

OFFICIAL



Monitoring Immigration Detention

THE OMBUDSMAN'S ACTIVITIES IN OVERSEEING
IMMIGRATION DETENTION

January–June 2020

Report by the Commonwealth Ombudsman,
Michael Manthorpe PSM, under the *Ombudsman Act 1976*

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INTRODUCTION

Oversight of immigration detention

1.1. This report summarises the Office of the Commonwealth Ombudsman’s (the Office) activities to monitor the administration and conditions of immigration detention between January and June 2020. It is the Office’s third public report of this kind, following reports for the periods from January to June 2019 and from July to December 2019.

1.2. The Office provides oversight of immigration detention in several ways, each of which is discussed separately within this report.

1.3. Under its responsibilities as a member nation to the United Nations (UN) Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT), the Australian Government designated the Office as the National Preventive Mechanism (NPM) for places of detention under the control of the Commonwealth, including immigration detention facilities. In this capacity, the Office is tasked with conducting regular preventive visits to places where people are deprived of their liberty and may be vulnerable to mistreatment or abuse, and preparing public reports about our findings. Details of our monitoring activities during this period are set out in **Part 2** of this report.

1.4. The Office also has broad jurisdiction, under the *Ombudsman Act 1976* (the Ombudsman Act), to investigate the administrative actions and decisions of Australian Government agencies, including the Department of Home Affairs (the department) which is responsible for immigration detention policy and administration. **Part 3** provides a summary of our complaint handling work during the first half of 2020.

1.5. Under section s 486O of the *Migration Act 1958* (the Migration Act) the Ombudsman is required to prepare and provide to the Minister an assessment of the appropriateness of arrangements for people who have been in immigration detention for more than two years, and then every six months for as long as they remain in detention. A summary of the assessments prepared during the first half of 2020 is set out in **Part 4**.

1.6. Every six months the department provides the Office with a report about any instances in which a person was held in immigration detention and then released on the basis that they were identified to not be unlawful. Our observations about the instances identified during the first half of 2020 are provided in **Part 5** of this report.

1.7. This report makes three recommendations about use of force within the immigration detention network, improving the quality of complaint handling records, and supporting the use of mechanisms to manage at risk or vulnerable people in immigration detention.

1.8. In April 2021, we provided the department with the opportunity to comment on our draft report and recommendations. The department accepted two recommendations and noted the recommendation regarding the quality of complaint handling records, acknowledging the Office’s concerns regarding inconsistency in the quality of complaint records. The department’s response is included at **Appendix A**.

Part 2: MONITORING ACTIVITIES UNDER OPCAT

- 2.1. In its capacity as Immigration Ombudsman, the Office has been handling complaints about immigration detention facilities since 2005 and has regularly visited facilities since 2010. Based on its investigations and inspections, the Office provided observations and recommendations directly to facility staff and the department. The main issues arising from these activities were also summarised in the Office's annual reports.
- 2.2. In December 2017 Australia ratified OPCAT. This is an international treaty designed to strengthen protections for people in situations where they are deprived of their liberty and potentially vulnerable to mistreatment and abuse. Upon ratifying OPCAT, member nations commit to establishing a system of regular preventive visits by independent bodies, known as NPMs, and receiving visits from the UN Subcommittee on Prevention of Torture (SPT).
- 2.3. OPCAT does not create new rights for people who are detained but seeks to reduce the likelihood of mistreatment. It makes clear that the rights of people in detention should be respected and upheld. The oversight mechanisms established in accordance with OPCAT ensure that conditions and treatment within places of detention are respectful, safe and humane.
- 2.4. In July 2018 the Australian Government designated the Office as the NPM for places of detention under the control of the Commonwealth. These include Australian Defence Force (ADF) detention facilities, Australian Federal Police (AFP) cells and immigration detention facilities. The Office will commence public reporting about its monitoring of ADF and AFP detention facilities in 2021–22.
- 2.5. The Office's visits to these places are designed to be preventive rather than reactive in nature, and consider systemic issues or systems where torture and other inhuman or degrading treatment or punishment may occur. The Office is expanding its inspection approach in line with OPCAT and is committed to providing regular public reports about its monitoring activities.

Our monitoring approach

2.6. Our monitoring of immigration detention involves:

- assessing information the department provides about detainee numbers and cohorts, health facilities, recent incidents, and other information relevant to our role
- wherever possible, attending the relevant detention facility in person to conduct a site visit.

2.7. A facility may include an immigration detention centre, immigration transit accommodation or another place designated as an alternative place of detention (APOD).

2.8. Based on this information, we assess the facility's overall performance based on the treatment of and conditions for detainees. Indicators of a healthy centre are:

Safety	Detainees are held in safety and consideration is given to the use of force and disciplinary procedures as a last resort.
Respect	Detainees are treated with respect for their human dignity and the circumstances of their detention.
Purposeful activity	The centre encourages activities and provides facilities to preserve and promote the mental and physical well-being of detainees.
Well-being and social care	Detainees can maintain contact with family and friends, support groups, and legal representatives, and have a right to make a request or complaint.
Physical and mental health	Detainees have access to appropriate medical care equivalent to that available within the community. Stakeholders work collaboratively to improve general and individual health conditions for detainees.

2.9. These indicators have been adapted from those used by similar international and domestic inspectorates.

2.10. During a site visit we may conduct some or all of the following activities to gather information about the operation of a facility:

- speaking with individuals or groups residing in the facility, to understand their experience
- attending meetings between, and with, the parties involved in running the centre namely the Australian Border Force (ABF), Serco and International Health and Medical Services (IHMS) walking through accommodation, eating, exercise and common areas
- observing escort and transport arrangements
- reviewing footage and records of incidents involving injury or use of force
- reviewing complaint records.

2.11. We compare our site visit observations to relevant governing policy and procedure documents to assess whether the services available and the treatment of detainees at the facility are consistent with the expectations set out by the ABF and service providers. Further, informed by the indicators of a healthy centre, we consider whether there are any risks of harm to detainees.

2.12. We also pay particular attention to problems and risks we previously highlighted and consider whether the department has made sufficient progress to address those matters.

Site visits, January to March 2020

2.13. In January 2020 and March 2020, our inspection staff visited the Melbourne Immigration Transit Accommodation (MITA), Mantra Bell City APOD, and the Villawood Immigration Detention Centre (VIDC). During these visits, we identified several issues that were a focus of our previous monitoring and reporting activities:

- the use of force to address behaviour and to support operational planning
- limited oversight of services at APODs, and
- missed opportunities to share information and proactively manage people at risk or in situations of vulnerability.

Use of force and restraints

2.14. The use of force and/or restraints within immigration detention should be consistent with the principles outlined in the ABF's Detention Services Manual. In particular *'that detainees will be treated fairly and reasonably within the law and that conditions of immigration detention will ensure the inherent dignity of the human person'*.¹ This expectation is consistent with the indicators of a healthy centre, particularly 'safety' and 'respect'.

2.15. The Detention Services manual also directs that, 'use of force and/or restraints should only be used as a last resort'.² Further, the manual outlines last resort principles and advises that: *'In the first instance, officers should seek to achieve the desired objective, whenever possible, by de-escalation techniques such as discussion, negotiation, verbal persuasion and co-operation.'*³

2.16. The Office previously made recommendations about the use of mechanical restraints and solitary confinement (known as High Care Accommodation (HCA)), and remains concerned about the use of force within Australia's immigration detention network, including instances of excessive use of force to resolve conflict or respond to non-compliant behaviour.

2.17. The Office also continues to be concerned about detainees being mechanically restrained to attend medical appointments when alternatives such as increased escorts are available. A list of recommendations made by the Office in its 2019 reports is at **Appendix B** and **Appendix C**.

2.18. During our inspections at MITA and VIDC, we conducted a thorough assessment of 20 use of force reports, including reports raised by detainees. Based on these reports we identified two occasions where it appeared the use of force may have been excessive or inappropriate. We wrote to the ABF about these incidents in January 2020.

2.19. Documents the department provided to our Office in relation to the first incident reflected Serco had responded to the detainee's complaint and acknowledged the use of force could have been avoided.

¹ Detention Services Manual — Safety and Security management — Use of force, PI 623, 10 October 2018

² Paragraph 4.1, Detention Services Manual — Safety and Security management — Use of force, PI 623, 10 October 2018

³ Paragraph 4.2.2, PI 623

2.20. In relation to the second incident – where we considered the use of force did not meet the ‘last resort’ principle because the detainee did not appear to have first been given sufficient opportunity to comply with a Serco officer’s direction – the department advised that incident and other matters relating to use of force had been referred to the department’s Detention Assurance Reporting Section for review. As at March 2021, the outcome of this review by the department has not yet been provided to our Office.

2.21. Due to the unavailability of appropriate video coverage at the Mantra Bell City APOD, we were unable to undertake a meaningful review of incidents that occurred there. We have not made a recommendation to address this gap, as the department is no longer using this location as an APOD.

2.22. At one facility, staff reflected that force is used in response to perceived or real personal safety concerns, particularly where staff are not confident using de-escalation techniques to respond to aggressive behaviour. Staff said they wanted more opportunities to practice alternative responses to different scenarios and felt they would benefit from training about effectively engaging with detainees to manage disruptive behaviour.

2.23. We also observed that, at one facility, staff were using a practice called ‘mandatory ground stabilisation’ when detainees were placed into HCA, even if the detainee was complying with instructions. Ground stabilisation involves physically restraining a person on the floor. Staff are trained to use this technique in self-defence, to prevent escape or to manage a person who refuses to comply with a lawful request. In our view, and consistent with both ABF and Serco use of force principles, this practice should be used as a last resort and only when there is no other way of managing the situation, securing the person’s safety and cooperation, or ensuring the safety of another person.

2.24. At VIDC, MITA and Mantra Bell City APOD we observed that staff continued to use mechanical restraints when escorting detainees to and from places of detention and during transfer and removal operations. Our observations indicate that use of restraints was a routine practice in contrast to the ‘last resort principles’ outlined in both ABF and Serco procedural documents.

2.25. The Office reviewed the department’s policy and procedures and the training provided to Emergency Response Team (ERT) staff. While we are satisfied there is a documented use of force framework, it was not clear how ABF ensures the framework is used to guide consistency in the way force is used across the network. It is also unclear how the ABF ensures all relevant staff, not just ERT members, understand the framework and how to work within it.

2.26. Based on the review of incident reports and the documentation regarding planned use of force, it appears the tolerance for risk is inconsistent between centres resulting in a more frequent reliance on planned use of force and the use of restraints.

Recommendation 1

The department should implement measures to track and assess the reasonableness of use of force and ‘mandatory ground stabilisation’ within the immigration detention network and, if appropriate, provide targeted training to support staff in using alternative strategies to manage detainee behaviour.

2.27. The Office will continue to closely monitor use of force, as well as the department’s actions to implement our recommendations regarding use of force.

APODs

2.28. While most people in held detention are accommodated in the six mainland immigration detention facilities, the Minister for Home Affairs may also designate other locations as Alternative Places of Detention (APODs). This may include hospitals, aged care facilities, psychiatric facilities and hotels.

2.29. In 2019 the Office recommended that, wherever possible, the department identify and use APODs that cater to the longer-term needs of detainees through the provision of appropriate and accessible facilities. The Office further recommended that the department ensure all detainees placed in APODs have access to appropriate services and supports.

2.30. In response, the department advised that APODs are usually used for short periods of time and agreed that, wherever possible, APODs used for longer periods should appropriately cater for detainees' needs. The department advised it was working with service providers to ensure that a range of services are provided to detainees in longer term APODs in Brisbane and Melbourne, including access to outside activity.

2.31. At the time of our inspection at the Mantra Bell City APOD in January 2020, 56 people were detained there and most had been there since August 2019. We observed improvements in the services available compared to our previous visit, including the introduction of onsite access to medical and welfare staff and an increase in excursions to MITA, where detainees could engage in programs and activities, access fresh air and socialise with other detainees.

2.32. However, we are aware that due to restrictions associated with COVID-19, these excursions from the Mantra Bell City APOD to MITA were subsequently suspended. We remain concerned about the suitability of hotel APODs for the long-term (greater than four weeks) accommodation of people held in immigration detention and the facilities' ability to meet basic human rights standards, including suitable access to fresh air, exercise and other programs and activities.

2.33. We **suggest** the department ensure that the provision of programs and activities, and access to medical and welfare services, are standard across all detention facilities, including APODs.

Complaint handling

2.34. In 2019, the Office recommended that all staff involved in handling complaints be provided with complaint investigation and management training, and that the department introduce a network-wide comprehensive quality assurance process for complaints. The department advised that all investigations into complaints raised by detainees or other third parties have a consolidated record detailing how the complaint was investigated, and the evidence considered. The department also advised that it undertakes a comprehensive, network-wide quality assurance process of complaint handling, as well as providing oversight of all responses and, where required, works with the service provider to improve the quality of written responses sent to detainees.

2.35. At each facility, Office staff review a copy of the facility's complaint register for the three months immediately preceding the site visit. The team assesses the frequency of certain types of complaints (usually about detainee treatment and access to services) and identifies a sample of complaints to examine in more detail. In reviewing the selected complaints, Office staff seek further information from the facility, discuss the issues raised in the complaint and consider how the department responded to and/or resolved the matter.

2.36. One of our main concerns with the handling of these complaints was inconsistency in the quality of complaint records across VIDC, MITA and the Mantra Bell City APOD. Complaint records at the Mantra Bell City APOD were particularly poor and, in most cases, did not demonstrate how the complaint had been managed and investigated, or how the outcome was decided. The complaints we reviewed at the Mantra Bell City APOD included several that were particularly serious, and we could not be satisfied they had been appropriately investigated.

Recommendation 2

The department should improve the quality and consistency of complaint records to demonstrate complaints are appropriately assessed, and investigated, and a suitable response is provided to the complainant.

Managing at risk or vulnerable people

2.37. Many detainees in immigration detention pose risks to themselves or others, while other detainees are (or are perceived to be) vulnerable to mistreatment or abuse. These risks and vulnerabilities may be associated with considerations including:

- personal characteristics (such as race, religion, language, gender and/or sexual identity)
- experiences of torture and trauma
- threatening or violent behaviours
- past offending behaviour (for example, child sex offences)
- physical or mental health concerns.

2.38. Many of these risks and vulnerabilities are also likely to be exacerbated by the restrictions on individual autonomy imposed by the detention environment.

2.39. The department and its contracted service providers have several mechanisms to manage detainees who present risks or are vulnerable, including the:

- Psychological Support Program (PSP) — a risk-management framework for all detainees in detention, to determine any current or emerging risks of suicide and self-harm⁴
- Behaviour Management Plans (BMPs)⁵ — a tool to manage detainees engaged in anti-social behaviour, involving behavioural objectives and support for their achievement
- use of High Care Accommodation (HCA) — a segregated environment within facilities where high-risk detainees can be managed with greater supervision and engagement.

2.40. The effective and appropriate use of these mechanisms to manage an individual's vulnerabilities or risks relies on appropriate information being shared between the department and service providers, and between the service providers.

⁴ Psychological Support Program, IHMS Procedure 3.6.2, August 2017

⁵ Detention Services Manual-Safety and security management – Behaviour management, PI 5027 23 August 2018

- 2.41. ABF, Serco and IHMS are all involved, in different ways, in delivering services within immigration detention. While clear communication and strong information sharing arrangements between these parties are always important, they are particularly crucial to effectively managing detainee welfare.
- 2.42. There are four regular meetings at each location where the primary service providers, ABF, Serco and IHMS, share information to identify and take steps to proactively manage vulnerable detainees including those with physical or mental health concerns. Office staff routinely attend these meetings during our inspections. These meetings assist the Office to assess whether centre staff work collaboratively to manage detainees at risk or in situations of vulnerability. At inspections during this cycle, Office staff attended all four meetings at MITA and three of the four meetings at VIDC.
- 2.43. We observed differences in the way these meetings were held at VIDC and MITA and in the quality of records that each maintained. The records of meetings at the VIDC were of a higher standard than those at MITA and provided additional information to assist staff to proactively identify vulnerable detainees.
- 2.44. We consider there were missed opportunities at MITA for staff to share information and proactively manage people at risk or in situations of vulnerability, with “medical-in-confidence” often cited by IHMS as the primary barrier to robust and meaningful discussion between service providers.
- 2.45. We noted that the process for seeking approval to place a detainee into HCA varied across the inspected facilities and, in some cases, staff did not record the restrictions they had placed on detainees.
- 2.46. We observed that centre staff do not appear to engage with detainees who demonstrate challenging behaviours or provide detainees with the opportunity for meaningful involvement in their own management plans. This is inconsistent with one of the fundamental principles of consultation set out in the Behaviour Management Policy Instruction.⁶
- 2.47. When developing and reviewing management plans, we did not observe stakeholders reviewing information to enable an appropriate assessment of the detainee over the previous 24 hours and, in most cases, it was unclear how stakeholders made decisions about the need for ongoing monitoring or alternative placements. Detainee management plans appeared to be generic in nature with little or no evidence of the supports available to empower detainees to manage their own welfare or behaviour. We observed cases at each of the meetings we attended where detainee management plans had not influenced behavioural change, yet stakeholders did not consider alternative strategies that may achieve a more positive outcome for detainees and staff.

⁶ Paragraph 4.2.3 Behaviour management PI 5027

2.48. In most cases stakeholders agreed that the restrictions and consequences outlined in these plans were to be enforced until the detainee could demonstrate a level of safety or behavioural compliance. In some cases, this resulted in detainees being denied access to movement, activities, or other services for protracted periods of time despite staff acknowledging the restrictions were unlikely to influence improvement.

Recommendation 3

The department should take responsibility for the effective and appropriate use of available mechanisms to manage individual detainees' vulnerabilities or risks, including through ensuring that:

1. service provider staff at detention facilities understand their obligation to collaborate and share information
2. meaningful exchange of information between service providers at detention facilities occurs
3. legal or contractual issues which might impede effective collaboration and information sharing between service providers at detention facilities are resolved to the extent possible, and balanced to have due regard to the privacy of detainees, and
4. high quality records of stakeholder meetings are maintained.

Programs and activities

2.49. All detainees have a right to access age-appropriate structured educational, recreational, and cultural programs and activities. This access is particularly important given the lengthy periods for which detainees are often held in immigration detention. While a range of programs and activities were available at each facility we visited, some detainees advised Office staff they were unhappy that, on entering immigration detention they lost access to rehabilitation programs they used in the community or in correctional settings, such as anger management and drug and alcohol counselling.

2.50. In response to our questions at the time, the department was unable to confirm which provider was responsible for providing rehabilitation and support programs under its current contractual arrangements. However, upon reviewing the IHMS contract, it is clear that IHMS have responsibility for 'Integrated Primary Health Care' which includes, but is not limited to:

- health promotion, education and prevention programmes
- nurse consultations
- general practitioner consultations
- mental health services including group programs.

2.51. We observed instances where staff perceived detainee access to programs and education as a privilege, to be awarded to detainees at staff's discretion and withdrawn for disciplinary purposes. We are concerned about this approach, and the loss of access to rehabilitation programs. We will closely monitor detainees' access to programs and activities in future inspections.

The Office's activities during COVID-19 (March 2020 onwards)

2.52. In March 2020, when the World Health Organisation declared a pandemic associated with COVID-19, and state quarantine requirements and border restrictions were imposed, it quickly became clear that:

- it was not practical or advisable for our staff to travel interstate to inspect immigration detention facilities
- putting aside the practicalities of travel, our attendance could pose serious health risks to detainees, service provider staff and inspection officers.

2.53. In turn, the Office decided to suspend its onsite inspections. We did not take this decision lightly and were mindful that, in many ways, the restrictions imposed in response to COVID-19 could make detainees more vulnerable. We were particularly conscious that, at the same time we paused our inspections, the department suspended in-person visits to detainees by family, friends, advocates, and legal representatives. These visits, in conjunction with oversight by our Office and other independent bodies, provide an important safeguard for people who live in closed environments.

2.54. While mindful of the potential for increased vulnerability, we were informed by the clear advice of the Communicable Diseases Network Australia (CDNA) that, in facilities where large numbers of people reside in close proximity, such as prisons, aged care facilities and detention centres, residents are at a much higher risk of transmission if the virus enters the population. On balance, we concluded it was not reasonable for us to place detainees at heightened risk by entering facilities if we could effectively monitor immigration detention remotely.

2.55. During this time,⁷ the Office remotely monitored the immigration detention network via weekly reports from, and regular meetings with, the department about individual detention facilities and the broader detention network. The Office received feedback from complaints, media, peer bodies and civil society stakeholders. Reviewing contemporaneous information from a broad range of sources meant that, although we were not attending facilities in person, we could maintain oversight of key areas of risk that if not addressed, might lead to torture or other cruel, inhuman or degrading treatment or punishment.

2.56. Throughout this period, we engaged regularly with the ABF and the department about issues of concern arising from these reports.

Public statement regarding the management of COVID-19 risks in immigration detention

2.57. In late May and early June 2020, the Office conducted onsite visits to all mainland Immigration Detention Centres and Immigration Transit Accommodation facilities specifically to assess the department's practical arrangements for preventing and managing COVID-19 in facilities.

2.58. The department based its approach on the CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Correctional and Detention Facilities in Australia in place at that time. The CDNA amended these guidelines during the pandemic.

⁷ This monitoring approach continued until we were able to safely resume inspections in November 2020, and certain elements have been absorbed into the Office's ongoing monitoring approach.

2.59. The Office’s monitoring focused on how the department adhered to these guidelines across the immigration detention network. Our visits involved reviewing closed circuit television footage, speaking with staff and considering written guidance materials but, in order to mitigate any risk to the detention population, did not include any contact with people residing at the facilities.

2.60. On 1 July 2020 the Ombudsman published a statement⁸ about the Office’s findings, including three recommendations to the department:

- **Recommendation 1**

The Ombudsman recommends the department takes action to ensure network-wide compliance with ON2020-16, which requires that all people entering or exiting an immigration detention facility are subject to temperature checks.

- **Recommendation 2**

The Ombudsman recommends the department implements an assurance program, to monitor its staff’s and contracted providers’ compliance with Outbreak Management Plans, operational notifications and provide guidance on areas for improvement.

- **Recommendation 3**

The Ombudsman recommends the department works with the relevant ministers to reduce the numbers of people held in immigration detention facilities, with a particular focus on achieving effective social distancing in the facilities, and with particular regard to detainees with underlying health issues that may render them susceptible to any outbreak of COVID-19.

2.61. In August 2020, the department reopened the North West Point Immigration Detention Centre on Christmas Island and transferred detainees there from mainland detention facilities. In early 2021 the department has also reduced the number of detainees held in APODs, particularly in Melbourne and Brisbane.

2.62. We acknowledge the efforts the department has made to reduce the number of detainees in individual centres but remain concerned about the high numbers of people who remain in held detention.

⁸ https://www.ombudsman.gov.au/_data/assets/pdf_file/0013/111235/1-July-2020-Statement-by-the-Commonwealth-Ombudsman-Michael-Manthorpe-on-the-management-of-COVID-19-risks-in-immigration-detention-facilities.pdf

Implementation of recommendations

January to June 2019 Report

2.63. In the Ombudsman's first publicly available report on immigration detention for the January to June 2019 period, we made 16 recommendations. The department agreed, in full or in part, with all those recommendations.

2.64. We consider five of the 16 recommendations do not currently require further action. A table of those recommendations and the department's progress against them is at **Appendix B**.

2.65. In the January to June 2019 report, we recommended the department remove the restriction on external recreational and religious excursions for detainees with an established low behavioural and/or flight risk. During this inspection period, the Office observed that detainees did not have the opportunity to participate in external excursions. We recognise this was likely associated with COVID-19 restrictions and will monitor this issue closely as restrictions ease.

2.66. The Office is concerned that, although detainees were transitioned from Blaxland High Security Compound (BHSC) in April 2020, it is still being used on occasion for quarantine purposes. We do not consider BHSC fit for purpose and **suggest** it should be fully decommissioned.

2.67. We remain concerned about the lack of improvement in the quality of analysis staff demonstrate when determining a detainee's risk assessment. We observed a lack of differentiation in the risk associated with, for example, a physical altercation related to a detainee's mental health condition compared to a violent, unprovoked attack. This assessment affects the conditions experienced by a detainee — including their placement within the detention network (which may in turn affect access to personal and legal visits and medical waiting lists), and the use of mechanical restraints — so it is concerning to see decisions being made without reference to relevant contextual information.

July to December 2019 Report

2.68. In the July to December 2019 immigration detention report, the Office made 12 recommendations. The department agreed, in full or in part with 11 of the recommendations.

2.69. The department has fully implemented several of the recommendations, but it seems that restrictions imposed by COVID-19 may have adversely affected the implementation of others. A table of those recommendations and the department's progress against them is at **Appendix C**.

Part 3: COMPLAINTS ABOUT IMMIGRATION DETENTION

Complaints

- 3.1. In the period from January to June 2020, the Office received 98 complaints about immigration detention facilities. Staff resolved 17 of these complaints during (pre COVID-19) onsite visits.
- 3.2. The Office referred 42 of these complaints to the department because they were not raised with the agency in the first instance. After assessing the others, the Office decided to investigate 23 complaints.
- 3.3. The impact of COVID-19 was a factor in 19 complaints.
- 3.4. Complaints received by the Office included concerns that the Department of Health recommendations, such as the wearing of masks and gloves by cleaning staff, physical distancing, frequent hand hygiene, rapid identification and monitoring, were not being met in all immigration detention facilities including within APODs. Other complaints related to the immigration detention facilities, such as overcrowding and room configuration issues which meant that it was not possible to practice safe physical distancing.
- 3.5. The Office received complaints regarding vulnerable detainees, particularly about individuals with underlying health issues that place them at high risk of COVID-19, remaining in immigration detention facilities. Concerns were raised about those suffering psychological conditions that may make lockdown conditions difficult, and whether sufficient action was being taken by the department to safeguard their well-being.
- 3.6. The Office also received complaints about treatment delays due in part to increased wait times because of the COVID-19 pandemic in relation to hospital-based treatment and specialist appointments.
- 3.7. During the reporting period, access to medical services, activities and conditions were two of the main drivers of complaints. This is consistent with previous periods and recognises that these two aspects of detention have a considerable impact on detainee wellbeing.

Table 1 – Complaint issues Jan-June 2020

Issues raised in complaints received January-June 2020	Number
Medical services (access, dental, general, medication, mental health)	29
COVID-19 impacts	19
Activities / Conditions (including suitability of accommodation)	10
Complaint handling	10
Assaults (by service provider or detainee)	5
Type of detention	<5
Visitors	<5
Transfer between centres	<5
Location of detention centre	<5
Property	<5
Safety and security	<5
Self-harm	<5
Mail	<5
<i>Other</i>	21
TOTAL	114

3.8. The complaints the Office receives play an important role in informing our work as the Commonwealth NPM by highlighting possible systemic issues for consideration at future monitoring visits.

Spotlight issue—delays in access to anti-viral treatment

3.9. In early 2020, the Office investigated a complaint from an advocacy organisation about significant delays detainees diagnosed with hepatitis C experienced in accessing anti-viral treatment.

3.10. The *Communicable Diseases — Prevention and Management* procedural instruction (the procedural instruction) provides guidance on the treatment and control of communicable diseases within the immigration detention network. The procedural instruction states that treatment for detainees diagnosed with hepatitis C should generally commence within two weeks of diagnosis or within one month of diagnosis for detainees with complex medical conditions.

3.11. Our investigation identified the department was not meeting the treatment timeframes contained in the procedural instruction. This was consistent with the department's response to questions on notice during Senate Estimates hearings on 2 March 2020, that *"the average length of time for immigration detainees to commence antiviral medication is 573 days"*.⁹

3.12. In response to this investigation, the department advised the increased timeframes were due to a number of factors including wait times for detainees to be reviewed by specialists working in the public health system, detainees declining treatment, and reduced access to medical care as a result of COVID-19 restrictions.

3.13. While acknowledging these circumstances contributed to delays, the Office was not satisfied these factors fully accounted for the delay detainees experienced in accessing anti-viral treatment.

3.14. To address the treatment delays identified in this investigation, the department acted to improve treatment timeframes. This included providing general practitioners with access to telehealth advice from specialists, supporting detainees to make informed decisions by providing them information about the benefits of receiving treatment, and giving detainees the option to access medical appointments in person or through telehealth facilities (where clinically indicated).

3.15. As a result, the number of detainees awaiting specialist review decreased and the number of detainees receiving treatment increased.

3.16. The department undertook to review the procedural instruction for the treatment of communicable diseases in immigration detention to ensure the treatment and management of hepatitis C in immigration detention aligns with community standards. The review includes seeking input from specialists and other healthcare professionals. We encouraged the department to also engage with external stakeholders, including relevant peak bodies, and the broader delivery of health and other programs in immigration detention.

3.17. In our capacity as NPM, we will continue to actively monitor the department's management of the provision of health services, including the timeliness of anti-viral treatment for detainees diagnosed with hepatitis C.

⁹ The department's response to questions placed on notice during estimates hearings on 2 March 2020.

3.18. People in immigration detention may be reluctant to complain because of concerns that complaining may impact future treatment or a belief that complaining will not make a difference. It is pleasing to report the outcome of this investigation, including the changes the department made to improve hepatitis C treatment times for detainees.¹⁰

¹⁰ See Article 12(1) International Covenant on Economic, Social and Cultural Rights 1966: The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

Part 4: REPORTING ON LONG-TERM DETENTION

4.1. Under s 486N of the Migration Act, the department is required to provide the Ombudsman with reports about each person who has been in immigration detention for more than two years, and every six months thereafter, for as long as the person remains in detention.

4.2. Under s 486O of the Migration Act, the Ombudsman provides the Minister with his assessment of the circumstances of each person's detention, including any recommendations he considers appropriate. The Minister is required to table a de-identified copy of the assessment in Parliament and may include a response to the Ombudsman's assessment and any recommendations.

4.3. When preparing an assessment the Ombudsman is required to consider the circumstances of all people in immigration detention, regardless of where a person is detained.¹¹ The majority of people for whom the department provides a report are in an immigration detention facility or in an APOD such as a hospital, motel or psychiatric facility. Others are living in the community on a residence determination or are held in a correctional facility. Sometimes people are released from detention, usually on a visa or to facilitate their departure from Australia, between the time the department provides the Office with a report and the time we send our assessment to the Minister.

4.4. Between January and June 2020, we sent 340 assessments to the Minister. All these assessments were tabled in Parliament between March and October 2020 in accordance with the Minister's obligation to table them within 15 sitting days of receipt.

Assessments undertaken

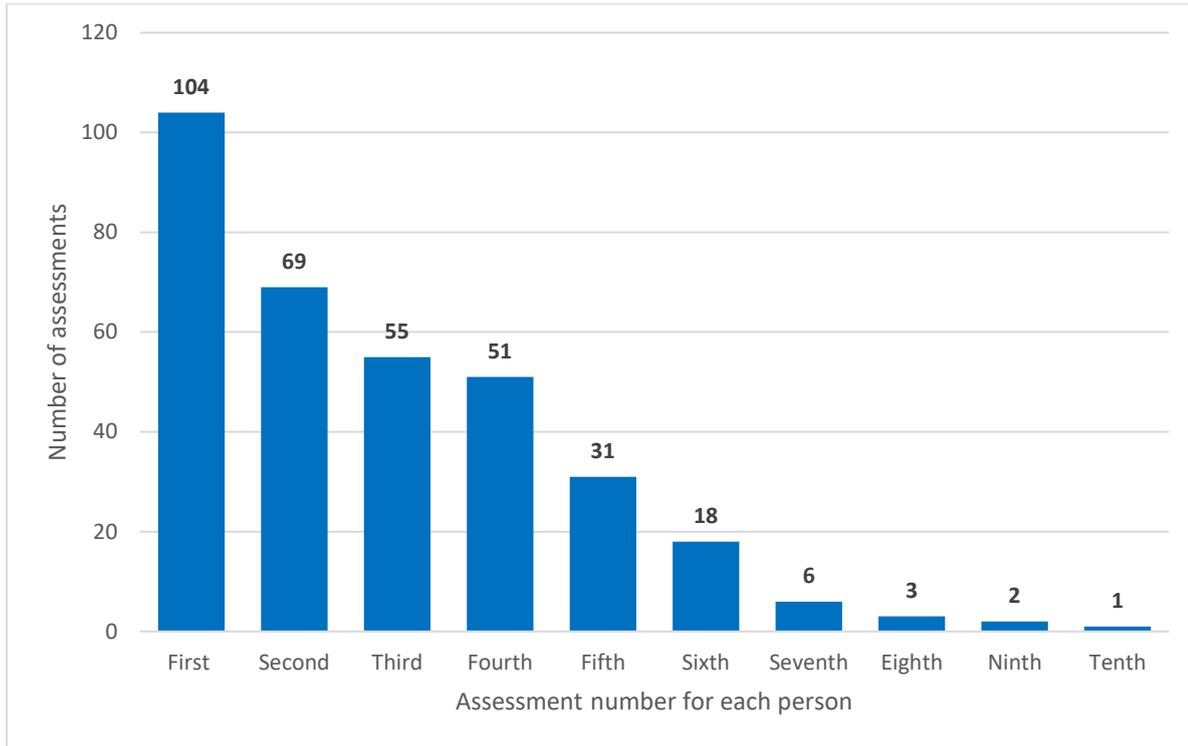
4.5. Figure 1, below, shows the assessments we completed in this reporting period, broken down by how many assessments the Office prepared for that person. For 104 people we completed their first assessment in this reporting period, and for one person we completed their tenth assessment.

4.6. Generally, first assessments and assessments for people who have been detained for lengthy periods are more complex. In each assessment we consider:

- the individual's migration history
- the circumstances of the individual's detention
- any notable events since the individual was detained, or since the last report we received from the department
- the progress of the individual's migration case (what actions the department, courts and tribunals have taken to consider the person's status)
- the individual's medical history and treatment.

¹¹ Time spent in Regional Processing Countries is not counted as time in immigration detention for the purposes of reporting under s 486N *Migration Act 1958*.

Figure 1 - Assessments completed January - June 2020



Recommendations

4.7. As we have reported in previous periods, the Ombudsman remains concerned about delays in the case progression of people in long term detention, including delays in administrative processes. During this reporting period the Ombudsman made 77 recommendations to expedite a process the department or Minister had already commenced. This included assessments against the guidelines for ministerial intervention and other aspects of a person’s case progression, such as the consideration of a visa, an International Treaties Obligations Assessment, or the lifting of a bar to allow a person to apply for a visa.

4.8. During the reporting period the Ombudsman made 70 recommendations for a person to be assessed against the Ministerial guidelines for consideration of a bridging visa or community placement under ss 195A and 197AB of the Migration Act. Whilst it is usual for the Minister to note, rather than accept or reject, the Ombudsman’s recommendations of this type, in almost all cases the individual was referred for assessment against the guidelines.

4.9. The Ombudsman made 17 recommendations about a person’s placement, either to move them within the detention network to be closer to support networks or change their current address in the community. In most instances the Minister’s response acknowledged the Ombudsman’s recommendation but advised that, for operational reasons, the move could not be facilitated. We acknowledge that, for much of this inspection period, the department limited moves between locations to mitigate any unnecessary risk that detainees could be exposed to COVID-19.

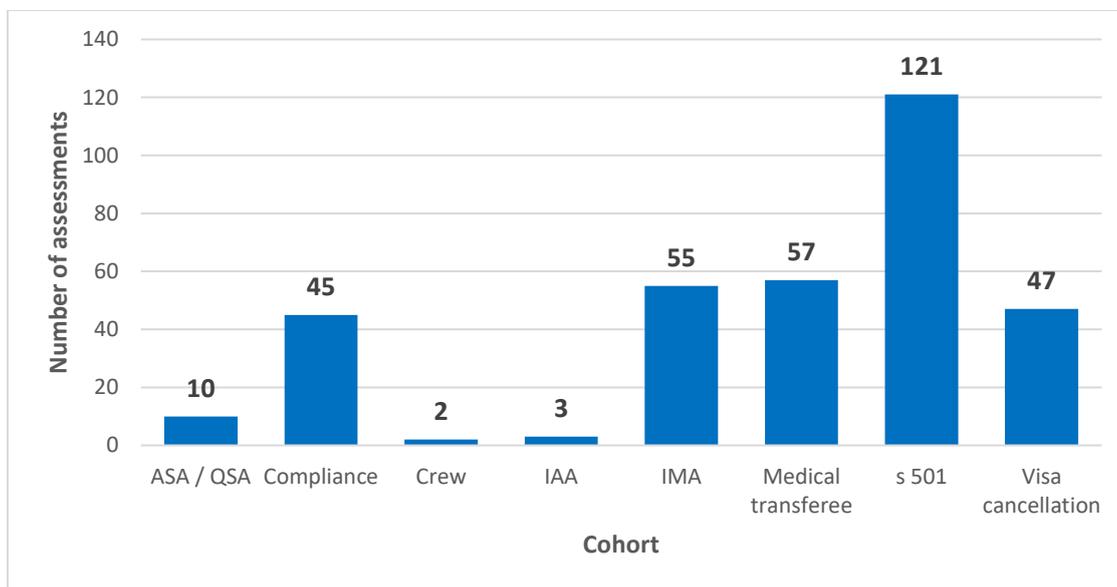
Cohorts of detainees

4.10. People are in immigration detention for many reasons. They include people who had their visa cancelled, or their visa has expired, people who arrived in Australia without a valid visa, and people who were returned to Australia from a Regional Processing Country for medical treatment.

4.11. The numbers in these groups change over time. From 2012 to 2018 the largest cohort was those who had arrived by sea without a visa and lodged a claim for protection. This group is now relatively small as the department either released those people on visas or removed them from Australia. In more recent times, people whose visas were cancelled under s 501 of the Migration Act because of criminal convictions make up the largest group in long-term detention.

4.12. Figure 2, below, shows the broad cohorts of people in immigration detention for whom the Office completed an assessment during the reporting period.

Figure 2 – Detainee cohorts



Legend

ASA / QSA	Person who holds an adverse or qualified security assessment
Compliance	Person detained for breaching visa conditions or not having a valid visa
Crew	Person who arrived as crew on a ship
IAA	Irregular air arrival
IMA	Irregular maritime arrival
Medical transferee	Person transferred to Australia from a Regional Processing Country for medical treatment
s 501	Person whose visa is cancelled under s 501 of the Migration Act
Visa cancellation	Person whose visa is cancelled

Part 5: DETAINED AND RELEASED AS NOT UNLAWFUL

5.1. Every six months the department provides the Office with a report about people who have been detained on suspicion of being unlawful non-citizens, who have subsequently been found to not be unlawful and released from detention. These situations often arise where the information in departmental systems is affected by gaps in record keeping and/or poor administrative practices which impacts the quality of decision making.

5.2. While the department acted in recent years to address issues leading to inappropriate detention, Australian citizens and lawful non-citizens are still detained on occasion. However, based on the continuing decrease in the number of people detained on this basis over the last three years, the department's controls appear to be effective in preventing, detecting, and correcting instances of inappropriate detention.

5.3. During the period from January to June 2020 (the relevant period) the department inappropriately detained seven people on suspicion of being unlawful non-citizens, compared to 10 people from July to December 2019 (the previous period). This represented 0.55 per cent of all people detained during January to June 2020, compared to 0.4 per cent during the previous period and 0.67 per cent in July to December 2017. The average length of time that the department held a person in inappropriate detention was 6.1 days, compared to 4.9 days in the previous period and 51.5 days in July to December 2017.

5.4. As noted in our previous report, *Monitoring Immigration Detention Report July to December 2019*, historically poor administrative practices and ineffective quality control continue to affect the accuracy of information in departmental systems. While the department implemented controls to mitigate the risk that historical errors will lead to further inappropriate detentions, on occasion these issues continue to contribute to errors in decision-making leading to inappropriate detention. For example, historical errors in letters notifying an applicant of a visa outcome (visa notifications) dating back more than 10 years contributed to an inappropriate detention in the January to June 2020 reporting period. This is consistent with previous reporting periods, in which visa notification errors were regularly a leading cause of inappropriate detentions since 2015. These errors provide information to the department and should be used and considered when developing and assessing current quality assurance processes. Overall errors of this type continue to decline.

5.5. Visa notification errors also affected cases in the relevant period where a person was released from criminal custody. In these cases, the person was detained in immigration detention following their release from criminal custody because they appeared as an unlawful non-citizen on departmental systems. The department should have identified these errors prior to prison release.

5.6. In September 2020, we released the *'Did They Do What They Said They Would?'* report about agencies' implementation of recommendations the Ombudsman made in reports between July 2017 and June 2019.¹² This included our assessment of the department's implementation of recommendations in two reports, *'Investigation into the circumstances of the detention of Mr G'* (April 2018) and *'Preventing the immigration detention of Australian citizens'* (December 2018), about circumstances that led to the inappropriate detention of Australian citizens and lawful non-citizens. We observed that, in response to our recommendations, the department improved its processes related to decisions to detain a person on suspicion of being an unlawful non-citizen, mitigating the risk of further inappropriate detentions. While the department implemented most of the recommendations made in these reports, these further instances of inappropriate detention highlight the need for the department to implement our recommendations in full.

¹² https://www.ombudsman.gov.au/_data/assets/pdf_file/0013/111460/Did-they-do-what-they-said-they-would-report.pdf

5.7. Specifically, there are two partially implemented recommendations in the report that are relevant and appropriate to mitigate the risk of further inappropriate immigration detentions:

- **Recommendation 2 in the ‘Investigation into the circumstances of the detention of Mr G’ (April 2018)**¹³ — this recommendation addresses issues with how the department maintains the reasonable suspicion that a person in immigration detention is an unlawful non-citizen. This recommendation makes suggestions for improvement to policies and procedures to ensure the ongoing lawfulness of a person’s detention is regularly reviewed, and steps taken to maintain the suspicion that the detainee is an unlawful non-citizen are appropriately recorded. This recommendation, once implemented, will address issues identified with lengthy periods of inappropriate detention by ensuring any cases of inappropriate detention are identified sooner and the individual released, reducing the period of inappropriate detention.
- **Recommendation 6 in ‘Preventing the immigration detention of Australian citizens’ (December 2018)**¹⁴ — this recommendation addressed our concerns with inconsistent processes we observed across ABF field offices for managing non-citizens in criminal detention and their transfer to immigration detention upon release from criminal custody. Once implemented, these processes will assist ABF field offices to prioritise more complex cases and identify potential issues, including citizenship issues and visa notification errors, in advance of a person’s release from prison, mitigating risk of further cases of inappropriate detention following an individual’s release from criminal custody.

5.8. These two recommendations address critical points of process failure that contributed to the detention of Australian citizens or lawful non-citizens. The department has committed to full implementation of both partially implemented recommendations and the Office will continue to monitor the department’s implementation progress.

5.9. Overall, we are generally satisfied with the corrective actions taken by the department in response to the other issues identified in the six-monthly report from January to June 2020, which will assist with the prevention of further inappropriate detentions.

¹³ https://www.ombudsman.gov.au/_data/assets/pdf_file/0018/83520/Investigation-into-the-circumstances-of-the-detention-of-Mr-G.pdf

¹⁴ https://www.ombudsman.gov.au/_data/assets/pdf_file/0026/92915/December-2018-Preventing-the-immigration-detention-of-Australian-citizens-Investigation-into-the-Department-of-Home-Affairs-implementation-of-the-recommendations-of-the-Thom-Review.pdf

Department response

The Department of Home Affairs (the Department) welcomes the Commonwealth Ombudsman's Report *Monitoring Immigration Detention – The Ombudsman's activities in overseeing immigration detention January to June 2020* (the Report).

The Department values the Commonwealth Ombudsman's oversight of immigration detention, and agrees with the majority of the recommendations made in the report.

Below is the Department's response to the recommendations and key themes of the report.

Part 2: Monitoring activities under OPCAT

Use of force and restraints (Recommendation one)

The Department acknowledges the Ombudsman's concerns about the use of force within the immigration detention network, including alleged instances of excessive use of force to resolve conflict or respond to non-compliant behaviour. The Department agrees with recommendation one and maintains that the appropriateness of use of force is reviewed through mandatory reporting mechanisms, and by reviews conducted by the respective facility Superintendent. The Department also maintains that Australian Border Force (ABF) and its contracted Facilities and Detainee Services Provider (FDSP) staff are trained in using alternative strategies to manage detainee behaviour. Any concerns regarding the appropriateness of use of force may be referred by senior executives within the Department and from external scrutiny agencies to the Department's Detention Assurance team for formal assurance.

The Department's use of force policy and procedural instructions apply to the use of reasonable force on detainees held in immigration detention and clearly document the expectation that use of force is a measure of last resort and should not be used unless it is reasonably necessary to achieve a lawful outcome. Departmental and FDSP staff must exercise care and informed decision making before using force against any person. The use of force must always be reasonable and departmental and FDSP staff must take into account the individual circumstances of any person against whom force is being considered.

The Department agrees that any use of 'mandatory ground stabilisation' would amount to use of force and should be reported as such by the FDSP. The Department will also engage with the FDSP to review training in the use of ground stabilisation techniques against the Department's framework for use of force in immigration detention, noting that no use of force is 'mandatory'.

Complaint handling (Recommendation two)

The Department acknowledges the Ombudsman's concern regarding inconsistency in the quality of complaint records, and notes recommendation two. All investigations into complaints raised by detainees or other third parties have a detailed single record of how the complaint was investigated and the evidence considered. All written complaints must be responded to in writing and the complainant informed of the outcome of any investigation undertaken into their complaint.

ABF staff at each facility undertake regular quality assurance of complaint records and responses, and where required, work with FDSP staff to improve the quality of response letters to detainees. Discussions are held at Weekly Review Meetings with FDSP staff about the circumstances of each complaint, and the management, resolution and response to each complaint. The Department will continue to work collaboratively with the FDSP to ensure complaints are adequately investigated and responded to, and will continue to provide input, advice and guidance where appropriate.

Managing at risk or vulnerable people (Recommendation three)

The Department agrees with recommendation three, and maintains that it does take responsibility for the effective and appropriate use of available mechanisms to manage individual detainees' vulnerabilities and risks. The FDSP and the Detention Health Service Provider (DHSP) are aware of and adhere to the requirement to share information with other service providers in accordance with the individual needs of detainees through onsite daily meetings as set out in both the FDSP and DHSP contracts.

The FDSP is contractually required to take a collaborative and integrated approach to the provision of services, to be effective in managing complex stakeholder and governance issues, and build long term relationships with the Department and other service providers.

The DHSP is also contractually required to collaborate with any other service providers appointed by the Department. In addition, the requirement to collaborate and share information, with patient consent, is in line with the Australian Health Practitioner Regulation Agency Code of Conduct and the Royal Australian College of General Practitioners Standards for Detention facilities.

Performance monitoring against FDSP and DHSP contractual obligations is undertaken by the Department, and record keeping practices for stakeholder meetings are regularly reviewed for compliance and quality.

Supporting these contractual requirements, the Department's Detention Policy Statement on Health Service and Delivery Standards requires that the delivery or communication of health information is communicated to people in a manner that enables participation in shared decision-making and that communication is effective, respects privacy and ensures safety when health information is shared. The Department's Detention Health Policy Procedural Instruction on Mental Health also sets out requirements for information exchange between key stakeholders.

When there is a need to share detainee's personal information, the FDSP and DHSP continue to operate within the limitations of legal, contractual, privacy principles and 'medical in confidence' provisions. As an example, the FDSP creates and maintains, in conjunction with the Department and other service providers, an individual management plan (IMP) for the care and support of each detainee. The FDSP also creates and maintains a security risk assessment for each detainee to monitor risk to themselves or where appropriate, to others, including the community. The IMP forms the basis for information sharing between the FDSP and the DHSP and is central to the individual management of each detainee. It is the mechanism that captures the relevant information associated with the welfare of all detainees as well as assisting stakeholders in undertaking a holistic approach to detainee wellbeing.

Public statement regarding the management of COVID-19 risks in immigration detention

The Department acknowledges the 1 July 2020 Statement by the Commonwealth Ombudsman on the management of COVID-19 risks in immigration detention facilities and welcomes the Ombudsman's broad satisfaction with the Department's implementation of site-level strategies to prevent and respond to COVID-19 and its adherence to the Communicable Diseases Network Australia (CDNA) Guidelines.

As outlined in the Department's response to the Ombudsman's 1 July 2020 Statement which is published on the Ombudsman's website, the ABF and its service providers remain focused on maintaining the health and safety of all people in its immigration detention facilities, including alternative places of detention, and continues to make every effort to prevent the entry of COVID-19 into immigration detention facilities.

The ABF notes the few instances of inconsistent application of the Operational Notice observed by the Ombudsman's Office during its inspections from May to June 2020, and has addressed any ambiguity in the Notice, and established further assurance and audit processes. The Department continues to monitor and adjust its COVID-19 response arrangements to the prevailing advice and CDNA guidelines.

Implementation of prior recommendations

The Department acknowledges the Ombudsman's analysis of the Department's progress against each of the 16 recommendations in the January to June 2019 report, and the 12 recommendations in the July to December 2019 report. The Ombudsman's analysis reflects improvements observed during the January to June 2020 inspection period. It is worth noting that in some cases, up to eighteen months has passed and further progress has been made, as the Department continues to progress and finalise the implementation of recommendations.

Part 3: Complaints about immigration detention

The Department acknowledges the important role complaints play in informing the Ombudsman's work by highlighting systemic issues for consideration at future immigration detention monitoring visits, and notes that 23 of the 98 complaints after being assessed, were investigated by the Ombudsman's office.

Part 4: Reporting on long-term detention

The Department notes the statistics presented regarding the Commonwealth Ombudsman's assessment of the circumstances of those in long-term detention under section 486O of *Migration Act 1958*, including the challenges presented by a changing demographic in detention.

While acknowledging the concerns raised by the Ombudsman about the timeliness of decision-making and case progression, the Department notes that decisions that affect an individual's case progression are complex and must take into account relevant court or tribunal proceedings, special health needs, information about the situation in their country of citizenship and also allow for the individual to have an opportunity to consider and respond to any adverse issues arising from the Department's assessment. In progressing these cases, the Department prioritises those in held detention and those with specific health conditions or compassionate situations. The Department also takes into account the issues raised by the Ombudsman in deciding the priority of individual cases.

In 14 (18%) of the 77 recommendations made by the Ombudsman (in the period January to June 2020) to expedite a process the Department or Minister had already commenced, the tabled response noted that decisions could not be expedited any further because:

- there were relevant ongoing court matters that needed to be considered
- the individual detainee or their representative had requested that the Department defer consideration whilst further information was gathered, or
- the individual had been offered an opportunity to comment on adverse information and the Department had agreed to multiple extension to the timeframes to respond.

In 15 (19%) of the 77 recommendations, the Department had already progressed an individual's case or referred the matter to the relevant Minister before the Ombudsman made the recommendation. In the remaining 48 (63%) of the 77 recommendations, the Department agreed to expedite the case.

Part 5: Detained and released as not unlawful

The Department welcomes the Ombudsman's recognition of the Department's effective controls over the last three years in preventing, detecting and correcting instances of inappropriate detention. The Department acknowledges those instances identified in the January to June 2020 reporting period, and notes that issues related to visa notification errors were considered isolated and not systemic. Visa notification errors continue to decline, with no errors of this type reported in the July to December 2020 reporting period.

Summary of Recommendations

January to June 2020

Recommendation #	Status
1	Agree
2	Noted
3	Agree

APPENDIX B

Recommendations from January–June 2019 report			
Recommendation	Department response	July–December 2019 report’s assessment of actions taken	Need for further action
Recommendation 1: We recommend that the department seek ministerial authority to bring forward a Bill, which would establish a legislative framework to support all internal operations of the immigration detention network.	Agreed	Since our previous report the <i>Migration Amendment (Prohibiting Items in Immigration Detention Facilities) Bill 2020</i> has been introduced to parliament. We remain of the view that while the administrative framework is comprehensive, a robust legislative framework that adopts preventive measures to reduce the risk of violence as well as protect the most vulnerable detainees is essential.	No further action required at this time.
Recommendation 2: We recommend that, as far as possible, the department: a) permit detainees maximum freedom of movement within an immigration detention facility (IDF) b) limit the use of the controlled movement model to circumstances where the use of this model is consistent with not only the ongoing safety and security of the facility but also the wellbeing of detainees.	Agreed	We acknowledge the department’s advice that it regularly reviews the operating models at each facility to provide optimal rights and privileges while maintaining safety and security provisions. We remain of the view that operating models should provide detainees with maximum opportunities to participate in meaningful fitness and educational programs wherever possible. However, in the context of COVID-19, it may be appropriate for movement to be restricted to comply with social distancing recommendations.	The Office will continue to monitor, especially in response to the easing of COVID-19 restrictions.
Recommendation 3: We recommend that, as a priority, the Blaxland High Security Compound (BHSC) be decommissioned.	Agreed	Since the time of our report the department has transitioned all detainees from the BHSC into the Villawood Immigration Detention Centre.	The Office notes the use of BHSC for quarantine purposes and will continue to monitor its use until it has been decommissioned entirely.
Recommendation 4: We recommend that, wherever practicable, the department sources APODs that cater to the longer-term needs of detainees through the provision of appropriate and accessible facilities.	Agreed	During this cycle we observed that the department had taken steps to increase the services available to detainees at the Mantra Bell City APOD, with the introduction of expanded common room facilities and daily excursions to the main detention facility. However, the department’s management of the risks associated with COVID-19 has impacted these services.	The Office will monitor the services available to detainees at APODs and, where it is safe to do so, will visit these facilities.

Commonwealth Ombudsman—Monitoring Immigration Detention January to June 2020

Recommendations from January–June 2019 report			
Recommendation	Department response	July–December 2019 report’s assessment of actions taken	Need for further action
<p>Recommendation 5: The department:</p> <p>a) addresses concerns with the design and fit out of the modular high security compounds, in particular by:</p> <ol style="list-style-type: none"> i. ensuring suitable access to facilities for mobility impaired detainees, including building access ii. providing privacy in all ablution areas and toilets iii. cabling individual accommodation rooms to enable access to free to air television programs iv. providing suitable in-room secure storage for in possession property. <p>b) ensures that all future use of the modularised compounds is designed and fitted out to support the ongoing health and welfare needs of detainees, in addition to the good order and safety of the centre.</p>	Agreed	The department confirmed capital works will be required to address several of the issues we have raised and that changes are unlikely to be addressed in the short term. We remain concerned that, despite the department’s assurances, the infrastructure available at most facilities does not adequately meet the needs of mobility impaired detainees.	The Office will visit detention facilities to assess the placement and accessibility options available to mobility impaired detainees when it is safe to do so.
<p>Recommendation 6: That:</p> <p>a) the department address the shortfalls identified in the property storage facilities at Villawood</p> <p>b) Serco ensure that all money and valuables held in trust for a detainee are stored securely.</p>	Agreed	The department has confirmed that storage units have been prepared and there is now appropriate, secure storage at Villawood.	No further action required.
<p>Recommendation 7: The department:</p> <p>a) ensures all detainees have appropriate access to programs and recreational facilities within accommodation compounds</p> <p>b) ensures equitable access to communal recreation and activity facilities for all detainees.</p>	Agreed	During this inspection cycle we observed an improvement in access to activities, both in-compound and in common access areas.	Noting our observations of instances where staff perceived detainee access to programs and education as a privilege, we will continue to monitor progress on this recommendation at future inspections.
<p>Recommendation 8: The department:</p> <p>a) reinstates the traditional POS model in all IDFs</p> <p>b) ensures each detainee has an allocated POS officer who is responsible for monitoring and reporting on his or her day-to-day welfare needs.</p>	Agreed	The department confirmed the allocation of one appropriately qualified Welfare Officer to four detainees at the Adelaide ITA. Up to two Personal Officers are allocated to detainees across other facilities to ensure at least one officer is available to a detainee on most days.	No further action required at this time.

Commonwealth Ombudsman—Monitoring Immigration Detention January to June 2020

Recommendations from January–June 2019 report			
Recommendation	Department response	July–December 2019 report’s assessment of actions taken	Need for further action
Recommendation 9: The department removes the restriction on external recreational and religious excursions for all detainees with an established low behavioural and/or flight risk.	Agreed	We remain concerned that, despite the department’s assurances the program and activity policy settings include the availability and eligibility of excursions, we have not observed any examples of detainees being provided with an opportunity to participate in external excursions.	The Office will engage with the department to confirm when external recreational and religious excursions will be available to long term detainees.
Recommendation 10: The department ensures that all detainees placed in an APOD have access to welfare support and age-appropriate educational, recreational, sporting and religious programs and activities, including access to outdoor recreational activities.	Agreed	During this inspection cycle we noted an improvement in the provision of welfare and programs and activities for detainees held in APODs.	The Office has made two recommendations in this reporting period that relate to the long-term use of APODs. The Office will monitor the treatment of detainees and conditions at APODs and, where it is safe to do so, will visit these facilities.

Commonwealth Ombudsman—Monitoring Immigration Detention January to June 2020

Recommendations from January–June 2019 report			
Recommendation	Department response	July–December 2019 report’s assessment of actions taken	Need for further action
<p>Recommendation 11: The department, in conjunction with its service providers:</p> <ul style="list-style-type: none"> a) review the Security Risk Assessment Tool and associated algorithm to ensure that, as far as possible, it does not unfairly skew the risk rating of detainees b) ensure intelligence analysts are empowered to make recommendations relating to the reduction or escalation of the initial risk assessment of a detainee within their initial 28 days in detention c) ensure a quality assurance program of the information (both historical and current) used to inform the Security Risk Assessments is undertaken prior to any risk assessment being applied to a detainee d) ensure a security, flight or behaviour risk rating of High or Extreme is only applied where there is substantiated evidence to support such a rating e) review and substantiate High or Extreme security risk assessments prior to the rating being used to: <ul style="list-style-type: none"> i) support the use of mechanical restraints; or ii) inform any other activity where a detainee will be placed in restraints, where such placement will cause public embarrassment, or cause the detainee to decline to participate in medical or mental health treatment. 	<p>Agreed in part</p>	<p>No improvement in the quality of analysis undertaken to determine a detainee’s risk assessment has been noted during this reporting period.</p> <p>We acknowledge that the department has completed a review of the Security Risk Assessment Tool (SRAT), but we are yet to see evidence of any substantive change to the outcomes of individual detainee SRATs.</p>	<p>The Office will engage with the department to confirm the implementation of recommendations arising from its review and will sample SRATs from all immigration detention facilities.</p>

Commonwealth Ombudsman—Monitoring Immigration Detention January to June 2020

Recommendations from January–June 2019 report			
Recommendation	Department response	July–December 2019 report’s assessment of actions taken	Need for further action
<p>Recommendation 12: The department in consultation with its service providers ensure that:</p> <p>a) all officers who attend an incident produce reports for inclusion in the Incident Report</p> <p>b) ABF and Serco procedures be updated to reflect the need for procedural fairness to be provided to detainees named as a person of interest, prior to the Incident Report being used in any administrative decision-making process.</p>	Agreed in part	<p>The department agreed with our recommendation that all officers involved in an incident should prepare an independent report. During this inspection period we continued to see instances where officers attending incidents did not prepare a report.</p> <p>We did not see evidence of the department giving procedural fairness to detainees who are alleged to have been involved in an incident. We remain of the view that incident reports may adversely impact a detainee’s privileges, placement and immigration pathway and that it is essential that procedural fairness is given and recorded.</p>	<p>The Office will sample incident records from each facility and review the quality and availability of officer reports.</p> <p>We will assess whether there is evidence that procedural fairness has been afforded to detainees and that records are available.</p>
<p>Recommendation 13: The department:</p> <p>a) ensure all BMPs are reviewed in a structured, minuted meeting with representatives from all relevant stakeholders in attendance</p> <p>b) introduce a robust quality assurance program for the development of BMPs to ensure content is relevant, fair, and applicable to the detainee’s individual circumstances.</p>	Agreed	<p>Our observations during this inspection cycle indicated that development and review of Behaviour Management Plans (BMPs) had not improved. We are concerned that the input from stakeholders involved in developing and reviewing BMPs lacks sufficient detail and does not consider the individual needs of detainees.</p>	<p>The Office will sample detainee BMPs from each facility to assess opportunities available to detainees to manage their own welfare and behaviour and the collaboration of stakeholders in managing persons at risk or in situations of vulnerability.</p>
<p>Recommendation 14: The department ensure that mechanical restraints are:</p> <p>a) only applied for the shortest time necessary</p> <p>b) never used for punitive purposes</p> <p>c) only applied when all other forms of mitigation have been exhausted.</p>	Agreed	<p>Based on our inspections during July – December 2019, we are satisfied that where restraints are applied, staff regularly check them, especially during long haul transfers. We are satisfied that sufficient safeguards are now in place to ensure that the approving authority is aware of the type of restraint and circumstances applied for in planned use of force and transport and escort requests.</p>	<p>No further action required at this time but we will continue to monitor.</p>

Commonwealth Ombudsman—Monitoring Immigration Detention January to June 2020

Recommendations from January–June 2019 report			
Recommendation	Department response	July–December 2019 report’s assessment of actions taken	Need for further action
<p>Recommendation 15: The department:</p> <ul style="list-style-type: none"> a) ensures that all risk/threat assessments for transfer operations are relevant to the operational task b) notes that the Aviation Transport Security Regulations restrict the use of mechanical restraints to circumstances where there is a genuine risk to the safety of the aircraft that cannot be mitigated by any other option c) direct that, wherever possible, the SureLock Humane restraint (body belt) is the preferred mechanical restraint for all transfer operations. 	Agreed	We are satisfied, based on our assessment of transfer operations between July – December 2019 that detainees are generally treated with dignity and respect throughout the operation.	No further action required at this time but we will continue to monitor.
<p>Recommendation 16: The department ensures that:</p> <ul style="list-style-type: none"> a) all staff, including service providers tasked with complaint investigations, are provided with complaint investigation and management training b) it introduces a network-wide comprehensive quality assurance process for handling complaints c) Serco includes complaint investigation and complaint management training in its Facility Operations Manager training. 	Agreed in part	Complaint records sampled at the Mantra Bell City APOD in January 2020 were particularly poor and, in most cases, did not demonstrate how service providers had investigated the complaint, or how the outcome was reached.	The Office has made two recommendations in this reporting period that relate to the long-term use of APODs. The Office will monitor the management of complaints at the APODs and, where it is safe to do so, will visit these facilities.

Recommendations from July-December 2019 report			
Recommendation	Department response	Action taken	Need for further action
Recommendation 1: The department remind staff that they are not to use force for purposes not outlined in its own procedures and reinforces the potential consequences of using force for other purposes.	Agreed	The department advised in its response that it would 'remind Serco that its Authorised Officers must only use force as a last resort, and only for the purposes outlined in policies and procedures.'	The Office still has concerns regarding use of force in this reporting period. The Office will continue to monitor the use of force in immigration detention.
Recommendation 2: The department ensure that reviews of use of force undertaken by their Detention Assurance Team are completed within six months of the incident being referred to them. This may mean developing a six-monthly forward plan. If the review is not completed in a timely manner, this is reported to the Risk and Audit Committee.	Agreed	The department confirmed 'a rolling annual forward work program of independent detention assurance reviews' is in place and reviewed quarterly. The department's progress is reported to its audit committee.	The Office still has concerns regarding use of force in this reporting period. The Office will continue to monitor the use of force in immigration detention and review the department's progress.
Recommendation 3: The department provide feedback to Serco that the response to this complaint was inadequate and update guidance to confirm that where an internal report has identified room for improvement in the department's handling of a matter, this can and should be shared with the complainant (even if in general terms).	Agreed in part	The department advised in its response that it would 'provide feedback to Serco regarding the concerns outlined in this report.'	No further action required at this time.
Recommendation 4: The department provide an apology to the complainant, for both the use of force and the way the complaint was managed.	Disagreed	The department advised in its response that it 'does not consider it appropriate to issue an apology at this time.'	Noted.
Recommendation 5: The department places signage in all detention centre compounds advising detainees of their right to access legal services.	Agreed	The department advised in its response that it would 'develop signage for display in immigration detention facilities advising detainees of their right to access legal services.'	The Office will continue to inspect placement of signage in compounds.
Recommendation 6: The department ensures that an interpreter or other appropriate support is used where a detainee's ability to read or comprehend induction information is impaired.	Agreed	The department advised in its response that the information provided by Serco at the time of induction 'is provided in the detainee's preferred language with the aid of an interpreter to read it to them or provide translated material as appropriate.'	No further action required at this time.

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Recommendations from July-December 2019 report

Recommendation	Department response	Action taken	Need for further action
Recommendation 7: The department considers permitting detainees to access books and magazines during transfer operations.	Agreed	The department advised in its response that SkyTraders ‘has agreed that it may provide reading materials to detainees during transfer operations. The provision of reading material will be based on availability and, for operational safety reasons, will be dependent on the detainees’ demeanour. It should be noted that in the current COVID-19 environment, the department does not support the provision of shared in-flight entertainment materials to detainees.’	The Office will monitor the department’s response to this recommendation as COVID-19 restrictions ease.
Recommendation 8: The department, in conjunction with its service providers, address the use of threats of placement in HCA to influence detainee compliance, through additional training to assist staff in managing non-compliant behaviour.	Agreed	The department advised in its response that it has ‘sought assurances from Serco that facility staff have been reminded that this is not appropriate in managing non-compliant behaviour, and this will also be reiterated in refresher training provided to Serco staff.’	The Office still has concerns regarding the use of negative inducements to influence detainee compliance and will monitor this issue closely.
Recommendation 9: The department, in conjunction with its service providers, identify and include potential external “safe locations” and liaison requirements in the relevant contingency plans.	Agreed	The department advised in its response that it is ‘currently reviewing all immigration detention facility business continuity plans (BCPs). The current BCPs provide that in the event of a disruption requiring evacuation of a facility, detainees will be transferred to a designated alternative location. Part of the review will include emergency consultation with all critical onsite stakeholders to relocate to a suitable alternative location, investigate potential external safe locations, and detail liaison requirements in the plans.’	No further action required at this time.
Recommendation 10: The department ensures all bed spaces have a secure storage area where a detainee may secure their in-possession property.	Agreed	The department advised that it is ‘committed to progressively providing further personal lockable storage across the immigration detention network so that detainees may secure their in-possession property.’	The Office will monitor during inspections.
Recommendation 11: The department, as part of its next review of the electronic visits system, explore options to enable a visitor to schedule visits with multiple detainees in one application.	Agreed	The department advised in its response that its Visitor Management policy ‘is scheduled for review this year. As part of the review, the Department will consider exploring options to enable a visitor to schedule visits with multiple detainees in one application.’	The Office will monitor the department’s review of the Visitor Management policy.

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Recommendations from July-December 2019 report

Recommendation	Department response	Action taken	Need for further action
<p>Recommendation 12: Where a high or extreme risk detainee refuses to attend a medical appointment due to being mechanically restrained, the department considers alternative mitigation such as increased escorts, onsite or telehealth consultations to encourage detainee attendance at medical appointments.</p>	<p>Agreed</p>	<p>The department advised in its response that wherever possible, it provides health and medical services onsite at the immigration detention facility in the first instance. Where clinically indicated, it will make appropriate referrals to external health professionals. If available, it can offer Telehealth as an alternative to an offsite appointment.</p>	<p>The Office remains concerned about the use of mechanical restraints for detainee attendance at medical appointments and will monitor this issue closely.</p>