



Australian
Human Rights
Commission

**Mr RG v
Commonwealth of
Australia (Department
of Home Affairs)**

[2023] AusHRC 148

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Report into a safe place of detention

Australian Human Rights Commission 2023



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Commission**

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**Australian
Human Rights
Commission**

The Hon Mark Dreyfus KC MP
Attorney-General
Parliament House
Canberra ACT 2600

Dear Attorney

I have completed my report pursuant to s 11(1)(f) of the *Australian Human Rights Commission Act 1986* (Cth) (AHRC Act) into the human rights complaint of Mr RG, alleging a breach of his human rights by the Department of Home Affairs (Department).

Mr RG complains that he was not provided with a safe place of detention while detained at Villawood Immigration Detention Centre (VIDC) in contravention of article 10(1) of the *International Covenant on Civil and Political Rights* (ICCPR), which provides for his right to be treated with humanity and respect for his inherent dignity.

As a result of this inquiry, I have found that the following act of the Commonwealth is inconsistent with, or contrary to, article 10(1) of the ICCPR:

the decision of the Department or Serco to continue to detain Mr RG in the Blaxland compound within VIDC (Blaxland) following two assaults on him by other detainees without undertaking a documented risk assessment process or other action to protect his safety.

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Pursuant to s 29(2)(b) of the AHRC Act, I have included seven recommendations to the Department in this report.

On 3 February 2023, I provided the Department with a notice issued under s 29(2) of the AHRC Act setting out my findings and recommendations in this matter.

The Department provided its response to my findings and recommendations on 13 April 2023. That response can be found in Part 9 of this report.

I enclose a copy of my report.

Yours sincerely,

A handwritten signature in black ink that reads "Rosalind Croucher". The signature is written in a cursive, flowing style.

Emeritus Professor Rosalind Croucher AM

President

Australian Human Rights Commission

June 2023

1 Introduction to this inquiry

1. The Australian Human Rights Commission (Commission) has conducted an inquiry into a complaint by Mr RG against the Commonwealth of Australia, specifically the Department of Home Affairs (Department), pursuant to s 11(1)(f) of the *Australian Human Rights Commission Act 1986* (Cth) (AHRC Act).
2. Mr RG complains that the Department and its service provider, Serco Australia Pty Limited (Serco), failed to provide a safe place of detention and to take appropriate measures to ensure his safety in immigration detention, in contravention of article 10(1) of the *International Covenant on Civil and Political Rights* (ICCPR).¹
3. People deprived of their liberty are wholly reliant on the authority managing their detention to provide for their basic needs and safety. The right for detained people to be treated with humanity and respect for their dignity is not protected by the Australian Constitution. The Commission's ability to inquire into human rights complaints under the AHRC Act is narrow in scope, being limited to a discretionary 'act' or 'practice' of the Commonwealth that is alleged to breach a person's human rights. The relevant authority is subject to a duty of care and positive obligations under article 10(1) of the ICCPR to take action to ensure that detained persons are treated with humanity and dignity, including an obligation to ensure that they are provided with a minimum of services to satisfy their basic needs.
4. In this case, Mr RG alleges that he was subjected to three separate assaults perpetrated by other detainees while he was detained at Villawood Immigration Detention Centre (VIDC) over a period of four months, causing him physical and psychological harm.
5. This report is issued pursuant to s 29(2) of the AHRC Act setting out the findings of the Commission as a result of its inquiry into Mr RG's complaint.
6. Mr RG has requested that his name not be published in connection with this inquiry. I consider that the preservation of his anonymity is necessary to protect his human rights. Accordingly, I have given a direction under s 14(2) of the AHRC Act and refer to the complainant as Mr 'RG' in this report.

2 Summary of findings and recommendations

7. As a result of the inquiry, I have found that the following act of the Commonwealth is inconsistent with, or contrary to, article 10(1) of the ICCPR:

the decision of the Department or Serco to continue to detain Mr RG in the Blaxland compound within VIDC (Blaxland) following two assaults on him by other detainees without undertaking a documented risk assessment process or other action to protect his safety.

8. As detailed in this report, the Commonwealth and its service provider have a positive obligation under article 10(1) of the ICCPR to take action to ensure that detained persons are treated with humanity and dignity, including ensuring a basic need for safety and security while in detention. The contractual arrangements between the Department and Serco require Serco to ensure the safety of detainees, including maintaining a safe and secure environment, and the duty of care owed to detainees to ensure their safety while in detention is recognised in the Department's internal policies. The reasons for my findings include consideration of the seriousness of the assaults on Mr RG, the Commonwealth's failure to undertake any assessment of the risk of further assaults on him after those assaults and the Commonwealth's conduct in returning him to the same dorm and compound as the offenders of those assaults, failing to conduct their own investigation of the assaults when the Australian Federal Police (AFP) decided not to investigate them, and the significant delay in taking steps to transfer Mr RG to a different compound.
9. In response to this finding, and having regard to the matters set out in the report below, the Commission makes the following recommendations:

Recommendation 1

A risk assessment should be undertaken for all detainees involved in an act of violence as part of the Department and its service provider Serco's response to that act of violence. The assessment should include an assessment of the likelihood of the alleged perpetrator engaging in a further act of violence in the future, the risks posed to the detainee who was the victim of the violence, and the steps necessary to mitigate those risks.

Recommendation 2

The Department should develop a mandatory protocol for responding to detainee-on-detainee violence, which includes the immediate separation of detainees following any such incident to accommodation where an alleged perpetrator can no longer have access to the alleged victim.

Recommendation 3

The Department should require Serco to review the Security Risk Assessment Tool to ensure that it clearly identifies detainees who are vulnerable to harm from other detainees, and detainees who present a risk to the safety of other detainees.

Recommendation 4

Decisions to transfer a detainee to different accommodation within the immigration detention network should take into account:

- a. any specific identified risks posed to that detainee from other detainees, for example, as a result of previous incidents
- b. any general risks identified to that detainee from other detainees, as revealed in the updated security risk assessment tool amended in accordance with recommendation 3, and
- c. that effective measures are put in place to mitigate or eliminate those risks.

Recommendation 5

The Department should immediately implement measures to protect people at risk of violence at VIDC, including by exploring alternative detention arrangements, including community detention or grants of bridging visas, that would allow for victims of violence to be separated from the alleged perpetrators.

Recommendation 6

The Department should establish an independent review of threatened and actual violence at VIDC, with a view to identifying measures to prevent violence and protect those at risk of harm.

Recommendation 7

The Department should conduct its own investigations into incidents of assault that have been referred to the AFP where the AFP decides to not conduct an investigation.

3 Background

10. On 16 June 2013, Mr RG arrived in Australia as an asylum seeker from Sudan. He was approximately 22 years old. Mr RG was taken into immigration detention on Christmas Island, and later transferred to Nauru Regional Processing Centre.
11. On 2 August 2013, Mr RG was transferred to mainland Australia under s 198B of the *Migration Act 1958* (Cth) (Migration Act) to receive psychiatric treatment and was detained at Yongah Hill Immigration Detention Centre. From 26 August 2013 to 4 September 2013, Mr RG received treatment at Graylands Psychiatric Hospital in Western Australia. He was diagnosed with an adjustment disorder, with disturbances of behaviour and mood.
12. On 17 November 2013, he was transferred to the Brisbane Immigration Transit Accommodation Centre. From 23 November 2013 to 18 December 2013, he received psychiatric care at Toowong Private Hospital in Queensland and was diagnosed with an adjustment disorder, with mixed disturbance of emotions and conduct, and post-traumatic stress symptoms. Following this treatment, Mr RG was transferred to VIDC.
13. On 26 March 2014, Mr RG was granted a bridging visa by the Minister exercising discretionary powers under s 195A of the Migration Act and was released into the community.
14. On 3 January 2015, Mr RG was charged by New South Wales Police with causing grievous bodily harm. He was held in remand at Silverwater Correctional Centre before being transferred to Bathurst Correctional Centre.
15. On 13 January 2015, Mr RG's bridging visa was cancelled under s 116 of the Migration Act.
16. On 10 December 2015, Mr RG was granted bail from Bathurst Correctional Centre and taken into immigration detention at VIDC on the same day under s 189(1) of the Migration Act. Mr RG was placed in Blaxland, a high security risk compound.

17. On 18 April 2016, the Minister raised the bar to allow Mr RG to apply for a Protection Visa or a Safe Haven Enterprise Visa (XE790) (SHEV). On 20 June 2016, Mr RG applied for a SHEV.
18. On 4 July 2016, Mr RG was transferred to Christmas Island Immigration Detention Centre.
19. On 28 August 2016, Mr RG was transferred back to VIDC and placed in dorm 1 within Blaxland.
20. Mr RG alleges that, on 7 September 2016, he was assaulted by another detainee in his dorm in Blaxland, which led to him being hospitalised and treated for wounds to his face (First Assault).
21. After being discharged from hospital, Mr RG was returned to Blaxland and placed in dorm 2.
22. Mr RG alleges that, at or about midnight on 8 September 2016, he was assaulted for a second time in his dorm by two other detainees (Second Assault). After the assault, Mr RG was taken by Serco officers to dorm 1 where the First Assault took place.
23. On 13 September 2016, the First Assault and Second Assault were referred to the AFP. The AFP ultimately declined to investigate the assaults and neither the Department nor Serco conducted their own investigation of the assaults.
24. On 13 October 2016, Mr RG was moved from Blaxland to another high security risk compound in VIDC, Mackenzie.
25. On 23 December 2016, Mr RG alleges he was assaulted by two detainees in Mackenzie (Third Assault) and was taken to Liverpool Hospital Emergency Department for assessment and treatment.
26. On 29 December 2016, the Department referred the Third Assault to the AFP for investigation. The AFP accepted the referral and, on 3 March 2017, arrested and charged the two offenders with offences related to the Third Assault.
27. On 22 February 2017, Mr RG was found 'not guilty' of the charge of grievous bodily harm.
28. On 8 March 2017, Mr RG appeared at Local Court relating to an outstanding Apprehended Violence Order (AVO). On 17 March 2017, the AVO was withdrawn and the matter was dismissed by the Court.

29. On 13 April 2017, Mr RG was granted a SHEV and released into the community.
30. In June 2018, the perpetrators of the Third Assault were each convicted of assault occasioning actual bodily harm in company of others and received sentences of imprisonment for 2 years, and 2 years and 4 months.
31. The Department indicated that it was not in a position to participate in a conciliation of this matter.

4 Procedural history of this inquiry

32. On 28 June 2021, I issued a preliminary view in this matter and gave Mr RG, the Department and the Minister an opportunity to respond to my preliminary findings.
33. On 14 September 2021, the Department provided a response to my preliminary view. No response was received from the Minister.
34. On 18 October 2021, Mr RG responded to my preliminary view.

5 Legal framework

5.1 Functions of the Commission

35. Section 11(1)(f) of the AHRC Act provides that the Commission has the function to inquire into any act or practice that may be inconsistent with or contrary to any human right.
36. Section 20(1)(b) of the AHRC Act requires the Commission to perform this function when a complaint is made to it in writing alleging that an 'act' or 'practice' is inconsistent with, or contrary to, any human right.
37. Section 8(6) of the AHRC Act requires the functions of the Commission under s 11(1)(f) to be performed by the President.

5.2 What is a 'human right'?

38. The phrase 'human rights' is defined by s 3(1) of the AHRC Act to include the rights and freedoms recognised in the ICCPR.

39. Relevantly, article 10(1) of the ICCPR provides:

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

5.3 What is an 'act' or 'practice'?

40. The terms 'act' and 'practice' are defined in s 3(1) of the AHRC Act to include an act done or a practice engaged in by or on behalf of the Commonwealth or an authority of the Commonwealth or under an enactment.
41. Section 3(3) of the AHRC Act provides that the reference to, or to the doing of, an 'act' includes a reference to a refusal or failure to do an act.
42. The functions of the Commission identified in s 11(1)(f) of the AHRC Act are only engaged where the act complained of is not one required by law to be taken;² that is, where the relevant act or practice is within the discretion of the Commonwealth, its officers or agents.

5.4 Act or practice of the Commonwealth

43. The following acts of the Department and Serco are 'acts' for the purposes of the AHRC Act:
- the decision of the Department or its service provider, Serco, to detain Mr RG in a high security risk compound, having regard to his known personal circumstances
 - the decision of the Department or Serco to continue to detain Mr RG in Blaxland following two assaults on him by other detainees without undertaking a documented risk assessment process or other action to protect his safety
 - the decision of the Department or Serco to transfer Mr RG to another high security risk compound without having undertaken a documented risk assessment process following the two assaults on him in Blaxland
 - the decision of the Department or Serco to continue to detain Mr RG in Mackenzie following an assault by other detainees on him without undertaking a documented risk assessment.

44. For the reasons discussed in this report, I have found that the second of these acts constituted a breach of article 10(1) of the ICCPR. I have not been able to be satisfied that the remaining three acts of the Department and Serco resulted in a breach of article 10(1) of the ICCPR.

6 Safe place of detention

45. Mr RG complains that he was not provided with a safe place of detention at VIDC, in contravention of article 10(1) of the ICCPR.

6.1 Law on article 10 of the ICCPR

46. Article 10(1) of the ICCPR imposes a positive obligation on States to ensure that detainees are treated with humanity and respect for their dignity.³ This is in recognition of the fact that detained persons are particularly vulnerable because they are wholly reliant on a relevant authority to provide for their basic needs.⁴ In this case, the relevant authority is the Commonwealth of Australia through the Department and its service providers.
47. These international law commitments require Australia to ensure that people in immigration detention are treated fairly and reasonably, and in a manner that upholds their dignity.
48. Similar obligations are also recognised in the common law of Australia and through the legal 'duty of care' that the Department and its service providers owe to people in immigration detention.
49. General Comment No 21 of the United Nations Human Right Committee (UN HR Committee) sets out the content of the obligation in article 10(1) of the ICCPR, stating:

Article 10, paragraph 1, imposes on State parties a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of their liberty, and complements for them the ban on torture or other cruel, inhuman or degrading treatment or punishment contained in article 7 of the Covenant. Thus, not only may persons deprived of their liberty not be subjected to treatment which is contrary to article 7 ... but neither may they be subjected to any hardship or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as that of free persons.⁵

50. Professor Manfred Nowak has commented on the threshold for establishing a breach of article 10(1), when compared to the related prohibition against 'cruel, inhuman or degrading treatment' in article 7 of the ICCPR, as follows:

In contrast to article 7, article 10 relates only to the treatment of persons who have been deprived of their liberty. Whereas article 7 primarily is directed at specific, usually violent attacks on personal integrity, article 10 relates more to the general state of a detention facility or some other closed institution and to the specific conditions of detention. As a result, article 10 primarily imposes on States parties a positive obligation to ensure human dignity. Regardless of economic difficulties, the State must establish a minimum standard for humane conditions of detention (requirement of humane treatment). In other words, it must provide detainees and prisoners with a minimum of services to satisfy their basic needs and human rights (food, clothing, medical care, sanitary facilities, education, work, recreation, communication, light, opportunity to move about, privacy, etc). ... Finally it is again stressed that the requirement of humane treatment pursuant to article 10 goes beyond the mere prohibition of inhuman treatment under article 7 with regard to the extent of the necessary 'respect for the inherent dignity of the human person'.⁶

51. These conclusions are also evident in the jurisprudence of the UN HR Committee, which discusses the positive obligation on relevant authorities to treat detainees with humanity and respect for their dignity.⁷

52. Professors Sarah Joseph and Melissa Castan recognise that article 10(1) obliges State parties to provide protection for detainees from other detainees,⁸ drawing from Concluding Observations on Croatia made by the UN HR Committee in which it was stated that the:

Committee is concerned at reports about abuse of prisoners by fellow prisoners and regrets that it was not provided with information by the State party on these reports and on the steps taken by the State party to ensure full compliance with article 10 of the [ICCPR].⁹

53. The content of article 10(1) has also been developed through a number of UN instruments that articulate minimum international standards in relation to people deprived of their liberty, including:

the *Standard Minimum Rules for the Treatment of Prisoners*, now known as the *Nelson Mandela Rules* (Mandela Rules)¹⁰

the *Body of Principles for the Protection of all Persons under Any Form of Detention* (Body of Principles).¹¹

54. In 2015, the Mandela Rules were adopted by the United Nations. They provide a restatement of a number of United Nations instruments that set out the standards and norms for the treatment of prisoners, and represent, as a whole, the minimum conditions which are accepted as suitable by the United Nations.¹²
55. The Human Rights Committee invites State Parties to indicate in their periodic reviews the extent to which they are applying the Mandela Rules and the Body of Principles.¹³ At least some of those principles have been determined to be minimum standards regarding the conditions of detention that must be observed, regardless of a State's level of development.¹⁴
56. Several of the Mandela Rules are relevant to the safety of detainees in respect of the behaviour of other detainees, and the general security and good order of detention facilities, including the following:
- Rule 1:* All prisoners shall be treated with the respect due to their inherent dignity and value as human beings ... The safety and security of prisoners, staff, service providers and visitors shall be ensured at all times.
 - Rule 12:* ... Where dormitories are used, they shall be occupied by prisoners carefully selected as being suitable to associate with one another in those conditions. There shall be regular supervision by night, in keeping with the nature of the prison.
 - Rule 36:* Discipline and order shall be maintained with no more restriction than is necessary to ensure safe custody, the secure operation of the prison and a well ordered community life.
57. The above jurisprudence supports the conclusions that:
- article 10(1) imposes a positive obligation on State parties to take action to ensure that detained persons are treated with humanity and dignity
 - minimum standards of humane treatment must be observed in the conditions of detention

- the threshold for establishing a breach of article 10(1) is lower than the threshold for establishing ‘cruel, inhuman or degrading treatment’ within the meaning of article 7 of the ICCPR, which is a negative obligation to refrain from such treatment
- article 10(1) may be breached if a detainee’s rights under other articles of the ICCPR are breached, unless that breach is necessitated by the deprivation of liberty
- article 10(1) requires that detainees and prisoners be provided with a minimum of services to satisfy their basic needs.

58. In my view, and consistent with the findings of past Commission inquiries,¹⁵ I consider that detainees in immigration detention have a basic need for their safety and security to be protected while in detention. Australia must ensure that immigration detainees have this basic need met in order to fulfil the obligations imposed on it by article 10(1) of the ICCPR to treat detainees with humanity and respect for the inherent dignity of the human person.

6.2 Contractual obligations of service provider

59. The Department’s Immigration Detention Facilities and Detainee Services Contract with Serco (Contract) in effect during Mr RG’s detention recognises the duty of care owed to detainees and requires that Serco complies with a Code of Conduct.¹⁶ The Code of Conduct requires Serco to carry out its duties with care and diligence, maintain a safe working environment and ‘be alert for Detainees who are or appear to be, traumatised and/or vulnerable to self-harm and by the actions of others, and manage and report on these’.¹⁷

60. The Contract enumerates several obligations on Serco which are relevant to ensuring the safety of detainees. Under the Contract, Serco is required to:

- provide and maintain a safe and secure environment for detainees,¹⁸ which also supports their individual health and safety needs¹⁹
- in exercising its responsibility to allocate accommodation:
 - take into consideration the individual welfare, cultural, family and security related needs and circumstances of the detainee and requests of the detainee²⁰

- participate in reviews and notify the Department where it believes that an existing placement is inappropriate for a detainee, including where it believes the Detainee should be moved within the existing Facility or should be transferred to another Facility²¹
- ‘immediately report to the Department any concerns that it may have regarding a Detainee’s safety and security’²²
- establish processes to:
 - promote the welfare of Detainees and create a safe and secure environment at each Facility²³
 - prevent detainees being subjected to illegal, anti-social or disruptive behaviour by detecting and managing those behaviours in other detainees²⁴
 - manage and defuse tensions and conflicts before they become serious or violent²⁵
 - identify if a detainee is emotionally distressed or at risk of self-harm or harm to others, ensuring the system accounts for advice from the Detention Health Services Provider and includes risk identification and mitigation strategies²⁶
- in responding to incidents,
 - ensure the safety and welfare of detainees and others at the facility²⁷
 - ‘immediately inform the Department of any Incidents it believes may have a significant adverse impact on the welfare of any person, or the security and safety of the Facility’²⁸
- upon identification or suspicion of a detainee having engaged in behaviour that is illegal, breaches detainee rights or is anti-social, including bullying, harassment, and assault, immediately notify the Department with recommendations for dealing with the perpetrator and preventing any recurrence²⁹
- ‘ensure that Detainees identified as victims of anti-social behaviour are supported by Service Provider Personnel’.³⁰

6.3 Departmental policies

61. The Department's Detention Services Manual (DSM) in effect at the time of Mr RG's initial placement in Blaxland sets out further obligations of the Department and its service providers with respect to immigration detention. The DSM was replaced on 2 September 2016 when the Department issued a revised suite of detention standard operating procedures, including in relation to incident management in immigration detention facilities and the management of detainee behaviour. These procedures were in effect at the time of the three assaults on Mr RG.

62. I understand that, in the following excerpts of the DSM, reference to:

- 'FDSP' is a reference to the Facilities and Detainee Services Provider – in this case, Serco
- 'DIBP' is a reference to the Department of Immigration and Border Protection – which was the name of the Department prior to December 2017.

63. Chapter 8 of the relevant DSM provides that:

The department is committed to providing a safe environment for staff, detainees and the public. However, incidents do happen in the detention network. Effective planning is aimed at minimising risks to staff and others and will assist staff to respond appropriately and in a timely and coordinated manner to such incidents.

...

As part of the contractual obligations between the FDSP and the department, the FDSP must use reasonable endeavours to prevent incidents from occurring and actively continue to assess current and planned activities and areas of responsibility for potential incidents. The FDSP must also implement plans, practices and procedures to prevent potential incidents from occurring.³¹

64. Chapter 8 does not provide any further detail about the 'reasonable endeavours' that service providers must employ to prevent incidents. Nor does it make any specific reference to the risk of violent or abusive behaviour between detainees.

65. Chapter 8 does note that:

Under the *Work Health and Safety Act 2011* (“the WHS Act”) the department and the facilities and detainee service provider (FDSP) have a duty to ensure, as far as is reasonably practicable, the health and safety of workers, detainees and other persons at an immigration detention facility (IDF)³²

66. The DSM states that both the Department and its service providers owe a duty of care to all persons held in immigration detention. This means that they are legally obliged to exercise reasonable care to prevent detainees from suffering reasonably foreseeable harm.³³ The Department’s duty of care is non-delegable.³⁴

67. The DSM describes the meaning of ‘duty of care’ in more detail as follows:

4 What is a duty of care?

DIBP and the FDSP owe a duty of care to all persons in all types of held immigration detention. This means that DIBP and the FDSP are legally obliged to exercise a [sic] reasonable care to prevent detainees from suffering reasonably foreseeable harm. ...

DIBP requires service providers, including the FDSP, to exercise reasonable care for the day-to-day needs, as well as the safety and welfare, of all detainees. It extends to taking reasonable care to prevent harm that could stem from the foreseeable activities of a detainee or from third persons. ...

DIBP’s non-delegable duty of care will cease when a detainee is released from held immigration detention.

...

6 Reasonably foreseeable risk of harm

A risk may be reasonably foreseeable if it is a risk which the authority knew or ought to have known or anticipated. Many risks of harm are reasonably foreseeable. A risk that is “not unlikely to occur” can be characterised as reasonably foreseeable, as opposed to one that is “far-fetched or fanciful”.³⁵

7 Reasonable authority

Reasonable authority, for the purposes of this policy means that DIBP must take those steps that an authority with the same powers, resources and duties would take in any given circumstance to prevent a detainee within held detention from suffering a reasonably foreseeable risk of harm.

A reasonable authority can breach its duty of care by:

- an omission to act (failing to do something that a reasonable authority would do) or
- performing an act which is unreasonable in the circumstances (doing something that a reasonable authority would not do).

68. The Department recognises that international human rights standards can inform the standard of care a detainee is to receive while detained in an immigration detention facility.³⁶
69. When the Department contracts out the provision of services to people in held detention to third parties, the DSM recognises that it has a responsibility to ensure the contracted service providers are qualified and can meet the standards outlined in the contract. While these third parties must also discharge their own duty of care obligations to a detainee in held detention, this duty is additional to, and does not substitute for, the Department's duty of care.³⁷
70. With respect to detainee safety, the DSM provides that the primary guiding principle is to 'ensure the safety and wellbeing of all employees, detainees and the general public'. It states that the secondary guiding principle is 'compliance with the department's duty of care, as incidents are a major risk to the safety and security of those who are either held in, work at, or visit an IDF'.³⁸
71. The DSM also provides that the duty of care includes ensuring that immigration detention is 'reasonably safe' for detainees:

12 Safety of premises

DIBP has a duty of care to ensure that an immigration detention facility/building in which a detainee is accommodated, or directed to live, is reasonably safe. This would include an assessment of the potential occupants, the condition of the premises and any detainees sharing the accommodation. Attention will need to be given to the potential occupants of the property as premises that might be safe for adults may pose different risks for minors.³⁹

72. The 'Incident Response and Management: Detention Standard Operating Procedure' issued on 2 September 2016 (SOP) sets out the actions required to manage an incident within an Immigration Detention Facility, including:
- responding to incidents – including minor incidents, major incidents and critical incidents
 - reporting on incidents
 - deploying emergency response teams
 - engaging with law enforcement agencies
 - post incident review and reporting.
73. The SOP states that the Department is committed to 'providing a safe environment for staff, detainees and visitors' and identifies the first management priority of staff to be 'the safety of all persons in the facility'.⁴⁰
74. With the exception of the actions listed for an ongoing incident, the SOP does not appear to address the Department's and Serco's obligation to ensure the safety of detainees. In the event of an ongoing incident, the SOP requires staff to consider 'the general welfare and safety of detainees and need for containment throughout the facility'.⁴¹
75. Notably, the procedures in the SOP for the resumption of routine operations after the resolution of an incident includes 'resolution of detainee needs' and lists '[a]rrange for the transfer of detainees to or from alternate accommodation if required' as an action immediately on resolution of an incident.⁴²

7 Findings

7.1 Placement in high security risk compound

(a) Reasons for placement

76. Mr RG was detained and transferred to Blaxland in VIDC after being released on bail in December 2015 for his charge of grievous bodily harm.

77. The Department states that:

The decision to place Mr [RG] in Blaxland was informed by his designated risk, alleged criminal antecedents and the need to balance detainee numbers between respective compounds within the wider VIDF. ...

Higher risk detainees, based on behaviour and background, may be placed in Blaxland as an operational decision. In making decisions on placement factors including the criminal history, associates, vulnerabilities and behaviours of the detainee whilst in detention are considered. In this instance the risk rating at that time and antecedents indicated that Blaxland was the most appropriate placement option for Mr [RG].

Blaxland and [Mackenzie] are considered to be comparable. Placement of detainees in either compound is typically informed by the need to balance the numbers of detainees, as well as any operational requirements.

Blaxland has its own secure perimeter fence forming the threshold between the centre and the public space outside the Immigration Detention Facility. Mackenzie is one of several compounds within the Villawood centre, having internal fencing which restricts movement to and from other compounds; however no perimeter fence is required.

...

Mackenzie and Blaxland are classified as High Security Risk Compounds and neither is more or less restrictive. As an overview, Mackenzie is preferred by detainees as it is twin share accommodation with en suite bathrooms rather than dormitory style in Blaxland. The key difference between Blaxland and Mackenzie is the bedding configuration where the majority of rooms in Blaxland house 4-6 detainees and the construction is much older whereas Mackenzie is a newer build which houses 2 detainees per room...

...

Placement of Mr [RG] was based on his risk profile which at the time was such that his appropriate placement was within a high risk compound. Because of his risk rating he was considered unsuitable for placement in the "less restrictive section of Villawood". Although not less restrictive Mackenzie is generally considered more desirable to detainees.

78. The Commission has been provided with Serco's Security Risk Assessments for Mr RG from 15 December 2015 to 9 December 2016. Each assessment records the following for Mr RG:
- categorisation as a 'HIGH Placement Risk detainee'
 - a single incident of 'Serious Violence' under Criminal History
 - 'Criminal History' and 'Violence' marked as red, and 'Disorder' marked as yellow, under Behavioural Risk Indicators
 - a note dated 14 December 2015 under 'Additional Comments' stating:
 - As per Day 1 interview, Mr [RG] has been hospitalised twice under the mental health act for self-harm attempts. Day 1 interview states Mr [RG] has PTSD, depression and adjustment disorder. Further states Mr [RG] was in a UN camp from aged 3 for 10 years and escaped it for his safety.
 - risk ratings of low for 'Demonstration', 'Escape' and 'Self Harm' and high for 'Aggression/Violence' and 'Criminal Profile'
 - a high 'DSP Placement Risk' and 'DSP Escort Risk'.
79. From 10 November 2016, 'Self Harm' was marked as yellow under Behavioural Risk Indicators with a risk rating of high for 'Self Harm'.
80. The Commission was also provided with internal Department correspondence dated 26 August 2016, requesting Mr RG's transfer to the Blaxland compound in VIDC from Christmas Island. Notwithstanding the Security Risk Assessment categorising Mr RG as a high placement risk detainee, this transfer request records Mr RG's risk as 'low'.
81. Mr RG asserts that he should not have been categorised as a high risk detainee and should not have been placed in Blaxland or Mackenzie because:
- it was known that he had previously suffered a significant mental health injury that left him vulnerable to further injury
 - the criminal charge against him was, 'at its highest, vexatious', had 'no substance' and could not be considered as falling in the same category of 'significant crimes' committed by persons placed in Blaxland and Mackenzie which would have been confirmed if even 'a scant enquiry by the Department had been conducted'

- the Minister had deemed him, on 18 April 2016, to be of sufficient standing to be entitled to apply for a Protection Visa or a SHEV
- he lodged his application for a SHEV on 20 June 2016, which was subsequently granted by the Minister on 13 April 2017 and, as such, was well advanced at the time he was placed in Blaxland
- ‘persons placed in the Blaxland section, and seemingly in the [Mackenzie] section as well, are convicted criminals or persons who have committed significant crimes’ and Mr RG should not be placed with them.

(b) Consideration

82. The Commission has repeatedly expressed concern about conditions of detention in Blaxland and recommended the closure of that compound.⁴³ From March 2020, detainees were transferred from Blaxland to a newly constructed high-security compound and Blaxland is now closed.
83. At the time of Mr RG’s assessment for placement in VIDC, he had no criminal convictions although he was facing a charge of grievous bodily harm and a pending application for an AVO against him. The Commission has not been provided with information indicating that Mr RG’s detention was a condition of his bail. Having been granted bail, it appears that the Court was satisfied that Mr RG was an appropriate candidate for release into the community, pending resolution of his criminal charges.
84. Significantly, Mr RG was known to the Department as a vulnerable person with a history of mental health issues, including post-traumatic stress disorder, depression, and adjustment disorder. Psychological reports indicating the history and extent of Mr RG’s psychological condition have not been provided to the Commission, however Mr RG had been transferred from Nauru to mainland Australia for psychiatric treatment, including inpatient treatment at psychiatric facilities. The Department described Mr RG’s hospitalisation for psychiatric treatment while in detention as follows:

Mr [RG] was admitted to Graylands Psychiatric hospital on 26 August 2013, as an involuntary patient and diagnosed with an adjustment disorder, with disturbances of behaviour and mood. During his admission he was agitated and upset about his move from Brisbane to Perth, threatening to ‘not eat or drink and to commit suicide’ if he was not returned to Brisbane. He was commenced on medication.

Mr [RG] was admitted to Toowong Private Hospital on 23 November 2013, as a voluntary patient for assessment and stabilisation of his mental state. He was diagnosed with an adjustment disorder, with mixed disturbance of emotions and conduct, and post-traumatic stress symptoms. Mr [RG] elected not to participate in any psychological or medical treatment throughout his admission.

85. International Health and Medical Services (IHMS) clinical records provided to the Commission include notes on Mr RG's background, including that he:

reports history of psych conditions before was admitted in psych hospital following suicide attempts. Had PTSD, anxiety, depression.

86. A letter dated 16 September 2016 from a representative from the Blue Mountains Refugee Support Group, purports to give some insight into the seriousness of his condition, describing an extremely traumatic past and grief after having all but one of his family members murdered during the ongoing persecution of his people.

87. While notes of Mr RG's psychological vulnerabilities are included in Serco's Security Risk Assessment, and 'Disorder' is marked as yellow under Behavioural Risk Indicators, the degree to which Mr RG's vulnerabilities were taken into consideration in decisions relating to his placement within VIDC is unclear. The Department's response is limited to stating that a detainee's vulnerabilities are included in its placement factors and that Mr RG's risk rating indicated that he was appropriate to be placed in Blaxland and was unsuitable for the less restrictive section of VIDC.

88. I note also that Serco's Security Risk Assessments classified Mr RG as High Risk, however correspondence directing his transfer to Blaxland categorised Mr RG as 'low risk'.

89. Grievous bodily harm is a serious charge relevant to determining a detainee's placement in detention. Notwithstanding Mr RG's assertions that the charges were vexatious, it is not the role of the Department to determine the veracity of pending charges against detainees. It is clear that Mr RG has significant psychological vulnerabilities and that a real concern in placing Mr RG in a high security risk compound is the deterioration of his mental health and the potential exposure to harm from other detainees. While it is concerning that the Department does not appear to have placed significant weight on these matters in placing

Mr RG in a high security risk compound, I do not consider that his placement in Blaxland rises to the level of conduct required for a breach of article 10(1) of the ICCPR.

7.2 Continued detention in Blaxland following two assaults without a risk assessment

(a) Assaults in Blaxland

90. On 7 September 2016, Mr RG alleges he was physically assaulted in his dorm in Blaxland by another detainee, during which he was slashed on the face with a razor blade. Clinical records provided by the Department confirm that Mr RG was treated in hospital on 7 September 2016 for two open bleeding wounds on his left upper face after an alleged assault. He received sutures for the lacerations and underwent a CT scan of his brain and facial bones, which was found to be normal.

91. An Incident Detail Report confirms that an assault took place in dorm 1 of VIDC in which Mr RG sustained a cut to his left eye. It classifies the incident as 'Minor' and records that Mr RG wanted the matter to be referred to the AFP for further investigation.

92. Mr RG says that after receiving treatment at the hospital, he was returned by Serco officers to the same dorm in which he was assaulted. Mr RG's complaint states that:

when he protested as to his fear of [the offender of the First Assault], they asked him to go to DOM2. The complainant then told the officers of [Serco] of his fear and concerns from [the offender of the First Assault's] friends in DOM2. His protest dropped into deaf ears and was told that 'it is not up to him to choose'. He then feared to go to bed and stayed awake.

93. In a statutory declaration dated 12 April 2018, Mr RG says that:

when I came back from hospital, I asked the SERCO officers to move me to another compound because I did not feel safe. The SERCO manager told me that you do not have any other option.

They kept me in the same Blaxland Compound and when I protest, they said that it is not up to me to choose the place where I am detained. I was so worried I did not go to sleep at night ...

94. Mr RG alleges that, at or about midnight on the night following the First Assault, two other detainees assaulted him causing his mouth and injuries from the First Assault to bleed. Mr RG alleges that the offenders were present during the First Assault and were known associates of the perpetrator of the First Assault. In his statutory declaration, Mr RG states that he knew the offenders were friends of the offender of the First Assault because he saw them speak through the fence.
95. Clinical documents record that Mr RG was seen by a doctor on 9 September 2016 and reported that he had been assaulted on 7 September 2016 and again the previous night. The notes record that Mr RG was '[f]earful and bitter about the situation as he can see it happen again – always the same guys doing it and for no reason' and the 'Plan' noted by the health professional was 'to help stop these assaults'.
96. The Department states that the Second Assault was witnessed by a Serco staff member who immediately intervened and reported the matter. The report classifies the incident as 'Minor' and records that Mr RG sustained redness on his left cheek and declined medical assistance.
97. Mr RG says that, after the Second Assault, officers took him out of dorm 2 to clean himself, however he was then brought back to dorm 2. The two perpetrators of the Second Assault were not in the dorm when he returned, however Mr RG asserts that another detainee who was a friend of the perpetrators approached him and said, 'don't stay here we rape you when you [go to] sleep'. Mr RG says that he stayed awake until the next morning and only slept a little when the other detainees had left the dorm.
98. Serco's report of the Second Assault includes a note stating that the offenders 'were transferred to Hotham observation room for the night'.
99. Mr RG alleges that, after the Second Assault, he asked Serco officers that he be moved from the Blaxland compound but was told that his only two options were to stay in the dorm in which the Second Assault took place or move back to the dorm in which the First Assault took place. He also says that he reported the rape threat made to him after the Second Assault to Serco officers.

100. The Department's response states that it has not identified any evidence to suggest that the Department or Serco officers were aware of the rape threat made to Mr RG after the Second Assault. It also states that there is 'no record to suggest that Mr RG had requested a change of placement to a less restrictive compound'.
101. Mr RG says that Serco officers then moved him back to dorm 1 close to the alleged perpetrator of the First Assault and he was told by Serco officers that, for his safety, he should stay close to the officers when he moved in the compound.
102. In response to the Commission's queries concerning the Department's knowledge of associates of the offender of the First Assault being located in dorm 2 and the concerns expressed by Mr RG about dorm 2, the Department states that:

There is no evidence to suggest that Mr [RG] or stakeholders of the Department were aware of the associates of other detainees in Dorm 2 prior to the assault of 7 September 2016.

...

There is no evidence to suggest Mr [RG] alerted the Department or stakeholders of any associates of the first offender being in Dorm 2 of the Blaxland Compound.

...

Serco have not been able to locate any evidence that Mr [RG] personally expressed concerns about his safety in Dorm 2.

103. In response to the Commission's request for information concerning the additional steps, if any, taken by the Department or Serco to prevent or mitigate further harm to Mr RG from the perpetrator of the First Assault or his associates between 7 September 2016 and 13 October 2016, the Department stated:

Mr [RG] is subject to the same safety and security provisions afforded to all people in immigration detention at all times while accommodated in an immigration detention facility. This includes the presence of Serco personnel in common areas, both in fixed stations and roving patrols. CCTV coverage of common areas is also in place. Mr [RG], was also able to raise any concerns he might have for his safety directly with Serco, IHMS or [Australian Border Force (ABF)] personnel at any time, verbally or in writing, so that those concerns could be addressed as appropriate.

The ABF has always been committed to the safety and security of all detainees, visitors and staff within the Villawood Immigration Detention Centre. Support services are in place in the form of Personal Officers, Welfare Officers and Health Support Services for detainees to utilise whilst located in Immigration Detention to raise any issues, concerns or provide medical and mental health support.

104. On 10 September 2016, the day following the Second Assault, Mr RG submitted a complaint to Serco which stated:

I got assaulted in Dorm 1 by one of the detainee. After the assault I requested to be moved out of Blaxland but was instead moved to Dorm 2 where I got assaulted again by 2 detainees and then they moved me to Dorm 1 again. Now I feel for my safety.

I want to get out of Blaxland and I would like to know why my safety is not the managements priority and if anything happens to me now management will be responsible for it.

105. Mr RG says that he also reported the assaults and his fears to the Red Cross, his case worker, and his lawyer. He states that, during the period of his detention in Blaxland after the Second Assault, he feared further assaults at any time and was not provided with any additional security. Mr RG asserts that, as a result:

- he avoided any activity where there was no Serco guard in attendance
- he would lock himself in his room for safety
- he was afraid to go to sleep in his dorm
- he would watch for officers to be around before he would get food or go to the bathroom
- he did not shower for almost a month because there were no officers in the shower area
- he continued to request to be moved out of the Blaxland compound
- his psychological condition deteriorated from living in constant fear.

106. On 13 September 2016, the Department received a telephone call from a representative of a Refugee Support Group advising that Mr RG had reported to the group that he had been involved in assault incidents and was in fear for his life in the Blaxland compound.
107. On the same date, the First Assault and Second Assault were referred to the AFP for investigation. However, the AFP later declined the referral and did not investigate the First Assault or the Second Assault. The Department informed the Commission that no other investigations into these assaults were conducted, stating that:
- Serco have advised that they did not investigate the matters further, relying on the AFP investigation of these matters. The Department can confirm that there is no requirement for Serco to duplicate an AFP investigation.
108. On 14 September 2016, Mr RG's placement was discussed at a Detainee Placement and Preventative Committee Meeting. The minutes of that meeting record that:
- a Serco representative raised concerns about Mr RG's placement in Blaxland and that, 'although he has been involved in physical altercations with other detainees, it has been observed that he is not the instigator'
 - a Department representative noted that 'advocates, such as the Red Cross, have previously expressed concerns for Mr RG's safety in Blaxland, and suggested that he be placed on the waitlist for placement in Mackenzie'
 - no stakeholders raised any issues with Mr RG being 'moved out of Blaxland'
 - 'all stakeholders agreed that Mr RG should be placed on the waitlist for placement in Mackenzie'.
109. On 16 September 2016, a representative from the Blue Mountains Refugee Support Group sent an email to NSW Detention Case Management requesting that Mr RG be transferred from the Blaxland compound, where he had been the victim of several attacks, to the Mackenzie compound. The email states that several messages had been received from Mr RG saying that 'he felt unsafe and that his life was in danger inside Blaxland'.

110. On 22 September 2016, Serco's Facility Operations Manager responded in writing to Mr RG's complaint. The letter records that the Facility Operations Manager had a discussion with Mr RG on 20 September 2016 in which:

- the Facility Operations Manager explained the detainee placement process to Mr RG, including that transfers are agreed by all stakeholders including Serco, IHMS and ABF
- the Facility Operations Manager said that:
 - it had been agreed that Mr RG's current placement 'remains appropriate'
 - as he had only been in detention for a limited period, his request to move out of Blaxland at this stage had been declined
 - in order to move accommodation, he would need to submit a detainee request form advising that he would like to move and the reasons why and that, once received, this would then be raised at the placement meeting
 - these meetings take into account a wide variety of factors which include health, wellbeing, availability of accommodation in other areas, immigration pathways and security
- Mr RG told the Facility Operations Manager that:
 - he does not trust people in Blaxland
 - he was scared to use the bathroom
 - he did not feel safe going to the shower block
 - he was experiencing some health issues
- the Facility Operations Manager told Mr RG that:
 - he had his own toilet
 - he should make staff aware when he was going to use the shower and explain to staff that he was concerned for his safety
 - the staff could ensure that they are present in the area of the common shower block whilst he used the facilities

- the Facility Operations Manager asked Mr RG directly if any detainees were threatening him or bullying him, to which he responded that he ‘just [didn’t] trust any of them’.

111. The letter also states:

If you experience any issues with other detainees in the future, please ensure that you notify a member of staff immediately in order for them to be able to adequately support you and investigate this accordingly at the time of the occurrence.

112. Mr RG says that he discussed the assaults and threats made against him with the Facility Operations Manager. The Department’s response states that it does not have any record of the rape threat being discussed in this meeting.

113. On 13 October 2016, Mr RG was moved from Blaxland to Mackenzie.

(b) Consideration

114. Assaults from other detainees are a serious risk to the personal safety of detainees in immigration detention. A Griffith Criminology Institute report on improving risk assessment of immigration detainees recorded 119 victims of minor assaults and 12 victims of serious assault in VIDC for the 10-month period between January and October 2018.⁴⁴

115. It is not clear on the information provided to the Commission whether the perpetrator of the First Assault was returned to the same area in Blaxland on the evening of the assault. Mr RG and the Department differ on whether Mr RG expressed to Serco officers his concerns about:

- being moved to dorm 2 after the First Assault
- associates of the offender of the First Assault being housed in dorm 2
- a threat of rape that Mr RG alleges had been made to him after the Second Assault, and
- remaining in Blaxland and his desire to be moved out of Blaxland after each of the assaults.

116. What is clear is that Serco was immediately notified by Mr RG of both assaults. Serco officers transferred Mr RG to hospital following the First Assault and prepared a Department Incident Detail Report. IHMS prepared an Incident Report recording his hospitalisation and injuries. Two Serco officers witnessed the Second Assault and prepared a Department Incident Detail Report and individual Serco Officer Reports. Mr RG made a formal written complaint to Serco the day after the Second Assault, indicating he feared for his safety in both dorm 1 and dorm 2 and requesting a transfer from Blaxland. Mr RG also complained about the assaults and his fears for his safety at Blaxland to his doctor and to members of a Refugee Support Group. Mr RG's concerns for his safety and his involvement in recent assault incidents were reported by the Refugee Support Group to the Department in a phone call on 13 September 2016 and to NSW Detention Case Management in an email dated 16 September 2016.
117. In the circumstances, after Mr RG sustained two assaults by three detainees within two days in Blaxland and complained about ongoing fears for his safety, it should have been clear to the Department and Serco that Mr RG's safety within Blaxland was at risk and required action. The assaults were sufficiently serious to warrant consideration by the Department or Serco of any ongoing risk to Mr RG and his safety in returning him to Blaxland. It is not a reasonable response to return Mr RG to the dorm where the First Assault occurred or the dorm where the Second Assault occurred, without any consideration of the ongoing risks to Mr RG's safety within Blaxland or providing additional security or protection. Such actions are not sufficient to ensure that the safety and security of Mr RG was protected.
118. The Department has not provided any information, policies or guidance concerning the way in which it and its service provider manage the specific risk of detainee-on-detainee violence. Additionally, it has not produced any documents to show that proper consideration was given to whether Mr RG remained at risk in Blaxland and, if so, how these risks could be managed. Such an assessment may have identified ongoing risks or harm to Mr RG, including from associates of the perpetrator of the First Assault. Undertaking such an assessment was a necessary step in considering and protecting Mr RG's basic right to safety.

119. It is evident that, from at least 14 September 2016, the Department and Serco held concerns for Mr RG's safety in Blaxland and agreed that he should be moved to Mackenzie. With this context, it is not clear why the Facility Operations Manager told Mr RG on 20 September 2016, six days later, that it had been agreed that his placement in Blaxland remained appropriate and that his request to be moved out of Blaxland had been declined.
120. Mr RG was not transferred out of Blaxland until 13 October 2016, when the Department says capacity at Mackenzie allowed the transfer. As a result, Mr RG remained in Blaxland for a further 34 days after the Second Assault and 29 days after it had been agreed by the Department and Serco that Mr RG should be moved out of Blaxland for his safety. While capacity constraints may have been a barrier to moving Mr RG to Mackenzie, the Department has not provided any information to show that proper consideration was given to the ongoing risk to Mr RG's safety in the period before space became available at Mackenzie and how those risks could be addressed or managed, including options for moving Mr RG to alternative accommodation within VIDC, moving him to a high security compound at another facility, or implementing additional security or protection to ensure his safety. Given the failure of the Department and Serco to consider these matters, I cannot be satisfied that sufficient steps were taken to ensure the safety and security of Mr RG.
121. It is also concerning that neither the Department, nor Serco, conducted its own investigation of the First Assault and the Second Assault. The fact of a referral to the AFP, days after the incident, is insufficient to discharge the Department's, and Serco's, duty of care to ensure the safety of detainees. Any AFP investigation would likely be focused on investigating the incident itself and the potential charges to be laid against the offenders; it would not consider the risks to Mr RG's safety after the relevant incident. Further, while the Department asserts that 'there is no requirement for Serco to duplicate an AFP investigation', it is unclear why the Department or Serco would not conduct its own investigation when the AFP declined the referral and did not investigate either incident. There was no AFP investigation to be duplicated.

122. In response to the Commission's preliminary view, the Department stated that it considers that:

steps were taken in consideration of Mr [RG]'s basic needs for safety and security. The Department provides the following information in relation to steps taken in consideration of Mr [RG]'s safety.

The Department agrees with the President's preliminary view that a basic need of detainees is that their safety and security while in detention be protected to the greatest extent possible and reiterates that the Australian Border Force (ABF) has always been committed to the safety and security of all detainees, visitors and staff within Immigration Detention Facilities (IDFs).

Support services are in place in the form of Personal Officers, Welfare Officers and Health Services for detainees to utilise while located in immigration detention to raise any issues, concerns or provide physical and mental health support.

While the ABF is ultimately responsible for detainees, the Department's Facilities and Detainee Service Provider (FDSP), Serco plays a vital role in the management of detainees.

The following is an excerpt from the Individual Management Plan Procedural Instructions:

"The Detention Superintendent (Facility) is ultimately accountable for ensuring appropriate care is provided to all detainees within the IDF against all reasonable and foreseeable risks...

The Individual Management Plan process and associated meetings assist in fulfilling this responsibility by providing the framework with which to ensure that the wellbeing of all detainees is being monitored and managed appropriately."

The FDSP is responsible for the safety and good order of IDFs by using Serco personnel in common areas, both in fixed stations and roving patrols. Closed Circuit Television (CCTV) coverage of common areas is also in place. Detainees are able to raise any concerns they might have for their safety directly with Serco, International Health and Medical Services (IHMS) or ABF personnel at any time, verbally or in writing, so that those concerns can be addressed appropriately.

The ABF and Serco rely on the Security Risk Assessment Tool (SRAT) to inform risk and vulnerabilities when making decisions relating to detainees.

In 2016, a revised departmental SRAT was produced to better support the changing cohorts accommodated in the immigration detention network. The revised SRAT takes into account a broader range of considerations when assessing the risk of individual detainees. The SRAT provides a consistent and agreed set of principles around risk assessment and subsequent mitigation strategies. The SRAT considers each detainee's individual circumstances, including consideration of an individual's capability (e.g. age, frailty, medical condition) and intent (e.g. immigration pathway, behaviour, prevalence of incidents).

Higher risk detainees, based on behaviour and background may be placed in Blaxland High Security Compound (BHSC) as an operational decision. In making decisions on placement factors including the criminal history, known associates, vulnerabilities and behaviours of the detainee whilst in detention are considered.

The decision to place Mr [RG] within the BHSC was informed by his designated risk rating at that time, alleged criminal antecedents and the need to balance detainee numbers between respective compounds within the wider Villawood Immigration Detention Centre (VIDC). In light of his risk rating, Mr [RG] was considered unsuitable for placement in a less restrictive section of VIDC.

Risk assessments are not routinely undertaken when moving detainees from one accommodation to another within the same IDF.

Movements of detainees within each compound are managed by Serco. This includes the movements of detainees between dormitories in BHSC (Dorm 1, Dorm 2, and Dorm 3). These movements are updated on the Department's Compliance Case Management and Detention portal. In addition to any intelligence holdings on individual detainees, Serco is required to take all available information into consideration as part of its decision making.

This includes the:

- Nature of any incidents.
- The dorm and incident location.
- Ability to move the offender or the victim.
- Any results of actions taken as part of detainee behaviour management, and /or
- Conversations with the offenders and the victim as part of the incident response.

The first time Mr [RG] raised any safety concerns in relation to his placement and safety within BHSC was on 10 September 2016, through a complaint form dated 9 September 2016.

In this complaint, Mr [RG] stated that he felt unsafe and wanted to be moved out of BHSC. Serco discussed Mr [RG]'s concerns and explained to him available steps to manage his concerns including how to immediately raise concerns with Serco.

As previously stated in the Department's responses dated 21 December 2017 and 27 July 2020 respectively in relation to Mr [RG]'s complaint there is:

- No evidence to suggest that Mr [RG] or stakeholders of the Department were aware of the associates of other detainees in Dorm 2 prior to the assault of 7 September 2016.
- No records or intelligence holdings to confirm that Mr [RG] had any previous issues or history with the alleged offender.
- No evidence that Mr [RG] personally expressed concerns about his safety in Dorm 2.
- No evidence to suggest Mr [RG] alerted the Department or stakeholders of any associates of the first offender being in Dorm 2 of the BHSC.
- No safety concerns were raised by Mr [RG] in relation to his placement within Dorm 1 or the alleged offender.
- Serco have not been able to locate any evidence that Mr [RG] personally expressed concerns about his safety in Dorm 2 that could have been used to do a risk assessment that would warrant a move to another compound.

Mr [RG] resided in BHSC until 13 October 2016, when he was moved to Mackenzie Compound in VIDC. He was not accommodated in BHSC at any time thereafter. BHSC and Mackenzie are classified as High Security Risk Compounds and neither is more or less restrictive. Placement of detainees in either compound is typically informed by the need to balance the numbers of detainees, as well as any operational requirements.

The steps taken to mitigate, to the greatest extent possible, the risk to Mr [RG]'s safety were as follows:

- On 8 September 2016, at 8.30am, following an alleged assault on 7 September 2017, Mr [RG] returned from the hospital and was placed into the Blaxland High Security Compound (BHSC) Dorm 3 Observation Room (the Annex) for closer supervision and engagement. The alleged assault was referred to the Australian Federal Police (AFP) for investigation. The AFP decided it would not pursue the matter further and closed the file. The Australian Border Force does not require Serco to conduct their own investigations following decisions made by the AFP.
- On 8 September 2016, at 10.20pm, Mr [RG] was moved to Dorm 2 within the BHSC. Dorm 2 is separate to Dorm 1 and detainees do not have unmonitored access between different dorms. This had the effect of distancing the alleged offender from Mr [RG].
- On 9 September 2016, a Serco staff member witnessed Mr [RG] being assaulted by another detainee and immediately intervened and reporting it accordingly. Serco treated Mr [RG]'s injury and took him to IHMS. IHMS assessed Mr [RG] and recommended he attend hospital for further assessment and treatment. He was transferred to hospital on the same day. The assault was referred to the AFP on 13 September 2016. Departmental records show that the matter was not accepted by the AFP.
- Following the incidents of 7 and 9 September 2016, Serco spoke to the alleged offenders and they were reminded of the code of behaviour and potential consequences of any inappropriate action. This is noted as part of the Incident Report for this matter.
- On 10 September 2016, Mr [RG] was moved to Blaxland Dorm 1 where he was placed in the Observation Room close to the Officers station. Mr [RG] remained in the Observation Room until 13 October 2016. While accommodated here there was no possibility for the alleged offenders coming in to contact with Mr [RG].
- On 13 September 2016, the Department received a call from a Refugee Advocate stating that Mr [RG] was in fear for his life in Blaxland. Mr [RG] was monitored closely at the time the Stakeholder Information Sheet was received by Serco.

- On 14 September 2016, at the Detainee Placement and Preventative Committee (DPPC) meeting, stakeholders including ABF, Case Management, Serco and IHMS discussed Mr [RG]'s placement. All stakeholders agreed that Mr [RG] should be placed on the waitlist for placement in Mackenzie. Immediate transfer did not occur due to capacity issues at that time.
- On 16 September 2016, NSW Case Management was forwarded an email by a Refugee Advocate, stating Mr [RG] had raised concerns for his safety in the BHSC.
- On 20 September 2016, Mr [RG] met with a Serco Facilities Operations Manager (FOM). In this discussion Serco advised Mr [RG] how he could seek a room change (i.e. by lodging a Detainee Request Form with the reasons for the request). Furthermore in this discussion, Mr [RG] stated that he did not trust people in BHSC and that he was scared to use the bathroom. Serco advised Mr [RG] was informed that as he was in an observation room he had access to his own toilet. Mr [RG] was also asked if any detainees were threatening him or bullying him. Mr [RG] stated he just did not trust anyone. Mr [RG] was told to advise Serco when he wanted to use the shower and a Serco officer would be present in the area while he was using the facilities.
- The Department notes that on 21 December 2017, a response was provided to the Commission which included a copy of a complaint from Mr [RG] and a response provided by Serco stating that a Serco FOM met with Mr [RG] on 20 September 2016. During this conversation Mr [RG] was advised that placement decisions are agreed by all stakeholders including Serco, IHMS and ABF. The Serco officer stated that at that time Mr [RG]'s placement was appropriate. Mr [RG] was advised that he would need to submit a Detainee Request Form seeking a placement change.
- While this information is correct, it is not the only way a placement change can occur. As happened in Mr [RG]'s situation, Serco nominated Mr [RG] for a room change.
- Transfer of detainees between compounds is facilitated regularly. Detainee requests (including from complaints) are just one part of the circumstances considered. Decisions on compound transfer are made in a weekly joint review meeting which includes Serco, IHMS, the Department and ABF.
- The DPPC Agenda for 21 September 2016 confirms that Mr [RG] was still on the waitlist for placement in Mackenzie Compound.

- On 13 October 2016, a place became available in Mackenzie Compound and Mr [RG] was moved from BHSC to Mackenzie Compound.

123. The Department admits that risk assessments are not routinely undertaken when moving detainees within an Immigration Detention Facility but asserts that Individual Management Plans are prepared for each detainee which provide 'the framework with which to ensure that the wellbeing of all detainees is being monitored and managed appropriately'. The Commission was not provided with any such plans for Mr RG or documents showing the way in which his safety and wellbeing was being appropriately considered and managed. It is unclear why the Individual Management Plan for Mr RG would not have been updated to consider the ongoing risks to his safety and wellbeing after he suffered two assaults by three detainees within two days in Blaxland.
124. The Department's Compliance Case Management and Detention Portal is said to record movements of detainees, including between dorms 1, 2 and 3 within Blaxland, and take into account all available information, including the nature of any incidents, the dorm and incident location, the ability to move the offender or victim, any results of actions taken as part of detainee behaviour management and conversations with the offenders and victim as part of the incident response. It is not clear whether the information contained in the portal is set out in the Department's response, however the Commission has not been provided with extracts from this portal or documentary evidence of actions taken by the Department or its service provider concerning behaviour management, conversations with offenders and victims as part of the incident response or setting out how the Department or its service provider considered the ongoing risks to Mr RG and how those risks would be appropriately managed.
125. The Department's response places emphasis on Mr RG not having personally expressed concern for his safety while in dorms 1 and 2 and that he only raised concerns for his safety in his complaint form dated 9 September 2016. Mr RG alerted Serco officers after the First Assault and the Second Assault was witnessed by Serco officers. The Department was aware of the assaults, at least through Department Incident Detail Reports from Serco, an Incident Report from IHMS, correspondence from a Refugee Support Group and reports from a Serco representative at the Detainee Placement and Preventative Committee Meeting. The

fact of the two assaults inflicted by three detainees on Mr RG within two days and the seriousness of those assaults should have triggered concerns for Mr RG's safety and wellbeing by the Department and Serco. In circumstances where the Department's service provider, and the Department, are aware of multiple assaults on a detainee, it should not be necessary for that detainee to take further steps to personally express concern or make a formal complaint to the Department or its service provider expressing concern for their welfare and safety before the Department or its service provider considers the detainee's safety and wellbeing and the risks of further assaults on the detainee.

126. On the information before the Commission, I cannot be satisfied that the Department or Serco took adequate steps to protect Mr RG's safety following the two assaults. Consequently, I consider that Mr RG was not treated with humanity and with respect for his inherent dignity as required by article 10(1) of the ICCPR.

7.3 Transfer to another high security risk compound without a risk assessment

(a) Transfer to Mackenzie

127. On 13 October 2016, Mr RG was transferred to Mackenzie, another high risk security compound within VIDC. Mr RG says that, while in Mackenzie, he was approached by two other detainees who asked him if he knew the perpetrator of the First Assault and called him a 'F... dog'. He alleges that, on 23 December 2016, the same two individuals came to his room and assaulted him.
128. A Serco 'Officer's Report' dated 24 December 2016 records that, at approximately 9.25pm on the evening of the alleged assault, Mr RG requested to see a nurse because 'he was feeling unwell and thought he had a broken leg'. The officer noted that, on inspection, Mr RG presented with 'swelling around his left eye' and 'a swollen left knee and was having difficulty walking'.

129. A Serco Security Information Report dated 24 December 2016 records the following description of the event:

AFTER RECEIVING BIO PURCHASE YESTARDAY [sic] DETAINEE WAS FOLLOWED BY DETAINEE [redacted] WHOM [RG] STATED [redacted] HAS BEEN FOLLOWING ME ALL DAY ASKING ME FOR MY PHONE CARDS IN EXCHANGE FOR DRUGS". DETAINEE [RG] STATED HE NEEDED THE CARD TO TALK TO HIS FAMILY AND HE WOULDN'T GIVE IT TO HIM. DETAINEE [redacted] ENTERED [RG]'S ROOM IN THE EVENING IN UNIT 5.1 AND TRIED TO GET THE PHONE CARDS OF [sic] HIM AGAIN THROUGH INTIMIDATION AND AGAIN [RG] STATED "HE REFUSED". PRESENT IN THE ROOM WAS DETAINEE [redacted] WHO SHARE [sic] THE ROOM WITH [RG]. DETAINEE [redacted] THEN PUNCH [sic] DETAINEE [RG] IN THE FACE MULTIPLE TIME [sic]. DETAINEE [redacted] WALKED OUT OF THE ROOM AND CLOSED THE DOOR WHEN DETAINEE [redacted] ENTERED THE ROOM. DETAINEE [RG] RESISTED AND DETAINEE [redacted] JUMPED IN TO HOLD AND RESTRAINT [sic] DETAINEE [RG]'S HANDS BEHIND THE BACK, WHILE DETAINEE [redacted] ASSAULTED HIM IN THE ROOM.

THIS INCIDENT/ASSAULT OCCURRED [sic] OVER 20 MIN PERIOD, BUT NO OTHER DETAINEE REPONDED TO HELP. DETAINEE STATED HE IS FEARFUL FOR HIS LIFE AND HE CAN'T BE HERE. DETAINEE [RG] STATED "HE DOESN'T FEEL SAFE" AND ALSO OTHER DETAINEES HAVE STATED HE DIDN'T DESERVE WHAT HAS HAPPENED TO HIM AS THE [sic] SHOW EMPATHY FOR HIS SAFETY DUE TO THE BEHAVIOUR OF INTIMIDATION BY DETAINEE [redacted] GROUP.

ALSO DETAINEE [RG] STATED THAT HE WAS THREATEN [sic] TODAY BY DETAINEE [redacted] IF HE PROCEEDS WITH CHARGES OF ASSAULT ON HIM, THAT "I WILL KILL YOU AND I HAVE FRIENDS TOO". DETAINEE [RG] HAS REQUIRED [sic] TO BE MOVED ANYWHERE [sic] BUT HERE AS HE FEARS FOR HIS LIFE, AS STATED "HE FEELS MORE SAFE I [sic] PRISON THEN [sic] HERE AS HIS LIFE IN [sic] AT RISK".

130. IHMS clinical records confirm Mr RG's treatment on 23 December 2016 for visible injuries to his face and left knee. Mr RG was taken to Liverpool hospital for treatment overnight and discharged the following morning.

131. A CT scan of Mr RG's brain and facial bones showed facial bone and nasal bone fractures, for which he was later referred to a plastic surgeon. An Xray on Mr RG's left knee noted a 'small joint effusion present', but no fracture. On 10 January 2017, Mr RG was diagnosed after an MRI on his left knee with the following and later referred to an orthopaedic surgeon for treatment:

- Moderate sized joint effusion
- Acute ACL rupture with associated bone marrow bruising and contusions involving the posterolateral femoral and tibial surfaces
- Further contusion at the posteromedial tibia and opposing femoral articular surface with adjacent high grade MCL sprain and partial thickness tearing of the deep fibres.

132. Clinical notes from a mental health consultation with Mr RG on 24 December 2016 record Mr RG's concern for his personal safety, including the following notes (punctuation in the clinical notes quoted in paragraphs 132, 144 and 145 is as it appears in the source document):

- He stated that he could not divulge any information about the attack/incidence last [night] until Serco/IHMS Manager can guarantee that he would be protected from the perpetrator
- He does not feel safe any longer
- Not willing to return to Mackenzie (location where he was assaulted)
- He was attacked for 1 hour without any Security officer being ;aware , notified nor ;come to his rescue
- the perpetrator had pre-warn him that should he divulge the information to anyone he would be dead
- "HE MENTIONED THAT HE'S BEEN FOLLOWED BY THE PERPERTRATOR'S FRIENDS". Hence he feels really unsettled and fearful of his safety.
- Similar encounter ;happened before in September 2016-perpetrated by the same group

133. 'Risks' were recorded in the clinical notes as '[h]igh risk of being assaulted if returned to the same environment (Mackenzie)' and that '[Mr RG] is vulnerable to attack due to physical disability from previous attacks'. The 'Plan' was recorded as 'Detainee protection issue'; 'Serco to organize safety measures'; '[redacted] Aware' and 'Detainee now placed on High Risk SME'.
134. The Department states that:
- [t]here is no information to suggest the Department or stakeholders were aware of any known associates of the offender from the assault on 7 September 2016 being located in Mackenzie Compound.

(b) Consideration

135. On 23 December 2016, Mr RG was assaulted a third time in Mackenzie, a high security compound within VIDC. Mr RG alleges that the perpetrator of the Third Assault was an associate of the perpetrators of the First and Second Assaults. There is, however, not enough information before the Commission to make that finding.
136. On the information before the Commission, it does not appear that Mr RG raised concerns with the Department or Serco prior to the Third Assault about his safety in Mackenzie or that he believed that associates of the perpetrators of the First Assault and Second Assault were detained in Mackenzie. The Department says that there is no evidence that the Department or its stakeholders were aware of any known associates of the perpetrator of the First Assault being located in Mackenzie.
137. As set out above, given the two assaults on Mr RG in Blaxland and his mental health vulnerabilities, it is concerning that the Department did not conduct an assessment of any ongoing risks to his safety in detention, including in respect of his transfer within VIDC and the risk of placing him with associates of the perpetrators of the assaults.
138. In my view, conducting a documented risk assessment of the ongoing risks to victims of assault in detention by other detainees would enable the Department to consider properly any ongoing risks to victims and how those risks could be addressed or managed, including identifying associates of the perpetrators of the assault, the location of those associates and any potential risks to victims in their placement in detention.

139. However, in circumstances where it does not appear that the Department was aware of any concerns in relation to Mr RG's safety in the Mackenzie compound, either from Mr RG or from other sources, prior to the assault, I do not consider that the Department's failure to conduct a risk assessment prior to the assault amounts to a breach of article 10 of the ICCPR.
140. Mr RG also complains about his placement in Mackenzie, another high security risk compound, in circumstances where he had mental health vulnerabilities and had been the victim of two assaults. For the reasons set out at paragraph 89 above in respect of Mr RG's placement in Blaxland, I do not consider that his placement in Mackenzie rises to the level of conduct required for a breach of article 10(1) of the ICCPR. It is, however, very concerning that Mr RG was the victim of three assaults during his detention in high security compounds in VIDC. I note with concern the findings of the Griffith Criminology Institute Report referred to above that the incidence of violence perpetrated by detainees against fellow detainees in VIDC is significant.

7.4 Continued detention in Mackenzie following assault without a risk assessment

(a) Actions after assault in Mackenzie

141. The Commission requested information from the Department concerning the additional steps, if any, taken by the Department or Serco to prevent or mitigate further harm to Mr RG between 13 October 2016 and 30 January 2017 in Mackenzie. In response, the Department repeated the response it provided for the period of 7 September 2016 to 13 October 2016, being:

Mr [RG] is subject to the same safety and security provisions afforded to all people in immigration detention at all times while accommodated in an immigration detention facility. This includes the presence of Serco personnel in common areas, both in fixed stations and roving patrols. CCTV coverage of common areas is also in place. Mr [RG], was also able to raise any concerns he might have for his safety directly with Serco, IHMS or ABF personnel at any time, verbally or in writing, so that those concerns could be addressed as appropriate.

The ABF has always been committed to the safety and security of all detainees, visitors and staff within the Villawood Immigration Detention Centre. Support services are in place in the form of Personal Officers, Welfare Officers and Health Support Services for detainees to utilise whilst located in Immigration Detention to raise any issues, concerns or provide medical and mental health support.

142. In response to the Commission's request for information concerning the steps taken after the Third Assault to ensure Mr RG's safety, the Department stated:

On 24 December 2016, Mr [RG] was released from hospital and returned to Mackenzie Compound and disclosed the names of the detainees involved in the assault on himself on 23 December 2016. Mr [RG] was placed on High Imminent Psychological Support Program by the International Health and Medical Service (IHMS).

...

Additionally, Mr [RG] was allocated a Support Officer on constant 24 hour observation. These measures were taken to ensure Mr [RG]'s safety until such time as the two detainees involved in the assault could be moved to Blaxland.

On 25 December 2016, the two detainees named in the assault of Mr [RG] were moved to Blaxland.

143. A Serco document titled 'KeepSAFE / PSP SME' records that 'PSP SME' was initiated on 24 December 2016 on the instigation of the IHMS mental health team. The 'Initial observation level' was categorised as 'High-imminent', noting 'Detainee is at high risk of assault / attack from others that may lead to serious injury or loss of life'. A Serco document titled 'Detainee history' records the ongoing close monitoring of Mr RG which ceased at 6.55am on 28 January 2017.
144. Clinical notes of a consultation with a Mental Health Nurse on 25 December 2016 record the following:
- nil changes to state of fear and anxiety about his safety
 - Stated that he has benefitted from High Risk SME
 - He feels protected by Serco security and has been staying indoors too for [his] own safety

- Feels downgrading the SME risk category would be dangerous for him
- Still feels ;fearful of more attacks from perpetrator and his accomplice
- Detainee protection issue
- Situational crisis.

The recorded 'Risks' included 'High risk of being assaulted if High risk SME ;status is downgraded' and '[h]e is vulnerable to attack due to physical disability from previous attacks'. The 'Plan' was recorded to be '[t]o remain on High Risk SME'.

145. Clinical notes of a further consultation with a Mental Health Nurse on 27 December 2016 records that:

- [Redacted] and the other accomplice has now been moved to Blaxland
- He still feels downgrading the SME risk category would be dangerous for him, however reassured that [redacted] will sort it out
- Also still feels fearful of more attacks from perpetrators' accomplice
- Reassured by [redacted] who will sort detainee protection issues out with stake holders tomorrow
- [Redacted] has been provided on-going security 1:1 and to keep monitoring till tomorrow morning (till discussion with stake holders)
- High risk of being assaulted if High risk SME status is downgraded [redacted] to provide security officer support 1:1 till management plan tomorrow.

146. The Department states that, on 29 December 2016, it referred two alleged assault incidents on Mr RG from 23 and 24 December, to the AFP for investigation. Mr RG's complaint does not allege a further incident of assault on 24 December 2016. Mr RG has confirmed that he was not assaulted on 24 December 2016, and I note that the reports dated 24 December 2016 provided to the Commission relate to the 23 December 2016 assault.

147. Mr RG asserts that he regularly asked to be moved to a lower security compound and that he should never have been placed in Mackenzie or any section where there were criminals or associates of the perpetrator of the First Assault.
148. The Department states that there 'is no record to suggest that Mr RG had requested a change of placement to a less restrictive compound'. It also states that:
- [t]here is no information to suggest the Department or stakeholders were aware of any known associates of the offender from the assault on 7 September 2016 being located in Mackenzie Compound.
149. Clinical records of a mental health consultation with a psychologist dated 6 February 2017 records that Mr RG was 'disappointed his requests for a transfer from Mackenzie have not had any result or feedback' and that he 'no longer feels safe in Mackenzie'.

(b) Consideration

150. After the Third Assault, IHMS instigated a process for the ongoing monitoring, ongoing security and escorting of Mr RG in Mackenzie. This appears to have ceased soon after the two perpetrators of the Third Assault were moved from Mackenzie to Blaxland. However, the clinical notes of Mr RG's consultations with IHMS record that:
- he feared friends and accomplices of the perpetrators of the Third Assault in Mackenzie
 - he believed the perpetrators had hundreds of supporters
 - four other detainees had watched the Third Assault without intervening
 - he had been followed by friends of the perpetrators
 - he had been threatened that if he divulged information to anyone, he would be dead
 - he felt that downgrading the SME risk category would be dangerous for him.

151. The threats made to Mr RG after the Third Assault concerning the perpetrators or their friends killing him should he divulge information concerning the Third Assault or press charges against them are serious matters warranting ongoing concern for Mr RG's safety. It does not appear that the Department or Serco conducted any further assessments of the ongoing risk to Mr RG after the perpetrators of the Third Assault were removed from Mackenzie.
152. The additional monitoring and security provided to Mr RG and the removal of the perpetrators of the Third Assault from Mackenzie was a reasonable approach to ensuring his safety immediately after the assault. However, an assessment of the ongoing risks to Mr RG after the Third Assault could have identified any ongoing risks or harm to Mr RG, including from friends or associates of the perpetrators of the assaults against him. Such an assessment may also have gone some way to alleviating Mr RG's concerns for his safety and security while detained in Mackenzie.
153. Having regard to the circumstances before the Commission, I consider that, while the Department should have conducted a risk assessment to identify any ongoing risks to Mr RG after the removal of the perpetrators of the Third Assault, the steps it took to implement additional monitoring, security and escorts for Mr RG until the perpetrators were moved from Mackenzie were reasonable. I do not consider that the actions of the Department or Serco rise to the level of a breach article 10(1) of the ICCPR.

8 Recommendations

154. As a result of the inquiry, I have found that the following act of the Commonwealth is inconsistent with, or contrary to, article 10(1) of the ICCPR:

the decision of the Department or Serco to continue to detain Mr RG in the Blaxland compound within VIDC (Blaxland) following two assaults on him by other detainees without undertaking a documented risk assessment process or other action to protect his safety.

155. Where, after conducting an inquiry, the Commission finds that an act or practice engaged in by a respondent is inconsistent with, or contrary to, any human right, the Commission is required to serve notice on the respondent setting out its findings and reasons for those findings.⁴⁵ The Commission may include in the notice any recommendation for preventing a repetition of the act or a continuation of the practice.⁴⁶
156. The Commission makes the following recommendations:

Recommendation 1

A risk assessment should be undertaken for all detainees involved in an act of violence as part of the Department and its service provider Serco's response to that act of violence. The assessment should include an assessment of the likelihood of the alleged perpetrator engaging in a further act of violence in the future, the risks posed to the detainee who was the victim of the violence, and the steps necessary to mitigate those risks.

Recommendation 2

The Department should develop a mandatory protocol for responding to detainee-on-detainee violence, which includes the immediate separation of detainees following any such incident to accommodation where an alleged perpetrator can no longer have access to the alleged victim.

Recommendation 3

The Department should require Serco to review the Security Risk Assessment Tool to ensure that it clearly identifies detainees who are vulnerable to harm from other detainees, and detainees who present a risk to the safety of other detainees.

Recommendation 4

Decisions to transfer a detainee to different accommodation within the immigration detention network should take into account:

- a. any specific identified risks posed to that detainee from other detainees, for example, as a result of previous incidents
- b. any general risks identified to that detainee from other detainees, as revealed in the updated security risk assessment tool amended in accordance with recommendation 3, and
- c. that effective measures are put in place to mitigate or eliminate those risks.

Recommendation 5

The Department should immediately implement measures to protect people at risk of violence at VIDC, including by exploring alternative detention arrangements, including community detention or grants of bridging visas, that would allow for victims of violence to be separated from the alleged perpetrators.

Recommendation 6

The Department should establish an independent review of threatened and actual violence at VIDC, with a view to identifying measures to prevent violence and protect those at risk of harm.

Recommendation 7

The Department should conduct its own investigations into incidents of assault that have been referred to the AFP where the AFP decides to not conduct an investigation.

9 The Department's response to my findings and recommendations

157. On 3 February 2023, I provided the Department with a notice of my findings and recommendations.
158. On 13 April 2023, the Department provided the following response to my findings and recommendations:

The Department of Home Affairs (the Department) values the role of the Australian Human Rights Commission (the Commission) to inquire into human rights complaints and acknowledges the findings identified in this report and the recommendations made by the President of the Commission.

In relation to the decision of the Department or Serco to continue to detain Mr RG in the Blaxland compound until he was moved to another compound, the Department notes the findings of the President however considers that steps were taken in consideration of Mr RG's basic needs for safety and security.

Risk Assessment

The Department notes recommendation one. The Department considers there are already documented risk assessments that are undertaken for all detainees involved in an act of violence. Indeed, a detainee's security risk assessment captures each incident a detainee is involved in regardless of whether they were an alleged victim, an alleged offender or involved in any other capacity. The risk assessment is reviewed every 28 days, and upon a major or critical incident, or if there is information obtained that may impact the risk rating of the detainee. This assessment uses quantitative and qualitative methods to assess and calculate risk based on known criteria for each detainee. At the completion of each review, the updated risk assessment is recorded on Departmental systems.

The Facilities and Detainee Service Provider (FDSP) monitors detainee interactions and has mitigation strategies in place to maintain detainee safety and security. The FDSP maintains internal placement strategies and makes recommendations to the Australian Border Force (ABF) on appropriate placements within the facility.

In the event of an incident of detainee on detainee violence within the Immigration Detention Network (IDN), once the FDSP is aware, the involved persons would be immediately separated, and medical assistance offered where required. Depending on ABF approval, the alleged offender may be placed in High Care Accommodation (HCA). If there is a perceived risk to the alleged victim, temporary placement in the HCA may be sought or offered on a voluntary basis. Any placement in the HCA is at the discretion of the ABF based on security and health advice from service providers. Any HCA placement longer than 24 hours must be justified and approved by the ABF.

Within 24 to 48 hours of the incident, placement arrangements for the detainees involved must be reviewed by stakeholders to determine suitability. This includes considering accommodation availability and known intelligence holdings before placement recommendations are made. The final approval for internal compound movements is at the discretion of the ABF Superintendent.

If HCA placement or internal transfers do not occur, enhanced monitoring may be initiated for one or more involved detainees. For all alleged assaults, the FDSP will complete a referral package to the Australian Federal Police or state/territory law enforcement authorities and provide this to the ABF. The ABF will progress the referral package to relevant authorities for their consideration.

In addition, assessment on the likelihood of an alleged perpetrator engaging in a further act of violence in the future and the risks posed to the detainee who was the victim, is managed within the following two site based governance framework meetings. These site-based meetings capture the records of violence and enable relevant stakeholders to implement mitigation strategies.

Morning stakeholder meeting:

The morning stakeholder meetings are held every weekday with representatives from the ABF, the FDSP and Detention Health Service Provider (DHSP). The meetings are chaired by the ABF and discuss the following:

- Incidents that have occurred within the past 24 hours (72 hours on a Monday) including detainees involved and local management strategies that were used in response to those incidents, such as Keepsafe, enhanced monitoring and high care accommodation placements.
- Updates regarding the FDSP intelligence holdings.
- DHSP updates regarding detainees on the Psychological Support Program (PSP) and health related incidents in the last 24 hours.
- ABF overview and update.
- FDSP operational update on Keepsafe, enhanced monitoring, behaviour management plans and scheduling for upcoming external escorts.

Individual Management and Placement Review Committee (IMPRC) Meeting:

The IMPRC meetings are held monthly or more frequently as required, and are chaired by the ABF. The IMPRC is attended by all stakeholders including the ABF, DHSP and FDSP and provides a regular consultative forum for stakeholders to review 'at risk' or 'vulnerable' detainees, taking advice and recommendations that reflect the broad range of views and experience of the stakeholders in attendance. IMPRC discussions may include:

- Review, update and action Individual Management Plans (IMPs).
- Develop and implement prevention strategies for detainees at risk.

- Review detainee placement options for those at risk.
- Review, update and action Behaviour Management Plans (BMPs) for detainees engaging in inappropriate behaviours and actions.

Prior to IMPRC meetings, the most recent IMPs for the detainees to be discussed are reviewed and distributed to stakeholders. During the meeting, the agenda notes are reviewed for each detainee of concern, and assessments of their current care arrangements, along with proposed actions, are discussed. Following each IMPRC, the detainee's IMP is updated to include any actions and recommendations. The IMP is tabled at the following IMPRC to ensure that the recommendations and actions were conducted. The IMPRC meeting outcomes are recorded and circulated amongst stakeholders. The FDSP will also meet and discuss with the detainee any changes to their care arrangements.

In summary, the FDSP employs a risk assessment that involves the Security Risk Assessment Tool (SRAT), the morning stakeholder meeting and ongoing monthly reviews via the IMPRC. These risk assessments capture acts of violence and assist in preventing further violence from occurring and they entail ongoing and continuing review and monitoring of detainees. It is current practice that all incidents are documented and reported according to the FDSP and ABF's policies and procedures.

Mandatory Protocol for responding to detainee-on-detainee violence

The Department notes recommendation two as it considers that there are currently multiple measures to manage incidents of detainee-on-detainee violence, which are sufficient for responding to violence when it occurs. The Department remains committed to providing a safe environment for all persons in an IDF. The Department now has a suite of detention operational policy instructions which provide clear guidance to officers for managing incidents, such as violence, and providing appropriate placement within the IDF.

These procedural instructions and standard operating procedures specifically include incident management and reporting, managing and responding to offences against the person, and closer supervision and engagement of high-risk detainees. Separating high-risk detainees from the general population (high-care accommodation) is a last resort, and may be used when necessary and appropriate to manage the good order and security of an IDF and the safety of people within it.

Individual management plans (IMPs) are also an important tool to monitor and manage the welfare of detainees in immigration detention. The procedural instructions outline the circumstances which trigger reviews of a detainee's IMP. This includes responding to incidents that present an unacceptable risk to a detainee or to the safety of others. This can include assessment of placement arrangements of detainees post an incident. Post incident reviews, security intelligence reporting, and daily operational stakeholder meetings are additional mechanisms to ensure the appropriate placement of detainees post an incident, including detainee on detainee violence.

All of the above mentioned tools, forums and instructions work in collaboration to protect the safety of victims of detainee violence, and negates the need for further protocol development.

The Department notes that these measures to manage incidents for detainee-on-detainee violence have evolved over the last five years since the incidents that were the subject of this complaint, in late 2016 and 2017.

In 2018-2019, a revision of all detention related procedural instructions was conducted under a whole of ABF Policy and Procedure Control Framework (PPCF) project to revise all documentation held in the Departmental PPCF Register (the Register). As part of the PPCF, procedural instructions and standard operating procedures are reviewed on a three yearly cycle, with amendments and updates made on an as required basis. Since January 2021, the documents in the Register have been progressively updated. The FDSP also undertakes reviews of their relevant Policy Procedure Manuals (PPMs) concerning incident management (including reporting and handover), individual and behaviour management, and complex case reviews. There is a requirement for the FDSP under contractual agreements to update and align their PPMs in accordance to any Departmental policy or procedural changes.

Security Risk Assessment Tool (SRAT)

The Department notes recommendation three. Information on detainees who are vulnerable to harm from other detainees, and detainees who present a risk to the safety of other detainees is captured through the IMPs and BMPs.

As per contractual requirements, the SRAT is designed to provide a risk rating on an individual in relation to the security risks posed by that individual against the IDN, including other detainees and stakeholders. By elevating the risk rating for detainees who pose a threat to the IDN (including detainees and staff) the SRAT identifies those detainees that require further mitigation strategies to ensure the safety, security and good order of the IDF, and the detainees and staff within. The SRAT identifies risks including escape, demonstration, violence and aggression, self-harm and criminality.

The purpose of, and capability of, the SRAT is not to risk assess the vulnerability of harm to other detainees. When a detainee is involved in an incident of violence/harm or when there is information to suggest a detainee presents a risk to others, or a detainee is vulnerable to harm; consideration is made to update a detainee's IMP and/or create/update a BMP. The considerations are conducted through IMPRC meetings, where stakeholders consider risks and mitigation strategies for detainees, as referenced in recommendation one.

The Department continues to review the functionality of the SRAT to ensure the safety and security of the IDN, detainees, and staff.

Placement decisions within the Immigration Detention Network

The Department notes recommendation four. There is already a robust process in place which includes consideration of identified risks posed to a detainee from other detainees when determining the placement and potential transfer of a detainee. A decision to transfer a detainee to another IDF is made after consultation with stakeholders of both the sending and receiving IDFs. This includes internal stakeholders such as the Department's status resolution, ABF staff, and external stakeholders such as detention service providers and in the case of minors – Immigration Guardianship of Children (IGOC) delegates and/or the Department's Child Wellbeing Officer.

Prior to the transfer of any detainee, a rigorous assessment is undertaken which includes:

- feedback from stakeholders (Department, ABF and service providers) relating to a detainee's prior incidents in detention,
- the detainee's security risk rating,

- the detainee's family and community links,
- the detainee's criminal history,
- the detainee's vulnerabilities,
- the detainee's health and associated requirements, and
- any ongoing legal, criminal or immigration related matters.

The Department promotes flexible management of the capacity at each IDF due to the changing requirements of the individuals detained within each IDF. Transfer of detainees between compounds is facilitated regularly. Inter-compound placement decisions are made at the IDF and may at times need to be made quickly due to operational requirements. Detainee requests (including from complaints) are one part of the circumstances considered. Decisions in relation to detainee placement within the facility are taken 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. Transfers within the facility as part of inter-compound placement are also reviewed and discussed at the two on-site governance forums through the Morning Stakeholder meeting and the IMPRC.

The SRAT is one source of information that is considered when completing a Detention Placement Assessment (DPA) to identify any documented risks when making a placement consideration at an IDF. This includes, but is not limited to associations of the detainee and any vulnerabilities. Other points that are considered include identity, placement security risk and facility suitability, accommodation history, criminality offences and scheduled court details, family and community links, unlawful links and criminal association, escape risk, vulnerability and health details.

It is important to note that the Department's transfer procedures have evolved over the last five years since the incidents that were the subject of this complaint, in late 2016. Specifically, the DPA has been updated to streamline the assessment process and capture all of a detainee's information, including incidents. The development of the DPA was initiated approximately five years ago and was implemented officially onto a single online platform on 16 November 2020. The DPA assists officers in determining the most appropriate placement option for a detainee within the IDN. It is used for both record keeping and decision-making. The DPA assists officers in making an assessment of the risks

associated with individual detainees, while also taking welfare issues into consideration.

Limited capacity at IDFs necessitates transfers of detainees around the IDN in order to ensure facilities are managed at safe operating capacity and provide appropriate amenities for detainees. The placement process ensures that detainees will be suitably accommodated in a safe immigration detention environment.

Alternative Detention Arrangements

The Department notes recommendation five and as advised in recommendation three, the Department uses the SRAT to provide a risk rating on individuals in relation to the security risks posed by that individual in an IDN. The Department has previously provided advice to the Commission that the Department has a framework in place of regular reviews, escalations and referral points to ensure that 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 maintains that review mechanisms 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.

Escalation and referral points include the IMPRC and regular morning meetings. Attendance at these forums includes all key stakeholders within the relevant immigration detention facility, including departmental Status Resolution Officers (SRO). If detainees are raised in these meetings where concerns exist with regard to safety or violence, the case may be reviewed by SROs to determine if their current placement (detention or community) is appropriate. The Department reviews every detainee in held immigration detention each month through Detention Review Committee (DRC) meetings, to ensure efforts are directed towards resolving the status of people in detention and considering the most appropriate placement pending status resolution. Detainees that may be identified as victims of violence can also be raised through the DRC to consider if their current placement is appropriate.

Departmental SROs also conduct formal reviews of all persons in immigration detention on a monthly basis. The case reviews are conducted to ensure placement is appropriate and that cases are progressing towards a status resolution outcome. In conducting monthly reviews, SROs must consider any new information or new barriers to case progression, and escalate as appropriate.

In October 2016, the Department implemented the Community Protection Assessment Tool (CPAT) across the immigration detention network. The Commission would be aware the CPAT is a decision support tool to assist the Department in assessing the most appropriate placement of a non-citizen while status resolution is pursued. In this context, placement refers to whether the non-citizen should reside in the community on a bridging visa or under a residence determination arrangement, or placed in held immigration detention.

The CPAT provides a placement recommendation (detention or community) based on a point in time assessment of the level of risk a person poses to the community, through a set of defined parameters. Within the CPAT, SROs also consider additional factors as part of the placement assessment including potential vulnerabilities such as the non-citizen's age, health, if they have been, or are at, a higher risk of being the victim of a crime, and any behaviour impacting their own wellbeing. SROs can also record and consider strength based factors such as community support and employable skills, which would support a community placement, noting that non-citizens on bridging visas may have permission to work.

During his time in immigration detention, Mr RG continued to be regularly reviewed by the Department. On 24 November 2016, a CPAT was conducted that assessed Mr RG as being of high risk to the community due to his criminal charges and was recommended a Tier 3 (held immigration detention) placement. Mr RG was not eligible for the grant of a bridging visa, as he was barred under section 46A of the Migration Act 1958.

The reviews did not identify any circumstances that warranted a change of Mr RG's current placement until Mr RG was found to be 'not guilty' to the charge of grievous bodily harm on 22 February 2017. On 14 March 2017, a further CPAT was completed that assessed Mr RG as low risk to the community and recommended a Tier 1 (bridging visa) placement. On this same day, Mr RG's case was referred for assessment against the section 195A Ministerial Intervention guidelines.

On 13 April 2017, Mr RG was granted a Safe Haven Enterprise (Temporary) (subclass 790) visa and released from immigration detention.

Independent Review

The Department notes recommendation six.

The Department has a number of mechanisms in place to assess risk of harm to immigration detainees, visitors and personnel, as described in the response to recommendation two. These policies and procedures are subject to regular review by process owners to assess their effectiveness in proportion to identified or foreseeable threats within IDFs.

In addition to the AHRC, independent oversight of the immigration detention program including the management of safety and security, is conducted by the Commonwealth Ombudsman and Comcare.

The Department maintains a number of internal assurance processes in relation to the management of immigration detention separate to and independent from, operational areas of the ABF through the Detention Assurance Team and the Department's Clinical Assurance Team. Internal assurance and external oversight processes are in place to ensure that the health, safety and wellbeing of all detainees is maintained.

The Department uses three lines of assurance to assess, analyse and mitigate risks in immigration detention. These include:

- security risk assessments with controls identified to mitigate risks;
- independent assurance to review immigration detention practices, policies and detention-related decision-making; and
- post-incident reviews to identify measures to prevent similar incidents occurring and enhance processes such as police referrals.

Internal review of incidents of assault

The Department notes recommendation seven.

The Department and ABF already conduct enquiries into all incidents involving violence as part of internal risk assessment processes in order to inform subsequent decision making. This includes a consideration of a compound or facility move for the detainees involved to manage the safety, security and ongoing good order of the facility. Regardless of law enforcement referrals, the actual or alleged assault incident would be discussed in relevant governance forums (including Daily Stakeholder Meetings and IMPRC) and considered for appropriate response within the existing behavioural management framework. Where a systemic issue is identified, the Department and ABF have assurance measures available to undertake Management Initiated Reviews and / or Detention Assurance Reviews.

The Department works with stakeholders to ensure all detainees are safe in the event of an incident, including referrals being made to the relevant authorities. It is important to note, however, that the AFP decision on accepting or declining a referral is solely their responsibility and any internal review would exclude their decision making process. The relevant law enforcement agency may decide to accept the referral for investigation at any point in time.

The FDSP are also contractually obliged to conduct post-incident reviews (PIR) on all major and critical incidents to determine the cause and contributing factors of an incident and to identify any gaps in processes, procedures and training. The Department and ABF have the ability to direct the FDSP to conduct an inquiry into any incident. It is important to note any enquiries by the Department and ABF seek to ensure safe and secure detention and focus primarily on appropriate detainee placement.

The Department does not have jurisdiction to prosecute incidents of assault under the Act. The Department may conduct investigations under s197B of the Act in relation to the manufacture, possession, use and distribution of weapons if a weapon is used in an assault, however

any allegation or incidents of criminality is referred to the relevant authorities. It is also important to note that although the AFP or state police may initially decide not to conduct an investigation on incidents of assault, they can choose to conduct an investigation at a later time.

Table 1 – Summary of Department’s response to recommendations

Recommendation number	Department’s response
1	Noted
2	Noted
3	Noted
4	Noted
5	Noted
6	Noted
7	Noted

159. I report accordingly to the Attorney General.



Emeritus Professor Rosalind Croucher AM
President
Australian Human Rights Commission

June 2023

Endnotes

- 1 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) articles 7 and 10.
- 2 See *Secretary of the Department of Defence v Human Rights and Equal Opportunity Commission, Burgess & Ors* (1997) 78 FCR 208.
- 3 Human Rights Committee, *General Comment No 21: Article 10 (Humane treatment of persons deprived of their liberty)*, 44th sess, UN Doc HRI/GEN/1/Rev.1 at 33 (10 April 1992) [3].
- 4 Human Rights Committee, *General Comment No 21: Article 10 (Humane treatment of persons deprived of their liberty)*, 44th sess, UN Doc HRI/GEN/1/Rev.1 at 33 (10 April 1992) [3].
- 5 UN Human Rights Committee, *General Comment No 21: Article 10 (Humane treatment of persons deprived of their liberty)*, 44th sess, UN Doc HRI/GEN/1/Rev.9 (10 April 1992) 1 [3].
- 6 Manfred Nowak, *UN Covenant on Civil and Political Rights CCPR Commentary* (N.P. Engel, 2nd ed, 2005) 250.
- 7 UN Human Rights Committee, *Views: Communication No. 529/1993*, 60th sess, UN Doc CCPR/C/60/D/639/1995 (19 August 1997) (*Walker and Richards v Jamaica*); UN Human Rights Committee, *Views: Communication No 845/1998*, 74th sess, UN Doc CCPR/C/74/D/845/1998 (*Kennedy v Trinidad and Tobago*); UN Human Rights Committee, *Views: Communication No 684/1996*, 57th sess, UN Doc CCPR/C/74/D/684/1996 (*R.S. v Trinidad and Tobago*).
- 8 Joseph S, Schultz J, Castan M, *The International Covenant on Civil and Political Rights*, 2nd Edition, (OUP 2004) 284.
- 9 UN Doc CCPR/CO/71/HRV (30 April 2001) para 14 at [http://www.unhchr.ch/tbs/doc.nsf/\(Symbol\)/7c3306a53f34ff43c1256a2a0036d955?Opendocument](http://www.unhchr.ch/tbs/doc.nsf/(Symbol)/7c3306a53f34ff43c1256a2a0036d955?Opendocument).
- 10 The Standard Minimum Rules were approved by the UN Economic and Social Council by its resolutions ESC Res 663C (XXIV) 24 UN ESCOR Supp 1 UN Doc E/3048 (31 July 1957) and ESC Res 2076 (LXII) 62 UN ESCPR Supp 1 UN Doc E/5988 (13 May 1977). They were adopted by the UN General Assembly in resolutions *Human Rights in the Administration of Justice*, GA Res 2858 (XXVI), UN GAOR, 3rd Comm, 26th sess, 2027th plen mtg, Agenda Item 12, UN Doc A/8588 (20 December 1971) and 3144 of 1983: UN Doc A/CONF/611, Annex 1. The Rules were revised, adopted and approved to be known as the “Nelson Mandela Rules” by the seventieth session of the United Nations General Assembly on 17 December 2015, agenda item 106, on the report of the Third Committee (A/70/490), UN Doc A/RES/70/175.
- 11 The Body of Principles were adopted by the UN General Assembly in *Body of Principles for the Protection of all Persons Under Any Form of Detention or Imprisonment*, GA Res 43/173, UN GAOR, 6th Comm, 43rd sess, 76th plen mtg, Agenda Item 138, UN Doc A/43/49 (9 December 1988).

- 12 UN General Assembly, *Standard Minimum Rules for the Treatment of Prisoners*, adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, United Nations Publication, UN Doc. A/CONF/611 (30 August 1955), as amended by 'the Nelson Mandela Rules', UN Doc A/RES/70/175 (17 December 2015), preliminary observation 2(1), 7.
- 13 Human Rights Committee, *General Comment No 21: Article 10 (Humane treatment of persons deprived of their liberty)*, UN Doc HRI/GEN/1/Rev.1 at 33 (10 April 1992) [5].
- 14 Human Rights Committee, *Mukong v Cameroon*, Communication No. 458/1991, UN Doc CCPR/C/51/458/1991 (21 July 1994) 11 [9.3]; Human Rights Committee, *Potter v New Zealand*, Communication No. 632/1995, UN Doc CCPR/C/60/D/632/1995 (18 August 1997) 6 [6.3]. See also, Human Rights Committee, *Consideration of Reports Submitted by States Parties under Article 40 of the Covenant: United States of America*, UN GAOR, Supp No 40, UN Doc A/50/40 (3 October 1995) 55 [285], 57 [299].
- 15 Human Rights and Equal Opportunity Commission, *CD v Commonwealth (Department of Immigration and Multicultural Affairs)*, [2006] AusHRC 36 (1 August 2006).
- 16 Immigration Detention Facilities and Detainee Services Contract between the Commonwealth of Australia and Serco Australia Pty Ltd dated 10 December 2014 (Serco Contract), cl 13(a) & (b), 3.9.
- 17 Serco Contract, cl 2.1 of Annexure C to Schedule 2.
- 18 Serco Contract, cl 1.1(a), 3.1(a)(i) & 3.6(a) of Section 4 of Schedule 2; cl 7(a) of Section 2 of Schedule 2.
- 19 Serco Contract, cl 6(b) of Section 2 (Statement of Work); cl 1.2(d) & 7.1(a) of Section 6 of Schedule 2.
- 20 Serco Contract, cl 6.12(a) and (b)(i) & (iii) of Section 6 of Schedule 2.
- 21 Serco Contract, cl 6.13 of Section 6 of Schedule 2.
- 22 Serco Contract, cl 3.6(d) of Section 4 of Schedule 2.
- 23 Serco Contract, cl 1.2(e) of Section 6 of Schedule 2.
- 24 Serco Contract, cl 7.1(a)(iii), 7.9(a)(ii) & 7.10(a) of Section 6 of Schedule 2.
- 25 Serco Contract, cl 7.9(a)(ii) of Section 6 of Schedule 2.
- 26 Serco Contract, cl 7.13(a) of Section 6 of Schedule 2.
- 27 Serco Contract, cl 4.1(a)(i) of Section 4 of Schedule 2.
- 28 Serco Contract, cl 4.1(d) of Section 4 of Schedule 2.
- 29 Serco Contract, cl 7.10(b) & (d)(i) of Section 6 of Schedule 2.
- 30 Serco Contract, cl 7.10(f) of Section 6 of Schedule 2.
- 31 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 8 – Safety and Security – Incident Management and Reporting* (September 2015).
- 32 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 8 – Safety and Security – Incident Management and Reporting* (September 2015).

- 33 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (May 2015) 4.
- 34 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (May 2015) 5.
- 35 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (May 2015) 4-5.
- 36 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (May 2015) 7.
- 37 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (May 2015) 5.
- 38 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 8 – Safety and Security – Incident Management and Reporting* (September 2015) 4.
- 39 Department of Immigration and Border Protection, *Detention Services Manual – Chapter 1 – Legislative and principles overview – Duty of care to detainees* (May 2015) 6.
- 40 Department of Immigration and Border Protection, *Incident Response and Management: Detention Standard Operating Procedure* (September 2016) 4.
- 41 Department of Immigration and Border Protection, *Incident Response and Management: Detention Standard Operating Procedure* (September 2016), 7.
- 42 Department of Immigration and Border Protection, *Incident Response and Management: Detention Standard Operating Procedure* (September 2016), 13, 14.
- 43 See, for example, Australian Human Rights Commission, *Inspections of Australia’s immigration detention facilities 2019 report* (December 2020) 100 at https://humanrights.gov.au/sites/default/files/document/publication/ahrc_immigration_detention_inspections_2019_.pdf
- 44 Griffith Criminology Institute, *Final Report: Improving Risk Assessment of Immigration Detainees* (November 2019) 334 at <https://www.homeaffairs.gov.au/foi/files/2020/fa-200200255-document-released.PDF>.
- 45 *Australian Human Rights Commission Act 1986* (Cth) s 29(2)(a).
- 46 *Australian Human Rights Commission Act 1986* (Cth) s 29(2)(b).

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