COMMONWEALTH OMBUDSMAN

Monitoring Immigration Detention

THE OMBUDSMAN'S OVERSIGHT OF IMMIGRATION DETENTION

1 July 2020 to 30 June 2021

Report by the Acting Commonwealth Ombudsman,
Penny McKay, under the *Ombudsman Act 1976*

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FOREWORD

This report outlines the work of the Office of the Commonwealth Ombudsman (the Office) to monitor immigration detention between 1 July 2020 and 30 June 2021.

This is the fourth public report of its kind since the Australian Government appointed the Office as the Commonwealth National Preventive Mechanism (NPM) under the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).

As the Commonwealth NPM, the Office visits and monitors places of immigration detention. We engage with the Department of Home Affairs (the department) – including Australian Border Force (ABF) – and its service providers, and review records and reports provided by them. We speak with people in detention, their advocates and civil society. We monitor trends in complaints received by the Office, as well as media reporting and international developments. We use this work to make recommendations and suggestions to the department to strengthen protections for people held in detention, and to influence systemic improvement in the administration of immigration detention facilities.

In this report we make 17 recommendations and 20 suggestions to the department. Some of these repeat themes covered in our previous reports and work, notably:

- The department should continue to work with the relevant ministers to reduce the number of people held in immigration detention facilities (recommendation 1).
- The appropriateness of the use of Alternative Places of Detention (APODs), including hotels (recommendations 11 to 13). Importantly, we recommend the department cease the use of APODs for long-term detention (greater than 4 weeks).

I encourage the department to take timely action to address these ongoing issues.

The number of people held in immigration detention continues to increase. There are challenges in the capacity of the detention network to accommodate the rising number of detainees. The Government re-opened North West Point Immigration Detention Centre (IDC) on Christmas Island in August 2020 to provide more capacity in the network. We acknowledge the number of people in detention is rising for a range of reasons, including COVID-19 restrictions inhibiting removals from Australia in 2021–22. However, the challenges posed by COVID-19 are not insurmountable to reducing the number of people held in detention.

Some countries chose to reduce the number of people in detention as part of their COVID-19 risk mitigation – for example, the UK reduced its immigration detention population by 39.5 per cent in 2020 by using immigration bail[1] and Canada similarly reduced its population by 66.3 per cent by taking COVID-19 risks into account during individualised detention review hearings and using alternatives to detention such as ankle monitors.[2]

[1]Immigration detention in the UK, The Migration observatory, 16 September 2021. Immigration Detention in the UK - Migration Observatory - The Migration Observatory (ox.ac.uk)

[2] Global Detention Project, April 2021 Canada report, Canada Immigration Detention Profile – Global Detention Project | Mapping immigration detention around the world

Comparatively the immigration detention population in Australia grew by 11.7 per cent during a similar period.[3]

Re-opening North West Point IDC does not meet the intention of the Ombudsman's previous recommendation, reiterated in this report, to reduce the number of people held in detention. Christmas Island is isolated and, based on our visit in February 2021, we are concerned about the conditions in which people are being held. In this report we make 5 recommendations about the conditions at North West Point IDC – including the need for people in detention to access a commensurate level of programs, activities and health support, as people held in facilities on the mainland (recommendations 5 to 10).

We also recommend:

- changes to the use of high care accommodation for quarantine purposes (recommendations 2 and 3)
- retaining CCTV footage of incidents in immigration detention facilities (recommendation 4)
- developing memoranda of understanding on responsibilities for the care and management of people in immigration detention held in state and territory correctional facilities (recommendation 13), and
- a risk-based approach to the use of mechanical restraints and searches on excursions, in accordance with departmental policy (recommendation 16).

Monitoring the department's response to and management of COVID-19 was a particular focus of our oversight activities in 2020–21. In addition to assessing the appropriateness of controls, we considered the impacts on people in detention and whether the restrictions implemented were proportionate.

There were no outbreaks of COVID-19 amongst people held in immigration detention in the period covered by this report,[4] demonstrating the effectiveness of the controls aimed at preventing the infection and spread of the virus. While the department was responsive to identified risks, using a range of controls including entry screening protocols, quarantine arrangements and limitation of non-essential visitors, we acknowledge the impact these controls and restrictions had on people in detention. There are opportunities for improvement in how the department manages some of those controls with greater regard to the impact on people in detention, particularly the use of high care accommodation for quarantine purposes and limitations on movement and in-person engagement.

COVID-19 presented unique challenges to the immigration detention network and oversight bodies throughout the reporting period. As a closed facility where people are in close proximity, immigration detention facilities are particularly vulnerable to outbreaks of communicable disease.

[3] Management of COVID-19 risks in immigration detention (2021) | Australian Human Rights Commission, page 15

[4] The Office will consider the department's management of outbreaks in 2021–22 in our next report.

We recognise our responsibility to support the public health effort and the department in limiting the spread of COVID-19 in the community and preventing the infection entering vulnerable settings such as immigration detention.

Due to the risks posed to people held in detention and staff (of the department, service providers and the Office), we postponed some in-person inspections of detention facilities in 2020–21. Despite these challenges, the Office continued our monitoring activities.

We adapted to a remote monitoring approach, a key component of which includes regular updates from the department. We also source and review information from other means such as media, thematic issues arising from complaints about immigration detention, and engaging with representatives who are in direct contact with people in immigration detention. While we anticipate that COVID-19 will continue to impact the Australian community and the immigration detention network, we have resumed in-person inspections in 2022 when and where it is safe to do so.

We provided this report to the department before publication. The department provided a response, which is **APPENDIX A** and **APPENDIX B** to this report**.**

The department agreed with 12 of our recommendations, partially agreed with 1 recommendation, and noted the remaining 4 recommendations.

The department provided a detailed response to the Office's recommendations and suggestions. This ongoing dialogue between the department and the Office contributes to continuous improvements immigration detention and assists us to work in partnership with the department (including the ABF) and their contracted service providers to strengthen protections against ill-treatment for people in detention.

The department noted Recommendation 2 and partially agreed with Recommendation 3. This is on the basis High Care Accommodation (HCA) is only used for medical quarantine placements in restricted circumstances, and existing policies and procedures already exist for HCA and medical quarantine which outline the different arrangements. While the department has not fully agreed with our recommendations, its response reflects an appreciation of the concerns raised in our report. We continue to monitor the department's prevention and control of COVID-19 within the detention environment, including the use of HCA for quarantine placements.

The department noted Recommendation 6 relating to time out of compounds for people held at the North West Point IDC. We acknowledge that subsequent to our inspection of North West Point IDC in February 2021, a number of improvements to access to programs and activities and recreational space have been made.

The department noted Recommendation 11. As the Phosphate Hill APOD is not operational at this time, we are satisfied with the department's assurance that rectification works will occur before it is used again to accommodate people held in detention.

The department noted Recommendation 13, relating to the use of hotel APODs for long-term placements. We remain concerned about protracted placements at hotel APODs. In our view, access to safe and serviceable facilities, medical and welfare services, programs and activities, and fresh air should be standard across all detention facilities.

We will continue to monitor this issue and engage with the department on our concerns.

The existence and unfettered ability of an external independent oversight mechanism to monitor places where people are deprived of their liberty is critical to transparency, accountability of detention authorities, and mitigating the risk of harm to those held in detention.

I appreciate the ongoing cooperation of the department (including the ABF) and its service providers in facilitating the Office's inspections and ensuring people in detention can make complaints to, and speak with, our staff. I also appreciate the department's flexibility in adapting to remote monitoring and providing regular and timely information to complement our in-person inspections.

Penny McKay
Acting Commonwealth Ombudsman

LIST OF RECOMMENDATIONS AND SUGGESTIONS

Recommendation 1
The department should continue to work with the relevant ministers to reduce the numbers of people held in immigration detention facilities.

Recommendation 2
The department should make alterations to high care accommodation (HCA) rooms used for quarantine placements at all facilities to differentiate between traditional HCA placement and quarantine placement, such as installing power points for detainees to charge mobile devices, installing TVs for entertainment and providing normal mattresses and bedding.

Recommendation 3
The department should implement a policy which clearly outlines the different arrangements to apply to placements in HCA for quarantine purposes, to ensure consistency across the immigration detention network (IDN).

Recommendation 4
The ABF ensure CCTV footage of incidents in immigration detention facilities is retained, in line with departmental policy and the Archives Act, which will provide greater opportunity for review of activities in detention, including when detainees make claims of ill-treatment.

Recommendation 5
The department should ensure detainees can access meaningful programs and activities (P&A) at North West Point Immigration Detention Centre (IDC), including within accommodation compounds, commensurate with P&A provided at facilities on the mainland.

Recommendation 6
The department should provide more time out of accommodation compounds for detainees at North West Point IDC, particularly in the absence of meaningful programs and activities within the accommodation compounds.

Recommendation 7
The department should ensure removals staff are part of the staffing complement posted to North West Point IDC to facilitate detainee removals, particularly voluntary requests, and to ensure the distribution of timely and accurate information to detainees about the removal process.

Recommendation 8
The department should ensure IHMS engages specific drug and alcohol staff at North West Point IDC and facilitates drug and alcohol rehabilitation and redirection programs to detainees at North West Point IDC.

Recommendation 9
The department should engage specialised torture and trauma services to be located at North West Point IDC to support detainees, and require IHMS to proactively engage with detainees previously receiving torture and trauma services with a view to continuity of treatment.

Recommendation 10
The department should ensure body worn cameras are available, operative, and in use at North West Point IDC.

Recommendation 11
The department should discontinue the use of Phosphate Hill APOD until rectification works to make this facility safe and serviceable occur. Consistent with recommendation 13, APODs including Phosphate Hill should not be used for detention for periods greater than 4 weeks.

Recommendation 12
The department should ensure facilities across the network have the same provision of programs and activities and the same access to medical and welfare services, including APODs.

Recommendation 13
The department should cease the use of hotel APODs for long-term detention (greater than 4 weeks).

Recommendation 14
The department should develop and implement memoranda of understanding with state and territory correctional services which outline responsibilities in the care and management of detainees held in correctional facilities for the purposes of immigration detention under the Migration Act.

Recommendation 15
The department should work with relevant state and territory correctional services with a view to:

a. providing detainees placed in correctional facilities for immigration detention purposes (under the Migration Act) with a means to privately contact the Office to lodge complaints or provide information about their treatment and conditions.

b. ensuring the Office is able to contact detainees held in correctional facilities to follow up on complaints and investigations.

Recommendation 16
The department should ensure that detainees participating in excursions are only subjected to pat searches and the use of mechanical restraints when necessary, using a risk-based approach and in accordance with departmental policy.

Recommendation 17
The department should ensure detainees have free access to complaint forms and the ability to lodge complaints anonymously at all facilities.

Suggestions

The Office suggests (**suggestion 1**) the following should be considered for inclusion in the High Care Accommodation (HCA) policy:

- Consideration of a higher authorisation level for the use of HCA for quarantine purposes.

- Specify that detainees are to be provided with open air access for at least one hour daily, and access to outdoor exercise where possible.
- Specify that detainees are to be provided with personal effects.
- Specify that CCTV cameras are to be covered and detainees reassured of their privacy during quarantine placement in HCA.
- Specify that detainees are to be provided with activities and entertainment.
- Specify that detainees are to be provided with meaningful human contact every day, noting that meaningful human contact can take a variety of forms and does not need to be in-person contact.
- Specify that detainees are to be provided with mental health and social support services during their quarantine placement in HCA.

The Office suggests (**suggestion 2**) the department consider developing Outbreak Management Plans for specific Alternative Places of Detention (APODs), particularly the larger APODs like the Park Hotel.

The Office suggests (**suggestion 3**) the department continue to ensure the best interests of the child is a primary consideration when placing detainees in the immigration detention network, particularly at North West Point IDC noting the remote locality of the facility.

The Office suggests (**suggestion 4**) the department ensures the detainees at North West Point IDC are provided adequate supports and access to internet enabled computers to facilitate regular engagement with legal representatives in private, including the ability to print, scan and email documentation.

The Office suggests (**suggestion 5**) the department reconsider placing detainees with ongoing legal proceedings at North West Point IDC to ensure appropriate access to legal support and representation.

The Office suggests (**suggestion 6**) the department consider rostering IHMS staff onsite at North West Point IDC 24 hours a day, 7 days a week, to provide appropriate medical support to detainees and staff at the facility.

The Office suggests (**suggestion 7**) that detainees with medical needs or risks that are not able to be managed on Christmas Island should not be placed at North West Point IDC.

Given Christmas Island's isolation and limited capacity to manage a COVID-19 outbreak, the Office is concerned about 'at risk' detainees who remain at North West Point IDC and suggests (**suggestion 8**) the department consider alternative placement options.

The Office suggests (**suggestion 9**) the department consider establishing a policy, setting out the minimum acceptable standard for conditions in accommodation compounds at immigration detention facilities, having regard to minimum safety standards for staff and detainees and further ensuring the rights and dignity of detainees is respected.

The Office suggests (**suggestion 10**) the department ensure that our oversight role and ability to inspect places of detention, is referenced when drafting MoUs with state and territory correctional services.

The Office suggests (**suggestion 11**) the ABF to work with Serco at Melbourne ITA to mitigate the risk of errors in planned use of force requests.

The Office suggests (**suggestion 12**) ABF decision makers consistently record reasons for their decision when approving the use of mechanical restraints against the advice of IHMS.

The Office suggests (**suggestion 13**) the department apply a consistent decision-making framework across all centres in the network. Among other matters this framework should require the recording and retention of sufficient information to demonstrate how and why delegates made their decisions.

The Office suggests (**suggestion 14**) the department ensure IHMS conducts timely mental health reviews of at-risk detainees as a priority to avoid potentially unnecessary extended placements in High Care Accommodation, and to ensure appropriate medical supports are in place.

The Office suggests (**suggestion 15**) the department re-iterates to immigration detention facilities that placing a detainee in High Care Accommodation needs the establishment of a clear plan for the detainee's management including an exit plan in accordance with departmental policy.

The Office suggests (**suggestion 16**) the department consider a mechanism for notifying legal representatives of transfers of their clients within a reasonable timeframe.

The Office suggests (**suggestion 17**) the department ensure any removal of mobile phones from detainees occurs for the minimum time necessary to ensure compliance with aviation security regulations.

The Office further suggests that (**suggestion 18**), where phone confiscation is both necessary and legally supported, arrangements are in place to allow detainees to communicate promptly with family and legal representatives before and after transfer.

The Office considers the complaints quality assurance processes in place at Melbourne ITA a good practice and suggests (**suggestion 19**) similar practices be implemented at all facilities across the network.

The Office suggests (**suggestion 20**) the department consider expanding the availability of self-directed development programs to all detainees across the immigration detention network.

INTRODUCTION

Oversight of immigration detention

1.1. This report summarises the activities of the Office of the Commonwealth Ombudsman (the Office) to monitor immigration detention between 1 July 2020 and 30 June 2021 (the reporting period). This is the Office's fourth public report of this kind and the first annual, rather than 6 monthly, report.

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 State Party to the United Nations 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. As the NPM, 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 in **Part 2** of this report.

1.4. This report makes **17 recommendations** and **20 suggestions** arising from our monitoring activities under OPCAT.

1.5. 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) and the Australian Border Force (ABF) which are responsible for immigration detention policy and administration. **Part 3** provides a summary of our complaint handling work during the reporting period.

1.6. Under section s 486O of the *Migration Act 1958* (the Migration Act) the Ombudsman is required to provide the Minister with an assessment of the appropriateness of arrangements for people who are in immigration detention for more than 2 years, and then every 6 months for as long as these people remain in detention. A summary of the assessments prepared during the reporting period is in **Part 4**.

1.7. Every 6 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 reasonable suspicion could not be maintained they were unlawful non-citizens. Our observations about the instances identified during the reporting period are provided in **Part 5** of this report.

1.8. In April 2022, we provided the department with the opportunity to comment on our draft report and recommendations. In June 2022, the department provided a detailed response to our report. The department agreed with 12 recommendations, partially agreed to 1 recommendation, and noted the remaining 4 recommendations. The department's response to our report and recommendations is included at **APPENDIX A**. The department's response to our suggestions is included at **APPENDIX B.**

MONITORING ACTIVITIES UNDER OPCAT

2.1. In its capacity as Immigration Ombudsman, the Office has handled complaints about immigration detention facilities since 2005 and regularly visited facilities since 2010. Based on its investigations and inspections, the Office provides observations and recommendations directly to facility staff and the department. Issues arising from these activities are 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. On ratifying OPCAT, State Parties commit to establishing a system of regular preventive visits by independent bodies, known as NPMs, and receiving visits from the United Nations 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. OPCAT makes clear the rights of people in detention should be respected and upheld. The oversight mechanisms established in accordance with OPCAT seek to 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 places include Australian Defence Force (ADF) detention facilities, Australian Federal Police (AFP) cells, and immigration detention facilities. This 2020–21 report – covering a period before Australia's deadline for implementation of OPCAT – continues to focus on immigration detention facilities. The Office is working to expand our oversight approach, methodology and reporting to include AFP detention facilities and AFP cells. Our oversight will initially focus on primary places of detention, consistent with the Government's advice at the time of signing OPCAT, noting that OPCAT implementation is an iterative process.

2.5. The Office's visits to places of detention 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 refining 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 over the reporting period involved:

- assessing information the department provided about detainee numbers and cohorts, health facilities, recent incidents, emerging issues and other information relevant to our role, and
- wherever possible, attending detention facilities in person to conduct an inspection.

2.7. A facility may include an immigration detention centre, immigration transit accommodation or another place designated as an alternative place of detention. We do not inspect community-based detention, only held detention facilities.

2.8. Based on the information gathered, we assessed facilities' overall performance based on the treatment of, and conditions for, detainees.

2.9. Indicators of a healthy facility 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.

2.10. These indicators are adapted from those used by similar international and domestic inspectorates.

2.11. During an inspection we may conduct some or all of the following activities to gather information about the operation of a facility:

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

2.12. We compare our inspection 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.

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

Engagement with civil society organisations

2.14. The Office recognises there are many civil society organisations performing important functions relating to the oversight of Commonwealth places of detention, particularly immigration detention facilities. During the reporting period, the Office sought to leverage the experience and expertise of these organisations to support its inspection mandate as the Commonwealth NPM.

2.15. The Office regularly consults with civil society organisations to inform planned inspections of immigration detention facilities. The Office engaged with bodies such as Amnesty International, the Asylum Seeker Resource Centre, and the Refugee Council of Australia prior to visits to the Brisbane Immigration Transit Accommodation (ITA), Christmas Island detention facilities, and the Yongah Hill Immigration Detention Centre (IDC). The Office also engaged with civil society organisations in advance of planned visits to the Villawood IDC, and detention facilities in Melbourne in 2021, before those visits were postponed due to COVID-19 restrictions.

2.16. This engagement provides an opportunity for the Office to gather further information about the conditions of detention in particular facilities, and ensure our inspection staff are aware of any specific areas of concern and emerging trends. These contributions inform the Office's inspection strategy and assist in strengthening oversight and targeting the Office's focus during visits. Outside of visits, the Office also maintains communications throughout the year with civil society organisations as particular matters arise. Noting the valuable insights that civil society organisations can provide, the Office will continue this regular engagement.

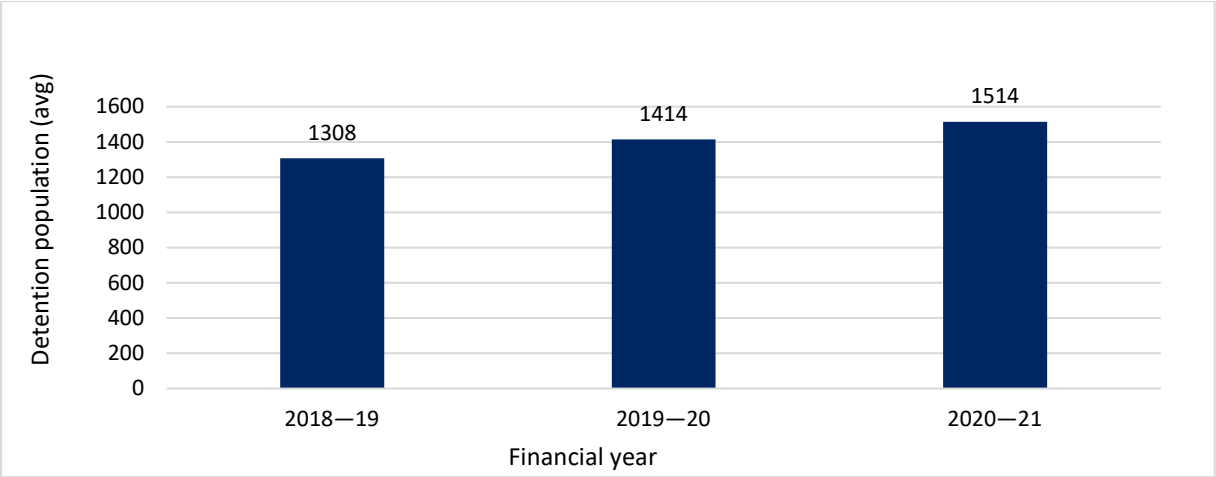
2.17. During the year, the Office held 3 meetings of the OPCAT Advisory Group (OAG). The OAG is a civil society advisory group that provides expert advice to the Commonwealth Ombudsman about the Office's role as the Commonwealth NPM and the NPM Coordinator for Australia's NPM network. Communiques for each of these meetings, dated 21 April 2021, 28 July 2021 and 30 November 2021, are available on the Commonwealth Ombudsman website.

2.18. To further promote engagement, the Office updated its website to enable civil society organisations and other stakeholders to provide information or make enquiries relating to the Office's functions under OPCAT.

Number of people in held immigration detention

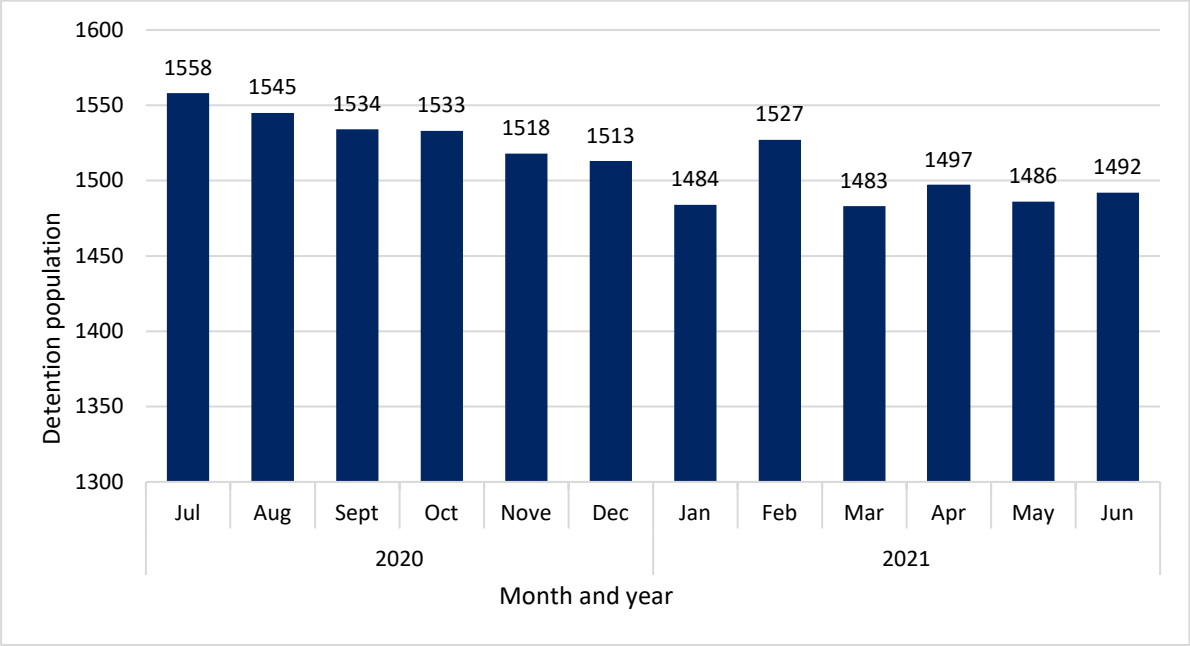
2.19. The number of people in immigration detention increased over the last 3 financial years – see **Figure 1**.

Figure 1: Average detention population by financial year



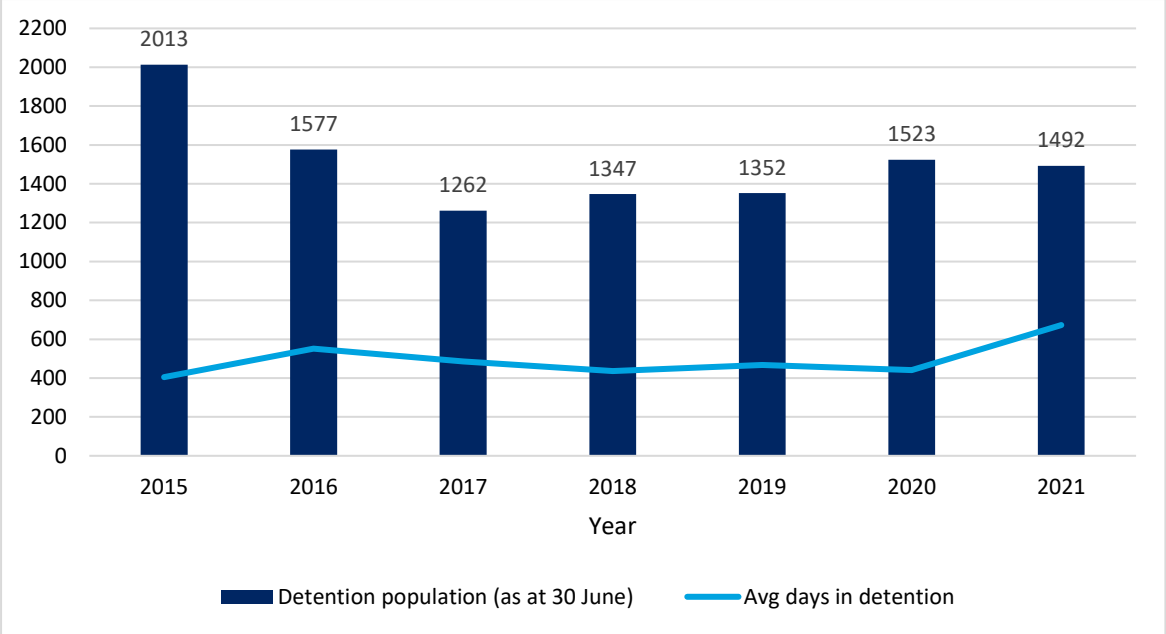
2.20. From June 2020 to January 2021 the number of people held in immigration detention remained above 1,500 (see **Figure 2**). This is approximately 200 more people than the average detention population 2 years earlier.

Figure 2: Number of people in held detention by month from July 2020 to June 2021.



Alongside this trend, the average time spent in detention increased over the reporting period (**Figure *3***).

Figure 3: Comparison of detention population with average length of detention



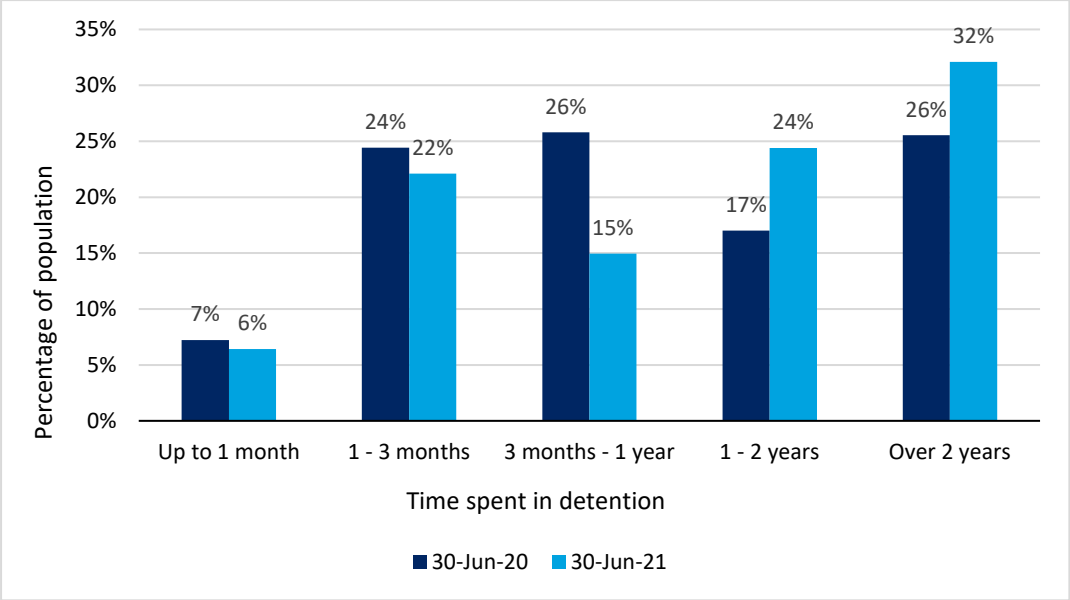
2.21. At the end of June 2020, there were 1,523 people held in immigration detention facilities. Of these people, 25.5 per cent (389) were detained for greater than 2 years.

2.22. At the end of June 2021, there were 1,492 people held in immigration detention facilities. Of these people, 32.1 per cent (479) were detained for greater than 2 years.

2.23. Although the total number of people held in immigration detention on 30 June 2021 was slightly lower than at the same time in 2020 (by 31 people), the average period in detention increased by 122 days over the reporting period. On 30 June 2021, the average period in detention was 673 days, compared to 551 days on 30 June 2020.

Figure 4 compares time spent in immigration detention for the 2019–20 and 2020–21 periods.

Figure 4: Comparison of time spent in detention 2020 versus 2021.



Monitoring during the COVID-19 pandemic

2.24. COVID-19 presents particular risks in detention environments and challenges for inspection bodies. The Office continues to actively monitor the department 's response to COVID-19, including its infection control measures across the immigration detention network.

2.25. During the reporting period, several state jurisdictions were either in lockdown or imposed movement restrictions in response to COVID-19 which impacted the Office's ability to conduct onsite visits to immigration detention facilities. In response, the Office continued remotely monitoring the Immigration Detention Network (IDN).

2.26. The Office's remote monitoring of the IDN included:

- weekly reports from, and regular meetings with, the department about individual detention facilities and the broader IDN, and
- feedback from complaints, media, peer bodies and civil society stakeholders.

2.27. Reviewing contemporaneous information from a broad range of sources meant 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.

2.28. Consistent with the preventive nature of our role as NPM, this remote monitoring now forms part of our ongoing approach. It includes regular engagement with the ABF and the department about issues of concern arising from these reports. The Office acknowledges the efforts of the department and the ABF in providing timely updates and responses to requests for information regarding the IDN.

2.29. During the reporting period, we also completed onsite visits and inspections when safe and consistent with relevant jurisdictional public health orders. Following the resumption of our onsite visits in November 2020, we completed inspections of facilities in New South Wales, Queensland, Western Australia, the Northern Territory and Christmas Island. Plans to inspect Melbourne and Sydney facilities in June 2021 were disrupted by restrictions within Victoria and New South Wales, as well as restrictions on interstate border movements. As a result, the Office suspended its onsite inspections and continued remote monitoring of the IDN.

2.30. The Office did not suspend visits lightly and was mindful that, in many ways, the restrictions imposed in response to COVID-19 could make detainees more vulnerable.

2.31. While mindful of the potential for increased vulnerability, the Office was informed by the clear advice of the Communicable Diseases Network Australia (CDNA) that detainees are at higher risk of transmission if the virus enters the population due to the large numbers of people residing in close proximity in immigration detention facilities. Further, the introduction of the Delta variant of COVID-19 posed additional risks compared to previous COVID-19 outbreaks, including greater transmissibility making control of outbreaks more difficult.

2.32. In planning inspection activities, the Office also considered risk mitigation strategies introduced locally at immigration detention facilities such as the suspension of 'non-essential' visitors and onsite activities. We elected not to pursue site visits where our attendance would be inconsistent with or contrary to risk mitigation strategies in place at detention facilities, particularly those risk mitigation strategies that were directed by state government public health units.

Monitoring the department's prevention and management of COVID-19

2.33. As one aspect of our monitoring, the Office assessed the department's arrangements for preventing and managing COVID-19 in immigration detention facilities. The department implemented strategies across the network informed by the CDNA Guidelines.[5] The Office's monitoring examined how the department adhered to the CDNA Guidelines in practice across the IDN.

2.34. For most of this reporting period there was no vaccine available for COVID-19.[6] The CDNA expected facilities to implement effective prevention and control measures to ensure the risk of an outbreak was as low as possible.

2.35. Overall, the Office remained satisfied with the department's strategies in response to COVID-19 and its adherence to the CDNA Guidelines, which were demonstrated by the absence of any COVID-19 positive cases among detainees during the reporting period.

2.36. There have been subsequent outbreaks at immigration detention facilities in 2021–22. These are outside the reporting period and will be covered in our next report.

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[5] The Communicable Diseases Network Australia Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Correctional and Detention Facilities in Australia.

[6] Australia began administering the Pfizer/BioNTech COVID-19 vaccine in February 2021, the AstraZeneca vaccine in March 2021 and the Moderna vaccine in September 2021. The vaccination program was rolled out in stages: the first people eligible to access the vaccine were staff and residents in aged care and disability centres, frontline health care workers and staff at border and quarantine facilities.

2.37. The Office is mindful of balancing public health risks and needs while minimising limits on the rights of people in held detention, as well as ensuring consistency between measures placed on people in detention and in the community.

Size of immigration detention population

2.38. In July 2020, the Office published a statement[7] by the Commonwealth Ombudsman on the management of COVID-19 risks in immigration detention facilities. The Ombudsman recommended the department work with the relevant ministers to reduce the numbers of people held in immigration detention facilities, with a specific focus on achieving effective social distancing in the facilities and regard to detainees with underlying health conditions that may render them susceptible to an outbreak of COVID-19.

2.39. The Office notes the reopening of North West Point IDC on Christmas Island in August 2020 provided some capacity relief. However, the Office considers this approach does not meet the intention of the Ombudsman's previous recommendation, nor does it address our concerns with the increasing detainee population across the IDN. Christmas Island is isolated, and we are concerned the limited health care facilities available put detainees at increased risk if an outbreak occurs.

2.40. The Office notes the increased use of APODs as another method to alleviate capacity constraints. APODs are routinely used within the detention network to separate detainees for quarantine purposes.

2.41. In December 2020, the Park Hotel in Melbourne began operating as an APOD. The Park Hotel was previously known as the Carlton Rydges Hotel which was the centre of the Melbourne COVID-19 outbreak in 2020 when it was operating as a hotel quarantine facility.

2.42. In the same month the Park Hotel began operating as an APOD, the Victorian Royal Commission COVID-19 Hotel Quarantine Inquiry Final Report[8] raised concerns with how it was operating as a hotel quarantine facility and more broadly with the use of hotels for the purpose of quarantine. While the requirements of hotel quarantine and detention differ, there is a risk that effective isolation strategies cannot be applied in the event of an outbreak at the Park Hotel APOD. As previously mentioned, the Office is aware that in October 2021 there were COVID-19 cases amongst detainees in the Park Hotel APOD. The department's management of these cases, including the effectiveness of isolation strategies to limit the transmission of the virus will be examined in our next report.

2.43. In light of these issues, the increase in the average detention population and the ongoing risk COVID-19 poses to people held in detention (particularly those who have vulnerabilities increasing their risk of serious illness), we remain concerned about the high numbers of people held in immigration detention facilities.

[7] Statement by the Commonwealth Ombudsman Michael Manthorpe on the management of COVID-19 risks in immigration detention facilities

[8] Royal Commission Victoria - COVID-19 Hotel Quarantine Inquiry Final Report and Recommendations

Recommendation 1

The department should continue to work with the relevant ministers to reduce the numbers of people held in immigration detention facilities.

Different types of quarantine in immigration detention

2.44. During the reporting period, the CDNA Guidelines advised:

- New detainees who were in a geographic location with elevated risk of community transmission within the past 14 days should be quarantined until 14 days from when they were last in the area with community transmission.
- Quarantine should be used for new detainees who are unwell, until they receive a negative COVID-19 test result.

2.45. On 12 August 2020, the CDNA Guidelines were revised to provide that some detainees, although located in areas with known community transmission, may be considered lower risk. These include detainees who are transferred directly from another facility, and where:

- that facility has no suspected, probable or confirmed cases of COVID-19,
- the detainee has only been in that facility within the preceding 14 days, and
- the detainee is screened for COVID-19 and is asymptomatic on entry.

2.46. The ABF has 3 categories of quarantine which are applied in different circumstances:

- Operational: 14-day quarantine for any new, asymptomatic detainees who have not arrived from prison.
- Medical: quarantine for detainees who are unwell; released from quarantine when a COVID-19 negative result is received.
- Isolation: used when a detainee is COVID-19 positive.

2.47. The classifications are broadly consistent with the CDNA Guidelines. However, the Office observed issues in the use of the ABF quarantine categories including:

- inconsistent application of operational quarantine across the IDN network,
- a "blanket" approach to quarantine – as in an approach that does not consider the circumstances and risk factors for individual detainees, and
- a more risk averse approach towards detainees resulting in a greater restriction compared to staff.

2.48. The department's interim policy advice and operational notifications (ONs) for detainee quarantine changed more frequently than the CDNA Guidelines. The Office commends the department's responsiveness to adapt to the evolving COVID-19 situation. The changes largely described the types of quarantine in more detail which suggests the

department recognises there was confusion about the operation of these classifications in practice.

Medical quarantine concerns

2.49. In the case of one detainee, the Office is concerned medical quarantine was used as a behavioural management tool on 4 occasions in June, September and November 2020 at the High Care Accommodation (HCA) unit at Brisbane ITA. The Office requested documentation from the department about the quarantine placements and identified the detainee did not meet the threshold for medical quarantine.

2.50. During one inspection, Serco officers supervising the quarantine units were not aware of which detainees were in medical quarantine, and which were in operational quarantine, and did not know how long each detainee had been in quarantine. From the Office's perspective, inaccurate on-hand reporting increases the risk of non-compliance with the department's policy and increases the risk that detainees may be subjected to quarantine conditions for longer than is necessary.

Operational quarantine for existing detainees

2.51. As per departmental policy, from 28 May 2020 existing detainees returning from an offsite activity could return to the general population without quarantine. Despite this direction, there were instances where detainees were put in quarantine following their offsite appointment. The reasons for quarantine were unclear in documents. Detainees also expressed frustration that while they were required to quarantine after an offsite visit, the Transport and Escort staff were not subject to any restrictions (for example, continued to be rostered in detainee facing roles).

2.52. Inconsistent requirements to manage COVID risks, between staff and detainees, was a common tension observed during this reporting period. At the Meriton Hotel APOD (Brisbane), we found one case where an ABF Officer entered a quarantine room without PPE before entering another room immediately afterwards. This led to additional days of quarantine for the detainees, however, the ABF officer and other staff onsite were not required to be tested or take any extra precautions when engaging with the detainee population.

Operational quarantine for incoming detainees from correctional facilities

2.53. During the reporting period, both the CDNA Guidelines and departmental policies advised asymptomatic detainees entering detention from a correctional facility did not have to quarantine, unless:

- the correctional facility had confirmed case(s) of COVID-19,
- they spent less than 14 days in the correctional facility, or
- the COVID status of the correctional facility was unable to be obtained.

2.54. The Office is aware that sometimes asymptomatic detainees covered by these circumstances were still quarantined because the correctional facility did not provide their COVID-19 status in a timely manner. The Office is pleased to note that communication between correctional facilities and the department improved, and expedited dissemination of information should prevent these occurrences in future.

Use of High Care Accommodation for quarantine purposes

2.55. The CDNA Guidelines advise that detainee quarantine should take place in a single room with bathroom facilities. The guidelines also state that 'solitary confinement rooms may be appropriate if alternative single room accommodation is not available'. In the context of immigration detention facilities, the Office understands 'solitary confinement rooms' to be the same as HCA rooms.

2.56. The Office observed that HCA rooms were used for quarantine purposes across the IDN. HCA is traditionally an environment for high-risk detainees who require a more closely controlled and intensive approach towards their management. HCA should only be used in the best interests of the detainee as part of a tailored detainee-focused management plan, or for the safety of the detainee, other detainees, or staff. HCA should not be used for punitive purposes.

2.57. The HCA rooms are sterile, low stimulus environments consisting of a bare room with a raised platform to hold a mattress with semi enclosed toilet and shower facilities, usually with limited access to personal property and limited external communication. The HCA rooms are under constant CCTV monitoring. Acknowledging these conditions, use of HCA usually requires approval by the ABF Superintendent for periods of less than 24 hours. HCA placements for more than 24 hours require approval by the ABF Commander for each 24-hour period as an additional layer of oversight.

2.58. The Office is concerned about the lack of high-level approval and oversight for detainees undertaking up to 14 days quarantine in HCA. This is particularly concerning given the usual strict clearance process, and that under normal circumstances, a detainee in HCA for over 24 hours is a concern to all stakeholders.

2.59. The Office observed in all but one facility (Yongah Hill IDC), alterations were not made to HCA rooms to make them more suitable for quarantine purposes. At Yongah Hill IDC, TVs were installed, and proper mattresses and bedding provided to detainees in HCA rooms for quarantine purposes.

2.60. In many instances, detainees were not provided with their personal belongings during their quarantine placement in HCA. The Office previously confirmed that arrangements were in place to ensure detainees can access their personal effects and entertainment during quarantine, as per the statement[9] by the Ombudsman published in July 2020. However, the Office is concerned this is not occurring consistently in practice across the IDN.

Recommendation 2

The department should make alterations to HCA rooms used for quarantine placements at all facilities to differentiate between traditional HCA placement and quarantine placement, such as installing power points for detainees to charge mobile devices, installing TVs for entertainment, and providing normal mattresses and bedding.

[9] Statement by the Commonwealth Ombudsman Michael Manthorpe on the management of COVID-19 risks in immigration detention facilities

2.61. The Office is also concerned with detainee privacy in HCA quarantine. In all facilities the CCTV cameras were still on, and detainees were still being observed by staff via CCTV, even though they were not in HCA for behavioural management or 'at risk' reasons.

2.62. The CDNA Guidelines recognise that extended periods of isolation can result in distress and deteriorating mental health, and facilities should ensure mental health and social support services are available to detainees while in quarantine. This is relevant for detainees placed in HCA in immigration detention facilities, and particularly for more vulnerable detainees with existing mental health concerns.

2.63. This point was raised by the Australian Human Rights Commission (AHRC) in its report,[10] which recommended the department cease the use of HCA for quarantine purpose and use alternative, less restrictive options for quarantine. The Office notes some detainees were placed in hotel APODs for quarantine purposes, but this was only for detainees considered 'low risk' and where hotel APODs were available.

2.64. The Office notes that during COVID-19, the United Nations SPT published advice[11] reiterating measures to be taken by authorities concerning all places of deprivation of liberty, including immigration detention. This advice reinforced the need to 'respect the minimum requirements for daily outdoor exercise'. Daily access to fresh air and one hour of outdoor exercise has long been regarded under international law as a minimum standard of treatment for people in detention facilities.

2.65. The Office also notes the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment recognises the right of daily access to at least one hour of open air for people placed in quarantine.[12] The Office is of the view that detainees in HCA for quarantine purposes must be provided with access to at least one hour of fresh air daily and, where possible, access to one hour of outdoor exercise daily.

2.66. The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment's principles[13] also state that detainees in quarantine should receive additional psychological support and be provided with meaningful human contact every day.

2.67. The Office notes that departmental policy acknowledges the difference between HCA placement and quarantine in HCA, but no other details are provided: 'Operational quarantine is not the same as HCA. Requirements of HCA remain the same'.

2.68. Noting the frequency with which HCA rooms are used for quarantine purposes across the IDN, the Office is concerned the department does not have a policy which outlines the specific arrangements to be implemented for HCA quarantine placements and believes this is contributing to the inconsistent approaches across the IDN.

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[10] Recommendation 13 - Management of COVID-19 risks in immigration detention - AHRC
[11] UN SPT Advice of the Subcommittee on Prevention of Torture to States Parties and National Preventive Mechanisms relating to the Coronavirus Pandemic
[12] Principle 7 - Statement of principles relating to the treatment of persons deprived of their liberty in the context of COVID-19
[13] Principle 8 - Statement of principles relating to the treatment of persons deprived of their liberty in the context of COVID-19

Recommendation 3

The department should implement a policy which clearly outlines the different arrangements to apply to placements in HCA for quarantine purposes, to ensure consistency across the IDN.

2.69. The Office suggests **(suggestion 1)** the following should be considered for inclusion in the HCA policy:

- Consideration of a higher authorisation level for the use of HCA for quarantine purposes.
- Specify that detainees are to be provided with open air access for at least one hour daily, and access to outdoor exercise where possible.
- Specify that detainees are to be provided with personal effects.
- Specify that CCTV cameras are to be covered and detainees reassured of their privacy during quarantine placement in HCA.
- Specify that detainees are to be provided with activities and entertainment.
- Specify that detainees are to be provided with meaningful human contact every day, noting that meaningful human contact can take a variety of forms and does not need to be in-person contact.
- Specify that detainees are to be provided mental health and social support services during their quarantine placement in HCA.

Screening

2.70. As per the CDNA Exposure Prevention actions and various directives from the department, the Office sighted the additional screening measures in place at all facilities visited including (but not limited to):

- questionnaire upon entry,
- hand washing stations, and
- temperature checks for all persons entering/exiting facilities.

2.71. At the Brisbane ITA, Yongah Hill IDC, Perth IDC, and Villawood IDC, the Office noted that a computer based thermal imaging camera was used to obtain a second temperature reading in addition to the use of hand-held non-contact thermometer for temperature checks. Hand sanitiser was also provided upon entry at some facilities.

2.72. The Office was broadly satisfied with the screening mechanisms in place across the IDN. We identified some inconsistencies in the application of screening arrangements and lack of adherence to the relevant operational notification (ON), including instances where staff were not temperature checked when exiting the facility. The Office notes the ON

was subsequently changed to remove the requirement for temperature checking when exiting a facility in May 2021.

2.73. The Office is pleased to note regular amendments to relevant ONs in line with updated CDNA Guidelines over the reporting period. For example, the CDNA Guidelines changed the temperature screening to equal to or greater than 37.5 degrees and this change was reflected in an updated ON issued on 24 July 2020.

Social distancing

2.74. While the CDNA Guidelines note the difficulty of practising physical distancing in detention settings, the Guidelines advise implementing social distancing as an infection prevention and control measure. While the Office observed some social distancing markings in all facilities we inspected, we noted that markings were absent from some communal areas, such as dining areas, in some facilities.

2.75. As per our previous observations, we observed detainees not adhering to social distancing advice during meal services, including no spacing when waiting in line and moving chairs to sit at tables with friends, contrary to the social distancing markers.

2.76. We remain satisfied there is sufficient information, guidance, education and signage to ensure detainees are aware of the COVID-19 risks and the need to maintain social distancing.

Cleaning

2.77. Environmental cleaning is another infection prevention and control measure in the CDNA Guidelines. Each facility's Outbreak Management Plan (OMP) requires additional cleaning measures, especially at high traffic points as a preventive function.

2.78. The Office was pleased to observe cleaning occurring between different cohorts accessing communal areas at most facilities. However, we did observe some lapses in cleaning processes including a dinner service at one facility where there was no full wipe down of the tables in between cohorts. The Office raised this issue with the Superintendent on site at the time.

Consumables

2.79. The CDNA Guidelines state that facilities should ensure they hold adequate stock levels of PPE, cleaning supplies and disinfectant. The Office was pleased to note the department maintained adequate supplies of consumables across the network during the reporting period.

Outbreak Management Plans

2.80. The Office is pleased to note that each facility maintained an OMP in accordance with the CDNA Guidelines. We note these plans were regularly updated, consistent with local health authority advice.

2.81. However, the Office notes that OMPs were not developed or in place for APODs. The department advised that APODs are governed by the OMP in place for the IDC/ITA in the same location. For example, the Park Hotel APOD in Melbourne is governed by the OMP for Melbourne ITA. The Office is concerned by this approach given operations at APODs can vary

significantly from centres and transit accommodation resulting in the OMPs not being sufficiently tailored to manage the different risks and logistical concerns of APODs.

2.82. The Office suggests (**suggestion 2**) the department consider developing OMPs for specific APODs, particularly the larger APODs like the Park Hotel.

COVID-19 vaccinations

2.83. The COVID-19 vaccination program commenced in Australia in late February 2021. Initial doses of the vaccine went to:

- aged care and disability care residents and workers,
- frontline healthcare workers, and
- quarantine and border workers.

2.84. The Office is concerned the vaccination roll-out in immigration detention facilities did not commence until 4 August 2021. By comparison, the vaccination roll-out commenced much earlier in correctional facilities, including:

- NSW: Vaccinations began in early March 2021.
- VIC: Vaccinations began on 7 May 2021.
- ACT: Vaccinations began on 31 May 2021.
- NT, SA and QLD: Vaccinations underway at the end of June 2021.

2.85. Noting vaccination rollout in immigration detention facilities did not commence in this reporting period, the Office will continue to monitor the rollout of the COVID-19 vaccine across the IDN and provide further comment in our next report.

Inspections and remote monitoring activities

2.86. The Office conducts its inspections of immigration detention facilities under the Ombudsman's own motion powers in s 5(1)(b) of the Ombudsman Act. The Office, as Commonwealth NPM, is also empowered to conduct its role under Regulation 16 (National Preventive Mechanism Body function) of the *Ombudsman Regulations 2017*.

2.87. The Commonwealth NPM conducted the following inspections of immigration detention facilities during the reporting period:

Facility	Date of visit by Commonwealth NPM
Villawood IDC (NSW)	November 2020
Brisbane ITA, Kangaroo Point APOD, Meriton Suites APOD (QLD)	December 2020
North West Point IDC, Phosphate Hill APOD (Christmas Island)	February 2021
Northern APOD (NT)	April 2021
Yongah Hill IDC (WA)	May 2021
Perth IDC (WA)	June 2021
Melbourne ITA, Broadmeadows Residential Precinct, APODs (VIC)	May/June 2021 – *conducted as a remote inspection due to COVID-19 restrictions*

2.88. The Office conducted a remote inspection of facilities in Melbourne in May/June 2021. The previous onsite visit to those facilities was in early 2020. The remote inspection involved attending facility meetings via audio link, conducting telephone-based interviews with staff, and reviewing a range of documentation and video footage.

2.89. Further visits scheduled in June 2021 to facilities in New South Wales and Victoria were impacted by the outbreak of the COVID-19 Delta variant and postponed.

2.90. The Office is prioritising site visits to facilities in New South Wales and Victoria in the next reporting period.

2.91. In November 2020, our inspection staff (Commonwealth NPM team) visited the Villawood IDC. During our visit, we were unable to engage with detainees in person, limiting our ability to hear from detainees about the conditions and their experiences in detention.

2.92. During our inspections of facilities in Brisbane in December 2020, the Commonwealth NPM team had restricted engagement with detainees due to the supervised walks through the compounds, and the meeting schedule in place to speak with detainees which was facilitated by Brisbane ITA staff. Detainees were bussed from the APODs to the Brisbane ITA for scheduled meetings to speak with the team, which restricted the team's ability to freely engage with detainees.

2.93. During our visit to the Meriton Suites APOD (Brisbane), a Serco officer did not leave the room during our detainee engagement, and another Serco officer interjected in a manner that sought to minimise a detainee's complaint about the duration of their placement at the APOD.

2.94. The team observed some detainees were reluctant to engage with us given the proximity of Serco staff at the APODs. Further, some detainees expressed concerns about reprisals for speaking with us.

2.95. We acknowledge the ongoing risk of COVID-19 at the time was the reason for ABF reducing the capacity of our team to engage freely with detainees and have freedom of movement within facilities. We also note the requirement for the Office to have full and free access to detainees and facilities to fulfil our OPCAT mandate. Article 20 of the OPCAT requires that NPMs be granted:

- Access to all places of detention and their installations and facilities.
- The opportunity to have private interviews with the persons deprived of their liberty, as well as with any other person who the NPM believes may supply relevant information.
- The liberty to choose the places they want to visit and the persons they want to interview.

2.96. Our Commonwealth NPM team had full and free access to all staff, detainees, and facilities during our visit to North West Point IDC. We intend to carry out our inspections of facilities across the IDN in future with the same level of freedom and access.

2.97. We will continue to work with the ABF and the department to achieve systemic improvement and safeguard detainees from risks of ill treatment through our independent and impartial oversight, and to ensure we can operate without restrictions in carrying out our preventive monitoring mandate.

Safety and Security

2.98. During our recent inspections, and as identified in previous inspections, we noted an absence of appropriate (or any) CCTV coverage at the APODs. We also identified that CCTV footage at Brisbane ITA is only available for 28 days unless specifically requested and saved. As a result, during our visit to Brisbane ITA we were unable to view CCTV of specific incidents of concern to the Office.

2.99. There were various other instances that were not thoroughly reviewed because the footage was no longer available when requested by the Office, or the footage was corrupted. This is particularly problematic for the Office's complaint handling team when investigating a complaint lodged with the Office.

2.100. The Office is concerned that allegations of mistreatment made outside the retention time frame (28 days) cannot be fully investigated. We are also aware that in the absence of corroborative evidence such as CCTV footage, police often decline to investigate a detainee's complaint of assault.

2.101. Departmental policy requires that 'any recordings that capture an incident must not be deleted and are to be retained in accordance with the Archives Act'. Our experience is this does not occur consistently in practice.

Recommendation 4

The Office recommends the ABF ensure CCTV footage of incidents in immigration detention facilities is retained, in line with departmental policy and the Archives Act, which will provide greater opportunity for review of activities in detention, including when detainees make claims of ill-treatment.

Spotlight – Christmas Island

2.102. On 4 August 2020, the ABF published a statement announcing, 'detainees will be temporarily transferred to the immigration detention facility at North West Point on Christmas Island in the weeks ahead'.[14] The re-opening of North West Point IDC was in response to increasing numbers of people in the IDN due to the impact of COVID-19 and the inability to remove unlawful non-citizens from Australia.

2.103. At that time, the onshore IDN was operating beyond the funded operational capacity and was estimated by ABF to grow to 1,620 detainees by the end of September 2020. In response, the ABF announced up to 250 detainees from the onshore IDN would be relocated to North West Point IDC to ease onshore capacity pressure and temporarily reduce the number of persons detained in mainland facilities.

2.104. In a media release, the ABF stated the cohort transferred to Christmas Island comprised those who were convicted of crimes involving assault, sexual offences, drugs and other violent offences. The media release also stated the cohort was detained due to their risk to the Australian community.

2.105. The ABF advised the Office that detainees whose visa was cancelled under ss 501, 116(1)(e) or 116(1)(g) of the Migration Act may be considered for transfer to North West Point IDC on Christmas Island.

- Section 501 allows the Minister to refuse to grant a visa or to cancel a visa if the Minister reasonably suspects that a person does not pass the character test.
- Section 116(1)(e) allows for the cancellation of a visa where the holder poses a risk to the health, safety or good order of the Australian community, or to an individual within the Australian community.
- Section 116(1)(g) allows for the cancellation of a visa where the holder poses a community protection risk.

2.106. This includes detainees who sought asylum in Australia and subsequently had their visa cancelled under the above sections of the Migration Act.

2.107. In practice, detainees transferred to Christmas Island may have their visa cancelled for offences other than those listed in the ABF media release.

2.108. The ABF advised that all transfers to North West Point IDC were also subject to the National Detention Placement model. Placement decisions are part of the process for establishing the best place for a detainee in the network and should consider the detainee's

[14] Statement regarding Christmas Island - Australian Border Force Newsroom (abf.gov.au)

medical needs, family and community links of the detainee, as well as a wider assessment of risk to other detainees, service providers, visitors and staff.

2.109. In considering the placement of an individual, the broader IDN is also considered. There is finite capacity across the IDN and there is often an operational need to transfer detainees to rebalance the network and ensure detention facility stability.

2.110. The department's position is that where possible it will not transfer a detainee where family or community links can be evidenced, but these links need to be weighed against competing requirements of capacity, legal and security obligations. In some circumstances, the department will make a finding that family and community links are outweighed by the competing requirements.

2.111. The Office monitored the ABF operation established to address actions necessary to re-open North West Point IDC to accommodate up to 250 detainees. Our monitoring included:

- regular briefings at officer level and with the Executive,
- weekly updates as part of our remote monitoring of the IDN, and
- a remote 'inspection' of North West Point IDC facilitated by viewing live and recorded CCTV footage of the facility via the ABF Major Incident Room at the Australian Border Operations Centre.

2.112. The Office also received information regarding the detainees identified for possible transfer to North West Point IDC, and the detainees subsequently transferred to North West Point IDC. The Office conducted assessments to form our own view of detainees' 'suitability' for transfer. These assessments considered the above cancellation criteria, medical needs, and legal proceedings.

- We identified one detainee with an ongoing Administrative Appeals Tribunal (AAT) matter who was released in early November 2020 after their visa was re-instated following AAT review. Noting the very short period between the detainee's transfer to North West Point IDC and subsequent release from detention, we suggest the department should have considered the AAT review as a barrier to the detainee's transfer to North West Point IDC.
- We also identified a case where the detainee was required to attend an in person hearing in an ongoing legal proceeding. However, the department failed to identify this requirement and confirmed this was not considered in assessing the detainee's suitability for transfer to North West Point IDC. This failure was due to not consulting with a particular Division of the AAT during the review process. The department subsequently rectified the error to ensure consultation captured all relevant Divisions of the AAT for all North West Point IDC transfer cases. The department also confirmed the requirement for the ABF to prepare transfer of the detainee back to the mainland for the hearing.

2.113. The transfer of staff to North West Point IDC commenced from 9 August 2020, and the first detainees were transferred from Yongah Hill IDC to North West Point IDC on Saturday 15 August 2020. The operation to transfer of detainees to North West Point IDC

concluded on 6 November 2020. A total of 232 detainees were transferred to North West Point IDC.

2.114. On 30 June 2021, there were 219 people detained at North West Point IDC.

2.115. Due to COVID-19 and resultant border restrictions, there were several detainees who were transferred from the east coast and were required to undertake a period of quarantine prior to transfer to North West Point IDC. The Office is aware this period of quarantine was extended due to detainees within the cohorts refusing to undergo mandatory day 11 COVID-19 testing.

Major disturbance at North West Point IDC – January 2021

2.116. On 5 January 2021, 5 months after the re-opening of Christmas Island, a peaceful protest at the North West Point IDC escalated to a large-scale disturbance lasting several days and resulting in significant damage, including fire damage to facility infrastructure, safety risks to detainees and staff, and disruption to essential service delivery.

2.117. The Office monitored the disturbance and received regular briefings from both the department and the ABF about their attempts to bring the unrest to a safe and effective resolution and ensure provision of essential services to the detainee population. We also received briefings about the department and ABF plan to recover services and operations once the disturbance concluded.

2.118. The disturbance appears to be a result of detainees' frustrations and dissatisfaction with the conditions of their detention at North West Point IDC, due to its isolated location and limited access to services. These issues included Wi-Fi connectivity which impacted on the ability to communicate with friends and family, limited access to recreational activities, and delays associated with voluntary removals.

2.119. The disturbance received media coverage, with images of active fires in the facility appearing on social media. The Office received information from civil society representatives raising concerns about the conditions at North West Point IDC and the disruption to essential services. Concerns were raised about the safety of detainees, particularly those who were not participating in the riot activity. It was also reported to us that provision of medical services, particularly medication, did not occur during the disturbance.

2.120. The Office made further enquiries regarding the incident, and treatment and conditions for detainees at North West Point IDC, during our onsite visit in February 2021.

Site visits to North West Point IDC and the Phosphate Hill APOD

2.121. Between 23 and 25 February 2021, the Office travelled to Christmas Island to conduct site visits at North West Point IDC and the Phosphate Hill APOD. Observations about the Phosphate Hill APOD are covered in the next section at paragraph 2.233.

2.122. This was the Office's first visit to Christmas Island following the reopening of North West Point IDC in August 2020, as COVID-19 related border restrictions and quarantine arrangements prevented us from visiting sooner.

2.123. The Office was granted full and free access to detention facilities, including the ability to inspect and move around the compounds and engage with detainees face to face. We also engaged with ABF staff and contracted services providers on site at both facilities.

2.124. The Office last visited North West Point IDC in August 2018, before its closure in October 2018.

2.125. The focus of our February 2021 site visit was to assess the treatment and conditions of detainees at North West Point IDC since its reopening, and review the department's progress in re-instituting services following the disturbance in January 2021.

2.126. Based on discussions with the ABF and Serco staff, we understand the re-opening of North West Point IDC occurred in a challenging and rapid timeframe, significantly impairing service providers' ability to ensure appropriate numbers of adequately trained and capable staff were available. Additionally, planning was impeded by the remote location of Christmas Island and was further exacerbated by COVID-19.

2.127. The re-opening of North West Point IDC was accelerated to a tighter timeframe than service providers advised was suitable. This meant service providers were not able to match the standard of service provision previously provided at North West Point IDC or standards comparable with mainland IDCs.

2.128. The facility was originally intended to be a temporary facility in use for 6 months. This significantly impacted service providers' ability to recruit staff for the facility, because it did not allow for the recruitment of staff on a longer contract. Most staff were on temporary or short term (3 month) contracts and there appeared to be high staff turnover. This issue continued after the initial 6 month period (in early 2021) due to delays in renewals of service providers' contracts. These uncertainties impacted the supports implemented at North West Point IDC (medical services, programs, activities etc) and the recruitment and retention of qualified staff for the facility.

2.129. During our visit, and post-disturbance, we were concerned about staff burnout due to the increasing numbers of staff calling in sick and the impact on other staff doing overtime. We were also concerned about the conditions in which some staff were working (damaged compounds) for almost 2 months (at that time).

2.130. The Office suggests the department should have ensured North West Point IDC was fully operational (including all appropriate equipment and staff in place) before transferring detainees to the facility. Additionally, once shipment and transfer/recruitment delays were identified, the department should have reassessed the total numbers of detainees to be transferred to the facility and considered delaying further transfers until North West Point IDC was fully staffed and operational.

2.131. The Office is concerned the fast-tracked re-opening of North West Point IDC, and the remote location of the facility, resulted in a reduced range of services, staff, and programs and activities (P&A) available at the time detainees arrived. Further, many services remained restricted at the time of our visit in February 2021.

2.132. We believe these issues contributed to detainees' dissatisfaction and the unrest at the facility in early January 2021.

Programs and Activities

2.133. North West Point IDC operates on a 'controlled movement model' which means, as a default, detainees can only mix with detainees from within their own compounds and can only access key communal facilities such as recreational, sporting and educational facilities at scheduled times. Unlike compounds at facilities on the mainland, accommodation

compounds at North West Point IDC do not contain areas with gym equipment and other recreational activities.

2.134. Many detainees reported feeling bored and dissatisfied with the activities on offer for them. The lack of activities to provide stimulus was felt acutely given the isolation, lack of visits from family and friends and the sub-standard internet access.

2.135. Before February 2021, detainees at North West Point IDC were only permitted access to the Greenheart (recreational area which contains the centre's gymnasium, sports, recreational and education facilities) for one hour per day. The remainder of their day was spent in their accommodation compound.

2.136. During our inspection, we identified significant differences in the operation, support services, and programs and activities available at North West Point IDC compared to facilities on the mainland. Detainees at North West Point IDC reported a significant gap in the conditions communicated to them by ABF prior to their transfer and those experienced on site.

2.137. The recreation and education activities were limited in their availability and content, particularly noting detainees were only provided one hour to access the activities each day. During the one hour in the Greenheart, detainees had to choose between going to the gym, speaking with friends through the fence of other compounds or doing educational activities. Normally, at IDCs on the mainland, detainees can access various activities daily and do not need to choose between them.

2.138. After the disturbances in January 2021, detainees' daily access to the Greenheart was doubled to 2 one-hour sessions. Detainees reported, and we observed, ABF advise detainees that following the disturbance in January 2021 detainees needed to 'earn' more freedom of movement.

2.139. Detainees expressed concerns to us about their lack of access to the Greenheart and P&A since their arrival at North West Point IDC. They acknowledged the increase in Greenheart access time since the disturbance but still felt it was not adequate time 'out of their compounds', and the P&A were not adequate to prevent boredom.

2.140. The Office notes that detainees were raising their concerns regarding limited Greenheart access since arriving at North West Point IDC, and it was also a factor raised in a peaceful protest preceding the disturbance in January 2021.

2.141. Since the increase in Greenheart time to 2 one-hour sessions, detainees can go to the gym as well as do educational activities, and still have time to speak with friends. However, programs which are well received and attended by detainees at other facilities on the mainland, such as coffee club and cooking classes, are not facilitated at North West Point IDC despite numerous requests by detainees.

2.142. ABF advised these activities were not available when the IDC first reopened due to delays in obtaining equipment and supplies (as result of to shipping delays) and a lack of appropriate staff to facilitate the activities. Staff advised the Office there was coffee making equipment on site, but not coffee beans, and they were still trying to engage an appropriately trained staff member to conduct cooking classes. A staff member provided cooking classes to detainees at Phosphate Hill APOD, but was not permitted to work at both North West Point IDC and Phosphate Hill APOD to mitigate COVID-19 risks.

2.143. Detainees advised that early morning timeframes for activities were not suitable for many people due to the tendency for people to stay up late to communicate with friends and family in different time zones. Christmas Island is GMT+7 which is one hour behind Perth, WA (AWST), and from October to April each year is 4 hours behind Sydney, NSW (AEDT).

2.144. Detainees were concerned that Serco did not provide activities there was a demand for, and requested equipment was provided in February 2021 only after some months' delay, and not all the equipment was provided to support activities occurring within the compounds. For example, a detainee was voluntarily (without incentive) running a morning bootcamp which would normally be the responsibility of a staff member. This placed pressure on the detainee and meant the activity would not go ahead if the detainee was unwell or unavailable.

2.145. The Office was advised there were not adequate staff members available on site to conduct morning activities like bootcamp. The Office is aware that detainees who volunteer to conduct activities in other facilities on the mainland are often provided additional points on the Individual Allowance Program (IAP) in recognition of their efforts.

2.146. Detainees also reported they were requesting various pieces of fitness equipment (such as sandbags) to assist with detainee led activities in the compound but limited or no equipment was provided. ABF advised the equipment was on the island's supply ship which had been unable to offload all its cargo since December 2020.

2.147. In February 2021, the staff started facilitating inter-compound games over and above the additional Greenheart time. During our visit, we observed the second game (touch football) and observed engagement between staff and detainees arranging the next game the following week. The detainees were excited for the opportunity to play sport and engage with other detainees, and we were pleased to note positive engagement between staff and detainees during the game.

2.148. The Office considers the P&A provided by the ABF to detainees at North West Point IDC, particularly up until February 2021, was not adequate. The Office further considers that the amount of time detainees spend in their accommodation compounds without access to meaningful activities is overly restrictive and not conducive to detainee wellbeing.

Recommendation 5

The department should ensure detainees can access meaningful programs and activities (P&A) at North West Point IDC, including within accommodation compounds, commensurate with P&A provided at facilities on the mainland.

Recommendation 6

The department should provide more time out of accommodation compounds for detainees at North West Point IDC, particularly in the absence of meaningful P&A within the accommodation compounds.

Supplies

2.149. Christmas Island is isolated and reliant on a supply ship visiting the island regularly to bring goods and equipment which are unsuitable for freight by air.

2.150. During our visit in February 2021, the supply ship which was attempting to offload cargo since December 2020 departed the island with only 30 containers unloaded. Weather conditions had hampered the unloading of the containers. Containers not unloaded included 18 containing food/groceries and 6 containing aviation fuel. This was the longest period in 10 years between shipments to Christmas Island.

2.151. The delayed shipment also affected the community on Christmas Island, and the staff at North West Point IDC living in the community.

2.152. The statement released by the shipping company stated the Australian government declined to further assist with the costs incurred waiting for the weather to clear.[15]

Visits

2.153. During discussions with detainees, many expressed unhappiness about their transfer and current placement at North West Point IDC due to the isolation of the facility and inability to see family and friends, particularly detainees with children. Many detainees reported they were previously located in detention facilities on the east coast and were regularly visited by their family. Detainees expressed concern they would not have visits from friends or family while located at North West Point IDC due to the high cost of travel to Christmas Island.

2.154. Options for travel to Christmas Island are limited and expensive:

- Virgin Australia is the only carrier to operate flights to Christmas Island (from Perth) limited to 2 days a week. An additional fortnightly service commenced operation in late September 2021.
- A travel website searched in November 2021 provided prices for return flights from Perth to Christmas Island ranging from $1,165 to $1,688.
- Flights for each member of the Office's inspection team to travel from Perth to Christmas Island in February 2021 cost approximately $1,180 return.
- Due to the limited flights to/from the mainland, visitors are on the island for a minimum of 3 nights, incurring accommodation costs.

2.155. The ABF website[16] states that visits generally run for one hour at Immigration Detention Facilities (IDF), except for Yongah Hill IDC and North West Point IDC where 'visitors may be permitted for up to two (2) hours per visit' and all visits must be pre-booked.

2.156. The Office notes that on 24 March 2020, non-essential visits were suspended across the IDN. In person visits did not resume across the IDN until 7 December 2020 (and a week

[15] Swell Weather Voyage Update 25/2 (zentnershipping.com.au)
[16] Visit Detention (abf.gov.au)

later in SA). This meant most detainees at North West Point IDC were not visited by family or friends for approximately 11 months at the time of our visit in February 2021.

2.157. The Office is concerned that most detainees at North West Point IDC did not have visitors for the entire reporting period, and approximately 15 months since visits were suspended across the IDN in March 2020.

2.158. The Office is concerned about family separation for detainees placed at North West Point IDC, particularly those with children. Article 3 of the United Nations Convention on the Rights of the Child states that in all actions concerning children, the best interests of the child shall be a primary consideration.[17] This article is also reflected in departmental policy.

2.159. The Office suggests (**suggestion 3**) the department continue to ensure the best interests of any relevant children is a primary consideration when placing detainees in the IDN, particularly at North West Point IDC noting the remote locality of the facility.

Access to the internet

2.160. The department is responsible for providing mechanisms for detainees' meaningful engagement with friends, family and legal representatives. Our visit indicated the telecommunications infrastructure available on Christmas Island can limit detainees' opportunities for meaningful engagement, compared to the opportunities available to detainees in mainland facilities. The Office notes the department is not responsible for telecommunications infrastructure on Christmas Island, and as such there are limitations on the department's scope to address issues itself with that infrastructure.

2.161. The Commonwealth Department of Infrastructure, Transport and Regional Services administers Christmas Island, which has no state level government. Mobile phone services on Christmas Island operate on the Telstra 2G (GSM) network in the populated areas of the island. There is no mobile data service (internet content delivered to mobile devices), and reception is patchy and impacted by inclement weather.

2.162. Between August and October 2020, detainees could only access the internet through internet enabled computers in the compounds at North West Point IDC. In October 2020, a Wi-Fi network was established in the facility to allow detainees to access internet from their personal devices in their compounds. However, there were reports of technical issues with the Wi-Fi resulting in slow connection speeds and unreliable connectivity.

2.163. We acknowledge the steps taken by ABF to introduce and improve Wi-Fi access at North West Point IDC since reopening the IDC. The Office monitored reports of the Wi-Fi issues at North West Point IDC and received regular updates from the ABF regarding actions taken to improve Wi-Fi access in the compounds for detainees to access the internet.

2.164. During our visit, detainees explained the Wi-Fi network within the compounds was not strong enough to allow them to use their own device in their own rooms. In these circumstances detainees were required to have private conversations with their families and legal representatives in communal areas. The signal strength differed between compounds

[17] OHCHR | Convention on the Rights of the Child

which impacted on detainees' willingness to accommodate ABF requests to move to another compound.

2.165. Detainees expressed frustration at not being able to video call their family, especially their children, in circumstances where the remote location of the facility impacts the ability for family and friends to visit.

2.166. In October 2020, ABF advised that North West Point IDC had 32 internet enabled workstations with access to Wi-Fi, and an additional 26 internet enabled workstations available for detainee use within the education compound (located in the Greenheart). Detainees could access the additional workstations when attending P&A.

2.167. The computer rooms in Green and Blue compounds were destroyed in the disturbance in January 2021, reducing the 32 workstations available to detainees. These workstations had not been replaced by the time of our inspection in late February 2021.

2.168. Inconsistent mobile reception, lack of access to mobile data services, and slow Wi-Fi connectivity has impacted detainees' ability to maintain meaningful contact with family, friends, lawyers, and other support networks.

Access to legal representation

2.169. Civil society and legal representatives expressed concerns about the impact of placement at North West Point IDC on detainees' access to legal representation due to the remote location (inability to visit) and telecommunications access (poor connectivity to facilitate video calls). Legal representatives also expressed issues with contacting detainees at North West Point IDC for ongoing legal proceedings and in preparation for attendance (virtual or in person) at legal proceedings.

2.170. Detainees expressed concerns with the limited access they had to their legal representatives due to the poor mobile reception and the poor Wi-Fi which impacted their ability to speak with their legal representatives in private. The limited access to the Greenheart also impacted detainees' ability to print, scan and email legal documents to their legal representatives.

2.171. The Office is also aware of ABF efforts to facilitate virtual attendance at legal proceedings for detainees at North West Point IDC. The Office is concerned the unreliable internet connectivity at North West Point IDC, even for the ABF and its service providers, may impact on detainees' ability to attend legal proceedings virtually and meaningfully engage in their legal matters.

2.172. The Office is concerned that detainees at North West Point IDC with ongoing legal matters do not have the same access to legal support as detainees at facilities on the mainland.

2.173. The Office suggests (**suggestion 4**) the department ensures the detainees at North West Point IDC are provided adequate supports and access to internet enabled computers to facilitate regular engagement with legal representatives in private, including the ability to print, scan and email documentation.

2.174. Noting the department's assessment for suitability for transfer to North West Point IDC considered ongoing legal matters and attendance at legal proceedings, the Office is concerned some detainees were transferred back to the mainland for legal matters within

3 months of being transferred to North West Point IDC. This includes one charter flight which returned a detainee from North West Point IDC to PIDC for a court appearance. This suggests that initial placement at North West Point IDC did not consider the need to be available to attend ongoing legal proceedings.

2.175. The Office suggests (**suggestion 5**) the department reconsider placing detainees with ongoing legal proceedings at North West Point IDC to ensure appropriate access to legal support and representation.

Detainee transfer requests

2.176. Many detainees at North West Point IDC advised that they submitted requests for transfers back to facilities on the mainland for compassionate reasons, such as family separation or a sick family member.

2.177. During our visit, the Office became aware of approximately 50 detainees who lodged transfer requests around the same time but were yet to receive a formal written response to their requests. The ABF said it verbally advised many of the detainees their transfer requests were not approved, and their transfer would not be facilitated.

2.178. The Office followed up with the ABF regarding the transfers and the lack of formal written responses to the requests. In response, the ABF advised that requests to transfer from North West Point IDC back to facilities on the mainland would not be approved unless there was a medical requirement. The ABF further advised of the need for careful drafting of written responses to the numerous detainee transfer requests. As a result, ABF formal written responses to detainees' requests were delayed. The ABF also advised formal responses were delayed so as not to reject 50 requests for transfer at the same time which may result in detainee unrest.

2.179. The ABF advised the Office that the process for placement consideration was conducted prior to transfer to North West Point IDC so no further placement assessments would occur, unless medically necessary. A transfer request from a detainee at North West Point IDC would not initiate a new placement assessment and would be automatically denied.

2.180. The Office is concerned about the inability for detainees to be considered for transfers to other facilities other than for medical reasons. This does not align with usual practice for detainees in the IDN and does not allow for detainees at risk of other detainees to be considered for placement elsewhere in the IDN to ensure their safety.

2.181. The ABF advised it does not want to establish a precedent by approving transfers in such cases, so more detainees follow suit. The ABF does not want detainees to think they can be transferred back to the mainland in response to bad behaviour. In our view, the concerns of detainees considered at risk from other detainees are being diminished by the ABF and there is an assumption that detainees are fabricating stories to be transferred back to the mainland.

2.182. The department also factored in concerns about detainees contriving circumstances to engineer transfer back to the Australian mainland, in the placement of 2 detainees involved in the disturbance who are now placed in correctional facilities on the mainland.

Voluntary removals

2.183. In June 2021, of the approximately 219 detainees at North West Point IDC, 89 detainees were on a voluntary or involuntary removal pathway.

2.184. Numerous detainees requested voluntary removal from Australia, however, the department is not able to facilitate their removal notably due to COVID-19. Many detainees did not know why they were still at North West Point IDC or why their removal request could not be actioned. As a result, many detainees believed they were being kept at North West Point IDC deliberately, as punishment.

2.185. Detainees also researched COVID-19 in relation to their home countries and did not understand why they could not be sent home noting the lack of restrictions in their home country.

2.186. There were no ABF Removals staff posted to North West Point IDC. The ABF advised that removals staff visited the centre approximately every 6 weeks but with no consistency in staff who visited. Consequently, detainees engaged with a different staff member each time and received inconsistent information and messaging from staff.

2.187. During our visit, in response to the detainee confusion and lack of information available, the Office suggested the ABF provide detainees with an updated list of countries currently accepting and facilitating removals and facilitate regular communication and updates regarding removals and the barriers to removal.

2.188. The Office is concerned about the lack of information provided to detainees at North West Point IDC about the removal process and barriers to removal, notably due to the complexities of COVID-19.

Recommendation 7

The department should ensure removals staff are part of the staffing complement posted to North West Point IDC to facilitate detainee removals, particularly voluntary requests, and to ensure the distribution of timely and accurate information to detainees about the removal process.

Detainee Engagement

2.189. The ABF acknowledged communication issues contributed to the disturbance on Christmas Island in January 2021 and has worked to improve communication and build detainee trust since the event.

2.190. We observed a Detainee Consultative Committee (DCC) meeting conducted during our visit which included detainee representatives from each of the compounds and staff from the ABF, Serco and IHMS. We observed frank and open discussions between the ABF, service providers, and detainees about improving conditions at the facility. The DCC meeting was a good example of the ABF and service providers working together to rebuild relationships and trust with detainees.

2.191. The Office acknowledges feedback from detainees who suggested the ABF and service providers were more constructive during the DCC meeting when we were present.

2.192. The Office recognises DCC meetings as a helpful platform for detainees to feel represented and have their concerns heard by the ABF and service providers. These meetings are also an opportunity for open and honest communication about issues and to rebuild trust with detainees.

2.193. The Office notes the ABF referenced the need to consult with, and seek approval from, the national office for some decisions, including inter-compound P&A. This seems inconsistent with the approach at other facilities across the network where the Superintendent in charge of the facility is authorised to make decisions, particularly regarding P&A conducted on site. Detainees expressed frustration with needing to rebuild trust with 'National' (ABF National Office) after the disturbance. Detainees felt their concerns did not receive due attention before the disturbance, and it took this incident for the ABF to listen to their views.

Medical

2.194. Health care available on Christmas Island is limited and acute medical care is not available. Detainees are sent to the local hospital for any conditions that IHMS cannot treat at North West Point IDC. The ABF advised that detainees requiring acute care would be transferred via air ambulance to Perth for treatment.

2.195. Other health service providers (such as dentists and physiotherapists) visit the facility approximately every 6 weeks and prioritise urgent cases. This can result in lengthy delays for detainees seeking treatment for non-urgent issues.

2.196. IHMS staff are available for medical support to detainees at North West Point IDC between 0800hrs and 1800hrs daily, which is like other facilities on the mainland. Staff must call the medical emergency line for advice if there is a medical incident outside those timings or phone 000 for emergencies.

2.197. IHMS advised it takes approximately 40 minutes for an ambulance to get to North West Point IDC in an emergency.

2.198. We made the following observations about the roads to the facility:

- During our visit, the newest main road to the facility was closed due to disrepair so all travel was via the old (mostly dirt) road. Speed of travel on the old road was drastically reduced due to the extensive number of potholes – in addition to the normal speed reductions to avoid local fauna, such as crabs, which are a protected species on Christmas Island.

- Staff at North West Point IDC are told to drive in convoys to/from the facility in case of an emergency. This is in recognition of the poor driving conditions, the lack of traffic on the roads, and the limited telecommunications service.

2.199. During our visit, the Office spoke to one detainee who was stabbed in the arm, allegedly by another detainee, in the early hours of the morning in February 2021. Officers from Serco's Emergency Response Team (ERT) attended to the detainee and provided first aid, but the detainee was not seen by a medical professional for approximately 3 hours until IHMS commenced shift at 0800hrs that morning.

2.200. During the disturbance in January 2021, IHMS staff were rostered on site 24/7 to respond to medical emergencies due to the remote location of the site.

2.201. The Office suggests (**suggestion 6**) the department consider rostering IHMS staff onsite at North West Point IDC 24 hours a day, 7 days a week, to provide appropriate medical support to detainees and staff at the facility.

2.202. The limited medical facilities on Christmas Island resulted in a detainee being transferred back to Perth in September 2020 for a medical appointment, then returning to North West Point IDC 3 days later. During our inspection of Perth IDC, the Office became aware of another detainee with complex health needs who was transferred back from North West Point IDC.

2.203. These cases raise concerns regarding the suitability of detainees with serious or complex medical needs or risks being transferred to North West Point IDC. The department advised the Office at the time of North West Point IDC's reopening that health factors would be considered as part of the suitability assessment for transfer to North West Point IDC. Further, the department's transfer policy states that a detainee's physical and mental health concerns are considered in a placement decision:

> The holistic circumstance of the detainee should be considered in order to determine the most appropriate placement option for the detainee. These may include, but are not limited to, physical and mental health concerns and available services and facilities at the receiving IDF.

2.204. The Office is concerned the department's initial medical assessments for suitability for transfer to North West Point IDC did not adequately consider ongoing medical requirements in these cases. The Office reiterates the need for the department to consider detainees' health vulnerabilities as part of any transfer, but particularly to North West Point IDC given the limited medical facilities available on Christmas Island.

2.205. The Office is also concerned about the impact on detainees of lengthy and repeat movements to and from Christmas Island to facilitate medical care.

2.206. The Office suggests (**suggestion 7**) that detainees with medical needs or risks that are not able to be managed on Christmas Island should not be placed at North West Point IDC.

2.207. The Office notes several detainees identified by the department as 'at risk' of COVID-19 remain at North West Point IDC. Given Christmas Island's isolation and limited capacity to manage a COVID-19 outbreak, the Office is concerned about 'at risk' detainees who remain at North West Point IDC and suggests (**suggestion 8**) the department consider alternative placement options.

2.208. During our visit, the Office identified that unlike mainland facilities, North West Point IDC does not have a Drug and Alcohol team onsite as part of the IHMS team. It was unclear whether drug and alcohol rehabilitation or redirection programs were facilitated at North West Point IDC. IHMS advised it did not see the need for a drug and alcohol rehabilitation program at North West Point IDC because the detainees did not demonstrate a desire to engage in the program which would reduce its chances of success.

2.209. Departmental statistics[18] indicate that in the reporting period, the primary offence category for visa cancellations (197 of the 946) on character grounds was drug-based

[18] Visa cancellation statistics (homeaffairs.gov.au)

offences. In the ABF media release, detainees transferred to North West Point IDC had convictions for one or more serious offences including drug offences. The department's 2020–21 annual report indicates that at 30 June 2021, 83.8 per cent of the individuals in held detention had a criminal history.[19] The annual report further states there were 1,570 detentions of unlawful non-citizens in the reporting period and the number of persons entering detention directly from a correctional setting remained steady. Many detainees at North West Point IDC likely entered immigration detention directly from a correctional facility. According to the Australian Institute of Health and Welfare publication *The health of Australia's prisoners 2018*, 65 per cent of prison entrants reported using illicit drugs.[20]

2.210. The Office acknowledges that lack of interest from detainees is a consideration for the selection of P&A at IDCs. However, it is our view that programs relating to health and rehabilitation should be a staple offered across the network regardless of interest and uptake from detainees.

2.211. The Office is concerned about the lack of drug and alcohol staff, and drug and alcohol rehabilitation programs available at North West Point IDC, noting the inconsistency with programs available to detainees at other facilities on the mainland, and the cohort of detainees chosen for placement at the facility.

Recommendation 8

The department should ensure IHMS engages specific drug and alcohol staff at North West Point IDC, and facilitates drug and alcohol rehabilitation and redirection programs to detainees at North West Point IDC.

2.212. The Office is also concerned with the lack of torture and trauma services available to detainees at North West Point IDC during the reporting period. In response to a request for information, the department advised that from August 2020 IHMS was contracted to provide torture and trauma services at North West Point IDC. However, there were no specialist torture and trauma staff in the IHMS team during our visit in February 2021. Further, IHMS did not provide any information regarding torture and trauma support services available to detainees on site during discussions with the inspection team.

2.213. Detainees placed at facilities on the mainland can access services from specialised torture and trauma service providers such as Foundation House (Victoria) and The Association for Services to Torture and Trauma Survivors (ASeTTS) (Western Australia). The Office is concerned with the lack of specialised torture and trauma support available to detainees at North West Point IDC.

2.214. Further, it appears that detainees previously receiving torture and trauma treatment were not afforded continuity of services once transferred to North West Point IDC. Information provided to the Office indicates that detainees were required to request torture and trauma services once they arrived at North West Point IDC rather than IHMS proactively engaging with detainees previously receiving torture and trauma services with a view to continuity of treatment.

[19] Department of Home Affairs 2020-21 Annual Report
[20] Australian Institute of Health and Welfare - The health of Australia's prisoners 2018

Recommendation 9

The department should engage specialised torture and trauma services to be located at North West Point IDC to support detainees, and require IHMS to proactively engage with detainees previously receiving torture and trauma services with a view to continuity of treatment.

Medical support during the disturbance in January 2021

2.215. During the disturbance in January 2021, there were reports that detainees could not access medication. During a verbal debrief after the disturbance, the ABF advised the Office these reports were inaccurate and there was no disruption to medication services at North West Point IDC.

2.216. During our inspection in February 2021, numerous detainees advised the Office they could not access regular medications from IHMS for 2 to 5 days.

2.217. The Office interrogated IHMS records on site regarding their service delivery during the disturbance. We identified discrepancies in record-keeping practices and confirmed there was a period of approximately 2 days during the disturbance that regular medications were not administered to detainees due to safety concerns for IHMS staff.

2.218. The Office identified:

- The IHMS records indicated 'Did not attend' if the detainee did not show up for medication rounds.
- The IHMS records also indicated 'Did not attend' when IHMS was unable to administer medication. IHMS advised this was because there was no other suitable option to select.

2.219. The Office notes the IHMS records did not indicate any disruption to service delivery (administering of medication) to detainees. As a result, the department was likely not aware of the issue at the time.

2.220. IHMS manually corrected the records to reflect the actual circumstances of administering medication. However, the Office is concerned that due to the time elapsed since the events, the records still may not be entirely accurate due to reliance on the recollection of events by the IHMS onsite lead.

2.221. IHMS advised it did provide high risk medication to a detainee for a heart condition. IHMS also advised detainees could alert ERT officers that they wanted their medications and IHMS would facilitate this. The Office notes this would occur only for people who were proactive in seeking their medication because IHMS did not provide any guidance at the time.

2.222. The Office acknowledges the risk posed to IHMS staff at the time of the disturbance and the efforts of IHMS staff on site at the time to facilitate medical support during the disturbance. The Office also notes the increase in ERT presence to provide protection for IHMS staff during the disturbance.

Security and safety

2.223. During our visit, we inspected all the compounds in use, including those damaged during the disturbance. The Office was concerned that compounds damaged during the disturbances were still being used to house detainees, particularly those without serviceable CCTV for security or a serviceable Officer's station for staff.

2.224. Green 1 compound was damaged during the disturbance. This included:

- The CCTV in the compound was damaged and unserviceable which is a safety concern for both detainees and staff. For example, an incident occurred in this compound not long before our visit, allegedly resulting in a detainee being stabbed in the arm. There was no CCTV footage of the incident.
- The Officer's station was damaged and unserviceable, so staff were stationed in the food servery area which provided no safety or security.
- The activity rooms in the compound were fire and water damaged and not serviceable.

2.225. The Office considers Green 1 was not an appropriate placement for detainees or a safe working environment for staff after the disturbance. At the time of our visit, the ABF was working towards moving the detainees from Green 1 to White 1, acknowledging the unsuitable conditions in Green 1. However, by that time detainees and staff had been living and working in the damaged compound for almost 2 months since the disturbance. The Office considers this was an unreasonable delay in providing a safe and secure environment for detainees and staff, and suggested during our visit in February 2021 that the ABF should have transferred detainees to a serviceable compound sooner as a priority. We understand this has been remedied since our visit.

2.226. Both Blue Compounds (1 and 2) were also damaged and were still in use to accommodate detainees after the incident. The damage included:

- The CCTV in Blue 1 was not serviceable after the disturbance. The ABF advised it acquired replacement cameras for the compound, but it was not known when these would be fitted and operational.
- The Officer's station was damaged, including:
  - the air-conditioning, which was replaced with a portable air-conditioner
  - the electronic swipe access was destroyed (burnt) so keys were required to open/close doors manually. A female staff member was transferred back to the mainland for medical treatment for an injury from manually operating damaged doors
  - the main door was damaged and propped open with a medicine ball to allow for entry and exit by staff
  - fire damage to the windows impeded the officers' view of the compound, especially at night
  - no electricity and no serviceable phone.

- Activity rooms in the compound were burnt out and water damaged (unserviceable)

- There was still glass on the ground in the compound near the damaged activity rooms.

2.227. The ABF advised it would not be moving detainees out of Blue 1 compound because only Gold compound was available, which was planned for use as the incentive compound.

2.228. The Office suggests (**suggestion 9**) the department consider establishing a policy setting out the minimum acceptable standard for conditions in accommodation compounds at immigration detention facilities, having regard to minimum safety standards for staff and detainees and further ensuring the rights and dignity of detainees is respected.

2.229. During our visit we were advised that body worn cameras were not available for ERT officers and therefore were not used during the disturbance. The Office was unable to view requested body camera footage from the disturbance for this reason.

Recommendation 10

The department should ensure body worn cameras are available, operative, and in use at North West Point IDC.

Alternative Places of Detention (APODs)

2.230. While most people in held detention are accommodated in purpose-built IDCs and ITAs, the Minister for the department may approve another location as an APOD. Due to the individual and specific needs of detainees, APODs may include places such as hospitals, aged care facilities, individual hotel rooms or entire hotels, or it may be a purpose-built detention facility such as the Phosphate Hill APOD on Christmas Island.

2.231. In many cases APODs will house individuals or small groups of detainees for short periods of time for specific circumstances or until a more suitable placement within the IDN is identified. For example, a hospital may be declared an APOD for a few days while a detainee is admitted.

2.232. Some APODs are also established to accommodate larger groups of detainees for longer periods of time. For example, the Kangaroo Point APOD in Brisbane operated from February 2019 to April 2021 and held up to 102 detainees. Some detainees may have been held there for the entire period.

2.233. During this reporting period:

- In December 2020, the Mantra Bell City APOD in Melbourne closed and the Park Hotel APOD opened to replace it.
- The Kangaroo Point APOD closed in April 2021.

2.234. Our report for the period January to June 2020 noted concerns about the limited oversight of services at APODs and the routine use of restraints when escorting detainees to and from places of detention. We also reiterated our recommendations from 2019 that the department identify and use APODs that cater to the longer-term needs of detainees, and ensure all detainees placed in APODs can access appropriate services and supports.

2.235. Although our previous report noted improvements in services available at the Mantra Bell City APOD, we remain concerned about services available to detainees at APODs, particularly the Meriton APOD in Brisbane and the now closed Kangaroo Point APOD. During this reporting period, we noted COVID-19 restrictions continued to impact on the provision of services at APODs, with access to outdoor recreation activities significantly impacted.

2.236. During this reporting period we physically inspected 4 APODs in Brisbane, Darwin and on Christmas Island. We also planned to inspect APODs in New South Wales and Victoria, however these inspections were postponed due to the impact of COVID-19 on travel and access to facilities.

Kangaroo Point APOD

2.237. In December 2020 we inspected the Kangaroo Point APOD in Brisbane. This APOD occupied an entire motel complex and accommodated transitory persons transferred from Manus Island and Nauru. It opened in February 2019 and closed in April 2021 and housed up to 102 detainees during the reporting period, with numbers peaking in July 2020.

2.238. Kangaroo Point APOD was also subject to sustained protest activity and media interest, particularly leading up to its closing, which resulted in a continually heightened security response and presence at the APOD.

2.239. The Office does not consider the Kangaroo Point APOD was fit for use as a long-term detention facility, or conducive to the health and wellbeing of detainees without significant changes to the operating model in place and facilities available.

2.240. Access to communal and recreation areas was limited and those that were available were often crowded. For example, the P&A room was a repurposed accommodation room and did not allow sufficient space for most recreational and educational activities. The only other recreational space available was a 'multipurpose room' which also served as the dining room, the visits room, and was used as the staff break room.

2.241. Access to fresh air at the Kangaroo Point APOD was limited with detainees having intermittent access to a small outdoor area that was poorly equipped and too small for most outdoor recreation activities. There was a program of excursions to the Brisbane ITA on weekdays so detainees could access P&A, the gym and fresh air. However, detainees reported that the irregular schedule and heavy security deterred participation in these excursions. This program of excursions was also periodically suspended due to COVID-19 restrictions.

2.242. When we examined the security arrangements, we identified that detainees were pat searched and scanned with a security wand 4 times during an excursion on:

- departure from the APOD,
- arrival at the Brisbane ITA,
- departure from the Brisbane ITA, and
- arrival at the APOD.

2.243. This occurred despite the detainees being under escort in secure transport vans and always remaining in secure detention facilities.

2.244. The Office believes these security measures were excessive and invasive, and a considerable deterrent to detainees participating in excursions. Although the Kangaroo Point APOD is no longer operational, the Office remains concerned about this practice. Pat searches are further discussed later in this report at paragraph 2.307.

Meriton Suites Hotel APOD

2.245. During our visit to Brisbane we also inspected the Meriton Hotel APOD. The Meriton Hotel APOD consisted of individual hotel rooms, not the entire hotel.

2.246. At the time of our visit there was one female detainee accommodated at the Meriton Hotel APOD, the remaining detainees were male.

2.247. Detainees either had their own hotel room or shared a suite with separate bedrooms and bathrooms. Detainees were provided with breakfast and staple items such as bread, tea, coffee and milk. Detainees were able to use the microwave and toaster but otherwise did not have access to cooking facilities.

2.248. The department advised the Meriton Hotel APOD was used as a short-term placement option for detainees who could not be accommodated at the Brisbane ITA. However, we identified several detainees who were held there for over 2 months.

2.249. The use of individual hotel rooms as an APOD significantly impacts on detainees' privacy and results in a greater presence of security officers close to detainees than would be the case at an IDC or ITA. Security officers are often situated within accommodation rooms or sit in an open doorway to each accommodation room, 24 hours per day, to monitor the activities of the detainee.

2.250. We noted significant privacy concerns during our visit, observing interactions between detainees and medical staff taking place within hearing of security officers and other detainees. The Office is concerned this impacted on the medical confidentiality of detainees.

2.251. In some circumstances, operating models at APODs require staff to maintain line of sight of the detainee, including when detainees are undertaking ablutions. Detainees are escorted by staff any time they leave their accommodation room and, in some cases, are physically restrained when they leave their rooms.

2.252. We noted security officers use the facilities within the accommodation rooms allocated to detainees, as they are not provided with appropriate access to toilet and break facilities elsewhere.

2.253. We were concerned about the access to appropriate P&A, including access to fresh air and outdoor recreations facilities, for detainees at individual hotel room APODs. Detainees at the Meriton Hotel APOD advised there were periods without access to fresh air for 2 days at a time because trips to the Brisbane ITA were not scheduled in advance, and often facilitated by Transport and Escort staff at the last minute, meaning detainees could miss out if they were sleeping at the time.

2.254. Daily access to fresh air and one hour of open-air exercise is regarded under international law as a minimum standard of treatment for people held in detention, including immigration detention facilities.[21]

2.255. During COVID-19, the United Nations SPT published advice[22] reiterating measures to be taken by authorities concerning all places of deprivation of liberty including immigration detention. This advice reinforced the need to 'respect the minimum requirements for daily outdoor exercise'.

2.256. At the Meriton Hotel APOD, we were advised there was no formal P&A schedule for detainees and a P&A activities trolley (containing magazines, games, puzzles, and exercise equipment) was taken to each detainee's room daily. One detainee advised that when he requested an activity, he was provided with a game that required 2 people to play despite being held in a room by himself. We also observed the magazines on the trolley to be dated, mostly topics aimed at females, and some were free supermarket cooking magazines.

2.257. Access to medical services is also problematic at individual hotel room APODs, with access to medical services either provided at a nearby detention facility (IDC or ITA) or an offsite medical clinic. As we observed at the Meriton Hotel APOD, access to medical services

[21] Rule 23, The United Nations Standard Minimum Rules for the treatment of Prisoners (Mandela Rules), by corollary

[22] UN SPT Advice of the Subcommittee on Prevention of Torture to States Parties and National Preventive Mechanisms relating to the Coronavirus Pandemic

offsite often meant detainees were physically restrained during transit and, in some cases, during the consultation with the medical professional.

2.258. The use of restraints on detainees accessing medical treatment risks exacerbating some medical conditions, especially some mental health issues, and often reduces the willingness of detainees to seek medical treatment. In our view, medical services should be available to detainees on site wherever possible, and where it is not possible, restraints should only be used as a last resort. The Office continues to closely monitor the use of mechanical restraints for detainee attendance at medical appointments. This issue is discussed further in this report under ***Use of restraints – offsite medical appointments*** (2.321).

Phosphate Hill APOD

2.259. On 23 February 2021, members of the Office visited the Phosphate Hill APOD, conducting an inspection of the accommodation facilities and engaging with detainees and staff on site. The Office notes the Phosphate Hill APOD was reopened for use in October 2019 after closing in 2014.

2.260. During the visit, we identified significant concerns with the suitability of the accommodation at the Phosphate Hill APOD for long term detention.

2.261. The accommodation in use at the time consisted of several long narrow demountable buildings set up along either side of a covered walkway. Two buildings were allocated for use. One had a small kitchenette and living area, and the other adjacent building had 2 rooms used for bedrooms. The only access to either of these buildings was from the outdoor covered walkway.

2.262. There was no control over who entered the door to the sleeping quarters from the walkway which presented safety and security concerns for the occupants. We also observed that one of the bedrooms was not large enough to accommodate the 2 beds comfortably, and there was insufficient storage for personal items.

2.263. Based on information provided and observations on site, we were concerned that some areas of the accommodation were structurally unsound. The ABF confirmed a previous incident causing injury due to rotted floorboards, and subsequent reinforcement of the floors for the 2 buildings in use. We also identified damage to the bottom of one of the walls in the bedroom which could be pushed to reveal a hole. The damage was reported to ABF on site at the time.

2.264. During the visit, the Office raised concerns about the suitability of accommodation on site and asked about access to other rooms within the APOD to provide greater space, security, and storage. The ABF advised this was not possible because the rooms in use were the only rooms where the floors were reinforced and structurally sound.

2.265. As a result of the visit, the Office is concerned the accommodation at the Phosphate Hill APOD is not reasonable or serviceable in terms of space, storage, configuration, and security.

Recommendation 11

The department should discontinue the use of Phosphate Hill APOD for placements until rectification works to make this facility safe and serviceable have occurred. Consistent with recommendation 13, below, the Phosphate Hill APOD should not be used for detention for periods greater than 4 weeks.

Northern APOD

2.266. In April 2021, we visited the Northern APOD in Darwin, Northern Territory. This APOD has been operational for several years and was previously primarily used to accommodate the crews of illegal foreign fishing vessels for short periods of time.

2.267. The APOD consists of demountable buildings in a fenced off area that was previously used as staff accommodation for an adjacent hotel complex. Since December 2019, the Northern APOD was used to accommodate mainly adult family groups of transitory people transferred to Australia from Manus Island or Nauru (Regional Processing Countries).

2.268. The Office noted the outward appearance of the Northern APOD was pleasant with well-maintained facilities and good access to fresh air for detainees. The accommodation areas, however, were small and cramped and offered no private areas for family groups to gather.

2.269. Recreation spaces were limited to a multi-purpose room used as a dining room, kitchenette, television room, P&A area and a small outdoor gym.

2.270. During our visit, we were advised that due to the low security infrastructure at the facility, and absence of CCTV, line of sight had to be maintained by security officers any time a detainee was outside of their accommodation room. This resulted in security officers being stationed on the veranda of each occupied building, watching the movement of detainees and reporting movements via radio or following detainees if they left line of sight.

2.271. Due to this operating model, detainees could not walk between their accommodation and the medical clinic or the dining room without being followed by a security officer. Detainees advised this resulted in a feeling of having no privacy and being constantly watched was significantly affecting their mental health and wellbeing.

Conclusion on use of APODs

2.272. Our inspection of APODs this reporting period highlighted several issues with the long-term use of APODs, especially the use of hotels or rooms within a hotel as an APOD, and the impact on detainees held in these APODs.

2.273. In our January to June 2020 report,[23] we suggested the department ensure the provision of P&A, and access to medical and welfare services, are standard across all detention facilities, including APODs. Due to our observations during this reporting period, particularly those at APODs and at North West Point IDC, the Office now makes **recommendation 12.**

[23] Monitoring Immigration Detention - the Ombudsman's activities in overseeing immigration detention January - June 2020

Recommendation 12

The department should ensure facilities across the network, including APODs, have the same provision of P&A and the same access to medical and welfare services.

2.274. In our January to June 2019 report,[24] in response to our recommendation about APODs, the department stated that 'APODs are usually used for short periods of time'. In our January to June 2020 report, we expressed concern about the suitability of hotel APODs for the long-term (greater than 4 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 P&A.

2.275. Due to our previous concerns, and our observations this reporting period, the Office now makes **recommendation 13.**

Recommendation 13

The department should cease the use of hotel APODs for long-term detention (greater than 4 weeks).

2.276. We will continue to monitor the use of APODs and detainees' access to appropriate amenities, such as recreation. We consider that APOD arrangements should not require a detainee to choose between the indignity of being mechanically restrained and pat searched or forfeiting their access to fresh air.

Specialised placements and criminal detention

2.277. Immigration detention placements are divided into 4 tiers. Placement decisions are made based on factors including risks to safety and good order, as well as welfare issues such as family unity, community links and health needs. Broadly, the placement tiers are:

- Tier 1: community placements under residential determinations (or release onto bridging visas).
- Tier 2: transit accommodation – short-term accommodation for individuals expected to be removed imminently (includes APODs but excludes APODs established for Tier 4 specialised detention).
- Tier 3: high security detention – individuals who pose a high risk to safety and security and cannot be managed in the community (includes IDCs).
- Tier 4: specialised detention – individuals of extreme risk or vulnerability requiring special care or intervention.

2.278. Tier 4 specialised detention is used where a detainee cannot be managed in the IDN. Tier 4 specialised detention locations may include correctional facilities, mental health facilities, palliative/aged care establishments, and other specialised medical facilities.

[24] Review of the Ombudsman's activities in overseeing immigration detention January - June 2019

Tier 4 placement in criminal detention

2.279. Under s 5(1) of the Migration Act, immigration detention can include being held in a prison or remand centre of the Commonwealth, a state or a territory. Under departmental policy, where a detainee is not held in such a location by virtue of serving a term of imprisonment or being on remand, these placements are also considered Tier 4 placements.

2.280. Reasons for such placements vary but include where a detainee's presence in an IDF is beyond that facility's management capability, or a detainee temporarily remaining in a correctional facility after completing a sentence of imprisonment pending transfer to an IDF.

2.281. In 2016, the Office suggested the department develop memoranda of understanding (MoU) with state and territory correctional services to ensure immigration detainees placed in correctional facilities have appropriate access to services, facilities and relevant ABF and departmental staff. The department agreed with that suggestion and advised MoUs were under development to 'formalise current arrangements'. The department noted detainees in correctional facilities are, in any event, offered appropriate access to services.

2.282. Despite our previously accepted suggestion, the department does not have MoUs in place to facilitate Tier 4 placements for detainees in correctional facilities. Further, the Office is aware of 2 detainees placed in correctional facilities for the purposes of long-term immigration detention during the reporting period (in circumstances where the detainees are not also serving a custodial sentence).

2.283. We remain concerned that in the absence of formal agreements, including detailing responsibilities and information sharing, the department is not fulfilling its responsibilities in providing appropriate care and support to detainees held under the Migration Act.
The Office is concerned that without MoUs, the department has less visibility of detainees in correctional facilities, including to ensure their conditions are suitable for an administrative immigration detention placement. Correctional facilities, by their nature, are not designed for immigration detention, and we note that, reflecting its administrative nature, immigration detention must not be punitive.

2.284. Information-sharing shortfalls also risk delaying detainees' status resolution, and potential release from detention, if status resolution officers and detainees cannot easily and regularly communicate to maintain awareness of status resolution needs and milestones.

2.285. The department must ensure that immigration detention placements in correctional facilities enable comprehensive visibility of detainee treatment and clear communication channels, so that any tier 4 placement in a correctional facility is reasonable and for the shortest possible time.

Recommendation 14
The department should develop and implement memoranda of understanding with state and territory correctional services outlining responsibilities in the care and management of detainees held in correctional facilities for the purposes of immigration detention under the Migration Act.

2.286. The Office is also concerned there are significant differences in freedoms and privacy afforded to detainees held in correctional facilities as a Tier 4 placement. Detainees in the IDN can own mobile phones and freely contact family, friends, legal representatives, and oversight bodies such as the Office, the AHRC and the Australian Red Cross at any time.

2.287. Detainees in the IDN can freely access various media including (but not limited to) social media, news, emails, and streaming services. This access can occur using personal mobile devices, or internet enabled computers made available to detainees.

2.288. Detainees in the IDN also have freedom to choose their daily activities including whether to engage in activities or appointments. Detainees have privacy in their accommodation blocks in the IDN and CCTV is not installed in their bedrooms.

2.289. These freedoms and level of privacy are not afforded to detainees held in correctional facilities as Tier 4 placements.

2.290. The Office is particularly concerned that detainees held in correctional facilities are not able to lodge complaints with the Office, or other oversight bodies, in private and/or anonymously. We are concerned detainees may not be provided with the details to lodge complaints with the Office given state/territory correctional services work with state/territory oversight bodies rather than Commonwealth oversight bodies.

2.291. Detainees held in correctional facilities as Tier 4 placements do not have access to the internet. Calls are timed and frequency limited, only permitted at certain times of the day, and recorded. Further, our ability to follow up privately with detainees regarding any complaint is not possible because detainees cannot be contacted directly while in correctional facilities.

Recommendation 15
The department should work with relevant state and territory correctional services with a view to:

a. providing detainees placed in correctional facilities for immigration detention purposes (under the Migration Act) with a means to privately contact the Office to lodge complaints or provide information about their treatment and conditions.

b. ensuring the Office is able to contact detainees held in correctional facilities to follow up on complaints and investigations.

2.292. The Office will continue to monitor closely any detainee placements in correctional facilities and will also consider visits to correctional facilities where detainees are held in immigration detention as we monitor places of detention under OPCAT.

2.293. The Office considers that we should be able to monitor any place a detainee is held for the purposes of the Migration Act. This includes correctional facilities where detainees are held under the Migration Act. The Office suggests (**suggestion 10**) the department ensure that our oversight role and ability to inspect places of detention, is referenced when drafting MoUs with state and territory correctional services.

Use of Force

2.294. We consider the use of force against a detainee in immigration detention as high risk due to the potential for such action to constitute abuse or ill-treatment. Consequently, the use of force remains a focus of our monitoring.

2.295. We review incidents in immigration detention to assess the use of force against relevant policies and procedures and with regard to the rights and dignity of detainees. The number of incidents we review depends on a range of factors. We may review a sample of use of force records for a set period, or specific occurrences that we identify through our regular monitoring.

2.296. The Migration Act provides for the use of force in the exercise of certain powers but does not detail its use for the day-to-day safety, security, and compliance of detainees. In our report for the January to June 2019 period[25], we recommended (Recommendation 1) the department seek ministerial authority to bring forward a Bill, which would establish a legislative framework to support all internal operation of the immigration detention network. In our subsequent report[26], we noted that the *Migration Amendment (Prohibiting Items in Immigration Detention Facilities) Bill 2020* (the Bill) had been introduced to parliament.

2.297. The Office remains of the view that while the department's administrative framework is comprehensive, a robust legislative framework that adopts preventive measures to reduce the risk of violence and protect the most vulnerable detainees is essential.

2.298. Use of force in immigration detention is regulated by policy and supported by comprehensive procedural documents and training. To minimise the risk of inappropriate use of force, departmental policy provides guidance to staff and service providers. These documents articulate considerations and obligations aimed at ensuring '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'.

2.299. Some of the obligations and considerations relating to the use of force include:

- use of force is a measure of last resort,
- force must not be used for punishment, and
- use of force and/or restraint may be used to prevent injury to self or others, escape, or property destruction.

Use of force within immigration detention can either be planned or unplanned. All instances of planned use of force require prior approval within a specific authorisation process which includes consultation with IHMS. In contrast, unplanned use of force may occur when there is an immediate risk that must be mitigated. There are limitations on what techniques of force can be used in unplanned incidences.

2.300. In both planned and unplanned uses of force, the actions must cease, and restraints (if used) must be removed once the risk has diminished. All uses of force must be reported in accordance with ABF reporting requirements and detainees must be offered medical care afterwards.

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[25] Review of the Ombudsman's activities in overseeing immigration detention January - June 2019

[26] Review of the Ombudsman's activities in overseeing immigration detention July – December 2019

Use of force (planned), pat searches – movements

2.301. The use of restraints for offsite transport and escort will generally occur for all detainees rated 'high risk' of escape and/or where the detainee presents safety risks to escort staff or others.

2.302. Under departmental policy, pat searches of detainees may be conducted when leaving and re-entering the facility on an external escort and/or when exceptional circumstances exist.

2.303. Departmental policy further advises that while a search procedure can be conducted at any time provided it is for a purpose specified in the Act, it would be unreasonable to repeatedly search a detainee within a short timeframe.

2.304. During our visit to immigration detention facilities in Brisbane, we observed an over-reliance on pat searches and mechanical restraints which did not appear consistent with respecting the rights or dignity of detainees.

2.305. Detainees escorted from the Kangaroo Point and Meriton Hotel APODs were pat searched 4 times when transferring to and from the Brisbane ITA. Detainees from the Fraser compound (high security) at Brisbane ITA were escorted by an officer to the property room and pat searched upon entry to the property room.

2.306. Detainees from the Meriton Hotel APOD who wished to engage in outdoor exercise needed to be transported to the Brisbane ITA, which required them to be subject to pat searches and mechanical restraints even though they are escorted directly from the hotel through to a controlled entry point at the Brisbane ITA. Consequently, detainees often declined to engage in the activity which was also their only access to fresh air.

2.307. We are concerned that detainees transferred from the Brisbane APODs to the Brisbane ITA were mechanically restrained and excessively pat searched, despite being lower risk rated and being taken to/from secure detention facilities. We are concerned these practices were conducted as a default procedural step rather than as part of a clear risk mitigation strategy.

2.308. During our inspection, detainees from the Meriton Hotel APOD reported they were handcuffed by default for transport to the Brisbane ITA to engage with our staff during our visit. We consider that alternate arrangements could have been explored, such as arrangements for meetings to be held at the Meriton Hotel. We are concerned about the risk of detainees being deterred from engaging with the Office due to the use of restraints.

2.309. In contrast, during our remote inspection of the Melbourne ITA in May to June 2021 we were informed that:

- detainees at the Park Hotel APOD would not be mechanically restrained for transport to Melbourne ITA for P&A, and
- while detainees were pat searched, this was generally only on the return journey to the APOD (unless known information required otherwise).

2.310. The Office considers that placements at APODs should not unreasonably submit a detainee to use of force (mechanical restraints) and/or pat searches by default to access

fresh air, outdoor recreation or other essential services such as medical or external oversight bodies.

2.311. At the Northern APOD, we were informed the use of mechanical restraints on detainees transported offsite was rare, given the 'low' to 'medium' risk of most detainees. We were informed mechanical restraints would only be used if there was a specific reason to do so, such as a sudden incident. We were satisfied with this approach.

2.312. We reviewed 2 weeks of planned use of force approval documentation for offsite movements as part of our remote inspection of Melbourne ITA. Overall, we were satisfied that at Melbourne ITA, ABF takes a case-by-case approach in considering Serco requests for mechanical restraint use and has a high level of awareness of the individual circumstances of detainees providing for an informed consideration of alternate risk mitigation strategies. Most of these requests related to offsite medical appointments; further discussion is at paragraph 2.325.

2.313. We noted the Melbourne ITA Superintendent identified and rectified several mistakes in the documentation prepared by Serco indicating poor attention to detail or insufficient individualisation in Serco's planned use of force requests for offsite transport. While key mistakes were picked up and addressed by the ABF decision maker, we note the risk similar mistakes may be missed and could result in inappropriate approval of restraint use. The Office suggests (**suggestion 11**) the ABF work with Serco at Melbourne ITA to mitigate the risk of errors in planned use of force requests.

2.314. By reviewing the documentation, we identified that at Melbourne ITA, restraints were often approved contrary to IHMS advice for detainees with a history of torture and/or trauma or with mental health conditions. Our inspection team discussed this with the Melbourne ITA Superintendent who was able to articulate the risk considerations which informed the approval of restraints. Often this was due to the detainee having a significant history of violence and, as such, safety risks could not be mitigated through alternate means.

2.315. We noted that where mechanical restraints were used against IHMS advice, a record of the considerations by the Superintendent were not always included in the documentation reviewed by the Office. The Office suggests (**suggestion 12**) ABF decision makers consistently record reasons for their decision when approving the use of mechanical restraints against the advice of IHMS.

2.316. During our inspection of Yongah Hill IDC in May 2021, we were advised by Serco that in instances where IHMS recommended against the use of restraints for offsite transports, the risks would be reviewed with particular focus on the escape risk. In these instances, consideration would be given to the use of an additional escort officer instead of restraints. We also note that Yongah Hill IDC has a large pool of staff who are trained to undertake escort duties.

2.317. We consider the risk-based approach which involves considering alternatives to restraint use to be more aligned with respecting the rights and dignity of detainees.

Recommendation 16

The department should ensure that detainees participating in excursions are only subjected to pat searches and the use of mechanical restraints when necessary, using a risk-based approach considering any possible alternative mitigations and in accordance with departmental policy.

Use of restraints – offsite medical appointments

2.318. In prior reports, the Office has expressed concerns about the use of mechanical restraints on detainees taken offsite for medical appointments and its resultant impact on some detainees' willingness to attend those appointments.

2.319. In our July to December 2019 report, where high or extreme risk detainees refused to attend an offsite medical appointment due to being mechanically restrained, we recommended the department consider alternative mitigation including increased escorts. We reiterated our ongoing concerns about this issue in our report for January to June 2020.

2.320. Detainees at Brisbane APODs and Brisbane ITA reported they must forego their medical appointments if they do not wish to be handcuffed. Detainees reported that it is humiliating to sit in handcuffs in waiting rooms during offsite medical appointments.

2.321. During our inspection of Villawood IDC, we noted some detainees were restrained during escorts to hospital for treatment after hours. The Office is concerned this practice could result in a reluctance from some detainees to seek medical treatment and be a barrier to detainees receiving medical treatment.

2.322. At the Melbourne ITA we observed that use of mechanical restraints for offsite medical appointments was common. We suggested the option of increased escorts in lieu of mechanical restraints, consistent with previous recommendations made by the Office. The Melbourne ITA Superintendent responded that this was often not an effective risk mitigation option. Serco also stated that additional officers are considered, but not always possible.

2.323. We noted examples from Melbourne ITA where the Superintendent directed Serco to use alternative approaches for offsite transport for medical appointments in specific cases for high and extreme risk rated detainees, based on knowledge of the detainees' histories. This included one refusal of mechanical restraint use because of the detainee's physical condition, and another instructing against mechanical restraints because this was more likely to achieve compliance from the detainee given his complex behavioural history.

2.324. We consider these positive examples of avoiding a default approach to use of force approvals, and evidence that alternatives to the use of mechanical restraints can be found including in some cases for high and extreme risk rated detainees. The Office reminds the department of our previous recommendation and suggests the department continue to consider alternative risk mitigations to the use of mechanical restraints to facilitate offsite medical appointments for detainees.

2.325. The Office remains concerned about the use of mechanical restraints for detainee attendance at offsite medical appointments and will continue to monitor the issue closely.

Unplanned use of force

2.326. As part of our remote inspection of Melbourne ITA, we reviewed the 3 unplanned use of force incidents that occurred in the 2 weeks immediately before our planned site visit. We reviewed further use of force incidents that occurred during the week of our inspection, and we subsequently reviewed one further use of force incident that came to our attention as part of our whole of network remote monitoring.

2.327. We considered one of the incidents an example of appropriate use of force noting officers gradually escalated their intervention until the detainee's agitation subsided.

2.328. Another incident raised concerns about an absence of attempts to de-escalate the situation, the suggestions to use 'ground stabilisation', and the use of force against the detainee. This incident escalated when the detainee moved suddenly during a pat search, resulting in the use of force. After reviewing the footage, we consider the detainee's action that triggered the use of force was largely an involuntary reaction to a poor pat search technique by the officer. The detainee was compliant with the pat search up until the point where the detainee became uncomfortable due to the search becoming intrusive.

2.329. The Migration Act allows for reasonable force to be used in conducting a pat search, however, we consider there were several deviations from documented procedure in this instance and the incident could have been better managed.

2.330. The detainee's stature provided a physical advantage over the officer conducting the search, which by its nature had to be conducted in physical proximity. The detainee was recently involved in an assault on a Serco officer.

2.331. At the point officers responded to the sudden movement of the detainee, we consider the pat search activity should have ceased to provide an opportunity for the detainee to demonstrate compliance (again) and to be informed of the officer's power to use force to conduct the search under s 252(8) of the Migration Act. The department's procedural instruction requires the amount of force used to be reasonable and that force may only be used for the shortest amount of time possible, to the extent it is both lawful and reasonably necessary.

2.332. Considering the detainee's physical capacity and violent antecedents, it was evident ERT officers were anticipating an adverse reaction from the detainee. The Office noted the large number of ERT officers present in the confined space even though the detainee was compliant at the start. We believe the high number of ERT officers present heightened tensions, and the reactivity of both the detainee and officers contributed in part to the detainee's level of agitation. The Office considers that a more appropriate alternative would be for the additional officers to wait in the hallway to respond if necessary.

2.333. The tension of the incident was further heightened by unclear leadership, with multiple ERT officers shouting different directions at the detainee. One ERT officer asked the detainee questions while the detainee was being held against the wall and facing away from the officers. The detainee's instinctive reaction to attempt to turn to see the person talking was considered as active resistance by the ERT officers, further contributing to the detainee's frustration.

2.334. As the detainee was initially compliant with the pat search, we are concerned that officers did not take the opportunity to de-escalate the situation. ERT's actions, including the

lack of clear leadership in managing the incident, heightened the tensions and prolonged the detainee's agitation.

2.335. In this instance, the use of force shifted from an unplanned use of force in response to a perceived risk of harm to the exercise of use of force as part of search powers under the Migration Act.

2.336. Our reviews of use of force incidents this reporting period give rise to concerns regarding a lack of de-escalation which we will continue to monitor next period.

Outstanding issue – use of force incident at Melbourne ITA in January 2020

2.337. In January 2020 we wrote to the ABF about 2 occasions of use of force that we considered excessive or inappropriate. One incident was finalised, but the other was referred to the department's Detention Assurance Reporting Section for review.

2.338. The department advised this review also includes 3 other incidents at Melbourne ITA relating to use of force for the period December 2019 to January 2020.

2.339. In November 2021, the department advised the Office that the review into the use of force at Melbourne ITA is complete and is with the Detention Assurance and Reporting Section for further review, assessment, and finalisation of a management action plan. The department provided a copy of the endorsed report to the Office in June 2022. We will review this report as part of our ongoing monitoring activities.

Use of High Care Accommodation

2.340. The department and its contracted service providers have several mechanisms to manage detainees who present risks or are vulnerable, including the use of High Care Accommodation (HCA). HCA is a segregated environment within facilities where high-risk detainees can be managed with greater supervision and engagement.

2.341. Previously, the Office recommended the department address the use of threats of placement in HCA to influence detainee compliance (July to December 2019 report). We remain concerned about the use of negative inducements to influence detainee compliance and will continue to monitor the issue closely.

2.342. Under departmental policy, placement in HCA may occur for 3 main reasons (other than quarantine, as discussed earlier in this report):

- where a detainee exhibits violent behaviour and repeatedly refuses a direction to cease,
- where they are pending transfer to a mental health facility, and
- where they seek relocation voluntarily for temporary respite.

2.343. Departmental policy requires that HCA be used for the shortest practicable time, and as a last resort.

Assessment of information provided during remote monitoring

2.344. As part of our remote monitoring, the Office reviewed a consolidated list of HCA placements across the network for the period 1 July to 31 July 2020. This information was provided by the department upon our request.

2.345. There were 74 reported uses of HCA across the network in July 2020, and the average duration was 3 days. The longest duration for an HCA placement was 21 days which was a behavioural placement.

2.346. The list did not include HCA placements that commenced prior to 1 July but ceased in the requested period.

2.347. We also reviewed documentation relating to the HCA placement decisions including HCA management plans, behaviour management plans where relevant, and exit planning where available.

Record keeping

2.348. We observed that record keeping practices relating to the use and approval of HCA placements are not consistent across the IDN, including the nature and quality of information provided to the decision maker. Further, evidence of a decision by a relevant ABF officer was not always included in the documentation provided.

2.349. We also noted that documentation provided from centres within the network was not consistent with the consolidated list of HCA placements provided to us. The centralised list contained incorrect dates for one placement and had a placement listed for a reason that was different to the documentation provided.

2.350. When comparing the documentation of placement decisions with the list, it appears the use of the placement reasons 'medical quarantine' and 'operational quarantine' may not be used in a consistent manner. It also appears some detainees were subject to a 14 day 'operational' quarantine on return from hospital.

Decision-making framework

2.351. The information provided did not always include evidence of a decision made by the relevant delegate: in many instances we received a copy of a request for placement made by Serco but not the corresponding ABF decision.

2.352. The documentation provided did not evidence a consistent framework for decision making, with requesting information often limited in nature and not reflecting threshold considerations or views on proportionality. In some instances, detainees were placed into HCA due to being a 'threat to the good order of the centre' without further detail of the threat to evidence consideration of the proportionality or necessity of the restrictive placement.

2.353. Given these observations, the Office suggests (**suggestion 13**) the department apply a consistent decision-making framework across all centres in the network. Among other matters, this framework should require the recording and retention of sufficient information to demonstrate how and why delegates made their decisions.

2.354. In the absence of other supporting documentation, some placements could be viewed as punitive based on the information provided which, in most cases, does not discuss

alternate strategies attempted (or the absence of feasible alternate strategies) to manage the risks identified. This includes placements following incidents like abusive/aggressive behaviour, damage to Commonwealth property or assault where the documentation did not indicate there was an ongoing risk or there was any intervention directed at de-escalation or resolution of the detainee's issues prior to placing them in HCA. In these instances, it was not evident that use of HCA was a last resort.

2.355. A further concern at some facilities is the apparent use of HCA to manage risks of self-harm. This involved placing at-risk detainees who require monitoring into HCA over several days because IHMS was not available to undertake a mental health review.

2.356. The Office considers this delay unreasonable and suggests (**suggestion 14**) the department ensure IHMS conducts timely mental health reviews of at-risk detainees as a priority to avoid potentially unnecessary extended placements in HCA, and to ensure appropriate medical supports are in place.

2.357. We note the use of HCA for this purpose is not consistent with the department's mental health policy or the department's closer supervision and engagement policy.

Management plans

2.358. Records from Villawood IDC and Melbourne ITA reflect a routine consideration of how the detainee would be managed in the more restrictive placement of HCA. Request templates from Villawood IDC and Melbourne ITA prompt the inclusion of information required by relevant policy for the decision maker, including reference to HCA management. However, we identified that requests for HCA placement did not always use the established template and the individual needs of a detainee were not always apparent or articulated.

2.359. In one case, there was no information about the detainee's health care requirements, or confirmation there were no such requirements, for a detainee placed in HCA for 'medical quarantine' following a stay in hospital to address mental health concerns. The documentation did not articulate how the detainee would be managed other than noting 'monitoring for safety (given risk of suicide or self-harm)' was required until review by IHMS. Further, there was no exit planning for the detainee's departure from HCA included in the documentation provided.

2.360. Documentation reviewed from other IDFs did not have an established template to prompt the inclusion of required information for the ABF decision maker and records provided did not indicate the establishment of a management plan or exit planning in the use of HCA.

2.361. The policy on closer supervision and engagement of high-risk detainees requires the establishment of a clear plan for the detainee's future exit from HCA in consultation with service providers and the detainee. Under policy, the plan must include a clear, written explanation of the reasons why it was necessary to place the detainee in HCA.

2.362. The Office suggests (**suggestion 15**) the department re-iterates to IDFs that placing a detainee in HCA needs the establishment of a clear plan for the detainee's management including an exit plan in accordance with departmental policy.

Removals from Australia

2.363. COVID-19 has challenged the department's ability to remove detainees from Australia since March 2020.

2.364. The department advised the Office that, at July 2021, 41 per cent of the detention population was on a removal pathway. Of those, approximately 38 per cent signed a request for removal (voluntary removal), 28 per cent refused to sign request for removal (involuntary removal) and 2 per cent signed a request for removal then withdrew the request. The department advised information is not recorded in the case management system for the remaining 30 per cent.

2.365. The department advised that during the period 1 July 2020 to 31 May 2021, the ABF removed 953 unlawful non-citizens from Australia to 64 countries on both commercial and chartered flights.

2.366. Statistics provided by the department indicate that in 2020, 1,455 people were removed from Australia compared to 5,061 people in 2019.

2.367. Due to the lowering of the arrival passenger cap into Australia, several airlines who regularly provide removal escorts were unavailable until at least 2022. Others reduced the number of escorted missions available to the ABF by half.

2.368. The ABF used chartered aircraft to undertake some removal operations predominantly focused on high risk and voluntary detainees. Between June 2020 and August 2021, the ABF conducted 31 chartered removal operations to 12 countries. A total of 506 persons were removed via charter.[27]

Removal considerations

2.369. The department advised that officers consider multiple factors in determining whether to remove a particular detainee, including whether they are unlawful non-citizens liable and available for removal (voluntary or involuntary but with no barriers to removal).

2.370. Various barriers may delay the process of removing a particular detainee. These include:

- judicial or merits reviews,
- countries' unwillingness to accept the return of their citizens if the removal is involuntary,
- inability or prolonged delays to obtain travel documents, and
- fitness to travel.

2.371. Additional barriers due to COVID-19 include:

[27] At July 2021.

- border closures,
- a lack of commercial flights,
- home countries not accepting the returns of their nationals (even voluntarily in some cases), and
- inability to perform escorted removal of high-risk persons on commercial flights to certain countries.

2.372. The *Aviation Transport Security Regulations 2005* deem that detainees considered 'dangerous' must be escorted while on aircraft. Circumstances in which a person is considered 'dangerous' include where they are convicted of an offence involving violence against a person or serious damage to property.[28]

2.373. However, during the reporting period whole of government decisions limiting who could depart Australia, hotel quarantine and caps on the number of persons who could enter Australia, affected Serco and IHMS's ability to perform escorts of international removals on commercial aircraft. International escorts risked being unable to re-enter Australia for a protracted period, and/or taking cap-imposed arrival places from returning Australian citizens unable to secure repatriation flights.

2.374. Adapting to the circumstances, the ABF negotiated permission to undertake international chartered operations to remove detainees, particularly to countries with limited or no commercial air routes open. However, most countries were not willing to accept bulk arrivals during the reporting period.

Network placements and transfers

2.375. Section 189 of the Migration Act requires unlawful non-citizens to be detained but does not state where each detainee is to be detained. Placement decisions occur under departmental policy, both for initial placements and any subsequent movements between facilities while in immigration detention.

2.376. Under department policy, initial placement decisions require a comprehensive assessment of:

- risks associated with individual detainees,
- risks to other detainees and staff,
- risks to safety and good order, and
- risks to the facility.

2.377. Placement decisions must also consider welfare issues, including:

- family unity,

[28] Regulation 4.75, subdivision 4.5 of the Aviation Transport Security Regulations 2005

- community links,
- health and welfare needs,
- status of minors,
- pending/existing marriages,
- immediate family relationships,
- physical and mental health concerns,
- the detainee's needs including age and length of detention,
- available services at the destination facility, and
- risk profiles of the detainee and the destination facility.

2.378. Movement within the immigration detention network is frequent and occurs for various reasons. These may be related to the detainee, such as health concerns, or broader issues such as safety, security, and capacity.

2.379. In considering movement, policy requires the holistic circumstances of the detainee be considered. Where a detainee has a dependent child, policy notes the best interests of the child will be a primary consideration, consistent with international law. However, under policy, where a transfer is required to address a matter of security, good order or another operational reason, family links are not a barrier to transfer.

2.380. The Office recognises the impact of COVID-19 on the management of held detention, including the placement of detainees in each facility. We recognise that border restrictions, COVID-19 risks and related issues inhibit the department's normal processes and network rebalancing activities. We also recognise the relevance of safety and security considerations to placement, and the potential for tension between operational decisions and individual detainees.

2.381. The Office wishes to emphasise the impact individual operational decisions can have on the detainee, and the need to always consider individual impacts of any such decision.

Previous observations

2.382. The Office previously made recommendations on the use of restraints on detainees, and access to activities, during transfers. While we did not inspect transfer operations this reporting period, we reiterate the impact prolonged mechanical restraint use, and lack of access to reading material or other entertainment during lengthy transfer operations can have on detainees' wellbeing.

2.383. We also noted in previous reports the need to ensure family links are considered, and provided a similar weighting to other factors, when determining network placement. Given our observations and the feedback we received from detainees during this reporting period, particularly those at North West Point IDC, we reiterate this point.

Detainee transfer requests

2.384. Access to family and friends outside of detention, including through a visits program, is a key element of international principles concerning detention.[29] Detainees should have the right to be visited by their family subject to reasonable conditions. The Office considers that enjoying this right must also be practically possible based on the location of those family links. International principles also provide that upon request, if possible, detainees should be held in a facility reasonably near their usual place of residence.[30]

2.385. Under departmental policy, placements should consider the need to keep families intact, as well as community links and immediate family relationships. In considering interstate transfer, policy also indicates that spouses and dependents who visit a detainee at least fortnightly would present a potential barrier to transfer.

2.386. Departmental policy states family links are not a barrier to transfer where required for operational reasons, including security and good order. However, various transfers are for capacity and logistical reasons rather than security (such as the transfer of detainees to North West Point IDC). Further, group/network rebalancing for capacity and logistical purposes is not typically an emergency measure so transfer considerations can be properly assessed.

2.387. During our inspection at Yongah Hill IDC, we received feedback from multiple detainees expressing frustration with their current facility placement. These detainees were unhappy with being moved around the network and, specifically, away from their families on the east coast. The same detainees also spoke of multiple denied transfer requests.

2.388. Multiple transfer requests to be closer to family interstate also arose in conversations with detainees in Brisbane. At the Northern APOD, detainees noted various family and friend links in Sydney, Melbourne and Adelaide, on top of their broader frustrations with their long-term detention. As previously noted, family separation was a focal point of discussions with detainees at North West Point IDC.

2.389. We were pleased to note ABF staff at Yongah Hill IDC indicated they would speak in person with detainees who submit requests for transfer to better understand the nature of their request and give the detainee the opportunity to provide further information. The ABF advised transfer requests would consider a detainee's history of visits from family/friends if they requested transfer back to a previous placement.

2.390. The Office considers the burden should rest with the ABF to justify why a detainee's placement cannot be close to family and support networks, as opposed to detainees' needing to justify why they are asking to be transferred to a facility closer to those links. Proximity to family and other supports is a protective factor which can support mental health and wellbeing and potentially reduce incidents because of detainee frustration.

2.391. Departmental policy explicitly indicates placement in a particular facility 'must **not** be used as a behavioural management tool or punitive measure'. The Office is concerned

[29] Principle 19 - Body of Principles for the Protection of all persons under any form of detention or imprisonment (The Office of the High Commissioner for Human Rights)
[30] Principle 20 – Body of Principles for the Protection of all persons under any form of detention or imprisonment (The Office of the High Commissioner for Human Rights)

there is some risk that inflexible placements may become punitive in effect, especially where this isolates detainees from their usual place of residence and their family.

Visibility by and access to legal representation during transfers

2.392. All detainees have a right to commence judicial proceedings on the lawfulness of their detention and the ability to do so must be available. Under human rights standards, access to lawyers must be prompt and regular. These standards also require that persons detained be given adequate opportunity, time, and facilities to communicate and consult with their legal adviser without delay.

2.393. International standards for the treatment of prisoners[31] require that prisoners be given the means to immediately inform a contact person about their transfer to another institution. Further, a prisoner should be entitled to notify family or other appropriate persons of their transfer.

2.394. Under departmental policy, the ABF is not required to advise a detainee's representative of a decision to transfer them to another facility.

2.395. The Office notes that detainees in immigration detention can access personal mobile devices providing them with the ability to freely contact legal representatives. Detainees can also access free phones and computers provided by the department to facilitate contact. The limitations faced by detainees on Christmas Island are discussed earlier in this report.

2.396. Civil society representatives, including those providing legal representation to detainees, raised concerns with the Office during the reporting period regarding sudden inter-facility transfers without notice to detainees' legal representatives. Concerns included delaying access to detainees, inhibiting communications with legal representatives, and negating the possibility of seeking injunctions to suspend transfer activity. Representatives noted this was particularly acute when detainees were transferred from an east coast facility to Western Australia and subsequently to Christmas Island.

2.397. The Office considers the department's policy placing the onus on detainees to advise their lawyers of transfers to be limiting, noting the feedback from civil society representatives. This is particularly relevant for some detainees, such as those with vulnerabilities, who may not otherwise be able to advise their legal representatives or recognise the importance of doing so.

2.398. While detainee placements are complex and at times require movement around the network, sometimes at short notice, the Office is concerned that detainees' legal representatives can be left for extended periods not knowing the location of their clients, especially during longer transfers.

2.399. The Office suggests (**suggestion 16**) the department consider a mechanism for notifying legal representatives of transfers of their clients within a reasonable timeframe.

[31] OHCHR | Standard Minimum Rules for the Treatment of Prisoners

Phone access during transfers

2.400. Due to aviation security regulations detainees' mobile phones are confiscated during aircraft transfers. We note our prior acknowledgement of concerns of device misuse by detainees during flights, leading to a ban on electronic devices during flights.[32]

2.401. Noting the importance of telephone access, detainees should be afforded access to their personal mobile devices unless it is legally required or permissible to confiscate phones. The Office recognises aviation regulations are not for the department to enforce, but consider the department is responsible for ensuring detainees can access their own phones when not precluded by law.

2.402. The Office suggests (**suggestion 17**) the department ensure any removal of mobile phones from detainees occurs for the minimum time necessary to ensure compliance with aviation security regulations.

2.403. The Office further suggests that (**suggestion 18**), where phone confiscation is both necessary and legally supported, arrangements are in place to allow detainees to communicate promptly with family and legal representatives before and after transfer.

Complaints

2.404. Access to an independent and impartial complaints management process is an essential element in ensuring the rights of detainees are respected in detention environments.

2.405. Within the IDN, detainees can access an internal complaints process managed by the Detention Service Provider. Detainees may also complain directly to the department through its Global Feedback Unit (GFU) and to external complaints and oversight bodies such as the Office and the AHRC.

Access to external complaints and oversight bodies

2.406. We are satisfied that detainees have appropriate access to external complaint and oversight bodies. The contact details of external complaints and oversight bodies were advertised in communal areas of all facilities we inspected this period. Contact details were also included in information provided to new detainees when they are inducted into a detention facility.

Access to internal complaints process

2.407. The Office identified that detainees had free access to complaint forms in communal areas of the facility and the ability to lodge complaints anonymously at all facilities visited, except Yongah Hill IDC. At Yongah Hill IDC, complaints forms were removed from communal areas and were only available on request from officers' stations within the compounds.

2.408. The requirement to request a form from a staff member is a considerable disincentive for detainees wanting to complain. The Office is concerned this inhibits the right

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of detainees to lodge anonymous complaints and raises the risk of real or perceived retaliation in response to making a complaint.

Recommendation 17

The department should ensure detainees have free access to complaint forms and the ability to lodge complaints anonymously at all facilities.

Quality assurance

2.409. During our inspections this reporting period, our assessment of complaints management focused on the implementation of our previous recommendations for the introduction of a quality assurance program. We found that quality assurance programs were in place at most facilities, but the thoroughness of the processes differed considerably.

2.410. We noted there was a comprehensive process in place at the Melbourne ITA to regularly review all new complaints lodged within the facility and the quality of investigations and response to complaints. We found evidence ABF staff were reviewing complaints and providing feedback to service providers when shortfalls were identified before their closure.

2.411. We noted the quality assurance process at Yongah Hill IDC related to an assessment of contractual obligations, such as compliance with timeframes, rather than the quality of the investigation, response and record keeping.

2.412. The Office considers the complaints quality assurance processes in place at Melbourne ITA a good practice and suggests (**suggestion 19**) similar practices be implemented at all facilities across the network.

Case study

During our assessment of complaints at North West Point IDC, we identified a complaint that was not responded to in accordance with the service standards prescribed in the department's Client Feedback Policy[33]. Under the Policy, the service standard for responding to complaints is 15 days.

Mr X lodged a complaint to the Global Feedback Unit (GFU) on behalf of Detainee Y regarding concerns for the safety of Detainee Y and an allegation that Detainee Y was assaulted by another detainee. The complaint was referred to Serco for further investigation.

Fourteen days later, Serco provided an interim response to Detainee Y advising the complaint was still under investigation and Serco would provide updates every 10 business days until the complaint was resolved. Another 14 days later, Serco provided a second interim response to Detainee Y advising the same.

A month after the complaint was lodged, the unresolved case was escalated by the GFU with a warning that it would be escalated further if a response was not received within 3 working days. Six days later, a final escalation was sent by GFU noting the case was outside the

[33] Compliments, complaints and suggestions (homeaffairs.gov.au)

department's service standard for responding to feedback. A few days later, a final response was provided to Detainee Y.

The Office is concerned with the significant delay in responding to this case (35 days), noting a response was required within 15 days and the seriousness of the allegation in the complaint. We note the Policy anticipates instances where complaints may take longer than 15 days to resolve, in which case an interim response must be provided to the complainant. However, in this case, the delay in resolving the complaint does not appear to relate to pursuing investigative lines of enquiry which would warrant an interim response.

After further analysis, we also identified that departmental records classified the alleged incident in the complaint as an 'assault – minor', even though the incident was an alleged stabbing of a detainee by another detainee.

The Office is also concerned that, in addition to the lengthy delays in resolving the complaint, the matter was not investigated further. The Office notes that Serco's response referenced 'no CCTV coverage in that area' and insufficient information and evidence to investigate the matter further.

During our inspection at North West Point IDC, we identified the CCTV was, in fact, not operational in that compound at the time of the alleged incident. Had the CCTV been operational, there may have been sufficient evidence to investigate the matter further.

The Office is concerned that Serco's complaint response, and reference to 'no CCTV coverage in that area', is misleading and does not accurately reflect the circumstances.

2.413. The Office remains concerned about the department's handling of detainee complaints and will continue to monitor the quality and quality assurance of the department's complaint handling processes.

Programs and activities

2.414. All detainees have a right to access age-appropriate structured educational, recreational, and cultural P&A. This is particularly important given the lengthy periods detainees are often held in immigration detention.

2.415. The IAP incentivises detainees to participate in structured activities to receive additional points in exchange for items through the facilities canteen. The IAP allows detainees to obtain a default minimum allocation of weekly IAP points and receive additional points based on participation in structured P&A.

2.416. While a range of P&A were available at each facility we visited, some detainees were unhappy they lost access to rehabilitation programs they used in the community or in correctional facilities, such as anger management programs and drug and alcohol counselling.

2.417. We reviewed P&A schedules for one facility and noted there were no educational programs on offer, and almost all the P&A was art and craft based. The sporting and recreational activities were limited to personal trainer sessions.

2.418. Staff on site advised that participation levels had dropped dramatically. Staff advised they conducted a survey of detainees to attract more participation. The survey showed all respondents wanted art and craft related activities as well as continuation of the personal trainer sessions, so this was included in the P&A schedule. As a result, detainee participation in P&A increased.

2.419. Staff indicated that self-paced online education would be on the schedule for the facility the following month to address the lack of education programs identified by the Office.

2.420. Staff advised they try to be flexible and allow detainees to undertake other meaningful activities during P&A sessions if they are not interested in the scheduled activity. Staff explained they encouraged this to ensure detainees remained active and socialised, despite this practice not being permitted under Serco's contract. Stakeholders were in discussions to establish if the practice would be allowed to continue.

2.421. During our visits to facilities in Brisbane, we were provided with an overview of some well-attended online self-development programs available to detainees. These programs resulted in observed positive improvements in participating detainees' self-agency over recent months. The Office notes these programs were not necessarily available to all cohorts, including the detainees at the Kangaroo Point APOD, Meriton Suites APOD and Fraser compound at Brisbane ITA.

2.422. The Office considers that online self-directed self-education programs offer a range of benefits and that all detainees should be able to access these programs, regardless of placement or 'cohort'.

2.423. The Office suggests (**suggestion 20**) the department consider expanding the availability of self-directed development programs to all detainees across the IDN.

2.424. As previously mentioned, we identified significant differences in the P&A available to detainees at the Brisbane ITA compared to those available to detainees at the APODs in Brisbane. The availability of appropriate P&A and outdoor recreation was raised at previous inspections. However, it appears no action was taken in response – see Recommendation 10 at **APPENDIX F.**

2.425. Earlier in this report we discussed the shortcomings in services and amenities available at APODs, resulting in **Recommendation 12** in this report.

2.426. The Office was satisfied with the range of P&A on offer at Yongah Hill IDC. The vocational offerings such as woodworking, leather work and cooking classes were constructive and well-attended activities which provided detainees with a genuine opportunity for meaningful engagement.

2.427. The Office considers that Serco at Yongah Hill IDC demonstrated innovation and a commitment to detainees' wellbeing by overcoming obstacles to the delivery of educational activities created by COVID-19 restrictions. Arrangements were made with external service providers to receive program material so that programs, such as 'Parenting and Life Skills', continued despite providers being unable to attend the site.

2.428. During our visit to Yongah Hill IDC, we were advised that external providers had commenced delivering some programs remotely via video link/Zoom.

2.429. Some detainees we spoke with expressed dissatisfaction with the lack of access to educational opportunities, including limitations on accessing online learning. We consider that providing opportunities for detainees to build skills is critical to enabling them to obtain gainful employment once they are released from detention, regardless of whether that is release into the Australian community or internationally.

2.430. During our site visit, we were advised of a pilot commencing at Yongah Hill IDC expanding the availability of P&A into the evenings and across the weekends. We consider this to be a positive initiative and anticipate it will offer several benefits, including to detainees' wellbeing.

Health services

2.431. During our visits this reporting period, we identified a lack of alternative strategies for detainee engagement by IHMS and welfare staff when detainees were sleeping during the day.

2.432. In one case, IHMS and welfare staff were not able to follow up with a detainee on long-term food and fluid refusal because he was sleeping during the day. However, no alternative strategies to engage with the detainee were discussed or proposed at stakeholder meetings, and the staff were reluctant to wake the detainee for observations.

Management of vulnerability

2.433. The Office notes the framework in place for managing detainee vulnerabilities, particularly mental health concerns, but during our inspections identified missed opportunities for information sharing between stakeholders.

2.434. At Villawood IDC, the Office noted that Serco were often identifying mental health issues early but were not provided advice by IHMS on how to keep people safe.

2.435. A further example discussed with the Office during our inspection at Villawood IDC was a case of poor planning for the arrival of a detainee from corrections known to be vulnerable and complex. Serco were advised that a stakeholder planning meeting was not required and that IHMS would become involved if there was a medical crisis. This lack of IHMS engagement limited Serco's ability to develop a thorough plan for the detainee's arrival.

2.436. A further example involved a detainee's recent changeof medication which impacted their behaviour. The Office acknowledges the principles of medical-in-confidence but suggests that IHMS could have informed Serco of relevant information, without breaching those principles, to ensure the detainee was well supported and monitored for behavioural changes.

2.437. During discussions, Serco staff identified the need for additional training and awareness sessions from IHMS regarding the warning signs for people under the influence of drugs, and how to manage people under the influence of drugs. This was expressed as relevant for staff responsible for day-to-day detainee care and to improve safety for both detainees and staff.

2.438. During discussions at Yongah Hill IDC we heard that Serco's detention service officers do not have the training or skills to provide a mental health response to detainees exhibiting mental health vulnerabilities or in crisis. The consequence of limited IHMS availability, particularly after hours, results in a security-focused response rather than the required mental health response to detainees presenting with mental health vulnerabilities. This shortfall introduces risks of further harm to vulnerable detainees and untrained security staff.

Implementation of recommendations

2.439. Monitoring the department's progress on previous recommendations made by the Office is undertaken in a range of forms which may include requesting information from the department, observations during site visits or examining specific records.

2.440. Due to breadth and varying complexity of activities that occur within the immigration detention network, the Office prioritises issues to focus on during the inspection cycle. This means that depending on the nature of the recommendation made, we may not immediately follow-up on a previous recommendation during a subsequent site visit.

2.441. Additionally, over the last 2 years, COVID-19 limited the time we spent at each facility, and at various periods during the reporting cycles the Office was unable attend facilities due to COVID-19 restrictions.

2.442. The Ombudsman released a statement in July 2020 on the management of COVID-19 risks and made 3 recommendations. One of these recommendations has been implemented and requires no further action. We have reiterated our ongoing concerns regarding the other two recommendations in Recommendation 1 and Suggestion 2 of this report. Progress in implementing these recommendations is found at **APPENDIX C**.

2.443. In the January to June 2020 immigration detention monitoring report, the Office made 3 recommendations. The department agreed to 2 recommendations, which have subsequently been implemented, and noted the third. Progress in implementing these recommendations is found at **APPENDIX D**.

2.444. 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 and the recommendation which the department disagreed with has subsequently been considered closed. Six of the 11 recommendations have been implemented and the Office is still monitoring the implementation of the other 5 recommendations. Progress in implementing these recommendations is found at **APPENDIX E**.

2.445. In the January to June 2019 immigration detention report, the Office made 16 recommendations and consider 3 of the 16 recommendations implemented. The Office continues to monitor the implementation of the other 13 recommendations, including 3 recommendations that were only agreed in part by the department. Progress in implementing these recommendations is found at **APPENDIX F**.

2.446. The Office has made a total of 34 recommendations in these reports and closed one recommendation (not agreed to by the department). The Office considers 12 of these recommendations to be implemented and the Office continues to monitor the implementation of the remaining 21 recommendations.

Recurring themes in our recommendations

2.447. While the Office acknowledges COVID-19 affected implementation of some recommendations, we are concerned the following issues recur in our monitoring reports since 2019:

- reducing the number of people in immigration detention,

- the use of APODs, and
- complaints management.

Reducing the number of people in immigration detention

2.448. In the Ombudsman's July 2020 statement and in this report, we recommended the department work with the relevant ministers to reduce the numbers of people in held immigration detention facilities. Whilst we note the impact of COVID-19 on detainee removal, the Office remains concerned with the lack of progress made against this recommendation – there has only been a decrease of 66 people across the IDN network. The Ombudsman considers population reduction a priority and will continue to monitor the population numbers.

The use of APODs

2.449. The Office first raised concerns on the use of APODs in the January to June 2019 report, recommending that wherever practicable, the department uses APODs that cater to the longer-term needs of detainees through the provision of appropriate and accessible facilities. Since this time, more APODS opened (Phosphate Hill, Meriton Suites Hotel, Park Hotel, and Kangaroo Point – now closed) and, as this report highlights, the suitability of the accommodation has not improved.

2.450. Consistent with our initial recommendation, it remains the view of the Office that APODs are not appropriate for long term use (over 4 weeks).

Complaints management

2.451. The January to June 2019 report, the January to June 2020 report and this report all raise concerns with complaints management across the immigration detention network. While there is some improvement in this area as quality assurance programs are in place at some facilities, the nature and comprehensiveness of these programs differs.

2.452. Effective and transparent complaints mechanisms are an important safeguard against ill-treatment. We will continue to monitor complaints management across the detention network as part of our ongoing oversight.

COMPLAINTS ABOUT IMMIGRATION DETENTION

3.1. In the period from July 2020 to June 2021, the Office received 151 complaints which raised 179 issues about immigration detention facilities.[34]

3.2. The Office assesses each complaint and decides the best tool for assisting the complainant and influencing improvements in public administration. This may be an investigation, information, transfer, or referral. Of the 179 issues, the Office referred 70 to the department because they were not raised with the department in the first instance and decided to investigate 50 issues. For the remaining issues, the Office provided information to the complainant and declined to investigate based on the circumstances.

3.3. Nine complaints raised issues about the management of COVID-19 in immigration detention. The Office received complaints about the risk to vulnerable detainees, particularly for individuals with underlying health conditions that place them at high risk of COVID-19, remaining in immigration detention facilities. Concerns were raised about the availability of vaccines for detainees and inadequate support for detainees' mental health.

3.4. The Office also received complaints about the impact of detention, and the conditions in detention, on detainees' mental health and complainants expressed dissatisfaction with the facilities in immigration detention (such as the size of living spaces and provision of goods such as personal care items and bedding). The Office also received complaints about the timing and lack of notice provided for transfers between facilities and delays in actioning requests to voluntarily return to a country of origin.

3.5. Consistent with previous periods, access to medical services and activities and conditions continued to be 2 of the key issues arising in complaints about detention.

[34] A complaint may raise more than one issue.

Table 1: Complaints issues July 2020 – June 2021

Main issues raised in complaints received July 2020 – June 2021	Number
Medical services	36
Activities/conditions	19
Complaint handling	16
Transfer between centres	10
Safety and security	10
Property	9
Management of COVID-19	9
Assault	8
Use of force	5
Type of detention	4
Discrimination	4
Location of detention centre	3
Mail	3
Self-harm	2
Visitors	1
Other/insufficient information provided[35]	40
Total	**179**

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

[35] Includes complaint issues which do not do not fall clearly within any of the specified categories, including delays in actioning requests to return to a country of origin and general dissatisfaction with detention.

Spotlight issue – Transfer of Food and Fluid Refusal detainees

3.7. In June 2020, the Office sent comments and suggestions under section 12(4) of the Ombudsman Act to the department concerning the decision-making process for transfers of vulnerable detainees who are on long term Food and Fluid Refusal.

3.8. Detainees on long term Food and Fluid Refusal (FFR) are among the most vulnerable in detention. It is critical that administrative processes to safeguard their wellbeing and safety are robust.

Case study

An investigation into the transfer of one detainee identified opportunities for improvement in the transfer decision-making process for long term FFR detainees. In that case, the involuntary transfer was intended to improve the detainee's long term FFR issues. However, it had the reverse effect and the detainee's health deteriorated because of the transfer away from his support networks.

We made 4 suggestions to the department which aimed to ensure:

- a more robust weighing of risk in decision making for transfers of FFR detainees,
- a commitment to adding FFR detainees to its list of 'vulnerable' detainees,
- greater involvement of the health provider (IHMS) in decisions to transfer people who are on FFR, and
- a specific follow up assessment to assess the impact of a transfer on an FFR detainee.

The department agreed to consider including FFR detainees on its list of 'vulnerable' detainees. This is positive as a 'vulnerable' status triggers a range of appropriate safeguards with transfer and other internal processes.

The department's view in relation to our other suggestions was that its existing policies were sufficient and no further changes to policy were warranted.

3.9. The department's current policies are designed to assess whether a person is 'fit to travel', however this is not qualitatively the same as assessing the potential impact of a transfer on a vulnerable detainee. Fitness to Travel forms do not ask for IHMS input on the likely impact of transfer or issues associated with continuity of care.

3.10. Similarly, while the department may consult IHMS as part of its Detention Placement Assessment (DPA), the DPA form does not clearly prompt the decision maker to weigh and record all the factors for and against transfer of a vulnerable detainee.

3.11. In addition to ongoing regular monitoring of FFR detainees, we think it is reasonable for the department to conduct a follow up assessment to specifically consider the mental health impact of long term FFR transfers, particularly if the primary reason for the transfer was to improve mental health, or the transfer was contrary to the wishes of the detainee. If the transfer has an adverse impact, prompt consideration should be given to whether a return or further transfer may be beneficial.

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 in immigration detention for more than 2 years, and every 6 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 an assessment of the circumstances of each person's detention, including any recommendations the Ombudsman considers appropriate. The Minister is required to table a de-identified copy of the assessment in Parliament within 15 sitting days of receiving it 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.[36] 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 aged care facility. Others are living in the community on a residence determination (under s 197AB of the Migration Act) 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.

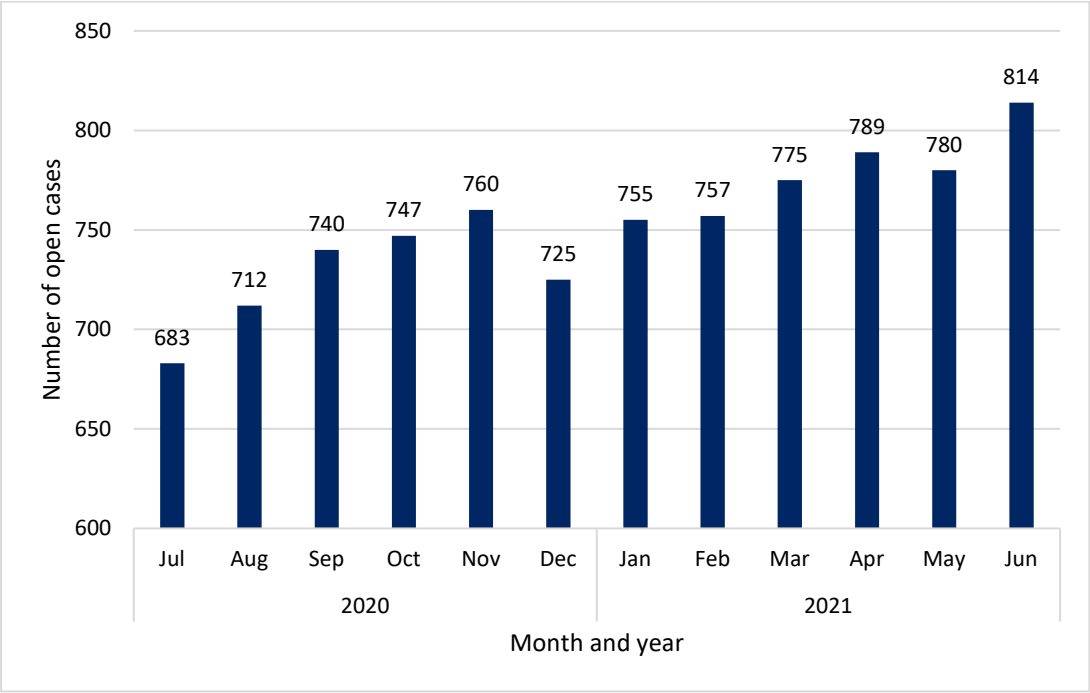
4.4. Between July 2020 and June 2021, we sent 787 assessments to the Minister. These assessments related to 1,372 people in immigration detention.

4.5. The Office's long-term detention caseload increased gradually in the reporting period, from 683 cases in July 2020 to 814 cases in June 2021, with an average caseload of 753 cases over the reporting period. One case may involve an individual detainee or a family group (multiple detainees). The increase in long-term detention cases is reflective of the fewer numbers of long-term detainees being removed from Australia due to travel restrictions imposed by COVID-19.

4.6. **Figure *5*** below shows the number of long-term detention cases each month for the reporting period.

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

Figure 5: Long-term detention caseload 2020–21



Assessments

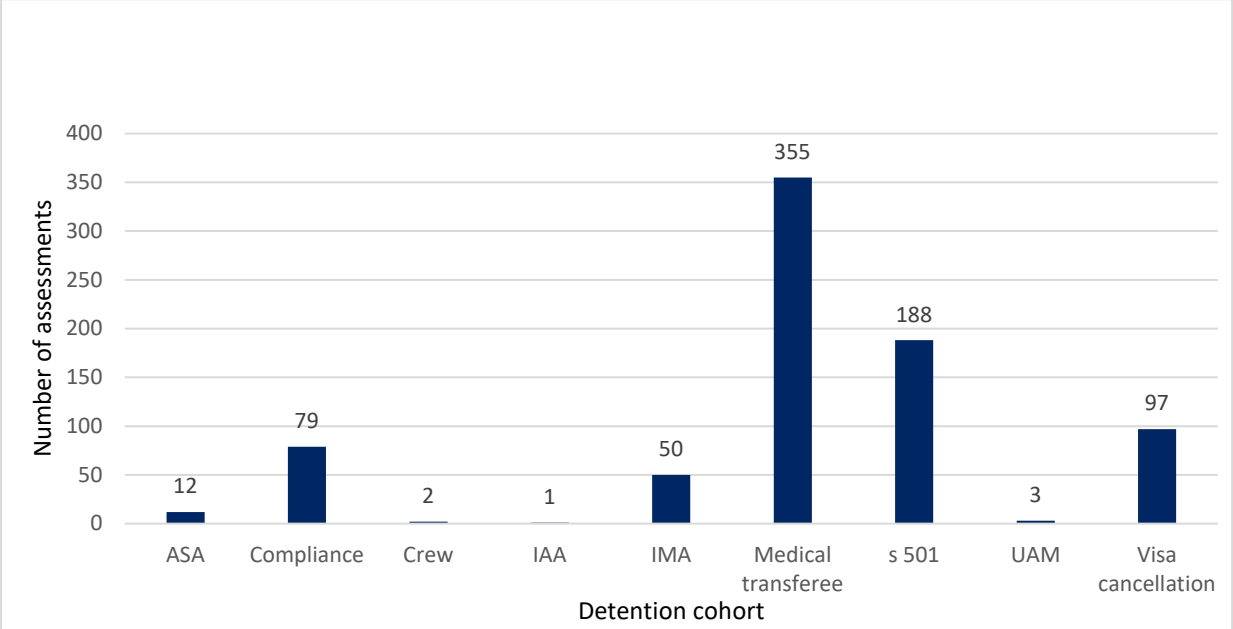
4.7. Generally, the first assessment for a detainee (arising when they are detained for 2 years) and assessments for people who are detained for multiple years are more complex. In each assessment we consider:

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

4.8. We also consider information provided by the person being reported on, their legal representatives, family, and advocates.

4.9. **Figure 6**, below, shows the broad cohorts of long-term detention cases for whom the Office completed an assessment during the reporting period.

Figure 6: Long term detention cohorts – assessments completed in the reporting period.



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 (character grounds)
UAM	Unaccompanied minor
Visa cancellation	Person whose visa is cancelled (other than under s 501 of the Migration Act)

Recommendations

4.10. Consistent with 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 the 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.

4.11. During the reporting period, the Ombudsman made 81 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.

4.12. The Ombudsman made 11 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, COVID-19 impacted moves between locations.

Persons facing the risk of indefinite detention

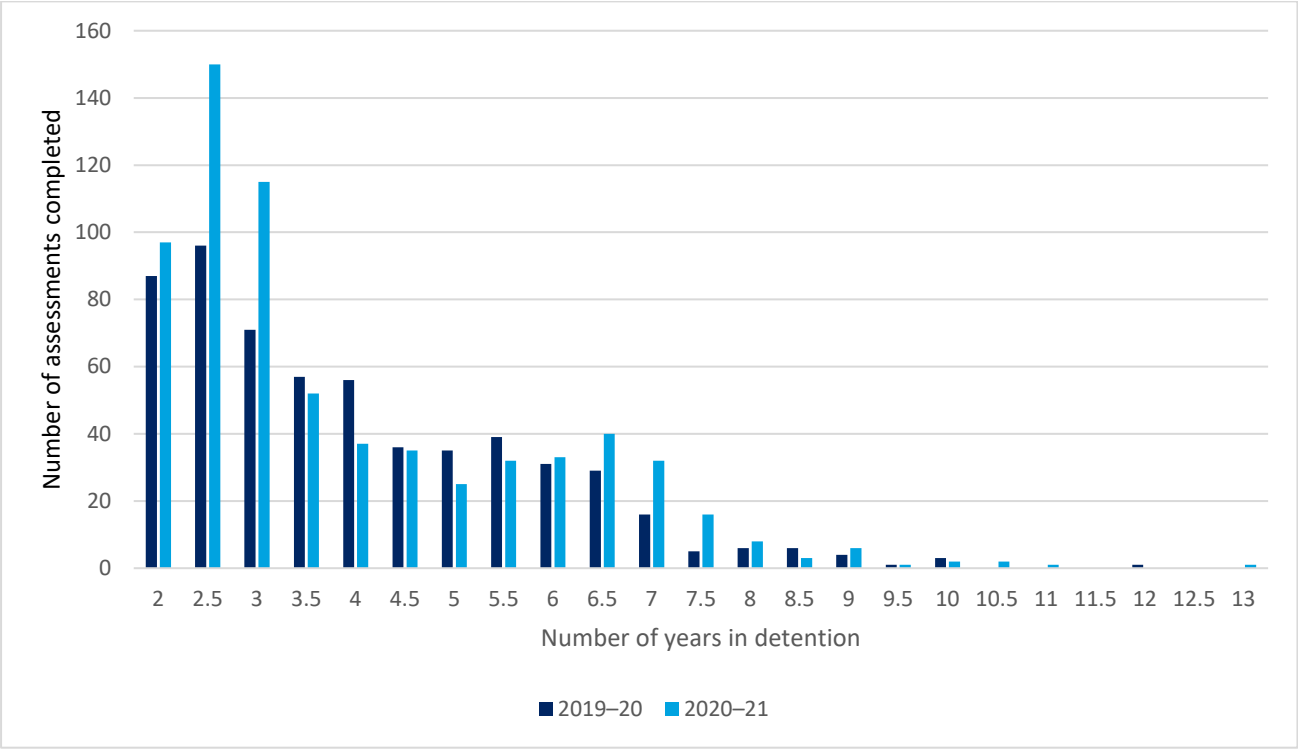
4.13. On 25 May 2021, the *Migration Amendment (Clarifying International Obligations for Removal) Act 2021* (the CIOR Act) commenced. The CIOR Act amended s 197C of the Migration Act to prevent unlawful non-citizens who engage Australia's protection obligations from being involuntarily removed. The Ombudsman is concerned these amendments may increase the risk of long-term or potentially indefinite detention, particularly for people assessed as engaging protection obligations but whose visa applications are refused or whose visas are cancelled.

4.14. At 30 June 2021, the Office identified 21 individuals in our long-term detention caseload as being potentially affected by this amendment and at risk of indefinite detention. All are found to engage Australia's *non-refoulement* obligations, but have a Protection visa application that is finally determined (refused) and they've exhausted all judicial review options. These individuals are prevented from lodging valid visa applications under the Migration Act and require Ministerial intervention to be granted a visa and released from detention.

4.15. Thirteen of these people have been in immigration detention for more than 5 years.

4.16. **Figure 7**, below, shows the time spent in detention for all people reported on during the reporting period. Comparative figures for the previous financial year are also included.

Figure 7: Time spent in detention for long-term detention cohort.



4.17. The Ombudsman is concerned about the significant risk prolonged or indefinite detention poses to a person's health and welfare. The Ombudsman is particularly concerned about the potential increase in detainees in prolonged or indefinite detention noting the upwards trends in overall numbers across the immigration detention network.

4.18. At 30 June 2021, there were 479 long-term detainees in held immigration detention, representing approximately 32 per cent of the overall detention population (1,492). This is a significant increase in the long-term detention cohort compared to 27 per cent of detainees in 2019 and 26 per cent in 2020.

4.19. Of the 479 long-term detainees, 114 detainees have been in held detention for more than 5 years.

4.20. The Office is also concerned that departmental forecasts indicate the long-term detainee cohort could rise to over 700 detainees by January 2022, representing almost 50 per cent of the detention cohort.

DETAINED AND RELEASED AS NOT UNLAWFUL

5.1. As part of an ongoing own motion investigation, the department provides the Office with a report about people who were detained on suspicion of being unlawful non-citizens and who were subsequently found to be not 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 impacting the quality of decision making.

5.2. This section provides a summary and analysis of the reports provided by the department to the Ombudsman for the periods 1 July to 31 December 2020 and 1 January to 30 June 2021.

1 July to 31 December 2020

5.3. Between 1 July and 31 December 2020 (the relevant period), 7 people were released from detention because the department no longer held a reasonable suspicion the individuals were unlawful non-citizens. This is the same number for the previous period, 1 January to 30 June 2020. While the average duration of inappropriate detention was 6.1 days in the first half of 2020, this decreased to 1.3 days in the relevant period. This is the lowest average time in inappropriate detention for a 6-month period since 2017.

5.4. The number of people detained inappropriately as a percentage of the total number of people detained on suspicion of being an unlawful non-citizen increased during the relevant period (0.97 per cent), when compared to the previous period (0.55 per cent). This is due to the significant decrease in the total number of people detained in the relevant period: 721 people were detained as suspected unlawful non-citizens, compared to 1,263 in the previous period.

5.5. Six of the seven cases of inappropriate detention in the relevant period were caused by administrative error in communication between the Minister's office and the department. In each of these cases, the Minister's decision to revoke cancellation of a non-citizen's visa was not communicated to the department until the following business day, delaying the release of the individual from immigration detention.

5.6. The other case of inappropriate detention was caused by departmental delay in responding to a notification from the AAT. In this case, the AAT notified the department of a decision to revoke cancellation of an individual's visa after normal business hours, however it was not viewed or acted upon by the relevant immigration detention centre until the following day.

5.7. In response to these cases, the department stated that Departmental Liaison Officers, relevant staff in the Minister's office and staff tasked with managing receipt and communication of tribunal decisions, were reminded of the need to ensure prompt notification of decisions affecting an individual's immigration status. The Office made suggestions to the department about further improvements to its policies and procedures for communication of decisions which impact a person's immigration status and acknowledges the steps taken by the department to implement continued improvements.

1 January to 30 June 2021

5.8. Between 1 January 2021 and 30 June 2021 (the relevant period), 6 people were released from detention because the department no longer held a reasonable suspicion the individuals were unlawful non-citizens. This is one less than the number of people released on this basis in the period 1 July 2020 and 31 December 2020 (the previous period). Overall, there is a downward trend over the last 4 years since a peak of 29 in 2017.

5.9. In the relevant period, the average length of time a person was held in inappropriate detention was 395 days. However, this figure is affected by one case where a person was inappropriately detained for 2,362 days. The remaining 5 cases in this period were resolved in 3 days or less.

5.10. The number of people detained inappropriately as a percentage of the total number of people detained on suspicion of being an unlawful non-citizen decreased during the relevant period (0.86 per cent) compared to the previous period (0.97 per cent) but was still higher than earlier periods. This is due to a decrease in the total number of people detained in the 2020–21 year relative to earlier periods. In the relevant period 694 people were detained as suspected unlawful non-citizens and 721 in July to December 2020, compared to 1,263 in January to June 2020. While the Office welcomes a decrease in the total number of detentions, we also expect to see a proportional decrease in the number of inappropriate detentions.

5.11. Five of the 6 cases of inappropriate detention in the relevant period were affected by administrative error. This includes one case where an 8-month-old child was inappropriately detained because the child incorrectly appeared as an unlawful non-citizen on departmental systems. The child was released later the same day, upon receipt of internal departmental advice confirming the child was the holder of a bridging visa from birth. The department reported it had updated operating procedures and quality assurance processes for children born in detention because of this case. The Office is seeking further information from the department to better understand the circumstances and may make suggestions to the department on preventing similar occurrences.

5.12. Another case was affected by a failure to identify an individual had an outstanding protection visa application and associated bridging visa and a failure to refer to the correct visa type in a separate visa refusal decision. The affected individual was detained inappropriately for 2,362 days. Although the department noted the case is affected by historical and complex changes to migration law, the Office is seeking further information from the department to understand how the department failed to identify the outstanding visa application and bridging visa, how the delegate came to use the incorrect visa type in the visa refusal decision and why these issues were not identified and addressed by the department sooner.

5.13. In a recurrence of issues identified in the previous period, one case each was affected by administrative error regarding communication between the Minister's office and the department, and the AAT and the department. One case was affected by a visa notification error following the individual's release from criminal custody.

5.14. For each of the cases identified, the department outlined remedial action it took to address the identified administrative deficiencies, including corrections to letter templates, improved quality assurance processes and ensuring that procedures, guidance and training for departmental staff and relevant staff in the AAT and Minister's office clearly articulate notification timeframes and the implications of not adhering to these.

5.15. While the Office observed that, overall, the department has improved policies and procedures over time, the inappropriate detention of lawful non-citizens continues to occur. There remains an important role for the Office to continue to monitor the issues identified in these cases to seek assurance that the controls implemented by the department are effective over time. The Office has sought further information from the department in relation to two cases reported this year and may make further suggestions to the department for improvements to address identified issues and mitigate the risk of further inappropriate detentions.

APPENDIX A: DEPARTMENT'S RESPONSE TO THE REPORT AND RECOMMENDATIONS

The Department of Home Affairs (the Department) welcomes the Commonwealth Ombudsman's Report *Monitoring Immigration Detention – The Ombudsman's activities in overseeing immigration detention: 1 July 2020 to 30 June 2021* (the Report).

The Department values the Commonwealth Ombudsman's oversight of immigration detention, and the observations made in this report regarding the Department's strategies in response to the COVID-19 pandemic and its adherence to the Department of Health Communicable Diseases Network Australia (CDNA) guidelines, which resulted in the absence of any COVID-19 positive cases among detainees for the reporting period.

The Department agrees with the majority of recommendations made in this report. The Department partially agrees with recommendation 3 and notes recommendations 2, 6, 11 and 13, and has provided responses indicating how those recommendations are already addressed through existing policies or procedures.

Implementation of Recommendations

The Department acknowledges the Ombudsman's analysis of the Department's progress against the recommendations from previous Monitoring Immigration Detention reports dating back to 2019, including that 21 recommendations continue to be monitored by the Office of the Commonwealth Ombudsman (the Office).

It is noted 7 of these previous recommendations are reiterated in recommendations or suggestions made within the July 2020 to June 2021 Report. Each of the 7 recommendations or suggestions are addressed in the Department's response below.

The Ombudsman's analysis reflects improvements observed during the July 2020 to June 2021 inspection period, as well as progress made by the Department. It is noted in some cases, up to 2 years has passed and further progress has been made, as the Department continues to progress and finalise the implementation of recommendations.

The Department notes the Ombudsman's concerns about recurring themes in the recommendations made since 2019, namely: reducing the number of people in immigration detention; the use of Alternative Places of Detention (APODs); and complaints management. The Department has addressed these themes in the below responses.

Reducing the number of people in immigration detention

The Department acknowledges the Ombudsman's concerns with the increase in detainee population across the Immigration Detention Network (IDN) and the impacts of prolonged immigration detention. The Department agrees with recommendation 1, and notes the Department continues to explore a range of measures aimed at addressing barriers to status resolution (including visa and return and removal pathways) and associated risks of long-term detention.

The Department has previously advised the Ombudsman of the use of the Community Protection Assessment Tool (CPAT), which is a decision support tool to assist in assessing the most appropriate placement (community placement or held immigration detention) of a

non-citizen while status resolution is pursued. The Department is currently reviewing the CPAT and will explore how the CPAT could give greater consideration to the nature of an individual's strengths and vulnerabilities when assessing community risk and how these factors may affect placement.

The Department has also previously advised the Ombudsman of its regular reviews, escalations and referral points to ensure people are detained in the most appropriate placement to manage their health and welfare, and to manage the resolution of their immigration status. The Department also maintains review mechanisms that regularly consider the necessity of detention and where appropriate, the identification of alternate means of detention or the grant of a visa, including through Ministerial Intervention.

The *Migration Act 1958* (the Migration Act) provides Home Affairs portfolio Ministers with personal intervention powers, allowing them to either grant a visa, or make a residence determination in respect of a person in immigration detention, if they think it is in the public interest to do so. These public interest powers are non-compellable, that is, the Ministers are not required to exercise their power. What is in the public interest is a matter for the Ministers to decide.

The Department also notes it remains open to individuals to end their detention by departing Australia voluntarily. Detainees who have no ongoing immigration processes and who will not cooperate with voluntary removal, are liable to be removed from Australia.

Detainees who have been in held detention for more than 2 years generally have complex case histories and significant barriers impeding the resolution of their immigration status. As outlined, the Department is aware of these barriers and continues to explore measures to address and resolve them where possible.

As a direct result of the COVID-19 pandemic, a significant proportion of international commercial flights were cancelled for an extended period in 2020 and 2021. For some countries, commercial flights as a whole were suspended indefinitely, and remain suspended or with significantly limited flight availability. Where commercial flights have resumed, or continue to operate, flight availability remains impacted by COVID-19 travel restrictions and border closures.

Whilst COVID-19 continues to impact removals, the Department continues to actively explore all avenues to remove unlawful non-citizens from Australia as soon as reasonably practicable, providing there are no legislative or administrative barriers to do so, and any logistical issues do not impact on removal viability e.g. availability of flights and escorts, border closures, or travel document issuance.

The Department has worked closely with State and Territory health departments and foreign governments to ensure overseas removal operations have continued throughout the pandemic, albeit at a lower rate than in pre COVID-19 times.

To enable the continued removal of high risk detainees, and overcome the limited availability of commercial flights, the Department has utilised chartered aircraft to continue operations during this period.

The Department aims to remove liable non-citizens from Australia at the completion of their custodial sentence with minimal or no accommodation in an immigration detention facility. The Department works closely with State and Territory correctional facilities to identify and

proactively engage with unlawful non-citizens prior to their release from prison, to facilitate this outcome.

There has been a considerable increase (50%) in the number of removals in 2022 since the same period in 2021. From January to April 2022, there were 429 removals conducted compared to 286 removals conducted in the corresponding period in 2021.

Use of High Care Accommodation for quarantine purposes

The Department notes recommendation 2 and considers no action is required, on the basis High Care Accommodation (HCA) is only used for medical quarantine placements in restricted circumstances (please see further detail below). In respect of recommendation 3, the Department partially agrees with this recommendation, and notes existing policies and procedures already exist for HCA and medical quarantine, which outline the different arrangements. As outlined below, differences across the immigration detention network require a level of flexibility within reason, which may be perceived as inconsistency.

The Department advises medical quarantine placement is for the exclusive purpose of managing COVID-19 risks to the health and safety of detainees and staff. Medical quarantine placement is not the same as HCA; however, rooms used for HCA have at times also been used for medical quarantine, depending on the risk posed by the detainee, along with capacity and other operational considerations.

Medical quarantine placements reflect current advice from the Department's Clinical Assurance Team and take into consideration the CDNA guidelines for the prevention, control and public health management of COVID-19 outbreaks in correctional and detention facilities in Australia. Additionally, in acknowledgement of varied COVID-19 responses and risks within each of the states as the pandemic has continued to evolve, strong engagement with the jurisdictional public health units continues to be relied upon for contemporary outbreak management planning, including quarantine arrangements.

While in medical quarantine, detainees have access to their phones and other devices, and can request access to a laptop, an online library of books, and activity packs. Departmental and Facility and Detention Service Provider (FDSP) staff have provided ongoing communication to detainees regarding this matter to alleviate any apprehension towards medical quarantine and to prevent the non-disclosure of symptoms to the Detention Health Service Provider (DHSP).

Where infrastructure and capacity allow, some immigration detention facilities (IDF) have converted entire compounds into quarantine areas. In these circumstances, the quarantine accommodation is similar to, or the same as the person's usual accommodation; including power points, bathroom, TVs and other standard comforts. These accommodation arrangements are utilised when operationally viable to do so.

The Department has existing policies, which outline the procedures and processes for HCA, and separately medical quarantine or isolation. These include:

- Closer supervision and engagement of high risk detainees (HCA) Standard Operating Procedure (SOP) DM-3301
- Closer supervision and engagement of high risk detainees (HCA) Procedural Instruction (PI) DM-626
- Communicable Diseases – Prevention and Management PI DM-5928 (Health Policy)
- Detention Health Screening and Management PI DM-6138 (Health Policy).

Quarantine arrangements sit separately to the HCA PI and SOPs. Efforts are made by the DSPs to ensure quarantine conditions are as least restrictive as possible, and include regular welfare and health checks and the provision of activity packs. Differences with IDF infrastructure, security, capacity and COVID-19 risks across the network require the ability for each IDF to respond flexibly to the individual circumstances applicable to their facility, of which is catered for in the procedural documents and operational notifications.

The Department has continued to review policies and procedures in relation to medical quarantine as the COVID-19 pandemic has evolved. Since 2020, the Department has released a number of Operational Notifications (ON) regarding medical quarantine/isolation, the majority of which have been superseded on more than one occasion to provide updated advice. The following ONs provide current advice:

- ON2020-35 Approving isolation placement arrangements for a detainee with COVID-19 in an immigration detention facility (IDF)
- ON2021-06 Offsite transport and escort of detainees in quarantine
- ON2021-23 Immigration detention COVID-19 quarantine placement arrangements for detainees transferred between IDF's
- ON2022-03 Updated immigration detention COVID-19 quarantine placement arrangements for detainees.

Safety and Security

The Department acknowledges the Ombudsman's concerns that allegations cannot be fully investigated in the absence of corroborative evidence being retained past the 28 day timeframe. The Department agrees with recommendation 4 and advises the departmental expectations under the policy documentation includes that all audio-visual (AV) records and other corporate records are held for a minimum of 28 days and at all time in line with the *Archives Act 1983.* As outlined below, steps have been taken by the Department to strengthen processes relating to retention of CCTV footage, and the Department considers existing policies and procedures are adequate. The Department considers this recommendation has been addressed.

The current PI provides records of certain events in IDFs ensure availability and continuity of evidence; incidents or situations are recorded as they occur; and the actions of all persons and detainees involved in an incident are recorded, so that any inappropriate activity can be acted upon as appropriate.

The importance of recording activities is referenced in policy documentation to ensure operational practices are adhered to and that the actions of individuals in the IDF are lawful, transparent and accountable. This requires that all officers are responsible for keeping comprehensive, authentic and reliable records that support and evidence sound decision making.

Given the high risk nature of many activities undertaken by the FDSP, and the reliance on recordings for internal and external scrutiny, the Department issued a Network Communication to ABF IDN personnel across all sites on 10 January 2022 to strengthen these processes and establish enhanced assurance processes for audio-visual recording. This includes the tracking of failures and tracking findings from other reviews, which relate to failure of AV recordings. This provides enhanced oversight of the Post Incident Review (PIR) auditing process and calls out the

relevant FDSP contractual obligations under *Performance Measure 3.6 – Implementation of Recommendations from Post Incident Review*.

Records made by the Department and its contracted service providers are Commonwealth records, and are managed in accordance with *Records Management Policy – Practice Statement (TI-1094)* and the *Archives Act 1983*. Procedures and instructions on the use of AV equipment to record particular events, actions and/or incidents occurring in immigration detention facilities, and during transport and escort tasks, are contained in the following policy documents:

- DM-3300 Detention Services Manual – Safety and security management – Audio-visual recording
- DM-614 Detention Services Manual – Safety and security management – Audio-visual recording

Programs and Activities

The Department acknowledges the Ombudsman's observations made on the Programs and Activities (P&A) within immigration detention facilities, specifically at North West Point Immigration Detention Centre (NWPIDC). The Department agrees with recommendation 5, and has noted recommendation 6. The Department notes the following work undertaken with the FDSP to make ongoing improvements to the P&A schedule, and that P&A offered at NWPIDC are proportional with those offered at other facilities. In respect of recommendation 6, the Department notes a range of P&A is provided to detainees at NWPIDC, and detainees can spend up to eight hours per day outside of their accommodation.

The Department and the FDSP jointly develop programs and activities (P&A) on a monthly basis, for the purpose of supporting detainee health and well-being. As part of the joint monthly development of the P&A schedule, the Department can confirm the frequency of held structured and unstructured P&A on NWPIDC is commensurate with P&A provided at facilities on the mainland.

The P&A schedule provides structured and unstructured programs that meet a range of detainee needs taking into consideration gender, culture, ability, age and other demographics. Examples of offerings within the P&A include life skills, English language courses, sporting and vocational activities. Depending on the structured and unstructured activity being undertaken determines whether it is held within an accommodation compound or within dedicated recreational and educational areas including the Greenheart area. Of note, gym access is now available to detainees seven days a week.

Engagement with detainees through Individual Management and Detainee Consultative Committees continues to occur, which cover a range of matters including P&A. Feedback is fed into developing the monthly P&A schedule.

In the accommodation compound at NWPIDC, P&A including low impact sports and art and crafts have been offered to detainees and has received good attendance. The NWPIDC Service Delivery team continue to work with Serco to explore further opportunities to enhance P&A within the accommodation compound, to reflect the needs to detainees in line with relevant security and risk profiles of detainees placed at NWPIDC.

The relevant procedural instructions for P&A are:

- DM-607 Detention Services Manual – Programs and activities – Programs and activities

- DM-3271 Standard Operating Procedure – Detention Services Manual – Programs and activities – Programs and activities

DM-607 defines the broad expectations for implementation under the outcomes based FDSP Contract as:

- Detainee-focused, targeted and flexible activities.
- Providing opportunities for detainees to maintain a level of self-agency and offer opportunities that will assist in the future integration and participation of detainees in society.
- Of consistent quality and quantity regardless of locality.
- Responsive to the changing needs of differing detainee cohorts.

Currently, detainees at NWPIDC are allowed 2 hours per day in the dedicated recreational and educational areas (i.e. the Greenheart area). Detainees are provided with additional access to the Greenheart area when participating in inter-compound sports and other educational or recreational programs and activities. Depending on which programs and activities a detainee chooses to participate in, a detainee could have up to 8 hours per day outside of their accommodation compound.

Removal Officers at NWPIDC

The Department recognises the importance of regular engagement with detainees at NWPIDC to ensure timely provision of removal information, and to support the Department's legal obligations to progress removal of unlawful non-citizens as soon as reasonably practicable. The Department agrees with recommendation 7, and notes steps have been taken to increase engagement for detainees at NWPIDC with Removals officers.

Throughout 2021, the Department increased the frequency of attendance by ABF Removals staff to the extent Removals staff have been continuously present at NWPIDC since September 2021. The Department is currently pursuing internal recruitment processes to ensure a pool of officers are available to deliver an ongoing presence, enabling regular Removal staff engagement with detainees at NWPIDC.

Medical

The Department acknowledges the Ombudsman's observations that specialised drug and alcohol staff and specialised torture and trauma services are made accessible to support detainees at NWPIDC. The Department agrees with recommendations 8 and 9. The Department confirms the DHSP currently provides drug and alcohol (D&A) services to detainees at NWPIDC, centred on a harm reduction framework. The Department can confirm discussions have commenced with IHMS to scope a comprehensive D&A service to deliver care across the entire IDN. Further, delivery of such services will be a consideration in the future detention procurement process.

While there are no specific D&A clinicians present on NWPIDC, this service is undertaken through a primary health approach, coordinated by the General Practitioner and supported by a multi-disciplined team of registered nurses, mental health nurses, counsellors and psychologists. All detainees have access to specialists where required via referral, in line with Australian community standards.

The scope of D&A services currently provided at NWPIDC include induction D&A screening, management of intoxication, withdrawal management, nicotine replacement therapy (NRT), psychosocial services and health promotional activities.

The DHSP, who are responsible for mental health care and support services, have sub-contracting arrangements with service providers at NWPIDC who are members of the Forum of Australian Services for Survivors of Torture and Trauma (FASSTT), which is the peak body for torture and trauma rehabilitation in Australia.

Sub-contracted support services are delivered by general practitioners, mental health nurses, psychologists, counsellors and psychiatrists, and are available to all detainees. These services are available by telehealth, when torture and trauma services are unable to be provided in person at NWPIDC.

Security and Safety at North West Point IDC

The Department welcomes the Ombudsman's observations that body worn cameras should be available, operative and in use at NWPIDC. The Department agrees with recommendation 10, and has already taken steps to address this recommendation. The Department confirms FDSP staff have access to and wear body-worn cameras that are in good working order.

The FDSP have advised new cameras are being rolled out to all Emergency Response Team and Transport and Escort staff. Technical issues with internet bandwidth unique to the NWPIDC site and location have now been resolved.

Phosphate Hill APOD

The Department notes recommendation 11. Phosphate Hill APOD was placed into hot contingency on 18 June 2021 and has not been used to hold detainees since that date. The site will remain available for use based on operational needs. The Department continues to maintain the site, and will undertake site assessments and rectification works as needed should the site required operational use.

Conclusion on Use of APODS

The Department agrees to recommendation 12, noting such programs, activities and services are available across the immigration detention network, but may not be site specific.

A range of structured and unstructured social, recreational and educational activities, as well as medical and welfare services are available to detainees in all IDFs, including APODs. Considering the diverse range of APODs (which may include hotel accommodation, hospitals, aged care or in-patient mental health facilities), on-site services are tailored according to detainee circumstances, site infrastructure, and the ability to transfer detainees to nearby IDFs to regularly access services.

The Department notes recommendation 13, and highlights the requirement to manage placement and accommodation decisions on a case-by-case basis. Where appropriate, detainees may be placed in hotel APODs rather than inside an IDF.

The length of time a detainee remains in an APOD depends on many considerations relating to the individual detainee and the immigration detention network. Decisions in relation to appropriate detainee placements are undertaken after careful consideration of a number of factors, including the operational capacity of each facility and the need to ensure the safety and

security of all detainees in immigration detention. In considering the placement of an individual, the safety and good order of the broader immigration detention network is also considered. Detainee placement within the network is continuously reviewed and assessed.

Tier 4 placement in criminal detention

The Department acknowledges the Ombudsman's concerns relating to the implementation of Memorandum of Understandings (MoUs) with State and Territory correctional services. The Department agrees with recommendation 14, and advises action has commenced to address this recommendation. The Department agrees to recommendation 15, and will raise this for consideration in the MoU negotiation processes outlined below.

In 2021, a section was established under the Detention Contracts Management Unit to assist in the development of MoUs with States and Territories. The section is responsible for administering and maintaining immigration detention related bi-partite and tri-partite MoUs, including for correctional services.

Negotiations have commenced with State and Territory correctional services to establish MoUs for the purpose of holding immigration detainees under the Migration Act within correctional facilities. These MoUs will outline the responsibilities between both organisations including the care and management of detainees.

The Department notes negotiations with the various State and Territory correctional services have been protracted over multiple years. To continue services for Tier 4 (specialised detention) placements until MoUs have been finalised, various pieces of correspondence between the Department and correctional facilities have been sent, outlining roles and responsibilities, information sharing and indemnity liability. The Department is committed to finalising MoUs in relation to correctional services, where state based legislation allows.

Temporary placement in correctional facilities may be required in circumstances where a detainee is considered to pose a significant risk to the good order and security of the immigration detention network. Placements in correctional facilities under immigration detention provisions are undertaken where there is an inability to manage these detainees in an IDF, rather than for punitive reasons.

In respect of recommendation 15, the ability to contact an external organisation such as the Commonwealth Ombudsman is regulated by each State and Territory Correctional Service. Therefore, the Department has no authority to ensure detainees' ability to access private communications. The Department agrees to include this recommendation in our negotiations with the State and Territory correctional services, for their consideration of inclusion in the MoUs.

Use of force (planned), pat searches – movements

The Department agrees with recommendation 16. Departmental policy and procedural settings remain that the searching of detainees and use of force, including instruments of restraint, is conducted on a basis of documented risk assessments and information outlined in the requests from the FDSP for planned use of force.

Screening procedures are undertaken to address safety and security risks posed where detainees have in their possession a weapon or means of escape. As these processes are conducted, detainees are advised of the reason they are being screened, so they understand the requirement for the screening procedure and the authorised officer's power.

Under policy, use of mechanical restraints during transport under escort is not a default setting, rather there is a presumption against the use of force for transport and escorting of detainees. If deemed necessary, mechanical restraints should only be used as a measure of last resort to:

- prevent the detainee inflicting self-injury;
- prevent injury to others;
- prevent escape;
- prevent destruction of property; and
- for the shortest amount of time possible to the extent that it is both lawfully and reasonably necessary.

Under policy, use of force and/or restraints must not include cruel, inhumane or degrading treatments, or be used for the purposes of punishment. Screening, searching and use of force policies are as follows:

- DM-619 Detention Services Manual – Safety and security management – Screening and searching of detainees and their property
- DM-3289 Detention Services Manual – Safety and security management – Screening and searching of detainees and their property
- DM-3291 DSM – Safety and Security Management – Use of force
- DM-623 Detention Services Manual – Safety and security management – Use of force

Access to internal complaints process

The Department is pleased the Ombudsman is satisfied detainees have appropriate access to external complaint and oversight bodies. The Department welcomes the Ombudsman's observation that detainees have free access to complaint forms in communal areas, and the ability to lodge complaints anonymously at all facilities visited, except Yongah Hill IDC.

The Department agrees with recommendation 17, and confirms complaint forms are now available to detainees in common areas in all facilities, including Yongah Hill IDC. The Department considers this recommendation to be addressed.

Reporting on Long-term Detention

The Department welcomes the reporting on long-term detention included at Part 4 of the report, and acknowledges the importance of the Ombudsman's independent review into the detention arrangements of persons who have been in detention for a period of two years or more. As noted earlier in the response, the Department regularly reviews detention cases, and the section 486O process provides further independent scrutiny.

The Department values the strong relationship with the Ombudsman's Office. The Department is committed to sustaining this relationship, to the effective delivery of the section 486N reporting obligations and to working collaboratively with the Ombudsman's Office to support the independent assurance the section 486O assessments provide.

In preparing the section 486O assessments, the Ombudsman's Office considers information provided by the Department to the Commonwealth Ombudsman under section 486N of the Act as well as information provided by the detainee, their legal representatives, family and advocates.

The Department notes the statistics on recommendations made in connection with the section 486O assessments, in particular, those relating to delays in the case progression of people in long-term detention. The case progression of long-term detainees and related decision making are complex, and as outlined in relation to recommendation 1, the Department continues to explore a range of measures aimed at addressing barriers to status resolution (including visa and return and removal pathways) and associated risks of long-term detention.

Detained and Released as Not Unlawful

The Department welcomes the Ombudsman's continued oversight and suggestions for further improvements to address identified issues and mitigate the risk of further inappropriate detentions.

On 13 April 2022, the Department provided the Ombudsman's Office with additional information in relation to 2 cases from the 1 January – 30 June 2021 reporting period. The response included further remedial actions the Department has implemented to address the issues outlined in these 2 cases and prevent re-occurrence.

The Department refers to the Ombudsman's observations at 5.11. The Department has commenced a range of corrective actions concerning the management of babies born to parents in residence determination arrangements. These remedial actions include revising policies and procedures, and providing consistent advice and support to Status Resolution Officers managing this cohort.

The Department refers to the Ombudsman's observations at 5.12 and acknowledges the circumstances that led to this individual's inappropriate detention. The Department has advised the Ombudsman that this case was considered unique and distinguishable from that of the contemporary departmental caseload. No similar cases have come to the Department's attention.

Since this individual's detention, the Department has implemented a range of measures to further safeguard lawful and appropriate detention decision-making, and mitigate associated risks. The *Reasonable Suspicion Framework* and *Status Tool* are now used by Status Resolution Officers for non-citizens in immigration detention. The *Status Tool* has become the effective detention review and status assessment mechanism to document the evidence base for the detaining officer's state of mind from the initial detention review (initiated within 2 business days of a person's detention), until the end of a person's detention (visa grant or departure from Australia). Status Resolution Officers review the *Status Tool* monthly (or by exception as required) and conduct an evidence-based assessment on whether reasonable suspicion the person is an unlawful non-citizen is maintained.

The Department has commenced work aimed at analysing corrective actions identified through inappropriate detentions reported to the Ombudsman since 2018. The purpose of this analysis is to assess their effectiveness in mitigating similar errors occurring. This analysis will also focus on identifying systemic or recurring trends across cases where further corrective actions or investigation may be required. This additional analysis will form part of the next report to the Ombudsman (January-June 2022).

Summary of Recommendations

1 July 2020 to 30 June 2021

Recommendation #	Status
1	Agreed
2	Noted
3	Partially agreed
4	Agreed
5	Agreed
6	Noted
7	Agreed
8	Agreed
9	Agreed
10	Agreed
11	Noted
12	Agreed
13	Noted
14	Agreed
15	Agreed
16	Agreed
17	Agreed

APPENDIX B: DEPARTMENT'S RESPONSE TO SUGGESTIONS

Monitoring Immigration Detention 1 July 2020 to 30 June 2021 – Department of Home Affairs responses to suggestions
Suggestion 1 - The Office suggests the following should be considered for inclusion in the High Care Accommodation (HCA) policy: • **Consideration of a higher authorisation level for the use of HCA for quarantine purposes.** • **Specify that detainees are to be provided with open air access for at least one hour daily, and access to outdoor exercise where possible.** • **Specify that detainees are to be provided with personal effects.** • **Specify that CCTV cameras are to be covered and detainees reassured of their privacy during quarantine placement in HCA.** • **Specify that detainees are to be provided with activities and entertainment.** • **Specify that detainees are to be provided with meaningful human contact every day, noting that meaningful human contact can take a variety of forms and does not need to be in-person contact.** • **Specify that detainees are to be provided with mental health and social support services during their quarantine placement in HCA.** The Department advises that while it may have used accommodation designed for use as HCA placement, the use of HCA for quarantine purposes is not managed under HCA settings, rather it is used to provide an appropriate placement for quarantine. The procedural advice on Closer Supervision and Engagement excludes "the placement of detainees in accommodation arrangements for health reasons such as medical and quarantine". Determining quarantine placements, including the decision to utilise HCA for quarantine purposes, is made with collaborative input from the Detention Service Providers. Specifically, under Operational Notice 2022-03 *Updated immigration detention COVID-19 quarantine placement arrangements for detainees*: "When making quarantine placement decisions, Serco is required to consult with IHMS to obtain their clinical advice regarding any mental or physical health considerations prior to determining the appropriate accommodation location for a particular detainee. Detainee health and wellbeing is a priority consideration, however, the placement also remains subject to capacity, available infrastructure, safety, security and good order of the centre for all detainees and staff." This placement process also applies to quarantine placements within HCA and the intent to mitigate transmission of COVID-19 within the facility. While a detainee is maintained in quarantine, under policy, there is the expectation that detainees are afforded access to their property in line with the established procedures for management of detainee property, acknowledging at times operational decisions may be made on an individual basis to manage risks and other operational considerations on a case-by-case basis. This same expectation applies to the provision of activities and entertainment whilst in quarantine, with the Facilities Detention Service Provider (FDSP) providing activity packs and material to keep detainees mentally active while in quarantine. The Detention Health Service Provider (DHSP) conducts regular checks and monitors detainees' health and wellbeing while in quarantine, along with daily checks conducted by the FDSP.
Suggestion 2 - The Office suggests the department consider developing Outbreak Management Plans (OMP) for specific Alternative Places of Detention (APODs), particularly the larger APODs like the Park Hotel. The Department advises in the past, some larger APODs did have an Outbreak Management Plan (OMP) specific to that site, while others were included within the relevant Immigration Detention Facility (IDF) in that State. OMPs are currently undergoing an update to be site specific, clinically led, succinct and incorporating lessons learnt.

Suggestion 3 - The Office suggests the department continue to ensure the best interests of the child is a primary consideration when placing detainees in the immigration detention network, particularly at North West Point IDC noting the remote locality of the facility.

The Department complies with the *United Nations Convention on the Rights of the Child*. When making decisions concerning children, the Department considers the best interests of children as a primary consideration. This includes cases which may indirectly affect children, including placement decisions regarding detainees who have children in the community.

If a child and/or their family are detained, it is a priority to accommodate them in the least restrictive form of appropriate accommodation and maintain the integrity and function of the family unit.

Suggestion 4 - The Office suggests the department ensures the detainees at North West Point IDC are provided adequate supports and access to internet enabled computers to facilitate regular engagement with legal representatives in private, including the ability to print, scan and email documentation

The Department advises all detainees at North West Point IDC are provided with fair and reasonable access to telecommunications and mail services, including landline phones, internet enabled computers, printers and scanners. Detainees at all IDFs are detainees are legally permitted to possess mobile phones.

The ABF has installed a high-speed fibre optic Wi-Fi internet service at NWPIDC, which is readily accessible to detainees on their personal devices in common areas and accommodation blocks within all compounds. This Wi-Fi internet service can support video calls and streaming in high definition. As a fibre optic connection, the service is not affected by weather. The ABF and Facilities and Detainees Service Provider regularly engage with detainees to address any identified connectivity issues.

Suggestion 5 - The Office suggests the department reconsider placing detainees with ongoing legal proceedings at North West Point IDC to ensure appropriate access to legal support and representation.

As there is finite capacity in each of the ABF's IDFs, there is often an operational need to transfer detainees to rebalance the immigration detention network. Prior to any transfers occurring, consultation with stakeholders, including the Department's litigation area, are completed to ensure detainees who have ongoing litigation or criminal court proceeding are suitable for transfer. Where a detainee is required to attend a matter in person, the Department ensures attendance is facilitated.

Suggestion 6 - The Office suggests the department consider rostering IHMS staff onsite at North West Point IDC 24 hours a day, 7 days a week, to provide appropriate medical support to detainees and staff at the facility.

The Department advises the DHSP provides primary health care commensurate with services available in the Australian community. After hours care is facilitated via a combination of telehealth (through the Health Advisory Service) and emergency options with the Christmas Island Hospital via a Memorandum of Understanding.

Suggestion 7 - The Office suggests that detainees with medical needs or risks that are not able to be managed on Christmas Island should not be placed at North West Point IDC.

The Department advises prior to the transfer of any detainee, including to North West Point IDC on Christmas Island, a Fit to Travel (FTT) assessment is conducted by the DHSP. Detainees who are deemed not fit to travel, or who are clinically assessed by IHMS as not suitable for placement at North West point IDC on Christmas Island, are not transferred.

Suggestion 8 - Given Christmas Island's isolation and limited capacity to manage a COVID-19 outbreak, the Office is concerned about 'at risk' detainees who remain at North West Point IDC and suggests the department consider alternative placement options.

The Department advises detainees are assessed on a regular basis by the DHSP in relation to their risk of COVID-19, in line with the Communicable Diseases Network Australia (CDNA) Guidelines. Detainees who are clinically assessed as being at highest risk from COVID-19 are not considered suitable for placement at NWPIDC and are identified for alternative placement options within the Immigration Detention Network.

Suggestion 9 - The Office suggests the department consider establishing a policy, setting out the minimum acceptable standard for conditions in accommodation compounds at immigration detention facilities, having regard to minimum safety standards for staff and detainees and further ensuring the rights and dignity of detainees is respected.
The Department notes the suggestion, and advises the provided immigration detention infrastructure is approved by the Commonwealth Public Works Committee and in conformance with regulatory standards. The Facility and Detainee Services Contract sets out the service delivery standards that must at a minimum address the management of the facility, and the provision of garrison, security and related services. Additionally, the suite of departmental detention operation policy documents set the standards within the detention environment, addressing the rights and dignity of detainees.

Suggestion 10 - The Office suggests the department ensure that our oversight role and ability to inspect places of detention, is referenced when drafting MoUs with state and territory correctional services.
The Department advises MoUs with state and territory correctional services are in the process of negotiations, and this suggestion will be considered through that process.

Suggestion 11 - The Office suggests the ABF to work with Serco at Melbourne ITA to mitigate the risk of errors in planned use of force requests.
The Department advises this already occurs on a daily basis. ABF is working with the FDSP to ensure individual risk assessments are undertaken for detainees and specific activities or escorts.

Suggestion 12 - The Office suggests ABF decision makers consistently record reasons for their decision when approving the use of mechanical restraints against the advice of IHMS.
The Department advises ABF officers endorse FDSP proposals to apply mechanical restraints, based on the advice and technical expertise of both the FDSP and DHSP. The established approval process includes Facility Superintendents documenting their decisions regarding mechanical restraints after assessment of the mechanical restraint risk assessments provided by the FDSP and DHSP.

Suggestion 13 - The Office suggests the department apply a consistent decision-making framework across all centres in the network. Among other matters this framework should require the recording and retention of sufficient information to demonstrate how and why delegates made their decisions.
The Department advises the Detainee Service Manual (DSM), which covers key themes, spilt into individual procedural documents and standard operating procedures, forms the consistent guidelines for ABF officers and detention service providers. Relevant record keeping expectations are also outlined within each individual procedural document.

Suggestion 14 - The Office suggests the department ensure IHMS conducts timely mental health reviews of at-risk detainees as a priority to avoid potentially unnecessary extended placements in High Care Accommodation, and to ensure appropriate medical supports are in place.

The Department advises upon entry into Immigration Detention, detainees undergo Mental health screening and assessment which is comprised of the following processes:

- preliminary mental health screening;
- comprehensive mental health assessment, undertaken within 10-30 days of arrival to an IDF;
- scheduled and triggered mental health re-screenings; and
- specialist clinical assessment, as required.

After initial mental health screening and assessment, detainees undergo scheduled mental health re-screening at six months, 12 months, 18 months and then at three monthly intervals thereafter. At 18 months, the DHSP offers a comprehensive assessment by a psychiatrist.

The Department has a number of policy documents that provide guidance for preventing and managing incidents of self-harm for individuals in immigration detention facilities and residence determination. The *Mental Health Procedural Instruction* (PI) and the *Responding to self-harm Standard Operating Procedure* (SOP) provide detailed information in relation to mental health reviews for at-risk detainees. Additionally, the *Suicide Prevention Framework in Immigration*

Detention Facilities Policy Statement aims to enhance existing measures in place to respond to threatened and risks of suicide among individuals in IDFs, and also explores new strategies to reduce the rates of suicidality.

As outlined in section 4.5 of the *Mental Health PI*, the Psychological Support Program (PSP) provides an overarching framework for clinically recommended approaches to identifying and supporting detainees who are at risk of self-harm and suicide. All detainees are placed on the PSP, which commences at reception and continues as long as a detainee remains in detention. The program is managed on a day-to-day basis by the Supportive Monitoring and Engagement (SME) review team, led by a senior mental health clinician from the DHSP and supported by representatives from the FDSP and the Department.

The SME is a component of the PSP and details the different risk levels (with corresponding monitoring and engagement requirements) for managing detainees identified as being at risk of self-harm or suicide. SME is an extension of the engagement that occurs on a daily basis between staff and detainees in immigration detention. SME aims to support detainees who may be vulnerable and in need of additional positive engagement. The risk of self-harm must be reassessed by the DHSP as required by the circumstances of the individual detainee. The outcome of any risk reassessment should be discussed and agreed to by all stakeholders at the daily SME review meeting. As per the *Responding to self-harm SOP*, when self-harm or suicide concerns arise, in the absence of a mental health clinician, the FDSP (and departmental staff, if appropriate) should immediately commence the *Keep SAFE* process and notify the DHSP as soon as reasonably practicable.

Relevant policy documents include:

- Responding to self-harm – Standard Operating Procedure (DM-3283)
- Suicide Prevention Framework – Immigration Detention facilities - Policy Statement (HR-4893)
- Mental Health Procedural Instruction (DM-6320)
- Closer supervision and engagement of high-risk detainees (High care accommodation) Procedural Instruction (DM-626)

The *Closer supervision PI* provides guidance on the use of closer supervision and engagement and high-care accommodation (HCA) for high-risk detainees. Under this policy, the provision of DHSP medical and mental health support is assessed, detailed and incorporated into the appropriate management planning for the detainee. In addition, HCA request forms have recently been updated including a requirement for input from the DHSP, which informs the delegate responsible for deciding on the placement.

The *Mental Health PI* is currently undergoing a comprehensive review, due to be finalised by October 2022. A comprehensive review of the *Responding to Self-Harm* SOP has also commenced and is expected to be finalised by November 2022. Noting suggestion 14 of the Ombudsman's report, the Department will consider appropriate wording to ensure potentially unnecessary extended placements in HCA, and to ensure appropriate medical supports are in place.

Suggestion 15 - The Office suggests the department re-iterates to immigration detention facilities that placing a detainee in High Care Accommodation needs the establishment of a clear plan for the detainee's management including an exit plan in accordance with departmental policy.

The Department advises the HCA template introduced to capture the detainee management plan is currently being reviewed, with feedback being sought from the relevant DSPs and Immigration Detention Network to assess its usability. This template has a requirement for stakeholders to include management plans for the detainee whilst in HCA. There are clear expectations on stakeholder input for Superintendent consideration when either approving an HCA request or exiting HCA, and whether HCA objectives have been met and placement/reintegration has been considered.

HCA cessation is now approved by the ABF Superintendent, which gives more visibility over an exit strategy, if one is required. In some immigration detention facilities, a gradual reduction of monitoring and support is applied when a detainee is removed from HCA, as required.

Suggestion 16 - The Office suggests the department consider a mechanism for notifying legal representatives of transfers of their clients within a reasonable timeframe. The Department advises all detainees are able to contact their legal representatives to inform them of their location via their personal devices, or on the provided telephones at each IDF. This can occur when they are notified of the inter-facility transfer (if advance notification is operationally viable), or on arrival to the new facility.
Suggestion 17 - The Office suggests the department ensure any removal of mobile phones from detainees occurs for the minimum time necessary to ensure compliance with aviation security regulations. The Department advises to preserve the integrity of detainee property processing, the personal effects normally retained 'in possession' are co-located with the property of the detainee being transferred. This reduces the risk of loss or damage to personal effects and reduces risks to of breaches to aviation safety requirements in the air. The IDF's make every effort to ensure the removal of mobile phones occur as late in the transfer process as possible, and for the minimum possible time.
Suggestion 18 - The Office further suggests that, where phone confiscation is both necessary and legally supported, arrangements are in place to allow detainees to communicate promptly with family and legal representatives before and after transfer. The Department advises under policy, mobile telephones and other personal electronic devices normally held 'in possession' by detainees are provided as soon as reasonably practicable following completion of property processing functions at the place of arrival. Where this is not immediately available due to logistical or other delays, fixed line and personal computer facilities are accessible subject to availability.
Suggestion 19 (refer 2.415) The Office considers the complaints quality assurance processes in place at Melbourne ITA a good practice and suggests similar practices be implemented at all facilities across the network. The Department welcomes the Office's feedback that the complaints quality assurance processes in place at the Melbourne ITA is good practice. The Department will continue to work with service providers to ensure they provide a high level of quality in the investigation of complaints and responses to complainants, in accordance with contractual requirements.
Suggestion 20 - The Office suggests the department consider expanding the availability of self-directed development programs to all detainees across the immigration detention. The Department advises unstructured activities (which include self-directed development programs) continue to be developed on a monthly basis as part of the programs and activities schedule, taking detainee feedback into consideration. More information is provided in response to recommendations five and six.

APPENDIX C

Implementation of recommendations from 1 July 2020 Ombudsman Statement			
Recommendation	Department response	Assessment of action taken	Need for further action
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.	The department previously advised they have addressed any ambiguity in the Notice and established further assurance and audit processes.	Overall, the Office was broadly satisfied with the screening mechanisms in place across the IDN.	Implemented. No further action required at this stage.
Recommendation 2: The Ombudsman recommends the Department implements an assurance program, to monitor its staff and contracted service providers' compliance with Outbreak Management Plans, operational notifications and provide guidance on areas for improvement.	The department previously advised the ABF will continue to monitor and adjust its COVID-19 response arrangements to the prevailing advice provided through CDNA guidelines.	The Office was pleased to observe that each facility maintained an Outbreak Management Plans in accordance with the CDNA Guidelines which regularly updated consistent with local health authority advice. However, the Office notes that OMPs were not developed or in place for APODs. The department advised that APODs are governed by the Outbreak Management Plan in place for the IDC/ITA in the same location.	The Office suggests the department consider developing Outbreak Management plans for APODs, especially for the larger ones. (Suggestion 2 of this report).

Recommendation	Department response	Assessment of action taken	Need for further action
Recommendation 3: The Ombudsman recommends the department works with the relevant ministers to reduce the numbers of people in held 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.	The department previously advised it is continuing to assess cases against the Ministerial Intervention guidelines. The Ministerial Intervention powers are non-compellable, meaning portfolio Ministers are under no obligation to exercise or to consider exercising these powers in any case.	During this inspection cycle the Office noted the increased use of APODs and the reopening of North West Point IDC on Christmas Island to provide capacity relief however, as our report details, we consider this approach does not meet the intention of this recommendation and moreover we are concerned with the appropriateness of these facilities.	The Office recommends the department continues to work with the relevant ministers to reduce the numbers of people held in immigration detention facilities and we will continue to monitor the detention population (Recommendation 1 of this report).

APPENDIX D

Implementation of recommendations from January–June 2020 report			
Recommendation	Department response	Assessment of actions taken	Need for further action
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.	Agreed	The department issued a new operational notification which classifies ground stabilisation as use of force which must be reported in accordance with the Incident Reporting Guidelines and the appropriates of alleged excessive force use, will be reviewed through mandatory reporting mechanisms and by reviews conducted by the respective ABF Detention Superintendent (Facility). The department also advised it will also engage with the Facilities and Detainee Services Provider (FDSP) to review training in the use of ground stabilisation techniques. The Office notes the department has taken appropriate steps to address this recommendation. However, we encourage training to staff on alternative strategies to manage behaviour as during this reporting period our reviews of use of force incidents give rise to concerns regarding a lack of de-escalation which we will continue to monitor next period.	No further action required at this time regarding measures to track and assess reasonableness of use of force. However, the Office remains concerned there is lack of training on alternative strategies to manage detainee behaviour. We will continue to monitor progress on this recommendation at future inspections.

Recommendation	Department response	Assessment of actions taken	Need for further action
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.	Noted	The Office notes that quality assurance programs are now in place at most facilities as per Recommendation 16b of our January to June 2019 report. However, implementation, as well as thoroughness in the complaints process was different across each facility. While Melbourne ITA demonstrated good practice quality assurance processes, our case study highlighted concerns with the complaints handling process.	The Office remains concerned about the department's handling of detainee complaints and will continue to monitor the quality assurance, comprehensiveness, and consistency of the department' complaint handling processes.
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 4. high quality records of stakeholder meetings are maintained.	Agreed	The Office observed a robust framework in place for managing a detainee with vulnerabilities. However, during this reporting period we noted there are opportunities for greater engagement and information-sharing between shareholders; particularly with IHMS.	The Office will continue to monitor this recommendation noting concerns raised in this report.

APPENDIX E

Implementation of recommendations from July to 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 released a new operational notification in June 2019 which emphasises that use of force is not mandatory. The policy also details obligations and considerations when using force.	Implemented. No further action
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	In our previous report, 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.	As noted in this report, 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 previously advised that feedback would be provided to Serco regarding the concerns.	Implemented. No further action required at this time.

Recommendation	Department response	Action taken	Need for further action
Recommendation 5: The department places signage in all detention centre compounds advising detainees of their right to access legal services.	Agreed	The department previously advised it would 'develop signage for display in immigration detention facilities advising detainees of their right to access legal services.'	Implemented. The Office will continue to inspect placement of signage in compounds as COVID-19 restrictions ease and inspections resume.
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 previously advised 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.'	Implemented. No further action required.
Recommendation 7: The department considers permitting detainees to access books and magazines during transfer operations.	Agreed	The department previously 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.'	Implemented. The Office was unable to inspect transport operation in this reporting period. We will monitor the department's response to this recommendation as COVID-19 restrictions ease and inspections resume.
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 previously advised 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	Department response	Action taken	Need for further action
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 previously 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.'	Implemented. 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 previously advised 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 still has concerns there is insufficient personal storage space for detainees, and this was observed during this inspection cycle at Phosphate Hill APOD. We will monitor during future 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 in line with COVID-19 restrictions.

Recommendation	Department response	Action taken	Need for further action
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.	Agreed	The department previously advised 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.	The Office continues to remain concerned about the use of mechanical restraints for detainee attendance at medical appointments and will monitor this issue closely.

APPENDIX F

Implementation of recommendations from January to June 2019 report			
Recommendation	Department response	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	On 14 May 2020 the *Migration Amendment (Prohibiting Items in Immigration Detention Facilities) Bill 2020* was introduced to parliament and progressed to the Senate in September 2020. The Bill was not debated in the Senate after it was introduced so it will lapse prior to the commencement of the 47th Parliament.	Implemented. This report reiterates our view that while the department's administrative framework is comprehensive, a robust legislative framework that adopts preventive measures to reduce the risk of violence and protect the most vulnerable detainees is essential.
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 previous 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.	We reiterate our concerns through Recommendation 6 in this report. The Office will continue to monitor, especially in response to the easing of COVID-19 restrictions.

Recommendation	Department response	Assessment of actions taken	Need for further action
Recommendation 3: We recommend that, as a priority, the Blaxland High Security Compound (BHSC) be decommissioned.	Agreed	The department has transitioned all detainees from the BHSC into the Villawood IDC.	The Office notes the use of BHSC for quarantine purposes and will continue to monitor its use until it is 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	In the July-December 2019 inspection cycle we observed the department was taking steps to address the shortfalls in facilities in long-term APODS and our previous report noted improvements in services available at the Mantra Bell City APOD. The department closed this recommendation in December 2020. However, during this reporting period, we noted COVID-19 restrictions continued to impact services at APODs, with access to outdoor recreation activities significantly impacted. We remain concerned about services available at APODs.	The Office makes 2 recommendations in this report regarding APODs, including to ensure P&A, and access to medical and welfare services, are standard across all detention facilities, including APODs.

Recommendation	Department response	Assessment of actions taken	Need for further action
Recommendation 5: The department: a) addresses concerns with the design and fit out of the modular high security compounds, in particular by: 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. 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.	Agreed	Our July to December 2019 report noted capital works are required to address several of the issues we raised and that changes are unlikely to be addressed in the short term. The department has not since provided an update on whether capital works have progressed. The office is not aware that any work has commenced.	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.
Recommendation 6: That: a) the department address the shortfalls identified in the property storage facilities at Villawood b) Serco ensure that all money and valuables held in trust for a detainee are stored securely.	Agreed	At the time of our last report (January to June 2020), the department confirmed that storage units were prepared and there is now appropriate, secure storage at Villawood.	Implemented. No further action required.

Recommendation	Department response	Assessment of actions taken	Need for further action
Recommendation 7: The department: a) ensures all detainees have appropriate access to programs and recreational facilities within accommodation compounds b) ensures equitable access to communal recreation and activity facilities for all detainees.	Agreed	In the January to June 2020 inspection cycle, we observed an improvement in access to activities, both in-compound and in common access areas. During this inspection cycle we acknowledge that programs and recreational activities were impacted by COVID-19. However, detainees advised they were unhappy they lost access to rehabilitation programs they used in the community or in correctional facilities, such as anger management programs and drug and alcohol counselling.	We reiterate our concerns about access to programs and activities, including within accommodation compounds, in Recommendation 5 of this report. We will continue to monitor progress on this recommendation at future inspections.
Recommendation 8: The department: a) reinstates the traditional POS model in all IDFs 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.	Agreed	The department confirmed the allocation of one appropriately qualified Welfare Officer to 4 detainees at the Adelaide ITA. Up to 2 Personal Officers are allocated to detainees across other facilities to ensure at least one officer is available to a detainee on most days.	Implemented. No further action required at this time.
Recommendation 9: The department remove the restriction on external recreational and religious excursions for all detainees with an established low behavioural and/or flight risk.	Agreed	The implementation of this recommendation is underway but not completed. We note COVID-19 impacted the opportunity for external excursions.	With the easing of COVID-19 restrictions, the Office will engage with the department to confirm when external recreational and religious excursions will become available to long term detainees.

Recommendation	Department response	Assessment of actions taken	Need for further action
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 P&A, including access to outdoor recreational activities.	Agreed	During the last inspection cycle, we noted an improvement in the provision of welfare and P&A for detainees held in APODs. However, this reporting period we observed limited access to activities at APODS; particularly at Kangaroo Point APOD and Meriton Hotel APOD (Brisbane).	The Office makes 2 recommendations in this report regarding APODs, including to ensure P&A, and access to medical and welfare services, are standard across all detention facilities, including APODs.
Recommendation 11: The department, in conjunction with its service providers: 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: 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	Agreed in part	No improvement in the quality of analysis undertaken to determine a detainee's risk assessment was noted during this reporting period. 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.	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.

Recommendation	Department response	Assessment of actions taken	Need for further action
to decline to participate in medical or mental health treatment.			
Recommendation 12: The department in consultation with its service providers ensure that: a) all officers who attend an incident produce reports for inclusion in the Incident Report 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.	Agreed in part	The department agreed with our recommendation that all officers involved in an incident should prepare an independent report. 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.	We will continue to monitor the implementation of this recommendation.
Recommendation 13: The department: a) ensure all Behaviour Management Plan (BMPs) are reviewed in a structured, minuted meeting with representatives from all relevant stakeholders in attendance 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.	Agreed	Our observations during the previous inspection cycle indicated that development and review of BMPs had not improved.	Once it is safe to resume inspections, 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.
Recommendation 14: The department ensure that mechanical restraints are: a) only applied for the shortest time necessary b) never used for punitive purposes c) only applied when all other forms of mitigation have been exhausted.	Agreed	On our inspections during July to December 2019, we were satisfied that where restraints are applied, staff regularly checked 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	We will continue to monitor the implementation of this recommendation noting our observations of inconsistent use of mechanical restraints this reporting period.

Recommendation	Department response	Assessment of actions taken	Need for further action
		applied for in planned use of force and transport and escort requests. During this inspection cycle, we observed inconsistent use of mechanical restraints across the network.	Our ongoing concerns are also reiterated in Recommendation 16 of this report.
Recommendation 15: The department: 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 were unable to inspect transfer operations this reporting period. However, our assessment of transfer operations between July to December 2019 concluded that detainees are generally treated with dignity and respect throughout the operation.	We will continue to monitor the implementation of this recommendation and assess at future inspections.

Recommendation	Department response	Assessment of actions taken	Need for further action
Recommendation 16: The department ensures that: 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 (16a and 16b)	The Office notes that quality assurance programs are now in place at most facilities. However, implementation, as well as thoroughness in the complaints process was different across each facility. Further, the Office is not aware of any complaint investigation and management training.	The Office remains concerned about the department's handling of detainee complaints and will continue to monitor the quality assurance, comprehensiveness, and consistency of the department's complaint handling processes.

GLOSSARY OF KEY TERMS

AAT	**Administrative Appeals Tribunal**
ABF	Australian Border Force
ADF	Australian Defence Force
AFP	Australian Federal Police
AHRC	Australian Human Rights Commission
APOD	Alternative place of detention
ASA	Adverse security assessment
BCP	Business Continuity Plan
BHSC	Blaxland High Security Compound
BMP	Behaviour Management Plans
CDNA	The Communicable Diseases Network Australia
CDNA Guidelines	The Communicable Diseases Network Australia Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Correctional and Detention Facilities in Australia.
Department policy	Policies and procedures of the ABF (part of the Department of the department)
DCC	Detainee Consultative Committee
DPA	Detention Placement Assessment
ERT	Emergency Response Team
FDSP	Facilities and Detainee Services Provider
FFR	Food and Fluid Refusal
GFU	Global Feedback Unit
HCA	High care accommodation
The department	The Department of Home Affairs
Held Detention	Held Detention refers to persons held in immigration detention facilities or Alternative Places of Detention (APOD). To be distinguished from community detention, where detainees reside in a designated place in the community.
IAA	Irregular Air Arrival
IAP	Individual Allowance Program
IDC	Immigration Detention Centre
IDF	Immigration Detention Facility
IDN	Immigration Detention Network
IHMS	International Health and Medical Services, contracted by the Commonwealth of Australia to provide health and medical services for immigration detention.
IMA	Irregular Maritime Arrival
ITA	Immigration Transit Accommodation
MoU	Memorandum of Understanding
NPM	National Preventive Mechanism – a system of regular preventive visits by independent bodies. Each state and territory and the Commonwealth need to establish a NPM to fulfill Australia's obligations under OPCAT. The NPM for Commonwealth places of detention – including immigration detention – is the Commonwealth Ombudsman.

NPM Coordinator	Coordinates the Australian NPM Network made up of NPMs in each state and territory and the Commonwealth. The Commonwealth Ombudsman fulfills this role.
OAG	The OPCAT Advisory Group created by the Commonwealth Ombudsman.
OMP	Outbreak Management Plan
ON	Operational notification –ABF interim policies and/or policy updates.
OPCAT	The United Nations Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment.
P&A	Programs and Activities
QSA	Qualified security assessment
Serco	Serco Australia Pty Limited is contracted to the Commonwealth of Australia to operate and manage immigration detention facilities around Australia.
SPT	Subcommittee on the Prevention of Torture
SRAT	Security Risk Assessment Tool
The CIOR Act	*Migration Amendment (Clarifying International Obligations for Removal) Act 2021*
The Migration Act	*Migration Act 1958*
The Office	The Office of the Commonwealth Ombudsman
The Ombudsman Act	*Ombudsman Act 1976*
UAM	Unaccompanied Minor