



Australian
Human Rights
Commission

Mr Andrwas v The Commonwealth of Australia
(Department of Home Affairs)

[2023] AusHRC 147

March 2023

ABN 47 996 232 602
GPO Box 5218, Sydney NSW 2001
General enquiries 1300 369 711
National Info Service 1300 656 419
TTY 1800 620 241

Australian Human Rights Commission
www.humanrights.gov.au

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Report into a safe place of detention

Australian Human Rights Commission 2023

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

Dear Attorney

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

Mr Andrwas complains that he was not provided with a safe place of detention whilst detained at Villawood Immigration Detention Centre in Sydney.

As a result of this inquiry, I have found that the following act of the Commonwealth was inconsistent with or contrary to Mr Andrwas' rights under article 10(1) of the *International Covenant on Civil and Political Rights* (ICCPR):

- the decision of the Department or Serco Australia Pty Ltd (Serco) to continue to detain Mr Andrwas in the Lachlan compound in Villawood following assaults on him on 11 November 2017 and 24 November 2017 by other detainees without undertaking a documented risk assessment process or other action to protect his safety.

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

On 12 October 2022, I provided the Department with a notice issued under section 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 20 December 2022. That response can be found in Part 10 of this report.

I enclose a copy of my report.

Yours sincerely,



Emeritus Professor Rosalind Croucher AM
President

Australian Human Rights Commission
3 March 2023

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1 Introduction to this inquiry

1. This is a report setting out the findings of the Australian Human Rights Commission (Commission) following an inquiry into a complaint made by Mr Issa Andrwas against the Commonwealth of Australia, specifically the Department of Home Affairs (Department). Mr Andrwas alleges that the Department breached his human rights by failing to provide him with a safe place of detention.
2. Mr Andrwas, a national of Jordan and a resident of Australia since 1997, was taken into immigration detention on 27 October 2017 following the cancellation of his visa. He was initially held at Villawood Immigration Detention Centre (Villawood) in Sydney.
3. Mr Andrwas alleges that he was assaulted on three occasions on 11 and 24 November 2017 while he was in Villawood. Mr Andrwas alleges that the assaults on 24 November left him with permanent damage to his face and right eye, two broken teeth and ongoing shoulder pain.
4. This inquiry is being undertaken pursuant to s 11(1)(f) of the AHRC Act.
5. This report is issued pursuant to s 29(2) of the AHRC Act setting out the findings of the Commission in relation to Mr Andrwas' complaint.

2 Summary of findings and recommendations

6. As a result of this inquiry, I find that the following act of the Commonwealth was inconsistent with or contrary to Mr Andrwas' rights under article 10(1) of the *International Covenant on Civil and Political Rights* (ICCPR):
 - the decision of the Department or Serco Australia Pty Ltd (Serco) to continue to detain Mr Andrwas in the Lachlan compound in Villawood following assaults on him on 11 November 2017 and 24 November 2017 by other detainees without undertaking a documented risk assessment process or other action to protect his safety.
7. I make the following recommendations:

Recommendation 1

A documented risk assessment is undertaken for all detainees involved in an act of violence as part of the Department and 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, the steps necessary to mitigate those risks.

Recommendation 2

The Department 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 the alleged perpetrator can no longer have access to the victim.

Recommendation 3

The Department ask 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

The Department should immediately implement measures to protect people at risk of violence at Villawood, 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 5

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

3 Background

3.1 Migration and detention history

8. Mr Andrwas arrived in Australia on a temporary partner visa in 1997. He was granted permanent residency in 1999. He sought to become a citizen in 2008, but his application was refused on the basis that there were proceedings pending for alleged offences at that time.
9. In 2009, Mr Andrwas received a notice informing him that his visa was being considered for cancellation. The visa was not cancelled at that time and Mr Andrwas received a warning letter.

10. In December 2014, his visa was cancelled under section 501 of the *Migration Act 1958* (Cth) (Migration Act). Mr Andrwas was detained at Villawood. In February 2015, the cancellation was revoked, his visa was reinstated and he was released from detention.
11. On 9 January 2017, Mr Andrwas' visa was cancelled under section 501(3A) of the Migration Act while he was serving a sentence of imprisonment. Mr Andrwas made an application seeking revocation of the decision to cancel his visa. Upon release from Bathurst Correctional Centre on 27 October 2017, Mr Andrwas was taken into immigration detention at Villawood.
12. On 9 April 2018, the Minister's delegate decided not to revoke the cancellation of his visa. Mr Andrwas sought review of that decision from the Administrative Appeals Tribunal (AAT). The AAT affirmed the decision not to revoke the cancellation of his visa. Mr Andrwas then sought judicial review of the AAT's decision but was unsuccessful.
13. On 7 June 2019, Mr Andrwas lodged a protection visa application, which was refused on 18 July 2019. This decision was affirmed on 11 November 2019 by the AAT. Mr Andrwas sought judicial review of that decision, which was ultimately successful and the decision was remitted to the AAT for redetermination. On 3 August 2021, the Department advised that the review is proceeding before the AAT.
14. Mr Andrwas remains subject to ongoing detention.

3.2 Incidents in Villawood

15. Prior to his detention in Villawood in October 2017, Mr Andrwas was in a relationship with a woman from around December 2012 to July 2016.
16. Mr Andrwas reported this woman to the Department and the NSW Police for breaching her visa conditions. Subsequently, in early November 2017, this woman was also detained at Villawood. I will subsequently refer to her as the 'female detainee'. The female detainee was aware that Mr Andrwas had reported her to the police.
17. In his complaint, Mr Andrwas alleges that the female detainee wanted 'revenge on me due to my report. As soon as she arrived, she started making trouble for me.'
18. In Villawood, Mr Andrwas was housed in the Lachlan compound, which is a lower-security compound that accommodates single adult men. The female detainee was housed nearby in the Lima compound, which is a

lower-security compound that accommodates single adult women and couples. These compounds are separate but have access to a large central common area (also known as the community area).¹

19. On 11 November 2017, Mr Andrwas alleges that he was hit in the chest four times by the female detainee in the common area outside the Lima compound (11 November Incident).
20. On 24 November 2017, Mr Andrwas alleges that he was assaulted by four male detainees acting on behalf of the female detainee in two separate incidents. I will refer to these men as the first, second, third and fourth male detainees. Mr Andrwas alleges that he was punched in the face by the first male detainee and punched in the back of the head by the second and third male detainees outside the Lachlan compound (First 24 November Incident). He then sought medical attention before returning to the Lachlan compound, where he was punched in the right eye by the fourth male detainee (Second 24 November Incident).
21. In his complaint, Mr Andrwas states that:

Serco officers could have done more from the beginning, including separating [the female detainee] and myself, so as to prevent this from happening to me in the first place. I believe that Serco has continually failed to look after my safety.
22. Mr Andrwas does not believe that appropriate action was taken in response to the assaults. Mr Andrwas says that 'the officers wrote a report on the assault for management. As far as I know there have been no consequences for the four men or [the female detainee].'
23. On 3 December 2018, Mr Andrwas made a complaint to the Commission regarding, amongst other things, the 11 November Incident and First and Second 24 November Incidents.

4 Conciliation

24. The Department indicated that it did not want to participate in conciliation of the matter.

5 Procedural history of this inquiry

25. On 11 November 2021, I issued a preliminary view in this matter and gave Mr Andrwas, and the Department the opportunity to respond to my preliminary findings.

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26. On 16 June 2022, the Department responded to my preliminary view.

6 Relevant legal framework

6.1 Functions of the Commission

27. 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.
28. 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.
29. Section 8(6) of the AHRC Act requires the functions of the Commission under s 11(1)(f) to be performed by the President.

6.2 What is a human right

30. The AHRC Act defines human rights to include the rights and freedoms recognised in the ICCPR.
31. 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.

6.3 What is an act or practice

32. 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.
33. 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.
34. 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.

6.4 Act or practice of the Commonwealth

35. It is my view that the following is an act for the purposes of section 3 of the AHRC Act:
- a. the decision of the Department or Serco to continue to detain Mr Andrwas in the Lachlan compound within Villawood following assaults on him on 11 November 2017 and 24 November 2017 by other detainees without undertaking a documented risk assessment process or other action to protect his safety.

7 Safe place of detention

36. Mr Andrwas complains that he has not been provided with a safe place of detention at Villawood, in contravention of article 10(1) of the ICCPR.

7.1 Law on article 10 of the ICCPR

37. 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.
38. 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.
39. 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.
40. The United Nations Human Right Committee (UN HR Committee) General Comment No 21 states that:
- 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

41. 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 7 principally accords a claim that State organs refrain from certain action (prohibition of mistreatment), while article 10 also covers positive State duties to ensure certain conduct: Regardless of economic difficulties, the State must establish a minimum standard for humane conditions of detention (requirement of human treatment).

In other words, it must provide detainees and prisoners with a minimum of services to satisfy their basic needs (food, clothing, medical care, sanitary facilities, communication, light, opportunity to move about, privacy, etc). Finally it is 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

42. 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
43. Commentators suggest that article 10(1) obliges States to provide protection for detainees from other detainees,⁸ drawing from the UN HR Committee's report, *Concluding Observations on Croatia*, in which it was stated:

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

44. 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 Rules¹⁰
 - the *Body of Principles for the Protection of all Persons under Any Form of Detention* (Body of Principles).¹¹
45. Several of the Nelson 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.
46. The above jurisprudence supports the conclusions that:
- a) article 10(1) imposes a positive obligation on State parties to take action to ensure that detained persons are treated with humanity and dignity
 - b) minimum standards of humane treatment must be observed in the conditions of detention
 - c) 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
 - d) 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

- e) article 10(1) requires that detainees and prisoners be provided with a minimum of services to satisfy their basic needs.

47. In my view, and consistent with the findings of a past Commission inquiry,¹² a basic need of detainees is that their safety and security while in detention is protected. Ensuring this is necessary for State parties to fulfil their obligation under article 10(1) to treat detainees with humanity and respect for the inherent dignity of the human person.

7.2 Contractual obligations of service provider

48. The Department's Immigration Detention Facilities and Detainee Services Contract with the Facility and Detainee Services Provider (FDSP), Serco (Contract) in effect during Mr Andrwas' detention recognises the duty of care owed to detainees and requires that Serco complies with a Code of Conduct.¹³ 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'.¹⁴

49. 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,¹⁵ which also supports their individual health and safety needs¹⁶
- 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 detainee¹⁷
 - 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 Facility¹⁸
- 'immediately report to the Department any concerns that it may have regarding a Detainee's safety and security'¹⁹
- establish processes to:

- promote the welfare of Detainees and create a safe and secure environment at each Facility²⁰
- prevent detainees being subjected to illegal, anti-social or disruptive behaviour by detecting and managing those behaviours in other detainees²¹
- manage and defuse tensions and conflicts before they become serious or violent²²
- 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 strategies²³
- in responding to incidents,
 - ensure the safety and welfare of detainees and others at the facility²⁴
 - ‘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’²⁵
- 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 recurrence²⁶
- ‘ensure that Detainees identified as victims of anti-social behaviour are supported by Service Provider Personnel’.²⁷

7.3 Departmental policies and processes

50. In September 2016, 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 alleged assaults on Mr Andrawas.
51. 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.
52. 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’.²⁸
53. 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’.²⁹
54. 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.³⁰

Risk assessment processes

55. The Department considers that the following risk assessment processes are in place to monitor the appropriate placement of detainees:
- **Support services** are in place in the form of Personal Officers, Welfare Officers and Health Services for detainees to utilise while in immigration detention to raise any issues or concerns, and provide physical and mental health support.
 - **CCTV and other monitoring systems:** The FDSP is responsible for the safety and good order of IDFs [Immigration Detention Facilities] by using FDSP personnel in common areas, both in fixed stations and roving patrols. Closed Circuit Television (CCTV) coverage of common areas is also in place.
 - **The Security Risk Assessment Tool (SRAT):** The ABF and FDSP rely on the Security Risk Assessment Tool (SRAT) to inform risk and vulnerabilities when making decisions relating to detainees. These are

reviewed monthly for all 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 [Individual Management Plan] and/or create/update a BMP [Behaviour Management Plan]. The SRAT is one source of information that is considered when completing a Detention Placement Assessment to identify any documented risks when making a placement consideration at an IDF [Immigration Detention Facility]. This includes, but is not limited to associations of the detainee and any vulnerabilities

- **IMP [Individual Management Plan] Reviews:** Detainees are able to raise any concerns they might have for their safety directly with FDSP [Serco] during IMP Reviews or at any other time.
- **Induction:** Detainees receive an induction package upon arriving into immigration detention along with detailed information on their rights and responsibilities.
- **Health and medical support:** Detainees are aware they can request to see the Detention Health Service Provider at any time, for medical treatment or mental health support.
- **Governance Forums:** including the weekday morning stakeholder meeting and IMPRC [Individual Management and Placement Review Committee] meetings.

Detainees are aware they can ask to speak to an ABF officer, verbally or in writing, so that concerns can be addressed appropriately.

Current processes

An overall risk assessment is undertaken for all detainees involved in any act of violence. 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. This assessment uses quantitative and qualitative methods to assess and calculate risk based on known criteria for each detainee.

The FDSP [Serco] 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 ABF, on appropriate intra-facility placements.

In the event of an incident of detainee-on-detainee violence within the Immigration Detention Network (IDN), it is current practice that the involved persons would be immediately separated once the FDSP is

aware, and medical assistance offered where required. Depending on ABF approval, the alleged offender may be placed in High Care Accommodation (HCA) for closer supervision. 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. Placement of detainees involved in the incident must be reviewed within 24 to 48 hours. The review must consider accommodation available and any known intelligence of the parties involved.

The FDSP may implement enhanced monitoring of the detainees as a means of ensuring safety.

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 DHSP. The meetings are chaired by the ABF, and discuss the following:

- Incidents that have occurred within the past 24 hours including detainees involved and local management strategies that were used in response to those incidents, such as Keepsafe, enhanced monitoring and HCA 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; and
- 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 and are chaired by the FDSP [Serco]. 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. Actions 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 conducting [themselves] in inappropriate behaviours and actions

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.

8 Findings

56. Mr Andrwas alleges that he was assaulted on three occasions while in Villawood, being the 11 November Incident, the First 24 November Incident and the Second 24 November Incident (defined above in paragraphs 13-14). I consider each of these incidents below.

8.1 11 November Incident

57. Mr Andrwas alleges that on 11 November 2017, the female detainee approached him outside the Lima compound, saying that she wanted to speak to him. Mr Andrwas told her he did not want to talk to her. She then ran in front of him blocking his path and hit him on the chest four times saying, 'Why did you did [sic] this to me?'. In response, Mr Andrwas said he was going to have her charged with assault and she said that, 'If you do that, I will do something to you'. Mr Andrwas says that he immediately reported the incident to Serco, asking for her to be charged with assault.

58. Mr Andrwas believes that the female detainee assaulted him because he had reported her to the Department and the NSW Police.
59. On 12 November 2017, Mr Andrwas reported the assault to the Facilities and Detainee Service Provider (FDSP). The FDSP Incident Detail Report states:

...detainee ANDRWAS was walking back to his accommodation Lachlan Compound and [the female detainee] approached him at village green area and started to [sic] talking to detainee ANDRWAS. Detainee ANDRWAS informed [the female detainee] he doesn't want to talk to her. Then detainee ANDRWAS alleged [the female detainee] punched him 4 times on his chest. This incident was not witnessed by any [FDSP] Staff member. Medical assistance was offered to detainee ANDRWAS but refused. Serco Security department will be notified for further investigation.
60. The Incident Detail Report does not record that Mr Andrwas reported the threat allegedly made by the female detainee when he said he was going to have her charged. The Department has advised that no further detail regarding the assault were provided by Mr Andrwas to ABF or the FDSP.
61. The Department has advised that it has no evidence that confirms an assault as described by Mr Andrwas occurred on 11 November 2017. It also advised that there is no information or CCTV footage to verify the claims made by Mr Andrwas.
62. On 12 November 2017, Mr Andrwas signed a Notification for Police Investigation form requesting the matter be referred to an Investigation Authority. The Incident Detail Report for this incident refers to this Australian Federal Police (AFP) referral form and states that: 'This incident is considered closed'.
63. On 26 September 2018, ABF referred the incident to the AFP. The Department has advised that the delay in referring the incident was due to human error, which resulted in ABF not receiving the referral form until 15 August 2018. The Department further advised that steps have been taken to address the error and ensure that all police referrals are actioned in an appropriate timeframe.
64. On 2 October 2018, the referral was considered, and rejected by the AFP Sydney Regional Operations Capacity and Capability Committee. It was rejected as there was no witnesses or CCTV for the incident, and in consideration of the availability of AFP resources at the time.

65. In relation to the placement of Mr Andrwas and the female detainee, the Department has advised that:

Movements of detainees within each compound are managed by FDSP [Serco]. This includes the movements of detainees between dormitories...In addition to any intelligence holdings on individual detainees, the FDSP 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.

66. On 13 November 2017, Serco and ABF officers exchanged emails regarding a request to move Mr Andrwas from Lachlan to Mitchell due to allegations that he was asking other detainees to assault the female detainee and intimidate her family. The emails are primarily focused on various allegations raised by the female detainee against Mr Andrwas. However, one email from the Serco officer states that, in response to the female detainee's allegations, Mr Andrwas said that the female detainee had assaulted him in the community grass area, and that Serco are waiting on footage to verify this.
67. Ultimately, the ABF officer's view was that there was not enough evidence to require Mr Andrwas to be moved to a more restrictive compound, noting the decision could be revisited if further evidence became available. The ABF officer also indicated that they 'can discuss placement at DPPC – or earlier if a critical threat to safety is established'.
68. On 15 November 2017 at 11:30am, there was a Detainee Placement Preventative Committee (DPPC) meeting with representatives from ABF, the Department, Serco, and International Health and Medical Services (IHMS). Amongst other things, the placement of Mr Andrwas in the Lachlan compound was discussed. The DPPC meeting minutes state that 'ABF advised behaviour expectations to be reflected in both IMPs. Stakeholders discussion regarding the detainees and all agreed at this time Placements Remain'. It is unclear what was discussed regarding the detainees and whether this included any discussion of the 11 November Incident.

69. On 15 November 2017 at 1pm, there was an Individual Management and Placement Review Committee (IMPRC) meeting. During that meeting, Serco made a referral for the IMPRC to consider the issues relating to Mr Andrwas and the female detainee, including whether their current placement was appropriate.
70. The Department indicated in its response to the Commission that the stakeholders agreed that there was insufficient evidence to move Mr Andrwas to a more restrictive compound. However, there was no discussion at that point of whether to move the female detainee to another facility.
71. This is confirmed by the minutes of the IMPRC meeting on 15 November 2017 (IMPRC minutes), which states that:
- a. the matter was referred to the IMPRC as ‘there appears to be emerging issues from their shared past relationship ... which has the potential to escalate in the future’.
 - b. ‘...the reason for nominating this detainee and detainee below is due to their previous history outside of detention and the hostility they show each other...Last week detainees were noted having aggressive conversations in the community area, when approached, told officers that they were only chatting and there are no issues between them.’
 - c. The detainees had a relationship outside of detention, which ended when Mr Andrwas went to jail.
 - d. The female detainee had informed her case manager that Mr Andrwas reported her to the police to have her brought to detention. The female detainee also said that ‘she does not feel safe around detainee ANDRWAS and he has threatened to have her beaten up by other detainees’.
 - e. In the previous week, the female detainee had asked ‘DSM officer to escort her visiting boyfriend from VIDC [Villawood] due to detainee ANDRWAS’s threats that someone was going to follow her boyfriend home. The DSM officer has not noted anyone suspicious when escorting her boyfriend.’
 - f. The case manager queried if the current placement of both detainees in the community area was appropriate. ABF stated that ‘due to allegations coming from both detainees and no proof of any wrong doing, at this stage, current placement is appropriate’.

- g. The Chair concluded that 'placement is appropriate, Serco continue to support and manage as per usual, encourage to stay away from each other. No actions identified.'

- 72. The IMPRC minutes do not expressly record any discussion or consideration of the 11 November Incident.
- 73. In his complaint, Mr Andrwas appears to refer to the complaints raised by the female detainee mentioned above. He says that in November 2017:

When we both had visitors at the same time, she went to the Serco officer and said it was going to be a problem for us to see visitors at the same time. She falsely accused me of wanting to bash her and that she was scared of me because she wanted to apply for a protection visa. I deny I had ever made any threats against her or tried to harm her. I avoided speaking to her at all.

- 74. The discussion in the IMPRC meeting was summarised in an Individual Management Review for Mr Andrwas dated 15 November 2021. It similarly confirms that no action items or further issues were identified. It also states that 'if further issues arise, then it will be actioned accordingly'.
- 75. The Department provided an Individual Management Plan Review (IMPR) for Mr Andrwas dated 16 November 2021. It states that Mr Andrwas 'was involved in an incident on 11/11/2017 Assault Minor IR727646' and provides the following summary of his conversation with a Serco officer:

[Redacted] assaulted him in the community grass area (awaiting footage to verify IR being completed).

He is the reason [Redacted] is in this place as he called immigration on her that's why she is making up story's [Redacted] just wants to get me back

Mr ANDRWAS denied all the allegations above.

DETAINEE ANDRWAS was reminded of his rights and responsibilities and that any further incidents could result in him being placed on a BMP [Behaviour Management Plan]. The incident was raised at the IMPRC meeting on the 15/11/2017.

- 76. I assume that the redacted name is the female detainee. It is unclear exactly what allegations were denied by Mr Andrwas, but I assume these were the complaints made by the female detainee against him (such as those discussed by the IMPRC in paragraph 68).

77. This document states that the incident was raised at the IMPRC meeting on 15 November 2017. However, it is unclear whether the incident referred to is the 11 November Incident or the complaints made by the female detainee. As stated above, the IMPRC minutes do not expressly record any discussion of the 11 November Incident, but do reference the complaints made by the female detainee.
78. The IMPR does not detail any other actions taken by the Department in response to the 11 November Incident or otherwise in relation to Mr Andrwas' safety.
79. The Department has advised that on 16 November 2017, a Detainee Service Officer (DSO) spoke to the female detainee as part of her IMPR. She was 'reminded of her rights and responsibilities and advised that further incidents could result in her being placed on a BMP. The incident was raised at the IMPRC meeting on 15 November 2017.' The Commission was not provided with a copy of that IMPR. It is unclear what was discussed with the female detainee and whether the 11 November incident was discussed. Regardless, it does not appear that any further action was taken in relation to the female detainee in response to the 11 November Incident.
80. The Commission requested but did not receive any other incident reports, post incident reviews, witness statement or officer reports relating to the 11 November Incident, except those described above.

8.2 Consideration

81. 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 Villawood for the 10-month period between January and October 2018, immediately after the events described in this report.³¹
82. On the evidence before the Commission, I accept that Mr Andrwas was assaulted by the female detainee on 11 November 2017. It does not appear that Mr Andrwas suffered any serious injury from this assault.
83. Although the Department and Serco were aware of the issues between Mr Andrwas and the female detainee prior to 11 November 2017, there is no evidence that the female detainee had made any threats against Mr Andrwas or that Mr Andrwas had raised any concerns for his safety with Serco or requested a placement away from the female detainee. Prior to

this incident, I do not consider that there was a particular risk of harm to Mr Andrwas that was reasonably foreseeable beyond the general risks involved in being in immigration detention.

84. Nonetheless, I am concerned about the steps taken by the Department and Serco following this incident to ensure Mr Andrwas' safety and security.
85. Serco discussed the incident with Mr Andrwas during an IMPR, together with the allegations raised by the female detainee. While there is reference to the Serco Security department being notified for further investigation and reference to Serco awaiting footage to verify the incident, no documents have been produced by the Department regarding any such further investigation.
86. Although an IMPR was also held with the female detainee on 16 November 2017 in which she was reminded of her rights and responsibilities, it is unclear whether the 11 November incident was discussed with the female detainee. No other action appears to have been taken in response to 11 November incident in relation to the female detainee.
87. Based on the evidence before the Commission, I cannot be satisfied that any further investigation was conducted into the 11 November Incident. Following Mr Andrwas' request for the incident to be referred to the AFP, it appears that the incident was closed. This is concerning for several reasons:
 - a. The incident was not referred to AFP until 26 September 2018 due to human error. The AFP rejected the referral on 2 October 2018. No investigation was ultimately conducted by the AFP into this incident.
 - b. Any AFP investigation would likely be focused on investigating the incident itself and the potential charges to be laid against the female detainee; it would not consider the risks to Mr Andrwas' safety after the relevant incident. A referral to the AFP is insufficient to discharge the Department's, and Serco's, duty of care to ensure the safety of detainees.
 - c. An investigation by Serco may have assisted in identifying any ongoing risks to Mr Andrwas' safety following this incident.
88. The Department was aware of the issues between Mr Andrwas and the female detainee.

89. On 13 November 2021, in response to the female detainee's allegations against Mr Andrwas, ABF and Serco officers discussed whether the placement of Mr Andrwas was appropriate, concluding that there was not enough evidence to require Mr Andrwas to be moved to a more restrictive compound.
90. On 15 November 2021, the DPPC and IMPRC further considered whether the placement of Mr Andrwas and the female detainee was appropriate.
91. In response to my preliminary view, the Department said that Serco's decision to continue to detain Mr Andrwas in the Lachlan compound following the alleged assault on 11 November 2017 was considered appropriate, noting prior to the alleged incident there was no particular risk identified to Mr Andrwas.
92. However, the above discussions regarding Mr Andrwas' placement were focused on the female detainee's allegations against Mr Andrwas. It does not appear that the IMPRC discussed the 11 November Incident, considered the appropriateness of the placement of the two detainees in light of this incident, or sufficiently considered Mr Andrwas' safety at that meeting in light of that incident.
93. The Commission asked the Department to advise of the steps taken to make sure Mr Andrwas was provided with a safe place of detention. In response, the Department advised that Mr Andrwas and the female detainee were located within different compounds of Villawood. While this is true, they both had access to one another in the common area. The Department further stated that:

As part of incident management, all detainees are reminded of their rights and responsibilities. All detainees are reminded to contact or approach a Detention Service Officer within their respective compounds should they continue to encounter any challenges or difficulties, including potential threats from other detainees.
94. In response to my preliminary view, the Department outlined the risk assessment processes in place to ensure appropriate placement of detainees and in response to any acts of violence (see paragraphs 55 above), which include the Security Risk Assessment Tool (SRAT), the morning stakeholder meeting and ongoing monthly reviews via the IMPRC. The Department has not otherwise 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.

95. Based on the information provided to the Commission, I am concerned that insufficient consideration was given to whether Mr Andrwas remained at risk in light of the 11 November Incident and, if so, how these risks could be managed. A documented risk assessment regarding this incident may have identified ongoing risks to Mr Andrwas, such as from the female detainee or her associates. Undertaking such an assessment was a necessary step in considering and protecting Mr Andrwas' right to safety.
96. The Commission acknowledges that Mr Andrwas and the female detainee raised allegations against each other. Nonetheless, I am concerned that the focus of the response by the Department and Serco was on the allegations raised by the female detainee, while the 11 November incident and the safety of Mr Andrwas received limited consideration.
97. In the circumstances, I find that there was not a sufficient response by the Department to the 11 November Incident to ensure the ongoing safety and security of Mr Andrwas.

8.3 *First 24 November Incident*

98. There are differing accounts of what occurred on the morning of 24 November 2017.
99. Mr Andrwas alleges that the female detainee organised four male detainees to assault him. He believes that her motive was to 'get a bridging visa and revenge on him for causing her detention and wanting to press assault charges against her'.
100. Mr Andrwas alleges that the female detainee had been talking to the four male detainees every day for several weeks leading up to the assault. He says that he had no issue with these men prior to her talking to them.
101. Mr Andrwas alleges that he was speaking to the first male detainee about the female detainee in the common area outside the Lachlan compound. The first male detainee told him to drop his assault charges against the female detainee. Mr Andrwas alleges that the first male detainee then punched him in the face. The second and third male detainees then punched him in the back of the head at the same time, which knocked him unconscious for around thirty seconds. Mr Andrwas says that he attended the IHMS medical centre due to this incident.
102. There is no evidence from any other witnesses to this assault.
103. The Commission requested that the Department provide any incident reports or other documents relating to the incident that occurred in the

morning of 24 November 2017. No documents were provided relating to an incident as alleged by Mr Andrwas.

104. The Department did, however, provide an Incident Detail Report, which states that at approximately 12:20pm on 24 November 2017, a Serco officer saw Mr Andrwas with a cut on his nose. When questioned, Mr Andrwas advised the Serco officer that he fell forward in the shower and cut his nose in the bathroom in Lachlan 1 Unit 1.
105. In the Department's response, it says Mr Andrwas was then brought to the IHMS medical centre by a Serco officer. Mr Andrwas was assessed by an IHMS Primary Health Nurse (PHN) who recorded that he had reportedly fallen in the shower, and that he sustained a deep 2cm laceration to the bridge of his nose. Mr Andrwas was briefly reviewed by the Duty General Practitioner (GP) who recommended transfer to hospital for further assessment and review of the laceration.
106. The Department has advised that Mr Andrwas did not disclose an assault to IHMS or raise any concerns for his safety following this incident. As there was no evidence to the contrary, the Department accepted Mr Andrwas' explanation that the injury was caused by him falling in the shower.
107. Mr Andrwas' assessment at the Hospital Emergency Department (Hospital) is discussed further below (see paragraph 125). However, according to the Hospital's discharge referral, Mr Andrwas reported that 'he was punched on the face and hit on his right wrist, had no loss of consciousness but his vision is blurry especially on the right side'.

8.4 Consideration

108. In respect of the First 24 November Incident, there is not enough information to make a finding as to whether Mr Andrwas was assaulted as he alleges or whether he was injured from falling in the shower as he previously reported to Serco and IHMS. However, I do not discount the possibility that Mr Andrwas was the victim of an assault that morning, particularly considering the serious assault on him later the same day.
109. On the evidence before the Commission, I am satisfied that Mr Andrwas did not report to Serco or the Department that his injury was a result of this assault, and that the Department was not otherwise aware of this alleged assault, on or around 24 November 2017.

110. Although it is unclear how it occurred, Mr Andrwas sustained a deep cut to his nose in the morning of the 24 November 2017. There does not appear to be any contemporaneous support for Mr Andrwas' claim that he lost consciousness as he alleges, given the Hospital's records indicate he reported no loss of consciousness.
111. Given the above, I otherwise do not make any findings regarding the First 24 November Incident.

8.5 *Second 24 November Incident*

112. Following the First 24 November Incident, Mr Andrwas says he attended the IHMS medical centre for medical attention, where he was told that he needed to go to hospital for stitches. Mr Andrwas says he had dropped his phone and identification card in the Lachlan common area. He says he was told by IHMS and Serco staff to go back and get it but the 'Serco officer did not come with me despite it being an unsafe environment for me'.
113. Mr Andrwas does not say that he raised any concerns regarding his safety with IHMS or Serco staff or otherwise requested that he be accompanied by Serco officers when returning to Lachlan. There is no evidence before the Commission which indicates that he did.
114. Mr Andrwas alleges that he returned to the Lachlan common areas to retrieve his phone and identification card. He says that the first and fourth male detainees started arguing with him about the female detainee. He says that the fourth male detainee started swearing at him. Two Serco officers intervened to stop the argument, but the fourth male detainee punched him in the right eye.
115. The Department has advised that there is no CCTV footage of this incident.
116. The Serco Officer's Report regarding the incident states:
 - a. At approximately 12:35pm, the officer, together with another Serco officer, were called to medical where Mr Andrwas was given instructions to return to his room to collect his identification card and then return to medical.
 - b. The Serco officers 'went after detainee which had left ahead of us then proceeded to the community area'. Mr Andrwas demanded his phone from another detainee. The Security Officers intervened instructing Mr Andrwas to collect his card and return to medical as he had been advised.

- c. Mr Andrwas then 'proceeded in a fast paced walk to Lachlan 1 where he entered Lachlan 1 unit 2 living room where he was speaking in Arabic to another detainee. Both detainees were close and in each other's faces.' The Serco Officers moved in between them to de-escalate the situation and separate them with their bodies. Nonetheless, the detainee 'did assault detainee ANDRWAS by throwing a closed fist punch with his right hand'. The detainee threw another punch but missed Mr Andrwas and punched the Serco officer.
 - d. The officer further states that Mr Andrwas did not 'become physical and I immediately guided detainee outside the building which was shouting in Arabic to the other detainee'. The officer then instructed Mr Andrwas to go to medical, where he was seen by an IHMS nurse. He also instructed the other detainee, who was continuing to shout in Arabic at Mr Andrwas, to go back inside his accommodation, which he did.
 - e. The officer concludes by stating that 'no further issues arose from this incident'.
117. The Incident Detail Report for the Second 24 November Incident similarly confirms that Mr Andrwas was punched in the right eye by a detainee in the Lachlan 1 Unit 2 common area. The incident was witnessed by two Serco officers.
118. The Incident Detail Report also states that, when Mr Andrwas was interviewed by Serco officers shortly after the incident, he advised that he had attended the Lachlan common area to look for his phone. He also said that the fourth male detainee swore at him, called him a 'mother fucker' and said that 'he was going to kill him' before punching him. The Incident Detail Report indicates that Mr Andrwas was then sent off to hospital 'due to an earlier incident'.
119. The Incident Detail Report also includes an interview with a detainee regarding this incident, who I assume is the fourth male detainee. In this interview, the detainee advised that:
- he went up to have his morning coffee in the Lachlan 1 Unit 2 kitchen area and was sitting on couch at the time. Detainee [Redacted] advised that he was verbally abused in Arabic by Detainee ANDRWAS who was calling him a "dog" and a "snitch". Detainee [Redacted] stated that ANDRWAS was threatening him and that Detainee [Redacted] was defending himself.

[Redacted] advised Detainee of his rights and responsibilities and advised him to stay out of trouble. Detainee [Redacted] agreed and stated that he did not have a problem with Detainee ANDRWAS.

120. The Department has provided an IMPR dated 24 November 2021 which similarly states:

On the 24th November at approximately 1235 Detainee [Redacted] was involved in an incident where he assaulted a Lachlan 1 Detainee by punching him in the face.

At approximately 1440 hours [Redacted] spoke to [Redacted] and advised him that further incidents may result in a BMP and he will not be entitled to 10 extra IAP points next week.

Detainee [Redacted] advised that he was defending himself as the Detainee that he punched was abusing him and calling him a dog and a snitch for reasons unknown.

121. As stated above, Mr Andrwas claims that he had no prior issues with the other male detainees and alleges that the female detainee organised the other male detainees to assault him as revenge. However, it is unclear whether Mr Andrwas raised these allegations with the Department or Serco at the time. The Department has not provided any documentation confirming that Mr Andrwas raised these allegations with them.
122. At approximately 1:25pm on 24 November 2017, following the Second 24 November Incident, Mr Andrwas was taken to the Hospital at the request of IHMS.
123. As result of the incidents on 24 November 2017, Mr Andrwas reports suffering:
- a. permanent damage to his right eye nerve. He claims he cannot see properly and may go blind in the future.
 - b. damage to his nose. He claims that he cannot breathe properly, that his nose feels blocked and he has a large scar.
 - c. two broken teeth during the assault, which has caused speaking and eating difficulties.
 - d. ongoing joint pain in shoulder.
124. Mr Andrwas was assessed by the doctors at Liverpool Hospital Emergency Department. The discharge referral indicates that Mr Andrwas:

- a. reported that ‘he was punched on the face and hit on his right wrist, had no loss of consciousness but his vision is blurry especially on the right side’.
 - b. had a ‘1.5cm, partial thickness, mildly bleeding laceration on the upper part of the nasal bridge’ but no nasal deformity, ‘his right eye was mildly swollen’, had an abrasion over the eyebrow, and a small corneal abrasion on the right side
 - c. did not have any broken teeth, noting that his ‘teeth were intact’
 - d. had his nasal laceration cleaned and glued.
125. According to the IHMS clinical records, on 25 November 2017, Mr Andrwas attended the IHMS clinic for a review post discharge from the Hospital. He complained of constant headache, blurry vision and dizziness. Mr Andrwas returned to the Hospital for further assessment, including CT brain scan which showed no intracranial or facial bone injuries. He was discharged with pain relief, hydration advice and recommendation for ophthalmology review, as had previously been arranged.
126. On 27 November 2017, Mr Andrwas was seen by the IHMS GP for post hospital discharge review. The GP noted that Mr Andrwas was recovering from his injuries.
127. In relation to Mr Andrwas’ following injuries, the Department has advised that:
- a. Eye:
 - i. In December 2017, the ophthalmologist diagnosed a mild cataract of the right eye, which may be secondary to trauma.
 - ii. In August 2018, Mr Andrwas’ treating team noted that they had found evidence of optic nerve damage injury which was likely to persist. The ophthalmologist documented a possible diagnosis of Stargardt disease (a form of inherited macular degeneration) for which further investigations were ordered.
 - b. Nose:
 - i. On 19 December 2018, the IHMS GP reviewed Mr Andrwas’ wound and documented that he had requested plastic surgery to remove the scar on his nose. The GP noted that

the scar was small and advised Mr Andrwas that plastic surgery was not warranted.

- ii. The first documented concerns of nasal congestion arose in a PHN consultation on 30 October 2018, where Mr Andrwas reported concerns regarding a blocked right nasal passage. He reported that this had resulted from the trauma he had sustained in November 2017.
- iii. On 17 June 2018, Mr Andrwas reported he had ongoing nasal congestion as a result of the alleged assault in November 2017. The IHMS GP recommended a CT scan of his sinuses which indicated 'evidence of mucosal thickening involving all the paranasal sinus' and was referred to an Ear Nose Throat specialist for review and management.

c. Teeth:

- i. Mr Andrwas is first documented to have reported dental concerns relating to his assault on 27 December 2017, when he advised an IHMS PHN that his top front tooth had been knocked out during the assault.
- ii. On 8 January 2018, Mr Andrwas attended a dentist appointment, who documented a fractured upper left lateral incisor, missing tooth and an infected lower right molar.

d. Shoulder:

- i. Mr Andrwas is not documented to have reported any concerns regarding shoulder pain at the time of his alleged assault or prior to 18 July 2018.
- ii. On 18 July 2018, Mr Andrwas advised the GP that that he had sustained injuries to his left shoulder during the assault in November 2017.
- iii. The GP ordered ultrasound scans and X-rays. The GP noted that imaging indicated degenerative changes of the shoulder with a left sub acronial bursitis, which is most commonly caused by repetitive strain and/or trauma.

128. On 24 November 2017, Mr Andrwas completed a Notification for Police Investigation form requesting that the matter be referred to an Investigation Authority, such as the AFP or NSW Police. However, on 28 November 2017, Mr Andrwas advised Serco that he wished to withdraw his police referral as he had changed his mind. He then completed a

further form confirming that he did not wish for any police action or investigation. The incident was subsequently closed. No explanation has been provided as to why Mr Andrwas changed his mind.

129. On 25 November 2017, Serco conducted an IMPR with Mr Andrwas. The IMPR states, amongst other things, that Mr Andrwas 'appears to be very respectful and polite to staff and other detainees'. The IMPR does not record any concerns raised by Mr Andrwas for his safety in relation to the female detainee. The Department has confirmed that no such concerns were raised by Mr Andrwas during this IMPR.
130. On 26 November 2017, a trigger IMPR was conducted in relation to Mr Andrwas. The IMPRC states that Mr Andrwas was spoken to regarding 'the assault and threats to a detainee [redacted] on several occasions'. The Department has confirmed that the discussion was centred on allegations made by the female detainee that Mr Andrwas was threatening her. The Commission does not have any other information regarding this alleged assault.
131. The IMPR states that Mr Andrwas denied 'the threats and assaulting her, and stated that she is liar'. It concludes by stating that Mr Andrwas was reminded of his rights and responsibilities and advised to stay away from the female detainee.
132. The IMPR also indicates that Mr Andrwas was advised that if he had any concerns, he should contact Serco staff. The IMPR does not record any concerns raised by Mr Andrwas for his safety in relation to the female detainee. The Department has confirmed that no such concerns were raised by Mr Andrwas during this IMPR.
133. The Department advised that the female detainee was relocated on 1 December 2017. According to Mr Andrwas, she was given a bridging visa.
134. The Commission requested all records of requests made by Mr Andrwas in relation to his concerns for his safety or requesting that his placement be away from the female detainee or the four male detainees. In response, the Department provided documents relating to complaints made by Mr Andrwas on 18 and 20 December 2017.
135. On 18 December 2017, Mr Andrwas made a complaint to Serco which, in part, related to the 24 November Incident. Mr Andrwas said that:

About 3 and half weeks ago, I was assault badly which required urgent medical treatment. Since that incident, I have not had any follow ups from Serco. All the offenders are still here and I believe

nothing has been done to justify that assault incident. I'm currently suffering mentally, physically and emotionally. It traumatises me every time I look at the mirror which consist of a huge scar on my nose.

136. According to a Serco Investigation Report dated 23 December 2017, Serco officers spoke to Mr Andrwas regarding the complaint. It states that Mr Andrwas was advised he would be referred to IHMS/MH for further treatment. It does not otherwise refer to the assault, the ongoing presence of the alleged offenders, or any other actions being taken by Serco.

137. In its letter dated 29 December 2017 responding to Mr Andrwas' complaint, Serco states that Mr Andrwas had been advised by the Detainee Services Manager that:

he has submitted a referral to the Mental Health team on your behalf to ensure that you receive appropriate review and support to manage your concerns. Thank you [for] bringing your concerns to our attention and we consider this complaint is now closed.

138. On 20 December 2017, Mr Andrwas made a further complaint to Serco stating that:

I would to follow up with my compensation regarding my eyes, my nose, and the damages done to me physically and mentally as a result from the assault. I want to take action in regards to that because Serco has not done nothing.

139. According to a Serco Investigation Report dated 23 December 2017, Serco officers spoke to Mr Andrwas regarding the complaint. Mr Andrwas was advised that:

IHMS/MH team were able to assist him with his injuries and damages done physically and mentally. Detainee was advised [Redacted] would do MH referral so that MH team would assess detainee. Detainee was happy and requested DSM to do MH referral.

140. The report does not otherwise indicate that any actions were taken by Serco in relation to the assault.

141. In its letter dated 8 January 2018 responding to Mr Andrwas' complaint, Serco stated that, after discussing the issue with the Detainee Services Manager, Mr Andrwas underwent a medical assessment and was sent to hospital for treatment. The letter further states that Mr Andrwas

completed but then withdrew the notification for police investigation form and that Serco considered the complaint closed.

142. The Department has confirmed that following the Second 24 November Incident, there was no consideration by either Serco or the ABF in re-locating either Mr Andrwas or the fourth male detainee to another compound.
143. On 22 December 2017, the Second 24 November Incident was referred to the AFP for information only. The Department's response states that it was referred for information only given that Mr Andrwas had not formally requested that the matter be investigated. However, it may have been referred to the AFP at this time at the request of Mr Andrwas. The Department provided a copy of an email to the ABF dated 20 December 2017, in which the Department stated that 'Mr Andrwas has now advised he wishes to pursue criminal charges'. In response, the ABF stated that 'we can refer this to the AFP even though he initially said he didn't want it to be investigated', whilst noting that 'just because a matter is referred to AFP it doesn't mean that they will accept it and investigate it'.
144. On 9 January 2017, the AFP responded, acknowledging the referral. No further correspondence from the AFP was received by the Department regarding this referral. As such, I assume that this incident was not investigated by the AFP.

8.6 Consideration

145. I accept that, on 24 November 2017, Mr Andrwas was punched in the right eye by a male detainee. Mr Andrwas alleges that the male detainee was acting on behalf of the female detainee. There is not enough information before the Commission to make that finding.
146. I accept that Mr Andrwas suffered an ongoing injury to his right eye due to the Second 24 November Incident. However, I do not accept that his teeth were broken during this incident. There is otherwise not enough information before the Commission to make findings as to whether Mr Andrwas' other injuries were caused by this assault.
147. While Mr Andrwas complains that he was sent back to Lachlan unaccompanied despite it being an 'unsafe environment', there is no information before me which indicates that the IHMS or the Serco staff who attended the IHMS medical centre were aware of the alleged First 24 November Incident. Therefore, in my view, the Serco officers were not aware of any particular risk to Mr Andrwas' safety from the four male

detainees, which might necessitate additional protection or security for Mr Andrwas in respect of his return to Lachlan.

148. Mr Andrwas was followed by two Serco officers on his return to Lachlan. Given the above, it is unclear why this occurred, particularly given the way it occurred. The officers did not directly accompany Mr Andrwas and he proceeded ahead of them, such that he was able to get into an argument with another detainee in the Lachlan common area regarding his phone. After that initial incident, Mr Andrwas again quickly proceeded ahead of the officers, such that he was also able to get into the altercation with the fourth male detainee that preceded the Second 24 November Incident.
149. Regardless, the Commission recognises that the Serco officers quickly intervened to end both these altercations. In respect of the Second 24 November Incident, Commission further recognises that the officers sought to protect the safety of Mr Andrwas by physically putting themselves between Mr Andrwas and the other detainee. Regrettably, Mr Andrwas and one of the Serco officers were still punched by the fourth male detainee.
150. There is no evidence before the Commission that indicates that Mr Andrwas told Serco or the Department that he believed the fourth male detainee was acting on behalf of the female detainee at the time of the incident or that Mr Andrwas otherwise raised any concerns specifically regarding the female detainee following the Second 24 November Incident.
151. The female detainee was removed from Villawood a week after this incident on 1 December 2017. Mr Andrwas says that she was given a bridging visa. The Commission does not have any other information as to why she was removed from Villawood.
152. Following the Second 24 November Incident, the fourth male detainee was interviewed, reminded of his rights and responsibilities and advised to stay out of trouble. No further action was taken in relation to the fourth male detainee.
153. Aside from referring the matter to the AFP 'for information only', there is no evidence before the Commission of the Department or Serco undertaking any other actions for the investigation of this incident.
154. Mr Andrwas and the fourth male detainee both remained housed in Lachlan, such that the fourth male detainee had ongoing access to Mr Andrwas. The Department confirmed that it gave no consideration to re-locating Mr Andrwas or the fourth male detainee.

155. On 18 December 2017, Mr Andrwas complained to Serco that ‘all the offenders are still here’, that nothing had been done and that he was ‘suffering mentally, physically and emotionally’. Whilst Serco arranged for further medical assistance for Mr Andrwas, it otherwise took no action in response to this complaint and considered it closed given that Mr Andrwas had withdrawn his request for police investigation.
156. Mr Andrwas raised a further complaint on 20 December 2017. Mr Andrwas appears to have then requested that criminal charges were pursued, such that the matter was then referred to the AFP for ‘information only’. However, no further investigation was undertaken by the AFP.
157. It is concerning that no further investigation or action was undertaken by the Department or Serco. A referral to the AFP, particularly one ‘for information only’ made one month after the incident, is insufficient to discharge the Department’s, and Serco’s, duty of care to ensure the safety of detainees. An investigation by Serco may have assisted in identifying any ongoing risks to Mr Andrwas’ safety following this incident.
158. In response to my preliminary view, the Department noted that Mr Andrwas did not raise any concerns regarding his safety in the IMPRs following the Second November Incidents. However, Mr Andrwas raised complaints with Serco in December regarding the placement of the alleged offenders and its impact on his mental and emotional health. Despite this, as stated above, the Department gave no consideration to re-locating Mr Andrwas or the fourth male detainee.
159. Although the Department outlined its general risk assessment processes in response to my preliminary view (see paragraphs 55 above), the Department has not produced any documents to show that consideration was given to whether Mr Andrwas remained at risk following the Second 24 November Incident and, if so, how these risks could be managed. Given that the Department was aware Mr Andrwas had been subject to at least two assaults in two weeks, sustained serious injury on 24 November 2017, and raised a complaint about the continuing presence of the alleged perpetrators and its impact on his mental health, I consider that undertaking a documented risk assessment was a necessary step in considering and protecting Mr Andrwas’ right to safety.
160. On the information before the Commission, I cannot be satisfied that the Department or Serco took adequate steps to protect Mr Andrwas’ safety in response to the Second 24 November Incident.

8.7 Conclusion

161. It is concerning that Mr Andrwas was the victim of at least two (and possibly three) assaults during a two-week period in November 2017 while in detention at Villawood. I again 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 Villawood around that time was significant.
162. In light of my findings above, particularly in paragraphs 97 and 160, I am of the view that Mr Andrwas was not treated with humanity and with respect for his inherent dignity as required by article 10(1) of the ICCPR because insufficient steps were taken by Serco and the Department to adequately protect his safety and security while he was detained by them.

9 Recommendations

163. As a result of this inquiry, I find that the following act of the Commonwealth was inconsistent with or contrary to Mr Andrwas' rights under article 10(1) of the ICCPR:
 - the decision of the Department or Serco to continue to detain Mr Andrwas in the Lachlan compound in Villawood following assaults on him on 11 November 2017 and 24 November 2017 by other detainees without undertaking a documented risk assessment process or other action to protect his safety.
164. 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 a report on the respondent setting out its findings and reasons for those findings.³² The Commission may include in the report any recommendation for preventing a repetition of the act or a continuation of the practice.³³ The Commission may also recommend other action to remedy or reduce the loss or damage suffered by a person.³⁴
165. The Department has outlined the general risk assessment processes that are in place to monitor the appropriate placement of detainees and respond to incidents of violence involving detainees, which include the use of the Security Risk Assessment Tool, morning stakeholder meetings and monthly reviews via the IMPRC.
166. The Commission has previously expressed concern regarding the adequacy of the security risk assessments that are undertaken by the Department and

Serco. Following an April 2017 inspection of Villawood, the Commission reported that:

The current risk assessment process may not allow for an accurate or appropriate determination of the risks posed by particular individuals. As such, risk assessments may result in some people being subject to measures that are more restrictive than necessary, or placed in environments where they could be at risk of harm.

Urgent action is necessary to ensure the safety of all people at the VIDC. Many people (especially those in higher-security compounds) ... did not feel safe in detention.³⁵

167. In that same report, the Commission expressed further concern that:
- the risk rating system may not be sufficiently nuanced to prevent unnecessary use of restrictive measures ... [nor] an effective means of ensuring the safety of people in detention. In particular, there appeared to be significant variation among people in higher-risk categories with regard to the level of risk they pose to the safety of others. The Commission is concerned that this variation may lead to the co-location of people who pose significant risks to others³⁶
168. A number of recommendations for reform of the SRAT were made in the Commission's May 2019 report *Use of force in immigration detention*.³⁷ The Department noted that, during the course of the Commission's inquiry, it had engaged an external consultant to review the security risk assessment tool.
169. In November 2019, the Griffith Criminology Institute provided the Department with its *Final Report: Improving Risk Assessment of Immigration Detainees*.³⁸ The Commission is not aware of what amendments (if any) have since been made to the SRAT in response to that report.
170. The risk of violence and the threat to detainees' safety by other detainees was reported on by the Commission in 2017 when it expressed deep concern about the lack of policies in place to manage these practices. The Commission is not aware of any new protocols since implemented in immigration detention centres to alleviate this risk and better protect detainees' safety from threats of or actual violence by other detainees.
171. Assaults from other detainees are a serious risk to the personal safety of detainees in immigration detention. I note again the findings of the Griffith Criminology Institute report. I also note that the Commission is currently inquiring into complaints from other people detained at Villawood that they have not been protected from violence by other detainees. The Commission

considers that particular attention should be given to threatened and actual violence at Villawood, and steps that can be taken to prevent it.

172. Accordingly, I make the following recommendations:

Recommendation 1

A documented risk assessment is undertaken for all detainees involved in an act of violence as part of the Department and 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, the steps necessary to mitigate those risks.

Recommendation 2

The Department 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 the alleged perpetrator can no longer have access to the victim.

Recommendation 3

The Department ask 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

The Department should immediately implement measures to protect people at risk of violence at Villawood, 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 5

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

10 The Department's response to my findings and recommendations

173. On 12 October 2022, I provided the Department with a notice of my findings and recommendations.
174. On 20 December 2022, 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 and recommendations made.

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. 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 is 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.

- 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 for 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 Immigration Detention Facility (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.

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 Policy and Procedural Control 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:

- Review, update and action IMPs.

- Develop and implement prevention strategies for detainees at risk.
- Review detainee placement options for those at risk to harm from other detainees, and detainees who present a risk to the safety of others.
- Review, update and action BMPs for detainees conducting in inappropriate behaviours and actions.

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

Alternative Detention Arrangements

The Department notes recommendation four. 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 (discussed above). 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 also 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.

The Department also uses the Community Protection Assessment Tool (CPAT), which 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.

Where a detainee's status cannot be resolved by a Departmental delegate (for example, where legislative bars prevent a person from making a valid visa application), Ministerial intervention may be required to enable a non-citizen to reside in the community while their status is resolved.

The Minister's personal powers under sections 195A and 197AB of the Migration Act 1958 (the Act) are non-delegable and non-compellable. The Minister is under no obligation to consider a case or to make a decision on a case. Ministerial intervention does not provide for automatic assessment, or assessment at certain intervals, against the ministerial intervention guidelines, or referral of detainees in immigration detention for possible Ministerial intervention.

The Department notes that in Mr Andrwas's case, and as outlined in the response to the Commission on 16 June 2022, Mr Andrwas did not raise any specific concerns for his ongoing safety following the incidents at Villawood Immigration Detention Centre (VIDC). There were no other circumstances identified by Mr Andrwas's SRO that warranted a change of Mr Andrwas's current placement.

Independent Review

The Department notes recommendation five, that an independent review of the management of risk at the VIDC is warranted, given current procedures and ongoing program governance arrangements.

Mr Andrwias v Commonwealth of Australia (Department of Home Affairs) [2023] AusHRC 147 March 2023

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 Commission, 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.

Table 1 – Summary of Department’s response to recommendations

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

175. I report accordingly to the Attorney General.

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

3 March 2023

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- ¹ Australian Human Rights Commission, *Inspection of Villawood Immigration Detention Centre: Report* (10-12 April 2017), at page 11.
 - 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, MP Engel, Germany, 1993, at page 186.
 - 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 (2001) U.N. Doc. CCPR/CO/71/HRV, para 14
[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 Human Rights and Equal Opportunity Commission, *CD v Commonwealth (Department of Immigration and Multicultural Affairs)*, [2006] AusHRC 36 (1 August 2006).
 - ¹³ 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.
 - ¹⁴ Serco Contract, cl 2.1 of Annexure C to Schedule 2.
 - ¹⁵ 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.
 - ¹⁶ Serco Contract, cl 6(b) of Section 2 (Statement of Work); cl 1.2(d) & 7.1(a) of Section 6 of Schedule 2.
 - ¹⁷ Serco Contract, cl 6.12(a) and (b)(i) & (iii) of Section 6 of Schedule 2.
 - ¹⁸ Serco Contract, cl 6.13 of Section 6 of Schedule 2.
 - ¹⁹ Serco Contract, cl 3.6(d) of Section 4 of Schedule 2.

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- ²⁰ Serco Contract, cl 1.2(e) of Section 6 of Schedule 2.
- ²¹ Serco Contract, cl 7.1(a)(iii), 7.9(a)(ii) & 7.10(a) of Section 6 of Schedule 2.
- ²² Serco Contract, cl 7.9(a)(ii) of Section 6 of Schedule 2.
- ²³ Serco Contract, cl 7.13(a) of Section 6 of Schedule 2.
- ²⁴ Serco Contract, cl 4.1(a)(i) of Section 4 of Schedule 2.
- ²⁵ Serco Contract, cl 4.1(d) of Section 4 of Schedule 2.
- ²⁶ Serco Contract, cl 7.10(b) & (d)(i) of Section 6 of Schedule 2.
- ²⁷ Serco Contract, cl 7.10(f) of Section 6 of Schedule 2.
- ²⁸ Department of Immigration and Border Protection, *Incident Response and Management: Detention Standard Operating Procedure* (September 2016) 4.
- ²⁹ Department of Immigration and Border Protection, *Incident Response and Management: Detention Standard Operating Procedure* (September 2016) 7.
- ³⁰ Department of Immigration and Border Protection, *Incident Response and Management: Detention Standard Operating Procedure* (September 2016) 13, 14.
- ³¹ 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>.
- ³² *Australian Human Rights Commission Act 1986* (Cth) s 29(2)(a).
- ³³ *Australian Human Rights Commission Act 1986* (Cth) s 29(2)(b).
- ³⁴ *Australian Human Rights Commission Act 1986* (Cth) s 29(2)(c).
- ³⁵ Australian Human Rights Commission Inspection of Villawood Immigration Detention Centre: Report (10-12 April 2017) available at <https://humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/inspection-villawood-immigration-detention-centre>
- ³⁶ Australian Human Rights Commission Inspection of Villawood Immigration Detention Centre: Report (10-12 April 2017) available at <https://humanrights.gov.au/our-work/asylum-seekers-and-refugees/publications/inspection-villawood-immigration-detention-centre> at [12]
- ³⁷ [2019] AusHRC 130.
- ³⁸ Griffith University, Griffith Criminology Institute, Final Report: Improving Risk Assessment of Immigration Detainees (November 2019), FA 20/02/00255, released under FOI on 20 August 2020 at <https://www.homeaffairs.gov.au/foi/files/2020/fa-200200255-document-released.PDF>.