fines and imprisonment.

This risk was recognised by the Select Committee:

‘The committee also notes the ... real possibility of future litigation in Australian courts in relation to duty of care and workplace health and safety, should care not be taken to ensure that suitable conditions are maintained for both contracted staff and asylum seekers at the RPC.’

1.7 Potential liability of the Commonwealth

Section 10 of the WHS Act provides that the Act binds the Commonwealth, which can be liable for offences against the Act and for contraventions of civil penalty provisions.

Under s245 of the WHS Act, if the Commonwealth is guilty of an offence against this Act, the penalty to be imposed on the Commonwealth is the penalty applicable to a body corporate.

For the purposes of the WHS Act, any conduct which is engaged in on behalf of the Commonwealth by an employee, agent or officer of the Commonwealth acting within the actual or apparent scope of his or her employment, or within his or her actual or apparent authority, is conduct also engaged in by the Commonwealth.

If an offence requires proof of knowledge, intention or recklessness, it is sufficient in proceedings against the Commonwealth for that offence to prove that the person referred to in s245(2) had the relevant knowledge, intention or recklessness: s245(3).

28 Ibid, at 125 [5.35].
29 Ibid, at 122 [5.18].
30 WHS Act 2011, s245(2).
Under s12A, strict liability applies to each physical element of each offence under the Act unless otherwise stated in the section containing the offence.

Officers have additional obligations under the WHS Act. An officer is defined in s247 as:

1. A person who makes, or participates in making, decisions that affect the whole, or a substantial part, of a business or undertaking of the Commonwealth is taken to be an officer of the Commonwealth for the purposes of this Act.

However, under s247(2), a Minister of a State or the Commonwealth is not in that capacity an officer for the purposes of the WHS Act.

1.7.1 Model litigant obligations

The Commonwealth and its agencies are under an obligation to ‘act honestly and fairly in handling claims and litigation by or against the Commonwealth or an agency’. This principle reflects the fact that the Commonwealth acts for the people and has ‘no legitimate private interest in the performance of its functions’. It must act as a ‘moral exemplar’.

The Legal Services Directions 2005 (Cth) clarify the substance of this obligation, which includes avoiding litigation where possible. The Commonwealth should pay legitimate claims without litigation where liability is clear. Where it is not possible to avoid litigation, the Commonwealth should not require the proof of facts that it knows to be true, not contest liability if the dispute is about quantum and not rely on technical defences unless its interests would be prejudiced by the failure to comply a specific requirement. Where its lawyers have acted wrongfully or improperly, it should apologise.

As such, if prosecutions or civil penalties were brought against the DIBP, Comcare or other Commonwealth agencies, it would be incumbent on them to respond in line with model litigant obligations.

1.8 Offences and civil penalty provisions under the WHS Act

Offences are specified throughout the WHS Act. A number of offences and penalties are detailed in Part 2, Division 5 of the Act relating to the failure to exercise a health and safety duty. See 1.4 above for more detail regarding these duties.

There are also civil penalty provisions under the WHS Act and Regulations. These are a lesser form of contravention and generally relate to workplace entry by WHS entry permit holders (such as union representatives). Contravention of a civil penalty provision is not an offence: s257.

31 Legal Services Directions 2005 (Cth), Appendix B, 2.
32 LVR (WA) Pty Ltd v AAT [2012] FCFCA 90 at [42].
33 Legal Services Directions 2005 (Cth), Appendix B, 2(b), (e), (g), (i).
Frequent incident reports were provided to the DIBP, meaning that there was relevant knowledge of the incidents. Incidents that were not brought to the attention of the DIBP point to a failure of due diligence obligations, which can be an offence under s27.

The WHS Act sets out three offences relating to failure to exercise a health and safety duty, as described above at 1.4.

It is likely that a number of the incidents described in this Report may constitute breaches of the WHS Act that are sufficient to establish a category three, category two or even category one offence.
Chapter 2 – Common law obligations

Overview

The position of the DIBP regarding control of, and duty of care in, immigration detention is inconsistent. While it has accepted that common law obligations exist in relation to immigration detention in Australia, the official attitude towards RPCs is characterised by vagueness and obfuscation.

The fact that the RPCs are in other sovereign nations is clearly a factor in the application of Australian law generally. In public communications, such as media stories and submissions, the DIBP asserts that it does not have control of regional processing centres in Nauru and Manus Island, but that it provides a support role to the governments of Nauru and Papua New Guinea.

However, when questioned regarding the WHS Act, the DIBP acknowledges that it is the person conducting a business or undertaking (PCBU), and has management and control of immigration detention centres. This role also applies in relation to Nauru and Manus Island. Further, the Memoranda of Understanding between Australia and the two countries indicate the extent to which Australia has control over the RPCs.

In legal proceedings for negligence, the DIBP has acknowledged that it has a non-delegable duty at common law to provide reasonable medical treatment to asylum seekers detained in Australia.34 A class action is currently on foot to determine whether this duty at common law extends to RPCs and whether detainees at the Manus Island RPC are eligible for compensation for personal injury.35 At the time of writing, this case has not been decided.

This chapter examines the extent of the DIBP’s obligations under the common law. Obligations under the WHS Act are explored in Chapter 1, above. The two sets of obligations are concurrent; they do not rely on one another for their binding force.

2.1 Duty of care at common law to immigration detainees in Australia

The DIBP has accepted in legal proceedings that the Commonwealth has a duty of care to detainees in immigration detention on Australian soil. This duty of care operates alongside obligations under the WHS Act: if either the duty of care or the WHS Act obligations were found not to apply, the DIBP would still be required to meet the other set of obligations.

The Commonwealth’s duty of care to detainees held in immigration detention on Australian soil is well established at common law. The ALA highlighted the nature of this duty to both the Senate Standing


Committee on Legal and Constitutional Affairs’ inquiry into the Incident at the Manus Island Detention Centre from 16 to 18 February 2014 (the ‘Manus Inquiry’) and Nauru Inquiry, with reference to case law.\(^{36}\)

As the High Court held in *Behrooz v Secretary, Department of Immigration & Multicultural & Indigenous Affairs* [2004] HCA 36; detainees:

‘do 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.’\(^{37}\)

Information obtained by the ALA under the FOI Act found that from 2000 to 2013, payments had been made to former immigration detainees totalling over $21 million in relation to claims of unlawful detention, and over $6.9 million for breach of statutory duty, breach of duty of care or negligence.\(^{38}\)

2.1.1 Duty of care in relation to prisoners

The Commonwealth Ombudsman stated in its report, *Suicide and Self-Harm in the Immigration Detention Network*, that:

‘The nature and extent of a person’s duty of care is affected by the level of control that the person has over others, and how vulnerable those others are. The higher the level of control the person has, and the greater the vulnerability of the others, the greater the person’s duty of care is’\(^{39}\) (emphasis added).

It is a well-established common law duty that prison authorities must exercise reasonable care for the safety of prisoners during their detention in custody,\(^{40}\) which may include the duty to take reasonable steps to protect them from others. This duty has been recognised to apply to immigration detention centres in Australia.\(^{41}\)

In *New South Wales v Bujdoso* [2005] HCA 76, a prisoner detained at Silverwater gaol was exposed to threats, of which prison authorities were aware. One night, the prisoner was attacked by other prisoners with iron bars and suffered serious injuries. At issue on appeal was whether the State was in breach of its duty of care to Mr Bujdoso when he was assaulted during his imprisonment. The Court

36 For further detail, see Australian Lawyers Alliance, ‘The Commonwealth has a duty of care in offshore detention centres: Considering Nauru and the Moss Review’, Submission to the Select Committee on the Recent Allegations relating to Conditions and Circumstances at the Regional Processing Centre in Nauru (27 April 2015); and Australian Lawyers Alliance, ‘The incident at Manus Island: Non-delegable duty of care,’ Submission to the Senate Standing Committee on Legal and Constitutional Affairs, Inquiry into the incident at Manus Island (2 May 2014).

37 *Behrooz v Secretary, Department of Immigration & Multicultural & Indigenous Affairs* [2004] HCA 36; 219 CLR 486; 208 ALR 271; 78 ALJR 271; 204 CLR 363; 78 ALJR 271; 78 ALJR 1056 (6 August 2004) Gleece CJ at para [21].


41 See *Behrooz v Secretary, Department of Immigration & Multicultural & Indigenous Affairs* (2004) 208 ALR 271; Secretary, *Department of Immigration and Multicultural and Indigenous Affairs v Mastipour* [2004] FCAFC 93; *SBEG v Commonwealth of Australia* [2012] FCAFC 189; S v *Secretary, Department of Immigration and Multicultural and Indigenous Affairs* [2005] FCA 549.
held that Mr Bujdoso did not need to prove that the State should have guaranteed his safety, but that there was a duty to exercise reasonable care, which was missing.

The Court quoted from a leading text on the law of torts:

‘An affirmative obligation to use care to control the conduct of others may also be raised by a special relationship between the actor and the person injured. Thus where one stands in loco parentis, or is put in charge of persons under circumstances that deprive them of normal means of self-protection (eg, prisoners), he must use care to restrain the foreseeable dangerous conduct of third persons that unreasonably threatens his wards’\(^42\) (emphasis added).

In *Price v State of NSW* [2011] NSWCA 341, a prisoner was injured. In considering the duty of care owed to Mr Price, the Court said that:

‘The custody of Mr Price involved detention and an assumption of control of his person resulting in a duty to exercise reasonable care for his safety during his detention... The relationship is a special one sufficient to include a responsibility to exercise care to prevent harm deliberately and unlawfully inflicted by others...

Critical to the special character for relevant purposes here is the control by the respondent of the appellant and its assumption of responsibility over the appellant. These matters no doubt purvey the whole life and existence of those in prison: most aspects of life, and autonomous existence, are subject to control and direction.

These considerations often assume their importance in the responsibility to control the violence of third parties, such as other inmates. These considerations are relevant, however, in recognising the duty no doubt extends to the taking of reasonable care in the exercise of powers of control and direction that exist in order to avoid injury to an inmate\(^43\) (emphasis added).

As will be seen in the investigation below, numerous injuries have been sustained by detainees in immigration detention. There is a duty for the same level of responsibility to be demonstrated in relation to those detainees.

### 2.1.2 Duty to provide reasonable medical care

Case law has also established that the Commonwealth has a duty of care to provide reasonable medical care to persons in detention. In *AS v Minister for Immigration and Border Protection & Anor* [2014] VSC 593, the Commonwealth accepted that it owed a non-delegable duty of care to provide reasonable healthcare to persons who were held in detention on Christmas Island pursuant to the *Migration Act 1958* (Cth).

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\(^42\) *New South Wales v Bujdoso* [2005] HCA 76, at [45].

\(^43\) Australian Lawyers Alliance, ‘The incident at Manus Island: Non-delegable duty of care,’ Submission to the Senate Standing Committee on Legal and Constitutional Affairs, Inquiry into the incident at Manus Island (2 May 2014), at [35].
In *MZYYR v Secretary, Department of Immigration and Citizenship*, the Commonwealth did not dispute that psychiatric care was included in determining the level of medical care which is reasonably designed to meet the healthcare needs of detainees.\(^{44}\)

### 2.1.3 A non-delegable duty

The ALA submits that the Commonwealth may have a non-delegable duty of care to detainees held in immigration detention, while noting that the question as to whether the Commonwealth’s duty to detainees is non-delegable has not yet been resolved at High Court level.\(^{45}\)

A non-delegable duty of care may be described as:

> ‘the category of tort liability to not only take care but ensure that care is taken. This area of liability has the effect of fixing liability for negligent acts to a particular person, even if that person has delegated responsibility for performance of those acts to a third party, for example an independent contractor. Non-delegable duties of care have been described as a kind of vicarious liability. Non-delegable duties of care are significant in that they form an exception to the normal rule that a person will not be liable for the acts of independent contractors’\(^{46}\) (emphasis added).

The effect of a non-delegable duty of care would be that any breaches of that duty arising from the acts or omissions of contractors, such as Transfield and IHMS, would be attributable to the Commonwealth.\(^{47}\)

The Commonwealth Ombudsman, in its 2013 report, *Suicide and Self-Harm in the Immigration Detention Network*, suggested that the duty of care in Australian immigration detention centres was non-delegable:

> ‘Even though the department has contracted out detention services, its duty of care is legally ‘non-delegable’, which means that it remains ultimately responsible for the care of each and every detainee. The department cannot discharge its duty simply by making reasonable arrangements for its service providers to perform the duty for it. It must ensure that its service providers actually provide the required level of care.

The department therefore has to ensure that detention facilities are adequately staffed by properly trained staff; that detention conditions are humane and not unreasonably restrictive or coercive; and that proper policies and procedures are in place to assess and manage risks and to ensure that individual needs are identified and met. The department also has to ensure that the service providers adhere to their contractual obligations to perform their duties in

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\(^{44}\) *MZYYR v Secretary, Department of Immigration and Citizenship* [2012] FCA 694, Jordon J at [20]. This is further supported by *S v Secretary, Department of Immigration and Multicultural and Indigenous Affairs* [2005] FCA 549; (2005) 143 FCR 217 at [218].

\(^{45}\) *SBEG v Secretary, Department of Immigration and Citizenship (No. 2)* [2012] FCA 569, Besanko J at [22].

accordance with standards of conduct, such as their duty of care to detainees, maintaining a healthy detention environment and providing a supportive culture and appropriate amenities.\textsuperscript{47}

Case law suggests that the special duty of a non-delegable duty of care arises in situations where there is a ‘central element of control’.\textsuperscript{48}

Bearers of a non-delegable duty usually have ‘undertaken the care, supervision or control of the person or property of another or is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised’.\textsuperscript{48} It seems clear that this phrase could describe the situation of detainees in immigration detention.

2.2 Common law obligations in RPCs

2.2.1 Background to RPCs

Between 2001 and 2008, a total of 1,637 asylum seekers were detained in the Nauru and Manus Island Regional Processing Centres (RPCs) under the ‘Pacific Solution’.\textsuperscript{50}

The Pacific Solution was formally ended during February 2008, under the Rudd government, when it announced that the processing centres on Nauru and Manus Island would no longer be used and that future unauthorised boat arrivals would be processed at Christmas Island. On 8 February 2008, the last asylum seekers were removed from Nauru, and the government announced that the Nauru centre would no longer be used.\textsuperscript{51}

However in 2012, in response to an increase in boat arrivals, the Gillard government reversed this decision and reintroduced the policy of transferring asylum seekers to offshore processing centres in Nauru and Papua New Guinea.\textsuperscript{52}

On 29 August 2012, the first memorandum of understanding (MOU) between the Commonwealth of Australia and the Republic of Nauru, was signed. A second MOU, also titled Memorandum of Understanding Between the Republic of Nauru and the Commonwealth of Australia, relating to the transfer to an assessment of persons in Nauru and related issues, was signed on 3 August 2013, superseding the previous agreement.\textsuperscript{53}

\begin{itemize}
  \item \textsuperscript{48} Burnie Port Authority v General Jones Pty Ltd (1994) 179 CLR 520, 550-554.
  \item \textsuperscript{49} Ibid.
  \item \textsuperscript{50} Report into the incident at Manus Island, at 4 [1.27], accessed at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Manus_Island/Report/c01.
  \item \textsuperscript{52} Report into incident at Manus Island, at [1.29], accessed at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Manus_Island/Report.
  \item \textsuperscript{53} Australian Lawyers Alliance, ‘The Commonwealth has a duty of care in offshore detention centres: Considering Nauru and the Moss Review,’ Submission to Select Committee on the Recent Allegations relating to Conditions and Circumstances at the Regional Processing Centre in Nauru, at 12.
\end{itemize}
On 8 September 2012, the Australian and Papua New Guinean governments entered into a MOU relating to regional processing arrangements in Papua New Guinea. About one month later, Papua New Guinea was designated as a regional processing country by an instrument signed by the then Minister for Immigration and Citizenship, the Hon Chris Bowen MP, under the Migration Act 1958.

On 14 September 2012, the Nauru RPC received the first group of asylum seekers.

On 21 November 2012, the Gillard government confirmed the first transfer of asylum seekers from Christmas Island to Manus Island.

On 20 June 2013, the Gillard government removed a group of 70 asylum seekers, comprising families with children and vulnerable men, from Manus Island. A spokesperson for the then Department of Immigration and Citizenship stated that the transfer had been made for ‘operational reasons’; however, refugee activists believed it was a ‘signal that the government was ending detention of families and children on the island’. According to G4S, the contractor managing the Manus Island RPC at that time, the decision to remove families from the centre and make the centre a single adult male only facility occurred on 15 June 2013.

As at November 2015, there were a total of 1,469 people detained in RPCs.

| Table 1 – Persons detained in RPCs as at 30 November 2015 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
|                 | Men             | Women           | Children        | Total           |
| Nauru RPC       | 393             | 80              | 70              | 543             |
| Manus RPC       | 926             | 0               | 0               | 926             |
| Total RPCs      | 1,319           | 80              | 70              | 1,469           |

As at January 2016, the Guardian Australia reports that approximately 800 people live in the Nauru community on temporary visas.

2.2.2 General application of Australian law in RPCs: DIBP control

The degree to which the DIBP has ‘control’ in RPCs is important, as this could trigger Australia’s responsibilities under international law, or potentially, comprise an element in establishing a non-delegable duty of care at common law. As was seen above in Chapter 1, however, the WHS Act applies in all immigration detention facilities, including RPCs.

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55 Ibid, at 5 [1.33].
58 Ibid, at 6 [1.35].
Under international law, Australia is responsible for activities that take place within the borders of third countries in areas where it can be shown to have ‘effective control’. The kinds of circumstances in which effective control have been found in the past include whether the country in question decided to send people to the third country, and where the country has detained people in a detention-centre type location. The fact that the detention centres are funded by Australia, the contracts are administered by Australia, the Australian Minister for Immigration and Border Protection has accepted that the DIBP is responsible for the welfare of detainees and the detention centres are staffed by a large number of Australians all suggests that international law would consider the Australian government responsible for ensuring that the rights of detainees are respected.

In 2014, the DIBP provided evidence regarding responsibility at the Manus Island RPC to the Manus Inquiry.

The departmental officer giving evidence rejected the argument that Australia has effective control of the Manus Island centre, stating:

‘[T]here has been a lot of focus and significant claims made that Australia runs this centre and has “effective control”. It is a legal context; it is a legal term.

We are very clear that we do not have “effective control”: we do not run the centre, we do not set the legal framework, we do not own the buildings, we do not employ the staff, we do not set the policy framework, we do not outline the labour laws under which people are employed, we do not have control over the occupational health and safety legislation, and we do not have control over the environmental legislation. What we do have is a contracting arrangement for service delivery consistent with the regional resettlement agreement… [It] needed to be clarified that the Australian government, through its arrangements there, does not exercise effective control. It manages contracts consistent with an agreement struck between the government of PNG and the government of Australia in July and August of 2013.’

The Nauru Inquiry cited in its final report that the DIBP characterises jurisdiction over the RPC as follows:

‘Nauru owns and administers the Nauru Regional Processing Centre, under Nauruan law. Australia provides capacity building and funding for Government of Nauru’s operation of the centre and coordinates the contract administration process.

The department advises that under the terms of the two Memoranda of Understanding and related arrangements between the Governments of Australia and Nauru, Nauru’s Secretary of Justice is responsible for the “security, good order and management of the centre, including the care and welfare of persons residing in the centre”. The RPC is managed by three Operational Managers appointed by the Government of Nauru, assisted by Deputy Operational Managers.

61 Bankovic & Ors v Belgium & Ors, European Court of Human Rights, application No. 52207/99, judgement date 19 December 2001; Al Skeini v United Kingdom, application No. 55721/07, judgement date 7 July 2011; Al Jedda v United Kingdom, application No. 27021/08, judgement date 7 July 2011.
62 Al Jedda v the United Kingdom, application No. 27021/08, (2011) ECHR (Grand Chamber).
63 Al Skeini v United Kingdom, application No. 55721/07, (2011) ECHR (Grand Chamber).
According to the department, it and its contracted service providers support Nauru’s Secretary of Justice and the Operational Managers in fulfilling their roles, as agreed between the two parties. The terms of the MOU require that activities undertaken by the Australian Government comply with Australia’s Constitution and laws. “In some cases, where no relevant Nauruan standard exists, services contracts require providers to adhere to Australian standards in the delivery of services.”  

The DIBP position regarding responsibility at the Nauru RPC can be seen in its 2015 submission to that inquiry.

The DIBP identified that the DIBP ‘provides support to the Government of Nauru’ and that ‘whilst the Government of Nauru has responsibility for the Nauru Regional Processing Centre, the Department supports the Government of Nauru through the administration of contracts for service provision’.

The DIBP referred to the Memorandum of Understanding between the Australian government and the Nauruan government, highlighting that ‘pursuant to the MOU, control of the Centre lies with the Nauruan Government which has undertaken to conduct all activities in line with its Constitution and all relevant domestic laws’.

2.2.3 Evidence of DIBP control of RPCs

The ALA has suggested in submissions to the Manus Inquiry and the Nauru Inquiry that the Memoranda of Understanding between Australia and Nauru, and Papua New Guinea, respectively indicate the level of control exercised by the DIBP regarding RPCs.

In its submission to the Nauru Inquiry in April 2015, the ALA noted that the terms of the MOUs with Nauru and Papua New Guinea indicate that:

- The Commonwealth initiated the concept of the Nauru RPC;
- The location of the site of the regional processing centre, despite being in Nauruan territory, was also to be ‘jointly determined and agreed’ [between Australia and Nauru];
- The Commonwealth was identified as the funder of the RPC on an indefinite basis;
- The Commonwealth maintained discretion regarding decisions to transfer ‘transferees’ to Nauru, while Nauru had a mandatory requirement to accept transferees;
- The Commonwealth appeared to have control regarding the departure, and timing of departure of transferees from Nauru;
- The MOU established direct communications with the Australian Department of Immigration and Citizenship (as it was then known) regarding the day-to-day operation of activities undertaken under the MOU;

68 Ibid, at 12.
• Clause 4 of the MOUs recognised that the ‘Commonwealth of Australia will conduct all activities in respect of this MOU in accordance with its Constitution and all relevant domestic laws’.  

The DIBP's contracts with various contractors are a further indication that Australian contract law applies in the RPCs. The Commonwealth administers contracts for service provision under the MOUs. While the terms of those contracts are have not been reviewed by the ALA, they will be governed by the laws of Australia, having been made in Australia between two Australian parties. Further, since the Commonwealth provides all funding under MOUs, any problems caused by inadequate resources or slow decision-making are a direct Commonwealth responsibility.

Therefore, it appears that while the centres are on Nauruan and Papua New Guinean soil, control is maintained by Australia, which continues to fund, makes decisions, and has the final say about whether a person will be detained within the RPCs.

The responsibility of the Commonwealth as the ‘head’ of the RPC appears to have been recognised on a factual basis by the Moss Review in its February 2015 report. Its assumption of responsibility and control is reflected in the following excerpts from the Review:

• Details about transferees who allegedly dealt in marijuana are provided to the DIBP for referral to the ‘relevant authorities’ (at [11]);
• The government of Nauru and the DIBP are urged ‘to ensure that [personal safety and privacy of the transferees] are factors considered in any decision-making’ [at 15];
• Information about some reported incidents was provided to the DIBP ‘for referral to the relevant authorities and for further investigation’ (at [20]);
• Information ‘that would assist relevant authorities to investigate [allegations of sexual and other physical assault of minors] was provided to the [DIBP]’ (at [21]);
• Information was provided to the DIBP for referral to the relevant authorities’ regarding ‘allegations from transferees about misconduct by staff members of contract service providers’ (at [22]).

The Moss Review recommended that:

‘The Department needs to provide effective coordination and adopt a lead role in ensuring that contract service providers work effectively together. This role needs to be played not only at the Centre in Nauru, but also at a head office level’ (emphasis added).

Further:

‘By appointing in September 2014, a Senior Executive Service Officer in Nauru, the Department has the basis to ensure that contract service providers achieve a more joined up approach in the Centre. The Department needs to develop its function beyond mere contract management. This enhanced coordination role needs to be performed jointly with the Nauruan operations managers (emphasis added).

Inherent in a more integrated approach would be improved training and supervision of all contract service provider staff members... the supervision provided to the Transfield Services and Wilson Security staff members, particularly locally engaged Nauruans, needs to be enhanced.'

In its final report, the Nauru Inquiry noted that:

‘In the committee’s view, the Government of Australia’s purported reliance on the sovereignty and legal system of Nauru in the face of allegations of human rights abuses and serious crimes at the RPC is a cynical and unjustifiable attempt to avoid accountability for a situation created by this country.’

The Senate Standing Committee on Legal and Constitutional Affairs in the Manus Inquiry noted that:

‘The view that Australia does not have effective control over asylum seekers held at the RPC (and consequently does not have concomitant obligations under international law) was strongly contested in the evidence of a number of legal and human rights organisations and academics to the inquiry...

A number of submitters and witnesses submitted that Australia has satisfied the test of ‘effective control’, and pointed particularly to the degree of Australia’s involvement in the operation of the Manus Island RPC. Specific factors identified as evidence of effective control included... Australia’s integral involvement in the establishment, arrangements, maintenance, funding and operation of the centre.’

2.2.4 The duty of care in relation to RPCs

The Commonwealth Ombudsman noted the complexity regarding duty of care in RPCs in its 2013 report, *Suicide and Self-Harm in the Immigration Detention Network*, stating, ‘we believe that the Commonwealth has some obligation to those held in Regional Processing Centres in Nauru or Manus Island but the arrangements in place with the respective governments make this a complex issue’.

In evidence provided to the Manus Inquiry on 17 September 2014, the DIBP noted the following in relation to any duty of care owed by Australia to transferees held at the Manus Island RPC:

‘The existence and nature or scope of a duty of care in the regional processing context is a complex question involving consideration of foreign laws and the roles played by a range of parties including foreign and Australian governments and their officers as well as non-government service providers and their employees. Such a question normally entails judicial evaluation of the relevant factors involved. As such issues are the subject of current litigation, it would not be appropriate to comment.’

72 Ibid, at 122 [5.19].
73 Ibid, at 135 [7.30], [7.31].
Proceedings addressing this issue are currently on foot. A claim for negligence has been brought in a class action on behalf of persons previously detained at Manus Island, and lodged against the Commonwealth, Transfield, G4S and IHMS in the Supreme Court of Victoria.\(^{76}\) A separate claim for negligence has also been brought on behalf of a five-year-old girl for injuries allegedly suffered by her while she was detained in the Nauru RPC. Proceedings were lodged in the Northern Territory Supreme Court against the Minister for Immigration and Border Protection and the Commonwealth of Australia, although the Court found that it did not have jurisdiction to resolve the questions it was asked.\(^{77}\)

It remains to be resolved by the courts as to whether the Commonwealth of Australia has a duty of care at common law to detainees held in immigration detention centres which are administered in Nauru and Manus Island and funded by Australia. It also remains to be seen to what degree ‘control’ will be considered in such proceedings.

### 2.3 Recommendations

The ALA recommends that:

- The DIBP acknowledge that its decision to locate RPCs outside of Australia does not absolve it from meeting its obligations under the WHS Act to ensure all immigration detention facilities are safe for workers and other persons.
- If the DIBP feels that it is unable to meet its obligations under the WHS Act in RPCs, it should consider closing RPCs or relocating them to a country in which it can meet its health and safety obligations.


Chapter 3 – Comcare’s monitoring of immigration detention centres and RPCs

Overview

Comcare is the Commonwealth agency with regulator responsibilities under the WHS Act. It is both a national regulator and national insurer for Commonwealth workplaces.

Comcare has the power to investigate incidents and to conduct regulatory and proactive inspections in workplaces covered by the WHS Act, including immigration detention facilities and RPCs. The agency has conducted regulatory inspections and investigations of these facilities for many years. Historically, Comcare has identified inadequacies in the DIBP’s reporting to the regulator, as well as non-compliance with the relevant Acts.

Comcare was established by the Safety, Rehabilitation and Compensation Act 1988 (Cth) (‘SRC Act’). It has a number of functions, as found under s69 of that Act. For the purposes of the present Report, the relevant functions include:

‘
(a) to make determinations accurately and quickly in relation to claims and requests made to Comcare under this Act;
(b) to minimise the duration and severity of injuries to its employees and employees of exempt authorities by arranging quickly for the rehabilitation of those employees under this Act;
(c) to cooperate with other bodies or persons with the aim of reducing the incidence of injury to employees;
(d) to conduct and promote research into the rehabilitation of employees and the incidence and prevention of injury to employees;
(da) to promote the adoption in Australia and elsewhere of effective strategies and procedures for the rehabilitation of injured workers;
(e) to publish material relating to any of the functions referred to in paragraphs (a), (c) and (d) and relating to the rehabilitation of employees under this Act;
...
(fb) such other functions as are conferred on Comcare by the regulations;
(g) such other functions as are conferred on Comcare by any other Act.’

The WHS Act confers a number of functions on Comcare, most of which can be found in Part 8. The functions centre on monitoring and compliance with the WHS Act (s152), collecting information (s155) and appointing inspectors (s156). Comcare also shares all powers of inspectors (s153(2)), which are
detailed under s160 to include providing information and advice regarding compliance with the WHS Act, to assist in resolving work health and safety issues in workplaces, issue notices (see also Part 10 division one detailing improvement notices) which may include financial penalty if not complied with, and assist in prosecutions. It can bring prosecutions under s230.

To facilitate these functions, Comcare ‘has power to do all things necessary or convenient to be done for, or in connection with, the performance of its functions’: s70 of the SRC Act.

3.1 Comcare’s 2011 investigation under the OHS Act

Prior to the WHS Act, which came into force on 1 January 2012, the Occupational Health and Safety Act 1991 (Cth) (‘OHS Act’) governed occupational health and safety in Commonwealth workplaces. Comcare was therefore empowered to undertake similar investigations prior to the commencement of the WHS Act under the OHS Act.

In March 2011, Comcare commenced an investigation under the OHS Act into the Department of Immigration and Citizenship (DIAC), as it was then known, management of the health and safety of detainees at immigration detention facilities and the potential impact on the health and safety of DIAC employees and contractors at seven immigration detention facilities controlled by DIAC on the Australian mainland and Christmas Island. This report did not consider conditions in RPCs, which were not in operation at the time the investigation commenced.

The report, which was provided to the Secretary of DIAC, Andrew Metcalfe, on 21 July 2011, found that:

‘There are a number of non-compliances evident nationally across all facilities which mean that DIAC is failing to comply with its duties under the Occupational Health and Safety Act 1991 and associated regulations’ (emphasis added).

The report specifically addressed the duty of DIAC in relation to detainees. The report identified that, under s17 of the OHS Act, DIAC, as an employer, has a general duty to take all reasonably practicable steps to ensure that third parties, including detainees, are not exposed to a risk to their health or safety arising from any activity done in the course of DIAC’s business. This duty extends to the protection of physical and psychological health and safety.

The report found that:

‘DIAC failed, in relation to the five areas of risk [risk management, staffing ratios, staff training, critical incident management, diversity of third parties], to take all reasonably practical steps to protect the health and safety of its employees, contractors and third parties such as detainees in the period leading up to and including the conduct of this investigation.’

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82 Ibid, at 6 of 19 [35].
The report also noted:

- DIAC retains a high level of control over the manner in which, and the arrangements in place for, the management of detainees by Serco.\(^{83}\)
- A level of under-reporting by DIAC of notifiable incidents required by s68 of the OHS Act.\(^{84}\)
- DIAC’s failure to notify Comcare of notifiable incidents within the required timeframe, with Comcare often alerted by the media (rather than DIAC) of DIAC’s notifiable incidents.\(^{85}\)
- No evidence of a comprehensive risk assessment process consistent with AS/NZS 401:2001 and AS/NZ 4360:2004 that assesses and manages the risks to staff, contractors, detainees and visitors to [immigration detention facilities], associated with the conduct of DIAC’s operations in the detention and management of immigration detainees.\(^{86}\)
- DIAC staff are generally unaware of their OHS responsibilities…in respect to themselves, colleagues, contractors, detainees and visitors. They are also generally unaware of their role in implementing DIAC’s duties under s16(1) of the Act and instead see the DIAC National Office as being solely responsible.\(^{87}\)
- DIAC had not made staff sufficiently aware of DIAC OHS policies and procedures and how they should be applied on the ground at each individual immigration detention facility.\(^{88}\)
- Differences between detainees and their associated needs, whether they be cultural, racial, religious or their personal stage in detention are not sufficiently identified by DIAC to ensure that they are taken into consideration so that tension levels may be reduced.\(^{89}\)
- The staff/detainee ratio is not sufficiently risk assessed and documented in order to identify and ensure adequate staffing levels at all times.\(^{90}\)
- Current levels of DIAC staff training are insufficient and not targeted to the particular requirements of roles.\(^{91}\)

Current levels of critical incident planning for DIAC or Serco staff are insufficient.\(^{92}\)

Of particular concern is the observation made by Comcare that:

> ‘This decision-making process causes Comcare to often be alerted by the media (rather than DIAC) of DIAC’s notifiable incidents’\(^{93}\) (emphasis added).

Importantly, Comcare identified non-compliance with workplace health and safety laws in DIBP operations onshore prior to the implementation of regional processing. These issues have been ongoing for many years.

Given that the DIBP was aware that such breaches were occurring in an onshore environment, introducing regional processing without rectifying those breaches may have been expected to lead inevitably to systemic and more widespread risks in the immigration detention network.

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83 Ibid, at 6 of 19 [36].  
84 Ibid, at 6 of 19 [38].  
86 Ibid, at 6 of 19 [40].  
87 Ibid, at 6 of 19 [42].  
88 Ibid, at 6 of 19 [43].  
89 Ibid, at 7 of 19 [44].  
90 Ibid, at 7 of 19 [45].  
91 Ibid, at 7 of 19 [46].  
92 Ibid, at 7 of 19 [47].  
93 Ibid, at 2, [89].
Perhaps unsurprisingly, therefore, much of the commentary in Comcare's 2011 review remains relevant today.

For example, in the present report, the ALA has identified that:

- DIBP exercises control regarding decision-making and funding of all immigration detention facilities, including RPCs;
- incidents in 2014 and 2015 were often reported in the media or other public forums but not reported to Comcare;
- there appears to have been ongoing confusion among DIBP staff regarding their obligations to report different types of incidents, and whether such incidents constitute a notifiable incident.

Such consistent and ongoing non-compliance with the obligations under the OHS Act and WHS Act over a period of years may arguably be indicative of recklessness on the part of the DIBP.

3.2 DIBP’s liaison with Comcare

The DIBP's liaison with Comcare is summarised in its Annual Reports, which state that DIBP liaises with Comcare on all regulatory and co-operative compliance matters, including the provision and monitoring of incident reports and information as required under the WHS Act.

In its Annual Report 2014-2015, the DIBP noted that:

‘The Department remains committed to fulfilling its duties, as a Person Conducting a Business or Undertaking (PCBU), under the WHS Act. It aims to manage and evaluate workplace safety through collaboration and high-level leadership. During 2014-15 the Department continued to review and modify its business operations to mitigate risks associated with work health and safety.’

3.2.1 Assessment of incidents

Under the FOI Act, the ALA obtained all incidents reported by the DIBP to Comcare across all of its activities in FY2013-2014 and FY2014-2015. This included all reported incidents that occurred in a DIBP workplace, and ranged from incidents that occurred in offices in Canberra, to incidents within immigration detention facilities in Australia, Christmas Island, Nauru and Manus Island.

A comparison of the number of incidents reported by the DIBP to Comcare over FY2013-2014 to FY2014-2015 indicates that the vast majority of incidents were assessed as not-notifiable incidents. See 1.5 above for a definition of notifiable incidents.

Of the 1,092 incidents reported by the DIBP to Comcare, only 247 incidents (23 per cent) were assessed as notifiable; and 845 incidents (77 per cent) were assessed as not-notifiable. See Appendix 2 for details.

While the ALA believes that over-reporting is to be preferred to under-reporting, the high number of not-notifiable incidents may suggest confusion among DIBP and/or Comcare staff regarding the nature of incidents that constitute work health and safety problems in immigration detention.

3.2.2 The past five years: incidents reported

Between 1 July 2011 and 31 December 2011, the DIBP notified Comcare, in accordance with s68 of the Occupational Health and Safety Act 1991 (Cth).

The WHS Act, which commenced on 1 January 2012, introduced new requirements in relation to the reporting of deaths, serious injuries or illnesses, and dangerous incidents.

In respect of incident-reporting, the new WHS legislation changed the incident classification descriptions and some reporting thresholds. It required the reporting of incidents to Comcare as soon as possible, but with no set time-frames for reporting as required under previous laws.95

The table below summarises the number of incidents reported to Comcare under s35, 36 and 37 of the WHS Act over the past five years as set out in the DIBP’s Annual Reports in FY2013-2014 and FY2014-2015. It covers all of the DIBP’s activities, and includes office workers, workers overseas, immigration detention facilities and regional processing centres.

Table 2 – Incidents notified to Comcare under s35, 36 and 37 of the Work, Health and Safety Act 201196

<table>
<thead>
<tr>
<th>Notifiable incident classification</th>
<th>2010 – 2011 (from 1 July 2011 to 31 December 2011, as per s68 of OHS Act)</th>
<th>2010-2011 (from 1 January 2012 to 30 June 2012, as per WHS Act)</th>
<th>2011-2012</th>
<th>2012-2013</th>
<th>2013-2014</th>
<th>2014-2015</th>
<th>5 year total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>3</td>
<td>8</td>
<td>6</td>
<td>25</td>
</tr>
<tr>
<td>Serious injury/illness (SII)</td>
<td>47</td>
<td>330</td>
<td>377</td>
<td>188</td>
<td>338</td>
<td>586</td>
<td>1,866</td>
</tr>
<tr>
<td>Dangerous incident (DI)</td>
<td>486</td>
<td>654</td>
<td>1,140</td>
<td>107</td>
<td>103</td>
<td>70</td>
<td>2,560</td>
</tr>
<tr>
<td>Total incidents</td>
<td>535</td>
<td>986</td>
<td>1,521</td>
<td>298</td>
<td>449</td>
<td>662</td>
<td>4,451</td>
</tr>
</tbody>
</table>

In its Annual Reports from the past five years, the DIBP has reported a total of 4,451 incidents to Comcare:

- 25 deaths;
- 1,866 incidents of serious injury or illness; and
- 2,560 dangerous incidents.

The DIBP Annual Report 2013-2014 states that ‘the higher number of incidents reported to Comcare in 2013-14, compared with 2012-13, can primarily be attributed to the department’s continued focus on improving the quality of guidance materials, training and support to help staff make decisions in accordance with the legislative requirements and to ensure all notifiable incidents are reported immediately. This ensures the department reports all incidents that meet the notifiable threshold.’

The DIBP Annual Report 2013-2014 cites that: ‘consequently, the department appears to have over-reported, although this ensures that all serious incidents are visible to Comcare. The department continues to liaise with Comcare on its incident-reporting activity and related systems’ (emphasis added).

It is important to note that the DIBP Annual Report 2013-2014 cited that ‘83 per cent (374 out of 449) of incidents the department notified to Comcare in 2013-14, including deaths, involved detainees and transferees in IDF and OPGs, and did not directly involve workers’ (emphasis added).

The DIBP Annual Report 2014-2015 cites that: ‘[t]he higher number of serious injury/illness incidents reported to Comcare in 2014–15, compared with 2013–14, is in part due to the introduction in July 2014 of the requirement to report incidents involving the transport of a person to hospital by ambulance, irrespective of the nature of the injury or illness, based on advice from Comcare. Comcare has withdrawn this recommendation.

A total of 86 per cent, or 572, of all incidents, including deaths, related to workers as well as contractors’ employees, interpreters, locally engaged overseas employees, volunteers and other persons (including detainees and transferees), as opposed to departmental staff. There were no deaths relating to staff’ (emphasis added).

However, the statistics available in the DIBP Annual Reports are not broken down to ascertain:

- the identity of the person: for example, detainee/asylum seeker, worker, contractor or member of the public;
- the age of the person affected: for example, infant, child, minor;
- the gender of the person affected; or
- locations of incidents, including specific statistics in relation to office environments, immigration detention facilities and regional processing centres.

These statistics also do not identify:

- sexual misconduct;
- bullying in the workplace; and
- incidents where psychological injury is foreseeable or likely.

Furthermore, there appears to be inconsistencies between the statistics cited in the DIBP Annual Reports and those that the ALA has formulated as a result of information obtained under the FOI Act.

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98 Ibid, at 280.
99 Ibid, at 280.
Table 3 – Differences between statistics in DIBP Annual Reports and information released under the FOI Act

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Death</td>
<td>11</td>
<td>Only two of these deaths were assessed as notifiable. 101</td>
<td>9</td>
<td>FOI revealed nine deaths. Only two of these deaths were assessed as notifiable. 102</td>
</tr>
<tr>
<td>Serious injury/illness</td>
<td>338</td>
<td>Only 51 of these incidents were assessed as notifiable. 103</td>
<td>586</td>
<td>Only 105 of these incidents were assessed as notifiable. 104</td>
</tr>
<tr>
<td>Dangerous incident</td>
<td>103</td>
<td>Only 45 of these incidents were assessed as notifiable. 105</td>
<td>70</td>
<td>Only 42 of these incidents were assessed as notifiable. 108</td>
</tr>
<tr>
<td>Total</td>
<td>449</td>
<td>Only 98 of these were assessed as notifiable.</td>
<td>662</td>
<td>Only 149 of these were assessed as notifiable.</td>
</tr>
</tbody>
</table>

Of the total 449, 239 (53 per cent) were assessed as not-notifiable on the grounds that the incident was assessed as not resulting from the conduct of the business or undertaking. 107

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101 DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 177, 192.
103 DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 5, 7, 9, 16, 23, 25, 26, 28, 29, 32, 35, 39, 42, 45, 59, 82, 86, 91, 92, 100, 101, 119, 125, 133, 134, 144, 163, 172, 178, 185, 186, 197, 205, 212, 221, 239, 245, 271, 310, 351, 352, 357, 359, 367, 375, 376, 403, 405, 421, 427, 441.
3.2.3 DIBP’s focus on workers in managing risks to health and safety

While the DIBP made a number of reports to Comcare regarding detainees, its approach to its duty to ensure health and safety appears to be more focussed on ‘workers’, and fails to adequately address its duty to ‘other persons’ also at the workplace, such as detainees, as per s19(2) of the WHS Act:

‘A person conducting a business or undertaking must ensure, so far as is reasonably practicable, that the health and safety of other persons is not put at risk from work carried out as part of the conduct of the business or undertaking’ (emphasis added).

In its 2014-2015 Annual Report, the DIBP describes its health and safety management arrangements:

‘Managers and supervisors play a critical role in supporting staff with injury or illness. In addition, managers have an important role in ensuring work health and safety (WHS) risks and processes are understood and implemented to ensure the wellbeing of workers’ (emphasis added).

Other arrangements described by the DIBP regarding health and safety training, health and safety committees and other measures all relate only to workers.

This omission is concerning, as in FY2013-2014, the DIBP acknowledged that of the 449 incidents that the DIBP notified to Comcare, 83 per cent (374 out of 449) involved detainees and transfeerees in IDF s and OPCs, and did not directly involve workers (emphasis added).

The measures undertaken by the DIBP to address health and safety of workers therefore are unlikely to be sufficient to fulfil its duty of care as a PCBU to ensure that the health and safety of other persons, such as detainees.

Measures described in the DIBP’s Annual Report 2014-2015 to mitigate health and safety risks are focussed exclusively on workers. Health and safety representatives, for example, only represent workers, not other persons. Likewise, only staff are required to complete health and safety training on an annual basis, even though the training is considered essential. Health and safety committees, which are convened quarterly by the DIBP to go through key work health and safety issues, are only required to consult with workers, even though detainees as ‘other persons’ are substantially affected by work health and safety in immigration detention.

Given the high incidence of work health and safety notifications regarding detainees, the DIBP may consider it appropriate to provide training to detainees and other persons using detention facilities, to ensure all obligations under s19(2) of the WHS Act are met.

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111 Ibid.

112 Ibid.
3.3 Some of the inadequacies revealed

Comcare has power to investigate incidents and to conduct regulatory and proactive inspections, including of immigration detention facilities and RPCs.

The ALA obtained a number of Comcare Inspector Reports over FY2013-2014 and FY2014-2015. Some of these were disclosed on Comcare’s FOI Disclosure Log, and indicated that Comcare clearly identifies that the DIBP is both the PCBU and has management and control of the RPCs on both Manus and Nauru. The ALA also obtained further investigation reports under the FOI Act, which described inspections undertaken at Manus and Nauru RPCs, and also on the Australian mainland.

3.3.1 Comcare’s assessment of immigration detention facilities in Australia

The content of Comcare’s inspection and investigation reports of immigration detention facilities on Australian soil are significant for a number of reasons. We provide a brief overview below:

- Some Inspector Reports indicate confusion among DIBP staff and contractors in assessing what constitutes a notifiable incident. This has occurred in relation to apparently similar self-harm incidents. Those reported in the spike in self-harm incidents in Nauru were generally assessed as not-notifiable, while most of the self-harm incidents constituting a similar spike on Manus Island were assessed as notifiable: see 7.1.4.1 and 7.1.4.2, below.

- Some of the issues about which Comcare was contacted are basic issues which employees of DIBP should have been appropriately trained in, such as whether finding asbestos in a workplace constitutes a notifiable incident.

- Some Inspector Reports identify that inadequate information has been submitted to Comcare in the form of original incident reports, which has in some cases been inaccurate: such as in November 2014, reporting the wrong place of a fatality that occurred at Villawood and failing to provide sufficient information to the regulator.

- Some Inspector Reports identify that issues of risk to health and safety have come to Comcare’s attention via an anonymous complaint to WorkCover NSW, which was subsequently referred to Comcare. For example, this occurred on a number of occasions in relation to the Villawood detention facility. This appears to indicate that existing structures of reporting and risk management within the DIBP and its contractors does not have the requisite trust of individual employees. This apparent lack of trust or confidence is also of concern as, without such notifications, serious incidents may not be investigated by Comcare.

- Some Inspector Reports are heavily focussed on the conditions surrounding workers, and fail to address s19(2) of the WHS Act: the duty to ‘other persons’ such as detainees, within workplaces.

We provide greater detail regarding these concerns in Part 2 of this Report.

113 FOI reference number: 2014/81832, 2 December 2014, Comcare’s reports on inspections carried out on Nauru, Christmas and Manus Islands detention centres between 1/7/13-30/6-14 as described on p280 of the DIPB annual report (copy obtained on request), accessed at: http://www.comcare.gov.au/about_us/access_to_information/disclosure_log.

114 DIBP, Annual Report 2014-2015, Incidents reported to Comcare, No. 325.
3.3.2 Regional processing centres

The confusion regarding work health and safety issues evident in some Australian immigration detention facilities suggests even greater confusion surrounding work health and safety in RPCs. Given the potential for the remoteness of RPCs to exacerbate work health and safety concerns and frustrate their resolution, it would be helpful if the DIBP publicised how this challenge is being met. As Comcare Inspector Reports of RPCs tend to focus heavily on physical, occupational health and safety risks, such as would normally be associated with factory or construction worksites. They typically fail to adequately address the risks posed in a detention environment to psychological health.

In some cases, Comcare has visited RPCs to conduct an inspection, but no formal opportunity has been provided to meet transferees – who are the ‘other persons’ attracting duties under s19(2) of the WHS Act – who might want to raise concerns regarding perceived risks to their physical and psychological health and safety. At times, Comcare has identified key issues of risk, but it is unclear whether recommendations have been adequately addressed and implemented by the DIBP, or communicated to its contractors.

For example, a Comcare Inspector identified risks posed to security via inadequate security fencing at the Manus RPC in December 2013. The DIBP had in fact been aware of fencing problems since June 2013 after being notified by G4S. The Comcare Inspector recommended that construction be expedited. During the incident from 16 to 18 February 2014, described by the DIBP variously as a major, serious or violent disturbance, members of the public entered the RPC. At least 70 people were injured during this incident.

Inadequate fencing was identified in the Manus Inquiry as one of the contributing factors to the unrest. Further elaboration on this issue is provided later in this Report.

It is important to ensure that, where recommendations have been made to enhance workplace health and safety, there is a mechanism for monitoring their implementation. If a health and safety incident occurs as a result of a failure to implement a recommendation, that fact should be recognised and dealt with accordingly.

There are obligations under the WHS Act to consider risks both to physical and psychological health: see definition of ‘health’ under s4 and the inclusion of psychological hazards in s5. However, Comcare Inspectors’ inspections of RPCs do not appear to have identified:

- risks posed to the physical and psychological health and safety of detainees, including the risk of ethnic tension, assault, harassment and intimidation, sexual harassment, sexual assault, psychological injury, or public health considerations including disease control;


118 Ibid, at 146 [8.8].
• risks to physical and psychological health and safety of workers posed by knowledge of and exposure to any of the misconduct among contractors alleged by the Moss Review and Nauru Inquiry; or

• risks to the physical and psychological health and safety of children of long-term detention and the potential damage this may have on their psychological development.

Comcare is uniquely empowered to identify these risks, and impose improvement notices or penalties.

The Open Letter to the Australian People noted that the DIBP was aware of assaults against children in November 2013 (see 6.4.1 for more detail on this Open Letter). Why these issues were not investigated by Comcare over such an extended period of time is unclear.

A Comcare Inspector Report dated 27 October 2014 is another pertinent example. Philip Moss was in attendance at the RPC at the same time to conduct his independent review into the allegations of abuse at the Nauru RPC. While the Comcare Inspector noted that ‘this review was initiated by DIBP and is not related to work health and safety’ (emphasis added), the Moss Review revealed numerous risks to individuals’ physical and psychological health and safety, including vulnerable groups such as single adult females and children.

An overview of the findings of some of the Comcare Inspector reports regarding Manus Island and Nauru RPCs can be found below.

3.4 Comcare inspections at Manus Island RPC

Below are summaries of a number of enquiries made and inspections undertaken by Comcare Inspectors of the Manus Island RPC. More detail about some of these incidents can be found in Part 2 of this Report.

3.4.1 July 2013 – Inquiry regarding the responsibility for contractors

In July 2013, months after re-establishment of the Manus Island RPC, and months after the first transfer of asylum seekers in November 2012, Aurecon Engineering contacted Comcare to enquire about jurisdiction and contractor responsibility for overseas projects.

The enquiry was in relation to the building of an RPC at Manus Island (most likely the centre at East Lorengau), funded by the Australian government, built by Decmil Global Constructions and administrated by Aurecon.

Comcare held that ‘the building of the RPC has been contracted out for construction by the Department of Immigration and Citizenship (DIAC) to Decmil Global Constructions, therefore DIAC are responsible for providing a safe work environment for all contractors at the worksite’ (emphasis added).

On the Comcare Inspector Report, the legal name and address of the person conducting the business or undertaking (PCBU), was listed as the Department of Immigration and Citizenship.121

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120 Ibid, at 1.
121 Ibid.
Further, the Comcare Inspector, Greg Zadro, noted that:

‘On 26 August 2013…

I advised [redacted] that for the purposes of the Work Health and Safety Act 2011 both Decmil and Aurecon are considered to be workers of DIAC and as such the responsibility for providing a safe workplace lies with DIAC.

I also advised [redacted] the responsibility for notification of any incidents that may occur, lies with DIAC, however, I recommend that they may want to consider notifying their own state based regulator.

I discussed the project [redacted] and advised [redacted] that Comcare was well aware of the intended construction of a new RPC on Manus Island and we are currently in discussions with DIAC to visit Manus Island and inspect the project.’122 (emphasis added)

3.4.2 December 2013 - Liaison inspection at Manus Island RPC

Between 2 and 5 December 2013, Comcare Inspector, Greg Zadro, travelled to Manus Island ‘to conduct a liaison inspection of the Department of Immigration and Border Protection Manus Island Regional Processing Centre’.123 This site visit was later referred to in the inquiry into the incident at Manus Island, considering information that was available to the DIBP prior to the incidents of February 2014.124

Over the course of Mr Zadro’s visit, meetings were conducted with the key stakeholders involved in the daily running of the centre. At the time, the key stakeholders were: DIBP, G4S; The Salvation Army and IHMS. Discussions were undertaken to determine the role, deployment rotation and type of activity carried out by each stakeholder.125 The Inspector Report does not record any meetings with transferees.

Inspector Zadro noted that ‘DIBP provide management and co-ordination of the delivery of services by contracted stakeholders at [the] centre’.126 The legal name and address of the PCBU cited in the report was the DIBP’s address in Belconnen, ACT.127

Observations

During the inspection, Inspector Zadro noted that the number of people detained had risen from 400 in July 2013 to 1,137 in December 2013.128 He also noted that the existing RPC was undergoing expansion to better accommodate this increase in numbers and provide for the expected arrival of further numbers of detainees.129 He raised issues of particular concern, including inadequate security and kitchen facilities.130 The absence of any emergency ambulance or fire services on Manus Island, the strain that the IHMS and RPC workers appeared to be under, were also an issue of concern.131

122 Ibid.
123 Ibid.
126 Ibid, at 1.
128 Ibid.
129 Ibid, at 3.
130 Ibid, at 3, 4.
131 Ibid, at 4.
Inadequate security

Regarding security, Inspector Zadro also noted that ‘risks to workers from inadequate security do not seem to be managed effectively:

- In the area leading to the kitchens it is possible to easily bypass security checkpoints as there is currently no security fencing in place. This situation is known to DIBP staff and the security contractor G4S. A plan is in place to improve access security but it is understood rectification work is tied in with the removal of old kitchen and ground contamination remediation and as such may take some time.
- Security at the main access to the [Manus Island RPC] seems ineffective; it was observed on a number of occasions that it is possible to enter/exit the facility without receiving a bag inspection or being monitored; for example even for signing in/out. Apart from risks from such open access by anyone, this situation can greatly reduce the ability to quickly and accurately account for workers in the event of a critical incident.¹³² (emphasis added)

At the Manus Inquiry, G4S submitted that it had requested improved fencing and security fencing from as early as June 2013 and continued until 6 February 2014.¹³³

It is unclear whether these security risks were adequately addressed over the next three months, before the incident that occurred at Manus Island between 16 and 18 February 2014, during which Mr Reza Barati sustained injuries that caused his death: see 3.4.3 and 5.1.2, below, for detail.

Table 4 – Requests made for further security fencing/lighting by G4S to the DIBP

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 June 2013</td>
<td>Revised Risk Assessment submitted by G4S requesting improved fencing and security lighting.¹³⁴</td>
<td>Informed verbally by the DIBP that the request is denied.</td>
</tr>
<tr>
<td>13 October 2013</td>
<td>Further formal proposal for improved security lighting and fencing submitted to the DIBP by G4S,¹³⁵</td>
<td>No response received from the DIBP.</td>
</tr>
<tr>
<td>15 December 2013</td>
<td>Further formal proposal for improved security lighting and fencing submitted to the DIBP by G4S,¹³⁶</td>
<td>No action taken by the DIBP.</td>
</tr>
<tr>
<td>2 January 2014</td>
<td>Further Security Risk Assessment advocated more robust fencing, installation of CCTV and improved security lighting by G4S,¹³⁷</td>
<td>No action taken by the DIBP.</td>
</tr>
<tr>
<td>4, 6 and 7 February 2014</td>
<td>Letters sent by G4S to Immigration Minister and the DIBP Secretary summarising concerns over security and lack of action by the DIBP,¹³⁸</td>
<td>Unknown.</td>
</tr>
</tbody>
</table>

¹³² Ibid.
¹³⁴ Ibid, at 3.
¹³⁵ Ibid.
¹³⁶ Ibid.
¹³⁷ Ibid.
¹³⁸ Ibid.
**IHMS under strain**

The Inspector also noted that the capability of IHMS to ‘provide health services to the facility as they are contracted to do seems to be under strain; it is understood this results from the increase in transferee numbers recently without a proportionate increase in medical services provision capability. For example:

- **Current ability to manage a critical injury event is limited due to the size of the single emergency medical procedures room. In the event of a mass casualty incident, this single room is probably inadequate.** Moreover, local medical services seem to be substandard.
- Emergency planning seems to include a reliance on instigating medical evacuation to Port Moresby being the closest place with better medical services provision capability than Manus Island. Meanwhile, Cairns is assessed to be the closest location with the most reliable and effective medical services provision capability.
- **Appropriate storage of pharmaceuticals is restricted due to the small number of refrigerators available for this task** on-site.
- Work is underway to expand IHMS capability including providing extra pharmaceuticals storage equipment (emphasis added).\(^{139}\)

At the inquiry into the incident at Manus Island, IHMS provided answers to questions on notice. According to those answers, IHMS had not been made aware of the findings of the Comcare Inspector’s report. They noted that they were in constant discussions with the DIBP regarding enhancement of services at the RPCs, although they were not aware of any direct link between those discussions and the Comcare Inspector’s findings.\(^{140}\)

It is relevant to ask as to whether the above issues, especially in relation to availability of pharmaceuticals, were resolved prior to the treatment of Mr Hamid Khazaei by IHMS in August and September 2014. Mr Khazaei’s experiences and tragic death are discussed in greater detail in 5.2, below.

**Recommendations**

Inspector Zadro noted that:

> ‘Based on the information gathered and the observations noted below, I am of the view that there are a number of reasonably practicable steps available to DIBP, who are in control of the workplace, to protect the health and safety of their workers, contractors and the transferees in their care in relation to the daily activities involved in the operation of the Manus RPC’\(^{141}\) (emphasis added).

He made a number of recommendations to eliminate health and safety risks to workers and third parties, including constructing security fencing and improving security capabilities.\(^{142}\)

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3.4.3 February 2014 – Death of Reza Barati

From 16 to 18 February 2014, there were a number of violent protests involving transferees at the Manus Island RPC. Many detainees sustained injuries, some very serious. 23-year-old Iranian national, Mr Reza Barati, suffered a head injury so severe that he died during the early hours of 18 February 2014.

The DIBP notified Comcare of Mr Barati’s death on 18 February 2014.143

In his report, *Review into the events of 16 - 18 February 2014 at the Manus Regional Processing Centre*, (*The Cornall Review*), Robert Cornall AO identified increasing tensions, frustration and anxiety among transferees regarding their detention in Papua New Guinea, uncertainty about their future and anger that they would not be resettled in Australia as ‘contributing factors’ to the incidents from 16 – 18 February 2014. This report appears to be at odds with the Comcare report, casting doubt over the accuracy of this, and possibly other, Comcare investigations.

Robert Cornall AO noted that there were underlying factors that contributed to the loss of control during the incidents from 16 – 18 February 2014:

‘The physical security arrangements at the Centre (inadequate fencing, inadequate lighting and no CCTV) were not up to the requirements for managing a large number of non-compliant transferees, and

A lack of clarity in the roles and responsibilities of the provincial Royal Papua New Guinea Constabulary based at Lorengau and the mobile squad stationed at the Manus RPC and the coordination of their actions with G4S.’144

The Cornall Review also noted that the Australian government undertook changes in March 2014, and ‘consolidated accountability for and management of key garrison, security and welfare services under a single, integrated provider, Transfield Services, for both Manus and Nauru RPCs’.145

Inspector Jason Briggs undertook a compliance inspection for Comcare. His report was signed on 26 June 2014, subsequent to the finalisation of the Cornell Review. Prior to requesting information, Inspector Briggs reviewed information obtained by Inspector Greg Zadro during his visit to Manus Island RPC in December 2013.146

Inspector Briggs made the following observations:

1. ‘DIBP’s position is that the WHS Act applies in full in the context of the [Manus Island RPC] and that [Manus Island RPC] satisfies the definition of ‘workplace’ for the purposes of the WHS Act.

2. The contract for services between DIBP and G4S contained numerous clauses relating to safety, emergency and contingency plans and systems. The evidence supports the existence and implementation of these plans.

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143 DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No.192.
145 Ibid, at 11.
3. **No DIBP workers were injured** during the protests, most likely due to effective implementation of the Emergency Management Plan.

4. There was a large percentage of Papua New Guinea (PNG) workers engaged in [Manus Island RPC]. This was a requirement of the contract for services.

5. DIBP appeared to have done what is reasonably practicable to provide a safe workplace at [Manus Island RPC]. **DIBP exhibited no control** over the events that transpired between 16-18 February that led to the death of Mr Barati.\(^{147}\) (emphasis added)

Inspector Briggs recommended that:

1. ‘Consideration is given to implementing the recommendations from the Cornall Review, particularly recommendations 5, 6, 7, 8, 9, 11 and 13 which all have a direct or indirect relationship with workplace safety.

2. The same consideration is given to adapting recommendations 1, 3, 4, 7 and 10 from the Nauru Review 2013 as they apply to [Manus Island RPC].

3. Comcare inspectors undertake a further site visit to [Manus Island RPC] prior to the end of 2014.\(^{148}\)

The compliance inspection concluded that:

‘After a thorough review of available evidence, Inspector Briggs **did not identify any breaches of the Work, Health and Safety Act 2011 (the WHS Act) by DIBP**. On the evidence reviewed, it **appears DIBP provided a safe workplace as far as reasonably practicable**. It is apparent that the injuries and death that occurred were the direct result of criminal actions, not as a result of inadequate WHS practices, processes or systems.’\(^{149}\) (emphasis added)

The Cornall Review recommendations suggest that the conduct of the business or undertaking was at least an underlying factor in the events of 16-18 February. The Comcare investigation, however, found that the DIBP had done “provided a safe workplace as far as reasonably practicable”.\(^{150}\) That assessment is at odds with the more contemporaneous Cornall Review and the actions of the DIBP itself, which changed its processes following the events. This comparison sheds doubt on the veracity this, and possibly other, Comcare investigations.

### 3.4.4 30 September and 1 October 2014 – Proactive inspection at Manus Island RPC

On 30 September and 1 October 2014, a Comcare Inspector (name redacted) carried out an inspection of the Manus Island RPC, hosted by the DIBP and involving meetings with key stakeholders, Transfield and IHMS. The visit included a full tour of the centre under escort by Wilson Security,\(^{151}\) but did not appear to include meetings with transferees at which risks to their physical and psychological health and safety could be raised.

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\(^{147}\) *Ibid*, at 2.

\(^{148}\) *Ibid*, at 3.

\(^{149}\) *Ibid*, at 1.

\(^{150}\) *Ibid*.

The Inspector held that: ‘as a result of my discussions and observations I am satisfied that DIBP are ensuring as far as reasonably practicable the health and safety of workers at the Manus Island RPC. There is no evidence of any non-compliance with s19 of the WHS Act’ (emphasis added). The Inspector did make a number of recommendations including improving transport around Manus Island for injured persons, streamlining the medivac approval process to ensure prompt access to medical care for injured parties, additional defibrillators be made available and mental health support for staff be continued.\(^{153}\)

However, the question of whether the DIBP was ensuring as far as reasonably practicable the health and safety of ‘other persons’, such as detainees, as required by s19(2) of the WHS Act, was not addressed.

### 3.5 Comcare inspections at Nauru RPC

A number of inspections have been undertaken by Comcare inspectors of the Nauru RPC. More detail about some of these incidents can be found in Part 2 of this Report.

Many of the inspection reports reveal the inspectors’ apparent lack of understanding regarding threats to health and safety in immigration detention facilities. Comparisons with evidence before the Nauru Inquiry and the Moss Review indicate threats to health and safety appear much more extensive than those disclosed in the inspector reports. These comparisons may also suggest gaps in legislative health and safety protections.

#### 3.5.1 February 2014 – Electric shock

Following notification by DIBP, Comcare commenced a liaison inspection into an incident occurring at the Nauru RPC where a contractor received an electric shock plugging in a phone charger, and was treated as an in-patient.\(^{154}\)

The Nauru RPC\(^3\) was listed as the actual site address of attendance or workplace(s) involved in the intervention activity. The legal name and address of the PCBU was listed as the DIBP’s ACT address in Belconnen.

The liaison inspection activity commenced by email on 5 February 2014, and a site visit and discussions were conducted by Inspector Greg Zadro on 11 February 2014.\(^{155}\) Allegations that the charger was ‘blu-tac’ed together were not substantiated. Following an inspection by an electrician, it became evident that the charger in question appeared to have faulted from simple wear and tear.\(^{156}\)

The recommendations issued following this inspection focussed on protecting workers:

- That DIBP ensures that all workers are provided with information reminding them of the hazards and risks of electrical equipment and the need for physical inspection each time an item is used;
- The DIBP review the procedure for testing and tagging to ensure it is appropriate for the environment in which the equipment is used.\(^{157}\)

\(^{152}\) Ibid.

\(^{153}\) Ibid.

\(^{154}\) DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 144.


\(^{156}\) Ibid, at 2.

\(^{157}\) Ibid, at 1.
3.5.2 February 2014 – Fire at Anibare Lodge

Comcare commenced a liaison inspection activity into an incident on Nauru on 30 January 2014, when a fire broke out in Anibare Lodge and workers inhaled powder from fire extinguishers. Anibare Lodge comprises 41 accommodation units for tourists and expats living in Nauru.

In May 2014, refugees would be settled at Anibare Lodge.

The liaison inspection commenced by email on 5 February 2014, with the liaison inspection conducted from 10 – 14 February 2014. A site inspection of the damaged room was conducted on 13 February 2014 by Inspector Zadro. The actual site address of attendance or workplace(s) involved in intervention activity were named as both the Nauru RPC (RPC1) and Anibare Lodge. Inspector Zadro reviewed the information provided by the DIBP regarding the incident and was satisfied that the DIBP has systems in place regarding contractor management.

Recommendations

Inspector Zadro made two recommendations for the consideration of the DIBP, focusing on providers of contracted services:

- That the DIBP ensures the corrective actions as outlined in the information provided to Comcare are completed.
- That the DIBP ensures all local providers of contracted services are offered the information, and if appropriate and required the education and training, on how to meet their Work, Health and Safety (WHS) requirements to the standard outlined in the contractual agreement.

The fact that Anibare Lodge is outside the RPC appears to indicate that Comcare assumes that it has the power to investigate any place in Nauru in which workers are housed.

Under s19(4) of the WHS Act, if a worker lives in accommodation owned or managed by the PCBU, the PCBU retains obligations to ensure that it meets health and safety standards. It would appear, however, that the same protection is not afforded to ‘other persons’ living in accommodation owned or managed by the PCBU. See 6.4.5 for more detail of our concerns in this regard.

The ALA believes that the PCBU should retain liability in circumstances where asylum seekers or refugees are being housed in accommodation as a result of decisions made by the DIBP. We therefore recommend that the legislation be amended so that the PCBU has obligations in relation to all places where workers or other persons are accommodated as a result of the conduct of the business or undertaking.

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158 DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 145.
162 Ibid, at 1.
163 Ibid, at 1.
3.5.3 February 2014 – Liaison inspection

On 9 February 2014, Inspector Greg Zadro travelled to Nauru to conduct a liaison inspection of the three Nauru RPCs managed by the DIBP. During the period of 10 – 13 February 2014, Inspector Zadro carried out site familiarisation, inspections and meetings with the management of key stakeholders.\(^{164}\) The key stakeholders at the time of the visit were the DIBP, Transfield Services, Wilsons Security, the Salvation Army, Save the Children Australia (‘SCA’) and IHMS. Discussions were undertaken to further understand the role and type of activity carried out by each stakeholder, along with deployment rotation, levels of training and standards of service provided.\(^{165}\) The Report noted that the DIBP provides management and coordination of the delivery of services by contracted stakeholders at the three centres.

The Inspector report did not identify any significant work health and safety issues,\(^ {166}\) despite evidence to the Nauru Inquiry suggesting that the DIBP had been aware of assaults against children occurring months earlier, in November 2013. Evidence that came to light in the Moss Review, including concerns raised by the DIBP itself, also make the findings of the Inspector Report surprising.

3.5.4 October 2014 – Proactive inspection

Between 27 and 29 October 2014, a Comcare inspector (name redacted) attended the Nauru RPC to undertake a proactive inspection. The visit was hosted by the DIBP and meetings were facilitated with key stakeholders: Transfield, IHMS, SCA, Australia, PsyCorp, Canstruct and Eigigu Holdings Corporation.

The Comcare inspection coincided with that of the Moss Review inspectors, who were ‘undertaking an independent review into recent allegations relating to conditions and circumstances at the RPC’.\(^ {167}\)

The Comcare inspector noted that ‘this review was initiated by DIBP and is not related to work health and safety’ (emphasis added).\(^ {168}\) Given the significant health and safety focus of the Moss Review, such as allegations of sexual misconduct, including rape, sexual abuse in the form of the trading of cigarettes and marijuana for sexual favours, and concerns expressed by detainees regarding their personal safety,\(^ {169}\) this conclusion is surprising, and illustrates the narrow view of health and safety being employed by Comcare workers.

**Outcome**

The Comcare inspector was ‘satisfied that DIBP are ensuring, as far as reasonably practicable, the health and safety of workers at Nauru RPC. There is no evidence of any non-compliance with s19 of the WHS Act.’\(^ {170}\)

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\(^{164}\) Ibid, at 1, 3.

\(^{165}\) Ibid, at 1.

\(^{166}\) Ibid, at 3.

\(^{167}\) Ibid, at 3.

\(^{168}\) Ibid, at 3.


Of the 12 recommendations made, nine related exclusively to worker health and safety. Those that might have related to detainees include providing ‘staff and stakeholders’ with information regarding the health impacts of ‘being geographically located near phosphate mining activity’ and ‘the impact of sun exposure of the quality of bottled water’.\(^{171}\)

With the primary findings focusing on workers, it appears that this inspection failed to appropriately assess duties under s19(2) of the WHS Act to detainees. This conclusion is supported by the findings of the Moss Review and the significant workplace health and safety concerns detailed in that report.

3.5.5 May 2015 – Self-harm of transferee

On 25 May 2015, Inspector Greg Zadro commenced a liaison inspection by email to enquire into or investigate a reported incident. Documentation regarding the DIBP internal investigation and any corrective actions associated with the investigation were requested and provided to Comcare on 9 June 2015.\(^{172}\)

On 3 May 2015, a transferee who had been on high watch after a previous incident had run away from staff and climbed on top of a marquee. The transferee secured a rope to a tent pole and placed it around his neck; he then jumped from the roof of the tent.

The incident had been described in the brief description previously released under freedom of information laws simply as ‘transferee attempted self-harm – no injury – Nauru’.\(^{173}\)

The Inspector report is heavily redacted.

However, Inspector Zadro was satisfied that the DIBP was undertaking appropriate actions at this time and that there was no evidence of any non-compliance with s19 of the WHS Act.

Inspector Zadro recommended that the DIBP ensure that the intended review and update of the [redacted] Risk Assessment regarding [redacted] is undertaken as indicated in the information provided to Comcare.\(^{174}\)

3.6 The need to ratify OPCAT and cooperate with UN experts

The deficiencies in the monitoring of immigration detention facilities flow from the very narrow definition of work, health and safety applied. The ALA believes that it would be appropriate for the Australian government to formally ratify the Optional Protocol to the Convention against Torture and Cruel, Inhuman and Degrading Treatment or Punishment (OPCAT), which was signed by Australia

\(^{171}\) Ibid, at 1.

\(^{172}\) Ibid, at 1, 2.

\(^{173}\) DIBP, Annual Report 2014-2015, Incidents reported to Comcare, No. 577.

in 2009. Implementation of the OPCAT is monitored by the Subcommittee on the Prevention of Torture (SPT), which provides guidance to states parties. The OPCAT requires the establishment of an independent National Prevention Mechanism (NPM), to review treatment of detained persons with a view to strengthening protections against torture and cruel, inhuman or degrading treatment or punishment. Strengthening protections can be achieved by the NPM or members of the SPT visiting places of detention and having confidential meetings with detained persons and anyone else who might have relevant information. Recommendations can be made to government to improve protections, and can also review and submit views on draft legislation.\(^{175}\)

The UN Special Rapporteur on torture has found that Australia’s immigration detention system violates the rights of detainees to be free from torture and other cruel, inhuman or degrading treatment or punishment. In particular, failure to provide adequate detention conditions, detention of children, escalating tension and violence at the Manus Island RPC, failure to adequately investigate acts of intimidation and ill treatment against individuals who provided statements following the events in February 2014 at the Manus Island RPC (when Reza Barati was murdered) and the passage of legislation that puts Australia at risk of violating the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), were identified as putting individuals at risk of torture and other cruel, inhuman or degrading treatment or punishment.\(^{176}\)

A risk of torture and other cruel, inhuman or degrading treatment or punishment is inherent in Australia’s detention network. Many of these risks relate to workplace health and safety issues identified in this Report, particularly in relation to psychological health. Ratifying the OPCAT and establishing an independent NPM would be positive steps towards improving workplace safety across the Australian immigration detention network. They would also provide useful guidance as to how to ensure that both physical and psychological health are adequately protected under existing workplace health and safety law.

A number of UN thematic human rights Special Rapporteurs have requested visits to Australia. Visits by the Special Rapporteurs on human rights defenders, racism, and violence against women are all scheduled to take place in the upcoming 12 months. A visit by the Special Rapporteur on migrants was cancelled in late 2015, “due to the lack of full cooperation from the Government regarding protection concerns and access to detention centres”. In particular he cited concerns regarding the implementation of the Border Force Act 2015 (Cth).\(^{177}\) The Special Rapporteur on torture has also requested a visit although this does not appear to be scheduled at the time of publication.\(^{178}\)

\(^{175}\) Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, Part IV.


In terms of RPCs, Australia should encourage full and open engagement of Nauru with the SPT. In the case of Papua New Guinea, ratification of or accession to the CAT and the OPCAT should also be encouraged.

Nauru acceded to the OPCAT in 2013 and the SPT conducted an advisory visit there in May 2015. During this visit, the Subcommittee visited the RPC. At the time of writing, the report for the visit had not been published. The ALA encourages Nauru to permit the publication of this Report in the interests of transparency.

3.7 Recommendations

The ALA recommends that the federal government:

- amend s19(4) of the WHS Act to ensure that accommodation for other persons receives the same level of workplace health and safety protections as accommodation for workers.
- ratify the OPCAT and create an independent NPM as a matter of priority.
- engage with all UN Special Rapporteurs, facilitate requested visits and implement their recommendations in a spirit of openness and good faith.
- encourage Papua New Guinea to ratify or accede to the CAT and the OPCAT.
- encourage Nauru to permit the publication of the report by the SPT detailing its visit to the RPC.

The ALA recommends that the DIBP:

- ensure that all workplace health and safety recommendations from Comcare are implemented as soon as reasonably practicable. Once recommendations are implemented, incident reports should be updated detailing how the recommendations were complied with to ensure implementation is monitored.
- ensure that all workplace health and safety recommendations from other inquiries are implemented.
- provide work health and safety training to detainees in a format that they understand, to ensure they are best equipped to protect their own health. This training should be designed to minimise the most common risks to psychological and physical health faced by detainees.

The ALA recommends that Comcare:

- conduct a comprehensive investigation of all immigration detention facilities both within Australia and offshore to assess compliance with recommendations made in 2011 and all other recommendations made by Comcare in investigating incidents reported to it under the WHS Act;
- continue to monitor media reports of workplace health and safety incidents and compare these to incidents reported by the DIBP. If there is a media report of an incident that has not been reported to it, Comcare should submit a query to the DIBP as to why the incident has not been reported.

179 Statement by Mr Malcolm Evans, Chairperson Subcommittee on Prevention of Torture and other Cruel, Inhuman or Degrading Treatment or Punishment at the 70th session of the UN General Assembly, New York, 20 October 2015, accessed at: http://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=16717&LangID=E.
• develop clear guidelines regarding incidents that Comcare must be notified of under s38(1), including when an incident arises from the conduct of the business or undertaking. These guidelines should apply a broad interpretation of the phrase to ensure that the objects of the WHS Act are fulfilled.
• once the OPCAT is ratified and an independent NPM is established, work with the NPM and the SPT to ensure workplace health and safety are protected to the maximum extent possible.
Chapter 4 – The DIBP

Overview

The DIBP is clearly the PCBU under the WHS Act, as it has acknowledged. The DIBP’s ability to meet its obligations under that Act is also influenced by its contractual relationships with other service providers. Any failure to appropriately report notifiable incidents to Comcare as required by the WHS Act must raise concerns regarding the reporting arrangements with the DIBP and its contractors in immigration detention centres and RPCs.

Many of the incidents reported to the Nauru Inquiry, the Manus Inquiry and the Moss Review, were identified by staffers who filed formal incident reports with the DIBP. That information was not always shared with Comcare.

It is clear that there are broken links in the chain of reporting, and that further inquiry into the parties responsible is required.

4.1 The DIBP’s arrangements with contractors regarding notification

The WHS Act provides that a PCBU must ensure that the regulator is notified immediately after becoming aware of a notifiable incident.

It appears that Transfield (and therefore also Transfield’s contractor, Wilson Security) and SCA must report notifiable incidents to the DIBP. While the contract between the DIBP and IHMS permits IHMS to report independently to Comcare or the appropriate regulator, Comcare does not appear to have any record of IHMS reporting directly to Comcare, according to documents released to the ALA under an FOI Act request. This suggests that the DIBP has assumed responsibility for the reporting of all notifiable incidents to Comcare.

The DIBP acknowledges that:

*Service providers are contractually bound to report incidents to the Operational Managers and Department in accordance with incident management and reporting guidelines. The guidelines have been in place since the commencement of operations at the Nauru Regional Processing Centre.*

At the Nauru Inquiry, the DIBP acknowledged that it must comply with, and ensure that all subcontractors comply with, WHS law. This reflects the WHS Act s272 (no contracting out) which prohibits PCBUs from entering contracts that would limit their obligations under the WHS Act. In particular, the DIBP acknowledged that:

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The Service Provider must at all times:

- not permit any act or omission that causes or may cause the Department to be in breach of the WHS Law;
- immediately notify the Department of any notifiable incident as defined in the WHS Law; and
- immediately notify the Department of any circumstance which may give rise to a work health and safety risk or a failure by the Service Provider, its subcontractors or the Department to comply with WHS Law''

The DIBP clearly understands and acknowledges its obligation to report any threats to health and safety directly to Comcare under the WHS Act. Contracts with contractors require that they report any notifiable incidents to the DIBP. As will be shown in the investigation below, however, contractors have been inconsistent in their reporting to the DIBP, the DIBP has been inconsistent in its reporting to Comcare and Comcare has also been inconsistent in its assessment of whether incidents are notifiable under the Act.

4.1.1 Transfield Services and Wilson Security

In FY 2013-2014, the contract between the Commonwealth and Transfield Services was worth $259,182,780. In October 2015, Transfield Services changed its name to Broadspectrum. The contract between the DIBP and Transfield requires that Transfield Services must:

- ‘immediately notify the Department of any notifiable incident as defined in the WHS Law’

Therefore, all notifiable incidents known to Transfield should be reported to the DIBP by Transfield. Any obligations of Transfield should extend to the operations of Wilson Security, which provides services at the RPCs as a subcontractor of Transfield.

Transfield does not appear to have reported health and safety incidents directly to Comcare itself. The ALA applied under the FOI Act for any incidents reported to Comcare by Transfield in FY2013-2014 to FY2014-2015, but the request was refused under s24A of the FOI Act:

- ‘as documents do not exist’.

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182 Ibid.
185 Contract in relation to the provision of garrison and welfare services at regional processing countries, Commonwealth of Australia represented by the Department of Immigration and Border Protection and Transfield Services (Australia) Pty Ltd, page 28 at c17.3.1 (a), (f), (g).
186 Comcare, correspondence to the Australian Lawyers Alliance, 13 January 2016.
4.1.2 Save the Children

The contract between SCA and DIBP was worth $6,142,596 in FY2013-2014.187

The contract between SCA and DIBP appears to indicate that SCA must immediately notify the DIBP directly of notifiable incidents, rather than the regulator.188

Evidence to the Nauru Inquiry indicated that SCA reported regularly to the DIBP regarding issues at the Nauru RPC. Viktoria Vibhakar, former worker with SCA, submitted that:

‘Many of these allegations [of sexual assault, exploitation and harassment of women and children in the Nauru RPC] were written in incident reports at the time of their alleged occurrence.

Every incident report is forwarded to DIBP staff at the Nauru detention facility. These are then sent to DIBP in Canberra where they are also reviewed. In addition, several of the child protection concerns have been documented in weekly Vulnerable Minor Meetings (VMM). I was informed by SCA management that the minutes of these meetings are forwarded weekly to DIBP Canberra. In addition to this, several of these incidents are also discussed in daily and weekly multi-Commonwealth contractor meetings where the DIBP Detention Manager is in attendance. The minutes of these meetings are also routinely forwarded to DIBP in Canberra.’189

This evidence suggests that the DIBP was well-informed of issues relevant to SCA’s work at the RPC through these regular reporting mechanisms.

The ALA applied under the FOI Act for the release of all incidents reported to Comcare by SCA over the past two years. We found that one incident had been reported by SCA: a complaint of uneven floor causing back injuries. The incident had been reported by SCA, but was reported by DIBP to Comcare.190 None of the allegations of sexual assault, exploitation and harassment referred to above appear to have been reported to Comcare by either SCA or the DIBP, despite a clear allegation that SCA made the DIBP aware of such incidents regularly.


190 Information obtained by the Australian Lawyers Alliance: FOI request 2015/12230 - Relevant to FY2013-2014 and FY2014-2015, all incidents reported by Save the Children, The Salvation Army and Any Individuals, and all incidents reported to Comcare by any party and that relate to Nauru, at 1.
4.1.3 IHMS

The contract between the Commonwealth and IHMS was worth $20,922,459 in FY2013-2014.191 This contract is for all of IHMS’s services to the DIBP, including detention centres on Australian soil. IHMS has been contracted to provide healthcare services to people in immigration detention since January 2009.192

It appears that the contract between IHMS and the DIBP contains provisions that are unique in comparison with the contracts of other service providers on Nauru.

Like other contractors, IHMS must ensure that the DIBP is notified immediately after a notifiable incident occurs. However, IHMS must also promptly notify the DIBP of each occasion that IHMS reports to or notifies a regulatory authority, which would include Comcare and state-based regulators.193

The ALA applied under the FOI Act, seeking the release of all incidents reported to Comcare by IHMS in FY2013-2014 and FY2014-2015.

Our request was refused under s24A of the FOI Act:

‘as documents do not exist’.194

This suggests that IHMS did not report any incidents of serious injury or illness to Comcare throughout the entire Australian immigration detention network, over a two year period. Evidence to parliamentary inquiries has indicated the schedule of reporting by IHMS to DIBP.195 The ALA has no information as to whether IHMS reported to state-based regulators.

In 2015, the Guardian Australia’s investigation into the quality of healthcare services provided by IHMS in immigration detention facilities, revealed that there were significant deficiencies in reporting, in the quality of healthcare provided, and that ‘fraud was inevitable’ within IHMS’s own ranks in response to the commercial indicators enabling the DIBP to measure its medical and clinical performance.196

Following the Guardian’s investigations, the Australian National Audit Office (‘ANAO’) commenced an investigation in July 2015, focusing on the contractual measurements in place between the DIBP and IHMS.197 It is anticipated that the ANAO report will be tabled in Parliament in June 2016.

194 Comcare, Correspondence to the Australian Lawyers Alliance, 13 January 2016.
4.1.4 G4S

The contract between the Commonwealth of Australia represented by the DIBP, and G4S in relation to the provision of services on Manus Island defines ‘WHS law’ as:

‘all statutes, regulations, statutory instruments, subordinate legislation, codes of practice and standards (including those of the Commonwealth of Australia and of the location where the Services are being delivered) dealing with or relevant to health and safety in workplaces and of workers and others who may be affected by the carrying out of work and includes any approvals, permits, licences, directions or requirements of an authority exercising regulatory powers in respect of such matters.’

In keeping with other contracts in place in immigration detention facilities, G4S is required to ensure that the WHS Act and other Australian laws are respected. It must ensure that the DIBP is immediately notified of any notifiable incidents under the WHS Act or any work health and safety failure by it, its personnel, subcontractors or the DIBP itself, to ensure compliance with WHS law.

In March 2014, the contract in relation to Manus Island ceased with G4S, and Transfield took over the contract.

4.1.5 The Salvation Army

The contract between the Salvation Army and the DIBP, made in January 2013, uses the same definition of ‘WHS law’ as the G4S contract, and it is similarly obliged to notify the DIBP of notifiable incidents.

In December 2013, the Salvation Army confirmed that its contract to provide humanitarian support services to adult asylum seekers in Manus Island and Nauru Offshore Processing Centres would not be renewed on a long-term basis beyond February 2014.

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198 'Contract in relation to the provision of services on Manus island (PNG), Commonwealth of Australia represented by Department of Immigration and Citizenship, G4S Australia Pty Ltd CAN 100 104 658 ABN 64 100 104 658, made on 1 February 2013, at 5. Information provided by the Department of Immigration and Border Protection - contracts (received 30 May 2014) to the Senate Standing Committee on Legal and Constitutional Affairs, Inquiry into the incident at the Manus Island Detention Centre from 16 to 18 February 2014, accessed at: http://www.aph.gov.au/DocumentStore.ashx?id=04c9f3c5-17d0-4d99-9900-6c4a335498d2.

199 Ibid.


201 Contract in relation to the provision of services in regional processing countries, Commonwealth of Australia represented by the Department of Immigration and Citizenship, The Salvation Army (New South Wales) Property Trust (ABM 57 507 607 457). Information provided by the Department of Immigration and Border Protection - contracts (received 30 May 2014) to the Senate Standing Committee on Legal and Constitutional Affairs, Inquiry into the incident at the Manus Island Detention Centre from 16 to 18 February 2014, accessed at: http://www.aph.gov.au/DocumentStore.ashx?id=04c9f3c5-17d0-4d99-9900-6c4a335498d2.

The ALA applied under the FOI Act for the release of all incidents reported to Comcare by the Salvation Army over the past two years. It appeared that only one incident was directly reported by the Salvation Army to Comcare. On 13 February 2015, contractors cut the wire of a fire alarm in a room to allow for smoking at Manus Island. No injuries were reported.

4.2 The extent of the DIBP’s knowledge

It appears on the evidence that the DIBP is required to have extensive knowledge of the risks to health and safety that exist in immigration detention facilities and RPCs. The terms of contracts for contractors detailed above indicate that, if there is a failure on behalf of one of the contractors to inform the DIBP of a health and safety incident, the DIBP is likely to be able to take legal action against them.

These risks pose a threat to both workers and other persons such as detainees, risks to whom must be considered under s19(2) of the WHS Act.

The extent of the DIBP’s knowledge of the risks to health and safety in RPCs is evidenced by the fact that:

- Service providers are contractually required to notify the DIBP of incidents under the WHS law.
- The DIBP has arrangements in place with contractors to be regularly informed regarding work, health and safety issues and also in relation to any significant issue raised within the RPCs;
- Allegations raised by whistle-blowers to the Nauru and Manus Island parliamentary inquiries;
- The Open Letter to the Australian People, discussed below at 6.4.1;
- The high numbers of incidents reported by the DIBP to Comcare in FY2013-2014 and FY2014-2015;
- The inconsistencies between what was reported by the DIBP to Comcare and to parliamentary inquiries;

On the evidence compiled within this Report, it appears that the DIBP knew of risks to detainees’ health, including sexual misconduct, hygiene and mental health. This included being aware of the unique risks to vulnerable groups, such as children, pregnant women and their unborn children, women generally, and sexual minorities.

The evidence in this Report also suggests that the DIBP knew of risks to individuals’ safety in the form of sexual assault, harassment and violence. In Nauru, the DIBP was aware that the Nauru Police Force was not adequately equipped to manage sexual assaults. While alleged to have been aware of assaults for more than 12 months, it does not appear that the DIBP availed itself of the opportunity to report knowledge of such assaults to Comcare. While Australian standards, such as food standards, are applied in a WHS context, Australian standards in relation to child protection do not appear to have been complied with.

Under-reporting and concealment of some risks to health and safety may mean that there were additional risks to health and safety that the DIBP was not aware of. These issues are explored.

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203 Information obtained by the Australian Lawyers Alliance, FOI request 2015/12230 - Relevant to FY2013-2014 and FY2014-2015, all incidents reported by Save the Children, The Salvation Army and Any Individuals, and all incidents reported to Comcare by any party and that relate to Nauru, at 1.
in Chapter 8, below. Lack of knowledge, however, does not excuse the DIBP from its reporting requirements: s14 of the WHS Act specifies that duties are not transferrable, including the duty under s38 to report notifiable incidents to Comcare. It is incumbent on the DIBP to put systems in place that ensures it is aware of all notifiable incidents, as a function of the due diligence obligations that apply to officers of the DIBP: s27.

As the PCBU, the DIBP had a responsibility to ensure, as far as reasonably practicable, that the health and safety of workers and other persons was not put at risk from work carried out as part of the conduct of the business or undertaking.

The WHS Act requires the DIBP to have made appropriate enquiries to inform itself of the risks, and subsequently take appropriate reasonably practicable steps to minimise or eliminate them. Lack of knowledge is no excuse.

While the DIBP has asserted that its role within RPCs is a supporting role to the nations of Nauru and Papua New Guinea, and that it does not have management and control of RPCs, it is clear from the contracts in place with contractors, the MOUs and statements made by departmental officials that this is not in fact the case.
Part Two – The investigation

This Part reveals a clearer picture of incidents across the span of the Department of Immigration and Border Protection’s (DIBP’s) activities, including people working and detained in immigration detention facilities and regional processing centres. It draws on relevant information obtained by the ALA as a result of applications under the Freedom of Information Act 1982 (Cth).

Chapter 5 – Deaths

Overview

Under s35 of the WHS Act, a death of any person is a notifiable incident. Any notifiable incident arising out of the conduct of the business or undertaking must be reported to Comcare: s38 of the WHS Act.

Between 1 July 2013 and 30 June 2015, across the whole of DIBP’s activities, there were a total of 20 deaths reported to Comcare: two deaths of contractors; three deaths of members of the public; 14 deaths of detainees; and one unspecified death. The detainee deaths include one suicide, one minor and two infants.

This differs from statistics in DIBP’s Annual Report 2014-2015, which states that 14 fatalities were reported across the two years.204

Of the 20 fatalities, 4 were assessed as notifiable: these included the suicide of Mr Dalvir Singh; the death of Mr Reza Barati; the death of a contractor; and the death of a member of the public. The death of Hamid Khazaei does not appear to have been reported as such, but rather as an update to the earlier report regarding his leg injury. It is thus not included in the 20 reported. Fourteen of the reported deaths were assessed as not-notifiable as they were assessed as not resulting from the conduct of the business or undertaking. This included the deaths of the two infants and one minor.

All deaths in immigration detention are investigated by state based coroners.205 The role of Comcare and coroners are different, however. Coroners have no obligation to assess workplace health and safety more broadly, and Comcare is obliged to investigate only the workplace health and safety aspects of a death. As such, coronial inquests do not meet the workplace health and safety needs for deaths to be investigated.

The ALA is concerned about apparent inconsistencies in the way in which deaths are reported by the DIBP, and the way they are assessed and investigated by Comcare.

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See Appendix 3 for a table of deaths notified to Comcare during the period under investigation.

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204 DIBP, Annual Report 2014-2015, Incidents reported to Comcare, at 229.
205 See: Coroners Act 1997 (ACT), s13; Coroners Act 2009 (NSW), s23; Coroners Act (NT), s15; Coroners Act 2003 (Qld), s21; Coroners Act 2003 (SA), s21; Coroners Act 1995 (Tas), s11; Coroners Act 2008 (Vic), s11; Coroners Act 1996 (WA), s22.
5.1 Notifiable deaths

Two deaths were assessed as notifiable by Comcare over the period under investigation. The ALA agrees with this assessment, confirming that they arose out of the conduct of the business or undertaking under s38 of the WHS Act. It is unclear why many of the other deaths were assessed as not-notifiable (see below at 5.3).

5.1.1 Death of Dalvir Singh

Over the past two years, there has been one suicide reported by the DIBP to Comcare. On 13 February 2014, 27-year-old Dalvir Singh, a detainee, committed suicide at Maribyrnong in Victoria. At approximately 6:35pm on 13 February 2014, Mr Singh was found deceased in his bedroom at the detention centre, where he had taken his life by hanging.\[206\]

The incident was assessed as notifiable by Comcare.

As the detainee’s death occurred while he was in the custody of the DIBP, an inquest into his death was mandatory.\[207\] In her report of 26 March 2015,\[208\] the Coroner found that:

‘No one single factor accounts for Mr Singh’s decision to take his own life. Rather it can be understood in the context of a combination of personal stressors, including a previous suicide attempt in custody, the breakdown of his relationship and separation from his son, the consequences of his alleged perpetration of family violence, his withdrawal from opiate dependence and immigration detention.

Although a number of deficiencies have been identified, particularly in relation to communication of critical information between agencies, I do not consider any to have contributed in a significant way to his death. However, the circumstances of Mr Singh’s death provide a good opportunity to reflect on current practices and procedures of those agencies involved in providing services to people in immigration detention.’\[209\]

The Coroner, in making findings in relation to the DIBP noted that:

‘The attachment to the AFP email to DIBP on 21 January 2014 contained a warning about Mr Singh’s history of self-harm. I find that the email was not actioned by any employee of the DIBP. I further find that there was a lack of appropriate systems or processes in place to guide the management, action and communication of new and critical information about a detainee. In particular, at the time of Mr Singh’s death there was no single point of accountability for reading and actioning this information. This is unfortunate because it was the first time this information had been provided to DIBP and it was another missed opportunity for this information to inform his management whilst in detention.'

\[207\] Ibid, at 6 [31].
\[209\] Ibid, at [216], [217].
Although I am unable to find that, had this information been actioned, Mr Singh’s death would have been prevented, the evidence is that it would have triggered a different response and management plan. However, I am satisfied that DIBP have taken appropriate measures to remedy this process breakdown to ensure that this situation does not occur again.\textsuperscript{210}

The Coroner also noted that:

Recognition of the multiple vulnerabilities experienced by immigration detainees is an essential first step in the provision of appropriate care and management. Many of these paths of vulnerability are common to all detainees including estrangement from family, friends and community, uncertainty about the future, and loss of liberty and control over their personal circumstances.

The importance of applying an understanding of these vulnerabilities when working with detainees cannot be understated and foreshadows the need to take positive action towards ensuring that this translates into effective policies and procedures for the promotion of health and well being.\textsuperscript{211}

These findings point to a failure of the DIBP’s officer to meet their due diligence obligations under s27 of the WHS Act, indicating an offence may have been committed. It is unclear why this death was assessed as notifiable and thus arising out of the conduct of the DIBP, but the self-harm incidents described below at 7.1 were not always found to be notifiable. The ALA believes the assessment of this death as notifiable was correct.

5.1.2 Death of Reza Barati

The DIBP reported to Comcare that, on 18 February 2014, a detainee presented with head injuries, was transferred to the hospital and died a short time later.\textsuperscript{212} No location was advised. The incident was assessed as notifiable as a death had occurred, which arose out of the conduct of the business or undertaking in line with s38 of the WHS Act.

This is likely to have been the death of 23-year-old Reza Barati, at Manus Island, Papua New Guinea. Further information about this tragic death is provided above at 3.4.3.

A Comcare inspector report identified that:

‘DIBP appeared to have done what is reasonably practicable to provide a safe workplace at MIOPC. **DIBP exhibited no control** over the events that transpired between 16-18 February that led to the death of Mr Barati\textsuperscript{213} (emphasis added).

\textsuperscript{210} Ibid, at [230] – [232].
\textsuperscript{211} Ibid, at [233].
\textsuperscript{212} DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 192.
Information before the Manus Inquiry, including from G4S, the Minister and Comcare, all indicate the
government has been aware of the problem with fencing at the compound for about eight months prior
to the unrest.\textsuperscript{214} This was also apparent from information obtained by the ALA following requests made
under the FOI Act: see section 3.4.2, above.

\section*{5.2 Death of Hamid Khazaei}

On 5 September 2014, 24-year-old Iranian detainee,
Hamid Khazaei (whose name has also been spelled
Hamid Kehazaei in media reports), died in Brisbane’s
Mater Hospital, after his life support was switched off.\textsuperscript{215}
His death is currently the subject of a coronial inquest.\textsuperscript{216}

Days earlier, Mr Khazaei was pronounced brain dead.
Weeks earlier, he had an injury to his foot or leg, while
detained at the Manus Island RPC.\textsuperscript{217}

Evidence available to the ALA suggests that there were serious failures in the care provided to Mr
Khazaei. The fact that a death could result from an apparent minor injury is cause for serious concern
regarding the workplace health and safety in Australia’s immigration detention facilities.

Doctors who were involved in Mr Khazaei’s treatment spoke out about their concerns regarding that
treatment to ABC’s \textit{Four Corners} program. Their concerns included:

- unreasonable delays in responding to the requests for transfer from Manus Island for
treatment. The initial request for transfer was made at 9.30am on Sunday 24 August for
Mr Khazaei to be transferred to Port Moresby on a flight leaving at 5.30pm that afternoon.
The DIBP did not respond to this request until after that flight had left. The transfer request
was altered at 9.30am on Monday 25 August for a transfer to Brisbane, due to Mr Khazaei’s
worsening condition. He was ultimately transferred to Port Moresby that afternoon, over 30
hours after the initial request had been made;

- the failure to follow medical advice. Requests made by doctors for transfer were repeatedly
questioned or ignored by DIBP officers and bureaucrats, causing delays in accessing possibly
lifesaving treatment;

- the inability to respond to medical emergencies outside of office hours. There was
a 13-hour delay in the response of a key decision-maker to a request for transfer (that request

\textsuperscript{214} Parliament of Australia, Senate Standing Committee on Legal and Constitutional Affairs, \textit{Report into incident at
www.aph.gov.au/Parliamentary_Business/Committees/Senate/Legal_and_Constitutional_Affairs/Manus_Island/
Report.

\textsuperscript{215} Sarah Whyte, ‘Asylum seeker Hamid Kehazaei dies in Brisbane hospital’, \textit{Sydney Morning Herald}, 5 September
brisbane-hospital-20140905-10d8qg.html#ixzz3wu2WmvJN.

\textsuperscript{216} See ‘Hamid Kehazaei case: Seriously ill asylum seeker forced to wait more than 24 hours for medical transfer,’
forced-to-wait-for-medical-transfer/5952756. As at 30 March 2016, the Coroner is waiting for additional
information to be supplied and is unable to estimate how long it will take to finalise their report: Telephone
conversation between the Australian Lawyers Alliance and the Office of the State Coroner, Queensland, 30 March
2016.

\textsuperscript{217} Emma Pollard and Lindy Kerin, ‘Iranian asylum seeker Hamid Kehazaei brain dead in Brisbane hospital: Refugee
itself having been delayed by many hours while medical advice was being questioned by bureaucrats), as the decision-maker had left the office for the evening; and

• inadequate transfer protocol. Mr Khazaei was transferred from Manus Island to Port Moresby without oxygen and left exposed to the tropical sun without shelter while waiting for the air ambulance to arrive. After arriving at Pacific International Hospital in Port Moresby, he waited on a stretcher in the corridor for an hour, as they were not aware he was coming.\(^\text{218}\)

Throughout this time, Mr Khazaei’s symptoms worsened quickly, with doctors aware that delays could have life-threatening consequences. He became so weak he was unable to walk, started vomiting, became delirious, ultimately suffering three heart attacks in Port Moresby the night before he was flown to Australia.\(^\text{219}\)

Mr Khazaei was well enough to play football with his friends five days prior to his evacuation from Manus Island. He was described as one of the strongest, healthiest men on the island by another detainee.\(^\text{220}\)

### 5.2.1 Possible offences committed under the WHS Act

This incident suggests a number of failures to meet WHS Act obligations. The primary duty of care found in s19 requires safe systems of work (s19(3)(c)) and the provision of information, training, instruction or supervision to protect all persons to risks to their health and safety (s19(3)(f)).

Systems of work that allow medical advice to be ignored or questioned by DIBP officers cannot be described as ‘safe’ in the view of the ALA.

Due diligence obligations also appear to have been breached repeatedly. The fact that it took 24 hours for a request for a medical evacuation to reach the person who could order it suggests that systems do not allow for up to date knowledge to be acted on (s27(5)(a)). It also points to problems with the “processes for receiving and considering information regarding incidents, hazards and risks and responding in a timely way to that information” (s27(5)(d)). Officers can be found guilty of offences under s27 even where the PCBU has not been found guilty. It is also possible that contractual obligations between the DIBP and contractors were not met.

According to the *Four Corners* report, the internal report commissioned by the DIBP to investigate this incident does not concede that its bureaucratic processes could have contributed to the death.\(^\text{221}\) This internal report is not currently publicly available. The ALA believes an independent review is required to investigate whether any offences under the WHS Act or any other legislation have been committed by the DIBP, its officers or any other person, in relation to the death of Mr Khazaei.


\(^{219}\) *Ibid.*

\(^{220}\) *Ibid.*

\(^{221}\) *Ibid.*
5.2.2 Reporting the incident to Comcare

It is not clear to the ALA if this death was reported to Comcare as a notifiable incident, or whether it was only the initial hospitalisation that was reported, with the death being reported as an ‘update’. The ALA has identified that two incidents reported by the DIBP to Comcare in FY2014-2015 may have related to the treatment received by Mr Khazaei, but it is not possible to confirm this conclusively.

Table 5 – possible incident reports related to Hamid Khazaei

<table>
<thead>
<tr>
<th>Incident No.</th>
<th>Date</th>
<th>Brief description</th>
<th>Place</th>
<th>Assessment reason</th>
<th>Intervention summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>129</td>
<td>27/8/14</td>
<td>Client presented to IHMS with severe infections – acute respiratory distress.</td>
<td>Manus Island</td>
<td>Not notifiable – an incident occurred but it did not result from the conduct of the business or undertaking.</td>
<td>Investigation complete – closed.</td>
</tr>
<tr>
<td>146</td>
<td>2/9/14</td>
<td>Detainee transferred to the hospital with undisclosed medical condition.</td>
<td>QLD – Brisbane</td>
<td>Not notifiable – an incident occurred but it did not result from the conduct of the business or undertaking.</td>
<td>Not investigated.</td>
</tr>
</tbody>
</table>

In the list of 643 incidents reported by the DIBP to Comcare in FY2014-2015, obtained by the ALA under the FOI Act, nine fatalities were recorded. None of these could have been identified as the death of Mr Khazaei. As such, based on this information, Mr Khazaei’s death does not appear to have been formally reported as a notifiable incident to Comcare by DIBP.

Rather, it appears that the death of Mr Khazaei was reported to Comcare as an ‘update’ on a previous incident report:

‘An update was provided on 28 August 2014 in which it was noted that the [redacted] subsequently died on 5 September.’

This appears to be non-compliant with the processes required by Comcare. Comcare’s 2012 Guide to Work, Health and Safety Notification requires:

‘Where Comcare has been notified of an incident and the PCBU receives information that changes the incident type, the PCBU must ensure Comcare is notified of those changes.

For example, if a notified serious injury or illness later results in death, Comcare must be advised about the changed situation immediately after the PCBU becomes aware of the changes. This will require the PCBU to submit another incident notification form, making
sure the section regarding previous notification of the incident has been completed and any other details are provided as required’.

It is clear from the Comcare Inspector Report that the DIBP was aware of the seriousness of the condition of the detainee in question:

‘Whilst no definitive cause of the initial injury or [redacted] could be determined, the information supplied to Comcare did however appear to indicate that a protracted timeframe occurred from when the initial request to [redacted] was made by [redacted] to when an approval was granted.

Whilst the delay in initiating and finalising the approval process was not necessarily a contributing factor to the final outcome of this incident, the limited medical facilities available to those in offshore processing locations may mean a delay in evacuation could be the deciding factor in the final outcome in any further incidents that may occur.’

The second paragraph above is in conflict with the information provided by doctors to Four Corners, outlined above.

The Comcare Inspector recommended:

The [redacted] approval process is streamlined to enable [redacted] to arrange prompt medical care for injured parties (emphasis added).

It is likely that the coronial inquest will provide further insights as to whether the treatment of Mr Khazaei and his subsequent death did in fact result from the conduct of the business or undertaking, which may include relevant acts and omissions undertaken by the DIBP and IHMS. A pre-inquest conference is currently scheduled for 10 June 2016.

Clearly an infection arising from a relatively minor injury should not result in an infection so serious that it caused death. Comcare should consider whether it is appropriate to prosecute the DIBP, its officers and/or related contractors for this failing, or refer the matter to the Australian Federal Police.

5.3 Not-notifiable deaths

The majority of deaths reported to Comcare were identified as not notifiable incidents, meaning that Comcare made an assessment that they did not arise out of the conduct of the business or undertaking under s38 of the WHS Act. This assessment for some of these deaths is of concern to the ALA.


5.3.1 October 2013 infant death

On 16 October 2013, an unresponsive three-month-old baby with breathing difficulties died in Darwin, Northern Territory. This death was assessed as not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.\(^{226}\)

5.3.2 November 2014 infant death

On 17 November 2014, a detainee suffering a pre-existing medical condition experienced difficulty breathing, and subsequently died in Prospect, South Australia.\(^{227}\) This fatality was also assessed as not notifiable, as an incident occurred but it did not result from the conduct of the business or undertaking. The ALA applied under the FOI Act for incident reports relating to fatalities in FY2014-2015. The incident report that may have related to this death identified that the 'client' was an infant, and provided further description regarding the incident:

‘xxxx having trouble breathing xxx called an ambulance, and xxx taken to the xxx hospital. Doctor advised the case worker that xxx had passed away. Xxx a pre-existing medical condition. Fatality due to the xxx pre-existing medical condition. Incident did not arise out of IMMI’s business or undertaking. Therefore incident does not appear to be notifiable.’\(^{228}\)

5.3.3 Assessing the infant deaths

Both infant deaths involved breathing difficulties that subsequently led to fatalities.

It is anticipated that the coronial inquests will provide further insights as to the causes of death.

On the limited, redacted data provided, it is not possible to identify either the cause of the breathing difficulties, or the pre-existing medical condition.

From the information available, it is also impossible to assess whether the response time between the initial discovery of the breathing difficulties and the child receiving medical treatment was adequate, and whether that treatment was appropriate in the circumstances.

Both incidents were assessed as ‘not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking’. It is for the coroner to determine cause of death, including whether the death in fact did result from the conduct of the business or undertaking. With that in mind, perhaps it would be more appropriate to assume that all deaths in immigration detention are as a result of the conduct of the business or undertaking unless a coroner finds otherwise.

It is also unclear whether any of the other fatalities reported by the DIBP to Comcare were the deaths of minors. For example, the age of the client who died from a pre-existing medical condition on 12 October 2013 in NSW is unknown to the ALA.\(^{229}\)

\(^{226}\) DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 56.
\(^{227}\) DIBP, Annual Report 2014-2015, Incidents reported to Comcare, No. 323.
\(^{228}\) Australian Government, Comcare, Telephone Advice or Notification of an Incident, No. 323, 17/11/2014.
\(^{229}\) DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No.55 12/10/2013.
On the incident report forms, there is no mandatory box to indicate that the incident involved a child (similarly, there is no box to indicate the gender of the person involved). This suggests that the initial component of the incident reporting system to Comcare does not adequately reflect the unique risks posed to children.

The ALA suggests that report forms should be amended to require identification of the injured person’s age, sex and any factors that might increase their vulnerability (potentially affecting the standard of care to which the DIBP should be held).

5.3.4 Pre-existing conditions

Since Comcare’s investigation into the 17 November 2014 death at Villawood, two further individuals in immigration detention have died in Sydney. The incident reports regarding these deaths indicate that there continues to be confusion surrounding the reporting of fatalities.

On 5 January 2015, a terminally ill cancer patient who was held in community detention died in hospital in Braeside, NSW (potentially the Braeside Hospital at Prairiewood) while receiving treatment for cancer. While the fatality was described as not notifiable, and not investigated, the initial incident report obtained under the FOI Act notes that ‘the links to the conduct of the business are unclear’, and the preliminary assessment was ‘uncertain’. The form was filled out by an ‘inspector’.

On 11 January 2015, a detainee died in Liverpool Hospital, NSW. The person had a number of pre-existing health issues that contributed to their death, but the details were redacted. The person was treated as an in-patient in hospital. The incident was assessed by Comcare as not notifiable, as an incident occurred but it did not result from the conduct of the business or undertaking.

The ongoing confusion surrounding the reporting of deaths suggests that the DIBP should take further steps to train staff appropriately in terms of reporting obligations under the WHS Act.

In the case of immigration detention, pre-existing medical conditions can be exacerbated by the actions of the DIBP. The assessment of deaths arising from these conditions as having not resulted from the conduct of the business or undertaking, and therefore not a notifiable incident, may not be accurate, or indeed in keeping with the objects of the Act.

For Comcare or the DIBP to assume that such deaths did not result from the conduct of the business or undertaking may effectively perpetuate risks to the health and safety of some of the most vulnerable detainees: those with pre-existing illnesses. People detained within such environments are particularly vulnerable to being affected by the conduct of the business or undertaking, given the control that PCBUs exert over many aspects of their lives.

It is possible that deaths of individuals with pre-existing conditions could have occurred as a result of the DIBP’s mismanagement of their pre-existing condition or of unreasonable delays in emergency medical situations by the DIBP or its contractors.
It is appropriate for Comcare to investigate in all such instances, and to assist the coroner as much as possible with enquiries as to any inadequacies in the workplace prior to the death of the individual, including any prior incidents and investigations.

### 5.4 Incomplete information in notifying Comcare of death

On 17 November 2014, it was noted that a detainee formerly held in the Villawood detention facility suffered a heart attack, was treated as an inpatient in hospital and died.\(^{235}\)

The incident was assessed as not notifiable, as an incident occurred but it did not result from the conduct of the business or undertaking. However, Comcare conducted an investigation into the death, which is now complete. The ALA obtained a copy of the Inspector Report under the FOI Act, which identified some deficiencies in the DIBP’s reporting to Comcare regarding the place of death.

The Inspector Report noted inadequacies in the incident notification provided to Comcare:

> ‘the incident occurred at the workplace, Villawood IDC, not [redacted] Hospital as notified. In this way, *incomplete information was submitted to Comcare.*

> **By failing to include relevant sequence of events information in the written notification to Comcare, I am of the opinion that DIBP are at risk of being found in non-compliance with s38(5) of the WHS Act.** The recommendations provided above are to assist DIBP to move towards compliance\(^{236}\) (emphasis added).

The Comcare Inspector Report also noted that:

> ‘the initial notification sent by DIBP to Comcare *did not contain sufficient information and details as required by the regulator* (Comcare) to satisfy s38(5) of the WHS Act [A written notice must be in a form, or contain the details, approved by the regulator.]

To move towards compliance, *I strongly recommend DIBP:*

1. **Revise their reporting incident notification system and process to ensure required details are provided to Comcare in full on the written notification, consistent with the WHS Act and WHS Regulations;** and
2. **Provide further information, instruction and training to workers at Villawood IDC to ensure sufficient information and details are provided in the written notification, and review the effectiveness of that information, instruction and training’** (emphasis added).\(^{237}\)

It is not known whether these recommendations have been implemented.

In addition to the failures pointed out in this Report, the ALA notes the absence of a field for the date that Comcare was notified of the incident. This means that it is not possible to assess the DIBP’s compliance with the requirement to notify Comcare ‘immediately’ under s38 of the WHS Act.

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\(^{237}\) Ibid, at 1 of 5.
5.5 The National Deaths in Custody Program

There has never been a national investigation or analysis of deaths in immigration detention, despite the extraordinary increase in the number of deaths in custody in recent years. In the 10 years to 2010, there were 27 fatalities in immigration detention. In the two years under investigation in this Report, 20 people usually resident in immigration detention died (including those who had been taken to hospital before they died). As Charandev Singh has suggested, the lack of data:

‘really undermines any capacity to understand deaths in detention in the context of our mandatory detention policy.’

There is, however, a Program that records all other deaths in custody. The National Deaths in Custody Program (‘NDICP’), run by the Australian Institute of Criminology, was established in 1992 in response to the Royal Commission into Aboriginal Deaths in Custody.

The data collected by NDICP appears to be far more detailed than that required by Comcare. NDICP data collection forms ‘allow information to be recorded on approximately 65 variables relating to the circumstances and characteristics of each death. Australian state and territory police and correctional authorities provide completed data collection reports and all relevant information is then extracted and entered into the NDICP database.’

Coronial data used in the NDICP data collection process (including coronial rulings and findings, and toxicology and pathology reports) are accessed through the National Coronial Information System (‘NCIS’) for every jurisdiction.

5.6 Recommendations

The ALA recommends that the federal government:

• amend s38 of the WHS Act to ensure that all deaths of individuals usually resident in immigration detention are presumed to result from the conduct of the business or undertaking. The existence of a pre-existing injury or illness should not preclude Comcare from investigating the role of the DIBP, if any, in the death.
• mandate the NDICP to record all deaths in immigration detention in the same way that all other deaths in custody are recorded. Expand the remit and resources of the NDICP for this purpose.
• institute an independent inquiry into the death of Hamid Khazaeei in light of evidence presented by ABC’s Four Corners.

The ALA recommends that the DIBP:

• ensure that all deaths of individuals usually resident in a detention facility (including where the death itself occurs in a different location) are clearly reported as such to Comcare. If a death is related to an earlier incident report, a new incident report should be lodged cross referencing the earlier report.

240 Ibid, at 7.
The ALA recommends that Comcare:

- consider appearing at all coronial inquests following deaths of individuals usually resident in a detention facility (including where the death itself occurs in a different location).
- consider prosecuting the DIBP and/or related contractors if evidence suggests that an offence under the WHS Act has been a factor in a death.
- develop clear policy clarifying how it should be informed of changes in the circumstances surrounding an incident that they have already been notified of. This policy should ensure that key details are captured so that the health and safety factors of these changes are clearly addressed.
- update reporting forms to ensure that the date of the incident and the age, sex and any other factors indicating particular vulnerability of the injured or deceased individual are clearly identifiable.
- investigate all deaths of individuals usually resident in immigration detention on the presumption that they arose from the conduct of the business or undertaking. Where a pre-existing injury or illness contributed to the death, consider the nature of the medical or health condition and what could have been done to prevent the death.
- develop clear guidance as to the phrase ‘arising out of the conduct of the business or undertaking’, ensuring it is interpreted broadly to meet the objects of the WHS Act. This guidance should reflect the understanding of the business of the DIBP outlined above at 1.4.1.
- provide training to the DIBP and contractors regarding any updates in policy or legislative changes.
Chapter 6 – Sexual misconduct

Overview

Over the past two years, significant allegations of sexual misconduct have been raised in immigration detention centres and RPCs in the media and in a range of parliamentary inquiries and independent reviews. These allegations have been investigated twice in recent years on Nauru, the Nauru Inquiry and the Moss Review, as well as the broader Australian Human Rights Commission investigation into children in detention. All of these investigations revealed serious concerns regarding sexual misconduct, including sexual assault, sexual abuse and sexual harassment, as well as evidence indicating that these phenomena are even more widespread than has been reported. While there has been no specific investigation into sexual misconduct on Manus Island or in onshore detention facilities, evidence suggests that similar problems may exist there as well.

Sexual misconduct can lead to serious health and safety problems for its victims. In addition to physical injuries, which can be significant, serious sexual assault or abuse almost invariably gives rise to psychological injury. Ongoing sexual harassment can also cause lasting serious psychological injuries. Injuries from these crimes can be exacerbated if initial treatment is inadequate or absent. Infection, and for women pregnancy, can also result from rape.

There appears to be a significant workplace health and safety gap in relation to sexual misconduct in Australia’s immigration detention centres. When comparing information available in the media with what the ALA has received following FOI Act requests, there would appear to be a significant under-reporting of instances of sexual misconduct to Comcare. In part this relates to the definitions of serious injury and dangerous incidents under the WHS Act. Evidence also suggests there is an official misunderstanding of the nature of the harm that sexual misconduct can cause both physically and psychologically.

Only three allegations of sexual assault have been reported by the DIBP to Comcare over the two years under investigation by the ALA. The findings of the Moss Review and the Nauru Inquiry, however, reveal extensive allegations of sexual harassment, sexual misconduct, sexual assault, physical assaults and violence occurring on Nauru. Of the three reported assaults, none related to Manus Island or Nauru.

Any incident of child sexual or physical assault that does not lead to the child being treated as an in-patient, is not required to be reported by DIBP to Comcare, according to Comcare.241 As the DIBP is not required to identify the age of an individual who suffers an injury or illness, the incidence or true extent of child abuse might not be adequately understood or recorded. These are significant oversights.

This section reviews evidence relating to sexual misconduct derived from the investigations in relation to Nauru, media reports and information provided to the ALA in response to requests made under the FOI Act. This evidence suggests that the objects of the WHS Act require both legislative reform and training of DIBP officers, contractors and Comcare inspectors. Further recommendations are made regarding broader concerns related to sexual misconduct in Nauru and the local law enforcement’s ability to investigate crimes of this nature.

241 Answers to questions taken on notice, provided by Comcare to the Nauru Inquiry, received 26 August 2015, at 1.
Terminology

Sexual misconduct is the term used to refer to all misconduct of a sexual nature. Sexual assault, including rape, refers to all touching of a sexual nature against the subject's wishes. Sexual assault can be serious with lifelong consequences. It can also be relatively minor, including the momentary touching of genitals or breasts. Sexual abuse refers to the exploitation of power imbalances in a sexual way and may include consensual sexual conduct: for example, in circumstances where individuals have engaged in sexual conduct to access favourable treatment or goods. Sexual assault usually involves sexual abuse, but sexual abuse is not necessarily accompanied by sexual assault.

Sexual harassment includes sexualised comments or behaviour that do not amount to sexual assault or sexual abuse. While not giving rise directly to physical injuries, sexual harassment can create an environment where individuals feel unsafe, and other forms of sexual misconduct are able to flourish. Psychological injuries can result from serious sexual harassment, especially if it takes the form of bullying.

There is often a degree of overlap between these concepts and a single incident can often involve more than one form of sexual misconduct.

6.1 Sexual assault and serious injury

6.1.1 Sexual misconduct under the WHS Act

Serious sexual assault can leave both physical and psychological long-term impacts and trauma. However, the WHS Act does not identify any sexual misconduct as a notifiable incident: in fact, it is entirely silent on the topic.

Serious sexual assault may be required to be reported as a notifiable incident if a serious injury has occurred. Thus far, it does not appear to have been interpreted as including psychiatric injury.

Under s35 of the WHS Act, a notifiable incident includes a serious injury or illness of a person, or a dangerous incident. Section 36 provides further detail regarding the meaning of serious injury or illness of a person, including immediate treatment as an in-patient in a hospital and serious injuries to specific body parts or of a specific nature. Dangerous incidents are defined under s37 as including exposure to a serious risk to a person's health or safety, such as an explosion or structural collapse. Serious injuries or illnesses and dangerous incidents can also be prescribed in the regulations.

6.1.2 Sexual misconduct against children

A number of sources identify as inappropriate the official response to the risk of sexual assault of children, or of threats or assaults against the family of the assaulted child within RPCs. These risks do not appear to have been minimised, mitigated or eliminated, and arguably represent a gross breach of the DIBP's duty to ensure health and safety.

The investigations in the Nauru RPC have provided useful information. While child sexual abuse occurred on Nauruan soil, the responsibility for tolerating or even concealing it can be sheeted back to the DIBP's offices in Canberra, the same office that was invested with the duty to ensure the health and safety of all detainees at Nauru RPC.
According to the evidence presented to various inquiries, sexual assault and abuse in Nauru were endemic. If this is true, prosecutions under the WHS Act may be appropriate. It may also be appropriate for the Commonwealth Department of Public Prosecutions to consider the appropriateness of laying charges for concealment of an indictable offence under the Crimes Act 1914 (Cth) and Criminal Code Act 1995 (Cth), given that such concealment may also have occurred on Australian soil.

6.2 Sexual misconduct that does not appear to have been reported to Comcare

The ALA has become aware of a number of alleged instances of sexual misconduct that do not appear to have been reported to Comcare, according to evidence we have received pursuant to FOI Act requests, even though many were serious and caused ongoing injuries. These instances were detailed in the inquiries regarding Nauru and in the media. Some are described below.

The extent of the problem is significant. According to evidence provided at the Nauru Inquiry, Transfield received 67 allegations of child abuse to May 2015, 30 of which were against workers at the centre. Thirty-three asylum seekers alleged that they had been raped or sexually assaulted, with five more alleging they had been asked for sexual favours in exchange for contraband.\(^242\) None of these allegations appear to have been brought to Comcare's attention.

A number of instances of sexual misconduct have come to light during the various investigations into the Nauru RPC. There has been less scrutiny of the Manus Island RPC and onshore detention. It is therefore possible that a significant number of unreported instances of abuse in those places of detention remain hidden.

Given the number of alleged instances of sexual misconduct, it is concerning that not a single instance of sexual assault against a detainee in either Manus Island or Nauru RPC has been reported to Comcare. This points to failures to meet due diligence obligations found in s27 of the WHS Act. It may be necessary to amend legislation so that the WHS Act's objects are met in relation to the injuries that stem from sexual misconduct.

6.2.1 Allegations of rape and torture on Manus Island

Rape and torture were endemic on Manus Island in 2013, according to whistle-blower Rod St George, former Head of Occupational Health and Safety. Speaking to Dateline in July 2013, St George alleged that abuse between detainees was occurring with full knowledge of the staff at the centre.\(^243\) According to St George, men who had been raped were forced back to the tents where they had been raped with the people that had perpetrated the abuse, to be raped again. Men had also been forced to sew their lips together by other detainees. He also suggested that departmental officials were covering up the extent of the assaults.

While this information came to light at the beginning of the period under investigation, none of the incident reports released to the ALA pursuant to requests made under the FOI Act indicate that reports


of inter-detainee assault of this nature were reported to Comcare. Of the 68 reports relating to Manus Island made between 1 July 2013 and 30 June 2015, the only reports that could be categorised as inter-detainee assault involved throwing furniture (although further investigation would be required before this assessment could be made conclusively). Given that the detainees were accommodated in this way as a direct result of the conduct of the business or undertaking, it is unclear why reports were not made.

6.2.2 Alleged assault of a 16-year-old minor, Nauru, November 2013

On 16 November 2013, a 16-year-old boy was allegedly indecently assaulted by a local Nauruan cleaner employed by Transfield. The incident was interrupted by security staff, and the perpetrator confessed at this point that he had come into contact with the boy’s genitals.244

This incident does not appear to have been reported by the DIBP to Comcare. The Moss Review referred to it,245 and evidence before the Nauru Inquiry suggests that the staff member’s employment was terminated and the incident referred to the police.246

Evidence provided to the Nauru Inquiry by Viktoria Vibhakar, a former worker at the RPC, indicated that there was a significant deterioration in the young person following the incident:

‘On my first deployment to Nauru, an adolescent male, “Danny” was sexually assaulted and then verbally mocked by a Commonwealth contractor on 16 November 2013. After his sexual assault, this boy demonstrated a significant deterioration in his mental health and functioning. He was placed on the SCA list for “vulnerable minors”.

The deterioration in his mental health and the mental health of other family members was discussed weekly by Commonwealth contractors and this information was routinely forwarded to DIBP. The assigned Child Protection and Support Worker informed the Child Protection and Support team that the child and family were fearful of retaliation for reporting the assault. There was an attempted physical assault on the child’s brother by another Commonwealth contractor later that week. It is unknown whether this was in retaliation or “just” another episode of violence against children247 (emphasis added).

Ms Vibhakar identified that the risk posed to the family after this incident did not appear to have been appropriately tackled:

‘Subsequently, this child and his family were subjected to multiple death threats and bullying from some adult asylum seekers, further contributing to severe mental distress and fear of all family members. In fact, two of the individuals in this family took turns staying awake.

245 See Moss Review, at 37 [3.98].
at night to keep watch over other family members due to extreme fears for their safety. **Danny was also subjected to another incident of assault** by another Commonwealth contracted employee. Please see the confidential submission that describes this additional abuse. **DIBP did not remove this child from the detention centre where his family was experiencing severe mental distress as a result of multiple assaults, threats, bullying, and intimidation**\(^{248}\) (emphasis added).

This alleged harassment clearly has the potential to impact on the health and safety of these people, both psychologically and physically.

Evidence to the Nauru Inquiry suggests that the Minister for Immigration and Border Protection personally knew about this assault.\(^{249}\)

Kirsty Diallo, the Child Protection and Support Worker for the affected child, provided further evidence regarding the incident:

‘Despite this knowledge **no further steps were taken to protect this child or his family from being targeted by other local staff who remained in the centre. No further steps were also taken** to conduct working with children checks or police checks of local staff, to ensure that potential threats to children were excluded from employment in the centre. **No forensic sexual assault services were established** to respond to incidents of sexual assault, and security staff as well as local Police received no additional training in regards to interview sexual assault victims. **Despite this, the Minister for DIBP continue to authorize the removal of children (including unaccompanied children) from Australia to Nauru**\(^{250}\) (emphasis added).

The decision to keep this child in the detention centre in which he had been assaulted, where he remained at future risk of abuse, and was subsequently subjected to further abuse, cannot be held to be an appropriate discharge of the duty to ensure health and safety of this young person.

If the risk, and subsequent occurrence of child sexual abuse had been tolerated on Australian soil, the workplace concerned could be comprehensively investigated by a Royal Commission, independent inquiry or the police. Individuals who knew of the abuse could potentially be charged under relevant concealment offences: in NSW, for example, s316 of the *Crimes Act* 1900 (NSW). Damages would also be likely to be awarded. This boy was being held in an environment where such protections were harder or impossible to access. In this context, the failure to report the incidents to Comcare for proper investigation and risk minimisation, is even more serious.

\(^{248}\) *Ibid*, at 11.


\(^{250}\) *Ibid.*
6.2.3 Alleged sexual assault of 23-year-old Iranian woman

In May 2015, a 23-year-old Iranian woman, ‘Zareen’, was visiting friends in the Nauru community, after being granted day release. She was allegedly raped on her way back to the RPC.\textsuperscript{251}

This incident does not appear to have been reported by the DIBP to Comcare according to information available to the ALA.

The Saturday Paper reported that ‘police found [Zareen] naked, bruised and disoriented, about 9pm that night. She was alive, but badly beaten and numb with trauma’.\textsuperscript{252}

Submission No. 99 to the Nauru Inquiry described how a female asylum seeker had been sexually assaulted for several hours by a Nauruan local, while waiting to catch a bus back to the RPC. She was found running half naked down the street and the police were called. On their way back to the station, they stopped to watch a fireworks display for 45 minutes, with this distraught, half-naked woman in the back of their vehicle. On arrival at the police station she was interviewed and then taken to hospital for treatment.\textsuperscript{253}

Refugees are being attacked and assaulted by locals on a weekly basis, according to the Submission. Some of these incidents are reported to police, however the fear of retaliation or police inaction means that many are not.\textsuperscript{254}

A journalist received a Facebook message following this assault which is likely to have been from Zareen’s brother, although we have not been able to confirm this:

\begin{quote}
After that they send her to nauru hospital she was shocked. after that they send her to ihms hospital in opc1 for 2 weeks. the mental health group and doctors and psychiatrist from ihms allways pushed emigration for sending my sister to special mental hospital in australia .and allways told us that we will support her she has physical and mental problem.

Because of her depression \textbf{she tried to kill herself two time….}

all staff here crying for her when they see her face .she went out to nauru to go to her friend home for dance practicing that in a way of coming back she assaulted and raped…. now one month she hasnt talk and eat any thing i can see only her tear and her eyes that asking me to help her we are alone here .she get too weak .even she cant stand on her feet. \textbf{ihms concern about her condition …}
\end{quote}


\textsuperscript{254} Ibid.
Msg 2: “The ihms promised us that they will support her but suddenly emigration forced ihms to keep my sister here. The doctors just told me contact with outside and say what happend this is the emigration decision and they want to cover up the story”

Given that medical professionals appear to have recommended that Zareen needed further treatment at a special mental hospital, the ALA believe that this incident should properly have been treated from the outset as a notifiable incident.

The Explanatory Memorandum to the WHS Bill provides that the test for determining what is a serious injury or illness ‘is an objective one and it does not matter whether a person actually received the treatment referred to in the provision. The test is whether the injury or illness could reasonably be considered to warrant such treatment’ (emphasis added).

The fact that Zareen did not receive that treatment as a result of a decision by the DIBP should not change the nature of the incident. The objects of the WHS Act would best be served if there was a legal obligation to provide treatment in accordance with medical advice.

The ALA submits that PCBU’s should be required to implement medical advice for people to whom it owes health and safety duties if the objects of the WHS Act are to be realised. It may be appropriate to require additional reporting as to how a PCBU is ensuring workplace health and safety if it is proposed that medical advice not be followed.

Further, the fact that the alleged rape took place outside of the RPC should not be seen as a means of avoiding notification obligations. Zareen was present on Nauru as a result of the conduct of the business or undertaking. As a resident of the RPC and subject to its authority, the RPC should be responsible for her health and safety. It is also incumbent on the DIBP to ensure that there are systems in place to ensure detainees are safe when they are in the community. This could include providing detainees with transport or mobile phones when leaving the RPC grounds, or restrictions on visiting known risk areas.

In any event, even though the alleged assault took place outside of the RPC grounds, the injury or illness that Zareen suffered may have been exacerbated by the refusal of the DIBP to afford her the medical treatment that her doctors recommended. At the very least, her subsequent suicide attempts should have been reported to Comcare. As far as the ALA is aware, no such reports were made.

6.2.4 Alleged sexual assault of a woman, August 2014, Nauru

A submission to the Nauru Inquiry explained what a worker at the Nauru RPC had witnessed in relation to an allegation being raised of sexual assault in August 2014:

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‘In around August 2014, I was walking through Family Area 3 when I heard extremely loud screaming in Farsi coming from the direction of the SAF [single adult female] area. I ran to the SAF area and was informed by Wilson Security that I should stay out of the way, and so I stood back and observed. I saw a young Iranian woman sitting on a plastic chair screaming loudly and incoherently.

I asked a Wilson Security officer nearby what had happened and he informed me that ‘she had made a complaint against a male officer for sexual assault and he was still working in the camp, but she wants him to be lynched for what he did to her’. As I watched, an IHMS car pulled up outside of the SAF area. Two female Nauruan officers attempted to lift the woman out of the plastic chair. However a male Australian officer directed them to ‘leave her, she can walk, she’s just carrying on and we aren’t going to carry her out of here’. The female officers had started lifting the woman and she was halfway out of the chair.

On the command from the other officer the female officers let go of the woman as she was taking a step. The woman stopped screaming, took a sharp intake of breath and lurched forward, her eyes appearing to roll back in her head. The woman did not put out her arms but fell limp face first onto the gravel.

The two Nauruan female officers then lifted her by her arms and dragged her out into the IHMS car with her feet dragging limply along the gravel, not moving. I do not believe the female client was lucid for any of this event.

I asked a Wilson Security officer to identify the client to me and then ran up the hill to Save the Children’s office tent. I looked for the client’s caseworker but they were not present, so I asked the team who else knew the client. The Casework Manager stated that she knew the history and so she went to the IHMS tent to check on the client.’

Neither the sexual assault allegation nor the Iranian woman’s admission to the IHMS tent appear to have been reported by the DIBP to Comcare.

6.2.5 Alleged sexual harassment of worker

Staff have also suffered sexual harassment while working at the Nauru RPC. The Guardian Australia reported that:

‘a former Wilson Security guard at the Nauru detention centre claims she was forced to work alongside a supervisor for five months after she lodged a sexual harassment complaint against him.

Chenoah Rose has accused the company of refusing to take the harassment claim seriously, later promoting the man to a senior role and making her redundant after she lodged a separate workplace injury claim…

She said her experience working in the detention centre was a nightmare in a workplace culture that was “horrendous” and claimed that it “comes right from the top”.

Rose alleged bullying and sexual harassment among staff was rife. She claimed her direct manager made repeated unwanted sexual advances, including asking her via computer for an “offshore arrangement”, telling her he would visit her at her Brisbane home.\footnote{Former Nauru Wilson Security guard claims sexual harassment of staff is 'rife', \textit{The Guardian}, 10 September 2015, accessed at: http://www.theguardian.com/australia-news/2015/sep/10/former-nauru-wilson-security-guard-claims-sexual-harassment-of-staff-is-rife.}

The ALA does not know whether this episode was reported to Comcare.

### 6.2.6 Further allegations of sexual misconduct

Submissions to the Nauru Inquiry allege that the following incidents occurred at the Nauru RPC, none of which appear to have been reported to Comcare. While not all of these instances should have been reported according to the legislation, the circumstances of many indicate that inquiries should at least have been made. Further, these incidents are indicative of a broader culture of sexual misconduct which threatens the safety of all of those occupying the workplace. The ALA understands that incident reports referred to were received by the DIBP, but we do not know whether Comcare was made aware of them.

**Sexual assault, sexual harassment, sexualised behaviour and misconduct**

- On 23 November 2013, an incident report was filed as a young mother feared her tent was being approached at night with men expecting sexual favours.\footnote{Submission No. 63 to the Nauru Inquiry, at 18, accessed at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Regional_processing_Nauru/Regional_processing_Nauru/Submissions?main_0_content_1_RadGrid1ChangePage=4_20.}
- From November 2013, a whistle-blower suspected that Commonwealth contractors were grooming children.\footnote{Ibid, at 19.}
- In December 2013, plans were overheard and reported regarding men planning to sexually assault a young adult female (management was informed).\footnote{Ibid, at 17.}
- On 8 December 2013, SCA management was notified that a client alleged that Wilson Security officers were attending women’s tents at 2am, and believed that there were inappropriate relations between women and staff.\footnote{Ibid, at 5.}
- On 30 December 2013, an incident report was filed – a nine-year-old boy was hiding half naked – it was suspected that a sexual incident had occurred, and a man jumped over the fence.\footnote{Ibid, at 23.}
- A whistle-blower noted that in January 2014, a four-year-old girl exhibited overtly sexualised behaviour consistent with sexual assault.\footnote{Ibid, at 12.}
- In January 2014, sexual assault allegations were reported regarding an eight-year-old girl.\footnote{Ibid, at 13.}
- On 7 February 2014, an eight-year-old boy was sexually assaulted by two men, which was witnessed by a Commonwealth employee.\footnote{Ibid, at 20.}
- On 30 April 2014, an incident report was filed: several older children were having sex with younger children.\footnote{Ibid, at 23.}
- In May 2014, a 13-year-old girl was afraid to walk around due to sexual harassment.\footnote{Ibid, at 21.}
In July 2014, an incident report was filed – sexual harassment/grooming of five-year-old boy.\textsuperscript{269}

A whistle-blower reported that Wilson Security informed her in July/August 2014 that Nauruan men were seen looking into the RPC with binoculars from the top of the hill into the single adult female area.\textsuperscript{270}

In February 2015, four pre-teen females stated that a friend’s father had touched them inappropriately.\textsuperscript{271}

In April 2015, the whistle-blower was informed that a former SCA employee had been sexually assaulting several young girls.\textsuperscript{272}

In April 2015, a whistle-blower was informed that there continued to be assaults in Area 1 accommodation near the toilets.\textsuperscript{273}

A number of submissions to the Nauru Inquiry noted that sexualised behaviour was witnessed daily in Nauru and definitely went under-reported.\textsuperscript{274} One submission stated that there was an understanding that sexual misconduct was common.\textsuperscript{275}

The awareness of the DIBP was further corroborated by Dr Peter Young, who stated that:

‘From my knowledge and experience I can state with certainty that: \textit{Officials within the Detention Health Section had knowledge of instances of children exposed to sexual abuse} by a contractor in Nauru in early February 2014’\textsuperscript{276} (emphasis added).

Dr Young also said that the DIBP:

\textquote[was well aware of the risks associated with deficits in the capacity of Nauru to investigate and respond to instances of child sexual assault and other forms of child abuse was well known to the Department when he [sic] Centre was established and before children were sent to Nauru. This included Nauru’s lack of any legislative child protection framework.]\textsuperscript{277} (emphasis added).

\subsection*{6.3 Sexual misconduct reported to Comcare}

It appears that only three allegations of sexual assault were reported to Comcare by the DIBP across the entire immigration detention network, from 1 July 2013 to 30 June 2015. This is despite the findings of the Australian Human Rights Commission, the Moss Review and the Nauru Inquiry, as well as reports in the Australian media that sexual assaults and misconduct are commonplace.

The assaults reported are described below.
6.3.1 Sexual assault or urinary tract infection, Christmas Island, May 2014

On 8 May 2014, a client was taken to hospital and treated as an in-patient ‘for a urinary tract infection or sexual assault’. This was held to constitute a notifiable incident, as a serious injury or illness had occurred. The ALA does not know whether Comcare investigated the incident.

6.3.2 Alleged sexual assault of a worker, Nauru, October 2014

On 5 October 2014, the DIBP reported that an IHMS worker who was off-duty at the time was allegedly sexually assaulted on 4 October 2014.

The incident was notified to Comcare. Following the alleged assault, a police investigation occurred, and a review of staff accommodation security was undertaken. Comcare did not investigate the incident. The incident was assessed as not notifiable by Comcare as an incident took place but no serious injury or illness or dangerous incident occurred. It is not known if psychological injuries were considered in making this assessment.

While little information is available, it is possible that a medical professional was sexually assaulted while in their accommodation.

6.3.3 Alleged sexual assault, Victoria, May 2015

On 23 May 2015, it was reported that an alleged sexual assault occurred while two detainees ‘engaged in horseplay’ in Maidstone, Victoria.

The incident report notes that CCTV captured the detainees laughing and pushing/kicking at each other. At one point, it appeared that someone kicked someone in the groin from behind and a person claimed that ‘….placed… hand down the back of …pants’.

The person was taken to the hospital for treatment but was not admitted, and was provided with pain relief medication. The incident report also noted that there was injury to testicle/bruising and alleged sexual assault. Victoria Police were contacted due to the allegation of sexual assault, and Serco was managing both detainees.

The incident was assessed as not notifiable as an incident occurred but no serious injury or illness or dangerous incident occurred. Comcare did not investigate the incident. It is not known if psychological injuries were considered in making this assessment.

6.4 Other evidence of sexual misconduct

6.4.1 The Open Letter to the Australian People

On 7 April 2015, a group of 24 current and former employees of the Nauru detention centre, released an Open Letter to the Australian People:

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280 Ibid.
‘We would like to be absolutely clear. **The Government of Australia and the Department of Immigration and Border Protection have tolerated the physical and sexual assault of children, and the sexual harassment and assault of vulnerable women in the centre for more than 17 months**’282 (emphasis added).

The letter also detailed the DIBP’s inaction in response to allegations, asserting that:

‘In November 2013, a boy was sexually assaulted by a detention centre employee.

The incident was substantiated and the allegations were also found to be credible in the Moss Review.

Former Immigration Minister Scott Morrison was notified of this assault.

Despite this knowledge, the DIBP chose to keep this child in the detention centre where he was assaulted and remained at risk of further abuse and retaliation. Indeed, this child was subjected to further incidents of abuse while he was in detention.

**Following this, there were several additional allegations regarding the sexual assault of children.** The DIBP refused to remove these children from further harm. They were forced to remain in the Nauru detention facility where they continued to be at risk of further abuse and retaliation. Furthermore, **there were allegations of significant sexualised behaviour amongst children indicative of sexual abuse.** Again, despite incident reports from IHMS and Save the Children, the DIBP refused to remove these children from harm’283 (emphasis added).

These sources strongly suggest that the DIBP, and the then-Minister for Immigration, were directly aware of assaults and failed to act. If these allegations are proved, prosecutions under the WHS Act and possibly other legislation may be appropriate.

### 6.4.2 Moss Review

On 3 October 2014, the then Minister for Immigration and Border Protection, the Hon. Scott Morrison MP, announced a review into recent allegations relating to conditions and circumstances at the Nauru RPC. This would become the Moss Review.284

The Review team visited Nauru on two occasions, between 25 October – 1 November 2014 and 12 – 19 November 2014, and covered the period between July 2013 and October 2014.285

Subsequently, the Moss Review detailed extensive findings regarding misconduct in Nauru, including allegations of rape, sexual harassment and misconduct.286

The Review found that:

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282 Open Letter to the Australian People, at 1 - 2.
283 Ibid.
284 Moss Review, at 3 [1].
286 Ibid.
• There were two specific allegations of the rapes of two adult women at the Centre, one of which had been reported to the Nauru Police Force, while the other was first reported to the Review.\textsuperscript{287}

• There were allegations of indecent assault, sexual harassment and physical assault occurring within the Centre. Some of these allegations had been reported and the relevant authorities were investigating or had investigated. Contract service provider staff members were the subject of some of these allegations,\textsuperscript{288} including a number of formally reported allegations of sexual and physical assault against minors.\textsuperscript{289}

• Many transferees were apprehensive about their personal safety and have concerns about their privacy in the Centre.\textsuperscript{290}

• There is a level of under-reporting by transferees of sexual and other physical assault.\textsuperscript{291}

The Moss Review concluded that ‘the arrangements for identifying, reporting, responding to, mitigating and preventing incidents of sexual and other physical assault at the Centre could be improved’.\textsuperscript{292} The DIBP accepted all 19 recommendations from the Moss Review, although the ALA is not aware of the extent to which the recommendations have been implemented as yet.\textsuperscript{293}

The ALA submitted to the Nauru Inquiry that the Moss Review appears to indicate that there is inadequate information or training to protect all persons, (including children and women detained at the centre) from risks to their health and safety, as per s19(3)(f) of the WHS Act.

The ALA submitted that ‘guidelines relating to sexual relationships and assault in the workplace should be so basic to employment, that the lack thereof may indicate the deficit of appropriate protection at the centre’.\textsuperscript{294}

\textbf{6.4.3 Trading sexual favours for basic necessities}

Allegations of guards or others engaging in sexual conduct with detainees include trading sexual favours for the provision of goods, and teenagers engaging in romantic relationships with guards. While the ALA acknowledges that consenting sexual relationships can take place between adults in a variety of contexts, concerns must be raised where those relationships arise in circumstances of significant power imbalances, such as in a detention environment.

The Moss Review heard that Nauruan guards had been trading marijuana with detainees in exchange for sexual favours. The Review, drawing upon information provided by transferees and Wilson Security intelligence reporting, concluded that this was ‘possibly occurring’.\textsuperscript{295} The Moss Review was established in October 2014 and finalised in February 2015, with additional reporting in March 2015.\textsuperscript{296}

\begin{thebibliography}{99}
\bibitem{287} Ibid, at 3 [8].
\bibitem{288} Ibid, at 4 [9].
\bibitem{289} Ibid, at 36 [3.97].
\bibitem{290} Ibid, at 4 [12].
\bibitem{291} Ibid, at 4 [16].
\bibitem{292} Ibid, at 5 [19].
\bibitem{293} DIBP, Annual Report 2014-2015, at 6.
\bibitem{295} Moss Review, at 4 [11] and at 33 [3.73].
\end{thebibliography}
This Review also heard that a joint Wilson Security Nauru Police Force operation was conducted between June and September 2014 in response to the allegations to trading contraband for sexual favours, which identified a local staff member as the subject. That staff member’s employment was terminated on other grounds.\[297\]

After the Moss Review was completed, Wilson Security knew of two further allegations of Wilson Security officers trading contraband for sexual favours in early 2015; one on 1 February 2015 and another on 13 March 2015.\[298\]

Both officers were subsequently terminated – the latter on the basis of other performance grounds as there was insufficient evidence.\[299\]

In March 2015, the Saturday Paper also alleged that inappropriate relationships between guards and teenage girls had been occurring:

‘This week I spoke to a former Save the Children staff member who had worked at the Nauru asylum seeker processing centre, and heard that expatriate security guards – employed by private contractor Wilson – were having relationships with detained teenage girls. “We saw proof of this,” the former officer told me. “We saw text messages the guards had sent the girls. There were at least four guards I know of, and some of the girls were under-age.

“The girls were desperate to keep the relationships secret. They were extremely frightened of people finding out. They also appeared very reliant upon the affection of these men.”’\[300\]

Following the Moss Review, a Senate Committee was established to investigate allegations of misconduct in the Nauru RPC (the Nauru Inquiry). Concerns regarding trading sex for goods were also raised with the Nauru Inquiry.\[301\]

The ALA is concerned about allegations that sexual exploitation of this kind apparently continued for some time after they allegedly came to the attention of the DIBP. In its final report, the Nauru Inquiry made the following recommendation:

‘Recommendation 14

5.91 The committee recommends that legislation be passed by the Australian Parliament requiring the mandatory reporting of any reasonably suspected unlawful sexual contact, sexual harassment, unreasonable use of force or other assault perpetrated against asylum seekers at the Regional Processing Centres, under similar terms as the mandatory reporting provisions contained in existing Commonwealth, state and territory laws.


\[298\] This included 1/2/15 – allegation of Wilson Security officer trading contraband for sexual favours; 13/3/15 – allegation of local officer trading contraband for sexual favours. See ibid, at 4-13.

\[299\] ibid, at 13.


5.92 Such legislation should require that the reporting is made to the Department of Immigration and Border Protection and the Australian Federal Police, as well as any relevant state, territory or foreign police force and, where the matter relates to a child, child protection authorities in any relevant jurisdictions. The legislation should utilise Category C or D extraterritorial jurisdiction to apply in Nauru, and impose penalties for noncompliance comparable with those which apply in existing legislation within Australia.’

The Australian government’s response this recommendation, that such allegations are matters for Nauruan authorities, does not appear to consider obligations under the WHS Act. It would appear that for the objects of the WHS Act to be realised, protections in line with the recommendations of the Nauru Inquiry would be required.

6.4.4 Knowledge of the DIBP and contractors

The Open Letter to the Australian People asserted that the DIBP had been regularly appraised of the extent of the assaults in Nauru RPC, and had failed to act:

‘The Department of Immigration and Border Protection and all service providers were informed, in writing, of several of the assaults detailed in the Moss Review in addition to many other assaults not mentioned in the report. In addition to the receipt of formal incident reports, DIBP management participated in weekly and daily meetings where these assaults were discussed. They were also routinely forwarded copies of internal Save the Children meetings regarding particularly vulnerable children for the entire time that women and children have been detained in the centre.

The statements recently made by Immigration Minister Peter Dutton regarding a “zero tolerance” to sexual abuse do not reflect the attitude or actual response that has been provided to women and children who reported assault and sexual harassment on Nauru.’

The DIBP acknowledged in evidence to the Nauru Inquiry that a number of allegations of sexual misconduct had been reported to DIBP:

‘In the month of September 2014, a number of information reports were submitted by service providers containing allegations of inappropriate sexual conduct. A number of reports relating to sexual assault were also reported in Australian media over the same period of time. Between 26 September 2014 and 10 October 2014 the Minister received correspondence containing allegations of sexual assault and other misconduct at the Regional Processing Centre in Nauru. These allegations are documented through the Moss report.’

New Matilda reported that:

‘The company tasked with running the centre has recorded 67 allegations of child abuse, with 30 of the allegations relating to staff.

Transfield Services, the primary contractor overseeing the facility, published the figures in its response to questions fielded at an ongoing Senate Inquiry.

In a detailed response, the company said 33 allegations of sexual assault or rape had been lodged via the complaint and incident reporting frameworks used in the centre.

“Each of these allegations has been reported to the Department,” Transfield noted.1303

Contractors could also potentially be liable under the Criminal Code (Cth) in relation to child sex offences outside of Australia (Div 272). The ALA does not have evidence to suggest infringement of this Division. If it were shown, however, that contractors were aware of grooming of a child under 16 and did not act to prevent the grooming, this could be seen as facilitating, aiding or abetting the offence and give rise to liability under s272.19. Other offences under that Division may also be relevant.

It would be necessary to show that such offending was undertaken by an employee, agent or officer of the body corporate acting within the actual or apparent scope of their employment or authority (s12.2), and that the body corporate acted intentionally or recklessly (s12.3). A body corporate could be considered complicit in these offences under s11.2 of the Criminal Code (Cth) if they aided or abetted the commission of the offence, including if they were reckless in this regard. These offences might be demonstrated by continuing to facilitate abuse after an allegation was made or it was otherwise discovered. Such infringements may be suggested by the Open Letter to the Australian People or evidence provided by the Saturday Paper above at 6.4.3 or New Matilda in this section.

6.4.5 The implications of an open centre

In October 2015, it was announced that the Nauru RPC would move to an open centre.304 While the ALA applauds the move towards greater freedom for asylum seekers and refugees, it is concerned that the Nauruan community environment has not been safe for these people. A number of reports have been received that asylum seekers and refugees have been subjected to threats, intimidation and acts of violence, including rape, by local members of the Nauruan community. Doubts regarding the efficacy of the Nauruan law enforcement officials to investigate and appropriately punish crimes against asylum seekers and refugees, these reports are particularly concerning.

The Saturday Paper notes that ‘[w]hile Connect finds accommodation for refugees, the Australian government pays the rent’.305

The Saturday Paper alleges that:

‘… the accommodation sought for refugees is woefully inadequate and leaves women vulnerable. There are doors without locks – merely flimsy latches – and single women who have been placed in the most remote parts of the island, where they have subsequently been sexually assaulted.’306
Submission No. 79 to the Nauru Inquiry suggested that:

‘As more and more asylum seekers are released into the Nauruan community, there are also more incidents in which refugees are assaulted and attacked by Nauruan locals, I have spoken with CONNECT staff (External Refugee Resettlement agency based in Nauru) and I have been advised that refugees are being targeted and assaulted on a weekly basis by locals, some of these matters are reported to the Nauruan police force, however many are not for fear of retaliation by Nauruan locals or inaction by the Nauru Police’ \(^{307}\) (emphasis added).

There are further allegations of abuse toward asylum seekers and refugees:

- in October 2015, a refugee living in the Nauru community said to ABC News that: ‘as we walk to work, Nauruan men charge us $5.00 to use the road, then they follow us and harass us or touch us’\(^{308}\);
- in January 2016, there was an alleged sexual assault of a six-year-old refugee girl living in the Nauru community\(^{309}\);
- in January 2016, an allegation was raised that a five-year-old asylum seeker was urinated on by a group of Nauruan boys and asylum seeker girls have been sexually harassed at school\(^{310}\).

Given the real risks faced by detainees, asylum seekers and refugees in the Nauruan community, better security is needed to ensure their safety. It should be possible to allow asylum seekers significantly greater freedom while ensuring their safety. These people are on Nauru as a result of the conduct of the DIBP’s business or undertaking. As such, the ALA believes the WHS Act requires is.

The ALA argues that it is incumbent on the DIBP to assess the safety of asylum seekers and refugees in the Nauruan community, and provide alternative places of accommodation for asylum seekers prior to relocating them there. Similar assessments would be required regarding the safety of asylum seekers and refugees in any country to which they were sent by Australia, including Papua New Guinea. This would be analogous to obligations of the PCBU under s19 of the WHS Act, to ensure that accommodation provided to workers meets health and safety standards. This obligation might well be found to be a component of the non-delegable duty of care that the DIBP owes asylum seekers and refugees in RPC countries.

6.5 Comcare’s understanding of sexual misconduct

The ALA is concerned that sexual misconduct is not taken sufficiently seriously by Comcare and DIBP officials, undermining the safety of detainees in immigration detention, especially in RPCs. Of particular concern is the inconsistency in Comcare’s position regarding whether ‘sexual assault’ constitutes a...

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‘serious injury or illness’ for the purposes of the WHS Act. The failure of the DIBP to report instances of sexual misconduct to Comcare is also alarming.

Comcare has been inconsistent in the way that it has characterised sexual assault, and reporting obligations associated with it. In 2015, Comcare described sexual assault as only being a notifiable incident if it requires treatment as an in-patient at a hospital.311 Where sexual assault does not require immediate treatment as an in-patient in a hospital, Comcare does not believe this meets the definition of serious injury or illness in s36 of the WHS Act. See Comcare’s responses to questions on notice to the Nauru Inquiry:

‘Q: Is a sexual assault, an alleged sexual assault or an incident of self-harm that takes place within or outside the Regional Processing Centre on Nauru a notifiable incident?

A: A sexual assault, or alleged sexual assault or an incident of self-harm would be notifiable under s38 of the WHS Act if the assault or self-harm results in a person requiring immediate treatment as an in-patient in a hospital.

Q: If not, why not?

A: If a sexual assault, an alleged sexual assault or an incident of self harm did not result in the death of a person or in a person requiring treatment as an in-patient in a hospital or otherwise did not meet the definition of ‘serious injury or illness’ in s36 of the WHS Act, then it would not meet the definition of ‘notifiable incident’ in s35 of the WHS Act.”312 (emphasis in original).

These responses conflict with information available from Comcare from 2014, in which sexual assault is defined as a critical incident that is reportable to Comcare.313

Comcare also revealed its misunderstanding of the health and safety implications of sexual misconduct during investigations undertaken for the Moss Review. A Comcare Inspector did not see the Moss Review as being related to health and safety, despite its inquiry into allegations of sexual misconduct.314

This lack of clarity points to a clear gap in health and safety protection for people who have suffered sexual assault.

Comcare’s interpretation of the WHS Act does not appear to meet the objects that it is designed to achieve in relation to sexual misconduct. Psychological health is almost invariably impacted by sexual misconduct, and in instances where intercourse occurs (such as rape or some sexual abuse, for example intercourse in exchange for contraband described above), infections or pregnancy can result. Comcare’s failure to understand the health and safety ramifications of this misconduct is alarming.

The broader ramifications of allowing sexual misconduct to occur without adequate care being taken of the victim means that a culture of such behaviour occurring with impunity, and bullying, can thrive. Testimony cited above indicates that a chilling effect was in place in the RPCs at the time the Moss Review and the Nauru Inquiry took place. As the example of the abuse of the 16-year-old-boy detailed above indicates, allowing such a culture to flourish can have disastrous consequences for a whole community, seriously undermining the health and safety of everyone in the workplace.
6.5.1 Comcare questioned on sexual assault

In an attempt to clarify the uncertainty surrounding the status of sexual assault as a notifiable incident under the WHS Act, the ALA wrote to the Chief Executive Officer of Comcare on 22 September 2015, seeking clarification as to the duty to report sexual assault in a Commonwealth workplace:

'We seek clarification from Comcare regarding the duty of the DIBP to report incidents of a sexual nature regarding the incidents set out below. We are also seeking clarification whether there is any change to the duty when these incidents are affecting children:

a. sexual harassment.
b. indecent sexual assault not requiring medical treatment (for example, touching a child’s genitalia), however the incident later requires psychological treatment.
c. allegation of rape where medical treatment is provided.
d. allegation of rape where medical treatment was not provided.
e. allegation of rape where obvious physical injuries are incurred but the person is not admitted as an in-patient.
f. allegation of rape where obvious physical injuries are incurred and the person is admitted as an in-patient.
g. allegation of rape where the person is transferred to Australia for medical treatment as an outpatient.
h. allegation of rape where the person is transferred to Australia for medical treatment as an in-patient.'

The ALA further questioned Comcare:

a. does Comcare consider that incidents of sexual assault that did not require immediate treatment for physical injury, are notifiable incidents?
b. does this differ when a child is involved?
c. does this differ when the sexual assault is committed by multiple offenders at one time? (i.e. a ‘gang rape’ situation)?

The ALA sought further clarification regarding whether an incident may be characterised as notifiable:

‘Does Comcare consider that these incidents constitute ‘notifiable incidents’ for the purposes of the WHS Act:

a. rape requiring medical treatment;
b. allegation of rape;
c. allegation of rape that has been substantiated after the fact;
d. child sexual abuse requiring medical treatment;
e. child sexual abuse;
f. indecent sexual assault of a child;
g. sexual harassment;
h. sexual harassment of a minor….

315 Australian Lawyers Alliance, Correspondence to Comcare, dated 22 September 2015, at 21-22.
316 Ibid, at 17.
Comcare acknowledged the letter on 17 November 2015:

Comcare has requested further information from the Department of Immigration and Border Protection (DIBP) in relation to your letter dated 22 September. Comcare will be in contact when we have assessed the information.

Comcare continues to monitor, respond and take regulatory action where it is warranted, to ensure the work health and safety responsibilities of DIBP are upheld at regional processing centres and immigration detention centres.318

As at 30 April 2016, no further response has been received by the ALA from Comcare.

The nature of injuries that arise from sexual misconduct do not appear to be adequately understood. This appears to have resulted in an underreporting of such incidents and therefore a fundamental failure to satisfy the objects of the Act.

6.6 Recommendations

The ALA recommends that the federal government:

- amend s37 of the WHS Act to include sexual misconduct, including serious sexual assault, sexual abuse and serious sexual harassment, as an additional dangerous incident. There should be no requirement that physical injury results from this misconduct and it should be presumed that psychological injury does result from such misconduct.
- amend s37 of the WHS Act to include as a dangerous incident instances of bullying and harassment that cause workers or other persons to fear for their personal safety. Where such bullying and harassment occurs in the workplace, it should be considered as arising from the conduct of the business or undertaking.
- amend s36(a) of the WHS Act to reflect the requirement proposed below, in recommendations to Comcare, that that all medical advice that an individual should be hospitalised should be considered a serious injury or illness, regardless of whether hospitalisation occurred or not.
- amend s19(4) of the WHS Act to extend the primary duty of care to ensure that the accommodation of other persons owned, managed or paid for by the PCBU does not expose them to risks to their health and safety.
- implement all recommendations of the Nauru Inquiry, in particular recommendations 11, 13 and 14. Commonwealth responses to these recommendations - that allegations of a criminal nature be investigated by the Nauru Police Force and are the responsibility of the government of Nauru - are inadequate to discharge the DIBP's obligations under the WHS Act. Recommendation nine of the Nauru Inquiry should be implemented with adequate attention being paid to the health and safety of detainees who take advantage of open centre arrangements.
- implement all recommendations of the AHRC report, in particular that children should not be transferred to RPCs unless it is clear that their human rights will be respected, and that CCTV cameras be installed in all detention centres to capture significant incidents.

318 Correspondence from the CEO of Comcare to the Australian Lawyers Alliance, dated 17 November 2015, at 1.
319 Australian Government, Response to the report of the Select Committee on the Recent Allegations relating to Conditions and Circumstances at the Regional Processing Centre in Nauru, responses to recommendations 13 and 14.
The ALA recommends that the DIBP:

- report all instances of sexual misconduct, including serious sexual assault, sexual abuse and serious sexual harassment to Comcare.
- along with Comcare, ensure adequate accommodation is provided to asylum seekers released into the community in Nauru, within the context of its non-delegable duty of care. This includes ensuring that the accommodation is in a safe area and can be adequately secured against threats.
- consider the broader context of sexual misconduct in the Nauruan community as a component of its work health and safety obligations. All health and safety incidents involving workers or residents of the RPCs are covered by the WHS Act wherever on Nauru they occur, by virtue of the fact that those individuals are in Nauru as a result of the conduct of the business or undertaking of the DIBP.
- train Nauruan law enforcement officers on appropriate responses to sexual misconduct allegations, including respect for privacy, respectful gathering of evidence and appropriate sanctioning of perpetrators. The fact that Nauruan law enforcement officers work for a foreign sovereign nation does not absolve the DIBP of its work health and safety obligations to protect detainees from sexual misconduct.

The ALA recommends that Comcare:

- require the PCBUs to report, and then investigate, all allegations of sexual misconduct, including serious sexual assault, sexual abuse and serious sexual harassment. All sexual misconduct that occurs in immigration detention facilities should be presumed to be a result of the conduct of the business or undertaking and presumed to result in psychiatric injury. The need for such investigations is particularly pressing in RPCs, where other legislative protections against sexual misconduct that exist in Australia may not be present.
- thoroughly investigate any evidence that indicates the WHS Act has been infringed in relation to sexual misconduct. Where evidence suggests that offences have been committed, prosecutions should be conducted.
- refer any evidence that other state, territory or Commonwealth legislation has been infringed in relation to sexual misconduct to the appropriate government agency for further investigation and possible prosecution.
- conduct a comprehensive review of conditions in the Manus Island and Nauru RPCs and onshore detention facilities, including developing clear lines of reporting to ensure all instances of abuse and assault perpetrated against workers or other persons are reported as notifiable incidents.
- interpret workplace health and safety to include harassment and bullying. Incidents of harassment and bullying that cause workers or other persons to fear for their safety should be reported to Comcare as a notifiable incident and investigated accordingly.
- require notification where a worker or other person receives medical advice that they require hospitalisation, regardless of whether that hospitalisation occurs or not, in line with the recommendation to amend s36(a), above.
- along with the DIBP, ensure that adequate protections are provided to asylum seekers released into the community in Nauru, as a component of its non-delegable duty of care. This includes ensuring that the accommodation is in a safe area and can be adequately secured against threats.
Chapter 7 – High-risk groups and situations

Overview

A large number of high-risk groups are in immigration detention. As claimants of refugee status, the majority are likely to be fleeing persecution in their home countries. They are likely to have experienced additional trauma during their journeys to Australia or RPCs, as well as be suffering the dislocation of being far away from the people and places they know and love. Furthermore, some detainees will be at higher risk in terms of health and safety risks due to personal attributes, including their age, sex or other personal characteristics.

Under the WHS Act, the DIBP has a duty to ensure health and safety in its workplaces. This chapter outlines issues regarding the physical and psychological health of both detainees and workers and addresses reports of self-harm, mental health, disease, medical treatment, children undergoing medical treatment, and the treatment of pregnant women and sexual minorities.

We do not consider that the incidents reported by the DIBP to Comcare represent the full picture of health in immigration detention centres. This is confirmed by the inconsistencies with the evidence given to reviews and with parliamentary inquiries.

7.1 Psychological health: self-harm and threats of self-harm

Over the past two years, the DIBP reported 210 incidents of self-harm or threats of self-harm to Comcare across the immigration detention network: 61 in FY2013-2014 and 140 in FY2014-2015.

This included people:

- ingesting substances including laundry powder, shampoo, insect repellent, blister medication, liquid toilet paper, washing powder, medication and rinse-aid;
- swallowing nail clippers;
- setting themselves on fire;
- cutting themselves (for example, cutting their earlobes off and cutting across their abdomen);

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324 DIBP, Annual Report 2013-2014, incidents reported to Comcare, No.96.

325 DIBP, Annual Reports, incidents reported to Comcare, FY2013-2014 – No. 34; FY2014-2015 – No. 178.

As this Report was being finalised, two refugees on Nauru self-immolated five days apart, one of whom subsequently died. In the intervening days, six attempts at suicide were made. Clearly psychological health is an urgent issue on this island.

7.1.1 Under-reporting of self-harm to Comcare

The total number of 206 incidents reported to Comcare appears to be inconsistent with evidence provided both by IHMS to the Moss Review, and by the DIBP itself to the Nauru Inquiry.

In FY2013-2014, of the 60 incidents of self-harm or threats of self-harm that were reported to Comcare by the DIBP, only one related to Nauru: a client attempted self-harm and received IHMS treatment.

In answers to questions on notice to the Nauru Inquiry, the DIBP said that there were 55 self-harm incidents at the Nauru RPC during FY2013-2014. It is unclear why the DIBP chose not to report the 54 additional incidents of self-harm to Comcare. It is also unclear how many of these incidents concerned children.

This inconsistency suggests that the total of 60 self-harm incidents across the immigration detention network reported by the DIBP to Comcare is not a reliable figure.

Evidence provided by IHMS to the Moss Review further confirms that the number of self-harm incidents was higher than the one incident reported to Comcare in FY2013-2014. IHMS provided to the Moss Review a schedule of self-harm incidents which had occurred at the Nauru RPC between October 2013 and October 2014. During this period, 17 minors were recorded as having engaged in self-harm, including a 16 year old who attempted to hang themselves and an 11 year old who swallowed a metal bolt and a rock.

The Moss Review states that this document said that:

‘ten of the 17 self-harm incidents occurred during the 25-27 September 2014 period, immediately following the Ministerial announcement of 25 September 2014. These included three cases of lip stitching by minors aged between 16 and 17 years, six incidents of wounds predominately to left forearms (the youngest by a 14 year old) and one incident involving a 15-year-old who swallowed washing detergent.’

332 See the Moss Review, at 36.
333 Ibid.
In FY2014-2015, there were 26 self-harm incidents related to Nauru,\textsuperscript{334} out of a total of 146 self-harm incidents reported to Comcare by the DIBP.

By contrast, evidence given by the DIBP to the Nauru Inquiry in answers to questions on notice asserted that there were 161 self-harm incidents at the Nauru RPC from 1 July 2014 to 25 May 2015.\textsuperscript{335} According to these figures, the DIBP was aware of approximately 135 incidents of self-harm that were not reported to Comcare. It is also unknown how many of these incidents relate to children.

The under-reporting of incidents of self-harm is a cause for serious concern. There are a number of workplace health and safety factors that contribute to self-harm: the availability of the means to inflict injuries as well as the existence of an environment which makes self-harm an attractive option. This is particularly relevant where spikes in self-harm incidents occur, as detailed below.

Given that these findings refer to one detention centre only, the suspicion must be that the real number of incidents occurring within the entire immigration detention network is higher than the total of 146 incidents reported by the DIBP to Comcare for FY2014-2015, and higher than the two-year total of 206 incidents.

Table 6 – Incidents of self-harm and threats of self-harm, reported by the DIBP to Comcare, FY2013-FY2015

<table>
<thead>
<tr>
<th></th>
<th>FY2013-2014</th>
<th>FY2014-2015</th>
<th>2 Year Total</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total no. of incidents of self-harm/threat of self-harm reported by DIBP to Comcare</td>
<td>60</td>
<td>146</td>
<td>206</td>
<td>The real number of incidents that occurred is likely to be much higher.</td>
</tr>
<tr>
<td>No. of incidents of self-harm/threat of self-harm reported by DIBP to Comcare (included in numbers above) regarding Nauru</td>
<td>1\textsuperscript{336}</td>
<td>26\textsuperscript{337}</td>
<td>27</td>
<td>These figures contrast with evidence given by DIBP to the Nauru Inquiry that 55 self-harm incidents occurred at the Nauru RPC during FY2013-2014\textsuperscript{338} and 161 from 1 July 2014 to YYD (25 May 2015),\textsuperscript{339} suggesting a two year total of at least 216 incidents of self-harm.</td>
</tr>
<tr>
<td>No. of incidents of self-harm/threat of self-harm reported by DIBP to Comcare (included in numbers above) regarding Manus</td>
<td>1\textsuperscript{340}</td>
<td>12\textsuperscript{341}</td>
<td>13</td>
<td>Potential to be far higher.</td>
</tr>
</tbody>
</table>

Footnotes for Table 6, 336-341 on next page


\textsuperscript{335} Answers to questions taken on notice, provided by the Department of Immigration and Border Protection, received 09 June 2015, at 2, accessed at: http://www.aph.gov.au/DocumentStore.ashx?id=8bf36a60-5bc9-4200-a313-c8f9c1c758cb.
7.1.2 Children and self-harm

The Australian Human Rights Commission (AHRC) identified that ‘children detained indefinitely on Nauru are suffering from extreme levels of physical, emotional, psychological and developmental distress’.\(^{342}\)

The AHRC also identified that:

‘The level of mental distress of children in detention is evident by very high rates of self-harm. The Department of Immigration and Border Protection confirmed that during a 15 month period from January 2013 to March 2014, 128 children in detention engaged in actual self-harm. One hundred and seventy-one children threatened self-harm.

The age of children involved in self-harm ranged from 12 to 17 years old. One hundred and five children in detention were assessed under the Department’s Psychological Support Program as being of ‘high imminent risk’ or ‘moderate risk’ of suicide or self-harm and required ongoing monitoring. Ten of these children were aged 10 years or younger.’\(^{343}\)

It is not possible to determine how many of the 206 incidents that were reported by the DIBP to Comcare involved children, as ages of individuals was not included in the information received by the ALA pursuant to FOI Act requests.

Comparison between incidents reported and media stories, however, indicates that at least some self-harm incidents involving children were reported to Comcare. An incident on 25 September 2014, for example, which is listed as ‘client ingested laundry powder – medivaced off island – Nauru’, may describe the experience of a 16-year-old girl, who drank laundry detergent and began vomiting blood.\(^{344}\) The significant spike in self-harm incidents in September 2014 at the Nauru RPC is also likely to have included attempted suicide by children.\(^{345}\)

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\(^{336}\) DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 314.

\(^{337}\) DIBP, Annual Report 2014-2015, Incidents reported to Comcare, No. 59, 66, 94, 110, 150, 155, 210, 216, 217, 223, 225, 232, 234, 237, 254, 291, 364, 371, 406, 445, 447, 491, 531, 567, 577. See also No. 231; however, this may not have been a self-harm attempt and could have been an assault.


\(^{339}\) Ibid.

\(^{340}\) DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 96.


\(^{343}\) Ibid.


\(^{345}\) Ibid.
Submission No. 96 to the Nauru Inquiry noted that:

‘One of the biggest concerns I had was the clear and well documented deterioration of the mental health of children and their families. I witnessed children’s behaviours regress in the camp, with many beginning to experiencing things like bedwetting, night terrors, panic attacks and reported regular feelings of being sad and scared.

Many parents reported escalation in their children’s behaviour, stating they had become more defiant and aggressive. Very regularly children and parents would report feelings of extreme hopelessness, sadness and anxiety with some expressing feelings of suicidality and self-harm. I am aware that some clients followed through with attempts and there was regular self-harm from both children and parents.

As required by DIBP, I along with my colleagues, submitted regular individual management plans (IMPs) for children and parents outlining their progress and included information about this observed mental health deterioration and provided recommendations. Incident reports were also submitted if there were immediate grave concerns for clients. I was concerned by the fact that DIBP appeared to treat self-harm and suicide attempts as “behavioural concerns”, viewing these behaviours as manipulative rather than signs of mental health issues. As a qualified and experienced Social Worker I believe that the act of detaining people in detention centres combined with the conditions within the camp were directly negatively affected clients’ mental health. There were not sufficient mental health support available for clients, nor adequate responses from DIBT [sic].’

7.1.3 Spikes in incidents of self-harm assessed as not-notifiable

It is clear from reports by the DIBP to Comcare that there have been a number of ‘spikes’ in the reporting of self-harm incidents at certain detention centres within a specific timeframe. Something may have triggered these significant events, which is possibly causally connected to the way in which the DIBP is managing or controlling the centres.

However, in these examples, the incidents – which were characterised as ‘not-notifiable’ by Comcare – have been described as ‘not resulting from the conduct of the business or undertaking’.

Given that all of these incidents took place during spikes in the numbers of self-harm incidents, it is worth asking whether appropriate steps were taken by the DIBP to mitigate or eliminate the risk of self-harm, including the availability of potentially harmful materials to ingest.

Evidence detailed below suggests that a number of these spikes occurred following DIBP announcements regarding claims for refugee status or other details related to detention. Where spikes in self-harm follow specific DIBP announcements and appear to be causally related to them (for example, if people say they are engaging in self-harm because of the announcement), it is hard to understand how such incidents could be assessed as not resulting from the conduct of the business or undertaking. It would also seem to be incumbent on those making such announcements to consider how they can minimise risks that appear to be inherent in them.

7.1.3.1 September 2014, Nauru

On 25 September 2014, asylum seekers at Nauru were advised that the then-Minister of Immigration and Border Protection, Scott Morrison, had announced the reintroduction of temporary protection visas. However, transferees in Nauru would remain subject to regional processing arrangements and would not be eligible for temporary protection visas and resettlement in Australia.\(^{347}\)

Following this announcement, there was a spike in self-harm incidents reported to Comcare by the DIBP, with seven self-harm incidents reported in five days (some of which involved multiple people). It is not known if any incidents of self-harm were not reported to Comcare. All of the incidents were assessed as not notifiable. Six were held to be not notifiable, as the incidents did ‘not result from the conduct of the business or undertaking’ and one major incident was not notifiable because no serious injury or illness or dangerous incident occurred.

This is despite the fact that these reported incidents coincided with the Minister’s messaging on 25 September 2014 and may have been causally related to it.

Furthermore, these incidents may have involved children. In an interview to the \(ABC\)'s \(PM\) program, a refugee detained at the Nauru RPC said that seven children attempted suicide after they heard about the Cambodian deal, which was signed on 26 September 2014:\(^{348}\)

> REFUGEE: My friend, she's very young but because I care about her because she's had a mental problem, she tries to kill herself. She drink washing powder and she vomits blood. (Inaudible) many kids now, seven of them, they tried to kill themselves and many of them, they say, will complete it. Many kids here they are tired. Nothing, no school, no education, nothing.

> SARAH DINGLE: So you say seven kids have tried to kill themselves on Nauru. Is that because they have heard about the Cambodia deal?

> REFUGEE: Yes. Yes, because they heard about the Cambodia. People in Nauru will go to Cambodia and people in Christmas Island will go to Australia. Because these kids they have friends in the same boat in Christmas Island. And the friends tell them, “We'll get a visa to Australia.” And this kid: one day he's dead. They are very upset. And the mental, like, they need... They always try to keep calm but now everybody they can't. Really, they can't.

> SARAH DINGLE: The girl who tried to kill herself by drinking washing powder, your friend, how old is she?

\(^{347}\) Moss Review at 14, [1.1].

REFUGEE: She is 16 years old. She’s very young but because she has a mental problem, I always, like, tried to care about her because she is like my sister. I don’t know. Some people say they will send her to the hospital in Nauru or into Australia or I don’t know where.

SARAH DINGLE: And what about the other children? You said seven children had tried to kill themselves. What has happened to the other six?

REFUGEE: Today also we hear about these kids but they’ve tried to get them to the hospital, give them maybe tablets or something. I don’t know. Because they tried to kill themselves and the kids they are not happy. They have, they say, “If they’ll send us to Cambodia, we’ll all try to kill ourselves.”

We are hear that Cambodia, there’s many fighting in Cambodia. Also it’s a very poor country. It’s more poor than Nauru. How we can stay there? How we can eat? Even the people in Cambodia, they just find that they eat because they... how can a refugee go to Cambodia? And it’s very poor country.  

Table 7 – Spike in self-harm incidents in Nauru reported to Comcare, 25 – 30 September 2014

<table>
<thead>
<tr>
<th>Date</th>
<th>Incident</th>
<th>Assessment reason</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>25/9/2014</td>
<td>Client ingested laundry powder – medivaced off island</td>
<td>Not notifiable – an incident occurred but it did not result from the conduct of the business or undertaking.</td>
<td>Submission No. 83 to the Nauru Inquiry indicates that this was a teenage girl.</td>
</tr>
<tr>
<td>26/9/2014</td>
<td>Client ingested laundry powder – transported by ambulance to IHMS</td>
<td>Not notifiable – an incident occurred but it did not result from the conduct of the business or undertaking.</td>
<td></td>
</tr>
<tr>
<td>26/9/2014</td>
<td>Client ingested laundry powder – transported by ambulance to IHMS</td>
<td>Not notifiable – an incident occurred but it did not result from the conduct of the business or undertaking.</td>
<td></td>
</tr>
<tr>
<td>28/9/2014</td>
<td>Two clients ingested laundry powder – transported by ambulance to IHMS</td>
<td>Not notifiable – an incident occurred but it did not result from the conduct of the business or undertaking.</td>
<td>Submission No. 83 to the Nauru Inquiry appears to suggest these may have been women.</td>
</tr>
<tr>
<td>30/9/2014</td>
<td>Client hit himself in the head with guitar – head injury</td>
<td>Not notifiable – an incident occurred but it did not result from the conduct of the business or undertaking.</td>
<td></td>
</tr>
</tbody>
</table>

Footnotes for Table 7, 350-356 on next page

Submissions to the Nauru Inquiry indicated that following the ‘messaging’ conveyed to detainees at Nauru RPC on 25 September 2014, protests occurred. The full scale of these protests do not appear to have been reported to Comcare. This included plans for mass suicides, and peaceful protests involving up to 300 people.

Submission No. 83 to the Nauru Inquiry said that:

- 26/9/2014 – There was a large protest that had occurred until late at night on 25/9/2014, including involving six unaccompanied minors who self-harmed together using razors.
- 28/9/2014 – Seven males had stitched their lips together, including three minors.
- 28/9/2014 – Approximately 300 people had attended a protest the night before from 9pm to 11pm.
- 28/9/2014 – A man alleged that there are plans for mass suicide, involving driving star pickets from the fences through their chests.
- 29/9/2014 – Protest again occurred the night before involving approximately 270 people.
- 29/9/2014 – Client had beaten his head against the fence until he bled significantly.

While not captured by the current definition of dangerous incident under s37 of the WHS Act, it is clear that a series of incidents of this nature is a threat to the health and safety of detainees at the workplace.

7.1.3.2 January 2015, Manus Island

In January 2015, there was a spike in self-harm incidents on Manus Island. In two weeks, 18 incidents were reported. Five of these were reported as not-notifiable as they did not result from the conduct of the business or undertaking. It is questionable as to whether this was truly the case.

The context in January 2015 at Manus Island is relevant.

On Saturday 10 January 2015, ‘fears were heightened by the actions of locals smashing the kitchen in Foxtrot Compound, while more locals massed outside the compound fence’.

On 12 January 2015, a dangerous incident was reported: a large tree fell on accommodation buildings at Manus Island. No one was injured.

On 13 January 2015, protests began on Manus Island as running water had stopped, meaning that there was no water for showers or to wash. Hundreds of plastic bottles were piling up in shower blocks.
Refugee Action Coalition posted a photo, allegedly from the RPC, of a notice regarding ‘ Interruption to Water Use‘, which stated:

- ‘Some of our equipment we use to provide water to the Centre has broken down.
- This means that we have to impose water restrictions on staff and transferees until further notice.
- For transferees, this means that you can’t have showers today, but you can continue to use the washing machines (which uses a different system to provide water).
- For staff, this means no showers and no washing of clothes.
- These restrictions are effective immediately.
- You will be updated later today and we are doing everything possible to get this equipment fixed.
- Your patience and co-operation is appreciated.’

_The Guardian_ reported that, by 14 January 2015, ‘local security guards were on strike after going unpaid’.

In January, it was also announced that there would be a scheduled transfer of 50 male detainees to the Manus Island capital, Lorengau, on 22 January 2015.

An article published by Refugee Action Coalition on 14 January 2015 noted detainees’ fears about the proposed transfer:

‘One message from Mike Compound said, “If we are sent to Lorengau, they [the locals] will kill us. Please help us.”’

_The Guardian_ reported that protests began on 13 January 2015, when more than 100 asylum seekers on Manus Island went on hunger strike, protesting at their treatment in detention and the threat of being sent to live in the local community. The protest starts in Mike compound, with at least 50 men refusing food.

In two weeks, 16 incidents of self-harm or suspected self-harm at the Manus RPC were reported by the DIBP to Comcare.

Nine of the incidents reported were assessed by Comcare as not-notifiable incidents; four of these were assessed as not-notifiable as no serious injury, illness or dangerous incident occurred; five were not-notifiable as they ‘did not result from the conduct of the business or undertaking’.

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366 _Ibid._


368 _Ibid._


Table 8 – Spike in self-harm incidents in Manus Island reported to Comcare, 14 – 28 January 2015

<table>
<thead>
<tr>
<th>Date</th>
<th>Incident</th>
<th>Assessment reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>14/1/2015</td>
<td>Transferee self-harmed – internal injury[^371]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>15/1/2015</td>
<td>Transferee self-harmed – internal injury[^372]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>15/1/2015</td>
<td>Transferee self-harmed – unknown injury[^373]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>15/1/2015</td>
<td>Transferee attempted self-harm – unresponsive[^374]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>16/1/2015</td>
<td>Transferee attempted self-harm – unresponsive[^375]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>16/1/2015</td>
<td>Transferee attempted self-harm – unresponsive[^376]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>16/1/2015</td>
<td>Transferee attempted self-harm – unresponsive[^377]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>16/1/2015</td>
<td>Peaceful protest escalated with changing and objects being projected – no injuries[^378]</td>
<td>Not notifiable, an incident occurred but no serious injury or illness or dangerous incident occurred</td>
</tr>
<tr>
<td>16/1/2015</td>
<td>Transferee self-harmed – internal injury[^379]</td>
<td>Not notifiable, an incident occurred but no serious injury or illness or dangerous incident occurred</td>
</tr>
<tr>
<td>16/1/2015</td>
<td>Transferee self-harmed – collapsed[^380]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>23/1/2015</td>
<td>Transferee self-harm – acute abdominal pain[^381]</td>
<td>Not notifiable, an incident occurred but no serious injury or illness or dangerous incident occurred</td>
</tr>
<tr>
<td>23/1/2015</td>
<td>Transferee self-harm – suspected obstruction gastrointestinal tract[^382]</td>
<td>Not notifiable, an incident occurred but no serious injury or illness or dangerous incident occurred</td>
</tr>
<tr>
<td>23/1/2015</td>
<td>Transferee transported to Port Moresby – Pre-existing condition[^383]</td>
<td>Not notifiable, an incident occurred but it did not result from the conduct of the business or undertaking</td>
</tr>
<tr>
<td>23/1/2015</td>
<td>Detainee transported via air ambulance – unknown medical issue[^384]</td>
<td>Not notifiable, an incident occurred but it did not result from the conduct of the business or undertaking</td>
</tr>
<tr>
<td>28/1/2015</td>
<td>Transferee was found unconscious – IHMS treatment[^385]</td>
<td>Notifiable, serious injury or illness</td>
</tr>
<tr>
<td>28/1/2015</td>
<td>Transferee was treated by IHMS for abdominal pain and headache</td>
<td>Not notifiable, an incident occurred but it did not result from the conduct of the business or undertaking</td>
</tr>
</tbody>
</table>

[^371]: Untold Damage
[^372]: Untold Damage
[^373]: Untold Damage
[^374]: Untold Damage
[^375]: Untold Damage
[^376]: Untold Damage
[^377]: Untold Damage
[^378]: Untold Damage
[^379]: Untold Damage
[^380]: Untold Damage
[^381]: Untold Damage
[^382]: Untold Damage
[^383]: Untold Damage
[^384]: Untold Damage
[^385]: Untold Damage

Footnotes Table 8, 371-385 on next page
These reports failed to capture the extent of the protests at Manus Island and the risks and dangers posed to the health and safety of the detainees held there.

*The Guardian* reported that on 13 January 2015, more than 100 men were participating in a hunger strike, but this had increased to 500 men by the next day. By 17 January 2015, more than 100 men were under medical care, most from severe dehydration. By 18 January 2015, more than 200 detainees were allegedly receiving medical treatment after going on hunger strike, and there were reports that security police had begun rounding people up in a bid to end the protest.\(^{386}\)

In addition, *The Guardian* reported, on 18 January 2015:

> ‘four men were taken to the notorious “Chauka” solitary confinement unit. An urgent petition to the UN special rapporteurs on human rights, was lodged overnight by refugee advocates, describing multiple reports from staff and detainees saying the men were taken to Chauka, and urging the special rapporteurs to intervene and raise the matter with the Australian government’.\(^{387}\)

The ALA believes that Comcare could undertake more proactive investigations to assess whether systemic incidents of self-harm within a short timeframe are, as a matter of fact, connected with the conduct of the business or undertaking. This should include investigation of the extent to which the DIBP took steps to minimise the risks as reasonably practicable, in the period before, during and after the sudden increase in such incidents.

### 7.2 Psychological health: broader considerations

The Explanatory Memorandum to the *Work, Health and Safety Bill* 2011 (Cth) provides that:

> ‘The term ‘health’ is defined to clarify that it is used in its broadest sense and covers both physical and psychological health. This means that the Bill covers psychosocial risks to health like stress, fatigue and bullying.’\(^{388}\)

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387 *Ibid*.
Over the two years under investigation, there appear to have been 36 incidents reported by the DIBP involving a detainee who had specific mental health issues such as PTSD, anxiety or depression or mental health assessment (not including self-harm incidents): 11 FY2013-2014\textsuperscript{389} and 25 in FY2014-2015.\textsuperscript{390} Some of these have been characterised as not notifiable, as an incident occurred but it ‘did not result from the conduct of the business or undertaking’.

Of those reported in FY2014-2015, three\textsuperscript{391} incidents are identifiable as being reported regarding the Manus RPC and none regarding Nauru RPC.

It is likely that a much higher number of people were experiencing mental health issues. For example, from the period 1 May 2013 to 19 May 2015, 355 transferees at the Nauru RPC were prescribed psychotropic (including anti-depressant) medications.\textsuperscript{392} This indicates a higher number of people with mental health issues than has been identifiable by Comcare via the notifiable incident process.

The ALA acknowledges that detainees are claiming asylum, and may be experiencing trauma as a result of their experiences prior to detention. However, in such circumstances it is incumbent on the DIBP to ensure that the conditions in which they are kept do not exacerbate the illness: actions, inactions and any other treatment or conditions that do so could be seen to be a clear risk to the individual’s health and safety. This reflects the definition of health in s4 of the WHS Act.

The fact of pre-existing trauma within the detainee population does not mean that any mental health issue occurring within a detention facility does not arise out of the conduct of the business or undertaking. A careful and measured approach in assessing incidents is required, with a strong awareness of mental health.

The ALA also suggests that physical ailments experienced by detainees, such as back pain, headaches, and heart pain, could be characterised as a manifestation of a deterioration in psychological health and post-traumatic stress. For example, torture victims commonly suffer from physical complaints such as headaches, back pain and musculoskeletal pain, either as a direct result of the torture or for psychological reasons.\textsuperscript{393}

\textsuperscript{389} DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 107, 161, 201, 280, 381, 387, 408, 417, 419, 422, 423.


\textsuperscript{391} Ibid, No. 170, 395, 510.


7.2.1 The need for mental health professionals

The ability to respond adequately to self-harm incidents safely depends on having staff who are sufficiently trained in mental health. Submission No. 99 to the Nauru Inquiry highlighted that staff tasked to deal with self-harm incidents at the Nauru RPC were unqualified to deal appropriately with welfare issues. This raises questions regarding the ability to adequately manage, minimise and eliminate risk. The ALA suggests that the absence of people with adequate training to deal with a known problem of self-harm increases the risk that those self-harm incidents will lead to injury, illness or death.

Submission No. 99 asserted that:

‘Another area of major concern is the Wilson Security Behavioural unit, this is managed and staffed by inexperienced, unqualified Wilson employees, their role is a significant one however and they deal with all welfare issues relating to the asylum seekers, these can range from behavioural changes in the asylum seekers through to serious attempts at self-harm. I believe they are unqualified to make decisions regarding the mental and physical welfare of the asylum seekers, none of the behavioural team have a mental health or welfare background, How can these people determine what is the best end result for the asylum seekers when they themselves have no experience or skill set to draw upon.

The majority of the asylum seekers had prior significant mental health issues before they arrived in Nauru, however the conditions at Nauru appeared to have exacerbated these issues and the resulting behaviour of these Asylum seekers is recorded, monitored and their welfare needs and requirements decided by manifestly inadequately trained Client Service Officers under the guise of Behavioural specialists/managers.’

Mental health professionals would also be better-equipped to identify when mental illness is manifesting in unusual ways.

7.2.2 Possible physical manifestations of mental illness

Over the past two years, there have been 40 seizures reported to have been experienced by detainees across the immigration detention network: 21 in FY2013-2014 and 19 in FY2014-2015. There have also been 65 instances of detainees collapsing or fainting: 28 in FY2013-2014 and 37 in FY2014-2015; and 44 instances in which detainees were found unresponsive, catatonic or unconscious: 16 in FY2013-2014 and 28 in FY2014-2015.

The extent to which seizures, collapses, fainting, and incidents reported as ‘unknown medical condition/feeling unwell’, represent symptoms of psychological injury, and whether the detention served to exacerbate or trigger psychological injury, is unclear.

On 12 June 2014, a detainee suffered a seizure in Broadmeadows, Victoria, which was determined to be a psychological injury.\textsuperscript{401} However, it was characterised as being not notifiable, as an incident occurred but it did not result from the conduct of the business or undertaking.

The Epilepsy Foundation notes that:

‘psychogenic non-epileptic seizures (PNES) are attacks that may look like epileptic seizures, but are not caused by abnormal brain electrical discharges. They are a manifestation of psychological distress. Frequently, patients with PNES may look like they are experiencing generalized convulsions similar to tonic clonic seizures with falling and shaking. Less frequently, PNES may mimic absence seizures or complex partial seizures with temporary loss of attention or staring. A physician may suspect PNES when the seizures have unusual features such as type of movements, duration, triggers and frequency.’\textsuperscript{402}

The Epilepsy Foundation describes dissociative seizures (DS), which are a type of PNES:

‘Although DS start as an emotional reaction they cause a physical effect. Features of the seizures can include palpitations (being able to feel your heart beat), sweating, a dry mouth and hyperventilation (over-breathing).

Some features of DS are very similar to epileptic seizures. These physical features include loss of awareness, loss of sensation, and loss of control over bodily movement (which may include having convulsions).’\textsuperscript{403}

It is possible that this detainee’s seizure resulted from psychological distress rather than any pre-existing condition.

7.2.3 Asylum seeker syndrome

Medical professionals have identified the existence of ‘Asylum Seeker Syndrome’:\textsuperscript{404}

“The refugee determination process in Australia seems to contribute to the prevalence of post-traumatic stress disorders (PTSD) in asylum seekers insofar as asylum seekers insofar as asylum seekers who have had four or more rejections for protection visas, the level of PTSD correlates with the number of rejections that they have had,” Associate Professor Sundram said.

“Those asylum seekers who seem to have a protracted process of refugee determination, they seem to demonstrate clinical features that we haven’t seen before and certainly seem to characterise a unique, or distinct, syndrome from other people who have been through similar types of traumas.

\textsuperscript{401} DIBP, Annual Report 2014-2015, Incidents reported to Comcare, No. 417.
\textsuperscript{403} The Epilepsy Foundation, ‘Non-epileptic seizures,’ accessed at: http://www.epilepsysociety.org.uk/non-epileptic-seizures#.Ve5oJ_mqqVg.
“We’ve coined the term to best describe this subgroup of asylum seekers who’ve had this protracted and difficult refugee determination process.”

The existence of such a syndrome suggests a link between mental health issues and the conduct of the business or undertaking. It is important that the DIBP and Comcare are familiar with this research in assessing the safety of immigration detention facilities. Ensuring that these phenomena are minimised should be a routine part of meeting the DIBP's WHS Act obligations.

7.3 Pregnant women across the immigration detention network

Over the past two years, the DIBP reported 13 incidents to Comcare that affected pregnant women who were detainees: five in FY2013-2014 and eight in FY2014-2015. Of these, only one was assessed to be a notifiable incident.

7.3.1 Conditions in Nauru for pregnant women

No incidents were reported regarding pregnant women in Nauru. Evidence provided to the Nauru Inquiry, however, indicate that workplace health and safety could be impacting on these pregnancies. Evidence given by IHMS to the Nauru Inquiry noted that:

‘there were five miscarriages and four pregnancy terminations for transferees located at Nauru during the period 1 May 2013 to 19 May 2015 (noting that the transferees were transferred to Australia to undergo their pregnancy terminations)’. It does not appear that these miscarriages and terminations were reported by the DIBP to Comcare. Given the sparse information available in the documents provided to the ALA, however, it is not possible to say whether they were reported to Comcare or not.

Allegations of deficiency in the provision of vitamins, clothing and food to pregnant women were made to the Nauru Inquiry.

The media has reported that some asylum seekers had opted for abortion because the conditions were so bad in Nauru.

Two incidents have also been reported across DIBP’s activities regarding workers who were pregnant. Neither of these incidents constituted notifiable incidents as an incident occurred but it did not result from the conduct of the business or undertaking.

While miscarriages in Nauru were not reported to Comcare, the miscarriage of a female contractor on Manus Island was reported.

405 Ibid.
The ALA believes that all miscarriages that occur in immigration detention should be considered notifiable incidents under the WHS Act, and that Comcare should investigate accordingly. The women in question should be involved in the investigation to the extent they are comfortable, with sensitivity displayed given the likely emotional nature of such an investigation.

7.4 Children

Despite the numerous inquiries that have highlighted the particular vulnerability of children living in immigration detention, there is no clear way to identify the frequency with which children are involved in health and safety incidents in these workplaces.

The incident reporting system to Comcare cannot adequately reflect the risks posed to children (or other vulnerable groups), as discussed above at 5.3.3.

Across the two years under investigation, there were at least 28 incidents involving children: 15 in FY2013-2014 (including the fatality of one infant and one minor), and 13 in FY2014-2015. This included the death of an infant in November 2014. The ALA identified one additional incident involving a child by reviewing documents released pursuant to FOI Act requests. We suspect the real number to be far higher.

Of the 29 incidents that the ALA has identified that clearly relate to children, only two were deemed to constitute a notifiable incident. None of the three deaths of children was assessed as a notifiable incident. Consider also findings detailed above in relation to children and self-harm at 7.1.2.

7.4.1 Burning of baby Asha not reported

The burning of ‘baby Asha’ in January 2015 does not appear to have been reported by the DIBP to Comcare, despite the fact that the nature of her injuries appear to fall directly within the meaning of ‘serious injury’ under the WHS Act.

In February 2016, details regarding baby Asha’s medical records were released. The records indicated that baby Asha incurred a ‘~4% scald injury to chest [and that] hot water spilt on chest after child pulled on self. Hot water boiled in kettle.’

The medical records also indicated:

‘[Baby Asha] is a 12-month-old girl who was transferred to the Lady Cilento Children’s Hospital (LCCH) from the Nauru detention centre on 26.01.15, for assessment and management of a burn sustained 24 hours prior. The injury occurred when... [redacted] pulled a bowl containing recently boiled water off a table onto herself... [redacted] lives in a tent with no kitchen facilities except a kettle. [Redacted] mother boils all the water she consumes to ensure it is safe for drinking. Appropriate first aid was performed at the time of the injury.

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409 28 incidents are indicated clearly via brief descriptions; 1 was determined under the FOI Act.
[redacted] has a 3% body surface area burn on her chest which is of superficial partial thickness. There is no clinical evidence that the burn injury was non-accidental. The burn will require dressing changes and monitoring, she is expected to remain at LCCH for the duration of her treatment. Treatment is anticipated to continue for up to 2 weeks.  

Baby Asha was transferred for assessment and management of a burn sustained 24 hours prior, and was expected to remain at the hospital for the duration of her treatment: thus receiving treatment as an in-patient. This would appear to meet at least two of the definitions of ‘serious injury or illness of a person’ under s36 of the WHS Act.

Given that water was being boiled so that it was safe to drink, implying that the DIBP had not provided adequate safe drinking water, it is hard to see how such a burn could be assessed as not arising out of the conduct of the business or undertaking. However, information obtained by the ALA under the FOI Act suggests that the burning of baby Asha was not reported to Comcare by the DIBP.

7.5 Sexual minorities

The situation of homosexual men on Manus Island and Nauru has been highlighted as giving rise to particular risk.

Homosexuality is illegal in Papua New Guinea. Of the 14 sexual assaults of detainees of the RPC on Manus Island, none had resulted in prosecutions as at October 2015, according to evidence provided to Senate Estimates.  

Senator Hanson-Young told the ABC that she was particularly concerned for gay detainees on Manus Island as a result of the legal situation there.

Nauru also outlaws homosexuality. A Fairfax report recently detailed the plight of two male asylum seekers who had fallen in love at the Nauru RPC. While they were living at the RPC they suffered harassment from other detainees. Their asylum claims were accepted and they are now living in the Nauruan community as refugees. According to the report, the two men have been repeatedly bashed and verbally abused since their release. One of them was hospitalised as a result of an assault. Anna Brown of the Human Rights Law Centre has said that they face 14 years in prison.

Submissions to the Manus Inquiry detailed concerns regarding the safety of sexual minorities. Amnesty International pointed out that ‘because Papua New Guinea criminalises same-sex sexual conduct between consenting adults, gay, bisexual and transgender asylum seekers held on Manus Island may be deterred from pursuing their refugee claims or may face persecution in Papua New Guinea if they are eventually resettled there’. Similar concerns were raised by the UN High Commissioner for Human Rights: ‘[f]or such refugees, integration in a society which criminalises homosexuality may give rise to serious protection issues’.

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411 Ibid.
412 Hansard, Senate Estimates, Legal and Constitutional Affairs Committee, 19 October 2015, at 127-128.
Given the legal situation in the RPC countries and the reports of violence against homosexual men in both countries, it is clear that the RPCs are not safe workplaces for this group. While no reports of violence against homosexual women or other sexual minorities have come to the attention of the ALA, we also query whether the RPCs would be safe for these groups.

7.6 Hygiene

Reports to government inquiries repeatedly indicate that basic hygiene essentials were difficult to obtain. Conditions generally were also described as unhygienic. This both created vulnerability and increased existing vulnerability in detainees. One submission to the Nauru Inquiry, for example, explained that all of the detainees are using communal bathrooms that are dirty, causing diseases and infection; most of the women had vaginal infections.\(^\text{417}\)

Reports of vermin were also common, with mice, lizards, scorpions, spiders and mosquitos everywhere, including in the tents. This was causing additional distress to some detainees, who could not sleep because they were panicked by them.\(^\text{418}\) Whistle-blowers to parliamentary inquiries have said that there were significant hygiene issues within RPCs in particular, including problems in accessing sanitary items.\(^\text{419}\) Water shortages were also reported to be common. One individual had to be flown to Brisbane three times for treatment for an ear infection, caused by an allergy to the bird excrement that covers the ground. He was suffering hearing loss from the repeated infections which could not be avoided due to his allergy.\(^\text{420}\)

While hygiene concerns might not constitute traditional health and safety ‘incidents’, it is clear that they are having a significant impact on the health and safety of detainees in RPCs. Information concerning onshore detention is not available to the ALA, although it is possible that hygiene concerns exist there also. It may be appropriate to make additional provision in the WHS Act to require the reporting of ‘dangerous situations’ which would include serious hygiene concerns. This could be achieved either by the addition of a s37A and amendment of s35, or by including dangerous situations within the definition of ‘dangerous incidents’ in s37.

7.7 Recommendations

The ALA makes the following recommendations to the federal government:

- Amend s37 of the WHS Act to include a series of serious injuries or illnesses that might be related.


• Make provision for dangerous situations, including threats to health and safety related to
hygiene, by adding s37A on dangerous situations and amending s35 to include dangerous
situations in the definition of a notifiable incident.

The ALA makes the following recommendations to the DIBP and Comcare:

• Incidents of self-harm or suspected self-harm should be routinely reported by the DIBP and
investigated by Comcare as a workplace health and safety incident. These incidents should be
presumed to have arisen out of the conduct of the business or undertaking.
• The adequacy of mental health services in immigration detention should be properly
understood as a workplace health and safety issue. All workers employed should be
adequately trained to respond to issues presenting in immigration detention, including working
with survivors of trauma.
• The DIBP should report and Comcare should investigate series of serious injuries or illnesses
that might be related (including spikes in self-harm incidents), in line with the legislative
amendment recommended above. A broad interpretation of the phrase ‘arising out of the
conduct of the business or undertaking’ should be adopted.
• The DIBP should ensure that announcements made to detainees are made in the safest way
possible, to minimise a risk of a spike in self-harm incidents. Where announcements are similar
to those that have causes such spikes in the past, additional psychological health facilities
should be made available to ensure detainees are able to process the information safely.
• Officers of the DIBP and Comcare Inspectors should be familiar with the literature on physical
manifestations of mental illness and asylum seeker syndrome and ensure where relevant that
both the psychiatric and physical aspects of illness be recorded and investigated.
• All miscarriages should be reported by the DIBP and investigated by Comcare, with sufficient
sensitivity shown to the women and their partners affected by these events.
• The age, sex and other factors contributing to the vulnerability of all individuals who are the
subject of a report to Comcare should be recorded on the reporting form.
• All asylum seekers who identify as members of a sexual minority should have their claims
processed in a country that is safe for them. The existence of laws against homosexuality
should be understood to indicate that health and safety cannot be adequately protected for
individuals who identify as belonging to a sexual minority, as experiences in both Nauru and
Papua New Guinea have indicated.
• All hygiene concerns should be addressed as a matter of priority. Where an individual’s health
is being permanently affected by hygiene problems, lasting solutions should be found to
ensure that the DIBP is able to meet its obligations under the WHS Act. Such solutions could
include relocation to a different facility in Australia or community detention.
Chapter 8 – Under-reporting and concealment

Overview

Previous chapters have covered the under-reporting of health and safety incidents by the DIBP and inadequate investigation by Comcare. There are broader concerns regarding concealment of detainees’ complaints by contractors, indicating a systemic flaw in Comcare’s ability to oversee health and safety in immigration detention.

For the WHS Act system to function properly, it is essential that relevant incidents come to the attention of the appropriate authorities. Section 27 of the Act requires the DIBP and officers thereof to exercise due diligence to ensure they comply with the obligations under this Act. This specifically includes the obligation to ensure that ‘appropriate processes for receiving and considering information regarding incidents, hazards and risks’ are in place: s27(5)(d). Any obstacles that prevent the DIBP becoming aware of notifiable incidents puts it at risk of serious breaches of duties that exist under the Act. Allegations of fear of repercussions for making complaints and destroying records are particularly alarming.

Most of the information on this issue has been revealed in the inquiries that have been conducted investigating conditions on Nauru. It is not possible to know whether the problem of under-reporting and concealment is unique to that particular RPC or if it is more widespread throughout the detention network.

8.1 Concealment and destruction of evidence

Allegations of concealment of health and safety incidents are of particular concern. Evidence has been provided to public inquiries that contractors have purposely hidden or destroyed complaints against staff members, or that asylum seekers have refrained from reporting incidents due to fear of retribution.

Both of these allegations give rise to health and safety risks for detainees, making it impossible to mitigate risks by investigating and responding to allegations of misconduct. The ALA also queries whether evidence of criminal offences exists.

8.1.1 Concealment and destruction of evidence by contractors

Evidence provided to the Nauru Inquiry by Mr Jon Nichols indicated that concealment of allegations against security staff is commonplace:

‘There is a common feeling amongst transfield [sic] welfare workers that writing incidents reports that involve security is useless, this is because the reports must be filed with security to be actioned, as such many cases of abuse against transferee’s [sic] go unreported.

Incidents that do get reported are handled by security investigations, the common action is to encourage the transferee to sign a document with drawing [sic] their complaint, most of them don’t read or write English and so don’t have a clue what their [sic] signing., I have witnessed this first hand.'
There is also what is referred to as “file 13” THE SHREDDER If an incident report comes in that is a complaint about staff or what is deemed to be damming [sic] towards a staff member or in someone’s [sic] opinion ridiculous these are quite often shredded at the direction of Wilson Supervisors421 (emphasis added).

Submission No. 79 to the Nauru Inquiry also noted that ‘incident reports are processed by Wilson’s’,422 and alleged that detainees fear retribution if they report complaints:

‘It is my belief that information was withheld by asylum seekers who were fearful of retribution from security staff over any complaints. Any incident report or information report that was submitted went through the Wilson’s chain of management to investigate. This was also the case if the matter involved inappropriate behaviour by Wilson’s staff.

... The above systems created an environment where both asylum seekers and SCA staff were intimidated to not take action against security services. Asylum seekers held the valid fear that if they received refugee status and entered the community there would be retribution from Nauruan security officers. Asylum seekers were aware that it was possible that any complaint they made against a security officer could be seen by that person423 (emphasis added).

The Nauru Inquiry noted that Transfield was aware of a high number of assaults:

‘Despite the likelihood of significant under-reporting of incidents and concerns, which was remarked upon in the Moss Review and endorsed by witnesses before this committee, the internal complaints mechanism managed by Transfield Services recorded 725 complaints about service provider staff over a 14-month period to April 2015.

The incidents and complaints recorded by Transfield since 2012 included some 45 allegations of child abuse and sexual assault.

The committee is very deeply concerned about a situation in which this level of reported misconduct can occur and, at least until brought to light by the Moss Review, apparently be accepted424 (emphasis added).

It is not possible for workplace health and safety obligations to be met if the systems discourage or prevent the reporting of threats or injuries. The fact that Transfield was aware of so many more complaints about staff than Comcare was indicates a significant gap in the information available. While it is not alleged that all of those incidents were necessarily notifiable incidents that should have come to Comcare’s attention, a significant proportion may have been. Ultimately it is not possible to know.

421 Submission No. 95 to the Nauru Inquiry, at 9, accessed at: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Regional_processing_Nauru/Regional_processing_Nauru/Submissions?main_0_content_1_RadGrid1ChangePage=4_20
423 Ibid, at 6-7.
8.1.2 Concealment by DIBP officers

Allegations have surfaced in the media that DIBP officers themselves have refused to accept incident reports. An SCA worker told a journalist for the *Saturday Paper* that the DIBP had told them ‘not to include certain incriminating things in [their] reports. They asked us to change our reports.’\(^425\) The journalist was stunned:

‘The staff member was saying it was common for the Australian Immigration Department to ask that incident reports be altered to appear less damning. I asked the former officer to clarify the allegation.

“They simply wouldn’t accept them if they contained information they didn’t want in there.”’\(^426\)

If these allegations are true, they indicate offences under the WHS Act may have been committed. See 8.4.3 below for analysis of the possible legal ramifications.

8.2 Intimidation of workers

In September and October 2014, serious allegations of self-harm and rape came to the attention of the then Minister for Immigration and Border Protection. In response, he instituted the Moss Review to investigate both the substance of the allegations and the conduct and behaviour of staff members of the Nauru RPC.\(^427\) On the same day, the Minister stated that he had been provided reports that some contractors had:

‘allegedly engaged in a broader campaign with external advocates to seek to cast doubt on the Government’s border protection policies. This reporting included allegations of:

- Orchestration and facilitation to engage in non-compliant or harmful behaviour and protest activities, including the tactical use of children in those protests;
- Coaching and encouragement of self-harm;
- Fabrication of allegation as part of a campaign to seek to undermine operations and support for the offshore processing policy of the government; and
- Misuse and unauthorised disclosure of sensitive and confidential information.’\(^428\)

The ‘unauthorised disclosure of information by a specific Save the Children staff member’ was also referred to the Australian Federal Police.\(^429\)

The final report from the Moss Review indicated that it could not conclusively say whether the contract service provider engaged in the alleged activity regarding orchestrating or facilitating protest activity.\(^430\) There was ‘no conclusive information to suggest that particular staff members of Save the Children or any other contract service provider were either colluding with transferees to fabricate allegations or were fabricating them of their own accord.’\(^431\) Similarly, it was ‘unable to obtain any conclusive

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\(^426\) *Ibid*.

\(^427\) Moss Review at 3, [2].

\(^428\) *Ibid*, at 15, [1.6].

\(^429\) *Ibid*, at 15, [1.8].

\(^430\) *Ibid*, at 69, [4.105].

\(^431\) *Ibid*, at 69, [4.107].
information to suggest that SCA staff members coached or encouraged transferees to self-harm. The transferees who spoke to the Review were very clear that they received no encouragement to self-harm from any contract service provider staff member.\textsuperscript{432}

A journalist from the \textit{Saturday Paper} interviewed a previous employee from SCA, uncovering further information:

"They [SCA employees] were treated like criminals," the former Save the Children officer told me. "They were taken to the hotel, banished from the centre, and told they were being taken back to Australia. It seemed so random – there was nothing connecting these people. It’s also crazy that anyone here would have confected claims of abuse because we had personally witnessed so much of it. There is literally no reason to invent anything.

“As for coaching refugees to harm, it was frustrating because Save the Children were the only ones there who cared. It was a low blow. And this from the department that told us not to include certain incriminating things in our reports.”\textsuperscript{433}

On 6 May 2016, the DIBP stated that it regretted the decision to remove the SCA workers, and announced that it had reached a confidential financial settlement with SCA. It further ‘acknowledges that at the time of the removal direction and subsequently, it had no reason to cause doubt to be cast on SCA’s reputation’.\textsuperscript{434} However, earlier that week, Minister Dutton had made similar accusations against refugee advocates as those levelled against SCA workers:

‘I have previously expressed my frustration and anger at advocates and others who are in contact with those in regional processing centres and who are encouraging some of these people to behave in a certain way, believing that that pressure exerted on the Australian Government will see a change in our policy in relation to our border protection measures’.\textsuperscript{435}

No evidence was offered to support this accusation.

The ALA is concerned that this may be a further attempt to intimidate workers to refrain from reporting their concerns regarding health and safety conditions in immigration detention.

8.3 Under-reporting by detainees

In addition to the destruction or concealment of evidence, the ALA is concerned that detainees themselves have refrained from reporting risks to their health and safety. Some of this under-reporting is related to a lack of confidence that action would be taken as a result of the complaint, allowing threats to health and safety to go unresolved. More concerning, however, are reports that detainees feared negative repercussions if they made a complaint. Some of these fears have been outlined

\textsuperscript{432} \textit{Ibid}, at 70, [4.108].
in 8.1 and are also referred to in 6.2.2, above. A further concern expressed was that the outcome of their asylum claims would be impacted if they made a complaint. There is no way for the ALA to know whether this fear was well founded or not.

The lack of confidence on the part of detainees that complaints or allegations would be acted upon was noted by the Moss Review:

‘In some cases, transferees told the Review that they had not reported particular incidents because they had lost confidence that anything would be done about their complaints.’

The Moss Review also acknowledged the role of detainees in under-reporting:

‘Transferees also told the Review that they were concerned that making a complaint could result in a negative impact on the resolution of their asylum claims.’

The ALA noted in its submission to the Nauru Inquiry that transferees may have feared repercussions of reporting:

‘We note that the ability of transferees to provide information to the Moss Review may have also been hampered by the fact that they are still detained in the centre and may have feared repercussions if they spoke out against existing or previous staff. This could be potentially implied at [20], where the Review cites that:

“The Review became aware of claims that some allegations of abuse have been fabricated or exaggerated by transferees.”

It is likely that such claims of fabrication or exaggeration were not made by transferees themselves. It is likely that such claims could have been made by the people that may have been committing such abuse, whom potentially could have been sub-contractors paid by the Australian government.’

The ALA believes that the allegations above should be investigated by the DIBP and Comcare. If it is found that there is truth in the allegation that detainees are not able to adequately report health and safety instances to workers, or that such complaints are not adequately responded to, those processes must immediately be reviewed with a view to complying with the WHS Act. Due diligence obligations under the WHS Act require this. Comcare should consider issuing an improvement notice under s191 to ensure this review takes place in full compliance with the legislation.

8.4 Legal analysis: the WHS Act and possible criminal liability

Allegations of concealment and fears of retribution are serious. They present a real danger that risks to health and safety are not coming to the attention of the DIBP, making adequate investigation by Comcare impossible. They may also give rise to criminal liability under the WHS Act or the Crimes Act 1914 (Cth).

436 Moss Review, at [17].
437 Ibid.
In considering this analysis, it is important to recall s272 of the WHS Act:

‘A term of any agreement or contract that purports to exclude, limit or modify the operation of this Act or any duty owed under this Act or to transfer to another person any duty owed under this Act is void.’

This could have repercussions for confidentiality clauses that might otherwise present a hurdle to workers or other persons exercising their duties under the WHS Act, which includes taking “reasonable care that his or her acts or omissions do not adversely affect the health and safety of other persons”: s28 and s29. Reporting workplace health and safety concerns could arguably fall within this duty.

8.4.1 Due diligence

Officers of the DIBP are obliged to exhibit due diligence to ensure that the DIBP, as the PCBU, complies with duties and obligations under the WHS Act: s27(1). Due diligence includes taking reasonable steps ‘to acquire and keep up-to-date knowledge of work health and safety matters’ and ‘has appropriate processes for receiving and considering information regarding incidents, hazards and risks in a timely way to that information’: s27(5)(a), (d). Failure to comply with this provision may constitute an offence under the WHS Act: Part 1 Division 5.

The ALA considers that it was foreseeable that having Transfield and Wilson investigate complaints against their own officers was open to exploitation. At the very least, it is likely this system involved recklessness. The concerns raised in Submission 79 to the Nauru Inquiry, that making complaints against Nauruan security officers could result in retribution if the asylum seeker is released into the community, also indicate that the systems in place do not satisfy the DIBP’s due diligence obligations.

8.4.2 Discriminatory conduct

The accusations against and subsequent removal of nine SCA staff members outlined above at 8.2 were ostensibly related to allegations that they had encouraged detainees to protest and self-harm (a tenth SCA employee was removed but had resigned prior to the removal). SCA’s contract was not renewed following the incident, with Transfield taking over the welfare role.439

Both the Moss Review and the subsequent Review of Recommendation nine from the Moss Review conducted for the DIBP by Adjunct Professor Doogan (the ‘Doogan Review’) found that “there was in fact no evidence nor reliable information on which to specifically name nine of the ten SCA staff”.440 The Doogan Review went on to note that “[n]o consideration was given to whether or not there were any legislative provisions that may impact or have a bearing on the consequences of issuing the

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removal letter, e.g., the *Work Health and Safety Act 2009 [sic] (Cth)*. The Doogan Review report is heavily redacted and as such it is impossible to know whether any further reference to the WHS Act was made throughout the report.

Part of the reason the SCA staff members were targeted was because they had allegedly fabricated allegations and misused and disclosed sensitive information without authority. These reasons suggest that they may in fact have been removed from Nauru due to their activities in trying to protect the health and safety of detainees. The ALA is not in possession of any concrete information to support this possibility.

Suggestions that workers are suffering reprisals for reporting health and safety concerns are particularly concerning. They also indicate that an offence under s104 of the WHS Act may have been committed. Section 104 prohibits engaging “in discriminatory conduct for a prohibited reason”. Discriminatory conduct includes dismissing or altering the position of a worker to the worker’s detriment, refusing to engage a prospective worker, terminating a commercial relationship with another person or refusing or failing to enter into a commercial relationship with another person (s105). Prohibited reasons include ‘taking action… to seek compliance by any person with any duty or obligation under’ the WHS Act (s106(j)). Section 107 prohibits requesting, instructing, inducing, encouraging, authorising or assisting another person to engage in discriminatory conduct. As mentioned above, if the sensitive information was disclosed to further an obligation under the WHS Act, any confidentiality clause would not apply: s272.

Investigating the complainant rather than the complaint is likely to have a chilling effect on the reporting of incidents that pose a risk to workers and detainees of immigration detention centres. Reports that detainees do not disclose threats to their health and safety to workers due to a belief that nothing would be done or that they would suffer consequences, such as being targeted by the perpetrator, indicate this chilling effect exists.

### 8.4.3 Coercion and concealment

Allegations that DIBP have requested incident report be altered to ‘appear less damning’ are equally alarming. These allegations suggest that s108 of the WHS Act may have been contravened. That section prohibits taking, organising, or threatening to take or organise ‘any action against another person with the intent to coerce or induce the other person, or a third person’ to take specified actions under the Act. The actions specified include those which could bring threats to workplace health and safety to the attention of the DIBP and/or Comcare. While the ALA is not in possession of evidence that such coercion or inducement did in fact occur, further investigation is warranted.

In addition to failing to meet obligations under the WHS Act, allegations of concealment may breach the *Crimes Act 1914 (Cth)*. Section 44 of that Act makes it an offence to conceal or withhold evidence of an offence and ask for or receive a benefit of any kind. If allegations that asylum seekers have been encouraged to withdraw their complaints or indeed records of complaints have been altered or destroyed are well founded, it is possible that an offence under s44 of the *Crimes Act 1914 (Cth)* has

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441 Ibid, at 21 [57(c)].
442 Moss Review, at 15 [1.6].
been committed. Perpetrators of this offence could include officers of the DIBP, contractors or workers employed by contractors. The relevant benefit could be the absence of investigations or possibly employment or contract-related benefits. These allegations should be investigated by Comcare or other law enforcement authorities and, if well founded, prosecutions should be brought. It would also be prudent to investigate whether any contravention of s109 of the WHS Act concerning rights or obligations under the WHS Act has occurred.

There is an urgent need for these obstacles to obtaining full and frank disclosures of threats to health and safety to be overcome, to ensure that the DIBP’s and others’ obligations under the WHS Act and other legislation can be met.

8.5 Relevance of the Australian Border Force Act 2015

On 1 July 2015, the Australian Border Force Act 2015 (Cth) commenced.

The secrecy provisions of the Act suggest that employees who provide information regarding the conditions within immigration detention facilities or RPCs to bodies other than those sanctioned by the Act could face penalties.

Individuals retain the right to report incidents of abuse to the Nauru Police Force or Papua New Guinea Police Force, or to a list of bodies named in s44 of the Australian Border Force Act 2015 (Cth), but only if the person has been authorised in writing by the Secretary of the DIBP to disclose this information. The listed bodies are:

- a department, agency or authority of the Commonwealth, a state or a territory;
- the Australian Federal Police;
- a police force or police service of a state or territory;
- a coroner;
- any other person who holds an office or appointment under a law of the Commonwealth, a state or a territory; or
- any other body or person prescribed by the rules for the purposes of paragraph 44(4)(f) (excluding a foreign country, an agency or authority of a foreign country or a public international organisation).

Section 45(4)(b) of the Act authorises an entrusted person who is authorised by the Secretary for the purpose of that section to disclose protected information, including a class of protected information, to:

- a foreign country;
- an agency or authority of a foreign country; or
- a public international organisation;

if the Secretary is satisfied that the information will be used in accordance with an agreement with that foreign country, that agency or authority of a foreign country, or that public international organisation.443 Entrusted persons include officials of federal, state, territory or foreign governments, or contractors or consultants, whose services are available to the DIBP: s4.

443 Australian Border Force Act 2015 (Cth), s45.
However, in the event that these bodies fail to act, or interpret their powers too narrowly, the *Australian Border Force Act* 2015 (Cth) inhibits individuals from speaking without authorisation; an act which, under the ‘secrecy provisions’ could lead to a two-year term of imprisonment. This means that a whistle-blower seeking to ensure that risks to health and safety were not ignored could be gaolled for bringing this concern to the public attention.

If current mechanisms to deal with sexual assault, including of children, are inadequate, many practitioners are compelled by their professional duties to their clients to advocate. Complicity with any concealment of abuse runs counter to the professional obligations of many professionals, including medical practitioners, and could lead to disciplinary proceedings by appropriate profession regulators.

It appears that, of the bodies cited, few if any are independent and empowered to act on issues of child sexual abuse.

This Report makes clear that the media and public inquiries have often been key in highlighting incidents that have occurred at immigration detention facilities, incidents that Comcare was often not informed about by the DIBP. This echoes the finding of Comcare’s 2011 investigation into the then-DIAC’s management of the health and safety of detainees at immigration detention facilities under the former OHS Act.

The media retains an important role in providing scrutiny on the conditions in immigration detention about which Comcare has not been informed, and therefore acts as an important accountability tool on the government. The provisions of the *Australian Border Force Act* 2015 (Cth) appear to limit such accountability.

The many examples proffered throughout this Report indicate that current reporting mechanisms and disclosure that are authorised under the *Australian Border Force Act* 2015 (Cth) are not working. While parliamentary privilege might protect some of the disclosures to Parliamentary inquiries from prosecution, the fact remains that many parliamentary inquiries have been inspired by disclosures of abuse made to the media or elsewhere. This legislation has the capacity to further undermine health and safety in immigration detention.

8.6 Impact of under-reporting and concealment: compromised access to essential goods for health and safety

In addition to masking the extent of the problem of abuse as detailed in Chapter 6, above, obstacles to reporting perpetuate day to day threats to health and safety. In Nauru, for example, getting access to essential clothing and shoes is virtually impossible, according to reports. Detainees stopped reporting the need for these essential goods as they knew that nothing would be done to provide them.

Lack of access to these basic supplies regularly posed a risk to detainees’ health and safety. The ground, being covered in jagged gravel, had the potential to cause injuries as it was too sharp to walk on barefoot. Despite this risk, one asylum seeker told an SCA employee that she was sharing a pair of

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444 *Australian Border Force Act* 2015 (Cth), Part 6, s41 – 51.
thongs with four other women. They would take it in turns to wear them to go to the toilet block or to English classes. The lack of sufficient clothing meant that one girl had only one pair of underpants after having an operation to have a kidney removed. This exposed her to a high risk of infection.

The health and safety ramifications of this are twofold: firstly, unsafe situations persist for an unreasonable amount of time; secondly, it is likely that the severity of the risk is not adequately understood, as the reports are not received by people who can remedy the situation. The absence of basic supplies posed a daily risk of injury and infection to detainees.

8.7 The role of foreign law enforcement

The role of the Nauru Police Force in investigating crimes against detainees appears to have been problematic. It is troubling to note that Submission No. 71 to the Nauru Inquiry asserts that:

‘Not one assault case occurring in the RPCs which has been passed on to the NPF [Nauru Police Force] (including the boy who was sexually assaulted by the cleaner) have been investigated. None have proceeded to court.

Over 40 case files of crimes committed in the RPCs by Nauruan perpetrators passed to the NPF by Wilson’s investigators have gone “missing”. A female xxxx was sexually assaulted last year by a local (xxxxx - name withheld). This case did make it to court but the witness statements handed to the NPF by Wilson’s Investigators were “missing” as were other case files pertinent to the case.

The lack of investigation of alleged crimes by the Nauru Police Force have a direct impact on health and safety in the Nauru RPC. It can mean that perpetrators continue to have access to detainees who have made complaints against them. Others who might be inclined to commit crimes against asylum seekers will see that perpetrators go unpunished, removing any disincentive in this regard. Even where perpetrators’ employment is terminated, as was apparently the case for a cleaner who allegedly sexually abused a minor, the absence of pre-employment checks poses a direct threat to health and safety in the Nauru RPC.

The Nauru Inquiry recommended that Australia ensure that ‘Nauru’s justice system meets the standards of accountability and probity required by Australian and international law’. In response, the DIBP asserted that Nauru’s sovereignty means that Australia cannot ensure prescribed standards. It is essential that the DIBP can ensure that it can meet workplace health and safety obligations while respecting the sovereignty of other nations. Acknowledging the jurisdictional complexities that arise in RPCs, the DIBP and Comcare must not consider any local failure to prosecute to indicate that a health and safety complaint was invalid.


If local law enforcement agencies are unable or unwilling to adequately investigate and appropriately punish crimes constituting threats to workplace health and safety, it is incumbent on the DIBP and Comcare to factor this into their own approach to fulfilling their obligations under the WHS Act.

8.8 Recommendations

The ALA makes the following recommendations to the federal government:

- amend the *Border Force Act 2015* (Cth) to remove secrecy provisions relating to workplace health and safety.

The ALA makes the following recommendations to the DIBP:

- review all reporting lines in immigration detention to ensure that individuals investigating complaints have no interest in the outcome of the complaints. Where a complaint is made about a contractor, this would require assurance that investigations were not conducted by individuals from the same or related contractors.
- conduct training with officers and workers:
  - outlining the contents of obligations under legislation, including the due diligence obligations under the *WHS Act* and concealment offences under the *Crimes Act 1914* (Cth); and
  - emphasising the importance of accepting complaints as they are made, without exerting any pressure to alter complaints in any way.
- implement auditing procedures for complaints, including providing the opportunity to workers to raise concerns in a safe way, without the fear of repercussions or prosecution.
- ensure detainees’ identity is protected in all complaints. If it is not possible to protect the identity of a complainant who is in fear of retribution as a result of making a complaint, ensure that the safety of that complainant is protected in additional ways, including removing them from the area or country in question, assessing their refugee claim in Australia and if successful, granting them refugee status in Australia if they are not willing to relocate to a third country. No asylum seeker should be forced to relocate to a third country against their wishes as a result of making a complaint against a worker.

The ALA makes the following recommendations to Comcare:

- investigate and, if appropriate, prosecute all offences under the WHS Act, including the possible failure to exercise due diligence obligations under s27 and possible recklessness in this regard, and the possible breach of s104, s107, s108 or s109.
- if evidence exists that the *Crimes Act 1914* (Cth) or other legislation has been breached in relation to concealment or other matters, refer that evidence to the Australian Federal Police for investigation and possible prosecution.
- consider allegations that health and safety reports made by detainees have not been acted on. If those allegations are well founded, consider issuing an improvement notice under s191 of the WHS Act.
Chapter 9 – Conclusions and recommendations

This Report is based on a systematic review of legislation and evidence gathered after almost a year of investigations under the FOI Act, by a small team of dedicated individuals. It has revealed concerning gaps in reporting and investigation of workplace health and safety in immigration detention centres. Some of these gaps appear to have arisen from a lack of clarity concerning the legislative obligations of both the DIBP and Comcare. Others indicate possibly deliberate efforts to conceal offences, injuries and threats to workplace health and safety, potentially giving rise to criminal liability for the DIBP and contractors.

It is clear that the DIBP has the primary duty of care to ensure the health and safety of workers and others in immigration detention, both in Australia and offshore. This duty survives all contractor engagement and crosses international borders. Comcare, as the regulator, must monitor compliance with the WHS Act and take enforcement action where necessary. It may also be appropriate for Comcare to refer breaches of other legislation to the Australian Federal Police for investigation and prosecution.

This Report has identified that there are serious questions to be asked about whether the DIBP is fulfilling its duties under the WHS Act. Related to this is the apparent lack of clear guidance from Comcare as to how the WHS Act applies to threats to health and safety in immigration detention. The ALA believes that the issues revealed by this Report should be investigated by an inquiry with enforceable powers to subpoena and examine witnesses and documents. A Royal Commission or an independent judicial inquiry would be the appropriate forum.

Recommendations relating to most Chapters of the report are extracted below. For more detail as to the concerns underpinning the recommendations, see the relevant Chapter.

Recommendations: Chapter 2

The ALA recommends that:

- the DIBP acknowledge that its decision to locate RPCs outside of Australia does not absolve it from meeting its obligations under the WHS Act to ensure all immigration detention facilities are safe for workers and other persons.
- if the DIBP feels that it is unable to meet its obligations under the WHS Act in RPCs, it should consider closing RPCs or relocating them to a country in which it can meet its health and safety obligations.

Recommendations: Chapter 3

The ALA recommends that the federal government:

- amend s19(4) of the WHS Act to ensure that accommodation for other persons receives the same level of workplace health and safety protections as accommodation for workers.
- ratify the OPCAT and create an independent NPM as a matter of priority.
- engage with all UN Special Rapporteurs, facilitate requested visits and implement their recommendations in a spirit of openness and good faith.
- encourage Papua New Guinea to ratify or accede to the CAT and the OPCAT.
- encourage Nauru to permit the publication of the report by the SPT detailing its visit to the RPC.
The ALA recommends that the DIBP:

- ensure that all workplace health and safety recommendations from Comcare are implemented as soon as reasonably practicable. Once recommendations are implemented, incident reports should be updated detailing how the recommendations were complied with to ensure implementation is monitored.
- ensure that all workplace health and safety recommendations from other inquiries are implemented.
- provide work health and safety training to detainees in a format that they understand, to ensure they are best equipped to protect their own health. This training should be designed to minimise the most common risks to psychological and physical health faced by detainees.

The ALA recommends that Comcare:

- conduct a comprehensive investigation of all immigration detention facilities both within Australia and offshore to assess compliance with recommendations made in 2011 and all other recommendations made by Comcare in investigating incidents reported to it under the WHS Act;
- continue to monitor media reports of workplace health and safety incidents and compare these to incidents reported by the DIBP. If there is a media report of an incident that has not been reported to it, Comcare should submit a query to the DIBP as to why the incident has not been reported.
- develop clear guidelines regarding incidents that Comcare must be notified of under s38(1), including when an incident arises from the conduct of the business or undertaking. These guidelines should apply a broad interpretation of the phrase to ensure that the objects of the WHS Act are fulfilled.
- once the OPCAT is ratified and an independent NPM is established, work with the NPM and the SPT to ensure workplace health and safety are protected to the maximum extent possible.

Recommendations: Chapter 5

The ALA recommends that the federal government:

- amend s38 of the WHS Act to ensure that all deaths of individuals usually resident in immigration detention are presumed to result from the conduct of the business or undertaking. The existence of a pre-existing injury or illness should not preclude Comcare from investigating the role of the DIBP, if any, in the death.
- mandate the NDICP to record all deaths in immigration detention in the same way that all other deaths in custody are recorded. Expand the remit and resources of the NDICP for this purpose.
- institute an independent inquiry into the death of Hamid Khazaeei in light of evidence presented by ABC’s Four Corners.

The ALA recommends that the DIBP:

- ensure that all deaths of individuals usually resident in a detention facility (including where the death itself occurs in a different location) are clearly reported as such to Comcare. If a death is related to an earlier incident report, a new incident report should be lodged cross referencing the earlier report.
The ALA recommends that Comcare:

- consider appearing at all coronial inquests following deaths of individuals usually resident in a detention facility (including where the death itself occurs in a different location).
- consider prosecuting the DIBP and/or related contractors if evidence suggests that an offence under the WHS Act has been a factor in a death.
- develop clear policy clarifying how it should be informed of changes in the circumstances surrounding an incident that they have already been notified of. This policy should ensure that key details are captured so that the health and safety factors of these changes are clearly addressed.
- update reporting forms to ensure that the date of the incident and the age, sex and any other factors indicating particular vulnerability of the injured or deceased individual are clearly identifiable.
- investigate all deaths of individuals usually resident in immigration detention on the presumption that they arose from the conduct of the business or undertaking. Where a pre-existing injury or illness contributed to the death, consider the nature of the medical or health condition and what could have been done to prevent the death.
- develop clear guidance as to the phrase ‘arising out of the conduct of the business or undertaking’, ensuring it is interpreted broadly to meet the objects of the WHS Act. This guidance should reflect the understanding of the business of the DIBP outlined above at 1.4.1.
- provide training to the DIBP and contractors regarding any updates in policy or legislative changes.

**Recommendations: Chapter 6**

The ALA recommends that the federal government:

- amend s37 of the WHS Act to include sexual misconduct, including serious sexual assault, sexual abuse and serious sexual harassment, as an additional dangerous incident. There should be no requirement that physical injury results from this misconduct and it should be presumed that psychological injury does result from such misconduct.
- amend s37 of the WHS Act to include as a dangerous incident instances of bullying and harassment that cause workers or other persons to fear for their personal safety. Where such bullying and harassment occurs in the workplace, it should be considered as arising from the conduct of the business or undertaking.
- amend s36(a) of the WHS Act to reflect the requirement proposed below, in recommendations to Comcare, that that all medical advice that an individual should be hospitalised should be considered a serious injury or illness, regardless of whether hospitalisation occurred or not.
- amend s19(4) of the WHS Act to extend the primary duty of care to ensure that the accommodation of other persons owned, managed or paid for by the PCBU does not expose them to risks to their health and safety.
- implement all recommendations of the Nauru Inquiry, in particular recommendations 11, 13 and 14. Commonwealth responses to these recommendations - that allegations of a criminal nature be investigated by the Nauru Police Force and are the responsibility of the government of Nauru⁴⁵¹ - are inadequate to discharge the DIBP’s obligations under the WHS Act. Recommendation nine of the Nauru Inquiry should be implemented with adequate attention being paid to the health and safety of detainees who take advantage of open centre arrangements.

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⁴⁵¹ Australian Government, *Response to the report of the Select Committee on the Recent Allegations relating to Conditions and Circumstances at the Regional Processing Centre in Nauru*, responses to recommendations 13 and 14.
• implement all recommendations of the AHRC report,\(^\text{452}\) in particular that children should not be transferred to RPCs unless it is clear that their human rights will be respected, and that CCTV cameras be installed in all detention centres to capture significant incidents.

The ALA recommends that the DIBP:

• report all instances of sexual misconduct, including serious sexual assault, sexual abuse and serious sexual harassment to Comcare.
• along with Comcare, ensure adequate accommodation is provided to asylum seekers released into the community in Nauru, within the context of its non-delegable duty of care. This includes ensuring that the accommodation is in a safe area and can be adequately secured against threats.
• consider the broader context of sexual misconduct in the Nauruan community as a component of its work health and safety obligations. All health and safety incidents involving workers or residents of the RPCs are covered by the WHS Act wherever on Nauru they occur, by virtue of the fact that those individuals are in Nauru as a result of the conduct of the business or undertaking of the DIBP.
• train Nauruan law enforcement officers on appropriate responses to sexual misconduct allegations, including respect for privacy, respectful gathering of evidence and appropriate sanctioning of perpetrators. The fact that Nauruan law enforcement officers work for a foreign sovereign nation does not absolve the DIBP of its work health and safety obligations to protect detainees from sexual misconduct.

The ALA recommends that Comcare:

• require the PCBU to report, and then investigate, all allegations of sexual misconduct, including serious sexual assault, sexual abuse and serious sexual harassment. All sexual misconduct that occurs in immigration detention facilities should be presumed to be a result of the conduct of the business or undertaking and presumed to result in psychiatric injury. The need for such investigations is particularly pressing in RPCs, where other legislative protections against sexual misconduct that exist in Australia may not be present.
• thoroughly investigate any evidence that indicates the WHS Act has been infringed in relation to sexual misconduct. Where evidence suggests that offences have been committed, prosecutions should be conducted.
• refer any evidence that other state, territory or Commonwealth legislation has been infringed in relation to sexual misconduct to the appropriate government agency for further investigation and possible prosecution.
• conduct a comprehensive review of conditions in the Manus Island and Nauru RPCs and onshore detention facilities, including developing clear lines of reporting to ensure all instances of abuse and assault perpetrated against workers or other persons are reported as notifiable incidents.
• interpret workplace health and safety to include harassment and bullying. Incidents of harassment and bullying that cause workers or other persons to fear for their safety should be reported to Comcare as a notifiable incident and investigated accordingly.
• require notification where a worker or other person receives medical advice that they require hospitalisation, regardless of whether that hospitalisation occurs or not, in line with the recommendation to amend s36(a), above.

along with the DIBP, ensure that adequate protections are provided to asylum seekers released into the community in Nauru, as a component of its non-delegable duty of care. This includes ensuring that the accommodation is in a safe area and can be adequately secured against threats.

Recommendations: Chapter 7

The ALA makes the following recommendations to the federal government:

• amend s37 of the WHS Act to include a series of serious injuries or illnesses that might be related.
• make provision for dangerous situations, including threats to health and safety related to hygiene, by adding s37A on dangerous situations and amending s35 to include dangerous situations in the definition of a notifiable incident.

The ALA makes the following recommendations to the DIBP and Comcare:

• incidents of self-harm or suspected self-harm should be routinely reported by the DIBP and investigated by Comcare as a workplace health and safety incident. These incidents should be presumed to have arisen out of the conduct of the business or undertaking.
• the adequacy of mental health services in immigration detention should be properly understood as a workplace health and safety issue. All workers employed should be adequately trained to respond to issues presenting in immigration detention, including working with survivors of trauma.
• the DIBP should report and Comcare should investigate series of serious injuries or illnesses that might be related (including spikes in self-harm incidents), in line with the legislative amendment recommended above. A broad interpretation of the phrase ‘arising out of the conduct of the business or undertaking’ should be adopted.
• the DIBP should ensure that announcements made to detainees are made in the safest way possible, to minimise a risk of a spike in self-harm incidents. Where announcements are similar to those that have causes such spikes in the past, additional psychological health facilities should be made available to ensure detainees are able to process the information safely.
• officers of the DIBP and Comcare Inspectors should be familiar with the literature on physical manifestations of mental illness and asylum seeker syndrome and ensure where relevant that both the psychiatric and physical aspects of illness be recorded and investigated.
• all miscarriages should be reported by the DIBP and investigated by Comcare, with sufficient sensitivity shown to the women and their partners affected by these events.
• the age, sex and other factors contributing to the vulnerability of all individuals who are the subject of a report to Comcare should be recorded on the reporting form.
• all asylum seekers who identify as members of a sexual minority should have their claims processed in a country that is safe for them. The existence of laws against homosexuality should be understood to indicate that health and safety cannot be adequately protected for individuals who identify as belonging to a sexual minority, as experiences in both Nauru and Papua New Guinea have indicated.
• all hygiene concerns should be addressed as a matter of priority. Where an individual’s health is being permanently affected by hygiene problems, lasting solutions should be found to ensure that the DIBP is able to meet its obligations under the WHS Act. Such solutions could include relocation to a different facility in Australia or community detention.
Recommendations: Chapter 8

The ALA makes the following recommendations to the federal government:

- amend the *Border Force Act 2015* (Cth) to remove secrecy provisions relating to workplace health and safety.

The ALA makes the following recommendations to the DIBP:

- review all reporting lines in immigration detention to ensure that individuals investigating complaints have no interest in the outcome of the complaints. Where a complaint is made about a contractor, this would require assurance that investigations were not conducted by individuals from the same or related contractors.
- conduct training with officers and workers:
  - outlining the contents of obligations under legislation, including the due diligence obligations under the WHS Act and concealment offences under the *Crimes Act 1914* (Cth); and
  - emphasising the importance of accepting complaints as they are made, without exerting any pressure to alter complaints in any way.
- implement auditing procedures for complaints, including providing the opportunity to workers to raise concerns in a safe way, without the fear of repercussions or prosecution.
- ensure detainees’ identity is protected in all complaints. If it is not possible to protect the identity of a complainant who is in fear of retribution as a result of making a complaint, ensure that the safety of that complainant is protected in additional ways, including removing them from the area or country in question, assessing their refugee claim in Australia and if successful, granting them refugee status in Australia if they are not willing to relocate to a third country. No asylum seeker should be forced to relocate to a third country against their wishes as a result of making a complaint against a worker.

The ALA makes the following recommendations to Comcare:

- investigate and, if appropriate, prosecute all offences under the WHS Act, including the possible failure to exercise due diligence obligations under s27 and possible recklessness in this regard, and the possible breach of s104, s107, s108 or s109.
- if evidence exists that the *Crimes Act 1914* (Cth) or other legislation has been breached in relation to concealment or other matters, refer that evidence to the Australian Federal Police for investigation and possible prosecution.
- consider allegations that health and safety reports made by detainees have not been acted on. If those allegations are well founded, consider issuing an improvement notice under s191 of the WHS Act.
# Appendix 1

## Overview of incidents reported to Comcare in immigration detention facilities and regional processing centres

<table>
<thead>
<tr>
<th>Incident</th>
<th>FY2013-2014</th>
<th>FY2014-2015</th>
<th>2 year TOTAL</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatalities</td>
<td>11&lt;sup&gt;453&lt;/sup&gt;</td>
<td>9&lt;sup&gt;454&lt;/sup&gt;</td>
<td>20</td>
<td>This included the deaths of two infants and one minor. Only four deaths were assessed as notifiable incidents. Death of Hamid Khazaei was reported as an ‘update’ and not as a separate notifiable incident.</td>
</tr>
<tr>
<td>Allegations of sexual assault</td>
<td>1&lt;sup&gt;455&lt;/sup&gt;</td>
<td>2&lt;sup&gt;456&lt;/sup&gt;</td>
<td>3</td>
<td>Substantially lower than that asserted by the Moss Review and the Nauru Inquiry. Comcare does not require reporting of sexual assault. One of these concerned a worker.</td>
</tr>
<tr>
<td>Assault</td>
<td>18&lt;sup&gt;457&lt;/sup&gt;</td>
<td>31&lt;sup&gt;458&lt;/sup&gt;</td>
<td>49</td>
<td>This does not include sexual assault.</td>
</tr>
<tr>
<td>Detainee seizure</td>
<td>21&lt;sup&gt;459&lt;/sup&gt;</td>
<td>19&lt;sup&gt;480&lt;/sup&gt;</td>
<td>40</td>
<td>Seizures and other physical manifestations could be indicative of psychological injury.</td>
</tr>
<tr>
<td>Detainee transported to hospital</td>
<td>174&lt;sup&gt;461&lt;/sup&gt;</td>
<td>257&lt;sup&gt;482&lt;/sup&gt;</td>
<td>431</td>
<td></td>
</tr>
<tr>
<td>Detainee mental health issues/ mental health assessment</td>
<td>11&lt;sup&gt;463&lt;/sup&gt;</td>
<td>25&lt;sup&gt;464&lt;/sup&gt;</td>
<td>36</td>
<td>Includes only those issues/assessments that specify mental health.</td>
</tr>
<tr>
<td>Detainee fainting/collapsing</td>
<td>28&lt;sup&gt;465&lt;/sup&gt;</td>
<td>37&lt;sup&gt;468&lt;/sup&gt;</td>
<td>65</td>
<td>Could be indicative of psychological stress.</td>
</tr>
<tr>
<td>Detainee found unresponsive/unconscious</td>
<td>16&lt;sup&gt;467&lt;/sup&gt;</td>
<td>28&lt;sup&gt;488&lt;/sup&gt;</td>
<td>46</td>
<td></td>
</tr>
<tr>
<td>Stomach/abdominal pain</td>
<td>32&lt;sup&gt;489&lt;/sup&gt;</td>
<td>29&lt;sup&gt;470&lt;/sup&gt;</td>
<td>61</td>
<td></td>
</tr>
<tr>
<td>Breathing difficulties</td>
<td>11&lt;sup&gt;471&lt;/sup&gt;</td>
<td>20&lt;sup&gt;472&lt;/sup&gt;</td>
<td>31</td>
<td></td>
</tr>
<tr>
<td>Self-harm/threat of self-harm reported</td>
<td>61&lt;sup&gt;473&lt;/sup&gt;</td>
<td>148&lt;sup&gt;474&lt;/sup&gt;</td>
<td>209</td>
<td>Figures regarding Nauru are substantially lower than figures given by DIBP in evidence to Nauru Inquiry.</td>
</tr>
<tr>
<td>Incidents identified clearly as affecting children</td>
<td>17&lt;sup&gt;475&lt;/sup&gt;</td>
<td>12&lt;sup&gt;478&lt;/sup&gt;</td>
<td>29</td>
<td>This number would in reality be much higher, given under-reporting and lack of detail regarding whether a minor has been affected.</td>
</tr>
<tr>
<td>Incidents identified as involving pregnant detainee women (workers)</td>
<td>5&lt;sup&gt;477&lt;/sup&gt;</td>
<td>9&lt;sup&gt;478&lt;/sup&gt;</td>
<td>14</td>
<td>Two workers and 13 detainees. Actual number could be far higher.</td>
</tr>
<tr>
<td>Electric shock</td>
<td>5&lt;sup&gt;479&lt;/sup&gt;</td>
<td>10&lt;sup&gt;480&lt;/sup&gt;</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Fire</td>
<td>18&lt;sup&gt;481&lt;/sup&gt;</td>
<td>12&lt;sup&gt;482&lt;/sup&gt;</td>
<td>30</td>
<td></td>
</tr>
<tr>
<td>Appendicitis</td>
<td>3&lt;sup&gt;383&lt;/sup&gt;</td>
<td>5&lt;sup&gt;484&lt;/sup&gt;</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Kidney issues</td>
<td>1&lt;sup&gt;485&lt;/sup&gt;</td>
<td>9&lt;sup&gt;486&lt;/sup&gt;</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>Incident</td>
<td>FY2013-2014</td>
<td>FY2014-2015</td>
<td>2 year TOTAL</td>
<td>Notes</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>-------------</td>
<td>-------------</td>
<td>--------------</td>
<td>----------------------------------------------------------------------</td>
</tr>
<tr>
<td>Office-related injury</td>
<td>27&lt;sup&gt;487&lt;/sup&gt;</td>
<td>29&lt;sup&gt;488&lt;/sup&gt;</td>
<td>56</td>
<td></td>
</tr>
<tr>
<td>Asbestos</td>
<td>1&lt;sup&gt;489&lt;/sup&gt;</td>
<td>1&lt;sup&gt;490&lt;/sup&gt;</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Chest pain/ heart attack</td>
<td>22&lt;sup&gt;491&lt;/sup&gt;</td>
<td>37&lt;sup&gt;492&lt;/sup&gt;</td>
<td>59</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>92&lt;sup&gt;493&lt;/sup&gt;</td>
<td>129&lt;sup&gt;494&lt;/sup&gt;</td>
<td>221</td>
<td>This includes any incident that does not fall into any of the above categories, including malaria, tuberculosis and typhoid.</td>
</tr>
<tr>
<td>Total incidents affecting workers</td>
<td>92</td>
<td>106</td>
<td>198</td>
<td></td>
</tr>
<tr>
<td>Total incidents affecting asylum seekers</td>
<td>311</td>
<td>489</td>
<td>800</td>
<td></td>
</tr>
<tr>
<td>Total incidents affecting members of the public</td>
<td>3</td>
<td>1</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>Total incidents not specified whether worker or asylum seeker</td>
<td>43</td>
<td>47</td>
<td>90</td>
<td></td>
</tr>
<tr>
<td>Total notifiable incidents</td>
<td>98</td>
<td>149</td>
<td>247</td>
<td></td>
</tr>
<tr>
<td>Total not-notifiable incidents</td>
<td>351</td>
<td>494</td>
<td>845</td>
<td></td>
</tr>
<tr>
<td>Total incidents reported</td>
<td>449</td>
<td>643</td>
<td>1092</td>
<td>DIBP Annual Report in FY2014-2015 is inconsistent with these figures and cites that 662 incidents were reported.</td>
</tr>
</tbody>
</table>

453 DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 11, 13, 40, 54, 55, 56, 65, 177, 192, 379, 444.
455 DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 352.
Appendix 1

Untold Damage


DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 313.


## Appendix 2

### Total incidents reported across the whole of DIBP activities, compared by assessment as notifiable/not-notifiable incident

<table>
<thead>
<tr>
<th>Year (FY)</th>
<th>Notifiable incident</th>
<th>Total of notifiable incidents</th>
<th>Not-notifiable incident</th>
<th>Total of not-notifiable incidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>2013-2014</td>
<td>Serious injury/illness</td>
<td>51(^{495})</td>
<td>45</td>
<td>450(^{496})</td>
</tr>
<tr>
<td>2014-2015</td>
<td>Dangerous incident</td>
<td>105(^{500})</td>
<td>42(^{501})</td>
<td>2</td>
</tr>
<tr>
<td>Two year total</td>
<td>Fatality</td>
<td>156</td>
<td>87</td>
<td>4</td>
</tr>
</tbody>
</table>

495 DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 5, 7, 9, 16, 23, 25, 26, 28, 29, 32, 35, 39, 42, 45, 59, 82, 86, 91, 92, 100, 101, 119, 125, 133, 134, 144, 163, 172, 178, 185, 186, 197, 205, 212, 221, 239, 245, 271, 310, 351, 352, 357, 359, 367, 375, 376, 403, 405, 421, 427, 441.


## Appendix 3

### Fatalities reported across DIBP activities FY2013-2014 – FY2014-2015

<table>
<thead>
<tr>
<th>Incident</th>
<th>Place</th>
<th>Date</th>
<th>Person affected</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fatality – client suffered cardiac arrest.</td>
<td>Derby, Western Australia</td>
<td>22/07/2013</td>
<td>Detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>Member on a search warrant operation found deceased person.</td>
<td>Paringa, South Australia</td>
<td>22/07/2013</td>
<td>Unspecified</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>Fatality – a client died as the result of an inoperable brain tumour.</td>
<td>Carlisle, Western Australia</td>
<td>12/9/2013</td>
<td>Detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>A client died from a pre-existing condition as a hospital in-patient.</td>
<td>Bedford Park, South Australia</td>
<td>12/10/2013</td>
<td>Detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>Client suffering from a pre-existing medical condition died.</td>
<td>Unknown, NSW</td>
<td>12/10/2013</td>
<td>Detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>A three-month-old baby was unresponsive with breathing difficulties and died.</td>
<td>Darwin, Northern Territory</td>
<td>16/10/2013</td>
<td>Detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>A client suffered a heart attack waiting in a customs queue.</td>
<td>Tullamarine, Victoria</td>
<td>1/11/2013</td>
<td>Possible detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>Incident</td>
<td>Place</td>
<td>Date</td>
<td>Person affected</td>
<td>Assessment</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------------------------</td>
<td>-----------</td>
<td>---------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>A detainee presented with head injuries, was transferred to the hospital and died a short time later.</td>
<td>Not identified</td>
<td>18/2/2014</td>
<td>Detainee</td>
<td>Notifiable – death.</td>
</tr>
<tr>
<td>A member of the public suffered a cardiac arrest.</td>
<td>Papua New Guinea</td>
<td>21/5/2014</td>
<td>Member of public</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>A minor detainee passed away from a brain tumour.</td>
<td>Clayton, Victoria</td>
<td>27/6/2014</td>
<td>Detainee - minor</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>A member of the public was found to be unresponsive. Resuscitation was attempted, but the person died.</td>
<td>Manus Island, Papua New Guinea</td>
<td>2/7/2014</td>
<td>Member of the public</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>A contractor off duty arrived unconscious at the processing centre at Manus Island and subsequently died. The death was suspected to have been linked to ingested medication following a fight with family members.</td>
<td>Manus Island, Papua New Guinea</td>
<td>16/7/2014</td>
<td>Contractor</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>Incident</td>
<td>Place</td>
<td>Date</td>
<td>Person affected</td>
<td>Assessment</td>
</tr>
<tr>
<td>----------</td>
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<td>-----------------</td>
<td>------------</td>
</tr>
<tr>
<td>FY2014-2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A detainee detained in the community passed away due to liver cancer while at the Palliative Care Unit in hospital. Due to redactions, it is not possible to assess how long he had been at the hospital under palliative care for liver cancer.</td>
<td>Herston, Queensland</td>
<td>14/10/2014</td>
<td>Detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>A client suffering a pre-existing medical condition suffered difficulty breathing and died.</td>
<td>Prospect, South Australia</td>
<td>17/11/2014</td>
<td>Detainee - baby</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking.</td>
</tr>
<tr>
<td>A detainee formerly detained at Villawood suffered a heart attack, was treated as an in-patient in hospital and passed away.</td>
<td>Liverpool, NSW</td>
<td>17/11/2014</td>
<td>Detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking. However, Comcare conducted an investigation into the death.</td>
</tr>
<tr>
<td>A terminally ill cancer patient who was held in community detention passed away in hospital while receiving treatment for cancer.</td>
<td>Braeside, NSW</td>
<td>5/1/2015</td>
<td>Detainee</td>
<td>Not-notifiable, an incident occurred but it did not result from the conduct of the business or undertaking. However, incident report notes that ‘the links to the conduct of the business are unclear’, and the preliminary assessment was ‘uncertain’.</td>
</tr>
<tr>
<td>Incident</td>
<td>Place</td>
<td>Date</td>
<td>Person affected</td>
<td>Assessment</td>
</tr>
<tr>
<td>----------</td>
<td>-------</td>
<td>------------</td>
<td>-----------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>FY2014-2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A detainee passed away in hospital.(^\text{522}) The person had a number of pre-existing health issues that contributed to their death, including [redacted]. The person was treated as an in-patient in hospital.(^\text{523})</td>
<td>Liverpool Hospital, NSW</td>
<td>11/1/2015</td>
<td>Detainee</td>
<td>Not notifiable, an incident occurred but it did not result from the conduct of the business or undertaking. However, a person was advised by superiors that it needed to be reported to Comcare.(^\text{524})</td>
</tr>
<tr>
<td>A contractor – a case worker who was taking a client to an appointment, was killed in a motor vehicle accident, when a van collided with a truck. A student was injured in the accident, admitted to hospital in critical condition, and discharged the next day.(^\text{525})</td>
<td>Northmead, NSW</td>
<td>11/3/2015</td>
<td>Contractor</td>
<td>Notifiable – death. A Comcare investigation was ongoing at the time of freedom of information application.</td>
</tr>
<tr>
<td>A motorcycle rider was killed during a vehicle accident between a contractor’s van and a member of the public’s motorcycle.(^\text{526})</td>
<td>Nauru</td>
<td>22/6/2015</td>
<td>Member of public</td>
<td>Notifiable – death. Comcare subsequently undertook an investigation, which was completed.</td>
</tr>
</tbody>
</table>

\(^\text{505}\) DIBP, Annual Report 2013-2014, Incidents reported to Comcare, No. 11.
\(^\text{506}\) Ibid, No. 13.
\(^\text{507}\) Ibid, No. 40.
\(^\text{508}\) Ibid, No. 54.
\(^\text{509}\) Ibid, No. 55.
\(^\text{510}\) Ibid, No. 56.
\(^\text{511}\) Ibid, No. 65.
\(^\text{512}\) Ibid, No. 177.
\(^\text{513}\) Ibid, No. 192.
\(^\text{514}\) Ibid, No. 379.
\(^\text{515}\) Ibid, No. 444.
\(^\text{516}\) DIBP, Annual Report 2014-2015, Incidents reported to Comcare, No. 7.
Appendix 3

Untold Damage

517  Ibid, No. 40.
519  Ibid, No. 323.
520  Ibid, No. 325.
521  Ibid, No. 392.
522  Ibid, No. 405.
523  Australian Government, Comcare, Telephone Advice or Notification of an Incident, No. 405, 14/1/2015.
524  Ibid.
526  Ibid, No. 627.