ADDENDUM TO INVESTIGATION REPORT EVE00205473

INVESTIGATION REPORT – ADDENDUM

Investigation Number: EVE00205473

Background

1. This is an addendum to the report (dated 21 July 2011) of a Comcare investigation into the health and safety of federal workers, contractors and detainees at Immigration Detention Facilities (IDFs) controlled by the Department of Immigration and Citizenship (DIAC) (the Report).

2. The addendum sets out some minor amendments to the report. The amendments (which should be read with the report) provide clarification only, and do not alter the findings and conclusions contained in the report.

Amendments

3. The following paragraphs of the report to which the amendments relate are:

   • **Paragraph 50:** the amendment removes the reference to ‘current’ numbers at the CI Northwest Point Immigration Detention Centre and is amended to read:

   50. The current Detention Services Contract between DIAC and Serco states, "The Service Provider will ensure that the personnel levels at the Facilities are adequate to deliver the Services in accordance with this Contract." It also provides capacity details for each centre, which are not complied with. As an example, as at 12 April 2011 the detainee numbers at the CI Northwest Point Immigration Detention Centre (IDC) is said to be over 1000; however the DIAC/Serco contract states, "Northwest Point IDC has an operational capacity of 400 and a surge capacity of 800."
• **Paragraph 89:** the amendment reflects that DIAC sent a notification about the incident which occurred at Maribyrnong IDF on 5 July [redacted] in which the attempted escape by a detainee resulted in injuries treated by surgery. The notification was received by Comcare on 19 July 2011, two days in advance of the Report being finalised. Paragraph 89 is amended to read:

89. Evidence confirms that DIAC continues to fail to notify Comcare of incidents within the required timeframe. DIAC has on a number of occasions advised of their preference to first of all confirm the extent of the incident before notifying Comcare. This decision-making process causes Comcare to often be alerted by the media (rather than DIAC) of DIAC’s notifiable incidents. Recent examples include:

- In July 2011, the media reported an alleged incident at the Maribyrnong IDF as: ‘an escape, attempted escape and injuries to a detainee’. DIAC later confirmed to Comcare that a detainee had undergone surgery to treat injuries received in an attempted escape. DIAC also acknowledged that the matter should have been notified and subsequently notified it to Comcare on 19 July 2011. Serious personal injuries are required to be notified to Comcare within 24 hours of the employer becoming aware that the person has, or is likely to have suffered the injury.

- In July 2011, the media reported on an alleged incident at the Darwin IDF as: ‘detainees protesting on detention centre rooftop’. DIAC confirmed to Comcare that the protest had occurred.’

89. At the time of writing this report, Comcare had received notification of the former incident only. This notification was made some two weeks after the incident occurred, which is not within the legislatively prescribed timeframe.

4. The above amendments are the only amendments made to the Report.

Rhonda Murray

Investigator appointed under section 40 of the *Occupational Health and Safety Act 1991*

5 August 2011
21 July 2011

File Ref: EVE00205473

Mr Andrew Metcalfe
Secretary
Department of Immigration and Citizenship
6 Chan St
Belconnen ACT 2617

Dear Mr Metcalfe


I am writing to advise you of the findings of an investigation conducted by Comcare into concerns about the occupational health and safety (OHS) of federal workers, contractors and third parties including detainees at Immigration Detention Facilities (IDFs) that the Department of Immigration and Citizenship (DIAC) controls. The investigation is now complete. A copy of the investigation report is attached.

The investigator concluded that there are a number of non-compliances evident nationally across all facilities which mean that DIAC is failing to comply with its duties under the *Occupational Health and Safety Act 1991* (the Act) and associated regulations (further details appear on the attached investigation report). The investigator has provided a number of recommendations in the attached report related to these non-compliances and does not believe at this stage that they warrant enforcement action.

GPO BOX 9905
CANBERRA ACT 2601
P 1300 366 979
COMCARE.GOV.AU
Would you please provide to me by 22 August 2011, a plan addressing the action taken or proposed to be taken in relation to the recommendations contained in the investigation report and the expected date of completion of each outstanding action? This request is made under section 53(4) of the Act. Comcare reserves the right to review the implementation of the above action plan by DIAC.

If you have any questions, please contact Miss Rhonda Murray by telephone on (03) 9914 6336 or by email at rhonda.murray@comcare.gov.au.

Please direct your response to:

Rhonda Murray  
Director, Regional Service, Victoria/Tasmania  
Work Health and Safety Group  
GPO Box 9905  
Canberra ACT 2601

Yours sincerely,

Neil Quarmby  
General Manager  
Work Health and Safety Group

P: Ph 02 6275 0075  
M: 0434 070 866  
F: 02 6274 8625

Encl: Final Investigation Report
INVESTIGATION REPORT
Investigation Number: EVE00205473

Brief Overview

1. Comcare for some time has had concerns about the occupational health and safety (OHS) of federal workers, contractors and detainees at Immigration Detention Facilities (IDFs) that the Department of Immigration and Citizenship (DIAC) controlled. The concerns included the impact of work pressure and the risk of harm and mental stress.

2. In 2008, Comcare commenced an investigation into an attempted suicide of a detainee at the Perth IDF. In this investigation, Comcare focussed on contractual arrangements with IDF operators to ensure that DIAC’s duty of care under the Occupational Health and Safety Act 1991 (the OHS Act) was being met. At the conclusion of the investigation, Comcare recommended that, “DIAC provides employees and contractors with clear and unambiguous policies and procedures to be followed while performing custodial care to detainees at risk of suicide and self harm”.

3. In early 2010, Comcare entered into Cooperative Compliance¹ activities with DIAC in an attempt to resolve concerns about the unique factors at the Christmas Island (CI) IDF. By the end of 2010, the lack of cooperation exhibited by DIAC became such that a meeting between Comcare’s senior executive and DIAC was held to flag Comcare’s intentions of escalation.

4. Comcare’s concerns increased with the adverse findings on similar issues in a number of independent reports on DIAC’s management of detention facilities, for example, the Commonwealth and Immigration Ombudsman’s February 2011 report on Christmas Island and the Australian Human Rights Commission May 2011 report on Villawood. Significant concerns were also raised in both the domestic and international media that warranted Comcare’s attention.

5. In February 2011, Comcare investigators accompanied DIAC Canberra staff to CI. DIAC set Comcare an extremely tight itinerary that restricted Comcare’s ability to conduct ad hoc conversations with people or undertake inspections outside DIAC’s agenda.

¹ Cooperative Compliance is a targeted strategy to improve work health and safety compliance by working with employers that have been identified as requiring significant improvements.

This report has been prepared under section 53 of the Occupational Health and Safety Act 1991 (Cth) (the OHS Act) and is the property of the Safety, Rehabilitation and Compensation Commission (the Commission). Except as authorised by section 53 or another provision of the OHS Act, or otherwise required by or under statute, this report must not be published or reproduced without the written permission of the Commission.
INVESTIGATION-IN-CONFIDENCE

6. As a consequence of the tight itinerary, Comcare sought the documentation (Attachment A) they had hoped to gain during their visit. On leaving CI, DIAC advised Comcare that they were unable to provide the requested information because the DIAC hierarchy would not allow its release.

7. A meeting was later held between senior executive staff from DIAC and Comcare where documentation originally sought at CI was discussed. DIAC advised that it would consider providing the information but that it would take some time.

8. Comcare’s concerns about DIAC’s monitoring of and responding to health and safety issues at IDF’s were mounting. Comcare engaged with relevant state and territory OHS regulators to identify OHS concerns and safety gaps. It was agreed that a joint visit to the seven IDF’s identified as most critical be conducted.

9. On 25 March 2011, Comcare commenced an investigation under the OHS Act into DIAC’s management of the health and safety of detainees at IDF’s and the potential impact on the health and safety of DIAC employees and contractors at the following workplaces controlled by DIAC:
   • Christmas Island – Murray Road, North West Point, Christmas Island WA
   • Curtin – Curtin RAAF Base, Derby Highway, Derby WA
   • Inverbrackie – 100 Woodside-Nairne Road, Inverbrackie SA
   • Maribyrnong – 53 Hampstead Road, Maidstone Vic
   • Northern – Stuart Highway, Berrimah NT
   • Scherger – RAAF Base Scherger, Mission River Qld and
   • Villawood – 15 Birmingham Avenue, Villawood NSW.

10. The scope of the investigation was to verify that DIAC was complying with the broad overarching health and safety requirements of the OHS Act and the Occupational Health and Safety (Safety Standards) Regulations 1994 (the OHS Regulations).

11. The DIAC Secretary, when advised about the commencement of the investigation, committed to work cooperatively with Comcare in every possible way to ensure that DIAC’s obligations were met.

12. An IDF-specific verification checklist was used as a prompt for investigators. The checklist provided a consistent and systematic process for investigators to use as the basis of verifying DIAC’s OHS obligations in respect to its: structures, policies, procedures and practices. This included their implementation in IDF’s to determine whether they effectively supported the health and safety of employees, contractors and third parties in matters over which DIAC had responsibility under their duty of care in accordance with the legislation. At the request of DIAC, a template verification checklist is attached, should DIAC want to use it as the basis for future self-audits (Attachment B).

13. Joint visits between Comcare and state and territory OHS inspectors were conducted at the above-mentioned IDF’s over a two week period in March and April 2011. State regulators issued a range of improvement notices at a number of IDF’s.
14. At the commencement of each IDF visit, Comcare investigators provided an opening briefing to staff nominated by DIAC and highlighted the purpose of the investigation and laid a foundation of cooperation. The verification process included: physical inspections of the site and plant, conversations with detainees, and staff from both DIAC and Serco Australia Pty Ltd (Serco) (DIAC’s contracted IDF management).

15. At the conclusion of each visit, Comcare debriefed staff to highlight in real-time any site-specific areas of concern as well as relevant findings across other IDF’s visited.

16. During the Villawood visit in April 2011, significant and pressing health and safety issues were identified and an Improvement Notice (Attachment C) was issued. The notice focussed on:

16.1. Villawood’s lower level of security arrangements, and

16.2. the lack of risk management concerning the transfer to Villawood of the group of 10 alleged ring-leaders from the March 2011 riots at CI.

17. Three additional investigations were also commenced by Comcare into an incident at the Scherger IDF as well as the death of a detainee at both the Scherger and Curtin IDFs. Findings of these additional investigations will be reported separately.

Conclusions

18. Comcare’s investigation was conducted during a period of extraordinary demand on DIAC’s facilities and challenging pressures on IDF systems and people. The investigation found that overcrowding consistently presented itself as the most prevalent health and safety concern to staff across IDFs. While Comcare acknowledges that DIAC systems were under enormous strain, the effects of overcrowding in IDFs placed the health and safety of DIAC staff, their contractors and detainees at risk.

19. Standards of OHS varied across IDFs, with Inverbrackie (Adelaide) having the highest standard at the time of the visits. This higher standard was attributed to the open plan layout of the facility, low level of physical security and that the predominant detainee group was families; including young children. Villawood IDF was assessed as the facility with the most serious risks.

20. A number of improvements based on feedback provided by investigators have since been observed in IDFs; these were particularly apparent at Villawood.

21. Key areas of non-compliance were evident across all facilities. Of particular concern was the lack of effective risk assessment of DIAC’s systems of work.

22. A further area of non-compliance evident across all facilities was the lack of established local OHS leadership in operation. While fundamental OHS practices were seen to be in place, there was little evidence of local staff engaging in them. Instead evidence showed that ‘Canberra’ was seen to own OHS – not staff on the ground. DIAC’s approach to controlling OHS through its corporate support processes is seen to disempower local leadership from taking ownership of health and safety outcomes; a consequence that can lead to avoidance behaviours.
23. Based on the evidence gathered and the findings of fact below, I find that DIAC failed to comply with its health and safety obligations in the following five areas of significant risk across all IDFs in the period leading up to and during the Comcare investigation:

23.1. Risk Management
   1.05(1) OHS Regulations
   DIAC failed to have a documented site/role-specific risk assessment process across the IDFs or to ensure that Serco conducted effective risk assessment on its behalf. Such failure posed a risk to the health or safety of DIAC employees or contractors at work.

23.2. Staffing Ratios
   Section 16(2)(a) OHS Act
   DIAC failed to have a staff/detainee ratio level identified and implemented. Nor did it have a system for ensuring that ratios are adjusted according to identified levels of risk. In doing so, it failed to take all reasonably practicable steps to provide a working environment (including systems of work) that was safe for DIAC employees and contractors (and without risk to their health).

23.3. Staff Training
   Section 16(2)(e) OHS Act
   DIAC failed to take all reasonably practicable steps to ensure that DIAC and Serco staff were sufficiently trained and therefore competent and confident in performing their required roles.

23.4. Critical Incident Management
   Sections 16(2)(a) and 16(2)(e) OHS Act
   DIAC failed to take all reasonably practicable steps to protect the health and safety at work of DIAC employees and contractors by:
   23.4.1. failing to ensure that effective critical incident management plans were in place to deal with high risk situations such as threatened suicide, detainee violence etcetera
   23.4.2. failing to provide to the employees and contractors, in appropriate languages, the information, instruction, training and supervision necessary to enable them to perform their work in a manner that was safe and without risk to their health (specifically in relation to critical incidents)

23.5. Diversity of Third Parties i.e. detainees
   Section 17 OHS Act
   DIAC failed to take all reasonably practicable steps to ensure third parties i.e. detainees were not exposed to risk to their health and safety arising from the conduct from DIAC's undertaking by failing to identify and appropriately manage the diversity of detainees in areas such as: religion, culture, ethnic origin and individual needs.
Recommendations

24. I recommend that DIAC focus on developing OHS policy at the national level and invest in local leaders for their engagement and effective localised implementation of OHS policy and practice in order to maximise consistency while at the same time encouraging local leadership to own their OHS problems and solutions.

25. I recommend that the current level of DIAC's reporting of notifiable incidents to Comcare be further explored by DIAC to:

25.1. identify whether recent significant increases are caused by an actual increase in the number of incidents or an increase in the number of incidents being reported

25.2. ensure that DIAC can be satisfied that all notifiable incidents are captured and notified.

26. I recommend that the best-practice positive behaviours (of Serco in particular) being implemented in an IDF (CI in particular) be identified by DIAC and considered for implementation at other IDFs (see paragraphs 78 and 79 below).

27. I recommend that a comprehensive risk assessment process that accords with AS/NZS 4801:2001 and AS/NZS 4360:2004 be conducted to assess and manage the risks to staff, contractors, detainees and visitors to IDFs associated with the conduct of DIAC's detention of asylum seekers and addresses:

27.1. documenting a staff/detainee ratio to identify adequate staff/detainee levels and coping strategies should the ratio be unachievable

27.2. the effectiveness of the current risk assessment methodology used to determine the individual level of risk of each Irregular Maritime Arrivals (IMAs) at the time of entering Australia

27.3. the necessary training needs specific to each IDF role and that the identified training requirements be reflected in duty statements

27.4. critical incident planning across all IDFs, and

27.5. the management of overcrowding.

28. I recommend that a staff awareness campaign be conducted to emphasise:

28.1. DIAC's OHS policies and procedures to highlight their existence and how they should be applied on the ground at each individual IDF

28.2. OHS responsibility of DIAC staff in respect of DIAC's responsibilities to its contractors and detainees.

29. I recommend that the differences between detainees, whether they be cultural, racial, religious or their personal stage in detention, be further explored by DIAC and considered when accommodating them.
Findings of Fact

30. The conclusions listed above are based on the following findings of fact:

31. I find that DIAC was an employer (as defined by section 5 of the OHS Act) at the time of the investigation.

32. I find that as an employer, DIAC must take all reasonably practicable steps to protect the health and safety of employees, contractors and third parties i.e. detainees in accordance with section 16(1) of the OHS Act.

33. I find that as an employer, DIAC must provide a working environment that is safe for both the physical health and the psychological wellbeing of DIAC employees and (subject to some limitations) contractors such as Serco in accordance with section 16(1) of the OHS Act.

34. I find that as an employer, DIAC also has a general duty to take all reasonably practicable steps to ensure that third parties, including detainees, are not exposed to a risk to their health and safety arising from any activity done in the course of DIAC's business in accordance with section 17 of the OHS Act.

35. I find that as an employer, DIAC failed, in relation to the five matters summarised in paragraph 23 of this report, to take all reasonably practicable steps to protect the health and safety of its employees, contractors and third parties such as detainees in the period leading up to and including the conduct of this investigation.

36. I find that DIAC retains a high level of control over the manner in which and the arrangements in place for the management of detainees by Serco.

37. I find that as an employer, DIAC must notify Comcare of injuries, illnesses or diseases that meet the notification criteria required by section 68 of the OHS Act.

38. I find that there is level of under-reporting of notifiable incidents in accordance with s68 of the OHS Act.

39. I find no evidence that the positive behaviours (by Serco staff in particular) in one IDF (see paragraphs 78 and 79 below) are being identified by DIAC and considered for uniform implementation at other IDFs.

40. I find no evidence of a comprehensive risk assessment process consistent with AS/NZS 401:2001 and AS/NZS 4360:2004 that assesses and manages the risks to staff, contractors, detainees and visitors to IDFs, associated with the conduct of DIAC's operations in the detention and management of immigration detainees.

41. I find that the rudimentary risk assessment methodology used to determine the individual level of risk of IMAs entering Australia is inadequate (see paragraphs 61 to 63 below).

42. I find that DIAC staff are generally unaware of their OHS responsibilities as employees under s21 of the OHS Act in respect to themselves, their colleagues, contractors, detainees and visitors. They are also generally unaware of their role in implementing DIAC's duties under section 16(1) of the OHS Act and instead see the DIAC National Office as being solely responsible.

43. I find that DIAC has not made its staff sufficiently aware of DIAC OHS policies and procedures and how they should be applied on the ground at each individual IDF.
44. I find that the differences between detainees and their associated needs, whether they be: cultural, racial, religious or their personal stage in detention are not sufficiently identified by DIAC to ensure that they are taken into consideration so that the current levels of tension might be reduced.

45. I find that the staff/detainee ratio is not sufficiently risk assessed and documented to identify and ensure adequate levels of staffing at all times.

46. I find that the current levels of DIAC staff training are insufficient and not targeted to the particular requirements of roles.

47. I find that the current levels of critical incident planning for DIAC or Serco staff are insufficient.

**Reasons for Findings of Fact**

48. I made the findings of fact listed above because:

**Overcrowding and Staffing Ratios**

49. The most common concern raised by DIAC and Serco staff as well as detainees was the significant levels of overcrowding at most centres. The increase in numbers of IMAs fluctuates and the overcrowding has been exacerbated by detainee accommodation and DIAC buildings being destroyed during the recent CI and Villawood riots. DIAC is currently exploring other accommodation options to address the current and potential future levels of overcrowding. In the meantime the health and safety of DIAC staff, their contractors and third parties including detainees, may be at risk.

50. The current Detention Services Contract between DIAC and Serco states, "The Service Provider will ensure that the personnel levels at the Facilities are adequate to deliver the Services in accordance with this Contract". It also provides capacity details for each centre, which are not complied with. As an example, the current detainee numbers at the CI North West Point Immigration Detention Centre (IDC) is said to be over 1000; however the DIAC/Serco contract states, "Northwest Point IDC has an operational capacity of 400 and a surge capacity of 800".

51. What the contract fails to provide is any guidance on staff/detainee ratios.

**Legislative Obligations**

52. DIAC must take all reasonably practicable steps to protect the health and safety of employees, contractors and third parties in accordance with the OHS Act. The OHS Act provides for a number of general duties that aim to protect the health, safety and welfare of DIAC employees and contractors at work as well as that of other persons at or near DIAC workplaces, including IDFs.

53. DIAC has a general duty to take all reasonably practicable steps to protect the health and safety of its employees and contractors under section 16 of the OHS Act. This includes ensuring that DIAC provides a working environment that is safe for both the physical health and the psychological wellbeing of DIAC employees and (subject to some limitations) contractors such as Serco and International Health Management Services (IHMSS) staff. The duty also extends to providing safe systems of work, plant and any necessary information, instruction and training.
54. Under section 17 of the OHS Act, DIAC also has a general duty to take all reasonably practicable steps to ensure that third parties, including detainees, are not exposed to a risk to their health and safety arising from any activity done in the course of DIAC's business. Similarly, this duty extends to the protection of physical and psychological health and safety.

55. Under section 68 of the OHS Act, DIAC is required to notify Comcare of accidents and dangerous occurrences that meet the notification criteria. The Notification Decision Flowchart (Attachment D) provides further details.

56. Although the management of detainees is contracted to Serco at the IDF's, the contract in place indicates that DIAC retains a very high level of control over how that management takes place and associated arrangements.

Risk Management

57. Comcare was unable to identify any site-specific risk management procedures. DIAC Canberra staff accompanying the investigators on their IDF site visits during the investigation provided Comcare with a number of general risk policies; however local DIAC staff were unaware of the existence of the policies.

58. The lack of effective risk assessment of DIAC’s systems of work was of particular concern, for example, the focus of the Improvement Notice issued to DIAC at Villawood was the obvious risk associated with transferring the group of alleged ringleaders of the Cl riots to Villawood. Less than three weeks after the group transfer, riots occurred at Villawood. While it is acknowledged that the alleged Cl ringleaders were not involved in the Villawood riots, there were clear indicators (that Villawood staff advise were present at the time) that the riots were reasonably foreseeable. Despite the apparent clear indications, no critical incident plans were in place for staff to follow, should such a situation occur.

59. The inherent risk of not having a site-specific risk assessment is that staff are likely to be unaware that certain equipment, processes or training is required to reduce the level of risk to an acceptable level.

60. Based on information received from DIAC and Serco staff, Comcare had concerns about two particular areas of the detainee-specific risk assessment process:

Risk Assessment of Incoming IMAs

61. The first area of concern relates to the risk assessment process used to assess the individual risk level of IMAs when they first seek asylum in Australia. Serco and DIAC staff advised that all incoming IMAs are initially rated at the ‘Low risk level’ unless something adverse is known about the asylum seeker.

62. Serco staff, who are left to manage the IMAs once they are detained, raised concerns about the rationale behind this hard and fast risk assessment process. Staff suggested that IMAs should, as a matter of course, be initially rated at the High level until more is known that would warrant reducing the level of risk.
Individual Risk Assessment Documentation IMAs

64. The second area of concern relates to the individual risk assessment documentation of detainees where clear evidence was found of information having been cut and pasted from other detainees’ records, with part of the previous detainee’s details still in place. In addition, staff advised that the detainee’s risk profile is not, as a matter of course, transferred with the detainee to the next IDF.

Critical Incident Management

65. Comcare was unable to identify any holistic or site-specific critical incident management procedures in existence. Critical incidents are not unheard of occurrences at IDFs. With riots, detainees self-harming, escapes and the like, Comcare is concerned that there are no established procedures or training on how DIAC or Serco staff on the ground are to manage these types of situations.

Staff Training

66. Both DIAC and Serco staff across all IDFs cited staff training as being significantly deficient. Many DIAC staff deployed to remote locations such as CI highlighted that their pre-deployment training fell well short of meeting their personal and professional needs, for example, pre-deployment training was of a generic nature with little to no information specific to their new location.

67. Serco staff also advised investigators that they did not feel sufficiently trained to do their role, for example, what to do in case of an evacuation and the expected response to a riot or a detainee self-harming.

68. DIAC staff also raised concerns about role-specific training not being identified as a job requirement for certain roles with significant responsibility, for example, those in senior roles needing critical incident management training.

Culture within IDFs

69. The culture in each IDF is different, but is commonly one where the majority of staff are committed to their role and well aware of the importance of their role and their impact on the workplace. While there was little evidence that staff were aware of OHS policies and procedures, Comcare recognises that staff in general were seen to be working well and doing what was expected of them. In the more remote IDFs, such as CI, it was readily apparent that the staff of DIAC and Serco work together as a community both within and outside of the IDF.
Responsibility at the IDF}s

70. A consistent concern identified at each IDF was the lack of understanding by DIAC staff of their OHS responsibilities on the ground. When asked about safety or the wellbeing of detainees, DIAC staff consistently replied that the responsibility for detainees was with Serco. Furthermore, when DIAC staff were asked about OHS policies and procedures, for example, how to manage risks or critical incidents, the usual response was, “Canberra looks after that”.

71. The majority of DIAC staff at IDF{s were unable to put their hands on or explain the contents of a policy or necessary practice when asked. A consequence of this lack of awareness and/or understanding of policies is that staff are generally unable to assist DIAC to roll out national policies at the local level. Staff are also not sufficiently familiar with their individual OHS responsibilities as employees.

72. This approach was seen by Comcare investigators as a significant contributor to local leaders not accepting responsibility for OHS. It was also seen as a cause for local leaders not having engaged with or rolled out national OHS policies and practices and therefore weakening the health and safety on the ground at each facility.

73. At some IDF{s, OHS improvements were being implemented while Comcare investigators were at the facility, for example, the list of Health and Safety Representatives at the Darwin IDF was placed on the noticeboard during the day of the Comcare visit.

Differences at IDF{s

74. A significant difference in DIAC and Serco staff responsibilities at IDF{s is that DIAC staff deliver the outcomes of visa applications to detainees. Delivering a ‘negative hand-down’ i.e. when a visa application has been disallowed, can and does lead to animosity being directed by detainees towards DIAC staff. The planning before delivering a negative hand-down is extensive and takes into account the mental health of the detainee and more often than not, involves IHMS to assist in the OHS needs of detainees and staff.

Christmas Island

75. When first visiting CI in February 2011, Comcare investigators noted the high level of tension felt at the facility. There seemed a reluctance of detainees to engage with staff, whether they were Serco, DIAC or Comcare investigators.

76. During the CI riots in March 2011, it was reported and confirmed by the Australian Federal Police (AFP) that at the time of rioting, detainees pushed Serco staff into rooms to protect them and went about burning DIAC buildings. Serco staff seemed well aware of the protection offered to them by detainees. However, the DIAC staff spoken to seemed unaware that DIAC buildings had been targeted and that DIAC staff may be at greater risk.

77. In April 2011, when Comcare investigators returned to CI, there was still evidence of agitation among the detainees; however the level of agitation seemed to have reduced significantly from the February visit. During the April visit, detainees approached Comcare Investigators and openly discussed a number of issues. The
level of trust built so quickly between detainees and investigators that the detainees offered the investigators cold soft drinks and confectionary from their own personal supplies. In their discussions, the detainees seemed relaxed and praised the cooperative approach of Serco staff.

78. Indications of cultural change were observed in a number of detainees who were seen to be self-regulating their own behaviour and that of others. Initiatives recently rolled out by Serco staff at CI appear to be increasing detainees’ morale and reducing conflict. Initiatives affecting this cultural change appear to be:

- Stopping all-day breakfasts, to motivate detainees to be awake when the majority of staff are rostered on
- Restricting access to accommodation areas, to allow detainees to have a ‘home’ of sorts and a place to take refuge if necessary. This concept has seen detainees for the first time take pride in their areas
- Encouraging racial integration through Australian culture lesson as well as mixed-race teams to participate in sporting activities, for example, Aussie Rules teams comprising of different countries.

79. A senior Serco officer explained the new CI approach to detainees as being, “80% of a Serco officer’s work is social work, the other 20% is to make sure they don’t climb the fence”. Evidence of this more humanitarian approach was readily apparent throughout Comcare’s recent CI visit.

Villawood

80. Serco staff provided information about the level of serious assaults on staff, witnessing the deaths of detainees and the distress of having to deal with it. Staff also advised of feeling inadequately trained and the lack of instruction and supervision/support during times of critical incidents. Morale among staff at Villawood at this time was acknowledged by staff as being very low.

81. In mid-May 2011 Comcare revisited Villawood and observed significant improvements, particularly in the areas of: culture, safety and morale of both staff and detainees and the staff/detainee ratio.

82. While the Improvement Notice issued at Villawood on 1 April 2011 was never fully complied with, the immediate safety concerns pertaining to the notice had passed. Comcare has since worked with DIAC to ensure it has a better understanding of the substantiating information it needs to demonstrate for complete compliance with any future Improvement Notice. This information was provided to DIAC in writing at their request (Attachment E).

83. Improvements observed during this investigation, at Villawood in particular, need to be acknowledged. Investigators were pleased to see the significant changes in OHS that had occurred from Comcare’s first visit in April, to their second visit in mid-May 2011, for example, necessary training was being provided for key staff and vital security equipment was replaced.
Tension Amongst Detainees

84. A concern raised by detainees at each IDF visited was the lack of understanding and lack of consideration of differences between detainees. Cultural and religious differences were the main issues raised, for example, rooming detainees together with no regard to their religious beliefs or the long history of extreme conflict between their countries.

85. This lack of understanding was said to be a significant cause of tension between detainees and Serco/DIAC staff, which often resulted in disputes. A common situation mentioned was when new arrivals are given a room to themselves (without valid explanation) while those in detention for lengthy periods continue to have to share a room.

Reporting of Notifiable Incidents

86. In 2008, Comcare provided DIAC with a Process for Incident Notification (Attachment F) in an attempt to assist with DIAC’s reporting requirements. Comcare acknowledges that this schedule caused DIAC some confusion in respect to what is and what is not a notifiable incident. The schedule is now significantly outdated and as such DIAC has been advised in writing that the schedule is no longer recognised by Comcare.

87. The reporting of notifiable accidents and dangerous occurrences by DIAC has significantly increased since the commencement of this investigation. In March 2011, DIAC reported 14 incidents to Comcare for all IDF’s – at the time, this was an increase on the eight reported the month before. By June 2011, the number of incidents reported in that month had increased to 50.

88. The following graph depicts the type of incidents reported during June 2011:

```
Number of National IDF Notified Incidents - June 2011

        Assault of client     2
        Assault of staff       3
        Attempted Suicide      7
        Client protest         2
        Misc                   4
        Self harm              13
        Sewn lips              16
        Wilful damage          3
```

89. Evidence confirms that DIAC continues to fail to notify Comcare of incidents within the required time frame. DIAC has on a number of occasions advised of their preference to first of all confirm the extent of the incident before notifying Comcare. This decision-making process causes Comcare to often be alerted by the media (rather than DIAC) of DIAC’s notifiable incidents. Recent examples include:

- In July 2011, the media reported an alleged incident at the Maribyrnong IDF as: "an escape, attempted escape and injuries to a detainee". DIAC later confirmed to Comcare that a detainee had undergone surgery to treat injuries received in an attempted escape. DIAC also acknowledged that the matter should have been notified.
INVESTIGATION-IN-CONFIDENCE

- In July 2011, the media reported an alleged incident at the Darwin IDF as: 'detainees protesting on detention centre rooftop'. DIAC confirmed to Comcare that the protest had occurred.

89. At the time of writing this report, Comcare has not received a notification from DIAC for either of the above-mentioned incidents.

Relevant Evidence Collected

90. During the investigation, I collected the following evidence and information which are relevant to and support my findings of fact listed above:

- Personal observations during IDF site visits
- Contemporaneous notes
- Photographs taken during IDF site visits
- Audio recordings of conversations conducted during IDF site visits
- Signed witness statements taken during IDF site visits
- Documents provided by DIAC and Serco
- Notes of Comcare investigators taken during IDF site visits and completed investigator tool kits.

Notices Issued

91. An Improvement Notice was issued to DIAC at the Villawood IDF on 1 April 2011.

Rhonda Murray
Investigator appointed under section 40 of the Occupational Health and Safety Act 1991

21 July 2011

Attachments

A. List of Information sought by Comcare from DIAC at Christmas Island, February 2011
B. IDF specific Investigator Verification Checklist
C. Incident Notification Flowchart
D. Comcare Improvement Notice
E. Process for Incident Notification
F. Comcare’s ongoing concerns re Improvement Notice
List of information sought by Comcare from DIAC at Christmas Island, February 2011

Information is sought for Christmas Island from 1 January to 31 December 2010

<table>
<thead>
<tr>
<th>Information Sought</th>
<th>DIAC Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Copies of all health and safety incident reports from the Immigration Detention Centre (IDC)</td>
<td></td>
</tr>
<tr>
<td>2. Copies of all security incident reports from the IDC</td>
<td></td>
</tr>
<tr>
<td>3. Copies of all records of injuries requiring first aid and/or emergency treatment for IDC detainees</td>
<td></td>
</tr>
<tr>
<td>4. Copies of all records of injuries requiring first aid and/or emergency treatment for staff</td>
<td></td>
</tr>
<tr>
<td>5. Copy of all OHS Committee meeting minutes</td>
<td></td>
</tr>
<tr>
<td>6. Record of training of managers in hazard Inspections</td>
<td></td>
</tr>
<tr>
<td>7. Record of hazard inspections conducted</td>
<td></td>
</tr>
<tr>
<td>8. Record of HSR training</td>
<td></td>
</tr>
<tr>
<td>9. Record of emergency evacuation drills conducted</td>
<td></td>
</tr>
<tr>
<td>10. Record of all incident notifications Serco to DIAC</td>
<td></td>
</tr>
<tr>
<td>11. Record of all incident notifications DIAC to Comcare</td>
<td></td>
</tr>
<tr>
<td>12. Record of OHS induction for employees and contracted staff</td>
<td></td>
</tr>
<tr>
<td>13. Policy/guideline to manage the language and/or cultural barriers</td>
<td></td>
</tr>
</tbody>
</table>
IDF specific Investigator Toolkit Part 3

INVESTIGATOR’S TOOLKIT

PART 3: VERIFICATION CHECKLIST

This toolkit is specifically designed for
Comcare Investigators’ conducting
verification checks at Immigration
Detention Facilities Wed 30 March 2011.

* State/Territory DHS Regulators accompanying Comcare may also choose to use this toolkit.

PUTTING YOU FIRST

Further pages of this attachment can be accessed by double-clicking the above image on the original electronic (NON-PDF) version or contacting the author.
Villawood Improvement Notice

Improvement notice
Occupational Health and Safety (Safety Arrangements) Regulations 1991 (paragraph 34 (6))
No. EV6G20647301

To: The Secretary, Department of Immigration and Citizenship (DIAC) (the ‘responsible person’)
Add: Tracey Bell, OHS Manager, DIAC

I, Rhonica Murray, an investigator appointed under section 40 of the Occupational Health and Safety Act 1991 (the ‘Act’), am satisfied that the person named above as the responsible person is breaching or has breached and is likely to breach s 10(1) of the Act and regulations 1.05 and 1.06 of the Occupational Health and Safety (Safety Standards) Regulations 1994 (the ‘SS Regulations’) at:

Villawood Immigration Detention Facility, 16 Birmingham Avenue, Villawood NSW 2163

The reasons for my opinion are:

On 25 March 2011, Comcare commenced an investigation into DIAC’s management of the health and safety of detainees at the Immigration Detention Facilities (IDF’s) and the potential impact of these arrangements on the health and safety of DIAC employees and contractors. As a part of this investigation, Comcare investigators Paul Stevens, John MacNamara and I conducted a site inspection (‘the inspection’) of the Villawood IDF on 1 April 2011 where we:

1. physically inspected the IDF;
2. locked photographs inside and outside the IDF premises and the facility periphery;
3. conducted discussions and interviews with DIAC staff including the Director of the Villawood IDF;
4. conducted discussions and interviews with Serco contractors performing work at the Villawood IDF; and
5. conducted discussions and interviews with current detainees at the Villawood IDF.

During the course of the inspection, we were advised that a group of 10 detainees from the Christmas Island IDF (‘the Christmas Island detainees’) were to be relocated to the Villawood IDF on Monday 4 April 2011. We were advised and are aware that these detainees had previously been involved in violent behaviour at the Christmas Island IDF.

Having conducted an investigation into the incident, including lengthy discussions with the Director of the Villawood Detention Centre, Serco contractors and detainees and for the following reasons, I have formed the opinion that DIAC has not taken all reasonably practicable steps to identify hazards and assess risks to health and safety associated with the relocation of the Christmas Island detainees and consequently to eliminate or minimise those risks:

- A lower level of security arrangements exists at the Villawood IDF than that in place at the Christmas Island IDF including in relation to detainees recreation areas and the existence of broken and missing video cameras;
- There are likely to be significant risks to health and safety associated with the relocation of the Christmas Island detainees to the Villawood IDF;
- During the inspection, the Villawood IDF Director and others were unable to provide evidence to satisfy me that hazards had been properly identified and risks assessed associated with relocation of the Christmas Island detainees to the Villawood IDF;
- During the inspection, the Villawood IDF Director and others were unable to provide evidence to satisfy me that appropriate control measures had been put in place to control the risks associated with the relocation of the Christmas Island IDF detainees to the Villawood IDF;
- During the inspection, the Villawood IDF Director and others were unable to provide evidence to demonstrate that DIAC employees and Serco contractors at the Villawood IDF had been provided with information, instruction and training regarding the risks associated with the relocation and arrival of the Christmas Island detainees at the Villawood IDF.

(see additional notes over)

Copy 1 Responsible person
Copy 2 Comcare
Copy 3 Investigator

Further pages of this attachment can be accessed by double-clicking the above image on the original electronic (in-row) version or contacting the author.
Comcare’s ongoing concerns re Improvement Notice

31 May 2011

Jackie Wilson
Deputy Secretary
Department of Immigration and Citizenship
PO Box 25
Belconnen ACT 2616

By email: jackie.wilson@imm.au.gov.au

Copies: craig.farrell@imm.au.gov.au
Tracey.Bell@imm.au.gov.au

Dear Jackie

Comcare Improvement Notice E000200547301: Department of Immigration and Citizenship (DIAC), Villawood Immigration Detention Facility

I am writing in response to a request on 24 May 2011 from Tracey Bell that DIAC be provided with Comcare’s written views on DIAC’s response to Comcare improvement notice E000200547301 (the Improvement notice), dated 1 April 2011. DIAC provided written responses to the Improvement notice to Comcare on 4 April 2011 and 10 May 2011 (the latter resulting from a letter from Comcare dated 4 April 2011) requesting further and more detailed information.

I note that the immediate safety issues regarding the proposed relocation of the 10 detainees from Christmas Island to Villawood Immigration Detention Facility (IDF) which the Improvement notice sought to address at the time of its issue, have now passed. As you know (and as the Improvement notice makes clear), these issues related predominately to:
- the comparatively lower level of security arrangements at the Villawood IDF;
- the clear risks to health and safety associated with the relocation of high risk detainees to the Villawood IDF;
- staffing levels at the Villawood IDF; and
- the adequacy of DIAC’s hazard identification, risk assessment and risk control arrangements regarding the proposed relocation.

Further pages of this attachment can be accessed by double-clicking the above image on the original electronic (NON-PDF) version or contacting the author.
### Process for Incident Notification

<table>
<thead>
<tr>
<th>Critical Incidents</th>
<th>Reportable to Comcare?</th>
<th>Comcare comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Assault – occasioning grievous bodily harm</strong></td>
<td>Detainee</td>
<td>Yes</td>
</tr>
<tr>
<td>Detainee on detainee</td>
<td>Detainee on staff</td>
<td>Yes</td>
</tr>
<tr>
<td>Staff on detainee</td>
<td>Other [e.g., Visitor]</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Assault – sexual assault</strong></td>
<td>Detainee on detainee</td>
<td>Yes</td>
</tr>
<tr>
<td>Detainee on Staff</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Biological/chemical threat</strong></td>
<td></td>
<td>Not unless threat is actually carried out with a hazardous biological or chemical substance</td>
</tr>
<tr>
<td><strong>Bomb threat</strong></td>
<td>Any known complaint about critical incident</td>
<td>No</td>
</tr>
<tr>
<td><strong>Damage to facility: serious, including fire</strong></td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Death</strong></td>
<td>Detainee</td>
<td>Yes – within 2 hours to Comcare</td>
</tr>
<tr>
<td>Staff</td>
<td>Other [e.g., Visitor]</td>
<td>As above</td>
</tr>
<tr>
<td><strong>Accident</strong></td>
<td>To detainee – serious</td>
<td>Yes</td>
</tr>
<tr>
<td>To staff – serious</td>
<td>As above</td>
<td></td>
</tr>
<tr>
<td><strong>Demonstration</strong></td>
<td>Outside facility</td>
<td>No</td>
</tr>
<tr>
<td><strong>Disturbance</strong></td>
<td>Hostage situation</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Escape</strong></td>
<td>Successful (includes mass escapes)</td>
<td>No – unless SPI or could cause SPI/psychological injury</td>
</tr>
<tr>
<td><strong>Force Majeure</strong></td>
<td>Actual</td>
<td>As above</td>
</tr>
<tr>
<td><strong>Industrial action</strong></td>
<td>Withdrawal of labour</td>
<td>No</td>
</tr>
<tr>
<td><strong>Public Health risk</strong></td>
<td>Serious (includes epidemics)</td>
<td>No – unless it arose through DIAC's conduct</td>
</tr>
<tr>
<td><strong>Self Harm</strong></td>
<td>Actual</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Use of Observation Room/in unit support Unit – over 7 days</strong></td>
<td>High profile visitor refused access</td>
<td>No</td>
</tr>
<tr>
<td><strong>Visits</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Voluntary Starvation</strong></td>
<td>By a minor</td>
<td>No – unless SPI or could cause SPI/psychological injury</td>
</tr>
</tbody>
</table>

Further pages of this attachment can be accessed by double-clicking the above image on the original electronic (NON-PDF) version or contacting the author.