President
The Hon. John von Doussa, QC

4 December 2007

The Hon Robert McClelland MP
Attorney-General
House of Representatives
Parliament House
CANBERRA ACT 2600

Dear Attorney

I attach a report of my inquiry into complaints by Mr Huong Hai Nguyen and Mr Austin Okoye against the Commonwealth of Australia and GSL (Australia) Pty Ltd, pursuant to section 11(1)(f)(ii) of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth).

I have found that the human rights of Mr Nguyen, Mr Okoye and three other detainees were breached in the course of their immigration detention. This finding relates to the transportation of the detainees from Maribyrnong Immigration Detention Centre to Baxter Immigration Detention Facility on 17 September 2004. The conduct and conditions of that journey were in breach of the detainees' human rights pursuant to articles 7 and 10(1) of the *International Covenant on Civil and Political Rights* (ICCPR). In addition, certain acts toward Mr Nguyen prior to that journey constituted separate breaches of his human rights pursuant to articles 10(1) and 23(1) of the ICCPR.

Yours sincerely

John von Doussa QC
President

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PART A: INTRODUCTION

1. This is a report into two separate complaints lodged with the Human Rights and Equal Opportunity Commission ('HREOC') by Mr Huong Nguyen and Mr Austin Okoye respectively.

2. The complaints of Mr Nguyen and Mr Okoye make allegations against the Department of Immigration and Multicultural and Indigenous Affairs ('DIMIA')[1] and GSL (Australia) Pty Ltd ('GSL') of breaches of their human rights.

3. The complaints relate in particular to the transfer of Mr Nguyen, Mr Okoye and three other immigration detainees (collectively 'the detainees') on 17 September 2004 from Maribyrnong Immigration Detention Centre ('Maribyrnong IDC) to Baxter Immigration Detention Facility ('Baxter IDF').

4. Of the detainees, only Mr Nguyen and Mr Okoye lodged formal complaints with HREOC. However, pursuant to my power under s 20(1)(c) of the *Human Rights and Equal Opportunity Commission Act 1986* (Cth) ('the HREOC Act'), I have elected to inquire into whether the human rights of all of the detainees were breached in relation to the conduct of the journey from Maribyrnong IDC to Baxter IDF. Neither GSL nor DIMIA have raised any objection to my adopting this approach.

5. For privacy reasons, I have de-identified the three detainees who did not make complaints to HREOC. However, I provide the following description of the detainees:

The Detainees			
Name	Age (at time of transfer)	Gender	Nationality
Mr Huong Hai Nguyen	53	Male	Vietnamese
Mr Austin Okoye	26	Male	Nigerian
Mr A	21	Male	Afghani
Mr B	29	Male	Chinese
Ms C	24	Female	Indonesian

6. This report also considers additional allegations of human rights breaches raised in the complaints of Mr Nguyen and Mr Okoye. These additional alleged breaches relate to incidents immediately prior to their departure from Maribyrnong IDC and following their arrival at Baxter IDF.

7. This report is made pursuant to s 11(1)(f)(ii) of the HREOC Act.

PART B: EXECUTIVE SUMMARY

First leg of the journey breached the human rights of the detainees

8. The GSL escort of the detainees departed Maribyrnong IDC on 17 September 2004 at approximately 3.30 pm and arrived at Mildura approximately 6_ - 7 hours later. After a one hour break the journey resumed, using a different vehicle and different team of GSL officers, arriving at Baxter IDF at approximately 5.15 am the following morning.

9. The first leg of the journey, from Maribyrnong IDC to Mildura, is the focus of complaint. I have found that the conduct of this first leg of the journey breached the human rights of the detainees under articles 7 and 10(1) of the *International Covenant on Civil and Political Rights* ('the ICCPR'),[2] on the basis that:

- the detainees were subjected to degrading treatment, in breach of article 7; and
- the detainees, as persons deprived of their liberty, were not treated with humanity and with respect for the inherent dignity of the human person, in breach of article 10(1).

10. This finding is based on the condition of the van used for the first leg of the journey, which was exacerbated by the manner in which the journey was conducted. More specifically, this finding is based on the cumulative effect of the following circumstances:

- The steel compartments in the van where the detainees were separately held were:
    - o claustrophobic and cramped; and
    - o dark, with only a small amount of natural light.
- Due to the configuration of the van and the lack of facilities on board the van, the detainees were unable to:
    - o access toilet facilities;
    - o communicate with those in charge of their situation;
    - o see into each other's compartments or see outside the van;
    - o sleep or 'cat nap';
    - o stand upright or move about to any extent; or
    - o read or participate in any other comparable form of time passing distraction.
- The air-conditioning system in the van was poorly configured and was not operated properly during the journey, resulting in the compartments becoming uncomfortably overheated.
- The van did not stop for any breaks for the detainees during the 6_ - 7 hour journey from Maribyrnong IDC to Mildura. This lack of breaks:

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  - o exacerbated the discomfort and harshness of the conditions in the van;
  - o created a safety risk, given that the same officer drove the van for such a long period without a break; and
  - o resulted in the detainees being forced to suffer the indignity and discomfort of having to urinate in their own compartments. This indignity was further compounded by being:
    - recorded on CCTV tape, as well as being in view of the female driver and male co-driver of the van via the CCTV monitor; and
    - in Mr Nguyen and Mr A's case, in immediate view of a fellow detainee.
- None of the detainees were provided with any food during the journey from Maribyrnong IDC to Mildura.
- With the exception of Mr Nguyen and Mr A, the detainees were not provided with any fluids during the Maribyrnong IDC – Mildura leg of the journey. I also note that the need for fluids for the detainees was amplified by the over-heating of the compartments during the journey.
- The driver and co-driver of the van failed to adequately monitor the CCTV feed and also disregarded obvious:
  - o appeals for assistance by the detainees, such as banging on the walls and calling out;
  - o signs that the detainees required toilet breaks, particularly the driver seeing, via the CCTV monitor, Mr Nguyen urinating in his compartment;
  - o signs that the detainees were overheating in their compartments, such as seeing on the CCTV monitor detainees removing clothing; and
  - o general signs of distress of the detainees.
- The detainees were not provided with any reasonable opportunity to sleep at the Mildura Police Complex prior to continuing on to Baxter IDF.

11. I have found that the conduct of the second leg of the journey, from Mildura to Baxter IDF, did not breach the human rights of the detainees.

Additional factors in relation to Mr Nguyen and Mr Okoye

12. In the case of Mr Nguyen, my finding that his rights under article 10(1) were breached is also based on the poor standard of medical care provided to him immediately prior and subsequent to the journey to Baxter IDF.

13. In the case of Mr Okoye, my finding that his rights under articles 7 and 10(1) were breached is also based on my finding that, due to the lack of fluids and breaks during the journey from Maribyrnong IDC to Mildura, he suffered the additional indignity of drinking his own urine on two occasions in an attempt to relieve his excessive thirst.

Additional findings of human rights breaches in relation to Mr Nguyen

14. In addition to the above, I have also found the following further breaches of the human rights of Mr Nguyen:

- There was an arbitrary interference with Mr Nguyen's family life, in breach of articles 17(1) and 23(1) of the ICCPR, by failing to give adequate consideration to his family ties in Melbourne before transferring him to Baxter IDF.
- The use of force against Mr Nguyen in forcibly moving him from his dormitory room to the van immediately prior to the journey to Baxter IDF constituted a separate breach of article 10(1).

Additional allegations where no finding of human rights breaches

15. Mr Nguyen and Mr Okoye also raised a number of additional allegations in their respective complaints, as follows:

Mr Nguyen

- In the course of the transfer to Baxter IDF, some of his personal possessions were misplaced.

Mr Okoye

- He was not provided with adequate warning of his transfer to Baxter IDF and his requests to postpone his departure were unreasonably refused. Mr Okoye appears to allege that this impacted on his ability to prepare and file supplementary submissions in his proceedings before the Refugee Review Tribunal ('RRT').
- GSL officers used excessive force to remove him from his room to the van prior to his transfer to Baxter IDF.
- On 23 November 2004 he was placed in a 'management unit'[3] for 48 hours when he complained about the delays in arranging his departure from Australia and refused to leave the office of his caseworker.
  - His requests to depart Australia using his own funds were unreasonably refused or, alternatively, ignored.

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16. I have not found any breach of human rights in relation to these additional allegations.

Recommendations

17. In relation to the breaches of human rights identified in this report, I make the following recommendations:

- Compensation be paid by the Commonwealth to the detainees for breaches of their human rights arising from the conduct of the journey from Maribyrnong IDC to Mildura, as follows:
  - o $15,000 to each of the detainees;
  - o an additional $5,000 to Mr Okoye in respect of the additional indignity he suffered as a result of drinking his own urine in an attempt to relieve his excessive thirst; and
  - o an additional $5,000 to Mr Nguyen in respect of:
    - the arbitrary interference with this family life by transferring him to Baxter IDF without giving adequate consideration to his family ties in Melbourne;
    - the excessive use of force in moving him from his dormitory room to the van; and
    - the failure to provide adequate medical attention, particularly prior to the journey to Baxter IDF.
- The Commonwealth make a formal written apology to each of the detainees for the breaches of their human rights identified in this report.
- The Commonwealth take all appropriate steps to:
  - o locate the detainees (including those removed from Australia) in order to provide them with a copy of this report, compensation and an apology;
  - o ensure that a copy of this report is provided to each of the DIMIA and GSL personnel involved in this matter who remain employed by the Commonwealth or GSL; and
  - o increase human rights training for all current and future employees of the Department of Immigration and Citizenship (DIAC) (the current department that deals with immigration matters) and GSL personnel, including in relation to the findings in this report.
- I also adopt in their entirety the recommendations made by Knowledge Consulting following its detailed investigation into this matter (discussed in more detail below). A copy of these recommendations is annexed to this report as **Annexure A**.

Structure of this report

18. Following this Executive Summary, **Part C** of this report sets out the background to the complaints received from Mr Nguyen and Mr Okoye. **Part D** then outlines the relevant legal framework for this report.

19. In discussing the various allegations made by Mr Nguyen and Mr Okoye, Parts E - K of this report have been structured sequentially. That is, I have discussed the allegations made by Mr Nguyen and Mr Okoye in roughly the order in which the relevant events allegedly occurred, as follows:

- The decision to transfer Mr Nguyen and Mr Okoye to Baxter IDF and the refusal of their respective requests to remain at Maribyrnong IDC: **Part E**.
- The use of force to move Mr Nguyen and Mr Okoye to the van to transfer them to Baxter IDF, when each separately resisted: **Part F**.
- The journey from Maribyrnong IDC to Baxter IDF, including my findings in relation to:
  - the van used for the journey; and
  - the manner in which that journey was conducted: **Part G**.
- The adequacy of medical treatment provided to Mr Nguyen immediately prior and subsequent to his transfer to Baxter IDF: **Part H**.
- The misplacement of Mr Nguyen's personal possessions as a consequence of his transfer to Baxter IDF: **Part I**.
- The placement of Mr Okoye in a management unit at Baxter IDF on 23 November 2004 when he refused to leave the office of his DIMIA caseworker: **Part J**.
- The delays in arranging Mr Okoye's departure from Australia: **Part K**.

20. I have also found that there was a failure to properly investigate legitimate complaints made by Mr Nguyen, Mr Okoye and Mr B upon their arrival at Baxter IDF. In addition, when Mr Nguyen persevered by lodging formal complaints with the Commonwealth Ombudsman ('the Ombudsman') and HREOC, the complaints were again not properly investigated. This issue is discussed in **Part L.**

21. **Part M** of this report then sets out my recommendations and **Part N** provides an outline of the respondents' responses to those recommendations.

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PART C: BACKGROUND

Complaint from Mr Nguyen

22. On 26 October 2004, HREOC received a written complaint from Mr Nguyen. The complaint can be divided into five separate allegations:
    - His request to remain at Maribyrnong IDC to be near to his children was unreasonably refused or, alternatively, ignored.
    - GSL officers used excessive force to remove him from his room to the van prior to his transfer to Baxter IDF.
    - The conditions of the journey from Maribyrnong IDC to Baxter IDF were inhumane.
    - He was not provided with adequate medical treatment upon his arrival at Baxter IDF.
    - In the course of transferring him from Maribyrnong IDC to Baxter IDF, some of his personal possessions were misplaced.

Group complaint letter in support of Mr Nguyen's complaint

23. Mr Nguyen did not provide any documents in support of his complaint. However, his complaint was preceded by a letter received by HREOC on 24 September 2004 signed by a number of detainees ('the Group Complaint Letter').

24. The Group Complaint Letter complained in general about the treatment of detainees at Maribyrnong IDC, although the focus of the letter was on the treatment of a 'Vietnamese old man' which I find in the context of the letter to be a reference to Mr Nguyen. The letter described the treatment of Mr Nguyen in similar terms to Mr Nguyen's complaint in relation to the first two allegations noted above.

Complaint from Mr Okoye

25. On 21 December 2004, HREOC received a written complaint from Mr Okoye. This complaint can also be divided into five separate allegations:
    - He was not provided with adequate warning of his transfer to Baxter IDF and his request to postpone his departure was unreasonably refused. This appears to have impacted on his ability to prepare and file supplementary submissions in his RRT proceeding.
    - GSL officers used excessive force to remove him from his room to the van prior to his transfer to Baxter IDF.
    - The conditions of the journey from Maribyrnong IDC to Baxter IDF were inhumane.
    - On 23 November 2004 he was placed in a management unit for 48 hours when he complained about the delays in arranging his departure from Australia and refused to leave the office of his caseworker.

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- His requests to depart Australia using his own funds were unreasonably refused or, alternatively, ignored.

Initial Response from DIMIA

26. On 13 January 2005 DIMIA provided a formal response to Mr Nguyen's complaint which essentially refuted all of Mr Nguyen's allegations and denied that his human rights had been breached.

27. However, in response to Mr Okoye's complaint, DIMIA advised HREOC on 2 March 2005 that issues had been identified in relation to the transfer of detainees from Maribyrnong IDC to Baxter IDF on 17 September 2004 that warranted further scrutiny. It advised that it had appointed an independent expert (Knowledge Consulting) to investigate the matter further. DIMIA also advised that it would re-examine Mr Nguyen's complaint.

Investigation report prepared by Knowledge Consulting

28. On 28 February 2005 Knowledge Consulting commenced its investigation into the transfer of the detainees from Maribyrnong IDC to Baxter IDF on 17 September 2004. The investigation was conducted by Mr Keith Hamburger, with the assistance of GSL Director of Operations, Mr John McGowan.

29. In the course of this investigation, Mr Hamburger and Mr McGowan conducted interviews with a range of DIMIA and GSL personnel, as well as:
    - two of the detainees transferred to Baxter IDF, Mr A and Mr B (the remaining detainees had already been removed from Australia); and
    - a detainee who was present at Maribyrnong IDC during the forced removal of Mr Nguyen from his room to the van, who I have referred to in this report as Detainee X.

30. Mr Hamburger and Mr McGowan also reviewed all relevant documents held by DIMIA and GSL, as well as the CCTV footage from the compartments of Mr Nguyen and Mr Okoye during the first leg of the journey from Maribyrnong IDC to Mildura. However, the CCTV footage of the remaining compartments had already been destroyed.

31. Mr Hamburger and Mr McGowan also conducted inspections of Maribyrnong IDC, Baxter IDF and the van used during the Maribyrnong IDC – Mildura leg of the journey.

32. In June 2005 Knowledge Consulting completed its report, entitled *Investigation Report of Investigation on behalf of the Department of Immigration and Multicultural and Indigenous Affairs Concerning Allegations of Inappropriate Treatment of Five Detainees during Transfer from Maribyrnong Immigration Centre to Baxter Immigration Detention Facility* ('the Investigation Report').

33. Both DIMIA and GSL have advised HREOC that they accept the findings of the

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Investigation Report and neither party has raised any objection to my reliance on it in this matter. Having carefully read and considered the Investigation Report, including the transcripts of interviews conducted by Knowledge Consulting and a review of the relevant CCTV footage, I am satisfied that it is comprehensive, independent, fair and well-supported by the available evidence.

34. The findings of the Investigation Report are discussed below, where relevant to the various allegations made by Mr Nguyen and Mr Okoye.

Response from GSL

35. Subsequent to HREOC being provided with a copy of the Investigation Report, GSL provided a response to each of the complaints by Mr Nguyen and Mr Okoye.

36. GSL stated that it accepted the findings of the Investigation Report, although made comments in relation to a number of specific issues and allegations. These comments are discussed below, where relevant.

Additional response from DIMIA

37. On 16 March 2007, HREOC wrote to both GSL and DIMIA, inviting further submissions in relation to:

(a) my preliminary view that the treatment of the detainees appeared to constitute 'degrading treatment' in breach of article 7 of the ICCPR;

(b) my preliminary view that the transfer of Mr Nguyen from Maribyrnong IDC to Baxter IDF was, in the circumstances, an arbitrary interference with his family in breach of articles 17(1) and 23(1) of the ICCPR;

(c) my intention to direct the findings of this report to all of the detainees involved in the transfer, not simply Mr Nguyen and Mr Okoye; and

(d) appropriate recommendations.

38. GSL elected not to provide any further submissions on the above issues, relying instead on its earlier response.

39. On 15 June 2007, DIMIA provided a response which only commented on issue (b), namely the application of articles 17(1) and 23(1) in relation to Mr Nguyen. DIMIA's submissions on this issue are outlined in Part E, where relevant.

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Loss of contact with Mr Nguyen and Mr Okoye

40. HREOC has been advised by DIMIA that Mr Nguyen was returned to Vietnam on 18 November 2004 and Mr Okoye was returned to Nigeria on 13 January 2005.

41. HREOC has been unable to contact either Mr Nguyen or Mr Okoye since their removal from Australia. In addition, I have been advised by the Ombudsman's office that it has lost contact with Mr Nguyen's daughter-in-law who had originally lodged the complaint with the Ombudsman on Mr Nguyen's behalf.

42. Notwithstanding this loss of contact, I have formed the opinion that I have sufficient material upon which to make relevant findings in this matter.

Naming of individual employees of DIMIA and GSL

43. The Investigation Report made a number of critical findings in relation to the actions of particular employees of DIMIA and GSL. HREOC has not sought individual responses from these individuals and it is therefore not appropriate that they be named in this report.[4]

44. However, in order to provide some organisational context to the events that occurred, I have referred to certain individuals by reference to their role within DIMIA or GSL.

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PART D: RELEVANT LEGAL FRAMEWORK

Human rights inquiry and complaints function[5]

45. Section 11(1)(f) of the HREOC Act provides that HREOC has the function of inquiring into any act or practice that may be inconsistent with or contrary to any human right. Section 20 (1)(b) requires HREOC to perform that function when a complaint in writing is made to it alleging such an act or practice, such as the complaints received from Mr Nguyen and Mr Okoye.

46. Pursuant to s 20(1)(c), HREOC shall also perform its human rights inquiry function under s 11(1)(f) when 'it appears to the Commission to be desirable to do so.' In the circumstances of this complaint, I have considered it desirable to also inquire into whether there was a breach of the human rights of the other detainees transferred from Maribyrnong IDC to Baxter IDF on 17 September 2004, namely Mr A, Mr B and Ms C.

Act or practice by or on behalf of the Commonwealth

47. The expressions 'act' and 'practice' are defined in s 3(1) of the HREOC Act to include an act done or a practice engaged in 'by or on behalf of the Commonwealth', or under an enactment. Section 3(3) of the HREOC Act also provides that a reference to, or to the doing of, an act includes a reference to a refusal or failure to do an act.

48. In the circumstances of these complaints, many of the relevant acts (or omissions) were performed by officers employed by GSL, rather than the Commonwealth. GSL is a private company contractually engaged by the Commonwealth to provide immigration detention centre services.

49. It is not necessary for me to define the precise scope of the expression 'on behalf of the Commonwealth'. It is sufficient for present purposes that I find that this expression includes an act done by a GSL officer during an authorised operation in relation to a detention centre or detainee, notwithstanding that the particular act may not have been specifically authorised.

50. Applying the above interpretation, I consider that all relevant acts the subject of this inquiry fall within the scope of s 11(1)(f) as being acts done 'by or on behalf of the Commonwealth'.

Inconsistent with or contrary to any human right

51. The phrase 'inconsistent with or contrary to any human right' in Division 3 of the HREOC Act is not defined or otherwise explained in the Act. This raises a question as to whether the threshold for an act being **inconsistent** with a human right might be lower than the threshold for an act that is **contrary** to a human right.

52. On one view, it could be argued that by using two different expressions, Parliament intended that two different meanings should apply. Moreover, it could be said that 'contrary to' implies a higher threshold - that the act is antithetical to a person's human rights. By contrast, 'inconsistent with' could arguably encompass an act that is merely not in harmony with a person's human rights, but not necessarily in direct violation of those rights.

53. The United Nations Human Rights Committee ('UNHRC'), established by the ICCPR as the most authoritative interpreter of the ICCPR, has not directly considered this issue. However, its jurisprudence does not appear to draw any material distinction between an act being inconsistent with, compared with contrary to, a person's human rights.[6]

54. My preferred approach is to interpret the phrase 'inconsistent with or contrary to' as a composite expression referring simply to whether a person's human rights have been breached or violated, as those terms are applied in international human rights jurisprudence. However, it is not necessary for me to resolve this question at this time as I am satisfied that no distinction arises in this matter. This is because I am satisfied that the relevant acts the subject of my findings in this report were both inconsistent with **and** contrary to the human rights of the detainees. The same is true in the case of my findings where no breach of human rights had occurred.

55. For convenience, throughout this report I have referred to an act that is inconsistent with or contrary to a detainee's human rights as a 'breach' of the relevant human right.

'Human rights' relevant to these complaints

56. The expression 'human rights' is defined in s 3 of the HREOC Act and includes the rights and freedoms recognised in the ICCPR, which is set out in Schedule 2 to the HREOC Act.

57. Articles 7 and 10(1) of the ICCPR are of particular relevance to this inquiry. These articles provide:

> **Article 7**
>
> No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.
>
> **Article 10**
>
> (1) All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

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Relationship between article 7 and 10(1)

58. There is clearly an overlap between article 7 and 10(1) in the case of detained persons. That is, inhuman or degrading treatment or punishment will also constitute a lack of treatment with humanity and respect for the inherent dignity of the human person. However, the UNHRC has confirmed that 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.[7]

59. Furthermore, the UNHRC has confirmed that whilst article 7 imposes a prohibition against certain forms of treatment or punishment, article 10(1) imposes a positive obligation upon States to protect the humanity and dignity of detained prisoners due to their particular vulnerability:

> 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 the ban on torture or other cruel, inhuman or degrading treatment or punishment contained in article 7….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…[8]

60. Professor Manfred Nowak summarises the relationship between articles 7 and 10(1) as follows:

> [S]everal general conclusions may be drawn for the interpretation of Art. 10(1): In contrast to Art. 7, Art. 10 relates only to the treatment of persons who have been deprived of their liberty. Whereas Art. 7 primarily is directed at specific, usually violent attacks on personal integrity, Art. 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, Art. 10 primarily imposes on State parties a positive obligation to ensure human dignity. Regardless of economic difficulties, the State must establish a minimum standard for humane conditions of detention (requirement of 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 Art. 10 goes beyond the mere prohibition of inhuman treatment under Art. 7 with regard to the extent of the necessary 'respect for the inherent dignity of the human person'.[9]

61. Notwithstanding that article 7 is primarily designed to redress specific attacks on detainees, a specific use of force against a detainee which does not reach the requisite threshold to constitute a breach of article 7 may nevertheless be sufficient to constitute a breach of article 10(1).[10]

62. A more detailed discussion of the elements of article 7 is contained in Part G of this report, in relation to the conditions of the journey from Maribyrnong IDC to Mildura.

Standard Minimum Rules and the Body of Principles

63. The content of article 10(1) has also been developed with the assistance of a number of United Nations instruments that articulate minimum international standards in relation to people deprived of their liberty, including:

- The Standard Minimum Rules for the Treatment of Prisoners (the 'Standard Minimum Rules');[11] and
- The Body of Principles for the Protection of all Persons under Any Form of Detention (the 'Body of Principles').[12]

64. The UNHRC has indicated that compliance with the Standard Minimum Rules and the Body of Principles is the minimum requirement for compliance with the obligation imposed by the ICCPR that people in detention are to be treated humanely under article 10(1).[13]

65. As a matter of international law, the Standard Minimum Rules and Body of Principles are not binding of themselves on Australia and there is no specific obligation to implement them in Australia. However, the Standard Minimum Rules and the Body of Principles do elaborate the standards which the international community considers acceptable and are relevant to interpreting the scope and content of the protection given to persons deprived of their liberty under article 10(1).

66. The Body of Principles is expressed to apply for the protection of all persons under any form of detention or imprisonment. By contrast, the Standard Minimum Rules are directed at the treatment of prisoners and the management of penal institutions. Strictly speaking, immigration detention facilities are not penal institutions in the sense that they do not house convicted criminal or people charged with a criminal offence. Nevertheless, the Standard Minimum Rules are expressed to set out minimum conditions which are accepted as suitable by the United Nations for the general management of institutions housing all categories of prisoner.

67. I therefore consider that both the Standard Minimum Rules and the Body of Principles provide valuable guidance in interpreting and applying article 10(1) of the ICCPR. The particular Standard Minimum Rules and Body of Principles relevant to this inquiry are set out below where relevant to the various allegations made by Mr Nguyen and Mr Okoye.

Other relevant standards

68. DIMIA has provided copies of a number of its policies, known as Immigration Detention Standards, which relate to these complaints. It is my understanding that these policies govern the provision of immigration detention services by GSL and prescribe the standard of care to be provided to detainees.

69. I have referred throughout this report to excerpts from DIMIA's policies where relevant to the various allegations made by Mr Nguyen and Mr Okoye.

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Other articles of the ICCPR relevant to this inquiry

70. The following articles of the ICCPR are also relevant to particular allegations made by Mr Nguyen and Mr Okoye:

- Article 13 (Right of an alien to submit reasons against his or her expulsion).
- Article 14(1) (Right to a fair hearing).
- Article 17(1) (Prohibition against arbitrary interference with family).
- Article 23(1) (Protection of the family).

71. The content and application of these articles are discussed in more detail below, where relevant to the particular complaints made by Mr Nguyen and Mr Okoye.

Standard of proof

72. In making my findings, I have applied the civil standard of proof, namely the balance of probabilities. I have assessed the evidence in light of the well-established principle set out by Dixon J in *Briginshaw v Briginshaw*,[14] in which his Honour said:

> [R]easonable satisfaction is not a state of mind that is attained or established independently of the nature and consequence of the fact or facts to be proved. The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding are considerations which must affect the answer to the question whether the issue has been proved to the reasonable satisfaction of the tribunal. In such matters, 'reasonable satisfaction' should not be produced by inexact proofs, indefinite testimony, or indirect inferences. [15]

73. I regard the allegations made in this matter to be serious ones and recognise, in particular, that adverse findings may impact upon DIMIA, GSL and their staff. I have taken particular care in assessing the evidence before reaching my findings.

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PART E: REFUSAL OF REQUESTS TO REMAIN AT MARIBYRNONG IDC

MR NGUYEN

Complaint

74. Mr Nguyen alleged that he requested to remain at Maribyrnong IDC to enable him to be near to his children, however this request was unreasonably refused or, alternatively, ignored.

Relevant factual findings

75. I accept the following assertions made by DIMIA in its responses to Mr Nguyen's complaint:

- Maribyrnong is a small centre, designed for short-stay detainees only. By contrast, Baxter IDF was specifically built to house detainees for extended periods.
- It is the usual practice of DIMIA that decisions to transfer detainees are taken by DIMIA after consultations with GSL, taking into account the capacity of the centre, the probable length of detention and the individual circumstances of the detainee. I also accept that it is DIMIA's usual practice that detainees with close family ties in Melbourne are not normally transferred to another centre.
- At the time of his induction at Maribyrnong IDC, Mr Nguyen did not advise DIMIA that he had any family in Australia.
- Prior to deciding to transfer Mr Nguyen, the Acting DIMIA Business Manager at Maribyrnong IDC ('the DIMIA Business Manager'), checked Mr Nguyen's visitor records to see whether he had family ties in Melbourne. These records showed that visitors with the same surname of 'Nguyen' had visited Mr Nguyen. However, they had identified themselves as friends, not family, of Mr Nguyen. It has since been established that these persons were in fact Mr Nguyen's son and daughter-in-law.[16] It is not known why they had identified themselves as friends of Mr Nguyen, rather than family.
- Approximately five hours before departure, Mr Nguyen was advised of his transfer to Baxter IDF by the DIMIA Business Manager, with the aid of a Vietnamese interpreter.
- If information concerning Mr Nguyen's family had been communicated to DIMIA's Central Office, even on the day of his departure, DIMIA would have re-examined his situation and, if necessary, delayed his transfer to investigate his circumstances further. However, DIMIA is unable to say now whether or not this would have led to Mr Nguyen remaining at Maribyrnong IDC.

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76. The DIMIA Business Manager asserted that at no stage during his discussion with Mr Nguyen about his transfer to Baxter IDF did Mr Nguyen mention that he had family in Melbourne. By contrast, Mr Nguyen alleged in his complaint that, when told of his transfer, he explicitly stated that he wanted to remain at Maribyrnong IDC to be near to his family.

77. I accept the allegation by Mr Nguyen that he raised the fact that he had family in Melbourne during his discussion with the DIMIA Business Manager immediately prior to his transfer. My reasons for preferring the account of Mr Nguyen on this issue are as follows:

- As noted above, it has been established that Mr Nguyen's son and daughter-in-law lived in Melbourne and visited him at Maribyrnong IDC on a number of occasions (albeit under the guise of being friends, rather than family).
- In his interview with Knowledge Consulting, the GSL Manager of Maribyrnong IDC ('the Maribyrnong Manager') made the following comments:
  - He overheard Mr Nguyen shouting in the office of the DIMIA Business Manager when Mr Nguyen was informed of his transfer. The Maribyrnong Manager stated that he attended to lend assistance and heard the interpreter say that Mr Nguyen did not wish to go to Baxter IDF because he had a daughter in Melbourne who had been visiting him at Maribyrnong IDC.
  - Mr Nguyen 'tried for virtually 4 and a half hours to convince DIMIA that he shouldn't go'.
  - As the GSL officers took Mr Nguyen to the van, other detainees in the centre were saying 'he has got family here, why are they sending him?'
  - When Mr Nguyen was put into the van, he was still agitated and saying 'I don't want to go, I've got family here, I don't want to go'.
- A fellow Vietnamese detainee who was present when Mr Nguyen was forcibly removed from his room, Detainee X, was also interviewed by Knowledge Consulting. Detainee X stated that when he and the Maribyrnong Manager attempted to calm Mr Nguyen down (discussed further below), Detainee X translated to the Maribyrnong Manager that Mr Nguyen did not want to leave because he had children in Melbourne.
- The Group Complaint Letter stated:

  > On the 17/9/04 the immergration (sic) officers told him in the morning that he was getting transferred to Baxter IDF . He didn't want to go there as he would not be able to see his children and he started crying and begging not to go there.

- There is no other plausible explanation for why Mr Nguyen was so resistant to leaving Maribyrnong IDC.

78. In any event, I note that the Investigation Report found that planning of the

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transfer had commenced at least as early as 20 August 2004 when DIMIA first raised the necessary paperwork for the transfer. Mr B stated that he was advised of his transfer a week prior to departure. However, as noted above, it is not in dispute that Mr Nguyen was not informed of his transfer until the morning of his departure.

Articles 17(1) and 23(1) of the ICCPR

79. Mr Nguyen's complaint raises a potential breach of articles 17(1) and 23(1) of the ICCPR, which provide:

> **Article 17(1)**
> No one shall be subjected to arbitrary or unlawful interference with his privacy, family, home or correspondence, nor to unlawful attacks on his honour and reputation.
>
> **Article 23(1)**
> The family is the natural and fundamental group unit of society and is entitled to protection by society and the State.

Relationship between articles 17(1) and 23(1)

80. Professor Manfred Nowak attempts to explain the distinction between articles 17(1) (in relation to family) and 23(1) as follows:

> [T]he significance of Art. 23(1) lies in the protected existence of the institution "family", whereas the right to non-interference with family life is primarily guaranteed by Art. 17. However, this distinction is difficult to maintain in practice.[17]

81. However, to date, this theoretical distinction has failed to play out in the jurisprudence of the UNHRC. For example, in *Sahid v New Zealand*,[18] the author alleged a breach of article 23(1). He alleged that his deportation from New Zealand violated his right to protection of his family by the State, as his adult daughter had re-settled from Fiji to New Zealand. Oddly, he raised no breach of article 17(1). The State party argued that the claim under article 23(1) was inadmissible on the basis that:

> the obligation under article 23, paragraph 1, is an 'institutional guarantee', whereby the State is obliged within broad discretion to protect positively the family unit.[19]

82. The State Party then proceeded to demonstrate that the family unit as an institution was appropriately recognised and protected under New Zealand law, including in relation to deportation matters.[20]

83. The UNHRC rejected this admissibility argument, concluding that the facts gave rise to an arguable claim concerning article 23(1).[21] The Committee did not elaborate on this issue. However, its conclusion would appear to accept a broad view of article 23(1) that encompasses a protection against State interference with

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a person's particular family, rather than simply protection of the family unit as an institution.[22]

84. The UNHRC then rejected the claim on its merits. However, in doing so, its reasoning was essentially that the interference with the author's family was not arbitrary. No attempt was made to explain how this reasoning – which was based on the principles applicable to article 17(1) – was equally applicable to article 23(1).

85. Other decisions of the UNHRC have also tended to reach the same conclusion on article 17(1) (in relation to family) as for article 23(1).[23] No real attempt has been made in these decisions, or in the UNHRC's General Comments,[24] to explain how these two articles interact or differ. As noted by Joseph, Schultz and Castan:

> [D]espite an apparent qualitative difference between the article 17 and 23 guarantees, most cases regarding family rights have concerned violations, or exonerations, of States under both articles.[25]

86. Professor Nowak has suggested that in cases involving a State's negative interference with a person's family, it should be assessed primarily in relation to article 17(1).[26]

87. This approach appears to have been adopted, albeit not explicitly, in *Winata v Australia*,[27] where the UNHRC found that the deportation of two parents constituted an arbitrary interference with their family. This was on the basis that the decision to deport failed to adequately take into consideration the impact on the parents' child, who was an Australian resident and had grown up entirely in Australia. The UNHRC concluded that there was a breach of article 17(1) 'in conjunction with' article 23(1).[28] However, this conclusion was reached on the basis of an analysis of article 17(1) only. Other UNHRC cases relating to an alleged arbitrary interference with a person's family have taken a similar approach.[29]

88. On the basis of the above, it appears that in cases alleging a State's arbitrary interference with a person's family, it is appropriate to assess the alleged breach under article 17(1). If so, it will usually follow that that breach is in addition to (or in conjunction with) a breach of article 23(1).

Discussion of whether article 17(1) breached

89. There are three issues to consider in relation to whether there was a breach of Mr Nguyen's rights under article 17(1) in this matter:

- Did Mr Nguyen have a 'family' in Melbourne within the meaning of article 17(1)?
- If so, was there an 'interference' with that family?
- If so, was that interference 'arbitrary'? (On the available material I accept that, to the extent that there was any interference with Mr Nguyen's family, it was not unlawful).

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'Family'

90. The UNHRC has confirmed on a number of occasions that 'family' is to be interpreted broadly.[30] However, more than a formal familial relationship (ie father-son) is required to demonstrate a family for the purposes of article 17(1). Some degree of effective family life or family connection must also be shown to exist.[31] For example, in *Balaguer Santacana v Spain*,[32] after acknowledging that the term 'family' must be interpreted broadly, the UNHRC went on to say:

> Some minimal requirements for the existence of a family are, however, necessary, such as life together, economic ties, a regular and intense relationship, etc.[33]

91. I am satisfied that the 'minimal requirements' referred to above would be met in the case of Mr Nguyen's relationship with his son and daughter-in-law, for the following reasons:

- Mr Nguyen received a number of visits from his son and daughter-in-law whilst at Maribyrnong IDC.
- The Group Complaint Letter stated that Mr Nguyen had originally been sponsored by his children to come to Australia for a holiday and he had then overstayed his visa.
- Mr Nguyen stated in his complaint that he had been reliant on his children to provide him with food at Maribyrnong IDC, as he could not eat the curry that he was often served.
- It is clear that Mr Nguyen was very upset about being moved away from his children in Melbourne.
- I am advised by the Ombudsman's office that Mr Nguyen's complaint to the Ombudsman was lodged on his behalf by his daughter-in-law.

'Interference'

92. There is no clear guidance in the jurisprudence of the UNHRC as to whether a particular threshold is required in establishing that an act or practice constitutes an 'interference' with a person's family. However, in one decision, the UNHRC appeared to accept that a 'considerable inconvenience' could suffice.[34]

93. On a narrow view, it could be argued that there was no substantial interference with Mr Nguyen's family given that no restriction was imposed on his contact with his family. His family remained at liberty to contact Mr Nguyen, including in person (albeit with greater difficulty).[35]

94. An argument along these lines was made by DIMIA in its subsequent response in this matter, dated 15 June 2007. On the one hand, DIMIA accepted that its transfer of Mr Nguyen constituted an interference with his family life. However, it also argued that:

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> The Department submits that any interference with the family that inadvertently occurred did not have severe consequences, given that the disrupted relations were between a father and his adult son and daughter-in-law, with no spouse or dependent children involved.
>
> It is Departmental policy that a person held in detention is able to make phone calls, and receive and send postal mail and faxes. As such, the complainant would still have been able to maintain contact with his family in Melbourne, although personal visits would have been more difficult to arrange.

95. However, I consider that the word 'interference' in article 17(1) should be given its ordinary meaning. I see no reason for adding a proviso not included in the wording of article 17(1) that the interference must also be substantial.

96. I observe that cases dealing with interference with a person's privacy[36] or correspondence[37] have not required that an interference must be substantial in order to fall within the scope of article 17(1). I also consider that a robust prohibition against interferences with family life is consistent with the requirement under article 23(1) that 'the family is the natural and fundamental group unit of society and is entitled to protection by society and the State.'

97. To the extent that the operation of article 17(1) should be confined to serious cases, I note my power to not inquire, or to discontinue any existing inquiry, into a complaint that I consider to be frivolous or vexatious.[38] I also consider that a threshold of seriousness is provided by the fact that article 17(1) only prohibits interferences that are unlawful or arbitrary. Furthermore, the seriousness of any unlawful or arbitrary interference is a matter that can be taken into account in considering any appropriate remedy.

98. When 'interference' is interpreted using its ordinary meaning, I am satisfied that the removal of Mr Nguyen from Maribyrnong IDC to Baxter IDF amounted to an interference with his family life within the meaning of article 17(1). This is demonstrated by the simple fact that Mr Nguyen's only known family ties in Australia were his son and daughter-in-law who resided in Melbourne, a considerable distance from Baxter IDF. I also note that whilst in detention in Maribyrnong IDC, Mr Nguyen had received regular visits from his son and daughter-in-law. These visits would no doubt be substantially impaired by his transfer to Baxter IDF.

99. In addition, I note that Mr Nguyen was removed from Australia approximately two months after his transfer to Baxter IDF. It is therefore possible (if not probable) that his transfer to Baxter IDF interfered with his family by preventing him from farewelling his family in person before being returned to Vietnam.

100. Finally, as noted above, DIMIA has stated that it 'admits that interference with the family may have inadvertently resulted from the transfer of the complainant (Mr Nguyen)'. To the extent that DIMIA also made submissions regarding the severity of its interference with Mr Nguyen's family, I have taken these submissions into account when considering an appropriate remedy to recommend in relation to this issue.

'Arbitrary'

101. In its General Comment on article 17(1), the UNHRC confirmed that a lawful interference with a person's family may nevertheless be arbitrary unless it is in accordance with the provisions, aims and objectives of the Covenant and is reasonable in the particular circumstances.[39]

102. It follows that the prohibition against arbitrary interferences with family incorporates notions of reasonableness.[40] In relation to the meaning of 'reasonableness', the UNHRC stated in *Toonan v Australia*:[41]

> The Committee interprets the requirement of reasonableness to imply that any interference with privacy must be proportional to the end sought and be necessary in the circumstances of any given case.[42]

103. DIMIA has stated that its interference with Mr Nguyen's family was not arbitrary, as any interference was 'inadvertent' and his transfer 'did not involve unreasonableness, injustice, unpredictability and was not disproportionate in the circumstances.'

104. However, I consider that a failure by a State to give *adequate consideratio*n to the impact on a person's family life prior to 'interfering' with that family life is a relevant indicia of arbitrariness. This is consistent with the UNHRC's jurisprudence on article 17(1),[43] as well as the UNHRC's interpretation of 'arbitrary' in the context of the prohibition against arbitrary detention under article 9 of the ICCPR.[44] I also note that in *Estrella v Uruguay*,[45] the UNHRC found that Article 17(1) encompasses a general right of prisoners to receive regular visits by family members.[46]

105. I accept that there may be reasonable and legitimate operational reasons for DIMIA to transfer a detainee to another detention facility. I also accept that it was reasonable and legitimate for DIMIA to have a policy of using Maribyrnong IDC primarily as a short-stay facility. I also accept that DIMIA's records did not disclose that Mr Nguyen had any family members in Australia.

106. Nevertheless, I consider that adequate consideration was not given to Mr Nguyen's family ties in Melbourne before his transfer to Baxter IDF. This appears to have stemmed from the failure to consult with Mr Nguyen directly until the day of his transfer. By this time, the officers involved seem to have regarded the decision to transfer Mr Nguyen as final and therefore disregarded pleas by Mr Nguyen to remain at Maribyrnong IDC to be close to his family.

107. I do not consider that it was sufficient for DIMIA to assume that Mr Nguyen had no family ties based on his visitor records. It appears from the interviews conducted by Knowledge Consulting, particularly with the Maribyrnong Manager, that visitor records were known to be unreliable for this purpose. Similarly, I do not consider that it was adequate for DIMIA to rely on Mr Nguyen's induction interview to the effect that he did not have family in Australia. At the time of being inducted, there might be understandable reasons to explain Mr Nguyen's

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reluctance to disclose family members based on, for example, a fear they might also be rounded up and detained by the authorities.

108. Rather, I consider that when DIMIA was considering whether to transfer Mr Nguyen to Baxter IDF, it should have sought confirmation from Mr Nguyen of any family ties in Australia. This would not have imposed an unreasonable burden on DIMIA, yet would have provided a more secure basis for DIMIA's assumption that the transfer would not result in an arbitrary interference with his family life.

109. Alternatively, as noted above I have accepted that, immediately after being told of his pending transfer, Mr Nguyen raised with the DIMIA Business Manager that he had family in Australia. From this point onwards, DIMIA was clearly on notice of Mr Nguyen's family and could have taken steps to review his transfer. It is therefore not correct for DIMIA to say that its interference with Mr Nguyen's family was inadvertent. As noted above, the officers involved were informed by Mr Nguyen of his family ties in Melbourne, yet disregarded those appeals and pressed ahead with the transfer.

110. If adequate consideration had been given to Mr Nguyen's family, DIMIA is unable to now say whether or not Mr Nguyen would have still been transferred. Whilst this raises some doubt as to whether the failure to give consideration to Mr Nguyen's family was of any consequence, I am nevertheless satisfied that this failure was sufficient to make the decision to transfer Mr Nguyen arbitrary. In reaching this finding, I note the following:

- DIMIA has advised that it's usual practice was to **not** transfer detainees who had close family ties to Melbourne. A detainee's family was therefore clearly an important, albeit not determinative, consideration which should have been taken into account.
- I have found that Mr Nguyen did inform officers of DIMIA and GSL of his family in Melbourne in the course of protesting about his transfer. The failure to communicate this information to the relevant persons within DIMIA rests entirely with the respondents. Any doubt as to what might have occurred but for this failure therefore rests with the respondents. It would not be appropriate to now give the respondents the benefit of that doubt.
- If adequate consideration had been given to Mr Nguyen's family in Melbourne, he presumably would have at least been afforded an opportunity to express his views on the subject. Failing that, he possibly would have had an opportunity to say a proper farewell to his family. I consider that this would have ameliorated the impact of the interference with his family.

Conclusion regarding articles 17(1) and 23(1)

111. I conclude that the respondents interfered with Mr Nguyen's family by transferring him to Baxter IDF. I also conclude that, in deciding to transfer Mr Nguyen, there was a failure to give adequate consideration to the interference with his family. This failure was sufficient to make the interference with Mr Nguyen's family arbitrary.

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112. On the basis of the foregoing, I find that there was a breach of Mr Nguyen's human rights under article 17(1) in connection with article 23(1).

MR OKOYE

Complaint

113. Mr Okoye alleged that, when told of his transfer to Baxter IDF, he requested to remain at Maribyrnong IDC, at least until his RRT submissions were filed. He further alleged that this request was unreasonably refused or, alternatively, ignored.

114. In particular, Mr Okoye alleged that his RRT application had been heard two days prior and the RRT member had asked him to file further submissions by that day (17 September 2004). Whilst not entirely clear from his written complaint, it appears that Mr Okoye alleges that he was unable to complete or file those submissions due to the lack of advance warning of his transfer.

115. Mr Okoye also alleged that he was denied the opportunity to contact his lawyer after he was advised of his transfer.

116. Mr Okoye's allegations raise potential breaches of articles 10(1), 13 and 14(1) of the ICCPR.

Article 10(1) of the ICCPR

117. Mr Okoye has alleged that he was denied access to his lawyer. This allegedly occurred at a particularly important time in relation to his application before the RRT.

118. There is no explicit right under the ICCPR for an immigration detainee to communicate with his or her lawyer. However, as discussed above in Part D, the content of article 10(1) of the ICCPR has been elaborated upon by the Standard Minimum Rules and Body of Principles.

119. Principle 18 of the Body of Principles sets out a detained person's right to communicate with his or her lawyer:

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> **Principle 18**
>
> A detained or imprisoned person shall be entitled to communicate and consult with his legal counsel.
>
> A detained or imprisoned person shall be allowed adequate time and facilities for consultation with his legal counsel.
>
> The right of a detained or imprisoned person to be visited by and to consult and communicate, without delay or censorship and in full confidentiality, with his legal counsel may not be suspended or restricted save in exceptional circumstances, to be specified by law or lawful regulations, when it is considered indispensable by a judicial or other authority in order to maintain security and good order.

120. The wording of Principle 18 is strict. It provides that a detained person is entitled to communicate with his legal counsel without delay. This right may not be suspended or restricted except in extremely limited circumstances. Even then, Principle 15 provides that access to a detainee's legal counsel shall not be denied for more than a matter of days.[47]

121. It is in dispute whether Mr Okoye was in fact denied the right to contact his lawyer. The Investigation Report, whilst not making any finding on this issue, referred to an internal DIMIA email responding to enquiries about the circumstances surrounding the transfer of the detainees. The email stated:

> I don't recall any specific protests from Mr Okoye about any RRT or MRT hearings at the time of being told he was being transferred to Baxter IDF. He was placed in an interview room following being advised of his transfer, while I advised other detainees of their transfer. ... **a telephone call to his solicitor was facilitated**. (emphasis added)

122. On the material before me I am unable to resolve the conflicting evidence regarding whether Mr Okoye was refused access to his lawyer. I am therefore of the view that I cannot be positively satisfied that this allegation is made out.

Article 13 of the ICCPR

123. Article 13 of the ICCPR provides:

> An alien lawfully in the territory of a State Party to the present Covenant may be expelled therefrom only in pursuance of a decision reached in accordance with law and shall, except where compelling reasons of national security otherwise require, be allowed to submit the reasons against his expulsion and to have his case reviewed by, and be represented for the purpose before, the competent authority or a person or persons especially designated by the competent authority.

124. I am unable to determine on the material before me whether Mr Okoye was lawfully in the territory of the Commonwealth, although his detention as an immigration detainee would suggest that he was not.

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125. Nevertheless, taking Mr Okoye's complaint at its highest and assuming that Mr Okoye was prevented from filing supplementary submissions as requested by the RRT Member, I do not consider that this would reach the requisite level of severity to constitute a breach of his rights (if any) under article 13.

Article 14(1) of the ICCPR

126. Article 14(1) of the ICCPR relevantly provides:

> All persons shall be equal before the courts and tribunals. In the determination of any criminal charges against him, or of his rights and obligations in a suit at law, everyone shall be entitled to a fair and public hearing by a competent, independent and impartial tribunal established by law. ...

127. There is some uncertainty as to whether a 'suit at law' includes proceedings in relation to a person's deportation or immigration status.[48] I do not need to decide that question here. It is sufficient for me to conclude that Mr Okoye's complaint does not disclose that he was denied a fair and public hearing in relation to his RRT application, notwithstanding that, due to the actions of the respondents, he may have been:

- prevented from filing supplementary submissions in time; and
- denied access to his lawyer from the time he was informed of his transfer until some time after his arrival at Baxter IDF.

PART F: USE OF FORCE

MR NGUYEN

Complaint

128. Mr Nguyen alleged in his complaint that prior to his transfer from Maribyrnong IDC to Baxter IDF, the following occurred:

- Six or seven GSL officers burst into his dormitory room without warning.
- The officers pushed his head against the wall and then leaned heavily on his body on the floor. Mr Nguyen claims that his body was pressed against a cassette player which compounded the pain and discomfort of the weight of the GSL officers.
- One of the GSL officers used his thumb to press into a sensitive 'pressure point' behind his ear. Mr Nguyen claims that the pain was unbearable, causing him to scream.
- He was then handcuffed, carried out of the room 'like a pig' and then thrown into a van.

Uncontentious findings

129. I make the following findings on issues that appear to be uncontentious:

- When Mr Nguyen was told on the morning of 17 September 2004 that he was to be transferred from Baxter IDF to Maribyrnong IDC, he became agitated and strongly requested to remain at Maribyrnong IDC.
- Mr Nguyen was then returned to his dormitory room.
- Several hours later, GSL officers attended Mr Nguyen's dormitory room to remove him to the van. They were not accompanied by an interpreter.
- Force was used on Mr Nguyen to remove him from his room, although there is some dispute over the events that preceded that use of force and the level of force that was used (discussed below).
- Mr Nguyen was handcuffed and carried from the room to the van.
- The handcuffs were removed from Mr Nguyen prior to the journey to Baxter IDF commencing.
- Mr Nguyen was not medically examined following the use of force.
- The removal of Mr Nguyen from his dormitory room to the van was not video recorded.
- Incident reports in relation to the use of force on Mr Nguyen were prepared by the Maribyrnong Manager and the GSL Operations Manager at Maribyrnong IDC. No incident reports were prepared by any of the other GSL officers involved in the incident.

Lack of video footage

130. DIMIA's policy on the use of force requires that, wherever practical, when force is used in a planned way it should be video recorded.[49]

131. I find that the use of force against Mr Nguyen should have been video recorded. In making this finding, I am satisfied that video recording was practical in the circumstances, for the following reasons:

- It is not in dispute that video equipment was available.
- The Maribyrnong Manager stated that he was aware prior to attending Mr Nguyen's room that Mr Nguyen was agitated and refusing to leave his room. I consider that at this point he should have reasonably contemplated that force may have been required, thus requiring video recording.
- The Maribyrnong Manager stated that calling for video equipment would have resulted in a delay of approximately 5 – 10 minutes. I do not consider that this would have been an unreasonable delay in the circumstances.
- The Maribyrnong Manager claimed that, prior to instructing officers to use force on Mr Nguyen, he attempted to diffuse the situation with the assistance of a fellow Vietnamese detainee, Detainee X. According to Detainee X, this continued for approximately 10 minutes. There is no apparent reason why video equipment could not have been called for whilst this took place.
- Prior to using force on Mr Nguyen, the Maribyrnong Manager had already authorised the use of force on Mr Okoye to move him to the van (discussed below). I consider that he should have been aware from his dealings with Mr Okoye that force may have been also required to move Mr Nguyen, given that Mr Nguyen was also refusing to leave his room.
- One of the other GSL officers involved in the incident acknowledged in his interview with Knowledge Consulting that video recording could and should have been arranged.

Incident reports

132. DIMIA's policy on the use of force also requires that when force has been used as part of an organised team, every officer involved in the incident must complete an incident report. The policy also requires that incident reports must provide an accurate description of the kind of force used and the reasons why it was considered necessary.[50]

133. As noted above, of the six GSL officers involved in the use of force against Mr Nguyen, only the Maribyrnong Manager and the GSL Operations Manager prepared incident reports. I agree with the strong criticisms in the Investigation Report that those two incident reports were completely lacking in detail and did not comply with DIMIA's policy on the use of force. I also agree with the criticism in the Investigation Report that all officers involved in the use of force against Mr Nguyen should have prepared incident reports.

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Events that preceded the use of force

Threatening behaviour by Mr Nguyen

134. Mr Nguyen stated in his complaint that GSL officers burst into his room without warning. Similarly, Detainee X, the Vietnamese detainee who witnessed the incident, made no reference in his interview with Knowledge Consulting to any threatening behaviour on the part of Mr Nguyen. However, I note that Detainee X was not directly questioned on this particular issue.

135. Neither of the two GSL incident reports made any reference to any threatening behaviour by Mr Nguyen. However, when interviewed by Knowledge Consulting, GSL officers involved in the incident stated that prior to the use of force Mr Nguyen had armed himself with a bundle of plastic knives and forks in one hand and a glass jar in the other hand and was making threatening gestures.

136. I find that, prior to the use of force, Mr Nguyen was engaging in mild threatening behaviour with a bundle of plastic knives and forks and a glass jar. However, under the circumstances, I consider that any threat actually posed by Mr Nguyen was low. Had the risk been of any real significance, I would have expected that:

- videorecording of the incident would have been arranged;
- this risk would have been recorded in either of the two incident reports that were prepared;
- the other GSL officers involved in the incident would have felt it necessary to also prepare incident reports; and
- Detainee X would have referred to this in his interview with Knowledge Consulting when describing the circumstances surrounding the use of force, even if not directly asked.

Attempt to calm Mr Nguyen down prior to the use of force

137. As noted above, Mr Nguyen alleged in his complaint that the GSL officers burst into his room without warning.

138. However, I accept the Maribyrnong Manager's allegation that, prior to authorising the use of force, he enlisted the assistance of Detainee X and attempted (without success) to convince Mr Nguyen to co-operate with the GSL officers. This allegation is supported by Detainee X.

139. I consider that it would have been best practice for an interpreter to have been utilised in attempting to diffuse the situation. I note in particular the comment in the Investigation Report that Detainee X's level of English was extremely poor, requiring that Knowledge Consulting engage a translator to conduct its interview with him. I consider that the use of a qualified interpreter may have avoided the need to use force.

140. Nevertheless, I am satisfied that, despite his limited English, Detainee X

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understood and adequately translated the general thrust of the Maribyrnong Manager's direction to Mr Nguyen to move to the van. I also accept that Detainee X tried his best to calm Mr Nguyen down prior to the use of force.

141. I also accept that Mr Nguyen understood, but refused to comply with, GSL's direction to move from his room to the van.

Summary of findings on the circumstances surrounding the use of force

142. In relation to the events that preceded the use of force by GSL officers on Mr Nguyen, I find as follows:

- Mr Nguyen was engaging in threatening behaviour prior to the use of force, although the threat actually posed was low.
- Mr Nguyen was aware that he was being directed to move from his room to the van and refused to comply with that direction.
- The Maribyrnong Manager, with the assistance of Detainee X, attempted to encourage Mr Nguyen to move peacefully to the van without the need for force. This was not successful. Whilst it would have been best practice to have used a qualified interpreter to attempt to diffuse the situation prior to the use of force, the failure to do so probably would not have altered the outcome.

143. On the basis of the above, I accept that some level of force was warranted in the circumstances to remove Mr Nguyen from his room to the van when he refused to comply with GSL's direction to do so.

144. The following section considers the reasonableness of the level of force that was ultimately used by GSL officers in light of the circumstances described above.

Level of force used

145. There are differing accounts of the level of force used against Mr Nguyen. I have taken note of the more mild accounts provided by the GSL officers involved, compared with the more severe description in Mr Nguyen's complaint.

146. However, I have preferred the account given by Detainee X, for the following reasons:

- Detainee X was an independent witness in the room who was not directly involved in the incident. He was therefore able to observe the events with relative clarity and objectivity.

- The Investigation Report described Detainee X as a 'credible witness', a view stated in the report to have been shared by GSL's own Director of Operations, Mr McGowan.
- Detainee X's account was relatively balanced. For example, Detainee X:
  - o expressly denied that the officers used their knees or boots on Mr Nguyen; and
  - o agreed that the Maribyrnong Manager had sought his assistance to calm Mr Nguyen down prior to the use of force.
- The description given by Detainee X is consistent with the description of the incident contained in the Group Complaint Letter.

147. Detainee X's description of the level of force used by GSL officers, which I accept, can be summarised as follows:

- When the officers entered the room to restrain Mr Nguyen, Mr Nguyen jumped back and fell on his back across a cassette radio on a nearby table and appeared to hurt himself.
- GSL officers pinned Mr Nguyen to the wall using a mattress. Mr Nguyen slid down the wall behind the mattress and finished on his back on the floor. Officers handcuffed Mr Nguyen in front of his body while he was on the floor.
- GSL officers did not place their knees or boots upon Mr Nguyen.
- GSL officers lifted Mr Nguyen to his feet. One officer, using his index finger and thumb, grabbed Mr Nguyen behind the neck causing him to scream out. The GSL officers then carried Mr Nguyen out of the room.

148. There is some uncertainty as to the number of officers who were involved in the use of force against Mr Nguyen. However, I accept the statement by the Maribyrnong Manager that:

- four officers were involved in the use of force; and
- himself and another GSL officer were present during the incident, but were not directly involved in the use of force.

Relevant law

Articles 7 and 10(1) of the ICCPR

149. The complaint by Mr Nguyen (as well as Mr Okoye, discussed below) in relation to use of force raise for consideration articles 7 and 10(1) of the ICCPR, as set out above in Part D.

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Standard Minimum Rules

150. Standard Minimum Rule 54(1) describes the circumstances in which force may be used against detainees, as follows:

> **Standard Minimum Rule 54(1)**
>
> Officers of the institutions shall not, in their relations with the prisoners, use force except in self-defence or in cases of attempted escape, or active or passive physical resistance to an order based on law or regulations. Officers who have recourse to force must use no more than is strictly necessary and must report the incident immediately to the director of the institution.

DIMIA's policies

151. DIMIA's policy on the use of force is broadly consistent with the position under international law. In summary, it provides:

> In dealing with a detainee, detention services officers should not use force unnecessarily and, when the application of force to a detainee is necessary, no more than is necessary shall be used.[51]

152. This policy applies to the use of handcuffs and other restraints, although the policy does not set out any explicit guidelines on their use. However, the policy notes that officers are instructed in the use of a number of control locks and holds and states that these locks and holds are:

> ...to be preferred to the use of other kinds of force since, generally speaking, they enable detention services officers to overcome a detainee's resistance with the minimum of force.[52]

Conclusions on the use of force against Mr Nguyen

Level of force required

153. I consider that Mr Nguyen's age (53) indicated against the need for excessive force and should have prompted GSL officers to use greater care to avoid injury.

154. As noted above, whilst Mr Nguyen was engaging in threatening behaviour prior to the use of force, the actual threat posed by Mr Nguyen was low.

Manhandling

155. From the description provided by Detainee X of the force used against Mr Nguyen, I consider that this force was at the upper extreme of what appeared to be necessary in the circumstances.

156. Nevertheless, I accept that it was not an excessive use of force for the GSL officers to physically restrain Mr Nguyen, including with the use of a mattress, due to his refusal to comply with GSL's direction to leave the room and his agitated state. I also accept that it was not excessive for the GSL officers to have 'manhandled' Mr Nguyen out of his room, including carrying Mr Nguyen.

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157. I find that Mr Nguyen was injured in the course of being physically restrained. However, I am satisfied that his injuries were primarily a consequence of Mr Nguyen attempting to elude the GSL officers, rather than excessive force being used by the officers involved.

Handcuffs

158. As noted earlier, DIMIA's policy on the use of force requires that officers are to use holds to restrain detainees in preference to other forms of force, such as handcuffs. Mr Nguyen had already been overpowered and physically restrained by four GSL officers prior to the use of handcuffs. Indeed, even after handcuffs were applied to My Nguyen, he was physically carried from his room to the van by the four officers.

159. In these circumstances, and noting again Mr Nguyen's age, I find that the use of handcuffs was disproportionate and, consequently, constituted an excessive use of force. However, I note that the handcuffs were removed from Mr Nguyen shortly thereafter, when he was put into the van.

Pressure behind Mr Nguyen's ear

160. Notwithstanding strong denials by GSL, I accept that a GSL officer pressed a finger or thumb into a tender 'pressure point' behind Mr Nguyen's ear. In reaching this finding, I note that the Investigation Report found that:

> Detainee X was most definite that an officer did this and he defended officers against the allegations of kicking.

161. I find that this was an excessive use of force in the circumstances. Based on the accounts of both Mr Nguyen and Detainee X, this use of force occurred after Mr Nguyen had been fully restrained when there was no longer any need for the use of force. In any event, for the reasons outlined earlier, I do not consider that the circumstances warranted such a severe level of force even before Mr Nguyen had been restrained.

162. I accept that this excessive use of force caused Mr Nguyen to suffer severe, but short-lived, pain.

Conclusions on use of force

163. I conclude that the use of force against Mr Nguyen breached article 10(1) of the ICCPR in relation to the officer pressing his finger or thumb into a tender 'pressure point' behind Mr Nguyen's ear, causing him to scream out in pain. This finding is compounded by my additional finding that the use of handcuffs was not proportionate in the circumstances.

164. I do not consider that the use of force on Mr Nguyen was of sufficient severity to also constitute a breach of article 7.

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MR OKOYE

Complaint

165. Mr Okoye's complaint did not make any specific allegations about excessive force prior to the journey to Baxter IDF. However, he stated in his complaint that the GSL officers 'grabbed, handcuffed and force (sic) me into the isolation room.'

Relevant factual findings

166. I find that Mr Okoye was un-cooperative in being moved to the van prior to his transfer to Baxter IDF. This finding is based on the accounts given by the GSL officers involved and there is nothing in Mr Okoye's complaint that asserts otherwise. Indeed, it is consistent with Mr Okoye's complaint that the use of force was a consequence of Mr Okoye disputing his transfer.

167. I also find that force was used in removing Mr Okoye to the van, although there is some uncertainty as to the circumstances surrounding that use of force. I also find that Mr Okoye was handcuffed as part of his removal to the van, although the handcuffs were removed prior to the commencement of the journey to Baxter IDF.

168. It is unclear from the findings of the Investigation Report whether Mr Okoye was placed in an interview room pending the van's departure or taken directly to the van. However, even if Mr Okoye's allegation of being placed in an isolation room is accepted, this would have been limited to a couple of hours at most.

169. It is my understanding that Mr Okoye did not complain about the use of force in his complaint to the Ombudsman. As noted above, his reference to the use of force in his complaint to HREOC was more in passing than a specific allegation. On this basis, I am satisfied that he did not suffer any significant injury as a consequence of the use of force.

Conclusions

170. I do not consider that the use of force against Mr Okoye amounted to a breach of either article 7 or 10(1) of the ICCPR. Taking Mr Okoye's complaint at its highest, I am not satisfied that the alleged conduct was disproportionate in the circumstances or reached the requisite level of severity to constitute a breach of articles 7 or 10(1).

171. I would add that, whilst Mr Okoye was not medically examined following the use of force, I am satisfied that he had not suffered any injuries which would have required medical attention.

PART G: CONDITIONS OF THE JOURNEY FROM MARIBYRNONG IDC TO BAXTER IDF

172. Mr Nguyen and Mr Okoye both complained to HREOC about the conditions of the journey from Maribyrnong IDC to Baxter IDF. However, it is apparent from the findings of the Investigation Report that this complaint is actually focused on the first leg of the journey, between Maribyrnong IDC and Mildura.

173. This Part sets out my findings in relation to:

- the van used to transport the detainees to Mildura; and
- the conduct of the journey to Mildura.

174. For the sake of completeness, I have also made brief findings in relation to the conduct of the second leg of the journey, from Mildura to Baxter IDF.

THE VAN

175. The following description of the van is based on the description provided in the Investigation Report following an inspection carried out by Mr Hamburger and Mr McGowan. This description does not appear to be disputed by the respondents.

176. The van was a custom built, 10 seat *Mercedes Sprinter* van. The van had been borrowed from Victoria Police specifically for the purpose of this escort. It had been borrowed on one or two occasions previously, but always with drivers being supplied by Victoria Police. None of the GSL officers involved in escorting the detainees had seen or used the van previously or been trained on its use.

177. For the reasons set out below, I agree with the finding in the Investigation Report that the van was 'totally unsuitable for the task' of escorting the detainees from Maribyrnong IDC to Mildura.

178. The van was accompanied between Maribyrnong IDC and Mildura by a support vehicle, which was a hired sedan carrying three GSL officers.

Configuration of the van

179. The van comprised a drivers cabin for two people, separated from the rear of the van. The rear of the van was configured into four secure, stainless steel compartments. Mr Nguyen and Mr A were placed together in the largest compartment, with the other three detainees placed in the remaining separate compartments.

180. The detainees were kept behind two locked, steel doors - the external door of the van and the doors to their respective compartments.

181. I accept the findings in the Investigation Report that the configuration of the van

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did not allow for the detainees to:

- stand upright;
- move around to any extent; or
- sleep or even 'cat nap'.

182. I also accept the observation in the Investigation Report that the compartments were 'uncomfortable, claustrophobic, capable of causing panic and unsafe'.

Lighting and internal vision within the van

183. Whilst there was a glass window in the door to each compartment, there was only a darkly tinted, opaque glass window to the outside of the van. This window only allowed a small amount of light into the van, resulting in generally dark lighting inside.

184. It was not possible for the detainees to see outside the van from inside the compartments. It was also not possible for the detainees to see from one compartment into any of the other compartments.

Internal communication mechanisms

CCTV

185. There was a CCTV camera in each of the compartments, with a monitor mounted in the cabin that was visible to both the driver and co-driver.

186. As noted earlier, only two of the CCTV tapes were available for viewing as part of Knowledge Consulting's investigation, being from the camera in the compartment shared by Mr Nguyen and Mr A, and in the compartment occupied by Mr Okoye.

Intercom

187. There was a one-way intercom in the van to enable the drivers cabin to speak to the detainees in the compartments. However, there was no internal communication mechanism for any of the detainees in the compartments to make contact with the drivers cabin, such as to request food, water or a toilet break.

Toilet facilities

188. There were no toilet facilities on board the van.

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Temperature control

189. The van was fitted with a split-system air-conditioning system.

190. However, as discussed further below, the air-conditioning system was poorly configured and was not operated properly, resulting in the compartments being uncomfortably overheated for the duration of the journey from Maribyrnong IDC to Mildura.

CONDUCT OF THE JOURNEY

Planning of the transfer

191. Before commenting on the conduct of the journey, it is worth noting some of the findings of the Investigation Report in relation to the planning of the transfer. These findings assist in explaining how the journey came to be conducted so poorly.

192. I adopt the following findings from the Investigation Report in relation to the planning of the journey:

- The escort plan for the journey between Maribyrnong IDC and Mildura was:
  - o prepared by an officer who had not received proper training in the task, particularly in relation to risk assessment;
  - o not prepared in accordance with DIMIA's policy for the escort of detainees;[53]
  - o lacking in detail over a variety of essential matters, such as the proposed route, toilet and rest breaks, food and fluids for detainees, and reporting requirements during the journey;
  - o lacking in attention to risk assessment, particularly in relation to the selection of an appropriate vehicle;
  - o not reviewed adequately or at all by the Maribyrnong Manager; and
  - o 'totally inadequate and useless as a guide to officers for the humane, safe and secure transport of the detainees under their care and control'.
- There was poor co-ordination between Maribyrnong IDC and Baxter IDF in relation to the transfer of the detainees.
- There was only a cursory and inadequate briefing given to the GSL officers responsible for the Maribyrnong IDC - Mildura leg of the transfer. There was no evidence of a formal debrief with the GSL officers after the journey.
- As noted earlier, none of the GSL officers involved in the journey from Maribyrnong IDC to Mildura had seen or driven the van, or received any training in relation to the van.

Lack of breaks

Breaks taken

193. The van made two stops during the leg of the journey from Maribyrnong IDC to Mildura. The first stop occurred approximately 20 minutes into the journey, when the escort stopped for petrol. This break lasted for approximately 20 minutes, as the officers had left behind their fuel card and there were delays in arranging for it to be retrieved. The second stop was a brief stop of around 7 minutes to enable a change of driver in the support vehicle. The detainees remained in the van during each of these two stops.

194. The van did not stop for any breaks to let the detainees out of the van to rest, eat, drink, exercise or use a toilet, during the approximately 6_ - 7 hour journey from Maribyrnong IDC to Mildura.

195. The one GSL officer drove the van the entire distance from Maribyrnong IDC to Mildura.

Poor planning on the need for breaks

196. The failure of the escort to take any rest breaks for the detainees between Maribyrnong IDC and Mildura highlights the poor planning and preparation for the escort. The escort plan for the journey to Mildura did not state explicitly that breaks should be taken. The GSL Operations Manager who prepared the escort plan assumed that breaks would be taken by the officers conducting the journey as required. By contrast, the GSL officers who conducted the journey assumed that breaks were not to be taken, as none had been specified in the escort plan.

197. For example, the following passage is taken from Knowledge Consulting's interview with the GSL officer who drove the van to M\ildura:

> MR HAMBURGER:We have got that evidence of people attempting banging and calling out, wanting to stop for a toilet break and get fluids, urinating on the floor where they have to actually sit and we have got 2 people in the front of the cabin ignoring all of this, seemingly, just driving.
>
> GSL OFFICER: We were not told to do anything else, we were just told to drive. The order said drive, there was no pit stops as such, we were just told to drive.
>
> MR HAMBURGER: Did it cross your mind or did you and (the co-driver) have a discussion about 'gee, this must be pretty tough on the fellas in the back, do you think we should ask the team leader whether we should stop'?
>
> GSL OFFICER: I can't recall whether the discussion came up at all.
>
> MR HAMBURGER: Thinking back you can't, just thinking of yourself, did you think this is a bit tough on these people?
>
> GSL OFFICER: I was told to do a job and I did it and that is what I did, I was told to drive from here to Mildura.

198. Indeed, the officer stated that at one time during the journey she saw on the CCTV monitor what she thought to be Mr Nguyen urinating, yet still she did not consider that there was a need to stop the van.

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199. The co-driver of the van expressed similar views. For example:

> MR HAMBURGER: So when you got on the van nobody said to you 'look, we are going to stop at every hour for toilet breaks' nobody said anything like that?
>
> GSL OFFICER: Well we stop at the documented route instructions which was to stop at Mildura for a rest break, exercise, food and toilet.
>
> MR HAMBURGER: But there was nothing in between that you had to stop for? Did you think that was reasonable given the configuration of the compartments in the back and the fact that there was no toilet?
>
> GSL OFFICER: I am not qualified to make such a decision.
>
> Mr HAMBURGER: Ok. So on that basis would you want to comment on whether the van was suitable for that sort of escort?
>
> GSL OFFICER: It is not a decision I made so I can't really comment on it, I just followed instruction.

200. The GSL Team Leader of the escort, who travelled in the support vehicle during the journey, stated that his usual practice was to take breaks when needed, such as when a detainee requested to go to the toilet. However, given that he was not informed that any such request was made (due largely to the lack of any internal means of communication in the van) he did not direct the escort to take a break.

201. At one time during the journey, the Team Leader stated that he saw liquid trickling out the back of the van which he thought may have been urine. However, he did not direct the escort to stop:

> MR HAMBURGER: And what did you do when you saw the fluid?
>
> GSL TEAM LEADER: I just rang up and said there was fluid running out the back, is everything alright and they said yeah, so I didn't know if it was water or could have been urine.
>
> MR HAMBURGER: Did you think it might have been urine at the time?
>
> GSL TEAM LEADER: It could have been, yeah.
>
> MR HAMBURGER: But what did you think at the time?
>
> GSL TEAM LEADER: Just saw a fluid, at the time I thought it could have been urine or water.
>
> MR HAMBURGER: So they said it was fine?
>
> GSL TEAM LEADER: Yeah.
>
> MR HAMBURGER: What did that mean to you, that it wasn't urine?
>
> GSL TEAM LEADER: That it was fine.
>
> MR HAMBURGER: You didn't sort of quiz them any harder on that?
>
> GSL TEAM LEADER: No not really.

202. I find that the failure to take any rest stops between Maribyrnong IDC and Mildura was a consequence of:

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- the poorly documented escort plan;
- the failure of senior GSL officers involved in planning and preparing the transfer to direct the GSL officers involved in the escort to take rest stops frequently, such as every 1 – 2 hours;
- the absence of any internal means of communication for the detainees to request a break and the fact that the driver and co-driver disregarded pleas for assistance from the detainees (discussed below); and
- the failure of the GSL officers involved in the escort, particularly the driver, co-driver and Team Leader, to exercise basic common sense and good judgment on the need to take breaks.

Detainees urinated in compartments due to the lack of breaks

203. I find that all of the detainees urinated in their compartments during the journey from Maribyrnong IDC to Mildura due to the lack of breaks. This finding is based on the following:
    - It is clear from the CCTV footage that Mr Nguyen urinated in his compartment on two occasions and Mr A urinated on four occasions.
    - Whilst unclear from the CCTV footage, I also accept Mr Okoye's allegation that he urinated in his compartment on two occasions.
    - Mr B told Knowledge Consulting that he urinated in his compartment during the journey.
    - The driver of the van, Mr Martin, described seeing on the CCTV monitor Ms C squatting on the floor at one point during the journey, which is consistent with her urinating.

Pleas for assistance

Findings

204. Both Mr A and Mr B stated in their interviews with Knowledge Consulting that the detainees attempted on numerous occasions to attract the attention of the driver and co-driver by banging on the walls of their compartments and calling out. This allegation is supported by the CCTV footage, which shows Mr A, Mr Nguyen and Mr Okoye attempting to attract the attention of the drivers at various times during the journey.

205. The driver and co-driver acknowledged that they heard such noises and could see such activity on the CCTV monitor. However, they dismissed this activity as misbehaviour by the detainees, rather than pleas for assistance or to stop the van.

206. I consider that the assumption by the driver and co-driver that the detainees were misbehaving, rather than trying to attract the officers' attention, was wholly unjustified. In light of the various criticisms of the van outlined in this report, coupled with the length of the journey, the lack of rest stops and what the officers

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witnessed on the CCTV screens (particularly detainees urinating), I consider that the driver and co-driver should have properly interpreted the appeals by the detainees for assistance.

207. The driver and co-driver also acknowledged that there had been no pre-arranged signal for the detainees to communicate with the driving cabin.

208. I also adopt the finding in the Investigation Report that the driver and co-driver of the van did not adequately monitor the CCTV feed.

Conclusion

209. In summary, I accept that the detainees attempted to communicate with the officers driving the van but these pleas for assistance were ignored, due to:

- the lack of any communication device for communicating with the driving cabin;
- the failure to communicate to the detainees a pre-arranged signal to alert the attention of the drivers, either by banging on the wall of the compartment or using the CCTV camera;
- the failure of the driver and co-driver to adequately monitor the CCTV feed;
- the failure of the driver or co-driver to adequately check on the detainees during the journey, such as by stopping; and
- the failure of the driver and co-driver to properly interpret obvious pleas for assistance from the detainees.

Failure of air-conditioning system

210. I find that the air-conditioning system of the van did not adequately cool the compartments during the journey, resulting in those compartments becoming uncomfortably overheated. This finding is based on the following:

- Mr A and Mr B both stated in their interviews with Knowledge Consulting that it was very hot in the compartments. Indeed, Mr B stated that he removed most of his clothes because of the heat.
- The CCTV footage showed that Mr Nguyen also removed much of his clothing.
- A member of GSL's Fleet Management Team advised Knowledge Consulting that the detainees' complaints about overheating in the van were believable. He advised that the air-conditioning of the van had been a cause of concern and had since been modified to avoid overheating of the compartments.
- The Investigation Report concluded that the air-conditioning system was poorly configured and it was a known problem that, unless officers were properly instructed on how to operate the system, officers would commonly set the air-conditioning to a setting that was comfortable in the driving cabin, but

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which failed to cool the compartments.

- The driver and co-driver of the van stated that they had not received any training on how to properly operate the air-conditioning system to avoid overheating of the compartments. They also stated that at no stage did they check the air temperature inside the compartments.

Lack of food or fluids

Findings

211. In relation to the provision of food and fluids during the journey, I make the following findings:

- Lunch was served at Maribyrnong IDC at the normal lunch hour of noon to 1 pm. It is not known whether the detainees actually ate lunch at this time, although I have assumed this to be the case.
- None of the detainees were provided with any food during the journey from Maribyrnong IDC to Mildura. Whilst sandwiches and fruit were prepared for the journey, this food travelled separately in the support vehicle and was never provided to the detainees.
- The detainees, or at least some of them, were offered fluids just prior to the commencement of the journey. Only Mr Nguyen and Mr A accepted that offer and were given a bottle of cordial and one cup.

GSL justifications for lack of food and fluids

212. It was suggested by one of the GSL officers in his interview with Knowledge Consulting that the reason why food may not have been provided to the detainees was possibly due to a security risk that the detainees may have used the plastic food wrap inappropriately or smeared food on the CCTV cameras. I find that this comment was a post-facto justification. I do not accept that the officers involved actually turned their minds to consider such security risks at the relevant time. I further find that these concerns could have been adequately dealt with by less restrictive means, such as providing food and fluids at appropriate intervals to be consumed under supervision.

213. It was also suggested by GSL in its formal response that it adequately discharged its obligations by offering fluids to the detainees at the commencement of the journey, but this offer was declined (except by Mr Nguyen and Mr A). I do not accept that argument in the extraordinary circumstances of this matter, noting again that:

- the compartments became uncomfortably overheated during the journey, so the detainees would presumably have become thirsty during the journey;
- there was no means of communicating with the driving cabin to request food or fluids once the journey had commenced;
- the driver and co-driver disregarded pleas for assistance from the detainees; and
- the journey from Maribyrnong IDC to Mildura lasted for approximately 6_ - 7 hours without a break.

214. GSL also referred in its response to the mild outside temperatures on the day of the journey, which purportedly indicated against the need for fluids to be provided to the detainees. Whilst hotter external temperatures may have worsened the situation, I have found that the internal compartments were overheated in any event. The discomfort this caused was evident and was ignored.

Mr Okoye's allegation of drinking own urine

215. Mr Okoye has alleged that, out of desperation, he drank his own urine on two occasions during the journey from Maribyrnong IDC to Mildura in an attempt to relieve his excessive thirst. I accept this allegation, for the following reasons:

- Whilst the CCTV footage is not clear due to the positioning of the camera, the vision of his body actions at two times during the journey is consistent with him drinking his own urine.
- The footage of Mr Okoye shows him in significant distress for much of the journey, particularly leading up to the first occasion when he appeared to drink his urine.
- As noted earlier, I accept that the temperature inside the compartment was uncomfortably hot which would have exacerbated Mr Okoye's thirst.
- It is not in dispute that Mr Okoye was not provided with any fluids for the 6_ - 7 hour journey to Mildura.
- Mr A stated that he could hear 'the African man' (Mr Okoye was the only African detainee in the van) calling out for water.
- Mr Okoye made this explicit allegation during his induction interview at Baxter IDF.
- My impression of the CCTV footage seems to have been shared by the DIMIA officer who initially reviewed the footage from Mr Okoye's compartment. The Investigation Report found that this DIMIA officer, after reviewing the footage, 'became alarmed at what she saw on the tapes that appeared to support Mr Okoye's allegation that he had drunk urine and did not have access to food and water'. Indeed, as discussed below in Part L, this officer's alarm over what she saw on that footage appears to have been the main catalyst that ultimately led to the appointment of Knowledge Consulting to conduct its investigation.
- There is no evidence contrary to Mr Okoye's allegation.

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Lack of diversionary stimuli

216. The detainees were not provided with any form of diversionary stimuli to help them pass the time during the journey, such as television, music, reading material or magazines.

Treatment at Mildura Police Complex

217. The detainees arrived at Mildura at approximately 10.00 - 10.30 pm on 17 September 2004 and were placed in holding cells at the Mildura Police Complex.

218. The detainees remained at the Mildura Police Complex for approximately one hour. During this time they were allowed to use toilet facilities. They were also provided with a hot meal consisting of a plate of rice with some type of sauce, together with two slices of bread and a cup of coffee. However, I note the statement by Mr B that he felt very hungry during the journey to Mildura and called out for food but was ignored. By the time they arrived at Mildura he was feeling so unwell that he could only eat a small portion of the meal that was provided.

219. The detainees were not allowed any reasonable opportunity to sleep at the Mildura Police Complex. I accept the statement by Mr A that when he attempted to sleep he was shouted at by one of the officers.

JOURNEY FROM MILDURA TO BAXTER IDF

220. I make the following findings in relation to the treatment of the detainees from the time of their departure from Mildura until their arrival at Baxter IDF:

- The planning and preparation for the Mildura – Baxter IDF leg of the journey was of a higher standard than in relation to the Maribyrnong IDC – Mildura leg of the journey, although was still inadequate.
- The detainees were transported in a secure Hi-Ace Van. The Investigation Report did not make any findings on the suitability of that vehicle for the journey, although noted that the van allowed for officers and detainees to communicate with each other.
- During the approximately 6_ hour journey from Mildura to Baxter IDF the van stopped on two occasions, at which times the detainees were offered food, water and access to toilet facilities.
- None of the detainees interviewed by Knowledge Consulting made any complaints about their comfort, treatment or amenities during the Mildura – Baxter IDF leg of the journey.
- I accept the findings of the Investigation Report that:

  > In spite of the shortcomings in the Mildura – [Baxter IDF] escort plan, there is evidence that the GSL officers conducting this section of the escort did so without incident and in a humane, safe and secure manner.

RELEVANT LAW

221. The treatment of the detainees in the course of their transfer from Maribyrnong IDC to Baxter IDF raises for consideration articles 7 and 10(1) of the ICCPR.

222. The content of, and relationship between, articles 7 and 10(1) have been discussed earlier in this report in Part D. However, I wish to make the following additional observations on the application of article 7 in this matter.

Article 7

223. Article 7 prohibits not only torture, but also treatment or punishment that is 'cruel, inhuman or degrading'. Professor Nowak explains that these categories are arranged in a descending order of severity.[54]

224. The UNHRC has pointed out that it is not necessary to draw sharp distinctions between whether treatment or punishment is cruel, inhuman or degrading with respect to whether article 7 has been breached.[55] Indeed, much of the UNHRC jurisprudence does not do so.

225 The UNHRC has also confirmed that the prohibition in article 7 'relates not only to acts that cause pain but also to acts that cause mental suffering to the victim.'[56] Other relevant factors include the 'duration and manner of the treatment, its physical and mental effects as well as the sex, age and state of health of the victim.'[57]

226. The jurisprudence of the UNHRC also indicates that, unlike in the case of torture, it is not necessary that the perpetrator *intended* to inflict the relevant suffering on the victim for the treatment to be considered cruel, inhuman or degrading.[58] Indeed, Joseph, Schulz and Castan suggest that it may be possible to inflict such treatment negligently.[59]

Cruel and inhuman treatment

227. Professor Nowak explains that cruel and inhuman treatment under article 7 includes:

> ...all forms of imposition of severe suffering that are unable to be qualified as torture for lack of one of its essential elements. They also cover those practices imposing suffering that does not reach the necessary intensity.[60]

228. Examples of cases where the UNHRC has concluded that the relevant treatment of detained persons was cruel and inhuman, in breach of article 7, include the following:

- *Linton v Jamaica*,[61] where the author was beaten unconscious, subjected to mock execution and denied appropriate medical care.
- *Bailey v Jamaica*,[62] where the author was beaten repeatedly with clubs, iron pipes and batons and left without medical attention.

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- *Hylton v Jamaica*,[63] where the author was severely beaten by, and received repeated death threats from, prison warders.
- *Deidrick v Jamaica*,[64] where the author was locked in a cell for 23 hours per day, without a mattress, bedding, basic sanitation, natural light, recreational facilities, decent food or adequate medical care.
- *Mika Miha v Equatorial Guinea*,[65] where the author was deprived food and drink for a week after his arrest and denied medical treatment.

229. Examples of cases where the UNHRC has concluded that the relevant treatment was inhuman, but not cruel, include the following:

- *Polay Campos v Peru*,[66] where the author was kept in solitary confinement for one year without any correspondence.
- *Tshisekedi v Zaire*,[67] where the author was deprived food and drink for several days after arrest and then kept in unacceptable sanitary conditions.

Degrading treatment

230. In relation to degrading treatment, Professor Nowak states:

> Degrading treatment is the weakest level of a violation of Art. 7. The severity of the suffering imposed is of less importance here than the humiliation of the victim, regardless of whether this is in the eyes of others or those of the victim himself or herself.[68]

231. Professor Nowak goes on to note that the principle of proportionality is of particular relevance to whether treatment is degrading. He notes that the Austrian Constitutional Court has deemed that mere handcuffing, slapping or hairpulling is degrading treatment when this contradicts the principle of proportionality in light of the circumstances of the case.[69]

232. Examples of cases where the UNHRC has concluded that the relevant treatment was degrading, in breach of article 7, include:

- *Portorreal v Dominican Republic*,[70] where the author was detained for 50 hours in a police cell measuring 20 by 5 metres, where approximately 125 other persons were held. The cell was also overheated, extremely dirty and, owing to lack of space, some detainees had to sit on excrement. The author received no food or water until the following day. The UNHRC concluded that these conditions of detention amounted to both inhuman and degrading treatment.
- *Francis v Jamaica*,[71] where the author had been assaulted by soldiers and warders, who beat him, pushed him with a bayonet, emptied a urine bucket over his head, threw his food and water on the floor and his mattress out of the cell.
- *Thomas v Jamaica*,[72] where the author had been assaulted by soldiers and warders, who beat him with rifle butts, inflicting injuries for which he did not receive medical treatment.

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- *Young v Jamaica*,[73] where the author had been subjected to ill-treatment by prison warders, including assault and repeated soaking of his bedding.
- *Polay Campos v Peru*,[74] where the author had been displayed in a media cage.

Standard Minimum Rules

233. Standard Minimum Rule 45(2) relates to the transport of prisoners:

> **Standard Minimum Rule 45(2)**
>
> The transport of prisoners in conveyances with inadequate ventilation or light, or in any way which would subject them to unnecessary physical hardship, shall be prohibited.

DIMIA's policies

234. The following DIMIA policies are relevant to the complaints about the conditions of the journey:

> **Inter-centre Transfer Address and Checklist**
>
> The coach (for transporting detainees) should have a good supply of drinks and snacks (sandwiches etc) for the journey. The coach should be of good standard with facilities on board.
>
> **Generic Operational Procedure No. 12.5 – External Transport and Escort Services**
>
> …
>
> 1.4.1.1 Each detainee is treated with dignity and in a humane manner, and is accorded respect; and the individuality of each detainee is recognised and acknowledged.
>
> …
>
> 6.7.1 .Safe and dignified and timely transport is provided when a detainee is moved to or from detention.

235. I consider that the above policies are broadly consistent with the obligations imposed under articles 7 and 10(1) of the ICCPR in relation to the transport of detainees.

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CONCLUSIONS ON THE CONDUCT OF THE JOURNEY

Journey from Maribyrnong IDC to Mildura breached articles 7 and 10(1) of the ICCPR

Article 10(1)

236. Viewing all of the relevant circumstances together, I find that the treatment of the detainees in the course of their transfer from Maribyrnong IDC to Mildura constituted a clear breach of article 10(1) of the ICCPR. The detainees, as persons deprived of their liberty, were not treated with humanity and with respect for the inherent dignity of the human person.

237. As noted below, the respondents have each acknowledged that the treatment of the detainees during this journey breached their human rights.

Article 7

238. In relation to article 7, the situation is less clear. Whilst the treatment of the detainees was deplorable, I do not consider that it was of sufficient severity to constitute cruel or inhuman treatment within the meaning of article 7.

239. However, I am satisfied that the treatment of the detainees amounted to degrading treatment, the 'weakest' category of prohibited treatment under article 7.

240. I note that I have only limited information before me as to the physical and psychological effects of the relevant treatment on each of the detainees. However, I am satisfied that the detainees experienced feelings of considerable distress and indignity as a result of the journey from Maribyrnong IDC to Mildura. This impact is apparent from the tone of the complaints lodged by Mr Nguyen and Mr Okoye. It is also apparent from the transcript of interviews conducted with Mr A and Mr B, who both commented on the ongoing distress that they feel over the relevant events. For example, Mr A stated:

> ...[I was] praying, saying 'God, god, god, help me, help me', nothing help for 12 hours, a long big suffering, I never going to forget this. I am frightened gone, I never see something like this but this is bad, this is not about a human being, how come you treat human being like that, really, you wonder.

241. I also consider that the considerable distress and indignity experienced by the detainees is sufficiently self-evident from my findings in relation to the conduct of that journey (summarised below).

242. I am reinforced in my conclusion that article 7 was breached by the fact that by letter to DIMIA and GSL dated 16 March 2007, I specifically flagged my preliminary view that the treatment of the detainees was, in the circumstances, 'degrading treatment' in breach of article 7. Subject to my comments below regarding GSL's response, neither GSL nor DIMIA sought to challenge that preliminary view.

Summary of circumstances relevant to the breach of articles 7 and 10(1)

243. My finding that articles 7 and 10(1) were breached is based on the condition of the van used for the journey which was exacerbated by the manner in which the journey was conducted. More specifically, this finding is based on the cumulative effect of the following circumstances:

- The steel compartments in the van where the detainees were separately held were:
  - claustrophobic and cramped; and
  - dark, with only a small amount of natural light.
- Due to the configuration of the van and the lack of facilities on board the van, the detainees were unable to:
  - access toilet facilities;
  - communicate with those in charge of their situation;
  - see into each other's compartments or see outside the van;
  - sleep or 'cat nap';
  - stand upright or move about to any extent; or
  - read or participate in any other comparable form of time passing distraction.
- The air-conditioning system in the van was poorly configured and was not operated properly during the journey, resulting in the compartments becoming uncomfortably overheated.
- The van did not stop for any breaks for the detainees during the 6_ - 7 hour journey from Maribyrnong IDC to Mildura. This lack of breaks:
  - exacerbated the discomfort and harshness of the conditions in the van;
  - created a safety risk, given that the same officer drove the van for such a long period without a break; and
  - resulted in the detainees being forced to suffer the indignity and discomfort of having to urinate in their own compartments. This indignity was further compounded by being:
    - recorded on CCTV tape, as well as being in view of the female driver and male co-driver of the van via the CCTV monitor; and
    - in Mr Nguyen and Mr A's case, in immediate view of a fellow detainee.
- None of the detainees were provided with any food during the journey from Maribyrnong IDC to Mildura.
- With the exception of Mr Nguyen and Mr A, the detainees were not provided with any fluids during the Maribyrnong IDC – Mildura leg of the journey. I also note that the need for fluids for the detainees was amplified by the over-heating of the compartments during the journey.

- The driver and co-driver of the van failed to adequately monitor the CCTV feed and also disregarded obvious:
  - o appeals for assistance by the detainees, such as banging on the walls and calling out;
  - o signs that the detainees required toilet breaks, particularly the driver seeing Mr Nguyen urinating in his compartment via the CCTV monitor;
  - o signs that the detainees were overheating in the compartment, such as seeing on the CCTV monitor detainees removing clothing; and
  - o general signs of distress of the detainees.
- The detainees were not provided with any reasonable opportunity to sleep at the Mildura Police Complex prior to continuing on to Baxter IDF.

244. I have not found that the conduct of the second leg of the journey, from Mildura to Baxter IDF, breached the human rights of the detainees.

Additional factors in relation to Mr Nguyen and Mr Okoye

245. In the case of Mr Okoye, my finding that his rights under articles 7 and 10(1) were breached is also based on my finding that, due to the lack of fluids and breaks during the journey from Maribyrnong IDC to Mildura, he suffered the additional indignity of drinking his own urine on two occasions in a desperate attempt to relieve his excessive thirst.

246. In the case of Mr Nguyen, my finding that his rights under article 10(1) were breached is also based on the poor standard of medical care provided to him. This is discussed further in Part H below.

Journey from Mildura to Baxter IDF did not breach the detainees' human rights

247. I find that the treatment of the detainees during the Mildura – Baxter IDF leg of the journey did not amount to, or otherwise contribute to, a breach of articles 7 or 10(1) of the ICCPR.

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Comments on the responses from DIMIA and GSL

DIMIA

248. In its initial response to Mr Nguyen's complaint, DIMIA denied that it had breached Mr Nguyen's human rights.

249. However, in its letter to HREOC dated 29 July 2005, DIMIA acknowledged that, on the basis of the findings in the Investigation Report, the human rights of the five detainees involved in the transfer were breached. I congratulate DIMIA on this frank and unqualified admission.

250. In addition, as noted above, when I flagged with DIMIA my preliminary view that the treatment of the detainees amounted to 'degrading treatment' in breach of article 7, DIMIA did not seek to challenge that finding. I again congratulate DIMIA for its preparedness to accept responsibility in response to this allegation.

GSL

Limited admission on human rights breaches

251. By contrast to DIMIA, GSL made a more limited admission in relation to human rights breaches arising from the journey. It conceded that the human rights of Mr Nguyen and Mr Okoye were breached by the denial of access to toilet facilities during the journey. It also acknowledged that:

    - the GSL officers' disregard of appeals for assistance from the detainees was inconsistent with or contrary to their human rights; and
    - the inaccurate and misleading information provided by the Maribyrnong Manager in response to initial complaints about the journey (discussed further below in Part L) compounded the human rights breaches by preventing the complaints from being investigated sooner.

252. However, with the exception of the above matters, GSL otherwise denied that the human rights of Mr Nguyen or Mr Okoye (or any of the other detainees) were breached. For example, GSL explicitly stated that not providing Mr Okoye with food or drink during the journey did not breach his human rights.

253. I reject GSL's narrow characterisation of the breach of human rights in this matter. In complaints of this type, I consider that the appropriate approach is to consider whether the cumulative effect of all the relevant circumstances resulted in a breach of human rights. It is not necessary to establish that each and every circumstance contributing to that cumulative effect was sufficient, of itself, to constitute a breach of a person's human rights.

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Use of the van reasonable in circumstances

254. GSL accepted in its response that, with the benefit of hindsight, the van was unsuitable for the purpose of transferring the detainees from Maribyrnong IDC to Mildura. GSL further stated that the van would not be used again for detainee escorts. However, in contradiction to those concessions, GSL then went on to deny that the use of the van was unreasonable in the circumstances, stating:

> But we maintain that the [van] was not a vehicle that any reasonable inspection before the escort's departure would have identified as presenting a risk that the human rights of anyone travelling in it would be breached, even on a six-and-a-half hour journey.

255. I reject this assertion by GSL. All of the criticisms of the van outlined above would have been apparent from a basic inspection of the van.

256. GSL also asserted that the use of the van was reasonable in the circumstances on the basis that at least two (and possibly three) of the detainees required a higher level of security due to previous offences and/or escapes from custody. For reasons with which I agree, this assertion was strongly rejected in the Investigation Report which found that the van was a poor choice for the purported security risks. In particular, the lack of toilet facilities on board created (or, at least, should have created) a need to make unscheduled stops for toilet breaks which gives rise to a range of security issues.

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PART H: MEDICAL TREATMENT OF MR NGUYEN

Complaint

257. Mr Nguyen complained about the adequacy of medical treatment provided to him upon his arrival at Baxter IDF.

258. Whilst not specifically alleged, his complaint also raises for consideration the adequacy of medical treatment provided to Mr Nguyen:
   - following the use of force at Maribyrnong IDC; and
   - during the journey from Maribyrnong IDC to Baxter IDF.

Relevant factual findings

Following use of force at Maribyrnong IDC

259. As set out below, DIMIA's policies on health care provision and external transport and escort services require that a detainee must be medically examined prior to being transferred to another facility to assess his or her fitness to travel. It appears that Mr Nguyen was seen by a nurse on 17 September 2004 who recorded his blood pressure and respiratory rate. Whether the nurse conducted a more thorough examination is not clear.

260. In any event, it is not in dispute that Mr Nguyen was not medically examined after the use of force by GSL officers in removing him from his room and taking him to the van.

During journey

261. Mr Nguyen was not provided with any medical attention or treatment during the journey from Maribyrnong IDC to Baxter IDF.

262. I agree with the views stated in the Investigation Report that the CCTV tapes from the journey indicate that Mr Nguyen 'suffered considerable physical discomfort' during the escort. This is also confirmed by Mr A, who shared Mr Nguyen's compartment, who stated that Mr Nguyen complained of back pain throughout the journey.

Upon arrival at Baxter IDF

263. In relation to the medical treatment provided to Mr Nguyen upon his arrival at Baxter IDF, I make the following findings:
   - When Mr Nguyen arrived at Baxter IDF he complained of being in considerable pain. I accept that this pain was due to the use of force by GSL officers at Maribyrnong IDC, coupled with the uncomfortable and distressing journey in the van.

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- Mr Nguyen requested to see a doctor but was told that because it was Saturday, he would not be able to see a doctor until the Monday.
- Mr Nguyen was seen by a nurse ('the Baxter nurse') who, after speaking with a doctor via telephone, administered Panadol and some ointment for his bruising. The Baxter nurse recorded in her notes:

> No obvious bruising seen but information handed over ¢o officers suggest ? officers jumped on him when he was extracted from Maribyrnong ? area shape suggestive of ? boot injury.

- Mr Nguyen saw Dr Ahmad on the Monday (20 September 2004), who prescribed medication and said that if the medication was not effective he would arrange an x-ray at a later stage. Dr Ahmad did not take any photographs of Mr Nguyen's injuries.
- Mr Nguyen's injuries had resolved by at least as early as 28 September 2004, when he next saw Dr Ahmad and made no complaint in relation to his previous injuries.

Relevant law

Article 10(1) of the ICCPR

264. As noted above, article 10(1) of the ICCPR requires that minimum standards of humane treatment be observed in the conditions of detention.

265. The UNHRC has affirmed in numerous cases that the obligation imposed by article 10(1) to treat individuals with respect for the inherent dignity of the human person encompasses the provision of adequate medical care during any period of detention.[75]

Standard Minimum Rules and Body of Principles

266. The Standard Minimum Rules and the Body of Principles provide guidance on the standard of medical care that must be provided to persons in detention.

267. Rules 22, 24, 25 and 52 of the Standard Minimum Rules relevantly provide that:

> **Medical services**
>
> 22(1): At every institution there shall be available the services of at least one qualified medical officer ...
>
> 24: The medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary ...
>
> 25(1): The medical officer shall have the care of the physical and mental health of the prisoners and should **daily** see all sick prisoners, all who complain of illness, and any prisoner to whom medical attention is specifically directed. (emphasis added)

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Institution personnel

52(1): In institutions which are large enough to require the services of one or more full-time medical officers, at least one of them shall reside on the premises of the institution or its immediate vicinity.

52(2): In other institutions the medical officer shall visit **daily** and shall reside near enough to be able to attend without delay in cases of urgency. (emphasis added)

The Body of Principles relevantly provide:

Principle 24

A proper medical examination shall be offered to a detained or imprisoned person as promptly as possible after his admission to the place of detention or imprisonment, and thereafter medical care and treatment shall be provided whenever necessary. This care and treatment shall be provided free of charge.

DIMIA's policies

268. DIMIA's policy on Health Care Provision[76] provides detailed requirements in relation to medical treatment. Relevantly for present purposes, it provides:

Generic Operational Procedure No. 6.2 – Health Care Provision

2.2.1.3.6: (Performance Standards) On transfer from one detention facility to another, a detainee is examined by a doctor for fitness to travel and appropriate arrangements are made for the transfer of all medical records.

4.4.2: GSL reception staff will ensure that the IHMS Nurse is immediately notified of all new arrivals.

4.4.3: The IHMS nurse will undertake a Reception Health Assessment as soon as possible, but no later than within the first few hours.

4.4.9: The nurse will arrange an urgent consultation if s/he suspected any medical or psychological issues requiring urgent attention. The on call doctor or PSS professional must be requested to immediately consult with the detainee on site, or to provide 'over-the-phone' advice to the nurse.

4.4.11: GSL reception staff must alert the IHMS nurse immediately on arrival of a detainee who has been transferred from another facility. The IHMS nurse will undertake a Transfer Health Assessment on the newly arrived detainee and will make any necessary appointments for the detainee, within 24 hours of the arrival of the detainee.

269. The following additional DIMIA policies are also relevant to medical treatment:

Generic Operational Procedure No. 12.11 - Use of Force

4.4.1: If it has proved impossible or impractical to have Health Services Staff on hand when force was used, they must be called upon as soon as reasonably practicable to examine any detainee on whom force has been used. Officers must, in their own interest, notify the medical staff whenever they have had occasion to use force on a detainee, and arrange for the doctor (or a nurse) to see them as soon as possible.

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Generic Operational Procedure No. 12.5 – External Transport and Escort Services

4.6.2: All detainees leaving the facility will ... be seen by a member of the medical team to assess the fitness to travel when being discharged or being transported permanently to another location.

Discussion of the evidence

Medical treatment at Maribyrnong IDC

270. I find that Mr Nguyen should have been medically examined following the use of force at Maribyrnong IDC. My reasons are as follows:

- The failure to undertake a medical examination of Mr Nguyen was, in the circumstances, a direct breach of DIMIA's policy cited above on the use of force. It was also inconsistent with the need to ensure that a detainee is medically fit for travel, as required under DIMIA's policies cited above on:
  - external transport and escort services; and
  - health care provision.
- I accept Mr Nguyen's evidence that he was in pain following the use of force and that this would have been apparent to the GSL officers involved. This is supported by:
  - Mr Nguyen's description of the incident in his complaint;
  - Detainee X's description of the incident and his comments that Mr Nguyen appeared to hurt himself and screamed out in pain;
  - the description of the incident in the Group Complaint Letter;
  - the CCTV footage of Mr Nguyen in the van, which showed him to be in pain and distress;
  - the statement of Mr A, who shared the compartment with Mr Nguyen, that Mr Nguyen complained of back pain when being put into the van and throughout the journey; and
  - the Medical Progress Notes of the Baxter nurse upon Mr Nguyen's arrival at Baxter IDF to the effect that he was 'unable to stand/walk' and was 'very distressed and crying with pain'.
- Even accepting the more modest description of the level of force used on Mr Nguyen as described by the GSL officers, I consider that these circumstances should have raised a concern that Mr Nguyen may have been injured, especially given his age.

271. I also consider that if Mr Nguyen had been medically examined following the use of force he would have most likely received treatment and/or medication to ameliorate his symptoms during the journey or, alternatively, his transfer may have been postponed until he was medically fit to travel.

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Medical treatment at Baxter IDF

272. In seeking a telephone consultation with the on-call doctor, the Baxter nurse appears to have conformed with DIMIA's policy on Health Care Provision.[77]

273. Nevertheless, and without being critical of the care provided by the Baxter nurse, I find that it would have been best practice for Mr Nguyen to have been seen by a doctor sooner than 20 September 2004. In reaching this finding I rely on the following matters:

- Mr Nguyen explicitly requested to see a doctor. I find that this request was reasonable in the circumstances.
- The Baxter nurse's notes indicate that Mr Nguyen was in a significant degree of pain. Her notes also flagged a concern that he may have been assaulted by GSL officers.
- In light of Mr Nguyen's age, combined with the arduous journey he had just endured and the possibility of physical violence by GSL officers, it would have been appropriate to 'err on the side of caution' in arranging for Mr Nguyen to be seen by a doctor at the earliest opportunity.

274. 274. In addition to the above, I note that Standard Minimum Rules 25(1) and 52(1) both speak of the need for a 'medical officer' to be available. Whether a nurse would fall within the definition of a 'medical officer' for the purposes of the Standard Minimum Rules has not been explicitly considered by the UNHRC.[78] However, in my view, the reference to 'medical officer' in the Standard Minimum Rules is more likely intended to refer to a doctor, rather than a nurse.

275. Furthermore, Standard Minimum Rules 25(1) and 52(1) require that the medical officer be available on a *daily* basis, not merely on weekdays or by telephone. It is not necessary for me to determine whether it was reasonable that a doctor was not physically present at Baxter IDF on the weekend of 18 and 19 September 2004. It is sufficient for me to conclude that a doctor should have been available to attend Baxter IDF on that weekend if required. This would include being available to attend if requested by a detainee in circumstances where that request was reasonable which, as I have noted above, was the case here.

276. Notwithstanding the above, I accept that the failure to arrange for Mr Nguyen to be seen by a doctor earlier than 20 September 2004 did not materially affect his injuries or recovery.

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Conclusions on whether standard of medical treatment breached article 10(1)

277. I consider that there was a failure to provide Mr Nguyen with an optimal standard of medical care in the circumstances of this matter. This finding is based primarily on the failure to provide any medical attention immediately after the use of force by GSL officers at Maribyrnong IDC. In addition, this finding is compounded by the failure to:

- provide medical attention to Mr Nguyen during the journey to Baxter IDF; or
- arrange for Mr Nguyen to be seen by a doctor until Monday 20 September 2004, approximately three days after the use of force by GSL officers at Maribyrnong IDC and his arduous journey.

278. However, I do not consider that the level of care provided to Mr Nguyen was so inadequate as to be characterised, of itself, as a breach of article 10(1).

279. Notwithstanding the above, inadequacy of medical treatment may be a contributing factor towards a finding that article 10(1) has been breached in the context of other aggravating circumstances.[79] As I foreshadowed earlier, I consider that the suboptimal standard of medical care provided to Mr Nguyen was a relevant factor that contributed towards my finding that his rights under article 10(1) were breached in respect of his transfer from Maribyrnong IDC to Baxter IDF.

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PART I: LOSS OF MR NGUYEN'S PERSONAL POSSESSIONS

Complaint

280. Mr Nguyen alleged that DIMIA and/or GSL lost his leather jacket and two sets of reading glasses as a result of his transfer to Baxter IDF.

Relevant factual findings

281. In reply to Mr Nguyen's allegations concerning his lost jacket and reading glasses, DIMIA provided copies of records that satisfy me that Mr Nguyen's jacket and reading glass were eventually returned to him on 18 October 2004.

Conclusions

282. I note that the Investigation Report was critical of the management of the detainees' personal possessions in connection with their transfer from Maribyrnong IDC to Baxter IDF.

283. However, I accept that the relevant possessions complained of by Mr Nguyen were returned to him on or about 18 October 2004. I do not consider that this delay of approximately one month amounted to, or otherwise contributed to, any breach of his human rights.

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PART J: PLACEMENT OF MR OKOYE IN MANAGEMENT UNIT ON 23 NOVEMBER 2004

Complaint

284. Mr Okoye complained of being placed in a management unit at Baxter IDF on 23 November 2004 for 48 hours, during which time he was allegedly only allowed out for meals.

Relevant factual findings

285. This allegation was not investigated by Knowledge Consulting.

286. Having reviewed materials provided by DIMIA, I am satisfied of the following:

- The placement of Mr Okoye in the management unit was due to his refusal to comply with a request from his DIMIA case officer to stop shouting at him and to leave his office. This is confirmed by the relevant incident report and is also consistent with Mr Okoye's complaint.
- Monitoring sheets confirm that Mr Okoye spent time out of his room whilst in the management unit, including for activities such as general exercise and to receive several phone calls.

Conclusions

287. I do not consider that the placement of Mr Okoye in the management unit for 48 hours (commencing 23 November 2004), or the conditions of his confinement therein, amounted to a breach of his rights under articles 7 or 10(1) of the ICCPR. In reaching this finding I am satisfied that the actions of GSL were not disproportionate in the circumstances.

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PART K: DELAYS IN ARRANGING MR OKOYE'S DEPARTURE FROM AUSTRALIA

Complaint

288. Mr Okoye alleged that on 2 November 2004 he made a verbal and written request to voluntarily leave Australia using his own funds. In addition, he alleged that he made repeated requests, both verbally and in writing, as to what was happening with his departure from Australia. However, he alleged that these requests were ignored and his caseworker would hang up on his telephone calls.

289. I reiterate that Mr Okoye was ultimately removed from Australia to Nigeria on 13 January 2005.

Relevant factual findings

290. This allegation was not investigated by Knowledge Consulting.

291. On the basis of material provided by DIMIA, I find that the approximately two month period required to arrange Mr Okoye's departure from Australia was necessary in order to arrange a passport for Mr Okoye, as he had travelled to Australia using a false passport.

292. It was also necessary that Mr Okoye transit through South Africa as there were no direct flights between Australia and Nigeria. It was therefore necessary to arrange a transit visa for South Africa. In addition, because Mr Okoye was an unlawful non-citizen, the South African authorities required that Mr Okoye obtain airline security uplift approval and be accompanied by an escort of two officers.

293. I also note that the two month period required to make the above arrangements traversed the Christmas and New Year holiday period, which would have contributed to delays.

294. I am also satisfied from the records of Mr Okoye's caseworker that the steps involved in Mr Okoye's departure were advised to him throughout the process.

Conclusion

295. Whilst I appreciate that Mr Okoye's delayed departure would have been frustrating to him, I do not consider that this delay, in the circumstances described above, amounted to a breach of his human rights.

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PART L: FAILURE TO INVESTIGATE COMPLAINTS

Complaint

296. Neither Mr Nguyen nor Mr Okoye made specific complaints about the investigation of their complaints by the respondents, although Mr Nguyen did raise a concern that he had not received any reply to his complaint to DIMIA.

297. However, the Investigation Report expressed strong criticisms in relation to the initial investigations conducted by the respondents. Given that those criticisms are reflected in the recommendations made in this report, I consider it appropriate to comment on this issue briefly.

Relevant factual findings

298. The Investigation Report provided a detailed outline of the investigations conducted by DIMIA, in liaison with GSL, in this matter. I do not propose to set out that information in detail in this report. It is sufficient for me to note the following findings:

- As part of their induction at Baxter IDF on 20 September 2004, the detainees were interviewed by a DIMIA officer. Her notes of those interviews disclose that Mr Nguyen complained that he was 'beaten up' by GSL officers at Maribyrnong IDC. In addition, Mr Okoye and Mr B each separately complained about the conditions of the journey from Maribyrnong IDC. In particular, Mr Okoye alleged that he had drunk his own urine on two occasions during the journey to relieve his excessive thirst.
- The DIMIA induction officer forwarded the complaints of Mr Nguyen, Mr Okoye and Mr B to her manager at Baxter IDF and the complaints were ultimately relayed to the Maribyrnong Manager for a response. After a cursory investigation of the complaints, the Maribyrnong Manager advised that the complaints were groundless. This advice was relayed back to the complainants.
- The Investigation Report found, for reasons that I accept, that the information provided by the Maribyrnong Manager in response to the above complaints was 'inaccurate, inadequate and misleading'. In addition, the Investigation Report found:

  > [The Maribyrnong Manager] did not give priority to effective consideration of the detainee complaints. He made only cursory enquiries in relation to the complaints relayed [to him]. It was incumbent upon [the Maribyrnong Manager] to make rigorous enquiries to ascertain whether or not the detainees' complaints as reported to him … had validity. His level of questioning of the Escort Team Leader was totally inadequate in relation to such serious complaints.

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- Mr Nguyen persisted with his complaint by lodging formal complaints with both HREOC and the Ombudsman. In response to these complaints, the Maribyrnong Manager and another GSL officer reviewed parts of the CCTV footage from Mr Nguyen and Mr Okoye's compartments. The GSL officer assisting the Maribyrnong manager told Knowledge Consulting that she essentially 'buzzed' through the footage to make sure that they had been given the correct tapes. However, she acknowledged that she saw Mr Nguyen urinating in his compartment on the footage. She says that she mentioned her observation to the DIMIA officer co-ordinating the response, however her email to that officer, dated 6 October 2004, tells a different story:

  > 'CCTV footage – [the Maribyrnong Manager] and I have looked at approximately 30 minutes of the CCTV footage (various times during the trip) and can see nothing of significance.'

- DIMIA responded to both HREOC and the Ombudsman, refuting all allegations made in Mr Nguyen's complaint. These responses appear to have been largely based on the findings of the internal investigation into the complaints made by Mr Nguyen, Mr Okoye and Mr B during their induction.
- Mr Okoye then lodged his complaint with HREOC and the Ombudsman.
- A DIMIA case officer reviewed the CCTV footage of Mr Okoye's compartment and became alarmed by the fact that the footage appeared to support Mr Okoye's claims of drinking his own urine and the lack of access to food and water.
- Prompted by the DIMIA case officer's alarm over the CCTV footage and her further inquiries, a more comprehensive review was conducted by DIMIA into the transfer of the detainees from Maribyrnong IDC to Baxter IDF. This resulted in the matter eventually being brought to the attention of the Minister and the appointment of Knowledge Consulting to conduct its investigation.

Comments on the adequacy of the investigations conducted

Failure of officers involved to report breaches

299. Principle 7(2) of the Body of Principles states:

> Officials who have reason to believe that a violation of this Body of Principles has occurred or is about to occur shall report the matter to their superior authorities and, where necessary, to other appropriate authorities or organs vested with reviewing or remedial powers.

300. None of the GSL officers involved in the transfer of detainees between Maribyrnong IDC and Mildura reported to their superiors that a breach of human rights had (or may have) occurred. Indeed, the Team Leader for the escort reported back to the Maribyrnong Manager that the escort was without incident. This is disturbing, as it indicates that the officers involved either:

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- did not perceive that human rights breaches had occurred; or
- were aware that human rights breaches had occurred, but:
  - o were not concerned enough to report the matter, or
  - o the respondents did not have in place a sufficiently robust culture of encouraging and facilitating the reporting of such breaches.

301. Having reviewed the transcripts of interviews with the GSL officers involved in the journey, particularly the driver and co-driver of the van, I observed that the officers generally failed to recognise, even with the benefit of hindsight, that the human rights of the detainees may have been breached during the escort. This suggests that a poor human rights culture existed within GSL at the time of these incidents.

Complaints investigation system initially failed

302. It is also disturbing that once the complaints investigation process was triggered, by the complaints by Mr Nguyen, Mr Okoye and Mr B during their induction at Baxter IDF, that investigation process fundamentally failed. That process again failed when subsequent complaints were lodged by Mr Nguyen with the Ombudsman and HREOC.

303. The failure of the respondents' investigation processes is particularly concerning in this case, for the following reasons:

- The respondents had at their disposal the CCTV footage of the journey. The GSL officer who reviewed that footage stated that she saw what she thought to be a detainee urinating in his compartment, yet nothing seems to have been done about that observation.
- Complaints were made by three detainees from the same journey who each spoke different languages. The risk of collusion was therefore very low.
- No attempt was made to verify the complaints by discussing the matter with any other detainees either:
  - o involved in the escort; or
  - o present during the use of force against Mr Nguyen and Mr Okoye at Maribyrnong IDC.

Complaints investigation process was eventually effective

304. Fortunately, Mr Okoye subsequently lodged his complaint with HREOC which led to a further investigation by the respondents of the relevant circumstances in this matter. On this occasion, finally, the matter was properly investigated, leading to the appointment of Knowledge Consulting.

305. In this regard, credit must be given to:

- the DIMIA case officer who, after reviewing the CCTV footage of Mr Okoye's compartment, persevered with her concerns, which ultimately led to the matter being brought to the attention of the Minister; and

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- the prompt response by the Minister in commissioning the Investigation Report once the possibility emerged that the human rights of the detainees may have been breached.

306. As I have indicated earlier, I found Knowledge Consulting's Investigation Report in this matter to be comprehensive, independent, fair and well-supported by the available evidence. However, it must be emphasised that the six month delay caused by DIMIA and GSL's failure to properly investigate the complaints at first instance hampered the investigation ultimately carried out by Knowledge Consulting, given that:

    - the CCTV footage of the remaining compartments, other than Mr Nguyen and Mr Okoye, had been destroyed;
    - other than Mr A and Mr B, the remaining detainees had been removed from Australia and were not available for interview; and
    - the recollection of the persons involved in the incident had diminished.

307. Both Mr Nguyen and Mr Okoye were removed from Australia before DIMIA commissioned Knowledge Consulting to conduct its investigation. HREOC has lost contact with them both. As a result, despite my finding that Mr Nguyen and Mr Okoye's human rights were breached, it is unlikely that either will now receive any adequate remedy for those breaches. It is also questionable whether they will ever learn that their complaints about the circumstances surrounding their transfer were, in the main, ultimately substantiated.

308. In my view, this unfortunate outcome could have been avoided if DIMIA and GSL had properly investigated these legitimate complaints at first instance.

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PART M: RECOMMENDATIONS

Power to make recommendations

309. Where, after conducting an inquiry, HREOC finds that an act or practice engaged in by a respondent is inconsistent with or contrary to any human right, HREOC is required to serve notice on the respondent setting out its findings and reasons for those findings.[80] HREOC may include in the notice any recommendation for preventing a repetition of the act or a continuation of the practice.[81]

310. HREOC may also recommend:

- the payment of compensation to, or in respect of, a person who has suffered loss or damage; and
- the taking of other action to remedy or reduce the loss or damage suffered by a person.[82]

Compensation

Compensation should be paid to the detainees

311. As noted earlier in this report, I am satisfied that the detainees experienced feelings of considerable distress, discomfort and indignity as a result of the journey from Maribyrnong IDC to Mildura. I am therefore satisfied that it is appropriate that compensation be paid to the detainees.

Calculation of compensation

312. There is no judicial guidance dealing with the assessment of recommendations for financial compensation for breaches of human rights under the HREOC Act.

313. However, in considering the assessment of a recommendation for compensation under section 35 of the HREOC Act (relating to discrimination matters under Part II, Division 4 of the HREOC Act), the Federal Court has indicated that tort principles for the assessment of damages should be applied.[83] I am of the view that this is the appropriate approach to take to the present matter. As such, so far as is possible by a recommendation for compensation, the object should be to place the injured party in the same position as if the wrong had not occurred.[84]

314. Compensation for the detainees' pain and suffering would, in tort law, be characterised as 'non-economic loss'. There is no obvious monetary equivalent for such loss and courts therefore strive to achieve fair rather than full or perfect compensation.[85]

315. In reaching an appropriate figure, I have taken into consideration the following factors:

- The relevant breaches of human rights are of a serious nature. In particular, I note that the rights protected by article 7 have a 'special status' among the

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ICCPR rights, as these rights are non-derogable, even in times of public emergency, and are protected without any restriction.[86] I also note that the UNHRC has emphasised the extremely serious nature of breaches of articles 7[87] and 10.[88]

- None of the detainees appear to have suffered any permanent psychological or physical injury as a result of the conditions during the journey. Whilst Mr Nguyen suffered some physical injury, this was relatively minor and short-lived.
- The respondents failed to properly investigate legitimate complaints made by Mr Nguyen, Mr Okoye and Mr B. I consider that the delays arising from these investigations, combined with the respondents' initial denials of any wrongdoing, would have aggravated the frustration and distress experienced by Mr Nguyen, Mr Okoye and Mr B in this matter.
- There is no evidence to suggest a claim for loss of earnings or medical treatment costs.

316. Taking into account all of these matters, I recommend that the Commonwealth pay $15,000 in compensation to each of the detainees.

Additional compensation to Mr Okoye

317. I have accepted that Mr Okoye drank his own urine on two occasions in a desperate attempt to relieve his excessive thirst caused by the conditions of the journey to Mildura.

318. I consider that this finding constitutes a special circumstance that warrants an additional payment of $5,000 in compensation, to reflect the additional distress, indignity and humiliation suffered by Mr Okoye.

Additional compensation to Mr Nguyen

319. In relation to whether it is appropriate to recommend an additional payment of compensation to Mr Nguyen, I have taken account of the following matters:

- I have found that there was an arbitrary interference with his family life, in breach of articles 17(1) and 23(1) of the ICCPR, due to the failure to adequately take into consideration his family ties to Melbourne in transferring him to Baxter IDF.
- Notwithstanding my finding of a breach of articles 17(1) and 23(1), I note that DIMIA stated that it was unable to say whether it would have allowed Mr Nguyen to remain at Maribyrnong IDC even if it had taken into consideration his family ties to Melbourne. Accordingly, it is questionable whether the outcome for Mr Nguyen would have been any different in the absence of this breach. In addition, I acknowledge the submission by DIMIA that, despite his transfer to Baxter IDF, Mr Nguyen was able to maintain telephone, postal and facsimile contact with his family, although personal visits were made more difficult.

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- Nevertheless, I consider that the impact of the interference with his family life would have been less traumatic if his rights had not been breached. He would at least have had an opportunity to have his views heard, as well as possibly an opportunity to say a proper farewell to his family in Melbourne.
- I have found a breach of article 10(1) in relation to the excessive use of force against Mr Nguyen in moving him from his dormitory room to the van, primarily in relation to a GSL officer pressing his finger or thumb into a 'pressure point' behind Mr Nguyen's ear which inflicted severe, but short-lived, pain.
- I have found that Mr Nguyen was in significant pain during his journey to Baxter IDF. If he had received medical attention prior to the journey to Baxter IDF he would have most likely received treatment or medication to ameliorate his symptoms during the journey or, alternatively, the journey may have been postponed until he was medically fit to travel.
- I have also found that Mr Nguyen's relevant injuries were not permanent and he was provided with medication shortly after his arrival at Baxter IDF which appears to have resolved his symptoms relatively swiftly.

320. Taking into account all of these matters, I recommend that the Commonwealth make an additional payment of $5,000 to Mr Nguyen in compensation.

Additional recommendations

Apology

321. In addition to compensation, I consider that it is appropriate that the Commonwealth provide a formal written apology to each of the detainees for the breaches of their human rights identified in this report. Apologies are important remedies for breaches of human rights. They, at least to some extent, alleviate the suffering of those who have been wronged.[89]

Contact with detainees

322. Of the five detainees, Mr Nguyen, Mr Okoye and Ms C have been removed from Australia. However, I am advised by the Ombudsman's office that Mr A and Mr B remain in Australia and are still contactable.

323. I recommend that the Commonwealth undertake all appropriate measures to locate each of the detainees as soon as practicable (including those removed from Australia) in order to make payment of the compensation recommended above, as well as to provide the detainees with a copy of this report and an apology.

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Human rights culture

324. My findings in this report reflect poorly on the human rights culture that existed within DIMIA and GSL at the time of these incidents. I note in particular the following:

- The occurrence of the breaches of human rights identified in this report.
- The failure of the GSL officers involved in the transfer to recognise that breaches of human rights were occurring (despite obvious indications) or to report those breaches to their superior officers.
- The initial failure of DIMIA or GSL to properly investigate legitimate complaints made by Mr Nguyen, Mr Okoye and Mr B, despite the serious nature of those complaints and evidence available to support those complaints, including CCTV footage.
- The transcript of interviews with the GSL officers involved in the transfer of the detainees reveal that several of those officers, in my view, failed to fully appreciate or acknowledge any significant wrong-doing on their part.

325. In light of the above, I recommend that the Commonwealth take all appropriate steps to:

(a) ensure that a copy of this report is provided to each of the DIMIA and GSL personnel involved in this matter who remain employed by the Commonwealth or GSL; and

(b) increase human rights training for all current and future employees of the Department of Immigration and Citizenship (DIAC) (the current department that deals with immigration matters) and GSL personnel, including in relation to the findings in this report.

Investigation Report recommendations

326. In addition to the above, I note that the Investigation Report made detailed recommendations to address the various issues and criticisms identified in that report.

327. In my letter to DIMIA and GSL, dated 16 March 2007, I flagged that I might adopt in this report the recommendations made in the Investigation Report (in whole or in part). Neither party raised any objection to my doing so.

328. Having carefully reviewed the Investigation Report recommendations, I consider that it is appropriate to adopt those recommendations in their entirety. A complete copy of those recommendations is reproduced as **Annexure A** to this report.

PART N: ACTION TAKEN BY THE RESPONDENTS AS A RESULT OF HREOC'S FINDINGS AND RECOMMENDATIONS

Obligation to report on responses from respondents

329. Pursuant to s 29(2)(e) of the HREOC Act, if HREOC finds a breach of human rights and furnishes a report on the matter to the Attorney-General, HREOC is to include in the report details of any actions that the respondents have taken or are taking as a result of HREOC's findings and recommendations.

330. Accordingly, on 13 September 2007, HREOC forwarded to DIAC and GSL a copy of its findings and recommendations and invited their comments as to what action, if any, they had taken or were taking in response.

GSL response

331. On 18 October 2007, GSL provided its response. GSL accepted all of HREOC's findings and recommendations with the sole exception of the finding that Mr Okoye had drunk his own urine. In short, GSL stressed the implausibility of this allegation and objected to the payment of the additional compensation of $5,000 to Mr Okoye for this aspect of his complaint. A complete transcript of GSL's response is annexed to this report as **Annexure C**.

332. In light of GSL's strong objection to HREOC's finding that Mr Okoye drank his own urine, I have reconsidered the evidence surrounding this allegation. In doing so, I have had close regard to the principles discussed by Dixon J in *Briginshaw v Briginshaw*[90] about the need for a decision-maker, in being satisfied to the relevant standard of proof, to take into consideration such matters as the seriousness of an allegation, its inherent unlikelihood and the consequences for the respondent if the allegation is accepted. I have considered in particular the arguments raised by GSL as to the alleged implausibility of Mr Okoye's allegation, which arguments appear to be primarily directed to the inherent unlikelihood of this allegation.

333. I agree that Mr Okoye's allegation of drinking his own urine may appear, on its face, to be a somewhat extreme act. However, it is an allegation which must be evaluated in its proper context. For the reasons discussed at length in this report, I consider that the circumstances imposed upon Mr Okoye during the course of his journey from Maribyrnong IDC to Mildura on 17 September 2004 could be described as extreme. In light of the factors that I listed at paragraph 215 of this report, I remain satisfied that this allegation has been made out, notwithstanding GSL's arguments to the contrary.

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DIAC response

334. On 25 October 2007, DIAC provided a detailed response which addressed each of HREOC's recommendations, as well as each of the recommendations contained in the Knowledge Consulting report. A complete transcript of DIAC's response is annexed to this report as **Annexure D**.

335. DIAC's response included several annexures, a number of which were quite bulky. I am satisfied that DIAC's response sufficiently describes the nature and/or content of these annexures such that it is not necessary for them to be attached to this report.

Final clarification on compensation

336. On 26 October 2007, HREOC clarified with the respondents that the following action would be taken in respect of compensation:

    (a) the Commonwealth has committed to making the payments of compensation as recommended in this report, with the exception of the additional $5,000 to Mr Okoye in relation to his drinking of urine; and

    (b) GSL would indemnify the Commonwealth in respect of its payments of compensation.

I report accordingly to the Attorney-General.

John von Doussa
President
December 2007

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ANNEXURE A

RECOMMENDATIONS FROM KNOWLEDGE CONSULTING REPORT

Recommendation 1

Global Solutions Limited (Australia) Pty Ltd and the GSL officers involved in planning and executing this escort are requested to requested to apologize to each of the detainees involved for the distress inflicted during the escort under investigation.

Recommendation 2

DIMIA apologize to each of the detainees involved for what has occurred.

Recommendation 3

GSL give consideration to the actions of their officers involved in the planning and execution of this escort to decide whether any should be asked to show cause why disciplinary action should not be taken against them. The GSL officers involved in planning and execution of this escort should not be allowed to participate unsupervised in future similar work activities until they have satisfactorily completed retraining.

Recommendation 4

DIMIA seek legal advice as to whether any of the actions by GSL officers identified in this report may constitute offences under relevant laws.

Recommendation 5

The 10 seat *Mercedes Sprinter* vans from GSL's vehicle fleet are never used again for the transport of people in administrative detention. DIMIA should advise the Victorian Department of Corrective Services of the shortcomings of these vehicles identified in this investigation.

Recommendation 6

GSL's *Generic Operational Procedure No 12.5 - External Transport and Escort Service* be reviewed to incorporate guidance in relation to:

- Briefing of detainees prior to the escort commencing;
- De-briefing of detainees at the conclusion of the escort;
- Section 4.2.1, dealing with individual needs of each detainee be amended to read, *'Identifying the individual needs of each detainee to be transported, including provision for food, water, exercise and toilet facilities.' In addition, 'English language skills and/ or need*

for interpreter assistance during escort' should be added as a special need in this section of the procedure;

- Detainee complaints handling process for complaints made prior to, during and on completion of the escort, including preservation of evidence;
- Preservation of all records relating to the escort, including CCTV tapes;
- De-briefing of the escort officers on completion of the escort;
- Maintenance of logs by escorting officers;
- Specification of driver rest breaks;
- Ensuring escort vehicle drivers have appropriate licenses and training in driving the vehicle, training in operating equipment in the vehicle and are capable of carrying out emergency maintenance such as changing tyres; and
- Appropriate linkages to the *Operational Procedure* on the use of force, where force may be required to be used against detainees and/or restraints may be required to be applied.

Recommendation 7

In the light of evidence in this report that GSL officers at Maribrynong IDC and Baxter IDF disregarded approved Generic Operational Procedures in the planning and execution of this escort, all relevant GSL Managers and Operations Managers of Detention Centres and Facilities be required to attend a training workshop where:

- The experience from this escort under investigation is used as a case study to reinforce the need for strict adherence to GSL Generic Operational Procedures in all facets of Detention Centre and Facility operations;
- The work roles of GSL Managers and Supervisory Staff at Detention Centres and Facilities are discussed and reviewed with the aim of allocating time and priority on a scheduled basis to conduct/arrange ongoing *in service* training for GSL Detention Services Officers in the Generic Operational Procedures that impact on their day to day work roles;
- Consideration is given to whether additional external assistance is required for Managers and Supervisors to support their staff training effort, particularly over the next six months, when an intensive training effort should be mounted to give assurance that the deficiencies in performance detailed in this report are not repeated at any Centre or Facility;
- Use of force is discussed in the context of this case under investigation and various other scenarios to:
    - o reinforce that use of force is a last resort;
    - o define under a range of circumstances what *last resort* means; and
    - o ensure that all GSL Managers understand the *Generic Operational Procedure* governing the use of force and that they understand that disregard of this procedure will have serious consequences;

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- Incident reporting is discussed and all managers are instructed in good practice and the relevant procedures; and
- They are trained and/or re-trained in *"a risk assessment methodology"* appropriate for their role in detention services.

Recommendation 8

In the light of evidence in this report that relevant GSL Managers and officers at Maribyrnong IDC and Baxter IDF disregarded Generic Operational Procedures resulting in serious breaches of the Immigration Detention Standards relating to the humane treatment and safe custody of detainees and given that this disregard related to a range of operational matters including:

- Transport and escort;
- Supervision of officer performance;
- Coordination of planning between centres;
- Training of officers;
- Use of force;
- Incident reporting;
- Accurately maintaining visit records;
- Occupational health and safety, including smoking in vehicles and driver rest breaks;
- Use of equipment;
- Monitoring of detainees;
- Use of interpreters;
- Detainee dignity, privacy, safety and humane treatment;
- Investigation of complaints;
- Application of risk assessment methodology;
- Briefings of officers; and
- Adequate response to DIMIA enquiries;

GSL review, as a matter of urgency, internal audit and compliance systems and procedures at each Detention Centre and Facility and report upon this review to DIMIA.

Recommendation 9

In the light of evidence of non compliance by GSL officers at Maribyrnong IDC and Baxter IDF with approved *Generic Operational Procedures*, DIMIA, commencing immediately this recommendation is accepted, conduct or cause to be conducted an intensive program of unannounced audits, over the next six (6) months, of all Detention Centres and Facilities of GSL's performance in operational areas where deficiencies have been identified as a result of this investigation and in other identified *high risk* operational

areas.

Recommendation 10

DIMIA and GSL, as a matter of urgency, review and enhance their respective detainee complaint handling procedures having regard to the deficiencies identified in this report. These reviews should be coordinated and supervised in a manner that ensures the outcomes result in:

- Effective interface of the procedures; and
- Effective interface between complaints generally and Detention Services Contract performance scrutiny.

The complaints handling procedures must be *user friendly* for the detainees, provide for rigour in consideration and investigation of complaints and for timely, accurate evidence based responses to complainants and agencies of scrutiny.

Recommendation 11

That the Unauthorised Arrivals and Detention Division (UADD) within DIMIA give consideration to adopting a practice of tape recording formal interviews between detainees, DIMIA and GSL officers in relation to matters affecting the detainee's status or in relation to any matter that has the potential to be contentious, such as a complaint.

Recommendation 12

That the UADD give high priority to its current review of governance of the Detention Services Contract.

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ANNEXURE B

FUNCTIONS OF THE HUMAN RIGHTS AND EQUAL OPPORTUNITY COMMISSION

The Commission has specific legislative functions and responsibilities for the protection and promotion of human rights under the HREOC Act. Part II Divisions 2 and 3 of the HREOC Act confer functions on the Commission in relation to human rights. In particular, section 11(1)(f) of the HREOC Act empowers the Commission to inquire into acts or practices of the Commonwealth that may be inconsistent with or contrary to the rights set out in the human rights instruments scheduled to or declared under the HREOC Act.

Section 11(1)(f) of the HREOC Act states:

> (1) The functions of the Commission are:
>
> (f) to inquire into any act or practice that may be inconsistent with or contrary to any human right, and:
>
> (i) where the Commission considers it appropriate to do so-to endeavour, by conciliation, to effect a settlement of the matters that gave rise to the inquiry; and
>
> (ii) where the Commission is of the opinion that the act or practice is inconsistent with or contrary to any human right, and the Commission has not considered it appropriate to endeavour to effect a settlement of the matters that gave rise to the inquiry or has endeavoured without success to effect such a settlement-to report to the Minister in relation to the inquiry.

Section 3 of the HREOC Act defines an "act" or "practice" as including an act or practice done by or on behalf of the Commonwealth or an authority of the Commonwealth.

The Commission performs the functions referred to in section 11(1)(f) of the HREOC Act upon the Attorney-General's request, when a complaint is made in writing or when the Commission regards it desirable to do so (section 20(1) of the HREOC Act).

In addition, the Commission is obliged to perform all of its functions in accordance with the principles set out in section 10A of the HREOC Act, namely with regard for the indivisibility and universality of human rights and the principle that every person is free and equal in dignity and rights.

The Commission attempts to resolve complaints under the provisions of the HREOC Act through the process of conciliation. Where conciliation is not successful or not appropriate and the Commission is of the opinion that an act or practice constitutes a breach of human rights, the Commission shall not furnish a report to the Attorney-General until it has given the respondent to the complaint an opportunity to make written and/or oral submissions in relation to the complaint (section 27 of the HREOC Act).

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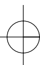
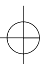


If, after the inquiry, the Commission finds a breach of human rights, it must serve a notice on the person doing the act or engaging in the practice setting out the findings and the reasons for those findings (section 29(2)(a) of the HREOC Act). The Commission may make recommendations for preventing a repetition of the act or practice, the payment of compensation or any other action or remedy to reduce the loss or damage suffered as a result of the breach of a person's human rights (sections 29(2)(b) and (c) of the HREOC Act).

If the Commission finds a breach of human rights and it furnishes a report on the matter to the Attorney-General, the Commission is to include in the report particulars of any recommendations made in the notice and details of any actions that the person is taking as a result of the findings and recommendations of the Commission (sections 29(2)(d) and (e) of the HREOC Act). The Attorney-General must table the report in both Houses of Federal Parliament within 15 sitting days in accordance with section 46 of the HREOC Act.

It should be noted that the Commission has a discretion to cease inquiry into an act or practice in certain circumstances (section 20(2) of the HREOC Act), including where the subject matter of the complaint has already been adequately dealt with by the Commission (section 20(2)(c)(v) of the HREOC Act).



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ANNEXURE C

RESPONSE OF GSL, DATED 18 OCTOBER 2007, TO HREOC'S NOTICE OF FINDINGS AND RECOMMENDATIONS

Complaints by Mr Austin OKOYE and Mr Hai Huong NGUYEN

I refer to the Notice of the findings of the President in relation to the above complaint and to your letter of 13 September 2007. GSL accepts all the findings and the recommendations with the exception of section 215 relating to the allegation that Mr Okoye 'out of desperation' drank his own urine. GSL takes strong exception to this finding and therefore to the recommendation that Mr Okoye should be compensated for it.

There is no evidence to substantiate that the incident ever occurred.

It is my understanding that a senior officer of the then Department of Immigration and Multicultural and Indigenous Affairs and an executive of GSL closely and separately viewed the footage and concluded, in the one case, that the alleged drinking of urine was 'fabricated'; and in the other that it did not support Mr Okoye's claim. Section 215 of your own report points out that the CCTV footage 'is not clear'.

Given that any reasonable person would consider it to be highly implausible that anyone would be so overcome by thirst on a journey from Melbourne to Mildura that they would be forced to resort to drinking their own urine – and we do not dispute that Mr Okoye was thirsty – alternative explanations must be considered. One such explanation is that Mr Okoye was pretending to drink his urine to make the point that he was thirsty. Another is that it was a theatrical gesture. Neither explanation is contradicted by the video. In spite of this, the report does not canvass the possibility that there could be some less controversial explanation than the one that HREOC has accepted.

GSL requests again that this part of the President's report be deleted and with it the recommendation that additional compensation of $5000 should be paid to Mr Okoye. Failing this, will you please attach this letter in its entirety to your report to the Attorney-General. A copy of this letter is being provided to the Department of Immigration and Citizenship. If it requires any further explanation, I shall be pleased to discuss it with you.

Yours sincerely,

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ANNEXURE D

RESPONSE OF DIAC TO HREOC'S NOTICE OF FINDINGS AND RECOMMENDATIONS

Recommendations from Knowledge Consulting Report

1. Global Solutions Limited (Australia) Pty Ltd and the GSL officers involved in planning and executing this escort are requested to apologize to each of the detainees involved for the distress inflicted during the escort under investigation.

Global Solutions Limited (Australia) Pty Ltd (GSL) issued an unqualified public apology to all five clients on 29 July 2005 and hand delivered letters of apology on 21 September 2005 to the two clients remaining in Australia (Attachment B). The GSL letters of apology were not sent to the three clients who had left Australia as they claimed there could be no assurance that the letters would be safely delivered to them.

2. DIMIA apologize to each of the detainees involved for what has occurred.

On 29 July 2005, the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA), now known as the Department of Immigration and Citizenship (the Department), sent letters of apology to all five detainees (Attachment C).

3. GSL give consideration to the actions of their officers involved in the planning and execution of this escort to decide whether any should be asked to show cause why disciplinary action should not be taken against them. The GSL officers involved in planning and execution of this escort should not be allowed to participate unsupervised in future similar work activities until they have satisfactorily completed retraining.

GSL has advised the Department that the following actions have been implemented:

> Letters were sent to the officers involved in the transfer asking them to 'show cause' why they should not face disciplinary action. The General Manager and Deputy General Manager resigned shortly after the facts became known in accordance with their previously advised intention to leave GSL. The staff on the escort were disciplined and counselled.
>
> Of the five officers who made up the Escort Team, the GSL Formal Disciplinary Process was invoked against four of them. The fifth member of the group had left GSL's employment several months before the investigation was completed. Of the four remaining officers, and after the comprehensive disciplinary process was concluded, one officer received a final written warning while the others received written warnings.

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As recommended in the Knowledge Consulting Report, all staff have subsequently received re-training in all aspects of escort operations including greater familiarisation of the Operational Procedures that relate to escorts.

The National Learning and Development Manager has developed a specific training program, modelled on the "Human Rights Charter" (Victorian legislation) that has been designed for delivery to all newly appointed staff as part of the mandatory initial training they must complete before commencing work in the centres.

4. DIMIA seek legal advice as to whether any of the actions by GSL officers identified in this report may constitute offences under relevant laws.

At this stage the Department has not sought external legal advice.

In October 2007, Victoria Police advised the Department that a report in relation to allegations of inappropriate treatment of the five detainees by GSL officers identified in the report, has been submitted to their Crime Department Management for consideration, pending further enquiries with the Australian Federal Police to locate some of the detainees in their country of origin.

5. The 10 seat *Mercedes Sprinter* vans from GSL's vehicle fleet are never used again for the transport of people in administrative detention. DIMIA should advise the Victorian Department of Corrective Services of the shortcomings of these vehicles identified in this investigation.

GSL has advised the Department that all GSL general managers have been notified, both orally and in writing, that this style of escort van will not be used to transfer immigration detainees again.

On 5 October 2005, the Department sent a letter to the Victorian Department of Corrective Services advising of the shortcomings of the vehicles used in the transfer.

6. GSL's *Generic Operational Procedure No 12.5 - External Transport and Escort Service* be reviewed to incorporate guidance in relation to:

a) Briefing of detainees prior to the escort commencing;

The Department has been advised by GSL that an Escort Pack, Document No: CO-02-150_2 (Attachment D) has been developed, which includes the Detention Services Escort Log Document No: CO-02-149_0 (Attachment D 1). The log requires the noting of client briefings before the commencement of an escort, if Translating and Interpreting Services (TIS) was used and who conducted the briefing.

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b) De-briefing of detainees at the conclusion of the escort;

The Department has been advised by GSL, that the action relating to recommendation 6 a) above, the Detention Services Escort Log Document provides for the noting of client briefings following an escort, if TIS was used and who conducted the briefing.

c) Section 4.2.1, dealing with individual needs of each detainee be amended to read, *'Identifying the individual needs of each detainee to be transported, including provision for food, water, exercise and toilet facilities.'* In addition, *'English language skills and/ or need for interpreter assistance during escort'* should be added as a special need in this section of the procedure;

GSL has advised the Department that information on the individual needs of clients to be transported is listed in Generic Operational Procedure (OP) No. 12.5, Section 4.2.1, (Attachment E). Initially, GSL developed a Long Haul Escort Checklist as an appendix to OP No. 12.5, but this is now located at Section 4.5 (Attachment E).

The Detention Services Escort Log (Attachment D 1) documents client's needs such as access to nourishment, opportunity for the toilet and exercise at regular intervals are met during an escort trip.

d) Detainee complaints handling process for complaints made prior to, during and on completion of the escort, including preservation of evidence;

The Department has been advised by GSL that Detainee Complaint Forms are listed in the "Equipment Check List for Vehicle Escorts" as an item to be made available for every transport/escort. This check list is to be checked-off by the escorting officers and can be found in Section 4.5 of OP No.12.5 (Attachment E).

e) Preservation of all records relating to the escort, including CCTV tapes;

GSL has advised the Department that it is aware that all records remain the property of the Department and must be managed in accordance with clause 11.6 - Records Management, of the Detention Services Contract.

f) De-briefing of the escort officers on completion of the escort;

The Escort Pack includes a Hot and Cold Debrief to record the debriefing of an escort, Document No: CO-02-154_0 (Attachment D 2).

g) Maintenance of logs by escorting officers;

The Department has been advised by GSL that Vehicle Daily Log Forms and a Vehicle Daily Log Continuation Sheet are listed in the "Equipment Check List for Vehicle Escorts" as items to be made available for every transport/escort. This check list is to be checked off by the escorting officers and can be found at Section 4.5 of OP No.12.5 (Attachment E).

h) Specification of driver rest breaks;

The Department has been advised by GSL that the Detention Services Escort Log Co-02-149_1 (Attachment D 1) stipulates that the driver takes rest breaks every two hours and provides a recording of the breaks and driver changes in the log.

i) Ensuring escort vehicle drivers have appropriate licenses and training in driving the vehicle, training in operating equipment in the vehicle and are capable of carrying out emergency maintenance such as changing tyres; and

The Department has been advised by GSL that OP No. 12.5 states in Section 4.2.1 (Attachment E) that the Operations Manager at each Facility is responsible for "allocating transport and escort duties to trained officers."

j) Appropriate linkages to the *Operational Procedure* on the use of force, where force may be required to be used against detainees and/or restraints may be required to be applied.

The Department has been advised by GSL that managing potential risk is addressed in OP No. 12.5, Section 4.2.1 (Attachment E). The circumstances under which cuffs may never be applied are outlined in OP No. 12.5, Section 2.2 (Attachment E), where it states that this operational procedure should be read in conjunction with other documents including

OP No. 12.11 – *Use of Force* at Attachment F. OP No. 12.11 states in Section 6.7.2 that "instruments of restraint during transport are used only when reasonably necessary and proportionate to the circumstances".

7. In the light of evidence in this report that GSL Managers at MIDC and BIDF disregarded approved Generic Operational Procedures in the planning and execution of this escort, all GSL Managers and Operations Managers of Detention Centres and Facilities be required to attend a training workshop where:

- **The experience from this escort under investigation is used as a case study to reinforce the need for strict adherence to GSL Generic Operational Procedures in all facets of Detention Centre and Facility operations.**

The Department has been advised by GSL that in October 2005, it conducted a case study workshop on the Maribyrnong/Baxter transfer escort, and the use of force with the Detention Services Senior Management Group at the Business Improvement Seminar.

Further information on GSL's response to the Knowledge Consulting Report and how this has impacted on their training program is at 3 b) GSL training, Additional Recommendations, at page 10 of this response.

- **The work roles of GSL Managers and Supervisory Staff at Detention Centres and Facilities are discussed and reviewed with the aim of allocating time and priority on a scheduled basis to conduct/arrange ongoing in service training for GSL Detention Services Officers in the Generic Operational Procedures that impact on their day to day work roles.**

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The Department has been advised by GSL that it has reviewed the work roles of its Managers and Supervisory Staff at Centres and Facilities. In order to ensure appropriate training is arranged and delivered, it has appointed a National Learning and Development Manager, a National Compliance Manager and a Compliance Advisor (whose exclusive area of responsibility is the Detention Services Contract).

- **Consideration is given to whether additional external assistance is required for Managers and Supervisors to support their staff training effort, particularly over the next six (6) months, when an intensive training effort should be mounted to give assurance that the deficiencies in performance detailed in this report are not repeated at any Centre or Facility.**

The Department has been advised by GSL that it considered that additional external assistance was required to support appropriate training and elected to appoint a National Learning and Development Manager, a National Compliance Manager and a Compliance Advisor as noted above. The concentrated focus on training ensures officers complete the, *Certificate III in Corrections*.

- **Use of force is discussed in the context of this case under investigation and various other scenarios to:**
  - **reinforce that use of force is a last resort;**
  - **define under a range of circumstances what last resort means; and**
  - **ensure that all GSL Managers understand the Generic Operational Procedure governing the use of force and that they understand that disregard of this procedure will have serious consequences.**
- **Incident reporting is discussed and all managers are instructed in good practice and the relevant procedures; and**
- **They are trained and/or re-trained in "a risk assessment methodology" appropriate for their role in detention services.**

GSL has advised the Department that the following actions have been implemented:

> In October 2005, GSL General Managers were instructed that clients must not be forced on to escort transport vehicles without the specific approval of Departmental staff.
>
> In March 2005, the GSL General Manager and Operations Manager at Maribyrnong Immigration Detention Centre attended a Risk Management Course, and principles of risk management were discussed at the General Managers' meeting in July 2005 and the Business Improvement Seminar in October 2005. Business Improvement Seminars are held quarterly throughout the year and attended by the Senior Management Team and Managers from all Detention Centres and Facilities. Incident reporting is a standard agenda item at these meetings.
>
> A risk assessment methodology is now used for the purpose of identifying risks and how those risks will be managed and is outlined in OP No. 12.5, Section 4.2.1 (Attachment E).

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8. **In the light of evidence in this report that relevant GSL Managers and officers at Maribyrnong IDC and Baxter IDF disregarded Generic Operational Procedures resulting in serious breaches of the Immigration Detention Standards relating to the humane treatment and safe custody of detainees and given that this disregard related to a range of operational matters including:**
   - **Transport and escort;**
   - **Supervision of officer performance;**
   - **Coordination of planning between centres;**
   - **Training of officers;**
   - **Use of force;**
   - **Incident reporting;**
   - **Accurately maintaining visit records;**
   - **Occupational health and safety, including smoking in vehicles and driver rest breaks;**
   - **Use of equipment;**
   - **Monitoring of detainees;**
   - **Use of interpreters;**
   - **Detainee dignity, privacy, safety and humane treatment;**
   - **Investigation of complaints;**
   - **Application of risk assessment methodology;**
   - **Briefings of officers; and**
   - **Adequate response to DIMIA enquiries;**

   GSL review, as a matter of urgency, internal audit and compliance systems and procedures at each Detention Centre and Facility and report upon this review to DIMIA.

The Department has been advised by GSL that it has established a Master Risk Register at each Centre and Facility. Escorts receive a high rating on the Master Risk Register and a formal process has been established by GSL to ensure risks are mitigated. The National Compliance Manager randomly selects three escorts from the previous month from each Centre or Facility, prepares an Internal Management Review (IMR) on each, which is then rated and scored on compliance with the Generic Operational Procedures and Immigration Detention Standards. The IMR is shared with the Department.

9. **In the light of evidence of non compliance by GSL officers at Maribyrnong IDC and Baxter IDF with approved Generic Operational Procedures, DIMIA, commencing immediately this recommendation is accepted, conduct or cause to be conducted an intensive program of unannounced audits, over the next six (6) months, of all Detention Centres and Facilities of GSL's performance in operational areas where deficiencies have been identified as a result of this investigation and in other identified high risk operational areas.**

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During 2005, the Department's National Office audited Transport and Escort processes across centres twice and the Department's staff at individual centres performed an additional two audits at each centre.

Baxter

Transport and Escort Audits were undertaken by the Department's National Office on 14-17 March and 13-15 December 2005.

Perth

Transport and Escort Audits were undertaken by the Department's National Office on 2-5 May 2005 and 11-13 January 2006 (Operational issues prevented this audit being conducted as planned in 2005).

Christmas Island

Transport and Escort Audits were undertaken by the Department's National Office on 2-5 May 2005.

Maribyrnong

Transport and Escort Audits were undertaken by the Department's National Office on 11-13 April and 15-16 December 2005.

Villawood

Transport and Escort Audits were undertaken by the Department's National Office on 21-25 February and 12-14 December 2005.

In 2006, the Department and GSL jointly performed a series of risk-based audits as part of a project to provide quality assurance to a number of services provided under the Detention Services Contract, including transport and escorts.

From July 2006, the Department and GSL implemented the Centre Management Model, increasing the Department's involvement in the running of centres and focussing on the resolution of day-to-day issues at the centre level, to improve client focus, communication and responsiveness.

The Detention Services Contract was amended (effective from 1 October 2006) to address the recommendations of an independent review commissioned as a result of the Palmer report. These amendments included the replacement of the original performance management system. The new system is designed to ensure mitigation of risks to GSL's achievement of the Immigration Detention Standards, and (with the exception of a small number of defined serious incidents) the emphasis of sanction provisions under the contract has been changed from penalising individual events to penalising any failure to address risks appropriately.

The combination of the Centre Management Model and the new Performance Management System (which was designed to complement it) ensures that GSL's

performance is constantly monitored at the centres, with issues addressed at the lowest appropriate management level, and escalation systems available for the risk management of more serious issues. Audits to address identified risks occur at both individual centres and at a national level, as appropriate.

10. DIMIA and GSL, as a matter of urgency, review and enhance their respective detainee complaint handling procedures having regard to the deficiencies identified in this report. These reviews should be coordinated and supervised in a manner that ensures the outcomes result in:

- **Effective interface of the procedures; and**
- **Effective interface between complaints generally and Detention Services Contract performance scrutiny.**
  The complaints handling procedures must be *user friendly* for the detainees, provide for rigour in consideration and investigation of complaints and for timely, accurate evidence based responses to complainants and agencies of scrutiny.

The current OP 14.1 - *Issues/Complaints Resolution* is at Attachment G.

A poster for clients outlining the steps required in lodging a complaint has been put up in all Immigration Detention Centres, a copy of this is at Attachment H.

The Department has implemented a Global Feedback Unit (GFU) for the centralised registration, monitoring and update of complaints and feedback received from detainees, visitors, advocates and persons seeking to provide feedback about immigration detention related activities.

11. That the Unauthorised Arrivals and Detention Division (UADD) within DIMIA give consideration to adopting a practice of tape recording formal interviews between detainees, DIMIA and GSL officers in relation to matters affecting the detainee's status or in relation to any matter that has the potential to be contentious, such as a complaint.

The Department is currently drafting new operating procedures to ensure that video footage of activities in detention centres is accurately and fully recorded. A copy of the Detention Operations Update will be forwarded to your office once it has been approved.

12. That the UADD give high priority to its current review of governance of the Detention Services Contract.

Following the report of a review of the detention contract that was completed in December 2005, governance structures for managing the contract were amended to reflect the revised governance arrangements.

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Additional Recommendations – Human Rights and Equal Opportunity Commission

1. *Compensation*

Compensation should be paid to the detainees.

$15,000 in compensation to each of the detainees by the Commonwealth

An additional payment of $5,000 in compensation to Mr Okoye to reflect the additional distress, indignity and humiliation suffered by him

An additional payment of $5,000 to Mr Nguyen in respect of:

- **the arbitrary interference with this family life by transferring him to Baxter IDF without giving adequate consideration to his family ties in Melbourne;**
- **the excessive use offeree in moving him from his dormitory room to the van; and**
- **the failure to provide adequate medical attention, particularly prior to the journey to Baxter IDF.**

GSL advised the Department, in a letter, on 18 October 2007, that it will indemnify the Commonwealth for any compensation paid to the five people on the escort. However, GSL advises that it does not accept the President's findings in respect of Mr Okoye drinking urine. GSL will be responding to this in a separate submission.

2. *Contact with detainees and apology*

The Commonwealth take all appropriate steps to locate the detainees (including those removed from Australia) in order to provide them with a copy of this report, compensation and a formal written apology to each of the detainees for the breaches of their human rights identified in the enclosed Notice.

The Department will take all reasonable steps to ensure that each of the five clients receive a copy of the HREOC Report and a formal written apology for the breaches of their human rights as identified in the HREOC Report. In respect to one of the clients, the Department provided a copy of the President's report to Mr Qi Peng, who is currently in Villawood Immigration Detention Centre, prior to this response.

3. *Human Rights Culture*

The Commonwealth take all appropriate steps to:

a) ensure that a copy of the report is provided to each of the Department of Immigration and Citizenship (DIAC) and GSL personnel involved in this matter who remain employed by the Commonwealth or GSL; and

b) increase human rights training for all current and future employees of the DIAC and GSL personnel, including in relation to the findings in the enclosed Notice.

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a) Provision of a copy of the report to GSL personnel involved

Of the GSL staff who were directly involved in the Mildura escort operation, numbering five in total, those still employed when the initial report was handed down in Knowledge Consulting Report were given it to read and were required to formally respond to certain aspects of the findings of the report. Of the staff that made up the escort team, one had left GSL's employment some time before the report was handed down.

The Centre General Manager and the Operations Manager at Maribyrnong IDC, directly responsible for the preparation and conduct of the operation on the day, had given notice of their resignations before the report had been handed down in June 2005, and had left GSL's employment before the report was available.

b) Human rights training

The Department

All training courses conducted under the Department's College of Immigration covers the concept of duty of care in significant detail. The three-week long College Detention course covers fundamental human rights in a number of sessions, especially under Duty of Care, where the Commonwealth's obligations are emphasized and discussed in specific scenarios, focussing on many aspects of immigration detention, including client transfers. The training course highlights the findings from external reviews and incorporates key learning as part of continuous improvement of the course delivery.

The detention training around the client placement model also includes the Australian Public Service (APS) risk management framework and covers individual circumstances relating to clients' immigration pathways and personal circumstances. The implementation of the new case management framework ensures each client is individually managed and their health and welfare needs are met at all stages of immigration processing.

GSL

The Knowledge Consulting Report was considered at length by GSL management and the findings were accepted resulting in operational and strategic changes because of the identified failings. GSL's initial strategy was for all senior managers to familiarise themselves with the report. Changes to the operational approach were introduced that included an emphasis on cultural and procedural changes. As a result, each general manager took responsibility for ensuring that the specified changes took place at their own operational centre and that all staff fully understood these changes.

GSL executive and senior managerial staff, including the Managing Director, participated in intensive training sessions developed from the Knowledge Consulting Report. The managing director wrote a memorandum which was presented to all staff members reinforcing the importance of ensuring the protection of human rights and that this responsibility rested with every single employee of GSL.

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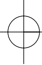
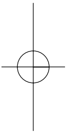
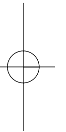
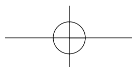


GSL's amended approach to the management of escort tasking includes additional training for staff delivered formally by lesson plan and informally by direction, oversight and guidance on the job.

The absolute importance of human rights was reinforced in all of these learning sessions and measures were introduced to ensure not only recognition of these basic rights but that they are always protected. For instance each escort task is accompanied by a rigorous process including the use of running logs in the GSL Escort Pack (Attachment D) documenting and ensuring that the client will always have access to nourishment, opportunity for the toilet and for exercise at regular intervals. The process is quality controlled with a number of escort tasks regularly audited by GSL executive staff.







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ENDNOTES

1 The relevant Department has since been renamed twice and is currently named the Department of Immigration and Citizenship (DIAC). To avoid confusion, I have chosen to refer to the Department as DIMIA throughout this report. DIMIA was the applicable name of the Department at the time of the relevant allegations and at the time the complaint was made to HREOC.

2 Opened for signature 16 December 1966, 999 UNTS 171 (entered into force 3 January 1976).

3 It is my understanding that a management unit in a detention centre is a separate area or cell used for isolating detainees in certain circumstances.

4 See HREOC Act s 27.

5 A more detailed outline of HREOC's functions in relation to the investigation and conciliation of complaints of human rights breaches against the Commonwealth and its functions in relation to reporting on substantiated complaints that have not been resolved through the process of conciliation is contained in **Annexure B.**

6 See, eg, *Polay Campos v Peru*, Communication No 577/1994, UN Doc CCPR/C/61/D/577/1994 (1998) at [8.2] – [8.7]. In finding that Articles 7 and 10(1) had been breached, the UNHRC used the expressions 'violation of', 'contrary to', 'incompatible with' and 'inconsistent with' without any apparent distinction. For other decisions of the UNHRC where the expression 'inconsistent with' has been used to refer to a breach of a person's human rights see, eg, *Faurisson v. France*, Communication No. 550/1993, UN Doc CCPR/C/58/D/550/1993 (1996) (per Bhagwati); *v.d.M. v The Netherlands*, Communication No. 478/1991, UN Doc CCPR/C/48/D/478/1991 (1993) at [6.3]; C. *Johnson v Jamaica*, Communication No. 592/1994, UN Doc CCPR/C/64/D/592/1994 (1998) (per Kretzmer). See also UNHRC General Comment 16 (The right to respect of privacy, family, home and correspondence, and protection of honour and reputation) at [9]; UNHRC General Comment 22 (The right to freedom of thought, conscience and religion) at [5] – [6]. Similarly, the UNHRC's Concluding Observations on State reports do not suggest that there is a material distinction between an act that is 'inconsistent with' a person's rights, compared with an act that is 'contrary to' or in breach of a person's rights. See, eg, Concluding Observations on the reports submitted by Argentina, UN Doc CCPR A/45/40 (1990) at [146]; Belarus, UN Doc CCPR A/33/40 (1978) at [536]; Belgium, UN Doc CCPR A/54/40 (1999) at [86]; Czech Republic, UN Doc CCPR A/33/40 (1978) at [117]; Denmark, UN Doc CCPR A/56/40 (2001) at [12]. Ecuador, UN Doc CCPR A/43/40 (1988) at [330]; Egypt, UN Doc CCPR A/58/40 (2003) at [15] and [21]; Estonia, UN Doc CCPR A/51/40 (1996) at [122]; Japan, UN Doc CCPR A/37/40 (1982) at [68].

7 M Nowak, *UN Covenant on Civil and Political Rights CCPR Commentary* (2nd ed, 2005) 247-8.

8 UNHRC General Comment 21 (Replaces general comment 9 concerning humane treatment of persons deprived of liberty) UN Doc HRI\GEN\1\Rev.1 AT 33 (1994) at [3].

9 M Nowak, *UN Covenant on Civil and Political Rights CCPR Commentary* (2nd ed, 2005) 250.

10 See, eg, *Walker and Richards v Jamaica*, Communication No. 639/1995, UN Doc CCPR/C/60/D/639/1995 (1997); *Solorzano v Venezuela*, Communication No. 156/1983, UN Doc CCPR/C/OP/2 at 183 (1990) at [10.2], [12]; *Chaplin v Jamaica*, Communication No. 596/1994, UN Doc CCPR/C/55/D/596/1994 (1995) at [9.4]; *Elahie v Jamaica*, Communication No. 533/1993, UN Doc CCPR/C/60/D/533/1993 (1997) at [8.3]; *Brown v Jamaica*, Communication No. 775/1997, UN Doc CCPR/C/65/D/775/1997 (1999) at [3.2], [6.5]; *Jones v Jamaica*, Communication No. 585/1994, UN Doc CCPR/C/62/D/585/1994 (1998) at [9.4]; *Marshall v Jamaica*, Communication No. 730/1996, UN Doc CCPR/C/64/D/730/1996 (1998) at [6.7]. See also S Joseph, J Schultz & M Castan, *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary* (2004) 280.

11 The Standard Minimum Rules were approved by the UN Economic and Social Council in 1957.

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They were subsequently adopted by the UN General Assembly in resolutions 2858 of 1971 and 3144 of 1983: UN Doc A/COMF/611, Annex 1.

12 The Body of Principles were adopted by the UN General Assembly in resolution 43/173 of 9 December 1988 Annex: UN Doc A/43/49 (1988).

13 UNHRC General Comment 21 (Replaces general comment 9 concerning humane treatment of persons deprived of liberty) UN Doc HRI\GEN\1\Rev.1 AT 33 (1994) at [5]. See also *Mukong v Cameroon*, Communication No. 458/1991, UN Doc CCPR/C/51/458/1991 at [9.3].

14 (1938) 60 CLR 266.

15 Ibid 362.

16 I should note that there is some uncertainty as to whether the nature of Mr Nguyen's family in Melbourne consisted of a son and daughter-in-law or daughter and son-in-law. This distinction is not material for the purposes of this report. For convenience, I have proceeded on the assumption that the relationship was the former.

17 M Nowak, *UN Covenant on Civil and Political Rights CCPR Commentary* (2nd ed, 2005) 518.

18 Communication No. 893/1999, UN Doc CCPR/C/77/D/893/1999 (2003).

19 Ibid [4.7].

20 Ibid [4.7]-[4.9].

21 Ibid [7.4]-[7.5].

22 See also *Canepa v. Canada*, Communication No. 558/1993 UN Doc CCPR/C/59/D/558/1993 where the author argued that the State had breached articles 17(1) and 23(1) by failing to provide clear legislative recognition of the protection of the family in respect of persons in his position. In response to this issue, the Committee stated, at [6.3]: 'To the extent that the author's claims refer to the failure of the Canadian legislature to guarantee the family life of non-Canadian residents in general, his communication is ... inadmissible.'

23 See, eg, *Stewart v Canada*, Communication No. 538/1993 UN Doc CCPR/C/59/D/558/1993 at [12.10]; *Hopu et al. v. France*, Communication No. 549/1993 UN Doc CCPR/C/60/D/549/1993 at [10.3]; *Truong v. Canada,* Communication No. 743/1997 UN Doc CCPR/C/77/D/743/1997 at [7.4]; *Winata v. Australia*, Communication No. 930/2000 ICCPR, UN Doc A/56/40 vol. II at [7.1] – [7.3]; *Bakhtiyari v. Australia*, Communication No. 1069/2002 UN Doc CCPR/C/79/D/1069/2002 at [9.6]; *Buckle v. New Zealand*, Communication No. 858/1999 ICCPR, UN Doc A/56/40 vol. II at [9.1] – [9.2]; *Mauritian Women v. Mauritius* Communication No. 35/1978 CCPR, UN Doc A/36/40/1978 at [9.2] – [10.1]; *Mónaco v. Argentina*, Communication No. 400/1990, UN Doc CCPR/C/53/D/400/1990 at [10.4]; *Rajan v. New Zealand* Communication No. 820/1998 UN Doc CCPR/C/78/D/820/1998 at [7.3]. See also the Individual Opinion of Abdelfattah Amor, Prafullachandra Natwarlal Bhagwati, Pilar Gaitan de Pombo and Hipólito Solari Yrigoyen in *Toala et al. v. New Zealand*, Communication No. 675/1995 ICCPR, UN Doc A/56/40 vol. II. I note that in *Patera v Czech Republic*, Communication No. 946/2000 UN Doc CCPR/C/75/D/946/2000 the UNHRC concluded that there was a breach of article 17(1). There was no discussion of whether article 23(1) had also been breached, although this was presumably because no breach of article 23 had been alleged in the complaint. See also *Coronel v Columbia*, Communication No. 778/1997 UN Doc CCPR/C/76/D/778/1997.

24 Compare UNHRC General Comment 16 (Article 17: The right to respect of privacy, family, home and correspondence, and protection of honour and reputation) with UNHRC General Comment 19 (Article 23: Protection of the Family, the Right to Marriage and Equality of the Spouses).

25 S Joseph, J Schultz & M Castan, *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary* (2004) 586.

26 M Nowak, *UN Covenant on Civil and Political Rights CCPR Commentary*, (2nd ed, 2005) 520.

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27 Communication No. 930/2000 UN Doc CCPR/C/72/D/930/2000.

28 Ibid [7.3].

29 See, eg, *Stewart v Canada*, Communication No. 538/1993 UN Doc CCPR/C/59/D/558/1993 at [12.10]; *Hopu et al. v. France*, Communication No. 549/1993 UN Doc CCPR/C/60/D/549/1993 at [10.3]. However, compare the approach taken in *Canepa v. Canada*, Communication No. 558/1993 UN Doc CCPR/C/59/D/558/1993 where the UNHRC concluded that the deportation of the author did not constitute an arbitrary interference with his family under article 17(1). Rather than applying this same approach or conclusion in relation to article 23(1), the UNHRC simply stated, at [11.6]: 'the facts of the case do not raise an issue under article 23 of the Covenant.'

30 See, eg, UNHRC General Comment 16 (Article 17: The right to respect of privacy, family, home and correspondence, and protection of honour and reputation) at [5]; UNHRC General Comment 19 (Article 23: Protection of the Family, the Right to Marriage and Equality of the Spouses) at [2]; *Hendriks v Netherlands*, Communication No. 201/1985, UN Doc CCPR/C/33/D/201/1985 (1988) at [10.3].

31 S Joseph, J Schultz & M Castan, *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary* (2004) 589.

32 Communication No. 417/1990, UN Doc CCPR/C/51/D/417/1990 (1994).

33 Ibid [10.2]. See also *A.S. v Canada*, Communication No. 68/1980, UN Doc CCPR/C/OP/1 at 27 (1985), where the UNHRC did not accept that the author and her adopted daughter met the definition of 'family' because they had not lived together as a family except for a period of 2 years approximately 17 years prior.

34 *Mauritian Women v Mauritius*, Communication No. 35/1978, UN Doc CCPR/C/OP/1 at 67 (1985) at [9.2(b)].

35 I note that a similar argument to this was rejected by the majority in Winata v Australia, Communication No. 930/2000, UN Doc CCPR/C/72/D/930/2000 (2001), at [4.8] – [4.10]. However, the argument attracted some support in the Individual Opinion in that case of Committee members Prafullachandra Natwarlal Bhagwati, Tawfik Khalil, David Kretzmer and Max Yalden (dissenting) at [3]. This argument also attracted some support in the Individual Opinion of Martin Schenin in *Canepa v Canada*, Communication No. 558/1993 UN Doc CCPR/C/59/D/558/1993.

36 *Toonen v. Australia*, Communication No. 488/1992, UN Doc CCPR/C/50/D/488/1992 (1994) at [8.2]: 'The Committee considers that Sections 122(a), (c) and 123 of the Tasmanian Criminal Code "interfere" with the author's privacy, even if these provisions have not been enforced for a decade.'

37 See, eg, *Estrella v. Uruguay*, Communication No. 74/1980 UN Doc ICCPR, A/38/40 (29 March 1983) 150 at [9.2]: 'With regard to the censorship of Miguel Angel Estrella's correspondence, the Committee accepts that it is normal for prison authorities to exercise measures of control and censorship over prisoners' correspondence. Nevertheless, article 17 of the Covenant provides that "no one shall be subjected to arbitrary or unlawful interference with his correspondence". This requires that **any such measures** of control or censorship shall be subject to satisfactory legal safeguards against arbitrary application.' (emphasis added).

38 HREOC Act s 20(c)(ii).

39 UNHRC General Comment 16 (The right to respect of privacy, family, home and correspondence, and protection of honour and reputation) at [4].

40 S Joseph, J Schultz & M Castan, *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary* (2004) 482-3.

41 Communication No. 488/1992 UN Doc CCPR/C/50/D/488/1992.

42 Ibid [8.3]. Whilst this case concerned a breach of article 17(1) in relation to privacy, these comments would apply equally to an arbitrary interference with family.

43 See, eg, *Stewart v Canada*, Communication No. 538/1993, UN Doc CCPR/C/58/D/538/1993 (1996) at [12.10]; *Winata v Australia*, Communication No. 930/2000, UN Doc CCPR/C/72/D/930/2000 (2001) at [7.3]; *Hopu and Bessert v France*, Communication No. 549/1993, UN Doc CCPR/C/60/D/549/1993/Rev.1. (1997) at [10.3]; *Buckle v. New Zealand*, Communication No. 858/1999, UN Doc CCPR/C/70/D/858/1999 (2000) at [9.1] – [9.2].

44 The UNHRC has emphasised that the failure of a State to take into consideration a detained person's individual circumstances may render that person's detention arbitrary. See, eg, *Shafiq v Australia*, Communication No. 1324/2004, UN Doc CCPR/C/88/D/1324/2004 (2006) at [7.2]-[7.3]; *A v Australia* Communication No. 560/1993, UN Doc CCPR/C/59/D/560/1993 (1997) at [9.4]; *C v Australia* Communication No. 900/1999, UN Doc CCPR/C/76/D/900/1999 (2002) at [8.2].

45 Communication No. 74/1980, UN Doc CCPR/C/OP/2 at 93 (1990).

46 Ibid [9.2].

47 Principle 15: 'Notwithstanding the exceptions contained in principle 16, paragraph 4, and principle 18, paragraph 3, communication of the detained or imprisoned person with the outside world, and in particular his family or counsel, shall not be denied for more than a matter of days.'

48 See *VMRB v Canada*, Communication No. 236/1987, UN Doc CCPR/C/33/D/236/1987 (1988).

49 *Generic Operational Procedure 12.11 – The Use of Force*, s 4.6.1.

50 *Generic Operational Procedure 12.11 – The Use of Force*, s 4.5.1.

51 *Generic Operational Procedure 12.11 – The Use of Force*; s 4.2.1.

52 *Generic Operational Procedure 12.11 – The Use of Force*; s 4.3.2.

53 *Generic Operational Procedure 12.5 – External Transport and Escort Services*.

54 M Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (2nd ed, 2005) 160.

55 UNHRC General Comment 20 (Replaces general comment 7 concerning prohibition of torture and cruel treatment and punishment) at [4].

56 Ibid [5].

57 *Vuolanne v Finland*, Communication No. 265/1987, UN Doc CCPR/C/35/D/265/1987 (1989) at [9.2]

58 See, eg, *Garcia v Colombia*, Communication No. 687/1996, UN Doc CCPR/C/71/D/687/1996 (2001); *Quinteros v Uruguay*, Communication No. 107/1981, UN Doc CCPR/C/OP/2 at 11 (1990); *Sarma v Sri Lanka*, Communication No. 950/2000, UN Doc CCPR/C/78/D/950/2000 (2003) at [9.5].

59 S Joseph, J Schultz & M Castan, *The International Covenant on Civil and Political Rights: Cases, Materials and Commentary* (2004) 209.

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60 M Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (2nd ed, 2005) 163.

61 Communication No. 255/1987, UN Doc CCPR/C/46/D/255/1987 (1992).

62 Communication No. 334/1988, UN Doc CCPR/C/47/D/334/1988 (1993).

63 Communication No. 407/1990, UN Doc CCPR/C/51/D/407/1990 (1994).

64 Communication No. 619/1995, UN Doc CCPR/C/62/D/619/1995 (1998).

65 Communication No. 414/1990, UN Doc CCPR/C/51/D/414/1990 (1994).

66 Communication No. 577/1994, UN Doc CCPR/C/61/D/577/1994 (1998).

67 Communication Nos. 241/1987 and 242/1987, UN Doc CCPR/C/37/D/241/1987 (1989) at [13].

68 M Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (2nd ed, 2005) 165.

69 Ibid 165-6.

70 Communication No. 188/1984 UN Doc ICCPR, A/43/40 (5 November 1987) 207 at [11].

71 Communication No. 320/1988 UN Doc CCPR/C/47/D/320/1988 at [12.4].

72 Communication No. 321/1988 UN Doc CCPR/C/49/D/321/1993 at [9.2].

73 Communication No. 615/1995 UN Doc CCPR/C/61/D/615/1995 at [5.2].

74 Communication No. 577/1994 UN Doc ICCPR, A/53/40 vol. II (6 November 1997) 36 at [8.5].

75 See, eg, *Pinto v Trinidad and Tobago*, Communication No. 232/1987, UN Doc CCPR/C/39/D/232/1987 at [12.7]; *Kelly v Jamaica*, Communication No. 253/1987, UN Doc CCPR/C/41/D/253/1987 at [5.7]; *Smith and Stewart v Jamaica*, Communication No. 688/1995, UN Doc CCPR/C/65/D/668/1995 at [7.5]; *Brown v Jamaica*, Communication No. 775/1997, UN Doc CCPR/C/65/D/775/1997 at [6.13]; *Simpson v Jamaica*, Communication No. 695/1996, UN Doc CCPR/C/73/D/695/1996 at [7.2]; *Morgan and Williams v Jamaica*, Communication No. 720/1996, UN Doc CCPR/C/64/D/720/1996 at [7.2]; *Williams v Jamaica*, Communication No. 609/1995, UN Doc CCPR/C/61/D/609/1995 at [6.5].

76 Generic Operational Procedure No. 6.2 – Health Care Provision.

77 Clause 4.4.9.

78 Although I note that in *Cariboni v Uruguay*, Communication No. 159/1983, UN Doc CCPR/C/OP/2 at 189 (1990) the author complained about various aspects of his detention. One of those complaints was that he was not given any regular medical care and was only watched over by a military nurse. The Committee found a violation of article 10(1) in relation to the conditions of detention. However, in its reasons it did not discuss the extent to which that conclusion was based on the level of medical treatment provided and whether provision of a nurse was sufficient for ensuring adequate medical care: see, esp at [4] and [10].

79 See, eg, *Howell v. Jamaica*, Communication No. 798/1998, UN Doc CCPR/C/79/D/798/1998 (2003) at [6.2]: '...the Committee considers that the author's conditions of detention, taken together with the lack of medical and dental care ..., violate the author's right to be treated with humanity and respect for the dignity of his person under article 10 (1) of the Covenant.' In a recent decision of the European Court of Human Rights, the Court found that inadequate medical care constituted, in the facts of that case, inhuman and degrading treatment: *Holomiov v Moldova* (Application No. 30649/05) 7 November 2006 (European Court of Human Rights).

80 HREOC Act s 29(2)(a).

81 HREOC Act s 29(2)(b).

82 HREOC Act s 29(2)(c).

83 *Peacock v The Commonwealth* (2000) 104 FCR 464, 483 (Wilcox J).

84 See *Hall v A & A Sheiban Pty Limited* (1989) 20 FCR 217, 239 (Lockhart J).

85 *Sharman v Evans* (1977) 138 CLR 563, 589 (Gibbs and Stephen JJ).

86 ICCPR article 4(2). Compare with, for example, articles 12(3), 18(3), 19(3), 21 and 22, which allow for limitation of those rights in the interests of public order or similar purposes.

87 See, eg, UNHRC General Comment 20 (Replaces general comment 7 on concerning prohibition of torture and cruel treatment or punishment) at [3]:'no justification or extenuating circumstances may be invoked to excuse a violation of article 7 for any reasons'; UNHRC General Comment 31 (The Nature of the General Legal Obligation Imposed on States Parties to the Covenant) at [18]: 'failure to bring to justice perpetrators of such violations, could in and of itself give rise to a separate breach of the Covenant.' In making this comment, the UNHRC was referring particularly to violations of articles 6, 7 and 9 of the ICCPR. See, generally, M Nowak, *UN Covenant on Civil and Political Rights: CCPR Commentary* (2nd ed, 2005) 157-8.

88 See, eg, *Blanco v Nicaragua*, Communication No. 328/1988, UN Doc CCPR/C/51/D/328/1988 at [10.6].

89 D Shelton, *Remedies in International Human Rights Law* (2000) 151.

90 (1938) 60 CLR 336, 361-2, as discussed further in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 110 ALR 449; G v H (1994) 181 CLR 387.