Findings and Recommendations from 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 Detention Centre to Baxter Immigration Detention Facility

Investigating Officer
Keith Hamburger AM

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Knowledge Consulting Pty Ltd does not take responsibility for any conclusions, observations or findings contained in this report, subsequently found to be misleading, that have been generated as the result of incorrect or misleading information or documentation provided by employees or agents of the Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) or GSL (Australia) Pty Ltd or detainees.

To ensure the requirements of *"due process"* were met, the investigator provided GSL senior executives with the opportunity to consider those sections of this report, where the actions of GSL officers are subject to criticism, while the report was at the *"draft stage"*. As a consequence, GSL provided additional information to the investigator which assisted in clarifying certain matters.

GSL has reserved the right to submit a written response to DIMIA in relation to the report when the final report is provided to GSL.

Two DIMIA officers were also afforded *"due process"* by being given the opportunity to consider sections of the report relating to their actions. One of these officers was able to guide the investigator to additional documentary evidence that clarified the officer's actions in relation to a particular matter.

1. Terms of Reference

The following *Terms of Reference* were provided to Mr Hamburger to guide his investigation:

The scope of this investigation is to inquire into, and make findings and recommendations on, the background to the transfer of detainees from MIDC to BIDF on 17-18 September 2004, and the sequence of events before, during and after the transfer, including, but not limited to, the following:

A. Planning and preparation for the transfer by GSL, including:

- *the planning process adopted;*
- *whether risk assessments were carried out, covering issues such as the risk of escape; and the individual needs of detainees being transferred eg medical, dietary, physical, emotional and religious/spiritual;*
- *any briefings given to the officers involved in the escort;*
- *whether there was appropriate involvement of DIMIA in the planning process;*
- *the suitability of the vehicles selected to carry out the transfer, considering the number of detainees being transferred and the duration of the travel, including security and provision of an adequate level of comfort, privacy and dignity for the detainees.*

B. Execution of the transfer by GSL, including:

- *whether the escort officers adhered to any transfer plan;*
- *the amenities provided to detainees during the transfer including whether sufficient rest stops were provided during the transfer; the extent to which appropriate amounts of food and liquids were provided before, during and on arrival to BIDF;*
- *the extent to which all relevant GSL operational procedures, and Immigration Detention Standards (IDS) were adhered to, particularly those relating to Duty of Care obligations and meeting the day to day needs of detainees;*
- *whether the number of GSL Officers involved in the transfer was appropriate;*
- *the extent to which GSL staff involved had received adequate training in the procedures for detainee transfers, and were aware of the requirements concerning the treatment of detainees whilst being transferred including appropriate and timely response to detainee needs for rest/toilet stops, food or liquids;*
- *the extent to which GSL staff monitored the condition of detainees during the transfer, including:*
    - *whether detainees were advised on how to communicate any requirement for a rest stop or assistance;*
    - *whether any CCTV within the transport vehicle was monitored by escort officers;*
    - *whether there was any oversight of the transfer by more senior GSL officers.*

C. Investigation and Complaints Handling by both GSL and DIMIA Subsequent to the Transfer, including:

- *when DIMIA and GSL Officers first became aware of detainee complaints and what actions they took;*
- *whether sufficient priority was given by GSL and DIMIA to effectively considering and resolving the complaints;*
- *the level of accuracy, completeness and timeliness of information provided by GSL to DIMIA when the complaints were first raised by detainees and the extent to which GSL*

adhered to the requirement to report all breaches of the IDS to the Department, including the requirement to report any breaches of the IDS within a specific timeframe;

- *the effectiveness of internal communications procedures within GSL regarding the notification to appropriate senior staff of any problems with the transfer, including communications between operational staff and GSL management;*
- *the level of analysis and scrutiny applied by DIMIA to the information provided by GSL in response to the detainees' complaints and the timeliness of DIMIA's response to the detainees' complaints;*
- *the effectiveness of internal communications procedures within DIMIA regarding the notification to appropriate senior staff of any problems with the transfer, including communication from DIMIA staff at MIDC and BIDF to DIMIA Officers and management in UADD; and*
- *the adequacy of information provided by DIMIA to the Minister, the media and to external agencies of scrutiny concerning the detainees' complaints.*

2. Executive Summary

This report finds that the transfer of five (5) detainees from Maribyrnong Immigration Detention Centre (MIDC) to Baxter Immigration Detention Facility (BIDF) on the 17th and 18th September 2004 was poorly planned and executed.

The Detention Services Provider, GSL (Australia) Pty Ltd (GSL), had in place a generally sound Operational Procedure that had been approved by DIMIA to govern the conduct of the *External Transport and Escort* of detainees between detention centres. The GSL (Australia) officers who planned and executed the escort failed to follow this approved procedure.

This failure to follow the approved procedure resulted in serious violations of the Immigration Detention Standards and of GSL's *External Transport and Escort Services Generic Operational Procedure No. 12.5* as follows:

- Failure to provide medical assessment and/or treatment for detainees upon whom force had been used and who may have been injured prior to them being placed in the escort van;
- Inadequate provision of basic amenities including food and fluids;
- Sensory deprivation;
- Denial of access to toilet facilities resulting in detainees having no option but to urinate in their compartments;
- Denial of rest and exercise;
- Failure to meet the special needs of detainees, that is, detainees who could not understand or speak English, by non provision of interpreter services during the escort;
- Disregard of appeals for assistance from detainees in obvious distress;
- Treating detainees in an inhumane and undignified manner;
- Not affording detainees as much personal privacy as is practicable;
- Humiliation of detainees; and
- Placing the health and safety of detainees at risk.

The investigation found deficiencies in the training of officers in certain areas.

It was found that the GSL officers who applied force to a particular detainee did not act in accordance with good practice and GSL's *Generic Operational Procedure 12.11 – The Use of Force*, including the requirement for medical examination of all involved, and as a consequence have:

- Exposed GSL and DIMIA to criticism;
- Made it impossible to defend their actions and to verify exactly what happened; and
- Caused a detainee to suffer unnecessary pain and distress during the journey between MIDC and BIDF.

Immediately prior to the escort commencing, evidence was available to a DIMIA officer that would have indicated to an experienced person serious deficiencies in planning by GSL for the escort. This evidence was not understood by the DIMIA officer due to lack of experience in the secure transport of people. This raises a concern in relation to DIMIA's practice of having DIMIA officers at Detention Centres, who typically have an administrative/clerical background, performing a monitoring role in relation to custodial and security functions performed by the Detention Services Provider.

Considering issues such as the number of detainees being transferred, the duration of the travel, security and provision of an adequate level of comfort, privacy and dignity for the detainees, the investigator believes that the vehicle used between MIDC and Mildura for the transport of the detainees was totally unsuitable for the task.

Further, the van is unsuitable in that its design creates an unsafe and inhumane environment for those in the secure compartments, as well as having design faults in the air-conditioning system that creates discomfort through failure to adequately cool the secure compartments.

The investigator has found that there were deficiencies in the manner in which the detainees' initial complaints were dealt with resulting in their genuine complaints being rejected in the first instance as being unsubstantiated. Subsequent complaints to the Ombudsman and HREOC resulted in a more rigorous examination of the matter and ultimately led to this investigation. The failure to give credence to the detainees' initial complaints caused an unacceptable delay in senior DIMIA and GSL management becoming aware of what had happened.

The failure to thoroughly investigate the detainees' complaints at the time they were first made resulted in incorrect and inadequate information being provided to the Minister, the media, the Ombudsman and HREOC.

The report contains a number of recommendations dealing with:

- The need to apologize to the detainees involved;
- Operational procedure changes;
- Referral of certain matters for legal advice;
- Whether officers should face disciplinary action;
- Retraining of officers;

- Not using a particular escort vehicle for the transport of detainees;
- Review of internal audit and compliance systems and procedures at each Detention Centre and Facility;
- Unannounced audits of detention centres and facilities; and
- Review of detainee complaints handling procedures;

The recommendations point to a need for enhanced governance arrangements for the Detention Services Contract within a *continuous improvement strategy*.

3. Summary of Findings

Finding 1

While GSL's *Generic Operational Procedure No 12.5 – External Transport and Escort Services* is generally sound, this procedure could be enhanced by inclusion of guidance relating 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 (suggested amendment shown in red), *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.

Finding 2

The planning process for this escort was a flawed process that had no regard to basic planning principles that are reflected in GSL's generally sound *Generic Operational Procedure No 12.5 - External Transport and Escort Services.* This procedure was disregarded by the relevant GSL officer in the development of the Escort Plan for the section of the Escort from MIDC to Mildura.

The outcome of this disregard was a plan that did not provide for the *dignity, privacy and care needs of individual detainees* and did not provide for the humane, safe and secure escort of the five (5) detainees between MIDC and Mildura.

Finding 3
The relevant GSL officer says that the escort plan that was developed was based on a planning model used at Port Phillip prison and that this model was used in lieu of the *Generic Operational Procedure for External Transport and Escort Services* with the knowledge and agreement of the relevant GSL officer.

Finding 4
The relevant GSL officers have had no training or experience in the application of *"a risk assessment methodolology"* which is a fundamental element contained in the *Generic Operational Procedure for External Transport and Escort Services* aimed at ensuring that the escort will provide for humane, safe and secure transportation.

Finding 5
While the plan prepared by the relevant GSL officer at BIDF is of a higher standard than the plan produced by the relevant GSL officer at MIDC, it still falls short of the requirements specified in GSL's *Generic Operational Procedure No 12.5 - External Transport and Escort Services.*

GSL have advised that the relevant GSL officers have not had training in *Risk Assessment*.

Finding 6
The relevant GSL officers have not followed the planning template specified in *Generic Operational Procedure No 12.5 - External Transport and Escort Services.*

Finding 7
The GSL MIDC and BIDF escort plans provide no evidence of a holistic risk assessment of the circumstances pertaining to this long distance escort or any evidence of any sharing/coordination between the plans of the security escape risk relating to two (2) of the detainees. Further, the plans do not provide evidence of any consideration of the individual needs of detainees.

Finding 8
Concerns by the relevant GSL MIDC officers in relation to security issues pertaining to two (2) of the detainees which were considered in isolation from all of the other potential risks pertaining to the escort and without regard to the requirements of the IDS and GSL's *Generic Operational Procedure,* contributed to:

- Breaches of the IDS and GSL's *Generic Operational Procedure;*
- Unjust and adverse impacts upon the other three (3) detainees; and
- Inhumane treatment of all five (5) detainees.

Finding 9

Given the deficiencies in the planning process previously covered, and from information provided at interview by GSL MIDC officers, the briefing given to MIDC escort officers was inadequate. There is evidence that the officers being briefed at MIDC did not challenge the *briefing officer* on the adequacy of the plan.

Finding 10

DIMIA's involvement in the planning process for the escort under investigation was appropriate. This finding is based on:

- DIMIA's action in ensuring that there was an approved Operational Procedure in place for *external transport and escort services;*
- A reasonable expectation by DIMIA that GSL Management and staff would follow the approved Operational Procedure, which was supported by advice from GSL that detainees' personal needs during the escort under investigation would be attended to;
- DIMIA's knowledge that GSL is a very experienced provider of escort services for police, corrective services and detention services;
- Evidence available to DIMIA that previous external escorts had been conducted without complaint from detainees; and
- Monitoring of GSL services by DIMIA Central Office monitors had revealed a generally satisfactory level of service in the areas that had been subject to monitoring.

Finding 11

Immediately prior to the escort commencing, evidence was available to the relevant DIMIA officer that would have indicated to an experienced person serious deficiencies in planning by GSL for the escort. This evidence was not understood by the relevant DIMIA officer due to a lack of experience in the secure transport of people.

There is also evidence that as at 17th September 2004, the date of the escort, the relevant DIMIA officer had not received relevant training including in the procedures to be followed in monitoring the performance of GSL at MIDC.

This finding raises a concern in relation to DIMIA's practice of having DIMIA officers at Detention Centres, who typically have an administrative/ clerical background, performing a monitoring role in relation to custodial and security functions performed by the Detention Services Provider.

Finding 12

Considering issues such as the number of detainees being transferred, the duration of the travel, security and provision of an adequate level of comfort, privacy and dignity for the detainees, the 10 seat *Mercedes Sprinter* van used between MIDC and Mildura was totally unsuitable for the task.

The van is unsuitable in that its design creates an unsafe and inhumane environment for those in the secure compartments, as well as having design faults in the air-conditioning system that creates discomfort through failure to adequately cool the secure compartments.

This unsuitability was compounded by the lack of professionalism and competence displayed by all GSL staff involved in the planning and execution of the escort, which includes their disregard of GSL's *Generic Operational Procedure No 12.5 – External Transport and Escort Services*.

Finding 13

It is concerning that there is conflicting evidence from the relevant GSL officer and the relevant DIMIA officer in relation to concerns being expressed by a detainee at an interview in the relevant DIMIA officer's office and that the record of interview is not fulsome.

Finding 14

While it is arguable that there may have been options other than force that could have been followed to diffuse the confrontation with a detainee, on the available evidence it would be unfair to be critical of the relevant GSL officer about the decision to apply force in this instance.

Finding 15

The relevant GSL officers who applied force to the detainee did not act in accordance with good practice and *GSL's Generic Operational Procedure 12.11 – The Use of Force*, including the requirement for medical examination of all involved, and as a consequence have:

- Exposed GSL and DIMIA to criticism;
- Made it impossible to defend their actions and to verify exactly what happened; and
- Caused a detainee to suffer unnecessary pain and distress during the journey between MIDC and BIDF.

Finding 16

Incident reporting procedures relating to the use of force as prescribed in *GSL's Generic Operational Procedure 12.11 – The Use of Force* have not been followed in that:

- All officers who participated in the incident involving the detainee did not submit Incident Reports; and
- The Incident Reports submitted by the two GSL officers who were present at the incident, one of whom directed and supervised the conduct of the application of force on the detainee, are so inadequate as to be useless as any meaningful record of what occurred.

Finding 17
It appears that visit records at MIDC have not been accurately maintained in relation to a detainee on 17th September 2004.

Finding 18
No evidence can be found that the Nurse at BIDF who examined the detainee submitted an incident report concerning the injuries noted on the detainee, nor were photographs taken of the injuries. Further, it appears that the GSL officers, who the nurse says provided information as to how the injuries may have occurred, also did not submit incident reports.

Finding 19
Mechanical restraints were applied to a detainee on 17th September 2004. The statement by the relevant GSL officer and the Incident Report by the relevant GSL officer refer to these restraints being applied just prior to the detainee being placed in the escort van. GSL officers have not reported use of force or application of restraints to place a detainee in an *isolation room*. A DIMIA officer at MIDC says that a detainee was placed in an interview room but makes no mention of restraints.

Finding 20
GSL Incident reporting in relation to the application of force and or mechanical restraints to a detainee was totally inadequate and conflicting in content. Reports submitted do not conform to the requirements of *GSL's Generic Operational Procedure 12.11 – The Use of Force.*

Finding 21
There is no evidence that a detainee was examined by a member of the Medical Team following removal of the mechanical restraints. This is in contravention of *GSL's Generic Operational Procedure 12.11 – The Use of Force – Section 4.4.*

Finding 22
The plan for the MIDC – Mildura section of the escort was totally inadequate and was useless as a guide to officers for the humane, safe and secure escort of the detainees under their care and control. The plan contained no performance measures that would allow for appropriate assessment of the officers' conduct of the escort. Officers did not stop the escort vehicle at any time during the escort to allow the detainees toilet and exercise breaks which contravenes oral advice to DIMIA officers that this would occur.

Finding 23
The plan for the Mildura - BIDF section of the escort while inadequate did provide guidance for officers. The GSL BIDF escort officers appear to have adhered to the plan for their section of the escort. There have been no complaints from detainees in relation to this section of the escort.

Finding 24
Concerning amenities provided to detainees during the escort between MIDC and Mildura, serious violations occurred of the Immigration Detention Standards and of GSL's *External Transport and Escort Services Generic Operational Procedure No. 12.5* as follows:

- Failure to provide medical assessment and/or treatment for detainees upon whom force had been used and who may have been injured prior to them being placed in the escort van;
- Non-provision of basic amenities including food and fluids;
- Sensory deprivation;
- Denial of access to toilet facilities resulting in detainees having no option but to urinate in their compartments;
- Denial of rest and exercise;
- Failure to meet the special needs of detainees, that is, detainees who could not understand or speak English, by non provision of interpreter services during the escort;
- Disregard of appeals for assistance from detainees in obvious distress;
- Treating detainees in an inhumane and undignified manner;
- Not affording detainees as much personal privacy as is practicable;
- Humiliation of detainees; and
- Placing the health and safety of detainees at risk.

Finding 25
During the hand over of detainees at Mildura Police Station from the GSL MIDC escort officers to the GSL BIDF escort officers, the detainees had a break from travel of approximately one (1) hour. During this break the detainees were held in the Police Station cells. There is evidence that the detainees were offered food. There is a statement from one detainee of being so hungry as a consequence of not being provided with food during the MIDC – Mildura escort that he could eat only a small portion of the food offered. Time was not provided for the detainees to sleep at Mildura Police Station.

Finding 26
In spite of the shortcomings in the Mildura - BIDF 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.

Finding 27
All of the evidence available to the investigator is that on arrival at BIDF, the detainees' needs were dealt with promptly and humanely by GSL and DIMIA officers.

Finding 28
In the investigator's opinion the number of officers allocated to this escort was appropriate.

Finding 29
All officers involved in the escort had received adequate training in the procedures for detainee transfers, and were aware of the requirements concerning the treatment of detainees whilst being transferred including appropriate and timely response to detainee needs for rest/toilet stops, food or liquids.

There is an issue in relation to access by officers to the Certificate III in Corrections course of study which requires resolution.

Finding 30
The safety of the escort was compromised through the officers responsible for conduct of the escort not being trained in the operation of the 10 seat *Mercedes Sprinter* escort van, including driving the van, operation of the equipment in the van and pre-use safety and security checks.

Finding 31
The relevant GSL officers failed to ensure that:

- All officers on the escort who may be involved in driving and operating the escort van were appropriately trained in its operation;
- An appropriate driver rotation system was in place; and
- Appropriate rest breaks were taken to ensure that officers remained fit to conduct the escort safely.

Finding 32
A GSL officer condoned a breach of GSL's Operational Procedures by allowing the driver and co-driver to smoke in the driving cabin of the 10 seat *Mercedes Sprinter* escort van during the escort.

Finding 33
Detainees were not advised on how to communicate any requirement for a rest stop or assistance and attempts by the detainees to communicate were ignored and/or misinterpreted by the officers in the driver's cabin as misbehaviour.

Finding 34
The CCTV within the 10 seat *Mercedes Sprinter* escort van was not adequately monitored by the driver and co-driver of the van. Officers either ignored or misinterpreted detainees' actions that they saw on the CCTV monitor that should have alerted them that all was not well with the detainees.

Finding 35
While there was oversight of the transfer by a more senior GSL officer, it was cursory in nature and could not be regarded as professional or adequate.

Finding 36
The relevant GSL officer did not give priority to effective consideration of the detainees' complaints and made only cursory enquiries in relation to the complaints relayed by the relevant DIMIA officer. It was incumbent upon the relevant GSL officer to make rigorous enquiries to ascertain whether or not the detainees' complaints as reported by the relevant DIMIA officer had validity. The level of questioning of the relevant GSL officer was totally inadequate in relation to such serious complaints.

Further, the responses by the relevant GSL officer to the questions posed by the relevant DIMIA officer in relation to the detainees' complaints were inaccurate, inadequate and misleading.

Finding 37
There is no evidence that officers in GSL senior to the relevant GSL officer were made aware of the detainees' complaints.

Finding 38
The relevant DIMIA officers acted with concern, promptly and appropriately to the complaints made by detainees concerning their treatment prior to and during their escort between MIDC and Mildura.

Finding 39
The relevant DIMIA officer acted promptly to investigate the detainees' complaints on the day they were received by putting specific questions to the relevant GSL officer for response and tasking a MIDC DIMIA Officer to review CCTV of the escort.

Finding 40
The response received by the relevant DIMIA officer from the relevant GSL officer to a request for information was inaccurate, inadequate, misleading and in one area conflicting. However, it would be unfair to criticise the relevant DIMIA officer for not detecting these shortcomings given:

- The advice previously available as to the manner in which the escort would be conducted;
- The relevant DIMIA officer's experience with the manner in which previous escorts had been conducted by GSL;
- Lack of any evidence of concern from MIDC DIMIA staff (due, as previously reported, to the level of experience and training of these staff); and
- The relevant DIMIA officer's faith in the professionalism of the relevant GSL officer.

Finding 41
While officers in DIMIA Central Office received copies of emails from the relevant DIMIA officer concerning the complaints, the unequivocal language used did not cause these officers to become concerned that the detainees' complaints had substance.

Finding 42
That the initial complaints made by three (3) detainees, which have now been found to be valid and which at the time they were made were thought to be valid by the DIMIA officer who initially received them, were quickly dismissed by the relevant GSL officer without rigorous investigation. Inadequate and misleading information was provided to a DIMIA officer by the relevant GSL officer which resulted in the detainees' valid complaints being dismissed by DIMIA.

Finding 43
That the relevant GSL officer did not follow *GSL's Generic Operational Procedure No 14.1 – Issues/Complaints Resolution,* in investigating the serious complaints made by detainees.

Finding 44
That in the light of the matters covered in this report, GSL and DIMA review their respective detainee complaints handling procedures, and in particular the interface between these procedures and the interface between complaints generally and Detention Services Contract performance scrutiny.

Finding 45
On receipt of enquiries from the Ombudsman and HREOC, the relevant DIMIA officer in Central Office gave priority and acted promptly and with persistence to attempt to establish the facts of the complaints made by detainees. Initial enquiries concerning a detainee's complaint were frustrated by receipt of misinformation.

Fortunately, because of the relevant DIMIA officer's knowledge and concern in relation to information surrounding a detainee's complaint during the same escort, HREOC's later enquiry concerning a complaint by another detainee came to the same DIMIA officer in Central Office who once again acted promptly and ascertained that the detainee's complaint had substance and immediately alerted senior officers.

Finding 46
The responses by the relevant DIMIA officer to requests for information from the relevant DIMIA officer in Central Office were not helpful. However, as previously reported, they were founded in inadequate and misleading information received from the relevant GSL officer and confidence in the relevant GSL officer's professionalism.

Finding 47
Senior DIMIA and GSL management on being made aware of the evidence identified by the relevant DIMIA officer in Central Office acted with urgency to assess the matter. As a consequence of this assessment, the Minister acted immediately to cause an independent investigation to be undertaken.

Senior DIMIA and GSL management have cooperated fully with the independent investigation.

Finding 48
Information provided by the relevant GSL officer when the complaints were first raised was provided promptly but was inaccurate, inadequate and misleading. GSL did not report a breach of the IDS at the time of the initial complaints as no GSL Manager was aware that a breach of the IDS had been committed.

Finding 49
Internal communications procedures within GSL regarding the notification to appropriate senior staff of any problems with the transfer were ineffective due to failure by the relevant GSL officer.

Finding 50
Given the information contained in the preceding sections of this report, it is clear that at the time of the initial complaints by the detainees, incorrect and inadequate information was provided to the Minister, the media and to external agencies of scrutiny.

Finding 51
That an adequate record of the interview with a detainee was not maintained such that the conflict in information as to what was said at this important interview can be resolved.

4. Summary of Recommendations

Recommendation 1
GSL (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.

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.

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 (suggested amendment shown in red), *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 relevant GSL officers disregarded approved Generic Operational Procedures in the planning and execution of this escort, all relevant GSL officers at 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 on going *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:
    - 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.

Recommendation 8

In the light of evidence in this report that relevant GSL officers at MIDC and BIDF disregarded Generic Operational Procedures resulting in serious breaches of the IDS 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 MIDC and BIDF 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 UADD 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 UADD give high priority to its current review of governance of the Detention Services Contract.