

**Inquiry into the Circumstances
of the Immigration Detention of
Cornelia Rau**

REPORT

July 2005

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6 July 2005

Senator the Hon. Amanda Vanstone
Minister for Immigration and Multicultural and Indigenous Affairs
Parliament House
CANBERRA ACT 2600

Dear Minister

I am pleased to present to you my report on the Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau.

The Inquiry was conducted in accordance with the terms of reference issued on 9 February 2005 and 2 May 2005.

As required by the additional terms of reference of 2 May 2005, my report includes commentary and preliminary findings arising from the Examination of the Vivian Alvarez Matter.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Mick Palmer', with a large loop at the top and a long tail extending to the right.

MJ Palmer

Principles

Protection of individual liberty is at the heart of Australian democracy. When there exist powers that have the capacity to interfere with individual liberty, they should be accompanied by checks and balances sufficient to engender public confidence that those powers are being exercised with integrity.

It is the intention of the Commonwealth Government that Australia's immigration detention policy be applied justly and equitably and that:

- every reasonable effort be made to ensure the right people are detained as being 'reasonably suspected of being an unlawful non-citizen'
- expeditious and comprehensive inquiries be made to establish the identity of detainees whose identity is in doubt
- the overall duty of care—including, in particular, medical care—owed to detainees be consistently and effectively applied
- detainees be held in detention only for so long as is necessary and justifiable.

Australia's immigration policy is deliberately directed at achieving a number of clear public policy objectives, among them the following:

- ensuring that unauthorised immigrants do not enter the Australian community until their claims have been properly assessed
- ensuring that unauthorised immigrants do not enter the community until essential identity and health checks have been completed and assessments have been made to clarify character and security considerations
- ensuring that the integrity of Australia's migration program is maintained.

This policy was introduced in 1992 and has been maintained by successive governments. The Inquiry's comments in this report are not intended to call the policy into question.

Contents

Principles	i
Main findings	viii
Recommendations.....	xv
1 Introduction	1
1.1 The conundrum.....	1
1.2 A perspective	1
1.3 Two independent streams of investigation	2
1.4 The Inquiry’s terms of reference	3
1.5 Inquiry processes and procedures.....	4
1.6 Submissions received	5
1.7 Some progress.....	6
1.8 A melting pot of stories	7
2 The sequence of events	8
2.1 The journey.....	8
2.2 The question of identity.....	8
2.3 Overview of main events.....	8
2.3.1 A private citizen	8
2.3.2 Timeline.....	9
3 Immigration detention	21
3.1 Immigration detention under s. 189 of the Migration Act	21
3.1.1 Reasonable suspicion.....	21
3.1.2 The lawfulness of detention.....	24
3.1.3 Training for compliance officers	28
3.2 Imprisonment in Brisbane Women’s Correctional Centre.....	29
3.2.1 Immigration detention arrangements.....	29

	3.2.2	Last resort	32
	3.2.3	Admission and accommodation	34
	3.2.4	Prison discipline	38
	3.2.5	Cooperation with BWCC	41
	3.2.6	An evaluation	43
3.3		Management responsibilities	45
	3.3.1	A failure of processes and management	45
	3.3.2	The requirement for regular review	47
	3.3.3	Accumulation of information	50
	3.3.4	Dealing with complex cases	53
	3.3.5	Detention review	55
4		Baxter Immigration Detention Facility	57
4.1		Context	57
4.2		Development and functions	59
	4.2.1	Establishment	59
	4.2.2	GSL's role and responsibility	60
	4.2.3	DIMIA's role and responsibility	61
	4.2.4	Detention	63
	4.2.5	The operating environment	65
	4.2.6	Remoteness and staffing	66
4.3		The immigration detention environment	67
	4.3.1	Containment and care	67
	4.3.2	Communication and feedback	70
	4.3.3	Food preparation	75
	4.3.4	Visitor arrangements	77
	4.3.5	Engagement with the community	78
4.4		Operational considerations	79
	4.4.1	Red One and the Management Unit	79
	4.4.2	Performance measurement and audit	82
	4.4.3	Case management	82
	4.4.4	Allegations of assault and inappropriate behaviour	84
	4.4.5	Management of detainees' personal information	88
4.5		Infrastructure	89
	4.5.1	The Management Unit	89
	4.5.2	An intermediate facility	91
	4.5.3	Accommodation for detainees	93

5	The circumstances and actions leading to the failure to identify Cornelia Rau.....	95
5.1	A baffling situation.....	95
5.2	Contributing reasons and circumstances	96
5.2.1	Information presented by the detainee.....	96
5.2.2	The footprints	97
5.2.3	Fingerprints and biodata	97
5.2.4	The Movements and Passports databases.....	99
5.2.5	Australian civil records.....	100
5.2.6	European immigration posts.....	100
5.2.7	German consular assistance.....	101
5.2.8	Events at Brisbane Women’s Correctional Centre	103
5.2.9	Cornelia Rau reported missing	103
5.2.10	Uncorrelated information	105
5.2.11	Three important questions	107
5.3	Some possible solutions.....	108
5.3.1	Identification guidelines	108
5.3.2	A national missing persons database	111
5.3.3	Privacy.....	114
5.3.4	Consular considerations.....	116
5.3.5	Fingerprints.....	117
6	Measures taken to deal with Anna’s medical needs	119
6.1	Perspective.....	119
6.2	Main conclusions.....	119
6.3	Events in New South Wales	121
6.3.1	Care and treatment.....	121
6.4	Events in Queensland	123
6.4.1	Coen watch-house and Cairns	123
6.4.2	Brisbane Women’s Correctional Centre and Princess Alexandra Hospital.....	124
6.4.3	Care and treatment.....	125
6.5	Events in South Australia	131
6.5.1	The medical time frame at Baxter	131
6.5.2	Leadership	136
6.5.3	Systems.....	138
6.5.4	Psychiatric services at Baxter	139

6.5.5	An alternative model for psychiatric services	141
6.5.6	A national facility	143
6.6	Clinical considerations	145
6.6.1	Understanding schizophrenia	145
6.6.2	Assessment	146
6.6.3	The assessment setting	147
6.6.4	Personality disorder	148
6.6.5	Detention and mental health	148
6.7	Standards of health care	149
6.7.1	The health care provided for Anna	149
6.7.2	Access	150
6.7.3	Quality and standards in the delivery of health services	151
6.7.4	Independent, external monitoring	153
6.8	Mental health legislation	156
6.8.1	Queensland	157
6.8.2	South Australia	157
6.8.3	A comparison	158
6.8.4	Difficulties arising from the legislation	158
7	Culture, structure and operations.....	160
7.1	Overview	160
7.2	Immigration policy and implementation	161
7.2.1	Immigration policy	161
7.2.2	Responsibility and accountability	162
7.2.3	Implementing immigration policy	164
7.3	Culture, processes and attitudes	166
7.3.1	Process and structure	166
7.3.2	An assumption culture	168
7.3.3	Processes, instructions and purpose	169
7.4	Structure and operations	171
7.4.1	Structure and cultural change	171
7.4.2	The context for operations	174
7.5	Contracting and government policy outcomes	176
7.5.1	The contract with GSL	176
7.5.2	A way forward	179

8	The Examination of the Vivian Alvarez Matter	183
8.1	Background.....	183
8.2	Summary of events	183
8.3	The facts at issue.....	186
8.4	Initial findings.....	188
8.4.1	Databases and operating systems	188
8.4.2	Training and selection	192
8.4.3	Case management.....	192
8.4.4	Culture	193
Appendix A	The Inquiry’s terms of reference.....	196
Appendix B	People interviewed.....	198
Appendix C	Anna’s placements at Baxter	206
	Shortened forms.....	208
	Attachment I Timeline of principal events and contacts	envelope
	Attachment II Timeline of medical events and contacts	envelope

Main findings

1. When Ms Cornelia Rau came to the attention of immigration authorities in north Queensland and throughout her detention in Brisbane Women's Correctional Centre and Baxter Immigration Detention Facility, Ms Rau consistently maintained that she was a German tourist. She gave several names and dates of birth and conflicting accounts of how and when she had arrived in Australia. She conducted her discussions with German consular officers in German.
2. On the evidence then reasonably available, the responsible compliance officer in the Department of Immigration and Multicultural and Indigenous Affairs had a proper and lawful basis for forming a 'reasonable suspicion' that 'Anna' (as Ms Rau called herself) was an unlawful non-citizen, sufficient to justify her detention. Nevertheless, officers should not only have continued inquiries aimed at identifying Anna; they should also have continued to question whether they were still able to demonstrate that the suspicion on which the detention was originally based persisted and that it was still reasonably held.
3. DIMIA's inquiries concerning Ms Rau focused on establishing her identity for the purpose of enabling her removal from Australia. There was no corporate policy for or instruction to review the continued validity of the 'reasonable suspicion' that Ms Rau was an unlawful non-citizen.
4. There is no automatic process of review sufficient to provide confidence to the Government, to the Secretary of DIMIA or to the public that the power to detain a person on reasonable suspicion of being an unlawful non-citizen under s. 189(1) of the Commonwealth's *Migration Act 1958* is being exercised lawfully, justifiably and with integrity.
5. The case complexity and workload associated with enforcing and managing immigration detention policy have placed much pressure on DIMIA staff. Individual workloads are high, and many of the matters to be dealt with are sensitive and difficult. The speed of change in the immigration detention environment since 2000 has led to policy, procedures and enabling structures

being developed on the run. This has created challenges for DIMIA and its compliance and immigration detention staff.

6. A strong government policy calls for strong executive leadership, together with careful management, to ensure that enforcement and application of the policy are justified and equitable. Such a policy places on the accountable department an onerous responsibility for having in operation systems and processes designed to ensure integrity of application and demonstrable accountability and for engendering public confidence in the policy's operation. Initiatives are now being introduced, but the Inquiry found inadequate evidence of the required systems and processes in the compliance and immigration detention areas of DIMIA during the period of Ms Rau's detention.
7. There is considerable evidence of highly committed DIMIA staff—particularly at Baxter Immigration Detention Facility—having heavy workloads and trying to operate effectively despite instructions and requirements that inhibit or prevent effective performance rather than facilitate it.
8. There is a serious cultural problem within DIMIA's immigration compliance and detention areas: urgent reform is necessary. The combination of pressure in these areas and the framework within which DIMIA has been required to operate has given rise to a culture that is overly self-protective and defensive, a culture largely unwilling to challenge organisational norms or to engage in genuine self-criticism or analysis.
9. DIMIA officers are authorised to exercise exceptional, even extraordinary, powers. That they should be permitted and expected to do so without adequate training, without proper management and oversight, with poor information systems, and with no genuine quality assurance and constraints on the exercise of these powers is of concern. The fact that this situation has been allowed to continue unchecked and unreviewed for several years is difficult to understand.

10. During Ms Rau's detention the DIMIA management approach to the complexities of implementing immigration detention policy appeared to be 'process rich' and 'outcomes poor', with the predominant, and often sole, emphasis being on the achievement of quantitative yardsticks rather than qualitative performance. The organisational structure and arrangements fail to deliver the outcomes required by the Government in a way that is firm but fair and respects human dignity.
11. The lack of comprehensive 'cradle to grave' case management and of any effective accumulated assessment and review process in relation to mental health care, general treatment, and the identity inquiries conducted during Cornelia Rau's 10 months in immigration detention significantly affected the quality of care she received and the amount of time she spent in detention.
12. Ms Rau was detained in Brisbane Women's Correctional Centre for six months—an excessively long time. She was not a prisoner, had done nothing wrong, and was put there simply for administrative convenience. These facts alone should have been sufficient to prompt immediate consideration by DIMIA of her early transfer to a more suitable facility.
13. Ms Rau was held in immigration detention at Brisbane Women's Correctional Centre for six months because of a failure in DIMIA processes. It was not a failure of instructions. Migration Series Instruction 244 is well written and clear. The instructions were not followed. It was a failure of management processes and corporate oversight.
14. Statements by DIMIA operational and field staff make it obvious that many of DIMIA's compliance officers have received little or no relevant formal training and seem to have a poor understanding of the legislation they are responsible for enforcing, the powers they are authorised to exercise, and the implications of the exercise of those powers. The induction training package for compliance officers is inadequate.
15. Officers with direct responsibility for detaining people suspected of being unlawful non-citizens and for conducting identity and immigration status inquiries often lack even basic investigative and management skills. The Vivian Alvarez matter has also demonstrated that their knowledge of the capability of DIMIA information systems is inadequate.

16. The DIMIA database infrastructure is ‘siloed’, with little connectivity between systems. Important information that needs to be linked frequently for reasons of operational effectiveness and integrity is not effectively networked. There is limited search capacity and until recently little evidence—despite the problems caused by these deficiencies—of any structured attempt to improve the systems and so remove gaps and vulnerabilities.
17. There are serious problems with the handling of immigration detention cases. They stem from deep-seated cultural and attitudinal problems within DIMIA and a failure of executive leadership in the immigration compliance and detention areas.
18. The Vivian Alvarez incident occurred in 2001 and entailed events, practices and actions in 2003 and 2004, most of which confirm the systemic nature of the problems identified by the Inquiry into Cornelia Rau’s detention.
19. During Ms Rau’s detention there seemed to be a ‘disconnect’ between DIMIA detention policy development and management in Canberra and the realities of time frames for dealing with operational requirements in Baxter and the Queensland Regional Office. This is reflected in the lack of responsiveness to operational concerns and the failure to achieve desired performance outcomes.
20. Reform will need to come from the top, and external professional assistance will be necessary. The current immigration compliance and detention executive management team is unlikely—without significant independent leadership and support—to have the perspective or capacity to lead and bring about the major changes in mindset and practice that are required.
21. During the term of this Inquiry DIMIA continued to introduce new arrangements to overcome deficiencies. In a statement to the Senate Estimates Committee on 25 May 2005, the Secretary expressed profound regret at what has happened in some cases and acknowledged that DIMIA had made mistakes and that there is a need for change. The Minister also made a statement to the Senate Estimates Committee on the same day, outlining the initiatives taken and emphasising that, although changes can be made to policy, processes and legislation, these will be of little benefit without cultural change.

22. Anna's mental health assessment at Princess Alexandra Hospital, Brisbane, was inadequate, and the finding that she did not fulfil any diagnostic criteria for mental illness seems to have influenced the treatment she received throughout her time in immigration detention. The Inquiry is not critical that a diagnosis of mental illness failed to be made: that was difficult in the circumstances. But the fact that illness behaviour does not seem to have been considered a reasonable possibility and actively pursued and evaluated over the 10 months Anna was in immigration detention is cause for concern.
23. In the mental health assessment of Anna insufficient weight was given to her behaviour patterns and her 'odd' presentation features and history. Collateral history should have been sought from officers, other contact people and fellow detainees at both Brisbane Women's Correctional Centre and Baxter. Collection of integrated, cumulative data is an essential basis for assessment, particularly when a patient is uncooperative. Anna was uncooperative.
24. The mental health care delivered to Cornelia Rau while she was detained at Baxter was inadequate. Clinical pathways had been agreed between DIMIA and the South Australian Department of Health, but they were not effective. There was evidence of a significant communication problem between Glenside Hospital and Baxter, which delayed Ms Rau's admittance to Glenside for assessment by more than two months.
25. The detainee population requires a much higher level of mental health care than the Australian community. The infrequency of the consulting psychiatrist's visits to Baxter constitutes a serious shortcoming. Expert mental health opinion has it that more frequent, regular visits—together with a sufficient number and structure of mental health-trained nurses, psychologists and primary practitioners who could initially assess and triage for mental illness—would allow a more effective clinical system of care.
26. The lack of any focused mechanism for external accountability and professional review of standards and arrangements for the delivery of health services is a significant omission. An expert body specifically focused on health matters is recommended, to complement and strengthen the efforts of the Immigration Detention Advisory Group and the Commonwealth Ombudsman.

27. The infrastructure and operations at Baxter do not allow the Government's policy expectations for the environment for immigration detainees to be realised. Structural modifications are needed, and greater flexibility should be allowed in the care and management of detainees and the treatment of problems associated with mental health.
28. The current detention services contract with Global Solutions Limited is fundamentally flawed and does not permit delivery of the immigration detention policy outcomes expected by the Government, detainees and the Australian people.
29. The systems and processes at Baxter that derive from the detention services contract make it impossible to deliver the desired policy outcomes. The problems result from a mix of poor procedures and processes; an excessive focus on auditing compliance with performance measures that often provide little information about the outcomes actually being delivered; limited management flexibility; and lack of oversight by executive management in Canberra.
30. The arrangements governing surveillance of female detainees in Red Compound and the Management Unit at Baxter are unacceptable. Contract requirements should insist that, in all but emergency or extraordinary circumstances, surveillance of female detainees should be done by female detention officers.
31. The primary deficiency in DIMIA's efforts to identify Anna was the lack of an organised, systematic approach to the inquiry process. Individual officers did their best, but their efforts were not coordinated and there was nothing to guide them in their actions. There was no coherent methodology, and nobody was in charge.
32. There is an urgent need for the establishment of a national missing persons database or capacity that will provide a national recording and search capability and enable searches against a range of biometric data—including photographic facial recognition, personal description and distinguishing features—that would aid in personal identification. This is a national priority, and it calls for a whole-of-government approach.

33. The links between managing ‘missing patients’ and ‘missing persons’ are not well defined in Australia. They do not consistently allow for the exchange of personal information between medical facilities and police sufficient to enable police to identify the level of risk and vulnerability of a mental health patient who goes missing.
34. DIMIA’s attitude to the provisions of the Commonwealth *Privacy Act 1988* is unduly cautious and has operated to limit the range and effectiveness of inquiries into the status and identity of suspected unlawful non-citizens in a way that is clearly against the public interest and the intent of the Act. Had a photograph of Anna been released early, her journey might have been a short one.

Recommendations

The Inquiry's recommendations are numbered according to the report section in which they appear.

3.1 Immigration detention under s. 189 of the Migration Act

Recommendation 3.1

The Inquiry recommends that DIMIA:

- design, implement and accredit—for all compliance officers and other staff who might reasonably be expected to exercise the power to detain a person under s. 189(1) of the *Migration Act 1958*—a legislative training package that provides the officers with the requisite knowledge, understanding and skills to fairly and lawfully exercise their power
- ensure that the training comprehensively covers the use of DIMIA and other agencies' databases and search capability and the conduct of searches to support investigations
- restrict the authority to exercise the power to detain a person under s. 189(1) to staff who have satisfactorily completed the training program and who are considered to be otherwise sufficiently experienced to exercise that power
- ensure that a component on 'avenues of inquiry' be included in the Certificate IV in Government (Statutory Investigation and Enforcement) Training Program delivered to DIMIA officers.

3.2 Imprisonment in Brisbane Women’s Correctional Centre

Recommendation 3.2

The Inquiry recommends that, as a matter of urgency, DIMIA:

- take all necessary action to formalise its arrangements with the Queensland Department of Corrective Services for the detention of immigration detainees, to ensure that the arrangements reflect the standards of care and treatment necessary for detainees and that the responsibilities, accountabilities and reporting arrangements of all parties are clarified and understood.
- adopt and confirm the principle that, unless there are exceptional circumstances, detainees will be held in correctional facilities only until alternative arrangements can be made for their immigration detention
- consistent with the foregoing—and having regard to the recently introduced government policy to restrict the period of detention in a prison to 28 days—take all necessary action to minimise the period of time that immigration detainees are held in a prison or other correctional facility
- settle arrangements with relevant governments or corrective services departments to enable the placement of a DIMIA officer (or officers) in each corrections facility in which immigration detainees are being held, to ensure that the Commonwealth’s duty of care obligations towards each person in immigration detention in a prison can be demonstrably met and that the Immigration Detention Standards are maintained.

3.3 Management responsibilities

Recommendation 3.3

The Inquiry recommends that, as a matter of priority, DIMIA ensure that when an immigration detainee who has committed no criminal offence is placed in a correctional facility immediate steps are taken to find a more suitable place of detention and to transfer the detainee to that place.

Recommendation 3.4

The Inquiry recommends that DIMIA create a dedicated Identity and Immigration Status Group to ensure that, where the identity or immigration status of a detainee remains unresolved after initial inquiries have been completed, frequent follow-up reviews are conducted.

The Identity and Immigration Status Group should:

- review the continued validity of ‘reasonable suspicion’-based detention on a regular basis—and at least every month—against the background of accumulating information
- be staffed by people who have wide experience in compliance and detention policy and operations, are familiar with the associated Commonwealth and state and territory legislation and arrangements, and have skills in investigation and analysis
- have the authority, responsibility and accountability for conducting and/or overseeing all necessary inquiries to establish the identity and immigration status of unidentified detainees
- report monthly to executive management on the status of individuals still in immigration detention, the reason why they are being detained, what is currently being done to resolve the situation, and the expected date for resolution.

Recommendation 3.5

The Inquiry recommends that DIMIA critically review the functions of the Detention Review Committee and restructure its focus and operations to ensure that it:

- is chaired at branch head level or higher, depending on the matter under consideration
- draws on advice and reports from the Identity and Immigration Status Group
- comprehensively reviews and analyses complex or difficult detainee cases

- seeks input from detention facility managers and provides feedback
- determines appropriate action and ensures monitoring and reporting on progress and outcomes to executive management
- clarifies case management responsibility, intended outcomes and reporting time frames
- is responsible for providing to executive management advice on critical or sensitive cases.

4.2 Development and functions

Recommendation 4.1

The Inquiry recommends that DIMIA develop and implement arrangements to ensure that a detainee’s file—together with their medical file and any related performance and behaviour notes or review—accompanies the detainee wherever they are placed or transferred. Such files should be tracked centrally by Canberra to ensure consistency in the briefings that are provided.

Recommendation 4.2

The Inquiry recommends that, as an integral part of renegotiating its contract with GSL (see recommendation 7.7), DIMIA:

- agree with GSL innovative changes to overcome the challenges to staffing and service delivery presented by Baxter’s remote location
- develop and implement effective arrangements for monitoring and managing the outcomes, to maintain quality services and ensure that the Government’s policy objectives are met in a way that protects the health, safety and dignity of detainees
- rely on the advice and leadership of the Detention Contract Management Group (see recommendation 7.6) when negotiating these changes.

4.3 The immigration detention environment

Recommendation 4.3

The Inquiry recommends that DIMIA and GSL—in consultation with detainees—establish a continuing program of communication and information provision to:

- ensure that all detainees understand why they are being kept in detention, the nature of the detention environment, the Commonwealth Government’s duty of care and its objectives for the immigration detention environment, and the respective roles of GSL and DIMIA
- explain to detainees how the different compounds and the Residential Housing Project work, why they have different rules and how they are administered, and the details of the complaints process and its purpose
- explain the visitor arrangements, the process visitors need to go through to get into the Visitors Centre, and why it is necessary
- explain to detainees the arrangements, and the reasons for them, in relation to such things as food storage, contraband and drugs, medical treatment, distribution of medicines, why requests for particular medications are refused, and any other concern that consultation with detainees might reveal
- establish a process for determining a list of topics for discussion one week before each consultation forum is to be held.

Recommendation 4.4

The Inquiry recommends that GSL and DIMIA prepare a small number of information posters for the Visitors Centre to inform visitors about important things such as:

- booking arrangements for visits, the ‘visitor lists’ prepared for each detainee, and why visitors can see only the detainees they have nominated on their visitor application form

- why food brought into the Visitors Centre must be consumed there and cannot be taken back to detainees' rooms and why parcels cannot be left for detainees but must be sent via Australia Post
- what is and is not allowed to be brought into the Visitors Centre—for example, photographs, photo albums, clothes and books
- what the security screening machine is, what it does, why it is necessary, and why some items and articles of clothing (such as shoes) give the wrong signal and might need to be removed.

GSL and DIMIA should also establish for visitors a program of information sessions that provide a general briefing on Baxter, covering such topics as what the compounds are, why they differ and how they operate, arrangements for food preparation and barbecues, the nature of education sessions and how they are run, access to telephones, inter-compound movement, and the arrangements for dealing with complaints. The arrangements for these information sessions—developed in consultation with visitors—should cover the frequency of the sessions, their format, and the topics for discussion.

Recommendation 4.5

The Inquiry recommends that GSL and DIMIA—in consultation with detainees and visitors—establish arrangements for regularly:

- providing to detainees and visitors feedback on questions they have raised
- informing them of action being taken and progress made
- advising them when action has been taken and the matter has been finalised and what were the outcomes.

Visitors should be encouraged to raise queries, perhaps through a request form, which must be promptly acknowledged and followed up.

Recommendation 4.6

The Inquiry recommends that DIMIA and GSL consult with detainees and explore options—such as cooking their own food—that will facilitate greater independence and variety in detainees’ food ordering and preparation.

Recommendation 4.7

The Inquiry recommends that GSL and DIMIA:

- replace the current security screening machinery with two or, preferably, three more modern machines
- take immediate steps to update and increase the size of the Visitors Centre
- in consultation with detainees and visitors, ensure that the environment is more open and hospitable
- establish processing arrangements for visitors that begin before the official visiting hours and do not result in a decrease in the available visiting time.

Recommendation 4.8

The Inquiry recommends that DIMIA, in consultation with GSL, consider allowing detainees to make regular, supervised monthly visits to Port Augusta and other suitable locations, to enable them to interact with the community and participate in activities such as sporting fixtures, picnics and barbecues. Participation would be a privilege that is earned. The arrangements should be reviewed after six months in order to determine how well they are working.

4.4 Operational considerations

Recommendation 4.9

The Inquiry recommends that, as an immediate priority, DIMIA and GSL:

- agree on and implement arrangements that will ensure that when female detainees are placed in Red One or the Management Unit they are checked only by female detention officers

- negotiate whatever changes to the contract are needed in order to accommodate this initiative
- ensure that staffing of detention officers when female detainees are in Red One and the Management Unit is reflected accurately in the operational records that are kept.

Recommendation 4.10

The Inquiry recommends that DIMIA develop and implement arrangements to ensure that:

- accurate, relevant, clear and concise briefing notes on each detainee are prepared before they arrive at Baxter and that these records are attached to the detainee's file
- DIMIA and GSL staff and contractors who are likely to have close contact with detainees are given an accurate briefing on each detainee before the detainee's arrival at Baxter or as soon as practical thereafter
- the briefing notes are used to inform the detainee induction process
- staff refer to the briefing notes for guidance, so that they can respond suitably to the needs of individual detainees.

4.5 Infrastructure

Recommendation 4.11

The Inquiry recommends that, having regard to the findings of the Royal Commission into Aboriginal Deaths in Custody, DIMIA and GSL:

- seek expert advice on the Muirhead standards as they relate to a custodial environment
- carry out an immediate review of the Management Unit and effect the changes necessary to conform with the Muirhead standards

- carry out a thorough review of the purpose and nature of the Management Unit in the light of a changed immigration detention environment and a changed detainee population
- agree on the changes that need to be made to the Operating Procedures in order to give effect to the new arrangements.

Recommendation 4.12

The Inquiry recommends that DIMIA consider constructing a flexible ‘intermediate facility’ at Baxter to enable more appropriate accommodation to be provided to detainees who cannot be allowed to remain in an open compound but who for various reasons should not be placed in the behaviour management environment of Red One or the Management Unit. The facility should be designed in such a way as to provide sufficient flexibility to be configured to accommodate a person with specific needs, such as Anna, or a family or individual requiring temporary relief from their compound or intensive medical observation.

Recommendation 4.13

The Inquiry recommends that DIMIA consider making structural changes to the Baxter compound accommodation for detainees in order to:

- create two-room and three-room family units from adjacent rooms by removing walls between adjoining rooms and replacing them with movable dividers
- open up the closed compound structure by removing some of the rooms and allowing views outside the compound and beyond the detention facility itself
- use the opened-up space to create a vegetable or native garden or to other good effect.

5.3 Some possible solutions

Recommendation 5.1

The Inquiry recommends that the DIMIA Secretary:

- commission and oversee a review of departmental processes for file creation, management and access
- take a leadership role in implementing the major changes that will probably be necessary as a result
- ensure that staff receive training in effective file management practices and the reasons for them
- make executive management personally accountable for ensuring that sound file management practices are followed.

Recommendation 5.2

The Inquiry recommends that the DIMIA executive ensure the preparation for staff of a checklist to be used as a minimum standards template for conducting identification inquiries. The checklist should provide a menu of avenues of inquiry, specify a sequential order for investigations, be included as an attachment to the DIMIA Interim Instruction on Establishing Identity in the Field and in Detention, and form a part of the personal investigation file.

The DIMIA executive should also:

- formalise the Interim Instruction together with the checklist attachment as soon as practicable
- ensure that suitable training modules are developed and delivered to all staff—including managers—who might be involved in identification inquiries
- institute management arrangements to ensure that such inquiries are linked as appropriate to the Identity and Immigration Status Group.

Recommendation 5.3

The Inquiry recommends that, as a matter of urgency, the Commonwealth Government take a leadership role with state and territory governments to develop a national missing persons policy to guide the development of an integrated, national missing persons database or capacity. Initial policy development could be carried out under the guidance of the Australasian Police Ministers Council, with the output submitted to governments for consideration and agreement.

Recommendation 5.4

The Inquiry recommends that, on the basis of an agreed national missing persons policy, the Commonwealth Government take a leadership role with state and territory governments in developing and implementing a national missing persons database or capacity that will provide an effective national recording and search capability under both names and biometric data. Discussions in this regard should be informed by reporting on the progress and success of the Minimum Nationwide Person Profile project to the Australasian Police Ministers Council.

Recommendation 5.5

The Inquiry recommends that DIMIA reassess its position in relation to privacy in all its public policy operations associated with immigration detention. In revising its practices, it should:

- seek advice from the Privacy Commissioner and the Minister
- take immediate steps to increase awareness and understanding on the part of relevant DIMIA staff—including executive staff—of the principles and provisions of the Commonwealth’s *Privacy Act 1988*
- revise and strengthen procedures relating to identity in immigration detention, to ensure that the wider options potentially created by this approach are considered.

Recommendation 5.6

The Inquiry recommends that DIMIA establish for inquiries about immigration detainees a ‘hotline’ facility that can deal with those inquiries as a ‘one-stop shop’. DIMIA should ensure that the contact officer position is continuously staffed, regardless of the absence of any officer, and that all embassies and high commissions are advised of the details of these arrangements and ask their consular officials to direct all immigration detention inquiries to the nominated DIMIA contact officer in the first instance.

Recommendation 5.7

The Inquiry recommends that DIMIA ensure that:

- fingerprints and other biometric data collected from individuals in immigration detention are stored on a national database to facilitate investigations by Commonwealth and state and territory police and other law enforcement agencies
- appropriate liaison arrangements are made with CrimTrac
- any DIMIA decisions in relation to the collection and storage of biometric data are consistent with strategies being pursued by CrimTrac in response to guidance by Australian governments.

6.3 Events in New South Wales

Recommendation 6.1

The Inquiry recommends that the Commonwealth Government encourage state and territory authorities to implement a requirement that on each occasion a ‘missing patient’ report is made to police by a hospital, a medical practitioner or other facility, the report must be accompanied by sufficient information about the patient’s history to clearly indicate the person’s degree of risk and vulnerability, so that police can determine whether the person should be also classified as a missing person and what immediate action is necessary.

6.4 Events in Queensland

Recommendation 6.2

The Inquiry recommends that governments and health authorities take steps to encourage clinicians to be more clinically assertive in creating the optimum conditions in which to assess patients—noting that there is little point in making a referral to an in-patient unit if adequate assessment cannot take place.

In consultation with the hospital, facility or clinic, DIMIA should establish containment arrangements that do not adversely affect the assessment environment and also meet the requirements of the Migration Act. If the problem lies in the Act, the Act should be changed.

Recommendation 6.3

The Inquiry recommends that, when immigration detainees are entrusted to the care of a hospital, medical centre or other health care facility, DIMIA ensure that clinicians are asked to pay particular attention to ‘odd’ presentation features and to any ‘odd’ history. If a detainee provides little information or is uncooperative, collateral history should be sought from officers and others, including fellow detainees.

Recommendation 6.4

The Inquiry recommends that DIMIA develop and implement procedures and systems at immigration detention facilities to provide for the progressive collection, integration and assessment of cumulative data from all records of detainee activity. It should ensure that such information is available and is provided along with medical information when clinicians are making mental health assessments and determining treatment options.

Recommendation 6.5

The Inquiry recommends that the Commonwealth Government initiate early discussions with the Queensland Government to identify and explore ways in the Queensland mental health system of more effectively aligning existing clinical pathways between prison and in-patient units, to allow for continuity of clinical care and assessment following an immigration detention patient’s return to prison, so that clinicians assessing patients can follow them up.

Recommendation 6.6

The Inquiry recommends that DIMIA work closely with the Queensland Department of Corrective Services to review existing clinical pathways and training to:

- identify and explore practical ways in which preliminary observations of an immigration detainee showing signs of possible mental illness could be more speedily advanced towards action for assessment
- institute effective reporting and consultation mechanisms, so that DIMIA can discharge its responsibilities for the care and safety of detainees.

6.5 Events in South Australia

Recommendation 6.7

The Inquiry recommends that DIMIA ensure that mechanisms are established to:

- require GSL to provide for detention officers training in observing, recognising and reporting behaviour and signs that may be symptomatic of mental illness
- ensure that as much emphasis is given to recruiting people with health and welfare training and skills as is given to custodial and security qualifications and experience
- capture significant concerns about the wellbeing of any detainee, as expressed by detention officers, other detainees and visitors
- ensure that this information is communicated in a timely manner to medical staff, to allow the information to be taken into account in the mental health assessment process.

Recommendation 6.8

The Inquiry recommends that DIMIA explore the possibility of contracting the South Australian Mental Health Service or the South Australian Forensic Mental Health Service to service the mental health care needs of immigration detainees at Baxter, with a view to providing seamless, effective service and improving the continuity of patient care.

Recommendation 6.9

The Inquiry recommends that—in consultation with the Rural and Remote Mental Health Service and the Baxter medical team—DIMIA and the South Australian Department of Health:

- conduct a thorough review of clinical pathways, arrangements and consultative machinery proposed in the memorandum of understanding to make certain that respective responsibilities, and particularly lead responsibilities, are clearly defined
- ensure that consultation, coordination and reporting arrangements are clearly defined and enable management oversight of the delivery of appropriate levels of mental health care to detainees and provide to DIMIA adequate information to enable it to demonstrably meet its duty of care on behalf of the Commonwealth Government.

6.7 Standards of health care

Recommendation 6.10

The Inquiry recommends that, as a matter of urgency, DIMIA establish the Health Advisory Panel, as specified in the detention services contract, to help GSL develop and review Baxter’s health plans and to provide, for health and social service professionals employed by GSL, access to well-qualified specialists and consultants—particularly in more complex cases or cases that have become protracted.

Recommendation 6.11

The Inquiry recommends that the Minister for Immigration establish an Immigration Detention Health Review Commission as an independent body under the Commonwealth Ombudsman's legislation to carry out independent external reviews of health and medical services provided to immigration detainees and of their welfare. The Commission should report to the Minister and:

- be appropriately staffed and resourced, with a core of experienced people with relevant skills
- have the ability to invite specialists to participate in particular reviews and audits
- have the power to initiate its own reviews and audits
- in consultation with the Immigration Detention Advisory Group and the Health Advisory Panel, carry out an independent assessment of the current structure of health care arrangements at immigration detention facilities and of the adequacy and quality of the services provided
- in consultation with the Detention Contract Management Group (see recommendation 7.6), review each health and medical care performance measure specified in the detention services contract and, where necessary, replace it with a more appropriate measure and propose arrangements for monitoring the measures
- recommend more effective arrangements for providing health and medical services to immigration detainees, together with arrangements for monitoring and management of the provision of those services
- identify the most appropriate national accreditation standards applicable to the immigration detention environment that service providers should be required to meet
- coordinate its operations with the Ombudsman and the Immigration Detention Advisory Group in order to maximise the effectiveness of oversight machinery.

Recommendation 6.12

The Inquiry recommends that the Immigration Detention Health Review Commission, in consultation with the Health Advisory Panel and the Mental Health Council of Australia, investigate relevant studies of detainee populations and advise on the level of mental health services applicable to the immigration detention population in Baxter, to reflect the much higher incidence of mental disorders that is evident.

Recommendation 6.13

The Inquiry recommends that the Immigration Detention Health Review Commission work closely with the Immigration Detention Advisory Group and the Health Advisory Panel to review the adequacy of current systems for continuing professional development, to ensure the maintenance of high standards in the delivery of health services to immigration detainees.

6.8 Mental health legislation

Recommendation 6.14

The Inquiry recommends that, in redrafting the state's *Mental Health Act 1993*, the South Australian Department of Health ensure that the Act makes provision for greater access to psychiatric in-patient assessment for involuntary patients. The Queensland *Mental Health Act 2000* and other legislation, such as that applying in New Zealand, might offer useful insights.

7.2 Immigration policy and implementation

Recommendation 7.1

The Inquiry recommends that DIMIA develop and implement a holistic corporate case management system that ensures every immigration detention case is assessed comprehensively, is managed to a consistent standard, is conducted in a fair and expeditious manner, and is subject to rigorous continuing review.

7.3 Culture, processes and attitudes

Recommendation 7.2

The Inquiry recommends that DIMIA critically review all Migration Series Instructions from an executive policy and operational management perspective with a view to:

- discarding those that no longer apply in the current environment
- where necessary, rewriting those that are essential to the effective implementation of policy, to ensure that they facilitate and guide effective management action and provide real guidance to busy staff
- ensuring that up-to-date, accurately targeted training is delivered to staff who are required to implement the policy guidelines and instructions
- establishing regular management audits that report to executive management, to ensure that the Migration Series Instructions are up to date and DIMIA officers are adhering to them.

7.4 Structure and operations

Recommendation 7.3

The Inquiry recommends that the Minister commission the Secretary of DIMIA to institute an independent professional review of the functions and operations of DIMIA's Border Control and Compliance Division and Unlawful Arrivals and Detention Division in order to identify arrangements and structures that will ensure the following:

- DIMIA's compliance and detention functions are effectively coordinated and integrated.
- The desired outcomes of these functions and the necessary resources—including the number and the skills profile of staff—are clearly identified before a decision is made on the structure that will best enable effective and equitable service delivery.

- The restructuring accommodates these requirements and ensures that arrangements are made to monitor and manage the high-level risks to the Commonwealth inherent in immigration detention.
- There is a seamless approach to dealing with immigration detention operations and case management.
- The aims and objectives of the Government's immigration detention policy are fairly and equitably achieved and human dignity is demonstrably respected.

Recommendation 7.4

The Inquiry recommends that DIMIA:

- review the current training programs for compliance and detention officers to ensure that induction and in-service programs convey an accurate and contemporary picture of DIMIA operations and adequately prepare operational and management staff for all aspects of the work they will be expected to do
- ensure that such training particularly deals with the consultation, coordination, reporting and management requirements of compliance and detention operations and shows how to manage the risks inherent in the performance of these functions
- immediately develop and implement a policy that requires that every decision to detain a person on the basis of 'reasonable suspicion of being an unlawful non-citizen' is reviewed and assessed within 24 hours or as soon as possible thereafter.

DIMIA should incorporate this policy of 24-hour review in all relevant training programs and operational guidelines to ensure that compliance officers understand the need to:

- objectively determine the reasons and facts upon which a decision to detain is made
- verify the validity of the grounds of 'reasonable suspicion' and the lawfulness of the detention

- take immediate remedial action as necessary and report the circumstances of any unresolved matter to the Identity and Immigration Status Group.

7.5 Contracting and government policy outcomes

Recommendation 7.5

The Inquiry recommends that DIMIA seek from the Australian National Audit Office a detailed briefing on the findings of the ANAO report on the detention services contract with GSL, to obtain the ANAO's guidance on reviewing the Commonwealth's current detention services contract with GSL and identify where and how changes can and should be made.

Recommendation 7.6

The Inquiry recommends that the Minister establish a Detention Contract Management Group made up of external experts to provide direction and guidance to DIMIA in relation to management of the detention services contract and report quarterly to the Minister. Group members should have expertise in the following areas:

- project management in a high-risk government policy environment
- corrections management
- contracting strategy and management
- performance monitoring and management
- legal contracting and statutory reporting requirements
- management accounting and financial management.

The Detention Contract Management Group should have DIMIA representation at First Assistant Secretary level to advise on policy implications and ensure that the Group's directions are implemented effectively through new departmental arrangements.

Recommendation 7.7

The Inquiry recommends that, as a priority task, the Detention Contract Management Group review the current contract for detention services and advise DIMIA, in consultation with GSL, in order to identify and agree changes in arrangements that would:

- facilitate delivery of the detention services outcomes required by the Government
- provide the basis for an effective, responsible business partnership that values and encourages innovation by GSL
- encourage GSL to carry out internal audits of its own performance and arrangements in order to maintain high-quality service delivery
- develop, in consultation with GSL, a new regime of performance measures and arrangements for their continued monitoring and management that are meaningful and add value to the delivery of high-quality services and outcomes
- agree with GSL arrangements for independent, external assessment and review as required
- provide for renegotiating arrangements for the provision of health care when the Immigration Detention Health Review Commission and the Health Advisory Panel have been established and have provided advice on new requirements
- foster a shared partnership interest in achieving effective policy outcomes to ensure that the Government's objectives and the high standards of behaviour expected by the Government are met.

8.4 The Vivian Alvarez matter

Recommendation 8.1

The Inquiry recommends that, as an urgent priority, DIMIA commission a thorough, independent review and analysis of its information management systems. The review should be carried out by an experienced, appropriately qualified information technology systems specialist and should aim to:

- identify the real organisational policy and operational information management requirements—particularly requirements for interconnectivity, search capacity and growth
- assess whether these requirements can be met cost effectively by further development of existing systems under the current architecture
- if not, identify the broad development parameters and indicative cost and time frame for implementation
- formulate an implementation plan for consideration by the DIMIA executive.

Recommendation 8.2

The Inquiry recommends that, as a priority, DIMIA take steps to establish links or authorised access to the Immigration Review Tribunal’s information systems, sufficient to ensure that the names and immigration status of people whose circumstances are subject to review are readily available to DIMIA compliance officers.

Recommendation 8.3

The Inquiry recommends that DIMIA:

- develop, for all immigration detention and compliance executives and managers, a briefing program that clearly explains the need for a decision to be made to remove from Australia a person reasonably suspected of being an unlawful non-citizen and the responsibilities associated with exercising that power
- ensure that the central factors relating to removals and the implications for identity investigations and the exercising of detention powers are included in departmental training programs for compliance and removals officers
- ensure that the implications of all aspects of identity checking, detention and removals are included in the checks and balances exercised by the Identity and Immigration Status Group.

1 Introduction

1.1 The conundrum

How could an Australian resident of German origin be detained in prison in Queensland for six months and at the Baxter Immigration Detention Facility for four months and not be identified for all that time? How could this person's long-standing medical condition remain undiagnosed? How could she undergo a six-day in-patient psychiatric assessment at Princess Alexandra Hospital and be diagnosed as not suffering from a mental illness? Why did it take so long to have her re-assessed in a dedicated psychiatric facility at the Glenside Campus of the Royal Adelaide Hospital, despite a continuing record of 'odd' and 'bizarre' behaviour?

1.2 A perspective

Cornelia Rau had a history of mental illness. The first indication was in October 1998, when, following evidence of unstable behaviour, she was hospitalised for about three months. Between January 1999 and 17 March 2004, when she went missing from Manly Hospital, Ms Rau suffered a series of episodes involving erratic behaviour and hospitalisation. On one occasion, in December 2003, her behaviour led her family to report her to police as a missing person. The diagnosis of Ms Rau's condition varied: sometimes she was assessed as having 'bipolar disorder', sometimes as having 'schizoaffective bipolar', and sometimes as suffering from 'chronic schizophrenia'.

Ms Rau came to Australia with her family in 1967, at the age of one-and-a-half years. The family lived in Australia for 13 years, then returned to Germany for two years, and then moved to Asia before returning to Australia permanently in 1983. During their school years Ms Rau and her sister spoke English in the community and German at home. They quickly learnt English and spoke what was described by people who met her during her 10 months in immigration detention as 'fluent Australian-accented English'.

At high school Ms Rau and her sister studied German and kept their German language skills current. Ms Rau's sister described their language ability: 'Phonetically our German has remained fluent, but

we don't have enough words to draw on for a sustained or very complex conversation'. When applied to Ms Rau, this assessment is consistent with other information provided to the Inquiry.

During her illness Ms Rau became distanced from her family. She became secretive about her private life, acted unpredictably and often went missing, sometimes travelling overseas without telling her family of her intentions or movements. On most occasions, however, she would eventually make contact, usually with her sister.

The young woman detained on 31 March 2004 in Queensland as a suspected unlawful non-citizen under s. 189 of the *Migration Act 1958* presented herself to the public and authorities as Anna Brotmeyer and as Anna Schmidt, a German tourist who had overstayed her visa. At that time Cornelia Rau was not a person of official interest: her family reported her missing on 11 August 2004, almost five months after 'Anna' had been detained.

Manly Hospital records show that Ms Rau was reported to NSW Police as a 'missing patient' on 18 March 2004, but she was not at that time considered a person at risk. Although they were worried about Ms Rau, her family—knowing her behaviour patterns, including her resistance to treatment and the fact that in the past she had always made contact with them if she ran into trouble—did not immediately report her to police as a missing person.

While in immigration detention at Brisbane Women's Correctional Centre and Baxter, Ms Rau maintained that she was a German tourist. She gave several names and dates of birth and conflicting accounts of how and when she had arrived in Australia. She conducted her discussions with German consular officers in German, although she did not provide sufficient details to enable them to issue a German passport.

This report is the story of a journey. To avoid premature conclusions, Ms Rau is referred to as 'Anna', the identity she presented until she was finally identified. It is, of course, Ms Rau who is reported missing to the police, not Anna.

1.3 Two independent streams of investigation

After her family reported Cornelia Rau missing on 11 August 2004, NSW Police made considerable efforts to find the missing person. But these efforts did not stem from, nor were they related to, the

immigration detention of Anna and the efforts the Department of Immigration and Multicultural and Indigenous Affairs and the German consulates were making to establish her identity for visa and passport documentation purposes.

There were two distinct streams of investigation, each focusing on a different person. One was searching for a missing person called Cornelia Rau; the other was seeking corroborative personal details relating to a suspected German unlawful non-citizen called Anna.

The two streams of investigation did not come together until 3 February 2005, when Anna was finally identified as Cornelia Rau. Friends of the Rau family had read a newspaper article about a 19-year-old German woman who was being held in immigration detention at Baxter and was behaving oddly. They raised with the Rau family the possibility that she could be Ms Rau. The Rau family drew this to the attention of Manly police, who acted quickly with DIMIA at Baxter to resolve the question beyond doubt. At that time Anna was in the process of being taken for psychiatric assessment at Glenside.

1.4 The Inquiry's terms of reference

The terms of reference (see Appendix A) required the Inquiry to report by 24 March 2005. This timetable was, however, affected by two factors: the large number of people it was necessary to interview in order to develop a reliable information base for analysis; and the legal arrangements and safeguards state governments sought for witnesses.

On 27 February 2005 the Minister for Immigration and Multicultural and Indigenous Affairs, Senator the Hon. Amanda Vanstone, extended the time for the Inquiry and agreed to provide additional resources. The Inquiry presented an interim report to the Minister on 23 March 2005.

On 2 May 2005 the Acting Minister for Immigration and Multicultural and Indigenous Affairs, the Hon. Peter McGauran, referred to the Inquiry a request to examine the circumstances surrounding the removal from Australia of Ms Vivian Alvarez, an Australian citizen. The Inquiry's terms of reference were extended to include this and other matters (see Appendix A).

Following discussions with the Minister it was agreed that the Inquiry's report on the immigration detention of Cornelia Rau should

not be delayed pending the completion of inquiries into other matters. It was agreed, however, that any issues and prima facie findings identified by the Examination of the Vivian Alvarez Matter during the term of this Inquiry be taken into account and dealt with in this report. This is done in Chapter 8.

At the time of submission of this report, recommendations were also to be made about the appropriate form of examination of other matters that may be referred to the Inquiry. This advice has been provided to the Minister separately.

1.5 Inquiry processes and procedures

The Inquiry's work spans events from March 2004, when Anna was taken into immigration detention, until she was identified as Cornelia Rau in February 2005. The sequence of events is described in Chapter 2, and Attachment I presents a flowchart of principal contacts and events.

The Inquiry team was led by Mr Mick Palmer and comprised Mr Neil Comrie, Ms Kathryn McMullan, Mr Rein Mere, Mr Peter Pearsall and Mr Glenn Ross; Ms Robyn Byrne and Ms Pia Davis provided secretariat support. The team brought a wide range of skills to the investigation and analysis of the Rau matter. In addition, the professional assistance and insights provided by Dr David Chaplow (Director of Mental Health in the New Zealand Ministry of Health), who acted as consulting psychiatrist to the Inquiry and contributed greatly to the reporting process, were greatly valued.

Ms Deborah Tyler and Mr Bruce Pope helped the Inquiry gain access to DIMIA records and arrange interviews with departmental officers; this, too, greatly facilitated the work of the Inquiry. In particular, the cooperation of officers from DIMIA and Global Solutions Limited (Australia) Pty Ltd, as well as its subcontractors International Health and Medical Services and Professional Support Services, was appreciated. The cooperation of and assistance provided by the Ambassador of the Federal Republic of Germany and consular officers in Brisbane, Melbourne and Cairns were also very valuable.

Many interviews and discussions were held—in Queensland (Brisbane, Coen and Cairns), Sydney, Canberra, Melbourne, Adelaide, Port Augusta and Baxter. (Appendix B lists the people interviewed.) With the consent of participants, interviews were digitally recorded and a copy of the transcript was offered to every interviewee. The

participants were given assurances of the confidentiality of the information they provided to the Inquiry. Most of the interviewees cooperated fully, but some individuals declined to have their interviews digitally recorded; a small number of people declined to be interviewed. These circumstances did not impede the Inquiry process or prevent the Inquiry from reaching sound conclusions on the areas of relevance to the terms of reference.

Discussions were held with the DIMIA Secretary and Deputy Secretaries. These were not formal interviews; rather, they were restructured to provide an opportunity to exchange perspectives on emerging findings and to correct any misconceptions.

The Inquiry team also analysed DIMIA and GSL files, contract documentation, operating practices and procedures, audits and performance reviews, and various reports. It inspected relevant Migration Series Instructions and Immigration Detention Standards, together with a range of operating documentation from Baxter. In addition, it explored consultation, coordination and cooperation arrangements with other agencies and organisations and assessed a wide variety of documents and advice provided to it.

Before this report was finalised, agencies and individuals potentially adversely affected by a finding or recommendation were given an opportunity to comment. All responses were considered.

The Examination of the Vivian Alvarez Matter is being led by Mr Neil Comrie, who is assisted by Mr Bill Severino. As noted, an interim report on this Examination is provided in Chapter 8 here. When the Examination is complete, it will be the subject of a separate report submitted by Mr Comrie.

1.6 Submissions received

In response to national newspaper advertisements, the Inquiry received 115 submissions. Of these, 86 were letters, mainly from parents, carers and family members discussing their experiences of schizophrenia. Other respondents expressed concern at the lack of a national missing persons database. In particular, the Inquiry received submissions from the solicitor for Cornelia Rau; her Guardian, the South Australian Public Advocate; and the lawyers for the Rau family.

These contributions were appreciated, and all submissions were carefully considered. Several respondents noted a wish for their

submission to remain confidential: as a result, this report does not provide a list of the submissions received.

Some respondents expressed concern about restricted access to hospital facilities because of the lack of beds, the shortage of psychiatrists and insufficient funding and about the perceived poor performance of mental health services. These subjects are beyond the scope of this Inquiry, although they did provide a valuable broader perspective against which to view the events in question.

1.7 Some progress

The Inquiry team became aware of considerable effort being made by a number of organisations, including DIMIA, to overcome perceived weaknesses in processes and procedures. Acceptance of responsibility and willingness to rectify deficiencies raised by the Inquiry team, so as to ensure that such situations do not arise again, are steps the Inquiry welcomes.

In particular, on 25 May 2005 the Minister and the Secretary presented to the Senate Estimates Committee a progress report on initiatives being taken to overcome deficiencies.

Because these initiatives are so recent, however, the Inquiry is not in a position to assess their impact. Additionally, such an assessment is beyond the Inquiry's terms of reference and its time frame. In the opinion of the Inquiry, such an assessment should be conducted as part of the recommended independent professional review of the functions and operations of compliance and immigration detention.

It should be noted that the Inquiry's recommendations are premised on major cultural change in the compliance and detention areas of DIMIA. The Inquiry formed the conclusion, on the basis of the systemic nature of the management deficiencies it identified, that the current executive management team would not, without significant external support, be able to effectively bring about the major changes in mindset that are necessary. Structural and procedural changes alone will not be sufficient.

The Inquiry strongly supports the Minister's statement that changes to policy, processes and legislation will be of little benefit without cultural change.

In Chapter 7 the Inquiry argues that enduring cultural change must be led from the top. In discussing this in an organisational sense, the Inquiry has sought to differentiate between the executive (comprising the Secretary, Deputy Secretaries and First Assistant Secretaries for compliance and detention) and executive management (including Assistant Secretaries in the compliance and detention areas and Directors at section head level).

1.8 A melting pot of stories

In recent years immigration detention policy has been the subject of lively debate in many quarters, especially as a result of the influx of ‘boat people’. Experiences involving incidents at a number of immigration detention centres—including Curtin and Woomera, which was closed in April 2003—have become woven into a melting pot of stories. The beliefs expressed are strongly and sincerely held, and it was often difficult to identify which stories relate to Baxter and the period being examined by the Inquiry.

The Inquiry also found many instances where poor communication has resulted in the perpetuation of assumptions that are not founded in fact. On occasion, it seems that cultural approaches to communication so as not to give offence were misinterpreted. Some of these situations were allowed to persist because Baxter staff offered inadequate information and explanation to visitors and detainees. This is discussed in the report.

Nevertheless, in order to form judgments about particular events occurring during the period of Anna’s immigration detention, the Inquiry sought to understand all the stories that were brought to its attention. An understanding of past stories was important in establishing context.

As far as practicable, the Inquiry investigated particular claims of abuse, neglect and poor practice. In all cases it formed its own judgment. These are reflected in its findings and recommendations.

The Inquiry is grateful to those detainees and carers who were prepared to share their stories and perceptions, which remain confidential. They provided a human context for the Inquiry’s work and support the primary goal of this report, which is to bring about enduring improvement and not to lay blame.

2 The sequence of events

2.1 The journey

This is the story of a mentally ill young woman. The mental health evidence available to the Inquiry suggests that she might have embarked on her journey and assumed other identities in order to escape her illness and the pain and distress it caused her.

The principal events in Anna's journey, from the time she was detained until she was identified as Cornelia Rau on 3 February 2005, are detailed in this chapter. It provides a reference. The issues that arise and their implications are discussed elsewhere in the report.

2.2 The question of identity

The young woman who was detained on 31 March 2004 in Queensland as a suspected unlawful non-citizen under s. 189 of the *Migration Act 1958* presented herself as Anna, a German tourist. At that time Cornelia Rau was not a person of official interest: she was reported missing by her family on 11 August 2004, some five months later.

NSW Police made considerable efforts to find the missing person Cornelia Rau. Those actions did not, however, stem from the efforts made by DIMIA while Anna was in immigration detention and, although studied by the Inquiry, are not recorded here. There were two distinct streams of investigation, focusing on two 'different' people: they became linked only when Anna was identified as Cornelia Rau.

2.3 Overview of main events

2.3.1 A private citizen

Cornelia Rau's journey did not begin at Coen in March 2004: it began up to eight years before. She and her family had endured a troubled journey of wellness interspersed with psychotic episodes.

Ms Rau had absconded from care before but had always ‘surfaced’ and contacted her family, not always when she was in Australia. When she disappeared from the East Wing of Manly Hospital on 17 March 2004, the family was reluctant to inform police because Ms Rau had only recently been reported missing, on 1 December 2003, and found. When there had been no word from Ms Rau for five months, however, the parents decided to again contact police.

The Inquiry studied all elements of Cornelia Rau’s journey carefully. It concluded that there are details of her journey that should remain private. Ms Rau’s dignity should be respected. To the extent that details affect the Inquiry’s findings, these are included in the timeline that follows, and other matters are raised in the report to define the context. Meanwhile, Cornelia Rau is continuing to receive care.

2.3.2 Timeline

The Inquiry prepared a detailed timeline in order to establish a reliable reference for its investigations and analysis. Only selected events are recorded here; Attachment I provides more information.

- 29 March 2004** Anna appears at the Hann River Roadhouse in Queensland. The proprietor is concerned about her safety.
- 30 March 2004** Painting contractors give Anna a lift from the Roadhouse to the Exchange Hotel in Coen. She says she is a German tourist, has no money and is planning to hitchhike to Weipa. The publican is concerned at the young German tourist hitchhiking alone in an inhospitable area in ‘the wet’ and contacts the police constable in Coen.

The constable comes to the hotel and talks to Anna. She gives limited information about her identity and cannot provide supporting documentation. She says she has no family or other people who would know she is missing or would report her as such. The constable reports his concerns to the DIMIA compliance officer in Cairns, who carries out travel movements and identity checks and finds no record of her coming into or leaving the country. The constable also searches the Queensland Police database, finding no record of Anna.

Anna stays the night at the Exchange Hotel. The local police tracker pays for her meal and the publican provides free accommodation. Her behaviour gives no cause for concern.

31 March 2004

Police return to the Hotel to seek further details, but Anna has left and been given a lift. Police find her walking north towards the quarantine inspection station, some 15 kilometres from Coen. They explain that the road north is flooded and invite her to accompany them to Coen Police Station to help them confirm her identity.

Anna provides the names Brotmeyer and Schmidt and gives various, conflicting accounts of her origins in Germany, her arrival in Australia by air or boat between two weeks and over two years ago, and her movements around Australia. This information is communicated to the DIMIA compliance officer in Cairns, who runs further checks. Unable to identify Anna, he asks the constable at Coen to detain her in immigration detention under s. 189 of the *Migration Act 1958*, on suspicion of being an unlawful non-citizen.

At Coen Police Station Anna produces a Norwegian passport and an envelope containing \$2413.10. The owner of the passport is contacted, but she does not know Anna. A search of Anna's property produces a WWOOF (Willing Workers on Organic Farms) Australia book containing, among other things, two names. These two people provide no useful information. Anna is then driven to the Cairns watch-house, a journey of about eight hours; her behaviour continues to give no cause for concern.

1 April 2004

DIMIA personnel interview Anna at the Cairns watch-house. She provides the names Anna Brotmeyer, Anna Sue Brotmeyer, Anna Schmidt and Anna Sue Schmidt and a birth date of 21 March 1970. She again gives conflicting accounts of her origins in Germany, her arrival in and travels around Australia, and how long she has been here.

2 April 2004

DIMIA asks the Honorary German Consul in Cairns to assist in determining Anna's identity. The interview is conducted entirely in German because it is assumed

that she cannot speak English. There is no indication that Anna is not German. She provides the same limited information previously given to DIMIA, which is insufficient for the issuing of German travel documentation.

- 3 April 2004** Anna provides further accounts of her arrival in Australia, which could have been two years or 18 months ago. She says she cannot remember the details. She claims her passport on departure from Germany was for Anna Schmidt and that the Brotmeyers are friends from overseas. Her parents are Veronika and Siegfried Schmidt and she says the money found in her possession was given to her by them some three years ago but she has since had no contact with them.
- 4 April 2004** The DIMIA compliance officer in Cairns visits Anna in the Cairns watch-house to give her another opportunity to provide new information about her identity or revise what she has said before being transferred to Brisbane Women's Correctional Centre. She does not provide any further information.
- 5 April 2004** Because there is no DIMIA immigration detention facility in Queensland, Anna is transferred to Brisbane Women's Correctional Centre, where she is placed in the general prison population. In contrast with the situation for men at the Arthur Gorrie Correctional Centre in Brisbane, there is no separate area in BWCC for women held in immigration detention.
- 6 April 2004** The DIMIA compliance officer in Brisbane carries out further checks of various permutations of the names provided by Anna on the Movements database but finds no records corroborating these names or names found in the WWOOF book in Anna's possession.
- 7 April 2004** The compliance officer visits BWCC to conduct a formal identification interview with Anna and take passport-style photographs. She again provides fictitious details of her arrival in Australia, family life in Germany and personal information.
- 9 April 2004** Anna contacts the compliance officer by telephone, saying she knows someone in Australia who can help her and providing a name. When contacted, the person

says he knows of Anna through an inmate at BWCC but has never met her.

- 27 April 2004** The compliance officer carries out further checks on DIMIA databases, using different permutations of names and close matches, and repeats earlier searches. One possible match is identified—a person living in Victoria, who was, however, found to be an Australian citizen born in Poland.
- 29 April 2004** The compliance officer contacts the Queensland Police Service Missing Persons Unit and faxes details of Anna together with a photograph, offering colour photos as digital or film versions if required. The Missing Persons Unit advises it has no record of the person referred.
- 30 April 2004** The compliance officer meets with Anna at BWCC; she declines to have the interview taped and is unable to add anything to the information already held.
- 11 May 2004** Anna asks to apply for a German passport. The compliance officer faxes to BWCC an application form for a German passport and a DIMIA Cooperation to Gain Travel Document form in the name of Anna Schmidt. She signs the forms but fails to provide a date of birth. She also states that her previous passport was stolen.
- 15 May 2004** The compliance officer telephones the German Consulate in Sydney to check the adequacy of the partially completed application for a German passport. The Consulate confirms that there is insufficient information for the passport application to proceed.
- 17 June 2004** The compliance officer sends to the Australian Embassy in Berlin an email containing the details provided by Anna and asking for help with identifying her.
- 5 July 2004** Anna is one of 25 inmates interviewed by an Ethical Standards Unit investigation team examining the conduct and behaviour of BWCC staff to ensure that prisoners are being treated fairly.

- 14 July 2004** The compliance officer sends a further email to DIMIA at the Australian Embassy in Berlin, providing more details of Anna.
- 19 July 2004** The compliance officer discusses options for Anna with Detention Review Committee members in Canberra because of continuing problems with identifying her and informal advice from BWCC that she is not behaving acceptably. (BWCC had reported to DIMIA that Anna had assaulted another inmate.)
- 22 July 2004** In discussions with Detention Review Committee members in Canberra it was noted that failure to identify Anna would present major difficulties for any attempt to remove her. The view was that, since Anna had no links to the local community in Queensland, she should be moved to Baxter.
- 27 July 2004** The DIMIA officer at the Australian Embassy in Berlin asks for further clarification of details and the names given by Anna. A digital photograph of Anna is provided.
- 30 July 2004** Following discussions between prison mental health staff and concerns expressed by inmates, the Prison Mental Health Team psychologist recommends that Anna have a psychiatric assessment.
- 5 August 2004** The Australian Embassy in Berlin replies that no match for Anna can be found in the Embassy's records or with German border police.
- 6 August 2004** The compliance officer asks BWCC for a psychological and medical evaluation of Anna's suitability for community placement.
- 10 August 2004** Anna is seen by the Prison Mental Health Team psychiatrist, who notes her increasingly bizarre behaviour and recommends in-patient psychiatric assessment. DIMIA believes this assessment is in response to its request to assess Anna for community placement.
- 11 August 2004** Cornelia Rau is reported missing by her family.

- 12 August 2004** Hornsby police ask DIMIA to carry out immigration status checks for Cornelia Rau through the iASK system.
- 13 August 2004** The Queensland Prison Mental Health Team psychiatrist recommends an external psychiatric assessment for Anna and asks the team leader for Prison Mental Health to find a bed for that purpose.
- 20 August 2004** A bed is found in Princess Alexandra Hospital in Brisbane and Anna is transferred to the acute assessment unit for initial assessment under the Queensland *Mental Health Act 2000*.
- 20–26 August 2004** Anna is psychiatrically assessed during six days at the Hospital. It is found that ‘although displaying some odd behaviour, [she] does not fulfil any diagnostic criteria for mental illness’.
- 26 August 2004** Anna is discharged from the Hospital and returned to BWCC.
- 17 September 2004** The Honorary German Consul in Brisbane visits Anna at BWCC after receiving a letter from her. She repeats her story but provides insufficient details to allow for the issuing of a German passport.
- 22 September 2004** The Honorary German Consul rings the DIMIA compliance officer, saying Anna had called him to provide a new date of birth—15 November 1979—which she claimed to be correct. Checks are made without result.
- 24 September 2004** Manly police contact DIMIA via the iASK system, seeking information on whether Cornelia Rau has left or entered the country. The response is that she has not left the country.
- 30 September 2004** The compliance officer visits Anna at BWCC to discuss her transfer to Baxter. Anna is in the Detention Unit because of her irregular behaviour. DIMIA explains that continued detention at BWCC is not appropriate and it is considering transferring her to Baxter because she is going to be difficult to identify and therefore a long-term stayer. Anna refuses to sign the Intended Transfer form and withdraws from the conversation.

- 6 October 2004** Anna is transferred to Baxter. She does not want to be transferred, resists the escorts, and has to be sedated and placed in restraints. Before she boards the aircraft the restraints are removed.
- On arrival at Baxter Anna receives a GSL reception assessment and medical induction, and a referral is made to the Professional Support Services psychologist.
- 7 October 2004** The Professional Support Services psychologist assesses Anna and determines that her problems appear to be behavioural in nature.
- 8 October 2004** Anna is vague and unresponsive at the DIMIA induction interview. The interview is suspended because effective communication is not possible.
- 12 October 2004** The psychologist reviews Anna's situation and finds her to be at very low risk of self-harm, although having 'significant personality features'.
- 14 October 2004** The psychologist reports that, because she has a personality disorder, Anna will not respond to therapy or medication and her condition deteriorates when she has an audience. The psychologist records that Baxter is not designed to handle cases like this and it would be better for Anna to be managed in an all-female compound such as the one at Villawood.
- For various reasons, including the 'open' nature of the compound, placement at Villawood is considered inappropriate and not pursued.
- 20 October 2004** A DIMIA Canberra officer who is visiting Baxter directly asks Anna if she is Australian; Anna does not respond.
- 3 November 2004** Anna continues to behave in a way described as 'attention seeking' and refuses to talk with the psychologist. She is scheduled for an appointment with the consulting psychiatrist.
- 6 November 2004** The consulting psychiatrist attempts to assess Anna, but she is uncooperative and he is unable to make a definitive diagnosis. He recommends further assessment at a psychiatric facility.

- 9 November 2004** The Professional Support Services psychologist contacts the Rural and Remote Mental Health Service triage team to discuss arrangements for further assessment of Anna in a psychiatric facility and provides information on Anna's case.
- 12 November 2004** The Glenside psychiatrist in Adelaide responds to contact from the Baxter psychologist and is briefed on Anna's behaviour. The Glenside psychiatrist advises that her problems sound behavioural, which is not a mental health concern.
- In its efforts to identify Anna, the German Consulate in Melbourne contacts a member of Victoria Police. The police officer contacts DIMIA in Canberra on 6 December, seeking assistance for the Consulate. DIMIA contacts the Consulate and is asked to give its number to Anna at Baxter.
- 16 November 2004** The Rural and Remote Mental Health Service contacts Baxter and offers a videoconference session for an assessment. Baxter responds that Anna is not cooperating and that this is unlikely to be successful. The RRMHS takes Anna off the waiting list (for in-patient placement) for admission on 17 November 2004 but does not notify Baxter staff, who continue to believe that their request is being pursued with some urgency.
- 17 November 2004** The Professional Support Services psychologist faxes medical collateral (a compendium of medical reports) to the Rural and Remote Mental Health Service at Glenside and refers to their earlier discussions about seeking in-patient assessment for Anna.
- 24 November 2004** At the Management Unit Review Team meeting, Anna's GSL case manager says she believes Anna to be an Australian national of German parents. This is communicated to DIMIA Baxter staff and to Canberra.
- 6 December 2004** DIMIA Baxter contacts the German Consulate in Melbourne to see if there have been any developments in identifying Anna. The Vice-Consul says there have not.

- 22 December 2004** Manly police contact DIMIA via the iASK system, seeking information on whether Cornelia Rau has left or entered Australia using her Australian passport. The police supply no photos or description. The request is not acted on by DIMIA because priority is being given to dealing with police requests arising from the 26 December 2004 Asian tsunami crisis.
- 4 January 2005** The Professional Support Services psychologist and the International Health and Medical Services medical practitioner fax a follow-up letter to the Glenside intake officer, seeking advice on how to proceed in managing Anna and on the availability of a bed for assessment.
- Glenside agrees to follow up on the medical collateral provided to it on 17 November 2004.
- 5 January 2005** The German Consulate in Melbourne emails DIMIA Canberra to advise that, in the absence of fingerprints, it has been unable to identify Anna.
- 6 January 2005** The Professional Support Services psychologist gives Glenside further information about Anna and again advises that the situation is urgent.
- 7 January 2005** The International Health and Medical Services medical practitioner assesses Anna and expresses the opinion that she may have schizoid or schizotypal personality features and possibly schizophrenia. He recommends further assessment by a psychiatrist.
- 14 January 2005** The German Consulate in Melbourne emails DIMIA Canberra to advise that there has been no result from Germany in relation to its intensive efforts to identify Anna as a German citizen and that there is thus no legal basis on which the Consulate can continue to act in the matter.
- 20 January 2005** Anna calls the German Consulate in Melbourne and the Vice-Consul again advises that they have been unable to identify her and need more information before they can issue a travel document. The Vice-Consul then speaks with Anna's DIMIA case officer at Baxter, reiterating that Anna's spoken German is childlike in terms of sentence structure and vocabulary

and suggesting that Anna might be an Australian citizen of German parents.

21 January 2005 The Asylum Seeker Resource Centre emails to a range of interested parties an article detailing the plight of a 19-year-old German woman being held in Baxter. The article had originally appeared on the Baxterwatch website.

DIMIA Canberra initiates discussions with the Australian Refugee Association in order to pursue possible options for alternative immigration detention for Anna.

24 January 2005 The German Consul-General in Melbourne advises DIMIA that, after extensive investigations and final checks by authorities in Germany, it has not been possible to establish any verifiable indication that Anna is a German citizen. In accordance with international law, therefore, the Consulate has no authority to pursue the matter.

In response to a telephone call from DIMIA Canberra, the head of the South Australian Mental Health Service contacts DIMIA Canberra and offers to receive Anna into Glenside for a period of assessment by a clinical psychiatrist, with or without committal under the state's *Mental Health Act 1993*. (The Inquiry was made aware of other calls by DIMIA Canberra that were not recorded on file.)

27 January 2005 In response to follow-up by DIMIA Canberra, the Director of the Rural and Remote Mental Health Service contacts DIMIA Baxter to suggest that adhering to the usual care pathways would achieve a quicker response, that an assessment should be undertaken directly by the Baxter medical practitioner, and that a Glenside psychiatrist would be available to confer with the medical practitioner.

The RRMHS Director undertakes to liaise with Baxter for an appointment with the medical practitioner. Baxter advises that the earliest appointment with the medical practitioner is on 31 January 2005.

- 31 January 2005** The *Age* newspaper follows up the Asylum Seeker Resource Centre's story and publishes an article entitled 'Mystery woman held at Baxter could be ill'. A similar article is published in the *Sydney Morning Herald*.
- The International Health and Medical Services medical practitioner tries to assess Anna but she is not communicative.
- 1 February 2005** A DIMIA Canberra officer has contacted the Coen police constable who had spoken with Anna to see whether any further information might be uncovered. After making inquiries, the police constable reports that a number of earlier presumptions about Anna were wrong. The new information does not, however, help to confirm Anna's identity; instead, it highlights the deficiencies in the management of information on detainees.
- 2 February 2005** A DIMIA Canberra officer creates an over-stayers report for Czech, Russian, Polish and German citizens, with no result.
- The International Health and Medical Services medical practitioner contacts the Glenside psychiatrist who has been nominated to assist. After discussing the matter with the psychiatrist, he decides to consider the matter overnight before making a decision to schedule Anna for assessment under the Mental Health Act.
- 3 February 2005** The International Health and Medical Services medical practitioner conducts an assessment of Anna at 15.15 South Australian time and, after a telephone consultation with a Glenside psychiatrist, decides to commit Anna for assessment under the South Australian Mental Health Act. The committal papers are signed at 16.00.
- The Rau family contacts Manly police after friends alert them to a 31 January newspaper article in which they think the woman mentioned might be Ms Rau. A New South Wales detective makes email contact with the DIMIA Manager at Baxter at 14.30 South Australian time in an effort to determine whether Anna is Cornelia Rau. At 16.20 the DIMIA Manager provides for the detective a photograph of Anna. At

17.55 New South Wales police advise that Anna has been officially identified as Cornelia Rau by her parents.

At 22.43 South Australian time Cornelia Rau—who is not an illegal immigrant and consequently may not be kept in immigration detention—is removed from Baxter by South Australian police and ambulance officers and taken to Port Augusta Hospital.

4 February 2005

Cornelia Rau is transferred from Port Augusta Hospital to Glenside, where she is committed for psychiatric care.

3 Immigration detention

3.1 Immigration detention under s. 189 of the Migration Act

Exercising the power to deprive someone of their liberty brings with it significant responsibilities.

3.1.1 Reasonable suspicion

The *Migration Act 1958*, particularly Division 7, contains provisions dealing with the detention of unlawful non-citizens. Under s. 189(1) of the Act authorised officers, including DIMIA compliance officers and police officers, are obliged to detain any person they know or reasonably suspect to be an unlawful non-citizen. An unlawful non-citizen is a non-citizen who does not hold a current visa.

Section 189(1) of the Act must be read in conjunction with s. 196, which deals with the ways in which a person detained under s. 189 may be released from immigration detention. In the opinion of the Inquiry, the way ss. 189 and 196 have been interpreted has shaped DIMIA immigration detention officers' attitude to people detained on the basis of reasonable suspicion and the nature and extent of post-detention DIMIA inquiries.

Section 189(1) provides that if an officer knows or reasonably suspects a person is an unlawful non-citizen the officer must detain that person. Because of the use of the word 'must', the section has been viewed as a mandatory provision in its entirety. What has not been fully appreciated is that s. 189(1) operates in a mandatory way only *after* an officer has formed the requisite 'reasonable suspicion' that a person 'is' an unlawful non-citizen.

In the Inquiry's discussions and interviews, DIMIA executives often argued that the s. 189(1) detention powers were administrative, not criminal, and not subject to review; that the section was mandatory in its effect; and that the only way a person detained under its provisions could be released from detention was if an event occurred. An 'event' was described as essentially being either the removal of the person from Australia or the granting of a visa.

The prevailing view seemed to be that, for the reasons just given, there was neither cause nor justification for a review of the operation of the power to detain on reasonable suspicion and that, once exercised, the power of detention remained lawful until an event occurred that resulted in the release of the person. Although this view was sincerely held, in the Inquiry's opinion it is erroneous and has led to flawed practice.

The forming of a 'reasonable suspicion' is an exercise of personal judgment. Exercise of this power places an obligation on officers who detain a person under the provisions of s. 189(1) to justify the reasonableness of their suspicion before they make the decision to detain. Indeed, a properly based exercise of discretion in the determination of a 'reasonable suspicion' provides, for a person facing possible immigration detention, the only protection against indefinite arbitrary detention.

Section 196(1) of the Act provides that an unlawful non-citizen detained under s. 189(1) must be kept in immigration detention until removed from Australia, deported or granted a visa. Section 196(2) provides, however, that, to avoid doubt, s. 196(1) does not prevent the release from detention of a citizen or a lawful non-citizen.

In the *Goldie Case* (*Goldie v Commonwealth* (2002) 188 ALR 708), the Full Federal Court explained the principles governing the operation of 'reasonable suspicion'. Explaining that the operation of s. 189 involved a more rigorous test than merely thinking a person might be unlawful, the Court said, 'The officer is not empowered to act on a suspicion reasonably formed that a person *may* be an unlawful non-citizen. The officer is to detain a person whom the officer reasonably suspects *is* an unlawful non-citizen'. [emphasis added]

The Court also made it clear that the exercise of a 'reasonable suspicion' detention 'must be justifiable upon objective examination of relevant material' and that the detaining officer must not simply rely on information immediately to hand but must make 'efforts of search and inquiry that are reasonable in the circumstances'. The wording of the section requires that the suspicion that a person is an unlawful non-citizen is, when viewed objectively, a suspicion that a reasonable person would form in the circumstances.

Perhaps more importantly, the detention provisions of the Act clearly assign to DIMIA officers other obligations and responsibilities that must be understood and observed. These were explained in the following terms by a special counsel from the Australian Government

Solicitor's Office, in a legal opinion prepared for DIMIA and provided to the Inquiry by the Secretary of DIMIA:

If a suspicion is sufficient to justify a person's detention under s189 (i.e. it is 'reasonable') it should, if it persists, be sufficient to justify the person's continued detention until the reasonable suspicion is displaced through further inquiry.

This does not mean that the onus is on a detainee to dispel or displace the 'reasonable suspicion' of a DIMIA officer. Rather, the obligation is on the officer or officers involved to keep the person's circumstances under review and to seek to resolve their immigration status as soon as possible by further inquiry, noting that an officer will necessarily be reliant in large part on information the suspected unlawful non-citizen provides as the basis for making inquiries. *The officer(s) must be able to demonstrate at any particular point in time that the suspicion persists and that it is reasonably held (which probably means, I think, that whatever further inquiries are made either strengthen the suspicion or dilute it).* [emphasis added]

And, later in the opinion, 'The justification for continued detention in these circumstances can only be that the officer continues to reasonably suspect that the person is an unlawful non-citizen'.

These principles are directly relevant to a proper consideration of the lawfulness of the detention, including the continued detention, of Cornelia Rau.

The Inquiry acknowledges that the conditions under which a person in detention and for whom 'reasonable suspicion of being an unlawful non-citizen' no longer validly exists can be released are not expressly explained in the statute. It also understands that some aspects of this question are subject to argument yet to be resolved by the High Court.

The Inquiry proceeded on the basis that it is obviously the intention of the Commonwealth Government—and of DIMIA as the agency with direct responsibility for application of the *Migration Act 1958*—to detain only people who are genuinely 'reasonably suspected' of being unlawful non-citizens and for only as long as is justified and necessary in the circumstances. Regardless of the fine wording of the law, it is difficult to imagine that either the Government or DIMIA would intend or wish to achieve any other outcome.

In *VHAF v Minister for Immigration and Multicultural and Indigenous Affairs* (2002) 122 FCR the Government argued that, in accordance with the Act, a person must continue to be detained until

‘no relevant officer of the Department held a reasonable suspicion that the applicant was an unlawful non-citizen’. As a result of the experience of its review, the Inquiry has difficulty understanding the merits of this argument, in either legal or moral terms.

In rejecting the Government’s argument, Justice Gray said:

It would be almost impossible to know whether, somewhere in the Department, there existed an officer, perhaps ignorant of recent developments or other facts, harbouring a suspicion that could therefore be considered to be reasonable, so that continued detention of a person was required. Even if the officer responsible for the original detention no longer had a reasonable suspicion that the person detained was an unlawful non-citizen, that officer would be powerless to arrange the release of the person unless he or she became satisfied that no other officer held such a reasonable suspicion. It would be almost impossible for a person in detention to know whom to contact for the purpose of providing information that would allay a reasonable suspicion.

And further, ‘The clear assumption underlying these provisions is that detention of a citizen, or a lawful non-citizen, is unlawful unless justified’.

The question posed by the Inquiry is ‘Why would the Government or DIMIA want to achieve any other outcome?’

As the Full Bench said in *VFAD* (2002) 196 ALR 111, citing the High Court in *Coco v R* (1994) 170 CLR 427 at 437–8, ‘The courts should not impute to the legislature an intention to interfere with fundamental rights. Such an intention must be clearly manifested by unmistakable and unambiguous language’.

In seeking to answer its own question, throughout its examination and analysis the Inquiry applied the principle of the fundamental importance of the proper protection of individual liberty. It is not possible to be confident that this principle was properly applied to aspects of the detention of Cornelia Rau.

3.1.2 The lawfulness of detention

The Inquiry found that many of the DIMIA officers who were interviewed and who use the detention powers under s. 189(1) of the *Migration Act 1958* had little understanding of what, in legal terms, constitutes ‘reasonable suspicion’ when applying it to a factual situation.

In particular, there appeared to be a general lack of understanding on the part of officers of their legislative responsibilities under the Act. This included what the Inquiry found to be a mistaken interpretation of the operation of s. 189(1) in circumstances where suspicion arose that a person may be an unlawful non-citizen and a belief that, when the person is detained, the detention is absolute. There also seemed to be a belief that the emphasis was on detaining people and that the follow-up investigation of a person's lawful situation was a matter of process, with no limitation on time and no need to execute the process as a matter of urgency.

This observation does not suggest that everyone suspected of being an unlawful non-citizen is detained: the majority of such people are not detained but are granted bridging visas. The concerns of the Inquiry arise from evidence of the lack of adequate understanding of the legal requirements of s. 189(1) where detention does occur or is being considered.

The fact that a person's liberty had been taken seemed to be accepted simply as a 'matter of fact' and a result of the person's own doing and circumstances brought about by their actions. These attitudes seem to be promoted by a culture in which detention of suspected unlawful non-citizens is the paramount consideration.

Comment was made to the Inquiry on a number of occasions that the operation of s. 189(1) was not reviewable since it was mandatory in nature and immigration detention was administrative, not criminal. There did not appear to be—even at senior management level—an understanding of the distinction between the discretionary nature of the exercise of 'reasonable suspicion' and the mandatory nature of the detention that must follow the forming of a 'reasonable suspicion'.

DIMIA suggested that any notion that officers must simply detain people sits at odds with the Migration Series Instructions, departmental training and operational experience. The Inquiry accepts this suggestion but is of the opinion that the level of knowledge and training of many officers is inadequate. Operational experience in these circumstances may exacerbate problems rather than add value. Instructions and training are dealt with elsewhere in the report.

The initial detention of Cornelia Rau, then known as Anna, was carried out by a police constable stationed at Coen, on the written instruction of a DIMIA compliance officer based in Cairns. The instruction was to detain Anna under s. 5 of the Migration Act, thereby, arguably, removing any obligation on the part of the police

constable to satisfy the test of ‘reasonable suspicion’ under s. 189(1) of the Act. In making this statement, the Inquiry does not suggest that the decision was made unlawfully, improperly or inappropriately. On the facts available, the judgment was exercised in order to achieve a practical and justified outcome in the circumstances.

In forming a ‘reasonable suspicion’ that Anna was an unlawful non-citizen, the Cairns DIMIA compliance officer relied on the information provided by Anna herself and his subsequent checks of DIMIA databases. He also asked the constable to check the Queensland Police databases. On the basis of the results of this process, the compliance officer formed a ‘reasonable suspicion’ that Anna was an unlawful non-citizen.

In the Inquiry’s view, the DIMIA compliance officer, using the evidence then available, had a proper and lawful basis for forming a ‘reasonable suspicion’ that Anna was an unlawful non-citizen, sufficient to justify her detention. In reaching this position the Inquiry had regard to the majority judgment in the *Goldie Case*, that ‘if, as in the present case, an officer is aware of conflicting facts, the reasonableness of any suspicion formed by that officer must be judged in the light of the facts available to him or her at the particular time’.

The question of whether the available facts supported a reasonable suspicion that Anna was an unlawful non-citizen or simply that she *may* have been will always be open to objective interpretation. On the facts then available, however, as the Inquiry understands it, the initial decision to detain was lawful and within the meaning of s. 189(1) of the Migration Act. Although Anna gave the names Anna Brotmeyer and Anna Schmidt and provided various accounts of how she came to Australia and of the amount of time she had been in the country, she was emphatic that she was a German tourist and she spoke German.

The various accounts Anna provided did, however, raise a responsibility for further and more extensive inquiries. Anna had given conflicting stories of her origins in Germany and of the circumstances and time of her arrival and travel in Australia. The DIMIA compliance officer’s searches of DIMIA movement records in order to identify Anna after she had been detained in Coen, and her lack of identification documents other than a Norwegian passport in another person’s name, would seem, on the face of it, to meet this standard.

It was important, though, not only that inquiries aimed at identifying Anna continue but also that DIMIA officers question and analyse

whether they were still able to demonstrate that the suspicion on which the detention was originally made persisted and that it was still reasonably held. It is evident that the inquiries did not have this focus and that at all relevant times there was no corporate policy or instruction likely to cause this to occur.

The continued efforts by a Brisbane DIMIA compliance officer to identify Anna through the German Consulate and the Australian Embassy in Berlin and Anna's refusal to provide further information—while perhaps satisfying s. 189(1) requirements in the immediate term—were basically aimed at identifying Anna with a view to removing her from Australia and returning her to Germany. They were not aimed at re-evaluating the continued reasonableness of suspicion or the validity and lawfulness of the consequent detention.

In essence, the inquiries were assumption based, narrowly focused, unplanned and not subject to any review. These are fundamental flaws in the inquiry process—not only as they affected Cornelia Rau but also, in their wider application, as they relate to detainee identification more generally.

Any decision to detain a person on the grounds of 'reasonable suspicion' under s. 189(1) carries with it a responsibility to continue to reassess the validity of the decision in the light of further inquiries and information, to determine whether the suspicion continues to exist and that it is still reasonably held. Further inquiries would either verify or put in question the reasonableness of the suspicion and could lead to a situation where there is no longer a reason to suspect that the detained person is an unlawful non-citizen. Once this position is reached there can be no lawful basis for the continued detention of the person under s. 189(1), regardless of any other doubts about the person's status.

This is discussed in more detail in Chapter 7. It is clear, however—from the way Cornelia Rau's detention was managed—that DIMIA had no adequate policy, practices or guidelines governing identity inquiries or requiring reassessment or oversight of a decision to detain on the basis of 'reasonable suspicion'. This important issue is dealt with in Section 5.3.1, which provides advice about establishing comprehensive, consistent guidelines for investigations.

In the period covered by this report it is evident that, once a decision to detain on this basis was made (by a DIMIA compliance officer, a police officer or another authorised officer), the legality of the detention was assumed and was not subject to any further questioning—regardless of the result of subsequent inquiries. The

consistency and strength of the behaviour and attitude of DIMIA staff, including executive managers, is a primary reason that such a large number of immigration detention matters were subsequently referred to this Inquiry.

Although it is not possible to state with certainty that more comprehensive review, assessment and inquiry would have resulted in earlier identification of Anna as Cornelia Rau, the failure to carry out such tasks is, in the opinion of the Inquiry, a manifest failure of DIMIA's duty of care.

3.1.3 Training for compliance officers

Training for DIMIA compliance officers is provided through a Certificate IV in Government (Statutory Investigation and Enforcement) Training Program that was delivered throughout 2003–04 and 2004–05. It is evident from the Inquiry's interviews with compliance officers, however, that this training has been delivered only for about the last two years, that its delivery is ad hoc, and that it does not properly accommodate many of the skills and the knowledge required.

Many DIMIA compliance officers seem to have received little, if any, training and have simply been transferred into compliance positions and expected to perform the associated tasks. This ignores the potential risks to the Commonwealth of adopting this approach, and it is unfair to the officers and to the people they are called on to deal with.

Training in the use and application of the powers under the Migration Act is inadequate. Otherwise experienced DIMIA officers' lack of knowledge of the principles underlying the exercise of 'reasonable suspicion' detention or of an adequate framework for the conduct of identity inquiries is evidence of this deficiency. The syllabus for the current training program does not have any specific focus on avenues of inquiry.

In comparison, the Fraud Guidelines of the Commonwealth and the Government's Investigation Standards require investigators employed by the Commonwealth to obtain a Certificate IV in Fraud Investigations before they are permitted to exercise the power of arrest against members of the community. The power of arrest leads to an outcome similar to detaining a person under the Migration Act: a person's liberty is removed.

The indefinite nature of immigration detention and the absence of any of the external checks and balances that apply in the criminal jurisdiction make properly focused skills- and values-based training for compliance and detention officers and managers imperative.

Recommendation 3.1

The Inquiry recommends that DIMIA:

- design, implement and accredit—for all compliance officers and other staff who might reasonably be expected to exercise the power to detain a person under s. 189(1) of the *Migration Act 1958*—a legislative training package that provides the officers with the requisite knowledge, understanding and skills to fairly and lawfully exercise their power
- ensure that the training comprehensively covers the use of DIMIA and other agencies' databases and search capability and the conduct of searches to support investigations
- restrict the authority to exercise the power to detain a person under s. 189(1) to staff who have satisfactorily completed the training program and who are considered to be otherwise sufficiently experienced to exercise that power
- ensure that a component on 'avenues of inquiry' be included in the Certificate IV in Government (Statutory Investigation and Enforcement) Training Program delivered to DIMIA officers.

3.2 Imprisonment in Brisbane Women's Correctional Centre

3.2.1 Immigration detention arrangements

Anna was transferred from the Cairns Police Station watch-house to Brisbane Women's Correctional Centre on Monday 5 April 2004 because there is no immigration detention facility in Queensland. Unlike the Arthur Gorrie Correctional Centre for men, BWCC has no separate or dedicated area in which to house immigration detainees. Consequently, Anna was placed with the general prison population.

Section 5(1) of the *Migration Act 1958* provides for immigration detention in a prison or remand centre of the Commonwealth or a state

or territory or in a police station or watch-house. Because DIMIA does not own or operate an immigration detention facility in Queensland, it quite often places immigration detainees in Queensland corrections facilities. DIMIA has with the Queensland Government what it calls ‘cooperative arrangements’ governing the placement and management of immigration detainees.

There is, however, no written agreement or memorandum of understanding; the last agreement, which came into operation in 1992, lapsed in 1995. This agreement was between the Commonwealth Government and the then Queensland Corrective Services Commission and allowed for ‘the provision of detention facilities for the containment of immigration detainees for the Department of Immigration, Local Government and Ethnic Affairs’ for three years.

Paragraph 4.2 of the agreement specified that at least 20 rooms would be made available for detainees. Although it was not spelt out in the agreement—because the great majority of detainees held in Queensland are male—the understanding was that the 20 rooms were for male detainees, and a separate wing was designated for detainees at the Arthur Gorrie Correctional Centre. The agreement noted that the detention of female immigration detainees was to be provided for at a different corrections centre.

Although section 2 of the agreement stated that detainees would be afforded the same rights as other people at the relevant centre and specified a range of available health, welfare and recreational services and facilities, it made no mention of segregation or specific ‘immigration detainee’ care requirements and standards. It made provision for DIMIA officers to visit Queensland corrections facilities but was silent in relation to Queensland corrections authorities reporting to DIMIA.

Although it seems that the 1992 agreement continues to be used as the framework for the present cooperative arrangements, there has been no signed agreement since 1995. Even at the executive level, there is an inadequate understanding of the separate and joint responsibilities and accountabilities of the parties to these arrangements.

DIMIA advised the Inquiry that negotiations for a new service level agreement began in 1999–2000, but these have not yet resulted in any agreement or formalisation of current arrangements. The Inquiry finds this situation unsatisfactory—not because of the critical importance of having a written document but because the length of time and the

uncertainty reflected in the negotiation process have been detrimental to the care and treatment of detainees.

In making this finding, the Inquiry recognises and accepts the difficulties involved in the negotiations, including changes to relevant legislation during the period concerned.

DIMIA informed the Inquiry that there was early agreement on accepting and including the Immigration Detention Standards to guide the care and management of detainees in custody in a correctional facility. The attitude of Queensland Corrective Services to this arrangement is not clear but, in terms of DIMIA responsibilities, there is little evidence that measures were in place to ensure the Standards were maintained.

An executive-level DIMIA officer advised the Inquiry that while early negotiations on the service level agreement included discussion that the Immigration Detention Standards would be part of the new agreement there was never an expectation that the Standards would form part of any agreement before the negotiations were finalised.

According to the advice, it was never agreed or suggested that the Immigration Detention Standards would be implemented separately from the service level agreement, and Queensland Corrective Services would not agree to such a proposal in the absence of a base document articulating the arrangement between the two parties.

It is accepted that this situation would have probably created difficulties for DIMIA officers in the management of detainees in prison custody. However, in the opinion of the Inquiry, the situation increased DIMIA's obligation to carefully oversee immigration detainees held in Queensland corrective facilities. The absence of an agreement did not reduce DIMIA's responsibility for the standard of care afforded immigration detainees held in prison custody.

Revised procedures have now been introduced to significantly increase the regularity of visits and the range of welfare and management factors requiring assessment and reporting. The Inquiry strongly supports this.

As discussed in Section 3.2.2, a range of DIMIA instructions explain the responsibilities of compliance officers and the processes that should be followed when managing immigration detainees in corrections facilities. It seems, however, that in the case of Anna these were neither followed nor properly understood.

Regardless of the current status of any written agreement, DIMIA undeniably retains overall responsibility and accountability for the health, welfare and standard of care of detainees, whether the detainee is in an immigration detention facility or in a corrections facility. This does not seem to be well understood.

During interviews with the Inquiry, a DIMIA officer with direct responsibility for this area expressed the view that DIMIA paid Queensland Corrective Services \$95 a day for each detainee and that therefore Queensland Corrective Services had total responsibility for the care and management of detainees in its custody. The executive did not see DIMIA as having any day-to-day responsibility in this area. Such a lack of understanding—and, indeed, the attitude that would underpin it—is of serious concern to the Inquiry and is indicative of the level and nature of operational oversight that occurred during the time Anna was in prison in Brisbane Women’s Correctional Centre.

The absence of any capacity to segregate Anna from the general prison population at BWCC created a situation that called for careful monitoring and assessment by DIMIA. This did not happen.

3.2.2 Last resort

DIMIA has a number of departmental instructions that are intended to provide direction and guidance to officers in the management and oversight of detainees and people known or reasonably suspected to be unlawful non-citizens. There are several relevant Migration Series Instructions, but MSI 244, titled ‘Transfer of Detainees to State Prisons’, is of particular relevance to the detention of Anna in BWCC.

MSI 244 was brought into force on 1 July 1999, partly in response to the findings in a December 1995 report of a Commonwealth Ombudsman’s ‘own motion’ investigation into the transfer of detainees from immigration detention centres to state prisons.

MSI 244 is important both in its relationship to the findings of the Ombudsman’s report and because it relates to the detention of immigration detainees in a correctional facility. Although it has not been updated since 1999, the Instruction is comprehensive and roles and responsibilities are well explained. The problem is that it was not applied.

In MSI 244 it is expressly stated in paragraph 2.1 that ‘detention of immigration detainees within prisons occurs *as a last resort* [emphasis

added]. In this restricted context it can occur for a number of reasons, which include: ...’ A number of reasons are then listed under three broad headings:

- behavioural concerns
- completion of a custodial sentence
- location—absence of an immigration detention centre.

Under the ‘location’ heading is the explanation, ‘No purpose built IDC [immigration detention centre] exists in the state or territory where the person entered Australia or was detained by DIMIA’.

It is clear from the wording of the Instruction that the sub-conditions just noted are meant to be considered only after the threshold condition of ‘last resort’ has been met. This interpretation is, however, qualified by paragraph 4.11.1, which states:

In those States and Territories where an IDC does not exist, and in remote locations, the only option available is to detain a person within a State prison until alternative arrangements are made, such as relocation to an IDC in another state, detention at a place designated by the Minister, relocation to an appropriate lower security prison or until the person is granted a Bridging Visa E. Officers should take into account the importance of having immigration detainees in an environment which offers fewer threats to personal security than a prison.

The focus of MSI 244 is on detainees who, for reasons essentially related to their own behaviour, are to be transferred to a correctional facility. The Instruction refers specifically to these transfers and outlines the factors likely to trigger such action as including unacceptable behaviour, continuing risk to other detainees, and a history of violence or psychiatric illness. Anna did not meet any of these criteria at the time.

There is no evidence that consideration was given to whether, as a threshold question, Anna’s placement in BWCC was necessary as a ‘last resort’ or that consideration was given to the specific reason of ‘location’ in this restricted context. Although in terms of paragraph 4.11.1 the decision would seem to be within the rules in the first instance, it was a decision that required close monitoring and early review. This did not occur.

Many of the requirements in MSI 244 focus primarily on responsibilities that apply if a detainee is transferred from an

immigration detention facility for behavioural reasons. As a minimum, the responsibilities apply at least equally to a detainee in Anna's situation. Although, technically, she had not been transferred to the prison from an immigration detention facility (unlike most transferees), Anna had contributed to the decision to place her in a prison only by virtue of being detained in Queensland. Accordingly, the requirement that DIMIA make 'alternative arrangements' should have assumed greater urgency.

Anna was not placed in BWCC because of previous inappropriate behaviour or concern about her mental health or because she had been identified as posing a risk to other detainees or to herself. It was vital to her care and wellbeing that these circumstances be understood and fully taken into account in her management and oversight by DIMIA officers during her time in BWCC. They were not.

An understanding of these circumstances should also have played a part in the process of deciding how long Anna would spend in a prison and when she would be transferred to an immigration detention facility. Although paragraph 4.11.1 expressly states that a detainee is to be placed in a prison (where there is no immigration detention centre) only 'until alternative arrangements are made', there is little evidence that this qualification was properly considered or acted on.

There is recorded evidence that Anna's DIMIA case officer raised with his immediate manager and his director concerns about her placement in BWCC. But it appears there was no response to these concerns. Much of the reason for Anna's extended stay in BWCC stems from the lack of regular review of her detention during this time.

3.2.3 Admission and accommodation

Admission and records

When a new arrival is being inducted into a corrections facility—or, for that matter, an immigration detention facility—corrections staff must satisfy themselves that the person named in the warrant or other custodial order is the person being admitted. This aside, it is not the role of corrections authorities to conduct or initiate any inquiry into the identity of the person. In the Queensland Corrective Services context these practices and requirements apply to immigration detainees.

On admission to BWCC on 5 April 2004, Anna confirmed her identity as Anna Brotmeyer. In accordance with standing arrangements she was not fingerprinted, but on 7 April she was photographed under the name Anna Brotmeyer. On the same day, a Brisbane-based DIMIA compliance officer attended BWCC, conducted a formal induction and identification interview with Anna, and took a number of passport-style photographs. Responsibility for determining Anna's identity rested with DIMIA.

Despite this, records in the BWCC Progress Notes show that BWCC officers did ask Anna about her personal details and background and recorded that Anna said she was 'raised in an alternative lifestyle in Germany therefore is unsure of her birthdate—thinks she may be 25 yrs old' and that 'her name is SCHMIDT and that BROTMAYER was just a name she gave to police'. The Inquiry was advised that the use of two or more names in a correctional environment is not uncommon: a number of people use aliases.

The Progress Notes record daily or contact information about an inmate. The records relating to Anna are quite detailed and are supported by a number of other reports, including Assessment Advice Reports completed by an assessing psychologist. These reports detailed a range of factors—such as external and internal support, the patient's interaction with staff and other prisoners, eating, sleeping, medication, behaviour and wellbeing.

The reports were submitted quite frequently, often weekly. There is nothing in them to suggest that the care and attention offered to Anna was not at least on a par with that offered to her at Baxter. Indeed, there is evidence to suggest that corrections officers made special allowance for Anna because they knew she was an immigration detainee. The problem was that Anna was in a prison, mixing with prisoners and subject to prison discipline and control. Prison discipline and control are obviously of a more rigid standard than the regime usually applied in an immigration detention facility.

As later at Baxter, the Progress Notes and other BWCC reports record behavioural and other information. Although these reports often contain comments such as 'nil evidence of psychomotor agitation', 'denies any psychotic symptoms' and 'nil evidence of psychotic features reported or disclosed', they also contain comments such as 'intense gaze', 'signs of irritation when informed that not able to be moved from the "cell" immediately', 'weepy and feeling sad, because she has been in DU [Detention Unit] for a long time', 'seen in DU—

aggressive—tearful, doesn't understand why she has been breached' and 'keen for the interview to be removed from the "cell"'.

Had these reports and comments been subject to effective and cumulative assessment and review, they should have triggered a response and action, including possible action to remove Anna from prison much earlier.

Prison accommodation

The BWCC records show that, from the time of her arrival at BWCC, Anna had 'maintained a defiant attitude to directions given by staff and had failed to comply with a variety of directions in relation to maintaining a clean cell, leaving the exercise yard without permission then refusing to return to the yard when instructed'. On occasions Anna had to be physically returned to her unit. Such behaviour led to her being placed in the Detention Unit.

Accommodation for prisoners at BWCC is segregated into five broad categories—Secure 1, Secure 6, Residential, the Health Centre and the Detention Unit.

- Secure 1, in which Anna spent most of her time at BWCC, is a block of four units. Three of these contain a total of six smaller units that can house six prisoners per unit. Secure 1 also contains a unit known as Secure 4, which serves the function of a crisis support unit and can accommodate up to nine prisoners. Placement in Secure 4 must be preceded by an assessment and the making of a crisis support order, in accordance with s. 42 of the *Queensland Corrective Services Act 2000*.
- Secure 6 is a block of four units, two of which accommodate 16 prisoners and two of which accommodate 24 prisoners. The block also has a unit of 24 beds that is used exclusively for inmates identified as requiring protection because of the nature of their crime, difficulties with other prisoners, or their status as protected witnesses.
- The Detention Unit consists of four separate confinement cells and two special treatment cells. The confinement cells are used to accommodate inmates who have been found to have breached disciplinary provisions under the *Corrective Services Act*. This is where Anna was placed on each of the occasions she was breached.

- Residential provides accommodation for 118 inmates in a series of units that are clustered four to a block and house six prisoners per unit. The prisoners live in campus-style accommodation, with access to shared cooking and showering facilities. They are considered trustees and are given greater autonomy. The area also has purpose-built accommodation designed to house mothers with babies and children.

Unless they are assessed as requiring additional protection for their own safety, all newly received prisoners and detainees are initially placed in Secure 1. Following an initial assessment, Anna was determined not to be at risk and was placed in Secure 1.

Depending on their behaviour, prisoners and detainees usually progress to Secure 6 or even directly to Residential. Apart from four periods in the Detention Unit, six days in Princess Alexandra Hospital for medical assessment and two short periods (two days and one day) in the Health Centre, Anna remained in Secure 1 for the entire time she was at BWCC. Although there is little to suggest that Anna was not treated appropriately (as a prisoner), it is difficult to accept that her treatment was suitable for an immigration detainee.

During her six months' detention at BWCC, Anna is recorded as having at times been quite difficult to manage and as having upset other prisoners by her behaviour. Her behaviour pattern in this regard is similar to the pattern she demonstrated during her time in detention at Baxter. Despite this recorded pattern, when interviewed at BWCC she frequently behaved politely and cooperatively and claimed to interact well with 'the guards'.

When interviewed in connection with a breach on 13 August 2004, Anna said she disobeyed an officer's orders 'because the officers mistreat me'. The question and her answer are recorded on an unsigned Determination Question Sheet, together with a further question 'Officers mistreat *you*. In what way?' and the comment 'Prisoner cried and could not answer'. There is no indication that this matter was brought to the attention of DIMIA officers or was subject to any further inquiry in BWCC.

Having considered all the available information, the Inquiry formed the view that Anna's complaint probably referred to the fact that officers gave and then enforced directions, rather than that they were guilty of any inappropriate conduct. Nevertheless, it is regrettable that this matter was not followed up, both by way of an internal investigation and by forwarding the information to DIMIA. Anna's

Ethical Standards Unit interview (see Section 3.2.4) had taken place one month earlier. Her six-day placement for assessment in Princess Alexandra Hospital on 20 August 2004 and her treatment are discussed in Chapter 6.

3.2.4 Prison discipline

At BWCC Anna was treated in the same way as the other inmates and was subject to the same rules. During the time she was there she was subjected to three findings of a breach of discipline. On each occasion the breach was for disobeying ‘a lawful direction of a Corrective Services Officer’, contrary to s. 15A of the Corrective Services Act. Her conduct associated with these breaches was similar to her conduct during her detention at Baxter. Had regular reviews of this pattern of behaviour been carried out and had adequate records been kept, a more comprehensive and informative basis for an accurate health assessment would have been established.

The first charge of breach of discipline related to Anna’s failure, on 4 June 2004, to comply with the direction of an officer to enter her cell and have a shower. On the Breach of Discipline form it was remarked, ‘The offender has a well documented history of failing to comply with directions and is defiant when under instructions’. The breach was upheld and Anna was ordered to spend two days in ‘separate confinement’.

The second charge occurred on 24 June. It arose from Anna asking to leave her area of the prison to go to the coke machine and then, instead of using the machine, moving directly towards another area and asking other prisoners for their newspaper. The Breach of Discipline form records that three times corrections officers ordered Anna to return to her own area, but she ignored the instructions. Anna was then forcibly returned to her secure area (Secure 5) by the use of a wrist lock. The breach was upheld and Anna was ordered to spend five days in separate confinement.

On 15 July Anna was again breached. According to BWCC records, she ignored repeated instructions to move to the Detention Unit ‘for a breach of Section 38’. After officers had explained that if she did not comply force would be used, Anna was placed in a ‘transport wrist lock’ and forcibly escorted to the Unit. The breach was upheld and Anna was ordered to spend seven days in separate confinement.

On 13 August Anna was breached a fourth time on the same charge—arising from a complaint by another inmate that Anna was ‘always

following her’—but the file shows ‘breach dismissed due to discharge of prisoner’. On 22 July and 19 September Anna is recorded as having been confined to the Detention Unit for further periods of seven days of separate confinement for what is recorded as ‘Special Treatment for the Security of the Centre’ or ‘Special Treatment for Her Safety’ in accordance with s. 38 of the Corrective Services Act and by order of the General Manager.

On 26 September Anna was transferred to the Health Centre. She returned to the Detention Unit on 30 September and remained there for her own protection from other inmates until 5 October, the day before her transfer to Baxter.

On 5 July 2004 Anna had been one of about 25 female inmates separately interviewed at BWCC by an investigator from the Ethical Standards Unit, an independent investigator, and a representative of the support group Sisters Inside, in connection with allegations of mistreatment of prisoners by Corrective Services officers. Essentially, Anna’s complaint related to the coke machine incident on 24 June. She also referred to the circumstances of her first breach, on 4 June, to an occasion when she was prevented from going to chapel and onto the tennis court, and to being locked in her cell early.

It is clear that Anna’s complaints were about being ‘punished’ for perceived wrongdoing, rather than complaints about physical mistreatment or abuse by corrections officers.

Although the breach actions seem to have been within the lawful authority of the Corrective Services Act, the provisions of that Act apply to the control and discipline of prisoners—not detainees. Particular care was required in their enforcement against a detainee who was not a prisoner, especially one whose conduct had not contributed to her presence in a prison in the first instance.

The Ethical Standards interview with Anna was tape-recorded. During the interview she again asserted that her name was Anna Schmidt (Schmitt), that she was ‘an illegal immigrant ... from Germany’, and that she had been in Australia ‘for three months now’. In the opinion of the Inquiry, the following excerpts from the transcript clearly demonstrate the importance of and need for early review and action. They are also illustrative of the facts potentially available to DIMIA officers. (ESU stands for Ethical Standards Unit; CR stands for Cornelia Rau.)

- ESU Where would you like to start? What would you like to tell me?
- CR Well I just got put into the DU [Detention Unit] for just want to get the newspaper. Like, basically I went out of my unit wanting to get a newspaper from the other unit and the officer just said ‘NO’ for no reason. And I said ‘Why?’ and he said ‘NO’ and then he just ...
- ESU And did he breach you?
- CR He breached me for just getting a newspaper, and that’s not right. I had to stay five days in that terrible setting where you only have one room and there’s nobody else, you, normally there’s somebody else there, one room that you had to put up with, to not have anything in the room, there’s only a Bible that’s all in the room.

And later in the interview, describing another complaint: ‘I was locked in my cell early last night as well by her. And it wasn’t nice. Like I hadn’t done, I didn’t do anything wrong, I was just walking around in the courtyard, like that’s quite a reasonable thing to do in jail, you need exercise’.

Quite early in the interview the Ethical Standards Unit investigator asked, ‘Your English is very good, did you learn English in Germany?’ to which Anna replied, ‘Yeah’. From a plain reading of the transcript—let alone listening to the tape-recording itself—it is obvious that Anna had an excellent grasp of English. This information should have formed part of the inquiries being made to establish her identity and status and should have triggered a reassessment of the inquiry focus.

There is no record that the details of these incidents were passed to Anna’s DIMIA case officer, either at the time they occurred or later, or that the case officer was otherwise aware that they had occurred. Although the DIMIA case officer and the BWCC contact officer had frequent telephone contact in relation to immigration detainees, DIMIA records do not show that any specific problems or concerns were raised about Anna or that serious consideration was given to transferring her to a more suitable detention facility until almost at the end of her time in BWCC. The Inquiry received advice that DIMIA made additional contact with BWCC but that this was not recorded.

The provisions of the detention services contract between the Commonwealth and GSL, as referred to and quoted from in Sections 4.2.4 and 4.3.1, are directly relevant to the factors identified

during Anna's interview on 5 July and to the breaches she incurred: the standards expected for detainees in prisons are supposed to mirror those applicable to detainees in immigration detention centres.

The contract emphasises, 'Immigration detention is for administrative not correctional purposes' and 'It is expected that consistent with legislative requirement to keep people in detention, detainees are able to go about their daily life with as few restrictions as possible'. The contract goes on to state, 'This imposes particular responsibilities on the Commonwealth with regard to duty of care for each and every person in immigration detention ...' and 'The Commonwealth exercises this duty of care through the Department'. Responsibility is clear.

Anna was held in immigration detention at Brisbane Women's Correctional Centre for six months. This is an unusually long time. The duty of care afforded her during that time was, by any measure, inadequate.

On 26 February 2005 the Minister announced measures to minimise possible similar occurrences in future, including a limit of 28 days on the time individuals could be detained in a prison, watch-house or similar corrections facility for immigration purposes. The Inquiry strongly supports the Minister's initiative, recognising that there might be a continued need to permit longer periods of stay in a correctional facility on compassionate grounds.

3.2.5 Cooperation with BWCC

Despite the absence of a current agreement with DIMIA or the Commonwealth Government, the Queensland Department of Corrective Services has continued to accept and hold immigration detainees in both the Arthur Gorrie Correctional Centre and the Brisbane Women's Correctional Centre on the basic terms and conditions of the memorandum of understanding that lapsed in 1995. Although this situation is indicative of reasonable cooperation between BWCC and DIMIA management, the absence of an agreement that clearly identifies respective responsibilities and arrangements for reporting and review has the potential to create opportunities for a range of problems to emerge. It significantly affects accountability processes that might be put in place.

Immigration detainees held at BWCC are absorbed into the general prison population: there are no special accommodation arrangements for them. This has created difficulties in ensuring that the Immigration

Detention Standards are maintained. Anna's experience shows how easily the distinction between correctional detention and immigration detention can become blurred.

BWCC's primary responsibility is its correctional duties. In the absence of clear and mutually agreed arrangements, and given the small numbers of immigration detainees held at the prison, it is understandable that there is little focus on the particular needs of these detainees.

In an environment where different accommodation models might be provided through the use of different, available, facilities it will be difficult to uniformly apply DIMIA standards. Accountability for ensuring that the Immigration Detention Standards are maintained must, in these circumstances, rest with DIMIA management.

It is DIMIA management's responsibility to ensure that unambiguous arrangements are in operation so that BWCC provides to DIMIA officers a continuous and contemporary flow of information on detainees' behaviour and wellbeing and that effective DIMIA oversight and contact arrangements exist and are maintained. These communication channels and management arrangements were not evident in Anna's case.

The damage that has the capacity to result from inadequate communication is reflected in some of BWCC's written records, which went either uncorrected or were unknown to DIMIA. On 5 April 2004, the day of her admission to BWCC, Anna is recorded as 'for deportation tomorrow'. An At Risk Prisoner form completed on 13 May records, 'Detainee soon to be returned to home in Germany'. Another entry, for 10 August, refers to 'ATSP by Department of Immigration—currently detained due to staying beyond expiry of visa'.

These records further reflect the assumptions that were apparently made by people throughout the 10 months Anna was held in immigration detention. There is no indication that any of the assumptions were corrected or qualified by DIMIA and, as explained in some detail in Chapter 6, the examining psychiatrist at Princess Alexandra Hospital believed Anna was to be deported to Germany immediately after her mental health assessment. This belief resulted in a lack of subsequent assessment of Anna, which, it was stated at interview, would otherwise have occurred.

The current arrangements governing the relationship between DIMIA and the Queensland Department of Corrective Services are fundamentally defective, lacking in clarity and certainty, and in need of immediate improvement. There is obviously cooperation between the two agencies, but the relationship lacks the discipline imposed by the need to clearly identify responsibilities, accountabilities and reporting arrangements, as would be necessary for a memorandum of understanding.

3.2.6 An evaluation

On any evaluation of the information available—almost all of which was provided by the agencies concerned—the management of Anna’s treatment during her time in BWCC fell well short of that expected to be provided to immigration detainees in accordance with DIMIA’s own instructions.

Despite the clear wording of Migration Series Instruction 244, which expressly provides that placement of a detainee in a prison facility should occur only ‘as a last resort’ and only ‘until alternative arrangements are made’, Anna was left at BWCC for six months. During almost all of this time the sole focus of inquiries was on identifying her with a view to her removal to Germany.

It was only the inability to confirm Anna’s identity that eventually led to a decision to transfer her to Baxter. Her case was not reviewed by the Detention Review Committee, either in terms of assessing the suitability of her continued detention in BWCC or by way of confirming that her detention was subject to continued monitoring sufficient to ensure, as expressly required by MSI 244, that Anna was being held in ‘the most appropriate place of detention’.

There is no indication that the Detention Review Committee, or even the regional DIMIA office, was aware that Anna had been placed in separate confinement on several occasions or that she had been interviewed by a BWCC Ethical Standards Unit investigator in relation to a complaint of mistreatment. There *is* a record of general advice from BWCC of Anna’s difficult behaviour, but there is no record of DIMIA having any contemporaneous knowledge that Anna was being placed in separate confinement or, if officers were aware, that this knowledge led to any review or closer monitoring of her situation.

The absence of any meaningful monitoring by DIMIA staff, the infrequency of their visits and other contact with Anna, and the

paucity of documented information and file note records of Anna's period of detention combined to almost ensure that her detention could not be adequately managed and assessed. This situation was in direct contravention of the wording and intent of MSI 244.

Responsibility for ensuring that Anna was properly treated as an immigration detainee rested at all times with DIMIA. In reaching the conclusion that Anna was not properly treated as a detainee, the Inquiry is not suggesting that there was a failure to treat her fairly and lawfully as a prisoner. But the level and nature of communication between BWCC officers and DIMIA was, in the Inquiry's view, unsatisfactory.

As a matter of urgency, the clarity and certainty of the current arrangements governing the relationship between DIMIA and the Queensland Department of Corrective Services should be improved. The operation of those arrangements is defective and inappropriate as a template for the care and treatment of immigration detainees.

Further, it is the opinion of the Inquiry—one corroborated by DIMIA officers and others with direct experience in the management of immigration detention facilities—that, in order to meet its monitoring and standards of care requirements, DIMIA should place case officers in each corrections facility in which immigration detainees are held. To satisfy the requirements of its own instructions and to ensure the maintenance of the agreed Immigration Detention Standards, the permanent presence of DIMIA case officers in prisons housing detainees is essential.

Given the importance of 'having immigration detainees in an environment which offers fewer threats to personal security' (MSI 244) and what is referred to in the contract with GSL as a requirement that, 'consistent with the legislative requirement to keep people in detention, detainees are able to go about their daily life with as few restrictions as possible', it is unlikely to be possible to 'closely monitor' the condition of a detainee held in a custodial institution in any other way.

Recommendation 3.2

The Inquiry recommends that, as a matter of urgency, DIMIA:

- take all necessary action to formalise its arrangements with the Queensland Department of Corrective Services for the detention of immigration detainees, to ensure that the arrangements reflect the standards of care and treatment necessary for detainees and that the responsibilities, accountabilities and reporting arrangements of all parties are clarified and understood.
- adopt and confirm the principle that, unless there are exceptional circumstances, detainees will be held in correctional facilities only until alternative arrangements can be made for their immigration detention
- consistent with the foregoing—and having regard to the recently introduced government policy to restrict the period of detention in a prison to 28 days—take all necessary action to minimise the period of time that immigration detainees are held in a prison or other correctional facility
- settle arrangements with relevant governments or corrective services departments to enable the placement of a DIMIA officer (or officers) in each corrections facility in which immigration detainees are being held, to ensure that the Commonwealth’s duty of care obligations towards each person in immigration detention in a prison can be demonstrably met and that the Immigration Detention Standards are maintained.

3.3 Management responsibilities

3.3.1 A failure of processes and management

Anna’s treatment at Brisbane Women’s Correctional Centre fell disturbingly short of any sensible standards for an immigration detainee. DIMIA’s processes failed. It was not a failure of instructions: Migration Series Instruction 244 is well written and clear. The instructions were simply not followed. This constitutes a serious failure of management process and executive oversight. The Inquiry was advised that in the six months Anna was held in prison her case

never came to the attention of the Canberra executive in charge of that area.

The basis on which Anna was detained and managed in BWCC was flawed. DIMIA has ultimate responsibility for the health and welfare of immigration detainees, but the current processes for monitoring and managing immigration detainees in BWCC are ineffective and do not enable DIMIA to properly discharge its responsibility. Competent management and oversight of Anna, conducted in accordance with DIMIA's own instructions, would have resulted in her being removed from BWCC much sooner than she was.

A Brisbane-based compliance officer discussed Anna's case with Detention Review Committee members in Canberra in July and noted the continuing difficulties with identifying her and the informal reports from BWCC about Anna's unacceptable behaviour. In further discussions, on 22 July 2004, it was proposed that, because Anna had no personal links in Queensland and because the problems with identity would present major difficulties for her removal, she should be transferred to Baxter.

It seems that no concerns were expressed about the appropriateness of Anna's detention in a prison. She was eventually transferred to Baxter on 6 October 2004.

It is the Inquiry's view that Anna's six-month detention in a prison where she was treated like any other prisoner was particularly stressful because of her mental illness. She often said she did not belong there because she had done nothing wrong. The Inquiry agrees.

In particular, Anna expressed her concerns to the Queensland Corrective Services Ethical Standards Unit, which was investigating complaints made to the Anti-Discrimination Commission about systemic breaches of human rights in women's prisons. Through her lawyer, Cornelia Rau also expressed these concerns to this Inquiry.

There is no way of knowing whether Anna would have been identified sooner if she had quickly been moved to a more suitable environment. But it would have been fairer and would have respected her dignity as a detainee whose immigration status was being confirmed. It is also the Commonwealth Government's policy. Further, it is possible that in a more open environment, where a range of people could observe her behaviour daily, Anna might have provided more clues to her identity. At that time, she was probably still receiving some benefit from the medication she received while an in-patient at Manly Hospital.

In considering the appropriateness of Anna’s detention in BWCC, it is important to recognise that, as a correctional facility, BWCC is modern, well equipped and, from the observations of the Inquiry, well managed. Both the Inquiry team members who visited BWCC and interviewed staff have experience with prisons, and one has managed and worked in corrections facilities. Both formed the view that the infrastructure at BWCC—including the health service arrangements and facilities and the amenities—is distinctly superior to that at Baxter.

The considerations surrounding correctional and administrative immigration detention are, however, quite different. Although BWCC is a modern and well-managed facility, it houses inmates who are either on remand for or have been convicted of criminal offences. The prison profile alone makes it an unsuitable place in which to house an immigration detainee in anything other than special and defined circumstances. This is clearly set out in MSI 244.

In particular, the freedom of movement afforded prison inmates is much more restricted than that applying to immigration detainees held in an immigration detention facility.

3.3.2 The requirement for regular review

Migration Series Instruction 244 requires that all decisions to transfer an immigration detainee to a prison must be fully documented and that each detainee should be assigned a case manager who is responsible for the continuing management of their case. The Instruction also states, ‘The ongoing monitoring of immigration detainees in state institutions is essential to ensure that they are always being held in the most appropriate place of detention’.

Additionally, the Instruction specifies that, where a detainee is being held in a state prison, the case officer, or detention review officer, should have regular weekly contact with the institution to monitor the detainee’s condition. Further, the case officer is required ‘to undertake monthly personal visits with the detainee which may be timed to coincide with the 30 day review’. This requirement refers to the fact that each regional office of DIMIA should have a detention review officer who is responsible for reviewing the detention details of each detainee every 30 days. The attachment to MSI 244 makes it clear: ‘The purpose of these regular contacts is to ensure that the detainee’s condition whilst held in a custodial institution is closely monitored. These contacts are to be documented and file notes placed on the detainee’s file’.

None of these responsibilities was adequately met. Perhaps more disturbingly, there is no indication whatever that, at any time during Anna's detention at BWCC, any manager or the Detention Review Committee ever sought further information about her, reviewed the level of oversight being provided by the DIMIA Regional Office, or otherwise questioned the lack of compliance with DIMIA's own Instruction.

In a medical-in-confidence interview held during her admission to BWCC on 5 April 2004, Anna was asked, 'How do you feel about being here?' She replied, 'Not good'. In the general Progress Notes of the same day the following comment was recorded: 'Transfer by AGCC [Arthur Gorrie Correctional Centre] staff of "illegal immigrant" for deportation tomorrow. Pleasant polite lady—answers all questions'.

There is no indication that DIMIA staff saw these documents or were otherwise made aware of the statements. This is important because under section 7.2.2 of the attachment to MSI 244, reference is made to the need for officers to 'accept and document oral requests for the review of the place of detention as it may not always be practical for the detainee to make this request in writing'. On her first day of detention at BWCC Anna—who answered other questions in a quite positive and uncomplaining way—was obviously unhappy about being placed in a prison.

In the Inquiry's discussions with Cornelia Rau's lawyer since the time of her identification and placement in Glenside, her lawyer emphasised that one of Ms Rau's primary concerns is that people will think she is a bad person because she has served time in a prison.

As noted, immigration detainees held at BWCC are, of necessity, absorbed into the general prison population, which creates a difficulty in ensuring that the Immigration Detention Standards are maintained. BWCC's primary responsibility is to perform its correctional duties and, given the small number of immigration detainees, it is understandable that there is little focus on the particular needs of these people.

The Inquiry considers, however, that it is precisely this situation that increases the importance of regular contact and visits by the responsible DIMIA officers, so that they can monitor and assess the standard of care being afforded a detainee and the state of the detainee's health and wellbeing.

In Anna's case, despite a requirement to visit her monthly, a DIMIA officer visited her on only three occasions during her six months of detention in BWCC. DIMIA records show that its Brisbane Regional Office was particularly busy during much of the period and that Anna's case officer had a high case load. It is also evident that the case officer continued to conduct inquiries with a view to identifying Anna and, in July 2004, discussed with the Detention Review Committee options for Anna's placement.

Nevertheless, the lack of oversight of Anna during her time in prison, as required by MSI 244, must be seen as an abrogation of the accountability and responsibilities that lie with DIMIA. It was DIMIA's responsibility to ensure that Anna was held in prison detention only for as long as was necessary and that the agreed Immigration Detention Standards were maintained to the extent that the prison environment would allow. The Inquiry was advised that, although the requirements of MSI 244 were not strictly followed, Ms Rau and all other people in immigration detention at the time were under at least weekly review by DIMIA officers. The advice received acknowledges that better records should have been maintained but explains that records were not made and kept unless a change of detention arrangements was assessed as being necessary.

The Inquiry is of the opinion that DIMIA assessments of the appropriateness of detention arrangements should ordinarily be based on cumulative data, rather than a single incident, and that maintenance of accurate records is fundamental to this. The Inquiry is satisfied that the clear facts of Ms Rau's behaviour and treatment in BWCC, as recorded on BWCC files, should have triggered an early reconsideration of her detention arrangements by DIMIA.

The Inquiry's recommendation 3.2—about placing a DIMIA officer (or officers) in each correctional facility—seeks to provide a direct link to day-to-day activity and reports relating to immigration detainees. In particular, any disciplinary breach should be brought to the officer's attention and, if the correctional facility agrees, the officer could be part of the Determination Team that decides whether a breach has been committed and the appropriate penalty. If the DIMIA officer considered that the penalty was not appropriate for an immigration detainee, the onus would be on the officer to initiate action to move the detainee to another, more suitable placement.

The Inquiry makes a distinction here between immigration detainees who have committed an unlawful act and are being held in custody and immigration detainees (such as Anna) who have committed no

offence. The ‘28 days rule’ recently announced by the Minister would adequately cover custodial immigration detainees. However, to hold an immigration detainee who has committed no criminal offence—or otherwise directly contributed to their situation by virtue of their own behaviour—in gaol for 28 days is, in the Inquiry’s view, excessive. It must be a priority for DIMIA to identify a more appropriate place of detention and move the detainee as soon as possible.

Recommendation 3.3

The Inquiry recommends that, as a matter of priority, DIMIA ensure that when an immigration detainee who has committed no criminal offence is placed in a correctional facility immediate steps are taken to find a more suitable place of detention and to transfer the detainee to that place.

3.3.3 Accumulation of information

As noted, during the six months Anna spent in BWCC the responsible Brisbane-based DIMIA compliance officer visited Anna three times. This frequency of visits was not only manifestly inadequate and in clear breach of DIMIA’s own instructions; arguably, it also operated to prevent any meaningful re-evaluation of the grounds of ‘reasonable suspicion’. The compliance officer did speak with Anna and the detainee contact officer several times by telephone and did evince concern for her welfare, but there was no structured approach to Anna’s ongoing care and there is no evidence of any form of managerial oversight of her wellbeing or of effective case management.

Once Anna was transferred to Baxter, there seems to have been no thorough or continuing review of the ‘reasonable suspicion’ foundation. Indeed, although identity inquiries were submitted to state and Commonwealth agencies and through the German Consulate, at different times a number of individuals involved in Anna’s case expressed a belief that she might in fact have been an Australian national of German heritage. Little was done to follow this line of inquiry.

On 20 October 2004 a DIMIA officer from Canberra who was visiting Baxter asked Anna if she was Australian and Anna made no response. On 24 November, at the Management Unit Review Team meeting, the GSL case manager said she believed Anna was an Australian national of German parents. This hypothesis was conveyed to DIMIA staff in

both Baxter and Canberra. On 20 January 2005 the German Consulate in Melbourne advised Anna's DIMIA case officer at Baxter that Anna might be an Australian citizen of German parents.

While investigations were conducted in Australia, there seems to have been no move towards identifying Anna through means other than the aliases she herself provided. There is no indication that the Australian Federal Police was contacted to assist in identifying Anna—as was proposed on 24 November 2004 in an email from DIMIA Baxter to a DIMIA officer in Canberra—nor was Anna's photograph made available to state and territory police to follow up on this possibility.

A photograph of Anna had been provided to Queensland police early in the investigations, on 29 April 2004, and a photograph was also provided to the Australian Embassy in Berlin on 27 July 2004. But Cornelia Rau was not reported missing until 11 August 2004.

No consideration seems to have been given to a public release of Anna's photograph or personal description, or both; nor was any approach made to the Privacy Commissioner to seek advice about the release of such personal information within the provisions of the federal *Privacy Act 1988*. DIMIA's attitude, as was evident throughout the Inquiry process, was extremely conservative. There seemed to be a consistent emphasis on using the privacy restrictions as a reason for not releasing personal information—no matter how serious the situation appeared to be—rather than actively exploring how, lawfully, important information could be released in the public interest.

As an example, in the cases of both Cornelia Rau and Vivian Alvarez, no consideration seems to have been given to the possible application of Principle 11 of the Information Privacy Principles of the Privacy Act or to exploring the release of personal information by way of a Public Interest Determination, as provided for by the Act.

The German Consulate in Melbourne confirmed on 24 January 2005 that it could not verify Anna's claim that she was a German national. This advice, together with the suggestion that Anna might in fact be Australian, should have pointed to the need for reviewing the 'reasonable suspicion' that Anna was a suspected unlawful non-citizen.

The Rau family noted in its submission to the Inquiry:

Germany has a sophisticated national ID system where any resident even moving house has to report to the local council to have their new address recorded on their identity card. Residents must have an identity card in addition to other documents like a driver's licence or passport.

On any objective assessment, Germany would be considered a country with a high level of identity regulation and record keeping. All inquiries aimed at identifying Anna in Germany—under any of the names she had provided—had proved fruitless. Taken together with the vague accounts Anna had provided of her life in Germany, the different stories she told about the circumstances of her arrival in Australia, her apparent knowledge of Australia, and her ability to speak and write English (as evidenced in video footage of her behaviour and in letters she wrote while in BWCC), these facts should have triggered alarm bells at a relatively early stage in Anna's detention and led to a comprehensive re-examination of her case.

Had DIMIA case management policy and practice required the gathering of a circumstantial case as part of a planned approach to accumulating information as inquiries proceeded, review would have been an automatic and continuing part of the identity inquiry process. Such a process is a basic investigative strategy that would probably be used by anyone with training in investigative management. The fact that DIMIA guidelines, training and practices did not require this, or even consider it should occur, is difficult to comprehend or defend.

The situation is aggravated when it is now understood that Anna was mentally ill throughout her 10 months in detention. Although she was not diagnosed as mentally ill, her behaviour had been described as 'odd', 'bizarre' and of concern throughout that time. The irrationality of much of her recorded behaviour—including her consistent refusal to provide details in support of her own case for returning to Germany and her refusal to engage in conversation about her past or to be medically assessed—should have raised concerns about the weight attached to the stories she told. It should also have been the trigger for wider and different avenues of inquiry.

Had Anna's case management linked her general and medical health contacts and observations (as recorded in daily incident sheets and other records) and had this collected information been objectively assessed and reviewed as part of developing a comprehensive and evolving personal profile, Anna would have received more

appropriate care and been transferred much sooner to an immigration detention facility. It is also possible that, had wider avenues of inquiry been pursued within the first few weeks of her detention, Anna might have been identified as Cornelia Rau and been released.

The fact that these avenues were denied to Anna is an indictment of the system. The lack of a coordinated approach was exacerbated by extremely poor file management practices and record keeping, a subject discussed in Section 5.3.1.

3.3.4 Dealing with complex cases

The Inquiry recognises that, in a complex and difficult environment, DIMIA handles the great majority of immigration detention matters with apparent success. It is also evident that the overwhelming number of matters fall into two basic categories—unlawful boat arrivals and visa over-stayers—where the profiles of the detainees are generally quite similar. As a result, standard procedures have been developed to deal with these types of matters and are understood.

But experience colours objectivity, and it is possible that the similarity of profile in the majority of cases is, in itself, a big part of the problem. While there are examples of the resolution of very complex cases being facilitated by the current systems and procedures, the Inquiry's examinations suggest that such successes are more related to the commitment of individual case officers than the support provided by organisational arrangements and practices.

The Inquiry identified what seems to be a 'disconnect' in planning, experience and communication between the central policy areas in Canberra and the operating environment in Baxter and the Queensland Regional Office. It was unable to uncover any processes for reviewing and assessing the effectiveness and appropriateness of DIMIA management and coordination arrangements; nor could it find any evidence of a mechanism for self-criticism. These deficiencies are particularly relevant to dealing successfully with complex cases.

The systems and processes that are in operation might be able to deal with the bulk of immigration detention matters, but they are not sufficiently finely tuned, flexible or responsive to allow for effective management and analysis of the more difficult cases that arise. Processes and systems connectivity must be improved. In particular, where the identity or immigration status of a detainee remains unresolved after initial inquiries have been completed, a mechanism is

required that would immediately see the matter transferred to an officer with greater experience at a more senior level.

DIMIA is now implementing a number of initiatives, among them the establishment of a National Identity Verification and Advice Unit, the appointment of Detention Review Managers in each state and territory where people are detained, and improvements in case-related information management processes.

It would not be practical to train all officers to a level where they can all deal with complex cases. The need could, however, be met by establishing a group of experienced and suitably skilled people who would have carriage of a matter after it has been referred for their attention. They would have sufficient experience to determine whether a matter should be immediately escalated to executive attention or whether they should deal with it themselves.

General training for staff could aim to teach them how to recognise and respond to the various ‘triggers’ and to provide a framework for the conduct of initial inquiries to a consistent standard. The Inquiry considers, however, that it will be necessary first to create a more encouraging and empowering internal environment, so that staff will be willing to exercise the discretion needed to achieve performance improvements.

The present culture seems to have operated to stifle original thought, inhibit individual action, and discourage wider consultation or referral. This must be changed. In particular, dramatic changes to the behaviour of executive management in the immigration compliance and detention areas will be necessary. If the required attitudinal improvements are to be achieved at the operational level, change will need to be embraced at the executive level and be led by the executive. The precondition to effectiveness is fundamental cultural change.

Recommendation 3.4

The Inquiry recommends that DIMIA create a dedicated Identity and Immigration Status Group to ensure that, where the identity or immigration status of a detainee remains unresolved after initial inquiries have been completed, frequent follow-up reviews are conducted.

The Identity and Immigration Status Group should:

- review the continued validity of ‘reasonable suspicion’-based detention on a regular basis—and at least every month—against the background of accumulating information
- be staffed by people who have wide experience in compliance and detention policy and operations, are familiar with the associated Commonwealth and state and territory legislation and arrangements, and have skills in investigation and analysis
- have the authority, responsibility and accountability for conducting and/or overseeing all necessary inquiries to establish the identity and immigration status of unidentified detainees
- report monthly to executive management on the status of individuals still in immigration detention, the reason why they are being detained, what is currently being done to resolve the situation, and the expected date for resolution.

The Inquiry was advised that an ‘escalating model’ of review is being developed by DIMIA. There is definitely a need to deal more effectively with complex and unfamiliar cases. Such valuable initiatives will, however, be ineffective if they depend solely on yet more processes, while critical weaknesses are not recognised or the ‘approved processes’ are not followed. Procedures must be accompanied by effective management oversight that is clearly tied back to executive responsibility.

3.3.5 Detention review

In recent years DIMIA has introduced new mechanisms for dealing more effectively with immigration detention matters. One such initiative has been the establishment of the Detention Review Committee. The Inquiry was surprised to learn that the Committee did not actually review detention or conduct inquiries into the reasons for detention and whether those reasons remain valid. Had the Committee done so, it is likely to have quickly brought the case of Anna to the attention of executive management.

Anna was referred to the Detention Review Committee only because she had been in detention for more than 30 days. Her name appeared with others on a list. The Committee also monitored the progress—or

lack of it—in identifying her so that travel papers could be arranged and she could be removed. Because the matter was not escalated to executive management and systematic identity inquiries pursued, the opportunity for early resolution of what was undeniably a complex and difficult case was lost.

The Inquiry concluded there is insufficient involvement of experienced operational staff in the consideration and development of policy and initiatives. These people could make a valuable contribution to the review of performance-related matters such as those considered by the Detention Review Committee. Their input is often required, but it is essentially ‘data’ input and there is no dialogue. The value experienced operational staff could add does not seem to be fully understood or sought or encouraged with any consistency.

Recommendation 3.5

The Inquiry recommends that DIMIA critically review the functions of the Detention Review Committee and restructure its focus and operations to ensure that it:

- is chaired at branch head level or higher, depending on the matter under consideration
- draws on advice and reports from the Identity and Immigration Status Group
- comprehensively reviews and analyses complex or difficult detainee cases
- seeks input from detention facility managers and provides feedback
- determines appropriate action and ensures monitoring and reporting on progress and outcomes to executive management
- clarifies case management responsibility, intended outcomes and reporting time frames
- is responsible for providing to executive management advice on critical or sensitive cases.

4 Baxter Immigration Detention Facility

4.1 Context

Much is wrong with Baxter. The Inquiry spent considerable time there, examined records, videos, transcripts and documentation, and interviewed detainees, Baxter staff, care visitors and advocates. It consulted widely and worked through a range of conflicting claims and stories so that it could objectively assess the situation.

Immigration detention policy is an emotive subject. But overstatement does not make a case and confuses constructive reform. Many of the stories about Baxter that circulate and have become folklore are just that. Elements of truth from different detention centres at different times are blended into the present. In many cases the beliefs are strongly and sincerely held. The following are examples:

- On a television program about Baxter a former detainee gave an eyewitness account of events in 2001 at Curtin, when Australasian Correctional Management Pty Ltd was the service provider. Curtin is no longer used; Baxter became operational in September 2002.
- Descriptions of hell and razor wire have been aired on television file footage. There is no razor wire at Baxter; the stories relate to Woomera, which was closed in April 2003.
- Reference has been made to cells and bars. At Baxter there are rooms with doors and windows.
- The Management Unit is represented as a punishment cell where no light enters and where people are incarcerated 24 hours a day. There are 10 single rooms, each with a door, a window, toilet and shower facilities, and a mattress. Detainees are permitted limited periods in outside courtyards.
- There are stories of inhuman treatment of detainees in Red Compound and the Management Unit. Most detainees are held in the Blue or White Compounds and never experience Red Compound or the Management Unit. These latter are used only in specific circumstances.

- Anna spent an unusually long time in Red Compound. She could not stay in Blue Compound and there was no other alternative at Baxter; this is discussed in Section 4.2.1.
- There are stories of guards invading individuals' privacy and staring at detainees in Red Compound and the Management Unit. In response to a recommendation by the Royal Commission into Aboriginal Deaths in Custody, it is a safety requirement that detainees in close containment be checked regularly. It is also a strong principle that such checks on women be made by female officers.
- It has been claimed that lights in 'cells' are left on all night to intimidate detainees. There is a light switch in every room. In Red Compound and the Management Unit there is also a dim blue light in each room: detention officers can switch this on from outside the door, using a 'press and hold' switch, and the detainee is observed through a small glass panel.
- There are stories that guards decide whether they will give medicine to detainees and what medicine should be prescribed. Detention officers deliver to detainees medicines that are prescribed and made up in tamper-proof blister packs by nursing staff. This happens because the nurses feel too intimidated by detainees to enter the compounds.
- Detainees are sometimes refused a particular medicine. In these instances medical officers have considered those medicines inappropriate for the detainee's needs and have prescribed the most suitable medicine.

Although they were critical about a number of aspects of Baxter life, the detainees interviewed by the Inquiry did not complain of poor or malicious treatment. They also said they had never witnessed mistreatment of Anna and rejected many of the popular claims made about her behaviour, although they did realise something was amiss. For them, the worst punishment was seen to be the open-ended nature of their detention and the fact of detention itself. Everything was done for them and they felt useless. As one detainee put it, 'It is like dying from the inside'.

The Inquiry was saddened by attempts on the part of some external parties to demonise detention officers and Baxter staff. At no time during its visits to Baxter and its analysis of Baxter records did it find evidence of malicious or demeaning behaviour by detention officers

or Baxter staff. It did, however, find many situations where processes and procedures should be improved. It also found considerable evidence of many people trying to do their job well in difficult circumstances.

4.2 Development and functions

4.2.1 Establishment

At the height of the influx of ‘boat people’, Woomera and other immigration detention facilities were filled to capacity. Operating arrangements, processes and procedures were stretched and people were dealing with a huge increase in workload. Detainees of many nationalities, backgrounds and religions were pushed close together in a confined space. It was a volatile mix, sometimes leading to violent episodes and destruction of property. Woomera’s open design did not lend itself to ensuring security of containment, and there were escapes.

The Baxter Immigration Detention Facility was built to redress the problems of Woomera, and it was built in a hurry. It consists of nine separate, self-contained and secure residential compounds of various sizes, where the doors of the rooms open onto a large, grassy courtyard with shade structures and an open area for activities such as soccer and volleyball. Access to the steel fence is gained only through controlled gates. There is a smaller, more secure area—the Management Unit—that can accommodate up to 10 detainees and is designed to separate dangerous and disruptive detainees when this is necessary.

Each of the compounds at Baxter has a purpose. White Compound is for single male detainees. Blue Compound is for families, although it is also used to accommodate single males for their protection when they might be victimised by detainees in White Compound and for accommodating single women.

Red Compound—also called Red One—was established in the first half of 2003 and used by GSL in early 2004, when it took over the contract from Australasian Correctional Management, to provide a ‘step-down’ facility, an alternative to the Management Unit for less disruptive situations. It has a ‘B’ side (more restricted) and an ‘A’ side (less restricted), both opening onto the same internal compound. Movement from the Management Unit to Red B then to Red A provides access to a progressively less restricted regime. The objective is to return the detainee to their compound as soon as practicable.

There have been violent episodes in which detainees have destroyed property, threatened other detainees, and engaged in attention-seeking behaviour, including self-harm. Such detainees can be a danger to themselves as well as to others, and their behaviour can prejudice the proper and peaceful operation of the facility. Until it is safe for them to return to their compound, they need to be isolated from other detainees and supervised to ensure that they do not harm themselves. The purpose of the Management Unit is to deal with such extreme situations and to contain disruptive or self-harming behaviour.

The Baxter facility was established from a low base and has continued to evolve as GSL and DIMIA have introduced improvements. The basic planning principles for Baxter have also changed because it was built to cope with a large number of detainees. As a consequence of the Commonwealth Government's immigration detention policy, the flood of unlawful immigrants—'asylum seekers'—has become a trickle. Many of the compounds at Baxter remain empty. The profile of detainees has also changed, with many now being long-term detainees. This has presented challenges for DIMIA in attempting to adjust processes, procedures for health care and related services, and staff training to deal with the new environment. In this it has not always been successful.

4.2.2 GSL's role and responsibility

The contract between DIMIA and GSL requires that GSL provide a custodial service for people held in immigration detention and take responsibility for the security, custody, health and welfare of detainees delivered into its custody by DIMIA. GSL has no role in or responsibility for establishing identity or providing any service or function that relates to the application of the *Migration Act 1958*.

GSL and DIMIA staff at Baxter have daily and weekly meetings to discuss matters relating to the detainees. Many records are kept, as required by the contract, but it was not clear to the Inquiry that the information was collated or assessed to inform a particular purpose. Many clues are likely to have emerged from records of Anna's behaviour, but the focus of activity seems to be more on 'feeding the system'.

Some GSL staff the Inquiry interviewed said they had a good working relationship with DIMIA staff and could approach them on any matter. Many said, however, the relationship was formal and rigid and that DIMIA staff did not always seem to want their input on matters they considered to be DIMIA's responsibility. All staff seemed to be

motivated by processes, procedures and requirements laid down in the contract.

The Inquiry recognises that ‘bedding down’ a new facility takes time and respective responsibilities will continue to evolve in the light of experience. It is difficult to get a complex project working smoothly from the beginning. Change should be expected and improvements, as necessary, facilitated by DIMIA. It is the view of the Inquiry that an unduly rigid, contract-driven approach has placed impediments in the way of achieving many of the required outcomes.

Nevertheless, GSL has continued to progressively implement improvements to the detention environment, such as ending the ‘bus everywhere’ requirement and allowing detainees to walk around the facility. In December 2004 some detainees took advantage of this freedom to climb onto the roofs of buildings in a protest action. This incident ended safely for all concerned and the policy of freedom of movement was allowed to continue. Efforts have also been made to introduce excursions, shopping trips, and other external activities for detainees.

The way GSL discharges its responsibilities is primarily determined by the contract and the way DIMIA manages it. The Inquiry found the contract and DIMIA’s contract management and auditing practices unsatisfactory—see Section 7.5.

4.2.3 DIMIA’s role and responsibility

Under the *Migration Act 1958* DIMIA has responsibility for unlawful non-citizens in detention, regardless of any contractual arrangements with service providers at Baxter. Although the DIMIA and GSL managers at Baxter say they have a good personal working relationship, it seems unclear where GSL responsibility ends and DIMIA responsibility begins. The responsibilities of GSL as the service provider are set out in the contract, but those of DIMIA staff are less clear.

There seem to be a number of reasons for the apparent lack of clarity. The process of policy change and development with GSL seems to be managed by DIMIA Canberra. These discussions and negotiations seem to take a long time, and Baxter staff are often unaware of the state of play. Development of operating practices for Red One and the clinical pathways with the South Australian Health Department are important examples. Because Baxter staff have responsibility for

working with and implementing the outcomes, the Inquiry would have expected the staff to be fully involved in these initiatives.

DIMIA Baxter staff also seem to be hampered by the fact that policy and direction are dictated from Canberra, allowing little or no local authority for managers to exercise discretion or control to overcome emerging difficulties. This has serious implications for the effective operation of Baxter and for achievement of the Government's immigration detention policy outcomes. It also affects the detention environment and the way detainees are treated. The inability of DIMIA managers at Baxter to exercise discretion and commonsense in carrying out their duties clearly restricts their capacity to manage.

It is apparently normal DIMIA practice not to send a detainee's file with them to Baxter; instead, the file is forwarded to the Removals Policy and Operations Section in Canberra. The Inquiry was told that the reason for this is that RPO would, eventually, have responsibility for handling the detainee's removal. From the perspective of managing individual detainees at Baxter, particularly since many of them are likely to be long-term detainees, this makes no sense.

Anna's file did not accompany her to Baxter. Baxter had to make a specific request to Canberra to have the file copied by RPO and then sent to Baxter to assist them in caring for Anna. This is not only bad practice: it defies commonsense. Good decisions can only be made on the basis of accurate and complete information. The need to assess all information about a detainee in order to be able to manage the case effectively is discussed in Section 3.3.3; poor file discipline is discussed in Section 5.3.1.

Recommendation 4.1

The Inquiry recommends that DIMIA develop and implement arrangements to ensure that a detainee's file—together with their medical file and any related performance and behaviour notes or review—accompanies the detainee wherever they are placed or transferred. Such files should be tracked centrally by Canberra to ensure consistency in the briefings that are provided.

4.2.4 Detention

The *Migration Act 1958* requires that certain unlawful non-citizens be detained. But immigration detention is intended to be administrative detention pending the clarification of a detainee's migration status. Schedule 2, clause 1.13, of the detention services contract between DIMIA and GSL states:

Immigration detention is for administrative not correctional purposes. It is expected that consistent with legislative requirement to keep people in detention, detainees are able to go about their daily life with as few restrictions as possible. Unlike a correctional setting, immigration detention is usually communal with families able to remain together and men, women and children able to mix. Despite this, persons in immigration detention are in an institutional setting in which their ability to have control over their daily life is limited. Many of those in detention also have come with high expectations about remaining in Australia and are faced with the prospect that they will not be able to do so. Unlike in a correctional setting, detainees do not know how long they will be detained, as this depends on issues such as visa processing times, the timing of any appeals from visa refusal decisions and the time required to obtain travel documents.

These objectives reflect the Government's policy. It is, however, very difficult to pursue such a policy in a remote location. Baxter is in a semi-arid area about 300 kilometres north of Adelaide and 10 kilometres south-west of Port Augusta, a town of about 15 000 people. It is within the Cultana Military Training Area and adjacent to El Alamein army training camp. Some detainee families are accommodated in Port Augusta under the Residential Housing Project. There are few similarities with the immigration detention centres at Villawood and Maribyrnong, which are in major metropolitan areas and have access to facilities and a range of support services.

The Inquiry found that both DIMIA and GSL had made efforts to establish an appropriate environment for detainees. The Baxter facility, although confined, provides for detainees access to a gymnasium, an education centre and library, and a canteen and, in every residential compound, unrestricted access to telephones with international dialling capacity. Detainees are also relatively free to move around the facility and visit detainees in other compounds. In addition, there are barbecue facilities, and there is a large grassed area with shade structures in each compound.

The rooms are simple but clean; they are air-conditioned and heated and have their own facilities, with hot and cold running water. In each

residential compound there is a dining room that caters for single-sitting meals for all detainees in the compound. There is also a laundry, plus two recreation rooms equipped with cable television, table tennis tables and pool tables. The officers' station is staffed 24 hours a day, and there is a first aid station and a multi-purpose room for interviews and meetings.

Baxter has a medical centre, and services are available on site 24 hours a day, seven days a week. General practitioners, psychologists and counsellors are available every day, and arrangements exist for facilitating access to specialist medical care when necessary. As in the community, appointments have to be made for specialist services. A male general practitioner from Port Augusta is on call 24 hours a day, and a female general practitioner is also available.

Many of the ingredients seem to be there, but the arrangements fall short in delivering an immigration detention environment that is required by the policy and described in the contract. It is too simple to just blame GSL or DIMIA: the situation is both complex and demanding. The Inquiry found considerable evidence of dedicated GSL and DIMIA staff doing their best to achieve results of value in what, by any standards, is a very difficult environment.

The Inquiry concluded that Baxter operations and initiatives were hampered by:

- poor procedures and processes
- an excessive focus on auditing compliance, with misdirected performance measures—to the exclusion of even noticing the tragic outcomes that are actually being delivered
- a lack of executive management oversight and concern from Canberra
- convoluted and ineffective health care arrangements
- inadequate and inappropriate training
- a lack of clarity about responsibilities and accountabilities
- ineffective and unclear clinical pathways to external specialist health services
- a lack of understanding of detainees' needs.

The arrangements are the consequence of poor contracting practice, which affects GSL and DIMIA Baxter staff alike. The unique nature of Baxter compared with Villawood and Maribyrnong is still becoming apparent in the light of experience and shows the limitations of generic operating procedures. One size does not fit all. The situation is not helped by Baxter's remote location and the construction of the facility itself.

It is the Inquiry's view that Baxter is not serving the purpose for which it was established and is failing to deliver the outcomes required by the Commonwealth Government in a way that the Government, the Australian people and detainees would expect.

4.2.5 The operating environment

The Inquiry formed strong views about the operation of Baxter. There is much that should and can be improved. Nevertheless, the Inquiry found many instances of good people trying to do a difficult job well, often despite the systems and processes and protocols they face.

The confrontational history of immigration detention in Australia has left its mark on the nature of immigration detention facilities and the way they are run. There is a very narrow field from which people with relevant experience can be recruited, and the links to a correctional regime were apparent at Baxter. The facilities were modelled on correctional facilities and the operating regime is based on correctional norms. This does not sit comfortably with the objectives of the Government's immigration detention policy.

When the new detention services contract was awarded to Group 4 Falck Global Solutions Pty Ltd the schedules in the contract showed that a new detention environment (as quoted in Section 4.2.4) would be established. For various reasons, this has not yet been achieved.

There is an enduring tension between containment and care, and the emphasis at Baxter is on containment. That is unsurprising when, as the Inquiry was advised, some 60 per cent of the former Australasian Correctional Management staff were absorbed by GSL. Culture is slow to change. Baxter managers are aware of the need for change, but the process is in the hands of the DIMIA executive in Canberra. Change is also inhibited by the training programs for GSL officers, which are based on correctional services training curricula.

The Inquiry emphasises that it does not consider a correctional services culture is 'wrong'. It is an effective and necessary part of the

corrections environment in Australia. The Inquiry's concern, however, is that it is inappropriate for creating and maintaining a sensitive immigration detention environment that is a central element of the Government's immigration detention policy. The policy makes a significant distinction between corrections detention and the nature of administrative detention for immigration purposes.

The primary operational considerations are dealt with in Section 4.4.

4.2.6 Remoteness and staffing

A critical factor affecting the nature of operations at Baxter is the facility's location in a semi-arid remote area. As noted, in contrast with, for example, Villawood Immigration Detention Centre in Sydney and Maribyrnong Immigration Detention Centre in Melbourne, Baxter does not have immediate access to 'big city' services. Port Augusta has 15 000 inhabitants; Adelaide is 300 kilometres away.

It is one thing to draw up specifications for how a facility should be operated and to draft standards and specifications for the people who should be employed to operate it. The challenge for GSL lies in recruiting enough experienced people who want to live in a remote location and take on what is, by any assessment, a demanding job. DIMIA is confronted by the same challenge. The Inquiry admires the people who have responded and taken up their work with integrity.

In relation to health care, the difficulty for Baxter is mirrored by the difficulty Port Augusta has in attracting and maintaining experienced doctors, nurses and specialists. Like all country towns, Port Augusta is supported by outpost services linked to capital city facilities; an example is the Rural and Remote Mental Health Service. For the South Australian Government, adequately servicing outlying areas of a large state where most people live within reach of Adelaide is a huge task.

There is no question that staffing and operating Baxter present major challenges. The Inquiry does not, however, consider that remoteness and the very real difficulties it creates are sufficient excuse to do nothing more than is required for the other immigration detention facilities located in large metropolitan areas. Responsibility rests firmly with DIMIA to sagely assess the situation and work out with its contractor how the obstacles can be overcome. If this means having to renegotiate the contract with GSL and paying for necessary changes, it should be done. GSL has demonstrated its willingness to work

through new challenges in a constructive and fair way. The situation cries out for inspired leadership.

Recommendation 4.2

The Inquiry recommends that, as an integral part of renegotiating its contract with GSL (see recommendation 7.7), DIMIA:

- agree with GSL innovative changes to overcome the challenges to staffing and service delivery presented by Baxter's remote location
- develop and implement effective arrangements for monitoring and managing the outcomes, to maintain quality services and ensure that the Government's policy objectives are met in a way that protects the health, safety and dignity of detainees
- rely on the advice and leadership of the Detention Contract Management Group (see recommendation 7.6) when negotiating these changes.

4.3 The immigration detention environment

4.3.1 Containment and care

Baxter is a corrections-style facility. It was constructed to redress the detention problems experienced at Woomera. Unavoidably, its appearance is severe. It is surrounded by a strong, high steel picket fence inside which is a perimeter fence topped with electrified wires. It looks like a prison. In many ways, the activities that occur in Baxter are similar to those in any Australian correctional institution; the untrained observer could not tell the difference. Baxter is effective in its purpose of containment.

As noted, the *Migration Act 1958* provides for certain unlawful non-citizens to be kept in detention. The Government recognises that this brings with it a duty of care. Schedule 2, clause 4.1.2, of the detention services contract states:

This imposes particular responsibilities on the Commonwealth with regard to duty of care for each and every person in immigration detention and, beyond the individual, to ensuring the safety and welfare of all detainees in a detention facility. The

Commonwealth exercises this duty of care through the Department.

In relation to health care, Schedule 2, clause 7.1.1, states:

The Department expects that detainees should be able to access either in a facility or externally, a level and standard and timeliness of health services, including optical and dental services, broadly consistent with that available in the Australian community, taking into account the special needs of the detainee population.

It is in these two areas of care that operations at Baxter fall short, but for different reasons. In particular, the Inquiry considers the second premise flawed because it does not recognise that the detainee population has specific needs that differentiate it from the broader Australian community. This is particularly the case in relation to mental health care. Chapter 6 discusses this.

Health care standards

The adequacy of health care falls short because the ‘standards’ set in the contract through the Immigration Detention Standards are neither measurable nor clear statements of requirement. The performance measures are exception based and not supported by any quality assurance mechanisms. An exception measure provides no information to management until the system has failed.

The two Immigration Detention Standards most relevant to medical care are IDS 2.2.1.1.1 and IDS 2.2.1.1.2.

IDS 2.2.1.1.1 provides that detainees should have access to timely and effective primary health care in a culturally responsive framework. This includes detainees receiving psychological or psychiatric services and counselling. The Standard further provides that, where a condition cannot be managed within the facility, it is to be referred for external advice or treatment, or both.

It is impossible to determine the meaning of ‘timely and effective’ or a ‘culturally responsive framework’ without more information. This is not provided in the contract. The performance measure described is ‘No substantiated instance of a detainee not having access to health care of this nature’. This is an exception measure that provides after-the-event information to management; there is no progressive information or early feedback to enable management to take remedial action should it be required. It is also not supported by any quality measure or risk management strategy that would protect the detainee

and the Commonwealth if the detainee did *not* have ‘access to health care of this nature’.

IDS 2.2.1.1.2 provides that, in establishing the health care service, the service provider (that is, GSL) must ensure that services are delivered by qualified, registered and appropriately trained health care professionals. The service provider is also to develop and implement a health care plan for the facility and, in doing so, draw on the advice, knowledge and experience of a health advisory panel.

To monitor and manage these objectives, the performance measures specified for IDS 2.2.1.1 are as follows:

- Department is provided with evidence on a monthly basis that the health care service is available and accessible.
- No substantiated instance of health care staff not being qualified registered and appropriately trained.
- No substantiated instance of the centre health plans not being implemented, effective or reviewed periodically.
- No substantiated instance of advice of the Health Advisory Panel not being drawn on.

There is no guidance on how the first performance measure should be measured or assessed in order to provide meaningful assurance to DIMIA. The other measures are exception based and not linked to intended action. The Standards do not take account of the quality of care or how that should be measured. Indeed, the health advisory panel referred to has not been established. These measures do not allow for the provision of useful information about the quality of health care being delivered; nor do they allow for the managing of risk.

The Inquiry is mindful of the need for high standards of health care in immigration detention (see Chapter 6). It is particularly concerned that suitably qualified, registered and trained specialists and nurses be present at Baxter to continuously monitor mental health and care. In Chapter 6 it recommends the development and implementation of independent expert monitoring and review arrangements and the establishment of a central mental health unit to service the needs of all immigration detention facilities.

The quality of health care

As discussed in Chapter 6, the Inquiry's primary finding is that the health care afforded Anna during the 10 months of her immigration detention was inadequate and did not meet her needs.

With a performance management regime that does not manage performance or service quality or risks in any meaningful way, it is not surprising DIMIA was caught unaware. The system did not 'fail': it was ill-conceived and could never deliver to the Commonwealth the information on performance, service quality and risk management that DIMIA was confident it would.

There is a need to reset the contractual parameters within which detention services are delivered. In Chapter 6 the Inquiry recommends that DIMIA and GSL reassess the way health care services are provided; in Chapter 7 it recommends renegotiation of the detention services contract so that the outcomes required by the Government's immigration detention policy can be achieved and the risks to the Commonwealth and GSL, as well as to detainees, are properly managed and protected. At present the risks are high.

4.3.2 Communication and feedback

The immigration detention environment is a crucial factor for determining the health and wellbeing of detainees. The detainees themselves and their visitors are an essential part of this environment. The Inquiry found that insufficient attention has been given to some fundamental concerns that have contributed to confusion and speculation.

Detainees

The Inquiry found that GSL and DIMIA staff attach no importance to communication with detainees and the provision of feedback on the progress of actions and requests. The present approach is, in effect, a one-way communication system that does not recognise the importance of ensuring that the 'message' is properly conveyed and understood. In view of the many nationalities represented at Baxter, the Inquiry expected to see greater efforts being made by staff, who, in the Inquiry's view, are genuinely concerned for the detainees' welfare.

Discussions with detainees, visitors and GSL and DIMIA staff made it clear to the Inquiry that many detainees do not fully understand the nature and purpose of their detention. There is an induction process, by both GSL and DIMIA, but this seems to be treated as something

that needs to be done, rather than as an essential task in informing detainees about their situation, what will happen, and what is required of them. At the time of the Inquiry's visits, information was not available in all the languages represented. Anna failed to cooperate with her induction.

The Inquiry was also surprised to learn that detainees had only a very general understanding about their compounds and how the different compounds work and why. In particular, most detainees never see the inside of Red One, and their impressions are gained from others. Similarly, the method of distributing medicines, the lack of understanding of the difference between a doctor and a specialist, and the reasons for the various processes that need to be followed by detainees did not seem to have been explained.

Detainees were also very sceptical about the 'complaints' process and its neutrality; this situation was aggravated by the lack of feedback on any action that might have been taken.

The Inquiry investigated many of the stories that abound and sought to confirm their veracity by using a combination of sources. It considers it gained an accurate and balanced understanding of the facts on which the stories are based. Many of them could be corrected if accurate information were provided to visitors and advocacy groups, although some of these views seem to be based on belief rather than fact. Some stories, however, identified real concerns to which the Inquiry responded.

One story of concern to many people involves claims of 'maggots in the food'. There is truth in this story, but the reason is not what has been implied. A detainee took meat from the barbecue back to his room. Because there are no refrigerators in detainees' rooms, the meat became fly-blown. In response, GSL introduced a rule that food could not be taken back to the rooms. Had detainees and visitors received a full explanation of this incident, the speculation could have been avoided. The quality of food is discussed in Section 4.3.3.

In relation to establishing a more informed environment in the compounds at Baxter, the Inquiry considers that GSL and DIMIA Baxter management, in consultation with detainees, should establish a well-targeted and inclusive program of communication with detainees—not just with two or three representatives. Such a forum should be for all detainees and not for visitors or advocacy groups. The purpose is to empower detainees and enable them to understand and participate in the operation of their own detention environment.

Their human rights and dignity, and the rights and dignity of GSL and DIMIA Baxter staff, should be respected and reflected in these arrangements.

It should be remembered that many languages are spoken at Baxter, a reflection of diverse cultural contexts and backgrounds. A literal translation will not necessarily convey meaning in another cultural framework. There must be emphasis on understanding.

Recommendation 4.3

The Inquiry recommends that DIMIA and GSL—in consultation with detainees—establish a continuing program of communication and information provision to:

- ensure that all detainees understand why they are being kept in detention, the nature of the detention environment, the Commonwealth Government’s duty of care and its objectives for the immigration detention environment, and the respective roles of GSL and DIMIA
- explain to detainees how the different compounds and the Residential Housing Project work, why they have different rules and how they are administered, and the details of the complaints process and its purpose
- explain the visitor arrangements, the process visitors need to go through to get into the Visitors Centre, and why it is necessary
- explain to detainees the arrangements, and the reasons for them, in relation to such things as food storage, contraband and drugs, medical treatment, distribution of medicines, why requests for particular medications are refused, and any other concern that consultation with detainees might reveal
- establish a process for determining a list of topics for discussion one week before each consultation forum is to be held.

Visitors

The lack of emphasis on communication seems to apply to communication with visitors as well. There appeared to be little effort made to engage in dialogue with visitors, and there is no

communication strategy. Many people who are unfamiliar with Baxter's operations see it as a forbidding place. The sensitivity of the environment alone should make it obvious that effective communication and making the visiting 'experience' more understandable and 'friendly' are necessary.

For detainees, visitors are an important part of their life at Baxter. Many care givers, individuals and members of the clergy provide valuable support, and their efforts should be facilitated. Most of them would probably be willing to abide by the rules—provided they know what they are and why they are necessary. If arrangements at Baxter are not explained to visitors, the visitors will continue to construct their own impressions of various situations, as has happened in the past.

For example, it seems that many visitors are unfamiliar with the X-ray screening machinery at Baxter. It is similar to what is used in airports but the technology is older. For some it is a daunting contraption; some people have objected to having their shoes 'rejected'. These things are easy to explain, as is the procedure for arranging visits and access and the reasons for it.

When a visitor comes to see a detainee, their arrival is announced by loudspeaker in the compounds. But, because many detainees have 'shifted the clock' in order to be able to talk with friends and family in their homeland, they often sleep until midday and are awake well into the night; sometimes they are asleep when a visitor arrives and do not hear the announcement.

Visitors should also be alerted to the possibility that, even if a visit has been agreed to, a detainee might not wish to be disturbed on that particular day and might refuse to see them. Detention officers rarely pass on such advice to visitors, not wishing to become involved in what they see as a matter between the detainee and their visitor. For some detainees, though, it is culturally more acceptable to blame their failure to attend on the 'guards' than to accept personal responsibility for not attending.

It is also essential that visitors have explained to them important housekeeping matters such as the policy relating to food and the reasons for it, as well as the arrangements for detainees in the various compounds. Simple things, such as the arrangements for the distribution of medicines by detention officers and why nurses are afraid to enter the compounds, also need to be explained. Visitors

should be encouraged to ask questions so that matters can be clarified and their questions answered.

Recommendation 4.4

The Inquiry recommends that GSL and DIMIA prepare a small number of information posters for the Visitors Centre to inform visitors about important things such as:

- booking arrangements for visits, the 'visitor lists' prepared for each detainee, and why visitors can see only the detainees they have nominated on their visitor application form
- why food brought into the Visitors Centre must be consumed there and cannot be taken back to detainees' rooms and why parcels cannot be left for detainees but must be sent via Australia Post
- what is and is not allowed to be brought into the Visitors Centre—for example, photographs, photo albums, clothes and books
- what the security screening machine is, what it does, why it is necessary, and why some items and articles of clothing (such as shoes) give the wrong signal and might need to be removed.

GSL and DIMIA should also establish for visitors a program of information sessions that provide a general briefing on Baxter, covering such topics as what the compounds are, why they differ and how they operate, arrangements for food preparation and barbecues, the nature of education sessions and how they are run, access to telephones, inter-compound movement, and the arrangements for dealing with complaints. The arrangements for these information sessions—developed in consultation with visitors—should cover the frequency of the sessions, their format, and the topics for discussion.

The Inquiry considers that the most important gap in communication with both detainees and visitors is the lack of feedback. The Inquiry was surprised to find how little attention is given to responding to complaints, requests lodged, questions asked or proposals submitted. This lack of response puts at risk the operations at Baxter and the implementation of government policy and diminishes the quality of life at Baxter for everyone, including staff. It also has adverse consequences for relationships between staff, detainees and visitors and feeds suspicion.

Visitors, as well as detainees, are an essential part of the Baxter environment and should be included in information and communication efforts. If Baxter management were responsive to queries raised by visitors, it would probably make a big difference to the way detainees and visitors view the current arrangements. For the communication strategy to be successful, the queries need to be responded to quickly.

Recommendation 4.5

The Inquiry recommends that GSL and DIMIA—in consultation with detainees and visitors—establish arrangements for regularly:

- providing to detainees and visitors feedback on questions they have raised
- informing them of action being taken and progress made
- advising them when action has been taken and the matter has been finalised and what were the outcomes.

Visitors should be encouraged to raise queries, perhaps through a request form, which must be promptly acknowledged and followed up.

4.3.3 Food preparation

Food was often discussed with the Inquiry. After looking into the situation the Inquiry found that generally the concern was not about the food's quality or adequacy; rather, it was that for many detainees the food is boring. Some people just do not like rice; others need rice regularly. Some prefer spicy food; others bland. Because of the large number of ethnic groups represented at Baxter, the problem of food preparation is much greater than it is in correctional communities, where the population tends to be more homogeneous and there are fewer cultural groups to cater for.

The Inquiry noted that barbecues and picnics were well received. Detainees commented that one of the problems of detention is boredom and the fact that everything is done for them. They have no opportunity to exercise any control in their environment. Incidents such as storing food in their rooms against the rules were simply ways of expressing individuality. Sometimes, however, these led to unforeseen and misinterpreted consequences—to wit, the maggots

incident. GSL advised the Inquiry that it was possible for individuals to cook their own food, but the opportunity did not seem to have been taken up.

There must be a better way of meeting all concerns and considerations. Despite GSL's advice, on the basis of its discussions the Inquiry concluded that many detainees would welcome the opportunity to cook for themselves, as a family or community group or even individually. This should be encouraged on a voluntary basis. Those who do not wish to participate should still have meals provided for them, but with a smaller 'feeder group' menus would be easier to compile and be more appetising for these detainees.

To return some responsibility to the detainees, the Inquiry proposes that those wishing to participate in the 'own cooking' initiative each be given a notional weekly allowance they can spend on a stock list from the local supermarket. They could order what they like. Nutritional advice and oversight from on-site medical staff would be available.

In implementing this initiative, it might be necessary to increase food storage capacity in the compounds and perhaps install some additional cooking facilities. But the benefits to detainees, to GSL and DIMIA staff, as well as to the reputation of Baxter and the way in which the Government's detention policy is seen to be implemented are likely to be significant.

If the 'own cooking' initiative proceeds well, it could be expanded. For detainees who have excellent behaviour records, consideration could be given to escorting them in groups once a week to Port Augusta, so they can do their own shopping at the supermarket. Baxter could establish a standing account. Shopping would be a privilege that is earned.

Recommendation 4.6

The Inquiry recommends that DIMIA and GSL consult with detainees and explore options—such as cooking their own food—that will facilitate greater independence and variety in detainees' food ordering and preparation.

4.3.4 Visitor arrangements

The facilities in the Visitors Centre are inadequate. The Centre is cramped and cannot always accommodate all visitors who would like to attend. Space is a serious problem, particularly during holiday periods, when more distant visitors find it easiest to come to Baxter.

The situation is exacerbated by some poorly thought through practices that lead to unacceptable consequences. For example, the X-ray security checking machinery is slow, cumbersome and daunting to some. Only five visitors can be 'processed' in each batch. At present the processing time is included in the time available for visits, which means that the actual time available to visitors at the end of the queue is greatly curtailed. This should be rectified immediately.

The visitor facilities at Baxter should be upgraded and practices should be changed, so that the processing time for visitors is not debited from the time available for visits. To speed up processing, there should be two, preferably three, modern security screening machines, and visitor accommodation should be expanded to deal with at least 50 visitors in a more open and hospitable environment. Coffee machines, for example, could be considered, as well as outside space in the sun. Detainees' and visitors' views about the arrangements and facilities should be sought.

Recommendation 4.7

The Inquiry recommends that GSL and DIMIA:

- replace the current security screening machinery with two or, preferably, three more modern machines
- take immediate steps to update and increase the size of the Visitors Centre
- in consultation with detainees and visitors, ensure that the environment is more open and hospitable
- establish processing arrangements for visitors that begin before the official visiting hours and do not result in a decrease in the available visiting time.

4.3.5 Engagement with the community

The detention environment has the potential to adversely affect the health and welfare of detainees. The significantly higher incidence of mental illness among detainee populations attests to this. It would seem to be commonsense that, if greater attention were paid to the quality and nature of the detention environment, the benefits to detainees' health and wellbeing would be considerable. It would also help to reduce the high level of risk exposure the Commonwealth currently has.

Detainees told the Inquiry that boredom is one of the worst parts of detention and that it causes much stress. All sensible steps should be taken to alleviate stress for detainees, commensurate with the provisions of the Act, which requires detention but also the provision of care. Most detainees enjoy football. Some time ago it was proposed that a football pitch be built at Baxter. DIMIA advised the Inquiry that funds have now been agreed and designs prepared and the project is to be implemented. The Inquiry supports this initiative.

The Inquiry understands that GSL has periodically tried a number of initiatives to improve the quality of life in detention for detainees, including town visits for shopping and picnics. These initiatives are of particular value to detainees and staff alike and should be expanded and regularised.

Visits to places such as Port Augusta could be combined with integrative activities aimed at building mutual respect and understanding between detainees, GSL officers and the community. Activities such as a football match (perhaps against 'town') and a picnic and barbecue could be easily arranged. Such outings would need to be treated as privileges that are earned. The Inquiry was informed that there is strong community support in Port Augusta for such initiatives.

Because the immigration detention environment is deliberately not a correctional environment, it seems to the Inquiry that such changes would be in support of the Government's policy. They would also contribute to managing mental health risks and to the wellbeing of detainees.

Recommendation 4.8

The Inquiry recommends that DIMIA, in consultation with GSL, consider allowing detainees to make regular, supervised monthly visits to Port Augusta and other suitable locations, to enable them to interact with the community and participate in activities such as sporting fixtures, picnics and barbecues. Participation would be a privilege that is earned. The arrangements should be reviewed after six months in order to determine how well they are working.

4.4 Operational considerations

4.4.1 Red One and the Management Unit

The operations of Red One and the Management Unit continue to evolve. In earlier times, there was violence in the compounds and the only sanction for violent or at-risk behaviour—such as detainees assessed as having a heightened risk of self-harm—was the Management Unit. Red One was established at the initiative of DIMIA and used under the new contract with GSL. DIMIA recognised that the detainee population was changing and there was a need for an intermediate facility that was less regimented than the Management Unit.

Behaviour management

Red One and the Management Unit are for behaviour management. The objective is to manage the behaviour and move the detainee back to their compound as soon as they no longer present a threat to others or themselves. These are special facilities and the arrangements for them differ from the normal living arrangements in Blue and White Compounds.

A behaviour management plan is prepared for detainees in Red One and the Management Unit; it specifies required behaviour and the privileges available to the detainee as they progress through a weekly regime. The Operating Procedures were prepared when the contract was signed in February 2004 and reflect strict correctional perspectives, attitudes and rules.

During 2004 GSL and DIMIA realised that the rigid, step-by-step protocols were becoming increasingly inappropriate and were potentially damaging to an immigration detention environment. Some

of the requirements defied commonsense: for example, in ‘week one’ a detainee was allowed access to books; in the following week the detainee was allowed to have reading glasses. This is another demonstration of the focus on process at the expense of commonsense.

Notwithstanding the problems arising from strict adherence to the Operating Procedures, in October 2004 DIMIA Canberra advised the Managing Director of GSL that GSL would be audited against the Procedures. Any deviation from them would mean GSL risked incurring a financial sanction. This reaction from Canberra did not resolve the problem and did nothing to assist GSL. It also overlooked the potentially serious consequences of continuing with flawed practices.

GSL and DIMIA managers at Baxter agreed that greater flexibility would be necessary if they were to deliver fair and equitable outcomes for detainees. GSL briefed the Inquiry on the proposed changes designed to provide greater flexibility and enable management discretion. For example, when a detainee asks for ‘time out’ from their compound to sort out personal problems, the only option is placement in Red One or the Management Unit. Once the detainee is placed in Red One or the Management Unit, the Operating Procedures require that he or she follow the specified lengthy process in order to return to their compound. There needs to be flexibility to expedite the return in consultation with the detainee.

The Inquiry also supports GSL’s proposal to reverse the present system of threats and privileges and to start the detainee on maximum privileges and time out (12 hours a day). Should the detainee offend, the privileges would be progressively reduced. There would also be flexibility in being able, for example, to start a detainee at ‘week two’ rather than ‘week four’ and to fast-track a return to their compound where this is appropriate. It is good management practice and commonsense.

Although these initiatives seem to have been agreed between DIMIA Canberra and GSL, the time taken to finalise and approve them seems extraordinarily long. GSL drafted local site-specific Operating Procedures for Red One and the Management Unit in the second half of 2004 and forwarded them to Canberra. DIMIA Canberra has been considering the revised Procedures since October 2004 and advised on 24 June 2005 that their introduction is imminent.

Commonsense

When it became clear that use of the Management Unit was leading to undesirable outcomes—outcomes contrary to policy objectives and defying commonsense—the GSL General Manager at Baxter took decisive action. He issued a directive to GSL staff that no detainee was to be placed in the Management Unit without his personal signed authority. The result was immediate and, except for a few specific cases, the Management Unit has since remained empty most of the time.

DIMIA does not seem to recognise that the nature of the contract determines behaviour. It is not enough to demand in the contract that the service provider act in partnership: there must be a basis for a real partnership that respects the rights and responsibilities of both parties. The Inquiry's findings in relation to the contract, contract management, performance measures and monitoring are discussed in Section 7.5.

Responsiveness and communication

The Inquiry formed the view that there is a considerable gap in understanding between DIMIA Canberra management responsible for detention policy and strategy and the reality of staff trying to deliver detention services on the ground. The time frames for action are vastly different. The speed of response from Canberra to urgent operational concerns was described as 'glacial'.

The slowness and lack of urgency displayed by DIMIA Canberra in responding to pressing operational concerns has delayed necessary reforms and adversely affected the welfare of detainees. The lack of response and executive management involvement from DIMIA Canberra in investigating the many concerns expressed by advocates and external parties have allowed poor practices to continue. These flawed processes and procedures do not only adversely affect detainees: they also adversely affect honest, hard-working GSL and DIMIA staff at Baxter who are trying to make a difference.

Senior operational DIMIA managers should have greater involvement in the formulation of detention policy and management and decision making. The DIMIA Canberra arrangements should be more consultative and more attuned to the nature and speed of events at immigration detention facilities and should recognise the attendant risks. This is dealt with in Chapter 7.

4.4.2 Performance measurement and audit

The DIMIA management model for Baxter is flawed and is the result of a poor contracting approach. The Commonwealth Purchasing Reforms were intended to ‘let the managers manage’. They forged a break with the process-driven *Commonwealth Purchasing Manual* and gave agencies responsibility for choosing the contracting approach and process that was most suited to their requirements and to identify and manage the risks in achieving value for money. The DIMIA contract fails to meet these objectives. Section 7.5 discusses contracting.

The DIMIA arrangements at Baxter seem to be strongly focused on ensuring operational compliance. The audit and performance management procedures are highly intensive and process driven and reinforce this perception. There is a major program of audit set out for the whole year and there is intense activity by DIMIA auditors from Canberra that also requires participation by GSL. The Inquiry has no confidence that these activities are providing to DIMIA executive management any useful information on the quality of services provided at Baxter or how risks are managed.

The Inquiry found little evidence of active policy oversight from Canberra or arrangements for evaluating the achievement of policy outcomes. It was unable to identify a risk management strategy that addressed real exposures to the Commonwealth, both nationally and internationally, or to determine how such risks were being identified and dealt with. Any comfort given to DIMIA executive management by the intensive audit program is misplaced.

The audit arrangements fall short especially in relation to the delivery of health care because they do not involve specialist staff experienced in examining performance in such critical areas. The arrangements also lack independence and as a consequence are potentially open to criticism, which has been voiced. The Inquiry recommends in Chapter 6 not only that a Health Advisory Panel be established as soon as possible but also that the Minister establish an independent body of specialists to provide advice on the adequacy of the services being provided.

4.4.3 Case management

The case management of Anna during her 10 months in detention was disjointed, fragmented and poorly coordinated. Each time she was moved a new case manager was appointed and started with very

limited knowledge of Anna's history. Anna had two case managers while at Baxter.

The Inquiry found a lack of clear responsibility for case management and a lack of provision for executive management oversight. No case manager was assigned continuous responsibility for a particular detainee (or group of detainees). Case managers were changed with apparently little consideration of what impact this might have on the detainee. There was no cohesive 'cradle to grave' case management to provide continuity and ensure consistency and dignity in the way detainees are treated.

A great deal of information about the activities of detainees is recorded, but there was no evidence that the information was ever brought together and assessed to determine particular approaches to managing detainees more effectively. For example, on 24 November 2004 at the Management Unit Review Team meeting, Anna's GSL case manager said she believed Anna was an Australian national of German parents and suggested that DIMIA should look into missing persons. This was communicated to DIMIA staff in Baxter and Canberra but does not seem to have prompted any action.

With mounting evidence, commonsense should have dictated that DIMIA immediately release to state and territory police and the media a photograph of Anna and seek public assistance in identifying her. The Inquiry is not persuaded by the DIMIA defence of privacy considerations. Section 5.3.3 deals with this important matter.

An organised, coordinated approach to case management would ensure that detainee information was properly recorded, collated and assessed. It should also bridge the current gap that exists between 'administrative' information and 'medical' information—and, indeed, between medical information held by International Health and Medical Services and Professional Support Services. IHMS and PSS also recognised the shortcomings of separate 'patient' information systems in relation to effective care and were looking at amalgamating their systems. Access to both sets of records is required if detainees are to be managed effectively and have their needs responded to. Case management is discussed in Section 7.2.3.

4.4.4 Allegations of assault and inappropriate behaviour

Allegations of assault

Through its examination of files and records and its interviews with GSL and DIMIA staff at Baxter, the Inquiry became aware that Anna had made an allegation of sexual assault. An examination of the circumstances surrounding the allegation strongly suggested that, although an incident was recorded, it did not involve assault or have any sexual connotations. The police were not informed of the allegation because Anna refused to sign the complaint form.

The decision not to follow the guidelines requiring that police be informed of allegations of possible criminal offences—regardless of whether or not the complaint form was signed—leaves staff open to allegations of misconduct. The incident was raised in the media by lawyers for the Rau family.

In the Inquiry's view, Anna's refusal to sign a complaint form was insufficient reason to not pursue a complaint. Anna's care needs and those of other detainees could not be met unless appropriate action was taken to manage and investigate complaints. There was a draft memorandum of understanding between DIMIA and South Australia Police, requiring a police officer to attend Baxter for the purpose of enforcing the state's criminal law. Protocols have now been introduced to ensure that any complaint of assault or illegal activity is referred to SA Police for investigation. The complaint procedures should reflect AS 4269—the Australian Standard for Complaints Process—and the arrangements should be incorporated in the MOU. It should be formalised quickly.

Anna's allegation of sexual assault was eventually referred to SA Police. During the associated investigations, Cornelia Rau's solicitor and the doctor treating her informed police that she was not fit to speak to them and that at that time her prognosis was unknown. The solicitor suggested that the matter be filed pending the conclusion of treatment she was receiving. When this happens, Ms Rau's solicitor advised that she would discuss the matter with Ms Rau and advise police accordingly. At the time of writing, Ms Rau is still unable to participate in police interviews.

Another incident involving Anna was an allegation that she had assaulted a GSL detention officer who was conducting a room search. This allegation was referred to police for action, but they declined to take any action because of lack of evidence and Anna's perceived mental state. This incident and its interpretation by SA police should

have caused both GSL and DIMIA further concern about Anna's mental state. Regrettably, this abnormal behaviour was treated as normal for Anna. GSL and DIMIA officers thought they were dealing with a behavioural problem.

Other incidents where Anna refused to comply with a legitimate direction, such as to return to her room when her 'time out' had expired, have been confused with 'assault'. On one occasion, after she had been asked three times to return to her room, a 'response team' was called. (Response teams are usually made up of five trained staff, each with a particular role, who combine to subdue a non-compliant detainee quickly and humanely and with a minimum of force. They do not wear flak jackets.) Such incidents are videotaped and recorded. The Inquiry viewed the tape of this incident and saw that Anna was quickly subdued on the grassy area in Red One and returned to her room. It is satisfied that the task was professionally and rapidly completed and no undue force was used.

The Inquiry is aware of only two occasions on which such coercion was used, the second being on the night when Anna was taken from Baxter to Port Augusta Hospital. In that case, the removal was performed by South Australian ambulance and police officers. It was observed by GSL and DIMIA staff, who played no role in it because Anna was no longer in detention at Baxter. A witness claimed—incorrectly—that it took '10 people to subdue one girl'.

There were other occasions when Anna was abusive to detention officers and DIMIA staff, but they had become so common they were no longer recorded. On the information available to the Inquiry, none of these incidents appears to have been provoked by behaviour of the detention officers other than in their attempt to enforce the rules. Detention officers saw this as 'part of the job'. The Inquiry considers that such behaviour should *not* be treated as part of the job. Like detainees, detention officers and DIMIA staff deserve to be treated with respect. At the same time, the incidents highlight the importance of accumulating information about behaviour patterns in order to ensure the proper treatment of detainees. It is clear, however, the incidents involving Anna were minor.

The Inquiry is concerned that, had such incidents been recorded, they would have added weight to the growing evidence of the need for Anna to be psychiatrically assessed. Chapter 6 discusses the clinical importance of the views of detention officers, staff and fellow detainees and the need to integrate and assess accumulated information.

The Inquiry became aware of a statement made by a detention officer who was critical of many aspects of Baxter operations. Despite his criticisms, he said he had not observed any mistreatment of Anna and he believed that most detention officers had treated her well. Many officers were concerned at Anna's condition and were wondering why more was not being done about it.

This perspective on Anna's treatment was confirmed in the Inquiry's interviews with detainees who had actually seen her. It is often overlooked that Anna spent only 14 days in the open Blue Compound and that few detainees have occupied Red One or the Management Unit. Other contact with Anna would have been through occasional sightings at education classes or at church services, which Anna attended on only four occasions.

Appendix C provides a brief history of Anna's behaviour at Baxter, the attempts to deal with it as a behavioural problem, and her movements between compounds.

Inappropriate behaviour

There have also been allegations of inappropriate behaviour by detention officers in relation to Anna. Among these are allegations of officers abusing their position to spy on Anna while she was showering or asleep in her room and Anna being denied curtains or a shower curtain for privacy. The Inquiry understands how such views could have been formed.

In Blue Compound all rooms have curtains and shower curtains. As noted, Red One and the Management Unit are special compounds designed for behaviour management; they have a special function and are not normal 'residential' compounds.

In Red One B there is no door or curtain between the bedroom and the en suite. The 'peephole' in the front door allows detention officers performing routine checks to see through partly to the toilet but not into the shower. There is no shower curtain, but there is a raised edge to the shower to prevent the water running into the room. Red One A is the same, except that there is a door between the bedroom and the en suite bathroom.

All rooms have window curtains that are held in place with Velcro. At various times Anna was placed in Red One A or Red One B. On some occasions she chose to not secure the curtain. The Inquiry was advised that she would often remove all her clothes while in her room.

The Management Unit has 10 single rooms, a dining and recreation room, and a television room. As noted, it is used to accommodate detainees who are assessed as being at high risk of self-harm or who present a danger to other detainees or staff. The situation is reviewed every day by the Management Unit Review Team, one member of which is a psychologist.

These rooms are air-conditioned and heated and have their own en suites, but they are 'bare' facilities that provide an environment where a detainee will not find assistance from their surroundings if they are contemplating self-harm. Consequently, there are no curtains and no shower curtains. There is continuous video surveillance of the rooms, but the camera angle is such that a person showering or using the toilet cannot be seen. Further, there is no complete view into the shower or the toilet from the window. Conducting an effective 'suicide watch' requires that there be a sufficient line of sight to observe at all times what is taking place. Similar units in other institutions make use of strategically positioned 'modesty screens' that do not hamper the view of the observer.

The Inquiry found the arrangements for checking on detainees in Red One and the Management Unit to be consistent with requirements. Having studied 'running sheets' and other records, it found no evidence of improper behaviour by detention officers. The reported remarks of some detainees reveal a lack of understanding of GSL's legal requirements to keep the facility 'safe' and to exercise the duty of custodial care.

Although the Inquiry found no substantiated instances of improper behaviour, it strongly urges that practices be improved. In particular, it considers that the monitoring of female detainees by male detention officers is inappropriate and ill-advised and could give rise to unfounded interpretations and to complaints against individual officers.

The Inquiry does not accept as adequate GSL's assurances that it will use female detention officers 'whenever rostering permits'. Contract requirements should insist that, other than in emergency or extraordinary circumstances, all surveillance of female detainees is done by female detention officers. Any lesser standard should be regarded as unacceptable.

Recommendation 4.9

The Inquiry recommends that, as an immediate priority, DIMIA and GSL:

- agree on and implement arrangements that will ensure that when female detainees are placed in Red One or the Management Unit they are checked only by female detention officers
- negotiate whatever changes to the contract are needed in order to accommodate this initiative
- ensure that staffing of detention officers when female detainees are in Red One and the Management Unit is reflected accurately in the operational records that are kept.

Given the amount of information now carried by the media on what the Inquiry had thought to be private events, it must be acknowledged that Anna often did behave disruptively and provocatively and often appeared partly clothed. It was because of such uninhibited behaviour and other incidents that Anna was kept isolated in Red One for her own protection. It would have been inappropriate for her to remain in the family compound. Her behaviour should, however, have been seen as providing more evidence of the need for a psychiatric assessment.

4.4.5 Management of detainees' personal information

The mismanagement of information about detainees, their backgrounds, and the circumstances that brought them to Baxter is of concern to the Inquiry. Incorrect or unguarded private information about an individual can cloud objectivity and influence the way in which they are treated.

On the basis of its interviews at Baxter, the Inquiry became aware of a belief among many of the GSL detention officers that before her arrival at Baxter Anna had been in gaol in Queensland for drug use or that she had been living with Indigenous Australians in far north Queensland and had been sniffing petrol. These misinformed stories about Anna's background led many GSL officers to see her odd behaviour as consistent with that of someone who had been involved with drugs or had suffered brain damage as a result of sniffing petrol. The perceptions tended to normalise abnormal behaviour.

Every detainee has a right to privacy in connection with their personal information. Where detainees are dependent on the effectiveness of care givers, however, it is important that officers are aware of relevant aspects of the detainee's administrative and medical history or trauma. Such information is essential if staff are to be able to provide high-quality care.

It is incumbent on DIMIA to ensure that accurate, relevant and timely information about a detainee is provided to all DIMIA staff and contractors who interact in any way with that person. There is also a duty of care to be alert to inaccurate and inappropriate information or gossip and to take steps to ensure that it is eradicated.

Recommendation 4.10

The Inquiry recommends that DIMIA develop and implement arrangements to ensure that:

- accurate, relevant, clear and concise briefing notes on each detainee are prepared before they arrive at Baxter and that these records are attached to the detainee's file
- DIMIA and GSL staff and contractors who are likely to have close contact with detainees are given an accurate briefing on each detainee before the detainee's arrival at Baxter or as soon as practical thereafter
- the briefing notes are used to inform the detainee induction process
- staff refer to the briefing notes for guidance, so that they can respond suitably to the needs of individual detainees.

4.5 Infrastructure

4.5.1 The Management Unit

The Inquiry supports the initiative of the GSL General Manager at Baxter in taking executive responsibility for the placement of detainees in the Management Unit. It also notes that the introduction of new, site-specific operating procedures for Red One and the Management Unit is imminent.

The Management Unit is not a suitable place in which to confine a person in detention because it does not seem to meet the Muirhead standards—the standards for cell design established by the Royal Commission into Aboriginal Deaths in Custody. There is also inadequate opportunity for interaction between people accommodated there, and the detention environment is non-therapeutic in nature. It is difficult in this environment to demonstrate that the purpose is not punitive.

Immediate steps should be taken to provide a safer, more therapeutic environment for detainees who need to be separated for management reasons—especially for those for whom there is a health component (such as suicidal tendencies or potential for self-harm) to the reason for their separation from the detainee community. The changes should be assessed and developed in consultation with experts on the requirements of the Muirhead standards.

These necessary changes to the structure and environment of the Management Unit mean that GSL and DIMIA should fundamentally reassess the Unit's purpose and nature in the light of a changed immigration detention environment and a changed detainee population. The changes to the Operating Procedures proposed by GSL will go some way towards dealing with the problem, but they do not go far enough.

Recommendation 4.11

The Inquiry recommends that, having regard to the findings of the Royal Commission into Aboriginal Deaths in Custody, DIMIA and GSL:

- seek expert advice on the Muirhead standards as they relate to a custodial environment
- carry out an immediate review of the Management Unit and effect the changes necessary to conform with the Muirhead standards
- carry out a thorough review of the purpose and nature of the Management Unit in the light of a changed immigration detention environment and a changed detainee population
- agree on the changes that need to be made to the Operating Procedures in order to give effect to the new arrangements.

4.5.2 An intermediate facility

The structural arrangements at Baxter are more suited to a correctional regime. It has become increasingly obvious that the facilities are inadequate for dealing effectively with the challenges presented by immigration detention and the requisite nature of the detention environment. These limitations were highlighted by the difficulties GSL and DIMIA experienced when dealing with Anna.

Anna presented new challenges to Baxter. Her provocative and disruptive behaviour was not acceptable to other detainees in Blue Compound and it was necessary to isolate her from them. The only alternative was Red One. As noted, Red One is normally used for short-term stays, with the objective of returning the detainee to their original compound as soon as possible. But the insistent and confronting nature of Anna's behaviour made it clear that she could not be safely returned to Blue Compound. It was a dilemma for all concerned.

The problem was exacerbated by the requirement that GSL comply with Operating Procedures that often lacked commonsense.

Because there is no accepted pharmacological treatment for 'personality disorders', there is a defaulting to behaviour management as the treatment option. Behaviour management involves developing and introducing rewards and sanctions that promote pro-social behaviour and discourage anti-social behaviour. In a custodial environment such as a detention facility this often involves placement in some form of administrative segregation, away from the general population of detainees. That is what happened with Anna.

For all but 14 days during her detention at Baxter Anna was in either Red One or in the Management Unit—in keeping with the requirements of the corrections-oriented Operating Procedures. Anna was usually the only occupant of Red One, and she was allowed various free periods in the grassy compound outside her room. She usually kicked a soccer ball around or went to watch television in the recreational facility.

There are stories that Anna was so traumatised by her treatment she would scream and cry because she was afraid to go into her 'cell'. The Inquiry established that at both Brisbane Women's Correctional Centre and Baxter Anna resisted authority and would not obey commands to return to her room when her specified 'time out' period was over. At times she had to be assisted firmly into her room. She

often screamed at the detention officers. It is noteworthy that, instead of being intimidated by her 'cell', Anna often chose to stay in her room and read a book rather than go out into the compound. When she finally came out, she would often demand her full 'time out' from that moment on. This also led to confrontation.

Although both GSL and DIMIA Baxter management recognised that the rigid Operating Procedures were inappropriate for Anna, the rules prevailed. When Anna committed certain breaches of her behaviour plan, she was placed in the Management Unit, as required by the Procedures. Her return to Red One had to follow the process specified in the Procedures, although this tended to be administered increasingly flexibly. But when she had settled into the routine in Red One and was considered suitable for return to Blue Compound she refused to move. It was decided to allow her to remain in Red One until she was ready to move.

Anna was held in Red One because there was no alternative. GSL is already using Red One more as a 'step-down' facility and has proposed more flexible operating procedures. However, even with a more flexible regime, this would still not have been appropriate for Anna. Such flexibility would also have been restricted whenever there were other detainees, particularly men, in Red One. Red One must be able to preserve its original purpose of behaviour modification, should that be required.

The fact that Red One is a 40-bed compound makes it an unsuitable place for accommodating detainees with special needs. This was the case with Anna. Trying to adapt these facilities to accommodate people with special needs is unlikely to be successful or appropriate. In Section 6.5.6 the Inquiry discusses the possible establishment of a national mental health unit to service all immigration detention centres in Australia. It should be located in a capital city so that it can avail itself of specialist staff and the resources of tertiary hospitals.

Consideration should also be given to establishing on site at Baxter a separate, flexible multi-purpose facility that can accommodate, for example, an individual or family that needs to be isolated from their compound or people such as Anna pending in-patient psychiatric assessment. Such a facility could be a simple demountable building of two or three bedrooms plus facilities. It could supplement the on-site medical centre and provide a 'bridging annexe' to specialist medical facilities in Adelaide as well as to the Residential Housing Project in Port Augusta.

The buildings could be constructed in such a way as to be able to be set up for on-site medical observation, should that be necessary. A facility of this nature, staffed by suitably trained nurses skilled in observations, would have greatly assisted GSL and DIMIA staff in developing evidence and indicators to support transferring Anna to Glenside in Adelaide.

Recommendation 4.12

The Inquiry recommends that DIMIA consider constructing a flexible 'intermediate facility' at Baxter to enable more appropriate accommodation to be provided to detainees who cannot be allowed to remain in an open compound but who for various reasons should not be placed in the behaviour management environment of Red One or the Management Unit. The facility should be designed in such a way as to provide sufficient flexibility to be configured to accommodate a person with specific needs, such as Anna, or a family or individual requiring temporary relief from their compound or intensive medical observation.

4.5.3 Accommodation for detainees

The compounds at Baxter were deliberately constructed in a 'closed' formation so as to overcome the problems of Woomera. The impact of the Government's immigration policy has been such that those reasons might no longer be valid. The number of immigration detainees has fallen considerably and the detainee profile has changed.

Simple changes to the construction of the buildings in the compounds could have a very positive impact on the quality of the detention environment. For example, in the case of families the walls between adjoining rooms could be removed and replaced with dividers to create a more family oriented environment; rather than being 'rooms', they could become 'family units'. There would seem to be more than sufficient capacity in the empty compounds to accept any 'single room' overflow requirements.

Concern is sometime expressed that detainees cannot see the horizon. While they remain in the compound this is true. But detainees are already free to move between compounds. Consideration could be given to demolishing some rooms, thus offering views to 'the outside', and the vacated space could be constructively used for recreational purposes or a garden. Such gaps could be used to delineate blocks of family units.

Recommendation 4.13

The Inquiry recommends that DIMIA consider making structural changes to the Baxter compound accommodation for detainees in order to:

- create two-room and three-room family units from adjacent rooms by removing walls between adjoining rooms and replacing them with movable dividers
- open up the closed compound structure by removing some of the rooms and allowing views outside the compound and beyond the detention facility itself
- use the opened-up space to create a vegetable or native garden or to other good effect.

5 The circumstances and actions leading to the failure to identify Cornelia Rau

5.1 A baffling situation

It is hard to believe that an Australian resident could remain unidentified for 10 months. Although inquiries were primarily focused on Germany, DIMIA made considerable efforts in Australia and through overseas posts to confirm the identity of the suspected unlawful non-citizen Anna but was unsuccessful. The German Consulate could not confirm Anna's identity as a German citizen. New South Wales police made extensive inquiries in their search for the missing person Cornelia Rau, but they too were unsuccessful. Why was it so difficult?

Three important factors combined to frustrate efforts aimed at identifying Anna as Cornelia Rau:

- The person Cornelia Rau presented as Anna does not exist.
- Too much reliance, over too lengthy a period, was placed on the information Anna provided.
- The identification process was ad hoc, unstructured and unmanaged.

Anna did not want to be found. We do not know why. We might conjecture that she did not wish to be returned to her world of frustration and pain, where she would be placed in a hospital because she was ill. As Anna, she was well and healthy and could escape that world and perhaps flee to Germany. Psychiatric opinion suggests that denial of the fact of being mentally ill is not uncommon among people suffering from schizophrenia. Such denial would serve to explain Ms Rau's failure to make contact with her family or to admit her real identity during the long period of her detention and, as the Inquiry understands it, for some time after her admission to Glenside.

When a person 'exists' they leave a trail and impressions in the sand. Anna left no trail, and her impressions in the sand were fantasies that could not be verified. She provided no real clues to her identity, only

fictional details, and did not assist in the process. She refused all offers of medical assistance, a refusal that was respected because it was her right. Australia has strict laws relating to administering medical assistance against a person's will.

A similar situation has recently arisen in England, where a gaunt, haunted-looking young man was found walking by a beach in a dripping wet tuxedo. He was unable or unwilling to provide details of his identity and has not spoken. All the labels on his clothes had been removed. What did emerge is that he is an artist and a gifted piano player. The search for his identity has resulted in his photograph being circulated around the world. So far he remains unidentified.

On the basis of its investigations and analysis, the Inquiry cannot point to any thing that, had it been done in the circumstances, would immediately have led to Anna's identity being discovered. There were, however, a number of factors that, together, would have improved the chances of earlier identification if they had been properly considered.

5.2 Contributing reasons and circumstances

5.2.1 Information presented by the detainee

When identifying a person, the starting point is usually the information provided by that person. Although such information always requires corroboration and validation, when no meaningful identity information is provided other strategies have to be pursued.

In the case of Cornelia Rau a range of information was provided. It was fictitious and designed to mislead. Ms Rau did not want to be found. The record shows that she prepared for her disappearance and withdrew a considerable sum of money to support her journey. Information available to the Inquiry suggests that she probably created the person Anna Schmidt from a combination of the names of two people with whom she had previously associated.

Throughout her 10 months of detention Anna maintained the false identities of Brotmeyer and Schmidt. Other than what she provided in the first stages of her detention, she gave very limited background information. There were some differences in her accounts of her movements in Australia and of when and how she had arrived, but she consistently maintained them throughout her detention and provided

nothing further. She continually insisted that she was well and did not need medical care.

The information Anna provided was given to police, DIMIA officers, staff of Brisbane Women's Correctional Centre, staff at the Princess Alexandra Hospital, German consular officers, and staff at Baxter. DIMIA and the German Consulate made extensive efforts to identify Anna under her alternative names and their near alternatives but were unsuccessful. That is unsurprising: Anna does not exist.

5.2.2 The footprints

When people go missing, the footprints they leave in the sand are things such as details of credit card transactions, money withdrawals, Medicare use, mobile phone records and airline ticket purchases. Cornelia Rau left no trail when she disappeared from Manly Hospital on 17 March 2004. Anna had no trail, other than through people who had given her a lift, when she appeared in Coen in far north Queensland. There was nothing to link Cornelia Rau with the young German tourist who was hitchhiking alone in potentially dangerous country. Anna had arrived. No one was yet looking for Cornelia Rau.

When detained and searched, Anna was carrying no personal identification, although she was in possession of someone else's Norwegian passport. That person was located but she did not know Anna. Any possible clues—such as names found in her WWOOF book—were followed up and produced no helpful information. She had what seemed a plausible explanation for the large sum of money she was carrying. There was no reason, at this time, to believe Anna was anyone other than who she claimed to be.

It is important to recognise that at that time there was no apparent concern about Anna's mental state. People were concerned for her welfare, but there was no reason to believe she had a mental illness. She may have still been benefiting from medication given her at Manly Hospital. Her family confirmed that Ms Rau was good at masking her symptoms when she wanted to.

5.2.3 Fingerprints and biodata

Some people have suggested that if Anna's fingerprints and other biodata had been taken she would have been identified immediately. They point to the superb efforts made by the NSW Police forensic team, the Australian Federal Police and officers of the Department of

Foreign Affairs and Trade in identifying the victims of the Bali bombing.

There is a significant difference though. The identity of most of the Bali victims was known, and the individual families cooperated fully. Movements and passport details existed. The challenge was to match remains with individuals. In the case of Anna there were no reference points and there was no family to corroborate information.

Anna was asked to give her fingerprints but she declined. At that time fingerprints could not be taken involuntarily. That situation has now changed.

If Anna's fingerprints had been taken there would not have been a match with police or any other records. Cornelia Rau's fingerprints were not on a police file. Her fingerprints had been taken while she was a volunteer for the 2000 Sydney Olympic Games, but they and the fingerprints of all other volunteers found not to have a criminal record were destroyed and were never transferred to the National Automated Fingerprint Identification System. Such is the nature of privacy laws in Australia. Unlike some European countries, Australia does not have a 'national card', and there is no national fingerprint database.

Although some biodata were recorded for Anna—including height, weight and eye colour—such information is not recorded on any national database. Indeed, at present there is no national missing persons or fully national persons of interest database. The CrimTrac agency operates a National Names Index on behalf of federal, state and territory police, but the Index provides only basic information and uses a series of flags to indicate to users that additional information exists in a particular jurisdiction.

Essentially, in its present form the National Names Index only allows searching for name and aliases, fingerprint identification and date of birth. It does not have the capacity to search by description without a name, does not contain or allow any exchange of photographic information, and flags only missing persons details. Users can search existing systems for a missing person, but the search is basically name based.

With the development of CrimTrac, however, this is changing. A Minimum Nationwide Person Profile project is being piloted as a basis for establishing the capacity for all police jurisdictions to nationally exchange higher quality, more comprehensive data on individuals of

interest. The MNPP is the lead development in a CrimTrac Police Reference System program approved by the Australasian Police Ministers Council. If the pilot program is successful, further extensions of the MNPP will increase the capacity and effectiveness of national management of missing persons data and inquiries. This is discussed further in Section 5.3.2.

Fingerprints would have been helpful for the German Consulate in its intensive efforts to identify Anna as a German citizen. Germany has effective, well-developed systems that support regional and national databases for all German citizens, and these were exhaustively searched for records of Anna. Nothing was found. The German Consulate asked that DIMIA forward Anna's fingerprints to Berlin, but this did not happen. As noted, Anna did not provide to the German Consulate sufficient information to allow it to confirm her identity and issue German travel documents.

5.2.4 The Movements and Passports databases

DIMIA carried out several searches of the Movements and Passports databases, using all the names given by Anna and variations on them and also using differing dates of birth. No records were found.

At present the Movements and Passports databases essentially search by name and date of birth. If the name is not correct there will be no match. There is no system that can perform a real-time data search by photograph—as seen in the television crime series *CSI*. That capability requires national cooperation and commitment to put the database together in the first place and, even if it is approved later this year, it will take some time to fully develop and implement it.

On the other hand, Australia has one of the most effective Movements databases in the world. If there is no record of a person's movement in or out of Australia, the chances are that the person has not travelled abroad. If a false name is provided by someone already in Australia and there is no record of that person entering the country, the person of that name is either providing a false name or is an Australian resident who has not travelled abroad.

The negative of such searches is a strong indicator. There is no indication that such conclusions were drawn in Anna's case. Had they been, her assumed names could have been eliminated as avenues of inquiry early in her detention and searches could have concentrated on the individual and other avenues of inquiry.

5.2.5 Australian civil records

On 22 November 2004 DIMIA asked Queensland government departments and agencies to search records of births, deaths and marriages, driving licences and vehicle registrations for all the names Anna had given. Such records are state-based and there is no national linking or search capability. The search of births, deaths and marriages was expanded on 12 January 2005 to all states and territories and passenger cards held by the Department of Foreign Affairs and Trade. No match was found.

DIMIA also asked Centrelink and the Health Insurance Commission to search their databases. These agencies keep records of all clients who use their services, and the records are linked to a national database. Because all records are based on name and date of birth, however, this system fails when a false name and date of birth are supplied. One agency did not respond to DIMIA but was not followed up.

These record checks were not carried out until several months after Anna's detention, which suggests an ad hoc approach to identifying Anna, rather than a systematic one from the outset. Searches under the names given by Anna would not have confirmed her identity or identified Cornelia Rau, but at least the assumed names could have been eliminated as avenues of inquiry early in Anna's detention.

At Princess Alexandra Hospital one of the psychiatric registrars initiated inquiries of the German Consulate in Sydney in relation to a passport for Anna. The Consulate advised that Anna had not provided sufficient details to allow a passport to be issued. The registrar also searched the AUSLAB pathology database and the HBCIS (the Queensland Health statewide hospital database) using the names Schmidt and Brotmeyer, with no result.

5.2.6 European immigration posts

Through the Australian Embassy in Berlin DIMIA made inquiries of authorities in Germany in an attempt to identify Anna. A photograph of her and background material were provided. Later DIMIA provided the name of a German over-stayer in Australia, but this person was found not to be of interest.

In January 2005 DIMIA widened the search and asked the Australian Embassy in Berlin to try to identify Anna through Polish, Ukrainian and Czech authorities. These inquiries were redirected to the

Australian Embassies in Warsaw, Moscow (for the Ukraine) and Vienna (for the Czech Republic). The Australian Embassy in Berlin pointed out that, with no fingerprints, identification would be difficult. None of the inquiries bore fruit.

DIMIA also conducted an internal database search for reports of overstayers of German, Polish, Czech, Russian and Ukrainian nationality, but no match was found.

5.2.7 German consular assistance

The German Consulates in Cairns, Brisbane, Sydney and Melbourne provided exemplary assistance, both in Australia and from Germany, in trying to establish whether Anna was a German citizen. They carried out extensive searches in Germany and regularly advised DIMIA of progress. At all times they were conscious of their duties under consular regulations, and their focus was to confirm whether Anna was a German citizen so that they could help her and issue to her a German passport. They were not looking for Cornelia Rau.

Initially, the Honorary German Consul in Cairns made contact with Anna. This contact was continued by the Honorary German Consul in Brisbane when Anna was transferred to Brisbane Women's Correctional Centre. There was discussion with the Consul-General in Sydney, who is responsible for New South Wales and Queensland.

When Anna was transferred to Baxter on 6 October 2004 her consular files were transferred to the Consul-General in Melbourne, who is responsible for Victoria and South Australia. Further efforts were made:

- On 11 November 2004 a letter from Anna addressed to the Brisbane Consulate was received at the Melbourne Consulate; in the letter Anna expressed a wish to go back to Germany and asked for help to get there. The Vice-Consul explained to Anna by telephone the requirements for a passport and told her that complete details would be needed.
- To expedite matters, the German Consulate sought from Victoria Police advice about who to contact in DIMIA. On 6 December 2004 Victoria Police advised that DIMIA would call the Consulate.
- Detailed searches of databases in Germany continued to provide no confirmation that Anna was a German citizen. A check with

the German police ‘wanted list’ revealed that Anna was not listed under the names she had given.

- On 21 December 2004 the German police, thinking Anna might be a Polish citizen, made inquiries in that regard.
- On 3 January 2005 Berlin advised that German police could not positively identify Anna without fingerprints. These were requested from DIMIA but not provided. If fingerprints had been taken and provided to Berlin it is doubtful that a match would have been found, since Cornelia Rau left Germany as a small child.
- The German Consulate in Melbourne contacted passport authorities in Dresden and Munich, where Anna said she had lived when in Germany.
- On 20 January 2005 the German Consulate in Melbourne suggested to DIMIA that perhaps Anna had come to Australia at an early age and had grown up in Australia. This information does not seem to have been picked up by DIMIA.

Throughout discussions with Anna there was no reason for consular officials to suspect she was not German. Anna spoke fluent German without an accent, although it was observed that her sentence construction was ‘child-like’.

On 24 January 2005 the German Consulate in Melbourne formally advised DIMIA that it could not establish any verifiable indication that Anna was a German citizen. As a result, in accordance with international law, it had no authority to continue its activities in this regard. The fact that—with access to one of the most sophisticated citizenship records systems in the world—the German Consulate was unable to confirm that Anna was a German citizen should have started alarm bells ringing in DIMIA. It did not.

Cornelia Rau had collected a new German passport from the German Consulate in Sydney on 27 February 2004. Her passport application would have included a photograph, but there was no reason to link this to Anna. If a search had been asked for, it would have been necessary to manually check Anna’s photograph against all passport applications. The German Consulate is small and could not divert resources to such a time-consuming task. In any case, no search was requested and no photograph of Anna was supplied to consuls in

Australia—other than to the German Consulate in Melbourne for forwarding to Berlin to assist with inquiries in Germany.

A police Missing Persons poster with a photograph of Anna had been displayed in the foyer of the German Consulate in Sydney. No one had recognised her.

5.2.8 Events at Brisbane Women’s Correctional Centre

On arrival at Brisbane Women’s Correctional Centre, Anna was submitted to the usual induction procedures, which are mostly aimed at identifying the special needs of incoming detainees or prisoners. When receiving a detainee, correctional staff are required to satisfy themselves that the person named in the warrant or other custodial order is the person being admitted. It is not their role to conduct independent investigations into the identity of immigration detainees. In accordance with standing arrangements, Anna was not fingerprinted at BWCC.

Anna was photographed on 7 April 2004 at BWCC, during the formal identification interview with the DIMIA Brisbane compliance officer. This photograph was attached to her file. It was also provided to Queensland police on 29 April 2004, in a request for checking Anna as a missing person. The Queensland police advised that no records were found.

It has been asserted on some television programs that, while in detention at BWCC, Anna declared she was Cornelia Rau. It was not possible to verify this assertion. There is, however, no reason why that name or any other name should have been recognised by custodial officers at BWCC. The disappearance of Cornelia Rau did not receive media attention until it was reported by national newspapers after New South Wales police released a media bulletin on 19 November 2004. By then, Anna had been transferred from BWCC and had been in Baxter for over a month.

Anna’s detention in BWCC is discussed in detail in Chapter 3. Had proper processes been adhered to, she might not have been there for more than a week.

5.2.9 Cornelia Rau reported missing

Some have claimed that as soon as Cornelia Rau was reported as a missing person to New South Wales police on 11 August 2004 she should have been identified as Anna. The argument lacks logic. NSW

police carried out extensive and comprehensive searches to try to locate Ms Rau. They also contacted DIMIA on four occasions, asking that the Movements databases be searched. The following summarises their efforts:

- On 23 August 2004 they asked for a nationwide check of all police record systems to ascertain whether Ms Rau had been recorded during the preceding six months.
- During September and October they contacted mental health facilities in New South Wales, Victoria and South Australia in an effort to determine if Ms Rau had made any contact for care or treatment.
- On 19 November they issued a nationwide briefing on Ms Rau, detailing her physical appearance and her ability to speak English and German.
- They investigated tourist accommodation in New South Wales.
- They contacted Ms Rau's former friends and partners to see whether she had contacted any of them. This resulted in a general understanding of her movements after 17 March 2004.
- On 22 November 2004 they asked missing persons units to carry out births, deaths and marriages and taxation checks.
- On 13 December they asked all federal and state and territory police services to check their indices for any records of Ms Rau.
- On 14 December Road Traffic Authority checks were conducted on Cornelia Rau's vehicle.
- The NSW Missing Persons Unit checked its Missing Persons database in an effort to match Ms Rau with any unidentified persons listed.
- On 21 December police attended the German Consulate in Sydney: staff said that in June 2003 Ms Rau had attempted to obtain a German passport in a false name and had been unsuccessful.

All of these searches, checks and consultations were unsuccessful. As discussed, databases generally hold information by name or date of birth, or both. If these parameters are wrong, no match will be found. A search using other parameters was not possible.

On 3 February 2005 NSW police received from Ms Rau's mother a telephone call about an article that had appeared in the *Sydney Morning Herald* on 31 January, stating that an unidentified 19-year-old German female was being held at Baxter. The police contacted the DIMIA Baxter Manager in order to ascertain if the woman in detention was in fact Cornelia Rau. Baxter emailed a photograph of Anna, and the Rau family identified their daughter.

Of course, we now know Anna is Cornelia Rau. But we must remember that NSW police were trying to locate a missing person called Cornelia Rau. They were not looking for Anna. There was nothing they knew at the time that would have linked Cornelia Rau to Anna.

5.2.10 Uncorrelated information

Throughout her detention at Brisbane Women's Correctional Centre and Baxter, Anna did not provide any further information on her identity. Baxter staff noted that she was adept at diverting the conversation when the subject of her identity was raised; at other times she would simply not answer or she would walk away.

Nevertheless, it should have become clear to DIMIA staff at an early stage that there was something strange about this situation and that more thorough assessment was called for. Although Anna was careful not to volunteer any new information, she did freely discuss a range of subjects with detainees and Baxter staff. There were many opportunities to observe her in a 'relaxed' environment.

Substantial records were kept on incidents and events relating to detainees, but the Inquiry found little evidence that these were used to guide action. The exception was when drawing up behaviour management plans for Anna. The value of accumulating this information in order to establish a basis for assessment did not seem to be recognised.

Correlating such information over time can provide a powerful focus for analysis. For example, in the 10 months of Anna's journey the following became known but was not acted upon:

- Anna's presentation was contrary to the norm. She was adamant that she did not want to stay in Australia; she wanted to go 'home' to Germany as soon as possible.

- It is rare to encounter a visa over-stayer from a developed country with a sound economy who expresses a desire to return home but is unable to produce a passport or establish their identity.
- For someone who had been in Australia only a relatively short time, Anna knew a lot about Australia and had developed an Australian accent.
- German consular staff found her German fluent but ‘child-like’. It was suggested that Anna might have come to Australia as a child and grown up here.
- The German Consulate had been unable to verify that Anna was a German citizen.
- Database checks in Australia had failed to reveal any record of Anna.
- There were no movements records for Anna coming into or leaving Australia under any of the names she used.
- At Brisbane Women’s Correctional Centre Anna often said she did not belong there because she had done nothing wrong.
- The GSL case manager at Baxter thought Anna might have been born in Australia of German parents.
- A DIMIA case coordinator suggested that Anna might be an Australian.
- In various taped events Anna is heard talking in accented English and also with no accent whatsoever.

Other, medically related, clues are discussed in Chapter 6.

It is impossible to judge whether or not the pursuit of an inquiry about Anna being an Australian citizen would have led to her identification at an earlier time. The success of the advocacy-driven publicity in the media in January 2005 would, however, suggest it is likely. Failure to focus on this possibility and the continued assumption that she was a German citizen unnecessarily diverted the avenues of inquiry available to DIMIA officers.

As noted, if Anna’s fictitious names had been ruled out at an early stage, critical analysis might have focused more on the probability that this person was an Australian using another name.

5.2.11 Three important questions

The Inquiry considers there are three important questions that need to be asked. Their timely resolution might have shortened Anna's time in detention, created for her an environment that was less stressful given her condition, and enabled earlier medical intervention. In a more relaxed environment, these initiatives could have led to her identity being uncovered.

A question for DIMIA

Why was Anna detained in a prison for six months when DIMIA's own instructions direct that this should be a 'last resort' and why was urgent action not taken to transfer her to a more appropriate facility, consistent with the detention environment clearly specified in Schedule 2, clause 1.13, of the detention services contract?

DIMIA's processes failed. It was not a failure of instructions. Migration Series Instruction 244 is well written and clear. The instructions were not followed. It was a serious failure of management process and corporate oversight.

There is no way of knowing if moving Anna quickly to a more suitable environment would have led to her being identified earlier. But it would have been fairer and would have respected her dignity as a detainee whose immigration status was being confirmed. It is possible that in a more open environment, where a range of people could observe her daily behaviour, Anna would have provided more clues about her identity.

A question for health professionals

Why did health professionals not be more assertive in making proper arrangements for assessment of Anna's mental health status and why did they fail to take responsibility for ensuring continuity of care for a person who, by any standards, obviously needed help?

Cornelia Rau's treatment raises serious questions for the health profession. No senior health professional took personal responsibility for ensuring that Anna received adequate care or exercised assertiveness in ensuring that assessments of Anna were carried out in a suitable assessment environment that could lead to a sound diagnosis. Everyone saw themselves as 'only a bit player'; no one was managing the process. The defined clinical pathways did not work effectively. The 'system' failed Cornelia Rau.

The Inquiry is confident that, had Ms Rau received proper medical attention earlier, she would have been diagnosed and admitted to a hospital. As far as delivering quality care is concerned, her identity and immigration status would have been irrelevant. She was simply a person who needed help.

A question for DIMIA and GSL

Why was the multi-layered contractual arrangement for delivering health care to immigration detainees approved and allowed to continue operating without independent expert review, when there was every indication to outside observers and Baxter staff that the arrangements were failing to meet the need?

In the Inquiry's opinion, the mental health care delivered at Baxter is inadequate by any standards. Further, the detention services contract is inappropriate and inadequate for delivering the range of policy outcomes the Government expects, and the current arrangements for monitoring and managing performance are poorly conceived and onerous for the service provider: they constrain, rather than enable, service delivery.

Contracting out of health services delivery cannot be divorced from the quality and standard of health care and the clinical pathways that are required. Had more suitable arrangements been in operation, Anna would have received the medical attention she needed. This would almost certainly have resulted in her being placed in a hospital. In a supportive care environment, she might well have revealed her identity.

5.3 Some possible solutions

5.3.1 Identification guidelines

The primary deficiency in DIMIA's approach to identifying Anna was the lack of an organised, systematic approach. Individual officers did their best, but there was nothing to guide their actions. The Inquiry found that search actions by one officer were often repeated by another, and there was no coordination of the efforts. Nobody was in charge. Most importantly, nobody was gathering and collating the results of individual search activities and making an intelligent assessment of what the outcomes should have been telling the investigators.

If not supported by appropriate systems and management arrangements, guidelines on their own can achieve little. The task of all DIMIA officers who made dedicated efforts to try, in their own way, to identify Anna would undoubtedly have been made easier by guidelines that provided clear instruction and a checklist for approaches to be followed. Nevertheless, although there are some common practical steps that should be undertaken in any investigation, every situation is different.

In relation to the organisational level, in Section 3.3.4 the Inquiry recommends the establishment of an Identity and Immigration Status Group that can, as required, take the lead in complex or sensitive cases. The Inquiry also recommends, in Section 3.3.5, a revised role for the Detention Review Committee, which would help to ensure that cases of identity are not neglected.

The Inquiry notes that on 23 March 2005 DIMIA issued an Interim Instruction on Establishing Identity in the Field and in Detention. This has the potential to greatly improve the process of identification of detainees by instituting a systematic approach, providing for continuity of inquiries, and identifying oversight and accountability processes. These objectives are consistent with the Inquiry's views.

In particular, section 5 of the Interim Instruction requires, 'Departmental employees must ensure that all actions taken in attempting to identify a person are documented, included on an individual case file, and an appropriate record created on ICSE [the Integrated Client Service Environment database] immediately after the action is taken'. The Inquiry strongly supports this. Recording relevant actions on file is not only good management practice: it is a principle running through the *Financial Management and Accountability Act 1997*, and it forms the base for sound public administration and accountability.

The Inquiry's examination of the DIMIA files maintained in relation to Anna provided evidence of a record keeping system that is seriously flawed. It was difficult to pull together all DIMIA records on this case because relevant documents were kept in several different locations and as both hard copy files and computer records.

Throughout its investigations the Inquiry found DIMIA file management practices poor, and there seemed to be no unified organisational approach to file establishment, access and control. Placement of documents on file lacked due consideration and consistency, and 'duplicate' files were often created and held by

different parts of the organisation without any way of linking them. File discipline was lax. This situation exposes DIMIA to risk.

Recommendation 5.1

The Inquiry recommends that the DIMIA Secretary:

- commission and oversee a review of departmental processes for file creation, management and access
- take a leadership role in implementing the major changes that will probably be necessary as a result
- ensure that staff receive training in effective file management practices and the reasons for them
- make executive management personally accountable for ensuring that sound file management practices are followed.

The effectiveness of actions taken in accordance with the Interim Instruction would be improved if additional guidance were provided by a checklist. Such a list should be simple and practical and offer clear guidance to staff who are not experienced in investigation. It should provide a menu of avenues of inquiry, with identification queries presented in sequential order. The checklist would help ensure that inquiries are systematic, comprehensive and properly recorded. The list would not be exhaustive; rather, it would provide a comprehensive 'minimum standards' template for investigations.

The instructions and checklist would need to be accompanied by training for staff who are not, and do not need to be, expert in investigation. The purpose is to establish uniformity and consistency in the actions DIMIA takes. To be effective, executive management would need to ensure that the instructions are followed and be accountable for their actions.

Recommendation 5.2

The Inquiry recommends that the DIMIA executive ensure the preparation for staff of a checklist to be used as a minimum standards template for conducting identification inquiries. The checklist should provide a menu of avenues of inquiry, specify a sequential order for investigations, be included as an attachment to the DIMIA Interim Instruction on Establishing Identity in the Field and in Detention, and form a part of the personal investigation file.

The DIMIA executive should also:

- formalise the Interim Instruction together with the checklist attachment as soon as practicable
- ensure that suitable training modules are developed and delivered to all staff—including managers—who might be involved in identification inquiries
- institute management arrangements to ensure that such inquiries are linked as appropriate to the Identity and Immigration Status Group.

5.3.2 A national missing persons database

The Inquiry found that DIMIA officers and many others mistakenly believed that if a person was reported as missing to one police agency they would be reported as missing to all police agencies by way of a national database of missing persons. This led DIMIA officers to believe that, because Anna had not been reported as missing by Queensland police, she was not reported as missing by any police agency in Australia. The conclusion was that Anna was not a missing person. That conclusion would not have changed, however, if existing missing persons databases had in fact been linked nationally.

Section 5.2.3 discusses matters associated with a national missing persons database. Such a database was planned in 1991, when user specifications were developed. It was advanced in 1995, when the National Exchange of Police Information contracted the Australian Bureau of Criminal Intelligence to develop a software package capable of managing a national missing persons database.

In July 2000 the National Exchange of Police Information was replaced by CrimTrac through an intergovernmental agreement. The

focus for development was the National Automated Fingerprint Identification System and a National Criminal Investigation DNA Database. Both were a response to the pressures generated by the 2000 Olympic Games in Sydney and subsequently the 11 September 2001 terrorist attack in New York.

The Cornelia Rau case demonstrates the urgent need for a national missing persons database that provides not only a name-only search capacity but also the capacity to search against a range of biometric data that would aid in personal identification. A database containing a selection of biometric data might have led to a positive outcome in relation to Ms Rau. A database with this kind of potential is being trialled by CrimTrac with the cooperation of New South Wales and Victorian police.

The Minimum Nationwide Person Profile project trial began on 29 March 2005. It is expected to provide the capacity to search against 26 descriptors and could incorporate a national ‘photo track’ system to allow for searches on photographs of missing persons. Although it will hold a ‘richer data set’ than is currently held on the National Names Index, the MNPP pilot project (despite having the capacity to store thumbnail photographs) will not provide for facial recognition matching against those photographs or against photographs requested from jurisdictions in response to a thumbnail match. The Inquiry is advised that to integrate facial recognition technology into the MNPP would be a major extension of the present project.

The MNPP could have a facility that allows for the placing of a ‘watchlist’ on a particular individual. This would be particularly helpful in situations where searches are made for an individual *before* they are formally recorded on the database as a missing person. In the case of Cornelia Rau, missing persons database searches were made some five months before she was officially reported as missing and entered into the system. There was no capacity to back-search or for retrospective inquiry to link to previous inquiries. The Royal Canadian Mounted Police has what it terms a ‘reverse hit’ capacity on its central system that performs a back-search function.

If additional functionality is approved by the CrimTrac Board of Management following a successful MNPP pilot and if additional funds are identified to build it and roll it out nationally, the present MNPP system could be modified to allow users to directly access and search against a broader range of timely information—including missing persons reports, photographic facial recognition and characteristics (such as physical description and distinguishing

features, including tattoos)—without the need for a name reference. These capabilities, particularly if linked to a retrospective functionality allowing a back-search of data from the date a person is reported missing until the date on which the last known sighting occurred, would greatly improve the effectiveness of police missing persons searches.

It has taken several years of considerable effort by a number of federal, state and territory police forces and organisations to reach agreement for the MNPP pilot project. It has been a long journey. The Cornelia Rau situation highlights the gaps that exist in the systems and how far Australia needs to travel to achieve a national system that is likely to be supported by every Australian. At present there is no clear national direction and no ‘road map’ to show how to get there. The Inquiry understands, however, that a scoping and requirements study for a national missing persons database was agreed by jurisdictions at a meeting hosted by the Australian Federal Police on 16 and 17 June 2005.

While a range of options and flexibility still remain, the Inquiry recommends that a unified national missing persons policy be developed through consultation between all Australian governments. Such a mechanism would integrate systems in each state and territory and with the Australian Federal Police. Careful consideration would need to be given to which citizen databases should be involved. If there were no access to ‘civil’ databases, albeit with strict access protocols, a national missing persons database would have reduced effectiveness.

Considerable missing persons experience and expertise resides among police, so initial development of the draft policy could be done under the guidance of the Australasian Police Ministers Council and submitted to individual governments for consideration. The final policy could be agreed in the context of the Council of Australian Governments.

Recommendation 5.3

The Inquiry recommends that, as a matter of urgency, the Commonwealth Government take a leadership role with state and territory governments to develop a national missing persons policy to guide the development of an integrated, national missing persons database or capacity. Initial policy development could be carried out under the guidance of the Australasian Police Ministers Council, with the output submitted to governments for consideration and agreement.

In the case of Cornelia Rau, searches for Anna by name were bound to fail. She did not exist. Had biometric searches been available, though, together with the ability to back-search and link to previous inquiries, she probably would have been identified.

Recommendation 5.4

The Inquiry recommends that, on the basis of an agreed national missing persons policy, the Commonwealth Government take a leadership role with state and territory governments in developing and implementing a national missing persons database or capacity that will provide an effective national recording and search capability under both names and biometric data. Discussions in this regard should be informed by reporting on the progress and success of the Minimum Nationwide Person Profile project to the Australasian Police Ministers Council.

5.3.3 Privacy

The efforts to identify Anna were significantly constrained by DIMIA's reluctance to publish Anna's photograph in the media, or even to circulate her photograph to agencies such as all Australian police forces, because of privacy concerns. In the Inquiry's view such concern about privacy when the safety and health of an individual are potentially at risk is misplaced. Privacy provisions have not been used sufficiently by DIMIA to help, facilitate and enable competent identity and status-related investigations.

The Commonwealth's *Privacy Act 1988* is not intended to prevent circulation of personal information when it is in the public interest to disclose that information. Indeed, if doubt exists about the legality of a

release in such circumstances, it is possible to seek a Public Interest Determination authorising the information to be disclosed.

The Privacy Act contains some well-crafted exceptions aimed at achieving a balance between privacy and commonsense community interest, health or safety considerations. In particular, Principle 11 of the Information Privacy Principles appears to provide for circumstances relevant to the situation of Cornelia Rau that would have permitted the release of personal information.

The Act's philosophy, or intent, is explained in the Preamble and in s. 3. Because of the sensitivity associated with the Act's operation, each Commonwealth government agency has a privacy contact officer appointed as the first point of contact with the Privacy Commissioner. The Privacy Commissioner has no record of any contact having been made seeking advice in relation to the release of information about Cornelia Rau—or Vivian Alvarez or any other detainees. There is no evidence that DIMIA sought a Public Interest Determination in relation to any detainee.

The Inquiry's discussions with the Privacy Commissioner made clear a number of facts that would have become apparent to DIMIA if any reasonable consideration or inquiry had been made. In particular, DIMIA had already disclosed 'personal information' in the form of Anna's name and date of birth—for example, to the Queensland Police Service, Centrelink and the German Consulate. This suggests they knew or should have realised they had authority to disclose.

As the Privacy Commissioner confirmed, a photograph is just another form of 'personal information' that, for the same reason, could be disclosed. In select circumstances, including when the final request was received from New South Wales police on 2 February 2005, DIMIA supplied a photograph without hesitation.

The Inquiry is convinced that, had Anna's photograph been more widely published early in her detention and as soon as the difficulties with identifying her were becoming apparent, she would have been identified. Photographs of her had been provided selectively, but decisions to disclose this information seem to have been ad hoc and unfocused. Indeed, if a more considered and assertive approach had been adopted, Anna might well have been identified as Cornelia Rau before Ms Rau's family reported her missing on 11 August 2004.

DIMIA staff asked themselves the wrong question. As the staff explained to the Inquiry, their starting point in relation to almost all

questions of identification was ‘We cannot release the information because of privacy restrictions’. In the circumstances of Cornelia Rau and Vivian Alvarez—and clearly of others—the question that should have been asked and pursued is, ‘Our lack of knowledge about who this person in immigration detention is requires us to make wider inquiries and to release personal information. How do we do so?’

Had this attitude to problematic identity-based detention cases been taken, a much more sensible and defensible outcome would probably have been achieved.

There is a pressing need to reassess the DIMIA position in relation to privacy in all of its public policy operations. The Inquiry’s concerns in this regard are part of its wider concerns about DIMIA’s lack of openness and transparency, despite existing external scrutiny. In revising its practices, DIMIA should seek advice from the Privacy Commissioner as well as the Minister. As part of this process, it will be important to clarify the impact, if any, of recent amendments to the Migration Act as they relate to collection and disclosure of biometric ‘identifying information’.

Recommendation 5.5

The Inquiry recommends that DIMIA reassess its position in relation to privacy in all its public policy operations associated with immigration detention. In revising its practices, it should:

- seek advice from the Privacy Commissioner and the Minister
- take immediate steps to increase awareness and understanding on the part of relevant DIMIA staff—including executive staff—of the principles and provisions of the Commonwealth’s *Privacy Act 1988*
- revise and strengthen procedures relating to identity in immigration detention, to ensure that the wider options potentially created by this approach are considered.

5.3.4 Consular considerations

The German consulates in Australia made extensive efforts to identify Anna and verify whether she was a German citizen. Embassies and consulates often have contact with the Department of Foreign Affairs and Trade and sometimes with DIMIA, but this case was unusual.

Although no complaints were made by consular officials, it became evident to the Inquiry that communication problems did arise. Contact points had not been clearly established, and delays were occasioned because of 'out of office' responses. In the absence of clear contact points, the Melbourne German Consulate sought guidance from an officer of Victoria Police.

The Inquiry considers that such a situation would be resolved largely if a consular contact officer were nominated in DIMIA, on a specific telephone number. This person could be the 'one-stop shop' for consular inquiries. DIMIA is a complex department, but the complexity must remain within. The name and telephone number of this contact officer should be distributed to all embassies and high commissions, which could then distribute them to their consular officers. There should be no confusion in such matters.

Recommendation 5.6

The Inquiry recommends that DIMIA establish for inquiries about immigration detainees a 'hotline' facility that can deal with those inquiries as a 'one-stop shop'. DIMIA should ensure that the contact officer position is continuously staffed, regardless of the absence of any officer, and that all embassies and high commissions are advised of the details of these arrangements and ask their consular officials to direct all immigration detention inquiries to the nominated DIMIA contact officer in the first instance.

5.3.5 Fingerprints

Because DIMIA considered there was no authority to fingerprint detainees, Anna was not fingerprinted at any time during her detention. Fingerprinting would be of assistance in positive identification only if the person had previously been fingerprinted and those fingerprints were on an accessible database. Nevertheless, the inability to fingerprint suspected illegal immigrants is an unsatisfactory situation and could be a major barrier to identification.

This situation has now been redressed by legislative amendments in the *Migration Legislation Amendment (Identification and Authentication) Act 2004*, which came into effect on 27 August 2004. The Act provides that people in immigration detention must provide personal identifiers (including fingerprints) and that these identifiers may be obtained with reasonable force in specific circumstances.

Supporting regulations and instruments were authorised in February 2005. The new legislation is also supported by a policy directive issued by the Minister on 26 February 2005, which requires that all people taken into immigration detention be fingerprinted.

DIMIA advised the Inquiry that consideration is being given to the storage, use and exchange of personal identifiers (including fingerprints) and that the possible registration of fingerprints on the National Automated Fingerprint Identification System database and the comparison of fingerprints and facial images against relevant CrimTrac databases are being pursued. These initiatives should be aligned with developments being trialled by CrimTrac under the Minimum Nationwide Person Profile project, discussed in Section 5.3.2.

Recommendation 5.7

The Inquiry recommends that DIMIA ensure that:

- fingerprints and other biometric data collected from individuals in immigration detention are stored on a national database to facilitate investigations by Commonwealth and state and territory police and other law enforcement agencies
- appropriate liaison arrangements are made with CrimTrac
- any DIMIA decisions in relation to the collection and storage of biometric data are consistent with strategies being pursued by CrimTrac in response to guidance by Australian governments.

6 Measures taken to deal with Anna’s medical needs

6.1 Perspective

Cornelia Rau has a mental illness; we know this now. It is often easy to see clearly when looking back. An ordinary person might well wonder how it was that someone with a severe illness could have their illness go undetected for so long.

This chapter explores Ms Rau’s contact with the medical and mental health systems in New South Wales, Queensland and South Australia. It also discusses matters such as the nature of mental illness—in particular, schizophrenia and personality disorder—as well as leadership and service provision.

Only high-level details of Cornelia Rau’s medical history and events that are already in the public domain are discussed here—simply to establish the context. It should be noted that the Inquiry was not able to meet or interview Ms Rau.

Attachment II provides a chronology of Anna’s medical treatment and assessment.

6.2 Main conclusions

The standard of health care provided to Anna during the 10 months in which she was held in immigration detention was inadequate. This is not to diminish the efforts made by many individuals who tried to provide care under difficult circumstances. But there is much that is deficient, and it can and should be improved.

The sections that follow discuss the main events and concerns relating to the health care afforded Anna during her 10-month journey. What went wrong is pointed out, and recommendations for possible solutions are made. At issue are the prevailing culture, lack of assertive leadership, uncertainty about roles and responsibilities, lack of appropriate training, lack of arrangements for effective

communication, poor coordination and consultation, and a failure of management responsibility and oversight.

In summary, the main weaknesses in people, systems and management that resulted in inadequate care being afforded Anna are as follows:

- An ‘assumption culture’ surrounded Anna, which shaped and limited the efforts made by DIMIA and other parties to provide quality health care.
- There was a lack of assertive leadership, at both the personal and the systemic levels, by DIMIA and health care staff and clinicians to ensure quality and continuity of mental health care for Anna.
- Anna was held prisoner in Brisbane Women’s Correctional Centre for six months and subjected to a prison regime, which almost certainly aggravated her mental illness.
- The overall framework for delivery of health care while Anna was at Baxter (including reliance on state mental health services) manifestly fell short of the standard of care she was entitled to expect.
- The infrastructure and the mental health care arrangements at Baxter fail to recognise the high level of morbidity in detainee populations and are inadequate for dealing with it.
- There is no effective, articulated protocol or clinical pathway between SA Health and the Commonwealth to support Baxter. This prevented the delivery of effective health care for Anna at Baxter and delayed her admission to the Glenside Campus of Royal Adelaide Hospital.
- In many cases the people involved in various stages of Anna’s journey generally lacked training sufficient for them to be able to operate effectively. There was a failure in management responsibility and oversight to ensure that systems, processes and procedures worked appropriately for Anna.
- The provisions of the South Australian *Mental Health Act 1993* presented a major impediment to the delivery of appropriate care.

6.3 Events in New South Wales

6.3.1 Care and treatment

Cornelia Rau had a history of mental illness. She was voluntarily admitted to Manly Hospital on 9 January 2004. She was transferred to Royal North Shore Hospital the same day because of a lack of beds and was returned to East Wing of Manly Hospital on 6 February. On 17 March she went missing while on unaccompanied day leave. The same day she was reported as a missing patient; after having previously withdrawn \$3000 from her bank account, she was reported as a missing person to the police on 11 August 2004, some five months later.

There is some uncertainty about whether Cornelia Rau was a voluntary or involuntary patient at Manly Hospital at the time she went missing. However, if a mental health patient does not return to a medical facility, staff will usually try to locate them and will notify relatives or caregivers of the situation. The Inquiry understands that Manly Hospital left a voice message for Ms Rau's parents. Hospital records viewed by the Inquiry show that the Hospital faxed to New South Wales police a report that Ms Rau had failed to return from unaccompanied day leave, although police have no record of receiving the fax.

Ms Rau was known to Manly Hospital. Staff were familiar with her condition and were aware that she had a history of absconding. When she failed to return from day leave—according to medical advice provided to the Inquiry, the day before she was to be committed for treatment under the New South Wales Mental Health Act—there was presumably concern among staff about her condition and safety. This concern, it seems, was demonstrated by the fact that they notified Ms Rau's parents and police that Ms Rau had gone missing. There is, however, no evidence of assertive follow-up activity by staff to locate her and ensure that her care needs were met.

If concerns did exist for Ms Rau's safety and wellbeing, the Inquiry would have expected to see evidence of more assertive follow-up by Manly Hospital staff and greater responsibility taken for someone who was known to be mentally ill—particularly if she was a patient who was to be committed, or scheduled, under the Mental Health Act the following day. Whilst it is surprising, if Ms Rau was known to suffer from active mental illness, that she was allowed unaccompanied day leave, the evidence of ATM withdrawals by her over preceding days

does suggest that she had left and returned safely to the Hospital while on unaccompanied leave on previous occasions.

The Inquiry was advised by the New South Wales Government that the medical information provided to the Inquiry concerning Ms Rau's care while in contact with New South Wales health services is incorrect and that the Inquiry's conclusions are consequently flawed. Because of confidentiality and privacy considerations, however, the New South Wales Government did not find itself able to provide a full account of Ms Rau's care and treatment during this period. The Inquiry took into account the advice of the Government but, on the material available to it, remains confident about the accuracy of its conclusions.

It is essential that any health care organisation exercise appropriate clinical accountability and monitoring of patients who are potentially at risk. If such a system had been in operation and Ms Rau had been retained in a framework of medical care and accountability, her unfortunate journey might not have begun.

The links between managing 'missing patients' and 'missing persons' are not well defined in Australia. The procedure followed at present seems to depend on individual initiative. In the case of Cornelia Rau, if sufficient information from her case notes had been included in the communication from Manly Hospital to New South Wales police and clearer reporting procedures had been established, police might have been able to form a judgment about her at-risk behaviour and the urgency of her need for care. There is also a need for better contact arrangements between hospitals and police to deal with circumstances of this kind.

State authorities are governed by state-based privacy laws but, regardless of the source of law, it is the opinion of the Inquiry that—to the extent that current privacy law restricts the exchange of personal information that is vital to identifying the level of risk and vulnerability of a patient who goes missing—consideration should be given to amending the law.

The Inquiry was advised that there already exists between police and health authorities in New South Wales a memorandum of understanding that establishes a framework for the management of people who might have a mental illness. This agreement is supported by local protocols that set out procedures for mental health services and local area commanders across the state. The Inquiry was informed that these procedures include arrangements to provide the outcomes of

a patient's clinical assessment of level of risk and mental condition to assist police in determining appropriate action.

These initiatives are to be applauded but, on the evidence available to the Inquiry, it appears they did not work effectively in Ms Rau's circumstances.

In the United Kingdom a 'vulnerable persons' database is integrated with the Missing Persons database to deal with these and other situations requiring sensitivity and the availability of contextual information to facilitate decision making and add perspective to inquiries.

Recommendation 6.1

The Inquiry recommends that the Commonwealth Government encourage state and territory authorities to implement a requirement that on each occasion a 'missing patient' report is made to police by a hospital, a medical practitioner or other facility, the report must be accompanied by sufficient information about the patient's history to clearly indicate the person's degree of risk and vulnerability, so that police can determine whether the person should be also classified as a missing person and what immediate action is necessary.

6.4 Events in Queensland

6.4.1 Coen watch-house and Cairns

On 30 March, about two weeks after leaving the East Wing of Manly Hospital, Cornelia Rau turned up in Coen, in far north Queensland. A publican reported her to the police because he and others were concerned for her welfare. At this stage she called herself Anna Brotmeyer or Anna Schmidt, or both. The police detained her after having received from DIMIA advice that she might be an unlawful non-citizen. Anna was searched by a female nurse, who was present for the purpose of the search and not because of any concern about her medical condition.

DIMIA interviewed Anna on 1 April 2004, and on 2 April 2004 the Honorary German Consul based in Cairns interviewed her. On 5 April 2004 she was transferred to Brisbane Women's Correctional Centre.

The first significant opportunity for contact with mental health professionals arose during the initial period of Anna's detention at the Cairns watch-house. Both Brisbane and Townsville have a Court Liaison Mental Health Forensic Service, which involves mental health workers attending courts and watch-houses to review people in custody in order to identify them and assess their suitability for inclusion under the provisions of Queensland's *Mental Health Act 2000*. This service is not available in Cairns.

In Cairns, when the need for support from a mental health worker becomes apparent the watch-house calls on the district mental health team. In Anna's case no need for such specialist support was recognised. Given the evidence then available, the Inquiry does not criticise this.

6.4.2 Brisbane Women's Correctional Centre and Princess Alexandra Hospital

Anna was held at BWCC from 5 April 2004 until 6 October 2004, when she was transferred to Baxter in South Australia.

On 6 April she was seen by a medical officer who observed that her 'odd' behaviour might be explained as that of 'a stranger in a strange land'. He examined her again on 14 May, concluding that there was no evidence of psychiatric illness. On 19 May Anna was examined by a psychologist, who noted that she was guarded in her responses but did not show positive symptoms of mental illness. The medical officer again examined Anna on 25 June and noted that she was 'anti-authority'.

On 30 July, following discussions between mental health staff and concerns expressed by prisoners, the Prison Mental Health Team psychologist recommended that Anna have a psychiatric assessment. This was conducted on 10 August by a psychiatrist, who noted Anna's increasingly bizarre behaviour and recommended in-patient psychiatric assessment. DIMIA believed this assessment was carried out in response to its request to assess Anna for community placement. Between 20 and 26 August Anna was an in-patient at Princess Alexandra Hospital, admitted under the Queensland Mental Health Act. Her admission was unusual in that she was escorted by two guards. She was initially seen by a psychiatric registrar, who found her uncooperative. A consultant psychiatrist made further assessments on 21 and 23 August and, finding Anna settled, moved her to an open ward. Two other doctors examined Anna, concluding,

‘This lady, although displaying some odd behaviour, does not fulfil any diagnostic criteria for mental illness’. This finding was recorded in the Hospital’s Discharge Summary for Anna.

Anna was returned to BWCC. It is the Inquiry’s view that the assessment conclusions—about the absence of mental illness—were to influence, at least initially, subsequent assessments of her, at times, aberrant behaviour.

6.4.3 Care and treatment

The inadequacy of the psychiatric assessment at Princess Alexandra Hospital

The psychiatric assessment at Princess Alexandra Hospital was largely dependent on observation by staff because Anna was not cooperative and no collateral history (from family) was available. In addition, encouraged by Anna, the clinical staff believed she had recently arrived from Germany.

The assessment was also hampered by the presence of two guards, which had the effect of changing the assessment setting. If guards are preventing adequate assessment, alternative arrangements should be made to ensure protection, safety and optimum conditions for making the assessment. In this case, placement in a closed or locked ward or unit for the duration of the assessment might have fulfilled the requirements, including the detention provisions of the Migration Act.

The Inquiry ascertained from two of the doctors who had examined Anna that at the time of assessment they both believed she was a German citizen who would be repatriated to Germany on discharge from the unit. This belief influenced them in their lack of assertiveness. They also said the presence of the two guards had limited their ability to make adequate assessments.

Guards are also present when immigration detainees are referred to Glenside in Adelaide. Although responsibility for the adequacy and appropriateness of care given to immigration detainees does rest with DIMIA, the Inquiry considers it incumbent on clinicians to be more assertive in creating a suitable assessment environment.

Recommendation 6.2

The Inquiry recommends that governments and health authorities take steps to encourage clinicians to be more clinically assertive in creating the optimum conditions in which to assess patients—noting that there is little point in making a referral to an in-patient unit if adequate assessment cannot take place.

In consultation with the hospital, facility or clinic, DIMIA should establish containment arrangements that do not adversely affect the assessment environment and also meet the requirements of the Migration Act. If the problem lies in the Act, the Act should be changed.

The Inquiry considers that greater weight should have been given to Anna's behaviour patterns and her odd presentation features and odd history and that collateral history should have been sought from officers, other contact people, and even fellow detainees at BWCC. These are the people who would have had most daily contact with Anna. If there had been a heightened 'index of suspicion'—for example, by including in the Discharge Summary the possibility that Anna could have an as yet undiagnosed mental disorder—this might have prompted later consultation and follow-up at BWCC or at other facilities.

Recommendation 6.3

The Inquiry recommends that, when immigration detainees are entrusted to the care of a hospital, medical centre or other health care facility, DIMIA ensure that clinicians are asked to pay particular attention to 'odd' presentation features and to any 'odd' history. If a detainee provides little information or is uncooperative, collateral history should be sought from officers and others, including fellow detainees.

Inherent in this approach is the importance attached to integrated, cumulative information as a basis for assessment. A good deal of information on Anna was captured in activity logs and incident reports, but the Inquiry found no evidence that these were collated or made available to Princess Alexandra Hospital or were sought by the assessing clinicians.

Indeed, the Inquiry was unable to find any evidence of a planned approach to the accumulation of data and other information on

detainees, sufficient to properly link daily behaviour patterns with medical symptoms and provide a comprehensive basis for effective medical assessment.

Recommendation 6.4

The Inquiry recommends that DIMIA develop and implement procedures and systems at immigration detention facilities to provide for the progressive collection, integration and assessment of cumulative data from all records of detainee activity. It should ensure that such information is available and is provided along with medical information when clinicians are making mental health assessments and determining treatment options.

The Inquiry is not critical that at Princess Alexandra Hospital a diagnosis of mental illness failed to be made. The circumstances made it difficult. However, the fact that illness behaviour was not considered a reasonable possibility and pursued and evaluated gives cause for concern.

The need to consider the possibility of mental illness presenting as aberrant behaviour is of particular relevance when the significantly higher incidence of mental illness among detainee populations (compared with the general Australian community) is taken into account.

The inadequacy of the system of referral to and placement in an in-patient unit and subsequent follow-up

At BWCC the Prison Mental Health Team, which is part of Forensic Mental Health Services, suspected that Anna had a mental illness and referred her for in-patient assessment. Instead of being admitted to the in-patient forensic service at Wolston Park, she was admitted to Princess Alexandra Hospital. This is important on three counts:

- Forensic Mental Health Services clinicians have experience in evaluating complex cases involving probable co-morbidity—as in the contemporaneous presence of both mental illness and personality disorder.
- Forensic Mental Health Services units have security systems that might have obviated the need for two guards to be present with Anna at all times. The presence of the guards would have complicated any observations by clinical staff; indeed, the

impression gained is that for much of her time in Princess Alexandra Hospital Anna remained apart from the other patients and staff.

- There was a lack of follow-up.

It was explained to the Inquiry, however, that the Wolston Park Centre for Mental Health caters for people who pose a serious risk to the community—such as individuals who have committed or are at risk of committing serious violent offences. The decision to place Anna in the less restricted setting of a general hospital was made on the basis of an assessment of her clinical and security needs.

On Anna's return from Princess Alexandra Hospital to BWCC, the psychiatrist from the Prison Mental Health Team tried to follow her up on two occasions. On the first occasion, shortly after Anna had returned, an appointment was made for 24 September 2004, but for 'operational reasons' in the prison it did not proceed.

This inability to see patients for operational reasons was commented on by two staff members, who separately advised the Inquiry that it was not an altogether infrequent occurrence. On questioning, both parties refuted a suggestion that the operational reasons would have been for the purpose of denying access. The Inquiry understands that operational exigencies can at times place great strain on the human resources of a prison or detention centre, but only in the most extreme circumstances should essential medical treatment be deferred.

The failed appointment on 24 September was rescheduled for 27 September. On this occasion contact was made briefly and then Anna declined further contact. The psychiatrist informed the Inquiry that corrections staff had advised her that Anna was to be deported to Germany that day. The psychiatrist maintains that, had she been aware of Anna's planned transfer to Baxter, she would have made contact with the treating practitioners there to discuss Anna's transfer and provide additional information. This opportunity was lost.

The Inquiry asked why patients referred for in-patient care are transferred from BWCC to a general hospital (such as Princess Alexandra) and was told that it was because the forensic unit was always full and other arrangements had to be made. The function of the Park Centre is explained above. The Inquiry was advised that an attempt was made to have Anna admitted to Royal Brisbane Hospital, but a bed was not available. A bed became available at Princess Alexandra Hospital.

The Inquiry recognises that at BWCC there is an on-site psychological service and a 24-hour medical service, with an on-call psychiatric service for the treatment of acute mental health conditions. It is clear that during the six months Anna was at BWCC she, like other inmates, received regular visits from medical staff.

It seems illogical to the Inquiry that a forensic mental health service is available but, because of overcrowding, cannot be used by the very people who might benefit from it. There is little point in making a referral if adequate assessment is not possible.

There would be definite advantage, to both patients and clinicians, in having the same mental health service screen people at the detention facility, assess them in an in-patient unit, and have some continuity when they return to the detention facility. If there were any doubt about the diagnosis, monitoring could continue, by the same mental health team or an extension of it.

Queensland has clinical pathways that are already linked to the Queensland Forensic Mental Health Policy 2002. This provides a framework for the development and delivery of mental health services to people with mental illness who are involved in the criminal justice system. The central principle reflects the Inquiry's view that the provision of assessment and treatment services should 'balance the rights of the individual to optimal care, provided in the least restrictive setting with the rights of the public to protection against risk of harm'.

Looking back over Anna's six months at BWCC, however, it is clear that Anna underwent in-patient assessment only once, and then after four months in prison. That this should be the case—despite the policies and principles that exist (and that the Inquiry supports) and particularly recognising that all BWCC staff receive training in identifying and dealing with people who have a major personality disorder or major mental illness—suggests to the Inquiry that greater effort is needed to make the system and clinical pathways operate more speedily and effectively.

To achieve this objective, the Inquiry considers it might be necessary, in the light of experience, to radically reorganise existing relationships, training and clinical pathways for the delivery of services in the Queensland mental health system. In particular, the Inquiry has in mind the need to advance preliminary observations of possible mental illness more speedily towards action for assessment and to look for practical ways in which clinical pathways will better ensure the continuity of care.

The Inquiry's proposals in relation to ongoing collation of information about detainees would provide a more comprehensive basis for assessment.

Recommendation 6.5

The Inquiry recommends that the Commonwealth Government initiate early discussions with the Queensland Government to identify and explore ways in the Queensland mental health system of more effectively aligning existing clinical pathways between prison and in-patient units, to allow for continuity of clinical care and assessment following an immigration detention patient's return to prison, so that clinicians assessing patients can follow them up.

In Section 3.2 the Inquiry makes recommendations about the placement of immigration detainees in prison. It recognises, however, that this might continue to be necessary while DIMIA is exploring more suitable arrangements. In those circumstances it is incumbent on DIMIA to establish, as far as practicable, an immigration detention environment for the detainee.

DIMIA should also ensure that effective reporting and consultation mechanisms exist with the prison, and are followed, so that DIMIA can discharge its responsibilities for the care and safety of detainees. Such arrangements do not at present exist, although DIMIA's own instructions make the responsibility very clear. It is also a question of attitude about the extent to which DIMIA responsibility for detainees applies.

Investigations should be undertaken jointly by DIMIA and the Queensland Department of Corrective Services to identify initiatives and put forward proposals, taking into account the existing policies, clinical pathways, relationships and training arrangements.

Recommendation 6.6

The Inquiry recommends that DIMIA work closely with the Queensland Department of Corrective Services to review existing clinical pathways and training to:

- identify and explore practical ways in which preliminary observations of an immigration detainee showing signs of possible mental illness could be more speedily advanced towards action for assessment
- institute effective reporting and consultation mechanisms, so that DIMIA can discharge its responsibilities for the care and safety of detainees.

6.5 Events in South Australia

6.5.1 The medical time frame at Baxter

On arrival at Baxter on 6 October 2004, Anna received a reception assessment and medical induction. She was uncooperative during the medical induction and was crying, confused and upset. To secure her care while she was settling in, Anna was placed on 60-minute observations in Blue Compound, an unrestricted family compound. As a precaution, she was referred for assessment by the Professional Support Services psychologist the next day.

The psychologist assessed Anna. The Inquiry was surprised to learn that Anna's medical history did not accompany her to Baxter. The psychologist noted that Anna's problems appeared to be 'behavioural', rather than stemming from a mental illness. Meanwhile Anna's behaviour continued to be bizarre.

On 14 October 2004 the psychologist reported that Anna was not responding to therapy or medication and that her condition deteriorated when she had an audience. He considered she had a 'personality disorder'. He recorded that Baxter was not designed to handle cases of this nature and it would be better for Anna to be managed in an all-female compound such as the one at Villawood. For various reasons—including concern about the detainee population profile and the suitability of the 'open' layout of the facility—this option was not pursued. Anna's inappropriate behaviour continued.

On 6 November the consulting psychiatrist tried to assess Anna, but she was uncooperative and he was unable to make a definitive diagnosis. He did not schedule her under the South Australian *Mental Health Act 1993* but instead recommended further assessment at a psychiatric facility, which was more likely to lead to a better assessment than the alternative of continued monitoring at Baxter.

It is not clear whose responsibility it became to take charge and carry out the instructions of the consulting psychiatrist. It was suggested to the Inquiry that DIMIA had a major role in these decisions, although DIMIA maintained that medical decisions and referrals are a matter for International Health and Medical Services and Professional Support Services. The Inquiry does not accept that DIMIA should devolve its responsibility in this way. Although relying on expert medical advice and competence, DIMIA should have had in operation monitoring processes to assure itself that such services were being promptly and efficiently provided. The Inquiry saw insufficient evidence of this.

From 9 November the Baxter medical team made efforts to engage the Rural and Remote Mental Health Service triage team to conduct a psychiatric assessment of Anna in preparation for admission. It was evident at this time that Anna's behaviour was deteriorating and, in spite of daily nursing visits, she refused to engage in any assessment or treatment. The RRMHS triage team seemed unsure of their relationship with Baxter and said they would need to clarify matters and then make further contact with the Baxter team. The RRMHS contacted Baxter on 10 November 2004 in response to a query about Anna.

On 12 November a Glenside psychiatrist responded to contact from the Professional Support Services psychologist and discussed Anna's condition with medical staff at Baxter. He advised that her problems sounded behavioural, which, he said, is not a mental health concern. At an interview with the Inquiry the Glenside psychiatrist acknowledged the discussion but said he could not recall a sense of urgency being conveyed to him at that time. The lack of urgency was also commented on by the RRMHS.

On 16 November the RRMHS contacted Baxter and offered a videoconference session for an assessment. Baxter responded that Anna was not cooperating and that this was unlikely to be successful. The RRMHS took Anna off the waiting list (for in-patient placement) for admission on 17 November but did not notify Baxter staff, who continued to believe that their request was being pursued with some urgency.

The Inquiry has no basis on which to make judgments on these differing perspectives. In the light of the continuing efforts by Baxter to have Anna admitted for in-patient assessment at Glenside, it can only conclude that there seems to have been a serious communication problem. The outcome for Anna was serious: it delayed her admission

to Glenside by more than two months. This situation is unacceptable and must be resolved.

The Inquiry is not persuaded by claims by DIMIA, GSL and the South Australian Health Department that, although a formal memorandum of understanding had not been signed, the clinical pathways and arrangements were clearly outlined, understood and working effectively. Obviously, they were not. This situation should not have been allowed to arise but, having arisen, should have been quickly and effectively resolved at an escalated management level. The situation is typical of the lack of leadership and acceptance of responsibility the Inquiry found on a number of occasions.

On 17 November the Baxter psychologist followed up and sent to Glenside a fax providing the consulting psychiatrist's assessment notes and the Princess Alexandra Hospital Discharge Summary and referring to their earlier discussions about seeking in-patient assessment for Anna. This information was apparently insufficient for Glenside to reactivate Anna's place on the waiting list for assessment. Glenside neglected to inform the Baxter medical staff that Anna remained 'off the list'.

Importantly, the Baxter consulting psychiatrist and the Glenside psychiatrists trying to make an initial assessment at a distance had never met or talked on the telephone.

A significant event occurred on 31 December 2004. A New South Wales psychiatrist, a lawyer and a local medical practitioner visited Baxter to see 12 detainees they had identified in their application to visit. Anna was not one of them. During their visit they briefly examined several of the detainees. Four of the detainees were considered very sick and two were admitted to hospital, one of them being scheduled under the South Australian Mental Health Act. The significance of this was that the staff of Glenside had a preference that only one Baxter patient should be admitted at a time to the RRMHS beds at Glenside because of the protracted average length of stay of Baxter patients and the disruptive presence on the ward of escorting officers. This meant that admitting Anna would take their unit 'over numbers' and was likely to be resisted by Glenside.

This event raises another question. If, after only a short consultation and assessment during their visit to Baxter, the New South Wales psychiatrist and team were able to diagnose and admit two detainees under the Mental Health Act, was the condition of these detainees known to the Baxter mental health clinicians and, if not, why not? The

implication is that if an independent psychiatrist were to conduct an assessment of all detainees at Baxter, more detainees with psychiatric disorders would probably be uncovered.

Section 6.6.5 discusses the increased incidence of mental illness among detainee populations. It also emphasises the importance of external monitoring and audit and the need to improve existing practices and procedures.

Because of the lack of response from Glenside to their earlier request, a Baxter psychologist and a medical practitioner again raised the matter of Anna on 4 January 2005, in a letter faxed to the Glenside intake officer. The letter sought advice about how to proceed in managing her and about the availability of a bed for assessment and when an assessment could be carried out. Anna's behaviour had not improved. On 6 January the Professional Support Services psychologist gave Glenside further information about Anna and advised that the situation was urgent.

Significantly, the International Health and Medical Services medical practitioner assessed Anna on 7 January, expressed the opinion that she may have schizoid or schizotypal personality features and possibly schizophrenia, and recommended further assessment by a psychiatrist. Anna was asked if she would voluntarily undergo assessment, but she refused. Following discussion with the Glenside psychiatrist, it was agreed that Anna's behaviour would not at that time justify detention under the Mental Health Act.

On 24 January the Head of South Australia's Mental Health Service became involved, after having received a telephone call from DIMIA Canberra. He offered to have Anna admitted for assessment and treatment with or without committal under the Mental Health Act. DIMIA Canberra contacted the Director of the RRMHS to make arrangements for Anna's assessment. The Director advised that she (the Director) was not aware of the discussion with the Head of the Mental Health Service and asked when the Baxter consulting psychiatrist would be able to undertake an assessment.

On 27 January the Director of the RRMHS contacted DIMIA Baxter to suggest that adhering to usual care pathways would achieve a quicker response, that an assessment should be undertaken directly by the Baxter medical practitioner, and that a Glenside psychiatrist would be available to confer with the medical practitioner. This was agreed and the RRMHS Director undertook to liaise with Baxter for an

appointment with the medical practitioner. She was advised by Baxter that the earliest appointment would be on 31 January 2005.

On 31 January the *Sydney Morning Herald* and the *Melbourne Age* published articles about a mentally ill German woman in Baxter. Although there was much subsequent activity on the part of all concerned, it is clear that the efforts made by Glenside, the RRMHS and Baxter were uncoordinated and that no one took overall responsibility for the arrangements across all the interfaces to admit Anna to in-patient care at Glenside. If there were clear pathways they were not working as they should.

The IHMS medical practitioner tried to assess Anna on 31 January 2005 but she was not communicative. He had also been unable to contact the nominated Glenside psychiatrist. He asked for copies of reports from the Professional Support Services psychologist and said he would make a decision on whether to schedule Anna for in-patient assessment under the Mental Health Act following discussion with the Glenside psychiatrist on 1 February.

On 1 February the IHMS medical practitioner was unable to contact the alternative Glenside psychiatrist who had been nominated to assist. He managed to contact the psychiatrist the next day and, after discussing the matter with the psychiatrist, decided to think about it overnight before making a decision to schedule Anna for assessment under the Mental Health Act.

On 3 February the IHMS medical practitioner conducted an assessment of Anna at 15.15 South Australian time and, after a telephone consultation with a Glenside psychiatrist, decided to commit Anna for assessment under the Mental Health Act. The committal papers were signed at 16.00.

By the evening of 3 February 2005 Anna had been identified as Cornelia Rau. Ms Rau was admitted to Glenside Hospital the next day.

Having reviewed the medical treatment of Anna at Baxter, the Inquiry is concerned by two broad factors: leadership and systems. Obviously, they are intertwined.

6.5.2 Leadership

Leadership entails knowledge of and confidence in clinical skills and awareness of who and what the clinician has responsibility for and to whom he or she is accountable. Additional qualities are assertiveness in response, the ability to negotiate boundaries, and the ability to communicate effectively. These details should be made explicit in the relevant contracts and in the memorandum of understanding between facilities. In fact, the MOU between DIMIA and SA Health was eventually finalised on 6 April 2005, well after Cornelia Rau had been identified.

The Inquiry accepts that the existence of an agreed MOU will not, in itself, ensure effective coordination and cooperation. Clarity about responsibility and clarity in communication are crucial. This was lacking in the relationship that existed between DIMIA and SA Health. Although pathways had been identified, there was clearly a blockage in the system.

On a number of occasions it was put to the Inquiry that central tenets for the efficient delivery of health services are leadership and continuity of care, as well as good communication. At Baxter at present there is no clearly defined leadership and no continuity of care. This is partly the result of medical and psychiatric services being provided by three subcontractors to GSL, the prime contractor to DIMIA. The three subcontractors are:

- International Health and Medical Services—providing nursing and psychiatric services
- Professional Support Services—providing psychology and counselling services
- Carlton Medical Service—providing general practitioner services under subcontract to IHMS.

The psychiatric service is provided by a consultant psychiatrist to IHMS on a ‘fly in, fly out’ basis.

Despite these subcontracting arrangements, any breach of the contractual conditions is a matter for DIMIA and GSL.

It is not clear on what basis these arrangements were made and what the rationale might be for splitting them in this way. But it would be in the interests of good patient care to minimise the number and tiers of organisations involved in delivering health services.

A number of health professionals the Inquiry interviewed were of the opinion that the arrangements are cumbersome and not conducive to the provision of an efficient, seamless service. Difficulties can arise in determining accountability where multiple parties are involved. Effective liaison between the parties is essential lest responsibility for the care of people ‘falls through the cracks’, with each party believing that primary responsibility lies with someone else.

The Inquiry observed that interpersonal relationships at Baxter, between DIMIA staff, GSL, IHMS and Professional Support Services, were good. But, with so many parties involved, there is a serious risk that service delivery could become less efficient than it might otherwise be. Although there was consultation between the parties, there appeared to be a lack of leadership and cohesion and no systematic approach to continuity of care. There was no question, however, that the parties involved were concerned to ensure the achievement of appropriate and effective outcomes.

As the Inquiry also observed at Brisbane Women’s Correctional Centre, at Baxter there was no accumulation of information from various sources, as is necessary for comprehensive and coordinated assessment; nor was there any process for coordination and review. There was a great deal of activity by staff making daily observations of detainees’ activities and compiling records, but this activity was largely meaningless. It was just treading water. There was no evidence of any attempt to integrate and assess the accumulated information in a systematic way.

As noted, at the time of Anna’s detention IHMS and Professional Support Services maintained separate medical systems and reports. The two agencies recognised the potential disadvantage of this and were moving to integrate their systems. This was difficult because one system was paper based and the other computerised.

The way the efforts to arrange for Anna’s admission to Glenside were handled provides clear evidence of these deficiencies. Everyone agreed that the matter was urgent, but this was not communicated clearly to Glenside. While Baxter medical staff continued to pursue admission to Glenside for Anna, the urgency of the situation did not seem to be appreciated by Glenside. Indeed, Glenside took Anna off the admission list without advising Baxter.

Although the reasons for the apparent ‘blockage’ to admitting Anna to Glenside are not clear, the Inquiry is of the view that more assertive attempts could have been made by the Baxter medical team,

particularly between 17 November 2004 and 4 January 2005, when, despite earlier identified concerns, no contact or follow-up occurred with SA Health and nothing seems to have happened. Effective leadership would have quickly escalated the matter to senior GSL management (and to DIMIA Canberra if necessary) to resolve the problem.

6.5.3 Systems

It is obvious to the Inquiry that in South Australia two systems operate to the detriment of the potential patient—the Baxter system of privately contracted clinicians and the South Australian Government’s mental health system. In using the word ‘systems’, the Inquiry refers to the integrity of clinical pathways, the alignment between systems, protocols, procedures and MOUs, and the availability of services to meet the assessed needs of a patient. The Inquiry also considers that the South Australian Mental Health Act and the way it is used constitute a systemic problem.

The RRMHS team is part of the South Australian Mental Health Service. It is based in Adelaide and has an Emergency Triage Liaison Service that uses telemedicine and telephone consultations to facilitate service provision in remote areas, with a psychiatrist being available 24 hours a day. The team also has 23 beds at Glenside and six beds in other locations. The nearest community team available to Baxter is at Port Augusta. If services are required at Baxter the expectation is that clinicians from Port Augusta will make the initial assessment and report their findings to the RRMHS team in Adelaide.

The Inquiry was told the relationship between the Mental Health Service and Baxter was ‘difficult’ from the beginning. It was not until April 2004 that a workshop was held—between DIMIA, Baxter and Glenside—to clarify the relationship and agree on protocols and procedures, communication paths, and crisis resolution mechanisms. Two meetings were held and a third was cancelled. The MOU was finally signed on 6 April 2005, well after this Inquiry began and after Cornelia Rau had been admitted to Glenside.

Leadership entails taking responsibility for matters within one’s jurisdiction. The Cornelia Rau saga is replete with evidence of lack of assertive communication, lack of clarity about respective jurisdictions, and failure to just ‘pick up the phone’ and talk to a professional colleague. The fact that this did not occur is itself indicative of systemic and relationship problems.

When one system interacts with another—as occurs with the Baxter medical team and the South Australian mental health system—the system with the patient continues to have jurisdiction and responsibility for that patient’s care until the patient has been transferred. This must be clearly understood and accepted.

6.5.4 Psychiatric services at Baxter

The psychiatric services at Baxter are primarily provided by a contracted visiting psychiatrist who has an arrangement to attend Baxter about every six weeks, on a ‘fly in, fly out’ basis.

The Inquiry’s audit of the services found, however, that the psychiatrist, who was based in New South Wales, attended Baxter less frequently than this during the period under review. The frequency of visits was found to be between six and eight weeks, with the length of time between visits varying significantly. The shortest gap was four weeks and the longest 14 weeks.

In particular, in the four months that Anna was detained at Baxter the consultant psychiatrist visited Baxter once. He saw her on 6 November 2004 and tried to assess her, but she was uncooperative. Nevertheless, he made a differential diagnosis and his treatment plan recommended in-patient assessment. When he next visited Baxter, Anna had already been identified as Cornelia Rau and was in psychiatric care at Glenside. The period of 14 weeks between visits to Baxter coincided with the psychiatrist’s absence on annual leave. No alternative arrangements were made—or, it seems, even considered—for psychiatric cover for detainees during his absence. The psychiatrist was potentially contactable by telephone but no calls were made. In the Inquiry’s view, however, the treating psychiatrist also had an obligation to follow up.

The consequence of the psychiatrist’s infrequent and irregular attendance at Baxter was a defaulting of responsibility to the on-site Professional Support Services psychologist. This is not satisfactory. While the option was always there for IHMS and PSS to refer patients for psychiatric assessment between the visits by the consulting psychiatrist, he (the consultant) did not receive any telephone call after he saw Anna on 6 November 2004. Baxter staff did, however, seek to have Anna admitted to Glenside during that period.

The Inquiry received expert advice that, in the light of the higher levels of morbidity among detainees, provision of mental health services at Baxter is inadequate. The Inquiry acknowledges the work

of the on-site psychologist, the nursing staff, and the medical officers, who seem to carry the day-to-day workload and acquit themselves with integrity. There does, however, seem to be uncertainty about who is in charge and what arrangements exist to cover sickness or leave.

The infrequency of the consultant psychiatrist's visits does not inspire confidence in the integrity of the system, and there is a clear lack of management and quality control oversight of the service delivery process.

Throughout Anna's detention at Baxter, the Discharge Summary from Princess Alexandra Hospital appears to have been relied on—albeit to a diminishing degree as time elapsed—as evidence that she did not have a mental illness and to have influenced the treatment she received. Baxter medical staff had the opportunity to observe Anna each day and modify their conclusions with mounting evidence, but Glenside did not. It appears to the Inquiry that the Discharge Summary from a reputable hospital influenced the urgency with which Glenside treated Anna's case. This would seem to be corroborated by the Glenside psychiatrist's advice to Baxter that Anna's problems sounded behavioural, which is not a mental health problem.

These possible influences demonstrate the difficulty in conducting assessments at a distance and the need for on-site re-evaluation. They also demonstrate the significant difficulties the South Australian Mental Health Act presented to medical practitioners in determining sufficient certifying causes for admission. Although triage arrangements are helpful and play a necessary and important part in enabling the delivery of medical care, the system must have sufficient flexibility and management control to facilitate in-patient assessment if there is any doubt.

Any psychiatric assessment that finds that a mental illness does not exist to the degree that would satisfy the requirements for involuntary admission under the Act is time limited. The Inquiry emphasises the importance of review and regular assessment. The further one moves from the date of assessment, the less reliance can be attached to the assessment results. If the system fails to respond for whatever reason, the clinical leadership should escalate the matter until it is resolved. The first question to be asked should be 'Does this person need help?'

Although there may have been over-reliance on the advice in the Discharge Summary from Princess Alexandra Hospital, insufficient notice was taken of the views and opinions of non-practitioners at Baxter. The Inquiry received evidence that 'non-clinicians are very

good at knowing that someone is unwell' and that patients, prisoners and other people often act in the collective interest. Such information is of particular value when a patient is unwilling to cooperate and collateral from family and friends is not available.

In this context, more notice should have been taken of the concerns expressed by fellow detainees, custodial officers and others who had contact with Anna and were able to observe her behaviour over time. Custodial officers should be given health and welfare training to identify behaviours that are indicative of mental health problems and need to be brought to the attention of medical staff. Such training should be supported by appropriate processes and procedures. There should be as much emphasis given to recruiting people with health and welfare training and skills as is given to custodial and security qualifications and experience.

Recommendation 6.7

The Inquiry recommends that DIMIA ensure that mechanisms are established to:

- require GSL to provide for detention officers training in observing, recognising and reporting behaviour and signs that may be symptomatic of mental illness
- ensure that as much emphasis is given to recruiting people with health and welfare training and skills as is given to custodial and security qualifications and experience
- capture significant concerns about the wellbeing of any detainee, as expressed by detention officers, other detainees and visitors
- ensure that this information is communicated in a timely manner to medical staff, to allow the information to be taken into account in the mental health assessment process.

6.5.5 An alternative model for psychiatric services

In tracking Anna's journey, reference is made to 'general' and 'forensic' psychiatry. General psychiatry refers to that area of medicine that deals with the assessment and treatment of mental disorder. Forensic psychiatry deals with mental disorder in the context of a legal system. It requires specialist interpretation of legal issues

and managing the interface between agencies such as courts correctional services and parole boards. It is also important to recognise that many patients who are in the care of forensic psychiatrists have committed no crime—for example, remandees and resectioned ‘special patients’.

Forensic psychiatrists have, among other skills, expertise in investigative assessment, reporting, and assessing and managing risk in relation to individuals who may not always be cooperative. These skills would have been valuable in the assessment of Anna.

The Inquiry proposes that DIMIA explore with the South Australian Mental Health Service the possibility of providing services directly to Baxter. This is more likely to provide:

- continuity between assessment and referral and subsequent follow-up
- a secure environment, thus obviating the need for accompanying guards during assessment
- expertise in dealing with complex cases involving multiple morbidities.

There is a pressing need to align what are at present two systems. In addition to resolving the problems just noted, there are several other benefits that would accrue from using SA Health employees in Baxter:

- elimination of any perception that health personnel are taking the ‘company line’ because they are indebted to the private contractor for their employment
- facilitation of seamless service delivery that makes full use of the recently established clinical pathway of care into the tertiary services of SA Health
- considerable simplification of the present multi-tiered system of service delivery at Baxter.

Such an initiative would also overcome a significant shortfall in the availability and continuity of patient information. For example, when a prisoner is transferred from a South Australian prison into James Nash House (the state’s forensic psychiatry facility) their medical file from the prison accompanies them and is available to the treating staff. Similarly, when the prisoner is sent back to the prison their

medical file, including the Discharge Summary from the hospital, travels with them. This is an important principle no matter who delivers the service. No such arrangements exist at Baxter at present.

In the current South Australian system continuity of care and communication is enhanced by ensuring responsibility for the transfer of information between community and in-patient settings.

Recommendation 6.8

The Inquiry recommends that DIMIA explore the possibility of contracting the South Australian Mental Health Service or the South Australian Forensic Mental Health Service to service the mental health care needs of immigration detainees at Baxter, with a view to providing seamless, effective service and improving the continuity of patient care.

6.5.6 A national facility

Baxter is not geared to the assessment and treatment of the mentally ill. Its remote location makes access by clinicians and support services very difficult. People needing assessment and treatment are referred to Glenside.

The Inquiry had discussions with the clinicians faced with assessing and treating patients from Baxter. Among other things, they raised the following:

- the difficulty of assessing patients who are accompanied by guards
- the difficulty of returning mentally ill but stabilised patients to Baxter because of the ‘toxic’ environment—for mental health and wellbeing—and the lack of step-down facilities and professional support. Patients who would ordinarily be in RRMHS beds for, on average, weeks are required to remain for months while alternative, more suitable arrangements are made for their care
- the need for Glenside to employ a protocol to limit the use of RRMHS beds for Baxter patients because of the major impact on Glenside’s outstanding case load, thus creating a waiting list for those assessed as needing admission.

It is the professional opinion of these interviewees that the facility at Baxter is unsatisfactory for accommodating the recovery needs of people with mental illness who might not need in-patient care or who have returned from in-patient assessment and treatment but need follow-up and support.

There is no suitable place at Baxter in which to promote and sustain the recovery of such detainees. The Inquiry's proposed multi-purpose facility (see recommendation 4.12) would, however, provide a step-down facility or offer a 'buffer' and open up other options.

The Inquiry considered the establishment of a purpose-built facility in a capital city for all immigration detainees who do not require in-patient accommodation at a mental health institution but who cannot be adequately accommodated at an immigration detention facility. Such a facility could also be used for detainees who are at elevated risk of suicide or self-harm, a factor that becomes ever more important as the length of stay increases.

With the exception of Baxter, all immigration detention facilities currently in use in Australia are located in capital cities. The challenges of remoteness at Baxter are real, but on balance the establishment of a separate facility for immigration detainees does not seem to be warranted.

In each state various arrangements and clinical pathways already exist. These have been, appropriately, developed to meet the unique needs of each jurisdiction. In Queensland, which presents a unique situation for DIMIA, the State Government has affirmed its willingness to explore with DIMIA changes in existing arrangements and clinical pathways that might facilitate the delivery of high-quality mental health care.

Similarly, the South Australian Department of Health has signed a memorandum of understanding with DIMIA, identifying agreed clinical pathways and arrangements for cooperation. In the light of the problems encountered in achieving adequate mental health care for Anna, the Inquiry proposes a thorough review by DIMIA and the South Australian Department of Health—in consultation with the Rural and Remote Mental Health Service and the Baxter medical team—of clinical pathways, arrangements and consultative machinery proposed in the MOU. It also recommends that clearly defined management arrangements be developed and implemented to ensure that the earlier communication problems can no longer occur.

These arrangements would support the Inquiry’s recommendation (number 6.8) for, in the case of Baxter, mental health services to be delivered by the South Australian Mental Health Service.

Consequently, the ‘national mental health facility’ model proposed by the Inquiry is to build on existing state arrangements. DIMIA should negotiate arrangements with the state government agency to ensure that immigration detainees’ particular needs for mental health care are met and that DIMIA can demonstrably exercise its duty of care on behalf of the Commonwealth Government.

Recommendation 6.9

The Inquiry recommends that—in consultation with the Rural and Remote Mental Health Service and the Baxter medical team—DIMIA and the South Australian Department of Health:

- conduct a thorough review of clinical pathways, arrangements and consultative machinery proposed in the memorandum of understanding to make certain that respective responsibilities, and particularly lead responsibilities, are clearly defined
- ensure that consultation, coordination and reporting arrangements are clearly defined and enable management oversight of the delivery of appropriate levels of mental health care to detainees and provide to DIMIA adequate information to enable it to demonstrably meet its duty of care on behalf of the Commonwealth Government.

6.6 Clinical considerations

6.6.1 Understanding schizophrenia

Doctors recorded that Cornelia Rau had a mental illness, possibly schizophrenia. Schizophrenia refers to a group of conditions or syndromes expressed as disorders of thinking, feeling, perceiving, or behaving, or a combination of these. It can have multiple aetiologies—for example, head injury, severe stress, and cultural dissonance and trauma—and most authorities accept that its expression implies a predisposition to it.

No two schizophrenic illnesses are the same. At the clinical level the illness can present with ‘positive symptoms’ (for example, hearing

people speaking when no one is present, bizarre behaviour such as posturing, and having aberrant beliefs) or ‘negative symptoms’ (for example, thought blocking, ‘blankness’, poverty of expression, and lack of insight into matters that most people regard as reality). Both sets of symptoms commonly occur together, but if the positive symptoms are absent diagnosis can be difficult and can lead to confusion with other conditions such as expressions of cultural difference, personality disorders, dementia or drug-taking behaviours.

It should be noted that the diagnosis of schizophrenia is not itself an indication for hospitalisation. If it were, thousands of patients with schizophrenia who are living in the community would be hospitalised. Rather, the concern revolves around the dangerousness and severity of the illness. The important question is whether the patient is at risk of harming themselves or others or of suffering serious mental or physical deterioration.

6.6.2 Assessment

Comment has been made about the failure of health practitioners involved with Anna to accurately diagnose her ‘obvious’ mental illness in a timely manner. Assessment of a person to determine whether they have an illness is not always straightforward. The primary method of diagnosing a psychiatric illness involves taking a thorough history, from both the patient and others, and conducting a mental status examination. History taking is obviously important, and in this case information was not available since there were no family or friends to assist and Anna provided either misinformation (intentionally or delusionally) or no information at all.

The mental status examination involves a clinical interview and subsequent observation, at which time various aspects of the patient’s presentation and responses to questions are assessed. This usually takes place after the examiner has developed sufficient rapport with the patient to enable the examination to proceed. In Anna’s case this appears to have been difficult to achieve because she avoided contact with medical practitioners whenever possible.

The file notes and transcripts of conversations show that, from the time she left Manly Hospital until she was recognised as Cornelia Rau by the authorities, Anna would not submit readily to examination by health practitioners, refused to engage with them and refrained from responding to questions posed. This made it difficult for the health practitioners involved to gain an understanding of the presence, level and extent of any mental illness.

When an interview is not possible, it is necessary to rely on the observations of other people who have contact with the person being assessed. It is significant in this case that fellow detainees expressed concern about Anna's behaviour and mental health. It is a well-recognised medical principle that when an adequate history cannot be obtained from the 'patient' a collateral history should be sought from staff, concerned friends and others. To justify the seeking of this wider information, there must be an 'index of suspicion' on the part of health professionals that illness is one possibility when confronted by the person's aberrant behaviour. In fact, in Anna's case the clues available to all clinicians suggest that schizophrenia should have been suspected until the contrary was confirmed.

6.6.3 The assessment setting

The setting in which people are assessed for mental illness is important. Privacy, suitable surroundings, and an adequate number of competent staff available to make observations over 24 hours are important.

Anna was held in several sites, which militated against staff being able to develop an accurate observational history over a reasonable period. Further, the staff who did spend the greatest amount of time with her were prison officers and detention officers, who were untrained in the type of clinical observation that is required to make a finding of mental illness, although their observations are nevertheless important.

Another challenge posed by an institutional setting concerns the degree of pathology that might be present in the population of detainees or prisoners and the extent of aberrant behaviour caused by such an environment. This adds further complications when seeking to determine whether someone's behaviour is simply odd or unusual or is a manifestation of a mental illness.

Yet another challenge for the staff of a detention facility lies in distinguishing between manipulative behaviour and mental illness. The consequence of this is that a person who has a genuine illness can be categorised as having a personality disorder or being manipulative and so not be afforded the mental health assessment and treatment that is needed. This seems to have been the case with Anna.

6.6.4 Personality disorder

Personality disorder refers to maladaptive patterns of behaving and interacting, both interpersonally and socially. It is not an illness: it can be seen in people who cannot keep a job, people who cannot stay in a relationship, and people whose behaviours and habits irritate others. People who have a personality disorder are often unhappy, discontented souls.

Diagnostic labelling can be a problem, and in Anna's case labelling her behaviour as 'difficult' or 'personality disordered' might have masked the index of suspicion that she had an illness. Labels such as 'personality disorder', when used to dismiss illness behaviour, are stigmatising and are often used as proxies for 'badness'.

Finally, and obviously, personality disorder can exist alone or in concert with mental illness. Schizophrenia is one such illness.

6.6.5 Detention and mental health

It is estimated that mental disorder afflicts one in five of the general population at any time. This estimate covers the multitude of mental disorders—such as drug and alcohol abuse and addiction, anxiety disorder, post-traumatic stress disorder, schizophrenia and depression—and includes the range from mild affliction to severe. It is important to bear this in mind because, at the very least, a significant proportion of immigration detainees will present with mental health problems that need attention at the primary (general practitioner) or secondary (mental health clinician) level.

Detainees suffer the additional burden of trauma, being arrivals in a new country, often having experienced abuse and deprivation, and having their immediate desire for migration status frustrated. Hopelessness is a major factor in depression. Repeated studies of national prison and refugee populations have found that incarcerated people have a much higher incidence of psychological and psychiatric morbidity than the general community—anything up to 50 per cent higher. Not all of these conditions, of course, would warrant the use of secondary or specialist services.

The contract for health services at Baxter states, 'The level of primary health care services available to detainees in detention facilities should sit broadly within the norms of primary health care available to members of the Australian community through a General Practitioner or a community health centre'. Although this statement might have

superficial appeal, for the reasons just given the detainee population in Baxter (or any other detention facility) is *not* similar to the general population in Australia, for whom a general practitioner service would be appropriate and adequate. Many members of the detainee population at Baxter have special needs reflective of their particular circumstances.

The detainee population is a needy cohort and requires a much higher level of mental health care than that required by the Australian community as a whole. The infrequency of the consulting psychiatrist's visits to Baxter is a serious shortcoming: expert mental health opinion holds that more frequent, regular visits—together with sufficient mental health nurses, psychologists and primary practitioners who could initially assess and triage for mental illness—would bring about a more effective clinical system of care.

6.7 Standards of health care

6.7.1 The health care provided for Anna

The health care provided for Anna was inadequate and failed to meet her needs. In Brisbane Women's Correctional Centre she was treated in the same way as any other prisoner, despite the fact that she was an immigration detainee and did not belong there because she 'had done nothing wrong'. She remained in prison for six months, during which time DIMIA was in breach of its own instructions. The mental health assessment at Princess Alexandra Hospital was inadequate for the reasons already discussed, and it tended to influence, at least initially, the treatment Anna received during her period in immigration detention.

Professional opinion presented to the Inquiry has it that psychiatric services provided by a consulting psychiatrist who flies infrequently to service a needy community are inadequate. As a consequence of a lack of continuity in psychiatric care, detainees at Baxter are vulnerable and exposed to heightened risk of mental illness.

The Inquiry was advised that, when Baxter was established, visits every six weeks were considered adequate. But Baxter was not planned to deal with the high level of morbidity that characterises detainee populations, and the current arrangements do not and cannot facilitate the treatment and recovery of mentally ill people.

Many clues to Anna’s mental condition were missed, and opportunities for accumulating corroborating information to facilitate assessment when a patient is not cooperating were not pursued. Simple clues such as the fact that someone walks out on an interview and persistently refuses to cooperate—which are diagnostically significant—were not recognised.

This report discusses the importance of attitude in the context of medical decision making. The Inquiry’s interviews confirmed that at times personal views about Australia’s detention policy and about incarcerated people influenced, both positively and negatively, the way in which clinical responsibilities were performed.

Assumptions about Anna’s behaviour, history, immigration status and medical condition contributed to her not receiving the medical attention she needed and deserved. Management of detainees’ personal information is discussed in Section 4.4.5.

Another assumption on the part of some staff at Baxter—openly shared with the Inquiry—was that a detainee released to Glenside for treatment was unlikely to ever return to Baxter and that transfer to Glenside was a ‘back door out of detention’. Such assumptions contributed to the general environment within which decisions about priorities for assessment and referral needed to be made.

The fact that a medical practitioner does not support Australia’s detention policy and the fact that detainees are assumed to have entered this country unlawfully should not be allowed to influence the level and nature of medical care provided to detainees.

6.7.2 Access

Standards of health care are meaningless if people are unable to gain access to services. It is well recognised that the provision of any service is limited by the availability of resources. *Tracking Tragedy*, a report by the New South Wales Mental Health Sentinel Events Review Committee comments, ‘The ability to provide a comprehensive range of quality mental health services is limited by the availability of beds’ and ‘... on occasions patients are not being admitted ... due to an inability to access an available bed’. These comments are also applicable to Glenside.

Glenside has 23 in-patient beds available for country patients, plus six beds for the southern metropolitan region of Adelaide. Baxter falls into the ‘country’ category, which is managed by the Rural and

Remote Mental Health Service. Given these small numbers, there is an obvious need to husband valuable resources.

Glenside has found that when immigration detainees are referred to it, they are already in an advanced state of illness. As a result, they need to occupy beds for longer than other mentally ill patients and require lengthier rehabilitation before being stabilised and returned to Baxter. As the Inquiry has already pointed out, Baxter lacks appropriate step-down and rehabilitation facilities to deal with such circumstances.

To cope with the problem of scarce resources, Glenside had a preferred operational principle of having only one bed available for immigration detainees at any one time. This resulted from the disruption caused by having present additional people such as interpreters, security officers, lawyers and DIMIA case coordinators. It is arguable whether this principle played a part in the apparent reluctance to admit Anna to Glenside, but the fact is that her admission did not occur as quickly as it should have.

It is the Inquiry's view that, in taking this approach to rationing an unquestionably valuable and scarce resource, the wrong question was being asked. When it is proposed to admit a patient, the question should be 'Does this patient need specialist care?' rather than 'Do we have a bed?' Glenside is already looking at its protocols with a view to ensuring appropriate access and the delivery of quality care.

6.7.3 Quality and standards in the delivery of health services

The delivery of health services is of concern to immigration detainees, the community and health professionals. In order to engender confidence that health services are being delivered in accordance with appropriate standards, a sophisticated national accreditation system has been developed for all health service providers. Health care professionals' possession of appropriate qualifications is emphasised in the detention services contract.

Schedule 2, clause 7.1.12, of the contract between DIMIA and GSL requires that GSL:

establish a Health Advisory Panel, which would be available to all detention facilities, to:

- (a) help the Services Provider to develop and review the facility health plans covering both physical and psychological health aspects; and

- (b) provide health and social service professionals employed by the Services Provider with access to well qualified specialists and consultants for high quality advice and assistance particularly in more complex cases or cases which have become protracted.

Clause 7.1.13 provides:

[The] Health Advisory Panel should comprise at least five members with expertise and experience appropriate to the health needs of the detainee population, appointed by the Service Provider in accordance with selection criteria to be agreed with the Department and in consultation with appropriate external professional bodies. The provision of recompense to Panel members is a matter to be agreed between the member and the Services Provider.

It is unclear why GSL has not established this specialist panel, and it is unclear why DIMIA has not enforced this contractual condition.

At present the only process for review is through engaging, on a consultancy basis, one general practitioner as the sole member of an Expert Panel. The Inquiry does not suggest that the sole member has failed to diligently apply himself to the tasks allocated him. This arrangement does not, however, in any genuine sense, meet the need identified for a multi-disciplinary panel.

Had a properly constituted Health Advisory Panel been in existence and had it contained a specialist in psychiatry, it might have made a difference to the treatment and mental health care Anna received. The Inquiry recognises, however, that there have been difficulties in finding enough suitably qualified applicants to establish an effective Health Advisory Panel resource pool. Despite letters having been sent to relevant professional bodies and advertisements being placed in national newspapers, apparently the response and level of interest have been poor. On 11 January 2005 DIMIA sought a professional opinion as to whether an effective Panel could be established from the current pool of applicants. The Inquiry understands work on this is proceeding.

Recommendation 6.10

The Inquiry recommends that, as a matter of urgency, DIMIA establish the Health Advisory Panel, as specified in the detention services contract, to help GSL develop and review Baxter's health plans and to provide, for health and social service professionals employed by GSL, access to well-qualified specialists and consultants—particularly in more complex cases or cases that have become protracted.

6.7.4 Independent, external monitoring

Given the importance and prominence of health care services, the Inquiry considers that the lack of any focused mechanism for external accountability and professional review of service delivery standards and arrangements is a major omission. It acknowledges the efforts made in this regard by the Immigration Detention Advisory Group and the Commonwealth Ombudsman, both of which have a much wider scope of responsibility. An expert body specifically dealing with health matters is required to complement and strengthen these efforts.

The question of service quality and standards extends beyond the detention services contract. The Inquiry concluded that the delivery of adequate and appropriate health care for immigration detainees, and their welfare in general, need to be safeguarded by continuous oversight by an independent, external review body to complement the operations of the Health Advisory Panel.

The review body would need to operate at several levels:

- At the operational level there is a need to review each health and medical care performance measure in the contract and, where necessary, replace it with one that is more suited to achieving the outputs and outcomes expected by government.
- It should advise on suitable arrangements for providing health and medical care to immigration detainees and propose measures for the monitoring and management of these arrangements.
- To maintain the quality of health care, it should advise the Health Advisory Panel on the national accreditation standards service providers should be required to achieve.

- At the highest level of oversight, it should be able to initiate reviews and audits of health care standards and the welfare of immigration detainees.

There are several ways in which this review body might be established. A primary consideration is that it must be overtly independent and be staffed by people of integrity. It should also have statutory powers to protect its independence and should not be involved in commercial undertakings.

The Inquiry is attracted to the idea of establishing the body—which it calls the Immigration Detention Health Review Commission—under the Commonwealth Ombudsman’s enabling legislation. It could, in effect, have the role of ‘Immigration Detention Ombudsman on Health and Welfare’ and work in close consultation with the Commonwealth Ombudsman and the Immigration Detention Advisory Group. Should such a body be established under the umbrella of the Commonwealth Ombudsman, it would need to be adequately resourced to sustain effective professional operations and win credibility.

The overwhelming conclusion reached by the Inquiry is that, in the light of the many health care difficulties and deficiencies that were raised, there is an urgent need to carry out an independent assessment of the structure of health care arrangements at immigration detention facilities and of the adequacy and quality of the health care services provided. This should be the priority task for the Immigration Detention Health Review Commission.

Recommendation 6.11

The Inquiry recommends that the Minister for Immigration establish an Immigration Detention Health Review Commission as an independent body under the Commonwealth Ombudsman’s legislation to carry out independent external reviews of health and medical services provided to immigration detainees and of their welfare. The Commission should report to the Minister and:

- be appropriately staffed and resourced, with a core of experienced people with relevant skills
- have the ability to invite specialists to participate in particular reviews and audits

- have the power to initiate its own reviews and audits
- in consultation with the Immigration Detention Advisory Group and the Health Advisory Panel, carry out an independent assessment of the current structure of health care arrangements at immigration detention facilities and of the adequacy and quality of the services provided
- in consultation with the Detention Contract Management Group (see recommendation 7.6), review each health and medical care performance measure specified in the detention services contract and, where necessary, replace it with a more appropriate measure and propose arrangements for monitoring the measures
- recommend more effective arrangements for providing health and medical services to immigration detainees, together with arrangements for monitoring and management of the provision of those services
- identify the most appropriate national accreditation standards applicable to the immigration detention environment that service providers should be required to meet
- coordinate its operations with the Ombudsman and the Immigration Detention Advisory Group in order to maximise the effectiveness of oversight machinery.

In view of the high incidence of mental disorders among detainee populations, a central question concerns the level of psychiatric services required to properly care for immigration detainees. This calls for independent analysis of relevant studies and data in order to determine their relevance to the environment at Baxter.

Identifying the appropriate level of such services might involve an iterative approach based on initial sampling of the detention population. It might also be necessary to consult external expert bodies such as the Mental Health Council of Australia and to test the feasibility of implementation with the Health Advisory Panel. Responding effectively to mental health needs is not a precise science.

Recommendation 6.12

The Inquiry recommends that the Immigration Detention Health Review Commission, in consultation with the Health Advisory Panel and the Mental Health Council of Australia, investigate relevant studies of detainee populations and advise on the level of mental health services applicable to the immigration detention population in Baxter, to reflect the much higher incidence of mental disorders that is evident.

Maintaining high standards of health care services is dependent on continuing professional development. The effectiveness of health care systems and their structures and processes depends on health professionals staying up to date in their knowledge of assessment and treatment improvements. Continuing professional development also enables these professionals to gain access to and contribute to developing knowledge in their specialty area. Opportunities should be created to ensure that health professionals working with immigration detainees maintain their professional skills.

Recommendation 6.13

The Inquiry recommends that the Immigration Detention Health Review Commission work closely with the Immigration Detention Advisory Group and the Health Advisory Panel to review the adequacy of current systems for continuing professional development, to ensure the maintenance of high standards in the delivery of health services to immigration detainees.

6.8 Mental health legislation

Anna was held in custody in Queensland at Brisbane Women's Correctional Centre and Princess Alexandra Hospital and in South Australia at Baxter. She was subsequently admitted to the Glenside Campus of Royal Adelaide Hospital. It is of interest to note the relative ease with which her involuntary admission to a psychiatric hospital took place in Queensland and the difficulties experienced in doing likewise in South Australia. Relevant here are the differences in the mental health legislation in the two states.

6.8.1 Queensland

Section 13(1) of the Queensland *Mental Health Act 2000* provides that the following ‘assessment criteria’ must be met in order for a person to be involuntarily detained:

- a) the person appears to have a mental illness;
- b) the person requires immediate assessment;
- c) the assessment can properly be made at an authorised mental health service;
- d) there is a risk that the person may:
 - i) cause harm to himself or herself or someone else; or
 - ii) suffer serious mental or physical deterioration;
- e) there is no less restrictive way of ensuring the person is assessed.

Also included as criteria are whether the subject person ‘(a) is lacking the capacity to consent to be assessed; or (b) has unreasonably refused to be assessed’.

The Inquiry’s discussions with mental health professionals in Queensland elicited no negative comments on these provisions, and no concerns were expressed about the provisions’ adequacy.

6.8.2 South Australia

Section 12 of the South Australian *Mental Health Act 1993* provides that, before making an order for a person to be detained as a non-voluntary patient in a treatment centre, the treating medical practitioner must be satisfied that the following three criteria are met:

- a) that the person has a mental illness that requires immediate treatment;
- b) that such treatment is available in an approved treatment centre; and
- c) that the person should be admitted as a patient and detained in an approved treatment centre in the interests of his or her own health and safety or for the protection of other persons.

Only when these preconditions are met may a medical practitioner make an order for the immediate admission and detention of the person in question.

6.8.3 A comparison

Although the Queensland and South Australian requirements for involuntary admission are generally similar, there are two distinct points of difference.

First, in Queensland the threshold to be met is that the person *appears to have* a mental illness, whereas in South Australia the requirement is that the person *has* a mental illness. Obviously, it is harder to satisfy the requirement in South Australia than it is in Queensland.

The second point of difference relates to consent. It is well recognised that some mentally ill people will deny the existence of their illness or be disinclined to accept treatment, to the extent that they will not willingly undergo the necessary assessment to determine their suitability for admission. The provisions of the Queensland legislation (and of other models such as that applying in New Zealand) are helpful in overcoming any resistance resulting from a lack of capacity or willingness to give consent or where there is an unreasonable refusal to be assessed.

In combination, these two points make it more difficult to satisfy the requirements for involuntary admission in South Australia as compared with Queensland.

6.8.4 Difficulties arising from the legislation

The medical notes and the testimony given to the Inquiry provided evidence of discussions between staff at Baxter and staff at Glenside with a view to determining whether the three criteria in the South Australian legislation were met. There was conjecture about whether there was sufficient evidence to support a belief that a mental illness was the cause of Anna's odd behaviour or whether there might be some other explanation—such as a personality disorder.

The staff at Baxter wanted Anna to be assessed to determine *whether* she had a mental illness, whereas the legislation required that it already be *established* that she had a mental illness. This they were reluctant to certify. There appears to have been genuine concern about satisfying the legal requirement to demonstrate that Anna had a mental illness.

The Inquiry understands that the South Australian Department of Health is redrafting its Mental Health Act for consideration by the State Parliament. The Inquiry urges that the opportunity be taken to

consider the points just made, to ensure that the Act makes provision for greater access to psychiatric in-patient assessment for involuntary patients.

Recommendation 6.14

The Inquiry recommends that, in redrafting the state's *Mental Health Act 1993*, the South Australian Department of Health ensure that the Act makes provision for greater access to psychiatric in-patient assessment for involuntary patients. The Queensland *Mental Health Act 2000* and other legislation, such as that applying in New Zealand, might offer useful insights.

7 Culture, structure and operations

7.1 Overview

The Inquiry recognises the complexity of DIMIA's task and responsibilities, of which immigration detention is an important part. It also recognises that, for the most part of what is a complex business, the processes and procedures seem to work well. However, because these processes and procedures affect the lives of real people, it is incumbent on DIMIA to ensure that they work as effectively in dealing with unusual and difficult cases as they do with those that are routine. For Cornelia Rau they did not.

It was suggested to the Inquiry that, of the thousands of removals and cases DIMIA deals with each year, the case of Cornelia Rau represents less than 0.001 per cent. The Inquiry considers that this statement, more than most, demonstrates the culture and mindset that have brought about the failures in policy implementation and practices. The case of Cornelia Rau was not the 'one in one hundred year flood' and could have, and should have, been resolved much earlier.

To place this observation in perspective, the Inquiry notes that, in relation to its immigration detention function, DIMIA locates over 55 000 suspected unlawful non-citizens each year and detains only about 20–25 per cent of them. It must also be noted, though, that the majority of detention cases are not complicated or problematic.

The Inquiry's investigations and its discussions with independent expert bodies, detention facility operators, medical services providers, Baxter immigration detainees, advocates, visitors and other interested parties led it to conclude that there are serious problems with the handling of immigration cases. These stem from a deep-seated culture and attitudes and a failure of executive leadership in the compliance and detention areas.

Understandably, DIMIA raised the point that the Inquiry focused only on the Cornelia Rau and Vivian Alvarez matters and is not able to make what DIMIA considers to be wider judgments. DIMIA also referred to initiatives it has taken and events that have occurred since Ms Rau was identified. Because of the recent nature of these

initiatives, the Inquiry cannot comment on their effectiveness, although their focus is on areas of obvious importance.

The Inquiry considers it important, however, to reiterate its fundamental point, which is that what has been identified is not so much incompetent management but instead an *absence* of management—not on a single occasion but during 10 months, in two jurisdictions and involving a wide range of practices, procedures and executive conduct that all pertained to the management and care of detainees more generally. This finding has wide and serious implications for a ‘front-line’ policy department. It is also relevant to the Vivian Alvarez matter.

An initial assessment of further cases referred to the Inquiry by the Acting Minister for Immigration and Multicultural and Indigenous Affairs served to confirm this view. Thus far, the analysis of these matters reveals underlying problems and deficiencies similar to those applying to the extended unlawful detention of Ms Rau and the removal of Vivian Alvarez. These problems appear to be at the root of a significant proportion of the other referred cases.

7.2 Immigration policy and implementation

7.2.1 Immigration policy

The Government has always had a strong immigration policy. In recent years it has had to contend with a huge influx of illegal immigrants, many of whom paid people smugglers to transport them to Australia and then sought refugee status. The flood of these people has now abated, but many people remain in long-term immigration detention in facilities such as Baxter and Villawood while their claims for refugee status and appeals against decisions are dealt with by the courts. This takes time.

Australia’s *Migration Act 1958* requires that all non-Australian citizens who are unlawfully in Australia be detained and that those who do not receive permission to remain be removed from Australia as soon as practicable. Section 189 of the Act makes detention mandatory for all people known to be or reasonably suspected of being non-citizens and unlawfully in mainland Australia.

Australia’s immigration policy is deliberately focused on achieving a number of public policy objectives, including the following:

- Unauthorised arrivals may not enter the Australian community until their claims have been properly assessed.
- Unauthorised arrivals may not enter the community until identity and health checks are completed and assessments are made to clarify character and security considerations.
- The integrity of Australia's migration program is maintained.

The policy was introduced in 1992 and has been maintained by successive governments. The Inquiry's comments in this report are not intended to call this policy into question.

The Inquiry did, however, proceed on the basis of the assumption that it is the Government's intention that the policy be applied fairly, justly and equitably and that:

- every reasonable effort be made to ensure the right people are detained as being reasonably suspected of being an unlawful non-citizen
- expeditious, comprehensive and effective inquiries be made to establish the identity of detainees where identity is in doubt
- the overall duty of care—particularly medical health care—owed to detainees be consistently and effectively applied
- detainees be held in detention only for as long as is necessary and justifiable.

The Inquiry found many instances where DIMIA failed to adhere to these fundamental principles. It was even more concerned to find that the principles were not actively pursued or reviewed at executive level. There seemed to be a blind trust in systems and processes that, on any reasonable assessment, had failed. The fact that Cornelia Rau could be held in prison for six months, in contravention of DIMIA's own instructions, and never come to the notice of the executive responsible for that area is evidence of a serious failure in executive management and leadership.

7.2.2 Responsibility and accountability

DIMIA is responsible and accountable to the Government for implementing Australia's immigration policy and for exercising the powers and authorities required by or related to that policy. The huge

increase in the number of illegal immigrants in recent years has placed much pressure on DIMIA, such that many arrangements and procedures have had to be implemented 'on the run'. There has been little time for reflection and review.

Part of DIMIA's responsibility for immigration detention is dealt with through a contractual arrangement with Global Solutions Limited, which operates the various immigration detention facilities on behalf of DIMIA, and International Health and Medical Services and Professional Support Services, which provide medical and health care services on subcontract to GSL. Ultimately, however, the responsibility rests with DIMIA.

Schedule 2 of the detention services contract states, among other things, 'Immigration is an extremely important area of public policy. To detain persons is a serious step and it is essential that this is done lawfully and as humanely as possible. It is for this reason that immigration detention is one of the most scrutinised government programs'. The Inquiry agrees with that. But DIMIA does not seem to have been mindful of these concerns in the case of Cornelia Rau. Additionally, the practices in operation throughout the period of her detention offer little confidence in the application of the principles to the immigration detention population more generally.

Many avenues of review exist. DIMIA is accountable to a number of external bodies, among them the Commonwealth Ombudsman and the Human Rights and Equal Opportunity Commission. Both have statutory power to investigate complaints and to initiate their own inquiries in relation to immigration detention. DIMIA itself reports to the Minister and is quite often required to provide information, advice and briefings to members of the Commonwealth Parliament and to parliamentary committees.

In addition, in February 2001 the Government established the Immigration Detention Advisory Group, which consists of eminent Australians and has the task of advising the Minister on the adequacy and appropriateness of detention services. As part of its mandate the Group visits and inspects immigration detention facilities. DIMIA is also subject to audit by the Australian National Audit Office.

The Immigration Detention Advisory Group, the Australian National Audit Office and the Commonwealth Ombudsman have each reported on aspects of DIMIA's immigration operations. There has also been considerable public comment and scrutiny by the media and special interest groups. But little seems to have changed. The existing DIMIA

procedures and practices and management perspectives allowed Cornelia Rau, an Australian resident, to be held in immigration detention for 10 months. Although investigations are not complete, the presence and systemic nature of these attitudes, processes and practices are reflected in the events associated with Ms Vivian Alvarez, which occurred some three years earlier.

7.2.3 Implementing immigration policy

The nature of immigration policy, its inevitably high public profile, and the level of scrutiny applied to its operation place a heavy burden of responsibility on DIMIA. The immigration-related functions for which DIMIA is responsible are complex and difficult and, in relation to matters of compliance and detention, include effective management of the tensions between custody and health care responsibilities.

The case complexity and workload associated with enforcing and managing immigration detention policy have placed considerable pressure on DIMIA employees. Individuals' workloads are high and many of the situations they have to deal with are sensitive and difficult. The speed of change in the immigration detention environment during 2000–01 required that policy, procedures and enabling structures be developed in tandem and on the run.

The immigration detainee profile and the arrangements and practices required to meet the needs of detainees have been changing so rapidly that it has often been difficult for DIMIA to keep up. But the very nature of the environment brings with it responsibilities that DIMIA must honour. If the existing structures, legislation or resources are inadequate, this should be brought to the Government's attention and proposals for redressing the situation should be made. That is the duty of the executive and executive management.

A strong government policy places on the agency tasked with its implementation a duty to provide assertive leadership and to have in operation systems that ensure integrity of application and accountability and engender public confidence. The Inquiry found insufficient evidence of this in DIMIA.

Instead, the Inquiry found considerable evidence of deafness to the concerns voiced repeatedly by a wide range of stakeholders, a firmly held belief in the correctness and appropriateness of the processes and procedures that exist, and a culture that ignores criticism and is unduly defensive, process motivated and unwilling to question itself. Energies

seemed to be channelled more into justifying and protecting the status quo.

In a sensitive and busy portfolio, the Inquiry would expect to see searching processes of high-level internal review to ensure that the organisation is achieving the outcomes expected of it by government. Such corporate quality assurance would be executive driven and visibly followed up to provide confidence to government and the public that policy is being properly and fairly administered. There was little evidence of this in DIMIA.

The Inquiry identified a clear ‘disconnect’ between policy development and management in Canberra and operational requirements in Baxter and the Queensland Regional Office. The functional separation of immigration detention responsibilities seems to have prevented effective, sensible ‘cradle to grave’ case management, oversight and review in matters where such management was undeniably important.

Such rigid attitudes and processes also seem to have created an environment in which people are unwilling to accept ownership of matters beyond their immediate responsibilities, regardless of the importance of the matter and the obvious need for continuity in its management. Nobody seemed willing to manage ‘the cracks’, and there was no effective executive management oversight.

In the absence of the effective management coordination and control that is essential for holistic case management, important decisions seem to have been made on the basis of incomplete information. There was little evidence of management arrangements for regular review and assessment of decisions made at lower levels.

The lack of effective case management arrangements has created a series of process weaknesses and management discontinuities that adversely affected the treatment of Cornelia Rau during her detention at Brisbane Women’s Correctional Centre. It also seems to have led to a lack of cohesion and coordination in compliance and detention functions generally.

In its submission to the Inquiry on 24 June 2005, DIMIA referred to its own governance initiatives. As noted, because these initiatives are so recent, the Inquiry cannot comment on their effectiveness. Additionally, the Inquiry’s terms of reference require it to examine and report on the situation that prevailed during the time of Ms Rau’s detention.

Recommendation 7.1

The Inquiry recommends that DIMIA develop and implement a holistic corporate case management system that ensures every immigration detention case is assessed comprehensively, is managed to a consistent standard, is conducted in a fair and expeditious manner, and is subject to rigorous continuing review.

The Inquiry notes that the Immigration Detention Advisory Group made a similar proposal for the development of a case management model in its Proposal for Case Management and Community Care, put to the Minister in January 2003. No action seems to have been taken.

7.3 Culture, processes and attitudes

7.3.1 Process and structure

Despite the best efforts of what is generally a highly committed workforce, DIMIA has struggled to do justice to the onerous responsibilities it has to government, immigration detainees and the Australian people. The Inquiry formed the view that many of the weaknesses and deficiencies it identified are the consequence of poor structure and a culture preoccupied with process and quantitative, rule-driven operational practice.

The Inquiry found that these practices and attitudes are often frustrating for staff at the operational and operational management levels, who strive to be effective in spite of the processes. It seems that the operational problems and poor performance stem essentially from two causes:

- the culture and attitudes pervading executive management in the immigration detention area
- the systems, processes and procedures that determine the way business is done.

The Inquiry acknowledges that DIMIA has had to contend with the public nature of the immigration detention environment and that some structures and processes have been developed in response to external audits and reviews. Nevertheless, it is the duty of executive management to reconcile these tensions.

What has been allowed to emerge is a strongly hierarchical, process-motivated, bureaucratic organisational structure within which responsibilities are allocated, both horizontally and vertically, on an often narrow functional basis. Although these arrangements have created a high degree of vertical control and apparent certainty, they constrain, rather than enable, effective management action. This is particularly important when responding to new and challenging situations, such as that presented by Cornelia Rau. In her case, the 'usual systems' failed.

With such a strong cultural focus on process, the arrangements have created an artificial separation from other clearly interrelated matters, with insufficient opportunity for staff to apply commonsense.

The compliance and detention functions are allocated between two divisions. The Inquiry was unable to find evidence of any effective mechanism for integrating the work of these divisions or provision for executive management intervention in the systems and processes that have been instituted. The fact that Cornelia Rau was detained in a prison for six months suggests that respective responsibilities, accountabilities and oversight arrangements are not clear.

There is little evidence of any meaningful continuity in the management of events and situations. There is, however, a heavy emphasis on procedural compliance, with little attention given to the achievement of outcomes and an apparent absence of risk management. This has limited, rather than facilitated, good immigration detention management and operations.

The present structural model is flawed. Placing the immigration compliance and detention functions in separate divisions not only creates an unnecessary boundary to continuity of executive oversight but also creates an impression that, somehow, these are unrelated functions. Compliance officers do not see themselves as part of the detention division. Physical separation and functional separation create a powerful mindset that ignores continuity of function. In the Inquiry's opinion, the separation very obviously exists at executive management level.

In the dynamic area of immigration detention, the challenge for executive management is to recognise potential weaknesses and ensure that the arrangements for monitoring, assessment, reporting and review are sensitive to the changing environment. In particular, the arrangements should provide for adequate and early feedback to enable corrective action by management, and there should be clear

triggers for involvement and oversight at executive level. Immigration detention operations necessitate a sense of urgency because they affect the lives of real people every day.

The Inquiry observed considerable activity dedicated to processes, but there seemed to be little effort applied to monitoring and managing the system itself or to ensuring effective consultation and coordination between the divisions. There also seemed to be an absence of effective linking between executive management in Canberra and regional operations. Although reporting requirements did exist, there seemed to be little critical consideration in Canberra of what was being provided.

7.3.2 An assumption culture

Within the DIMIA immigration detention function there is clear evidence of an ‘assumption culture’—sometimes bordering on denial—that generally allows matters to go unquestioned when, on any examination, a number of the assumptions are flawed. For example, the following is assumed:

- Section 189 of the Migration Act is a mandatory detention section and there is consequently no capacity and—perhaps more disturbingly—no requirement to review the validity of the exercise of ‘reasonable suspicion’ where it is formed or the basis on which the detention is made.
- Depression is simply a normal part of detention life, which consequently normalises abnormal behaviour in the assessment of medical and mental health.
- Organisational practice and levels of service are ‘about as good as could be expected’, and any deficiencies are essentially a reflection of the difficulty of the task.
- Criticism of the processes or systems is generally voiced by people who do not understand the complexity of the business or have their own agendas and therefore do not need to be considered seriously.

Such perspectives reflect a culture of denial and self-justification that the Inquiry found to be at the heart of the problem. Rigid, narrow thinking stymies initiative and limits the ability to deal successfully with new and complex situations. A wider, questioning and enabling culture is required.

The Inquiry found that these attitudes and perspectives were not, as some believed, confined to operational levels but were pervasive at senior executive management level. Executive managers, including Assistant Secretaries, should be in the vanguard of corporate leadership and should not be shackled by process-driven thinking and unable or unwilling to question existing structures, processes and procedures.

Through its actions and approach, executive management has sent to staff a clear message that process is paramount and should not be questioned. Achieving sensible and effective outcomes has become of secondary importance. An entrenched culture fixed on process and apparently oblivious to the outcomes being achieved should be of great concern to any organisation, but particularly one that must operate in a dynamic, volatile and sensitive policy environment.

7.3.3 Processes, instructions and purpose

The concern for the Inquiry lies not in any lack of instructions and processes. A large number of Migration Series Instructions and Immigration Detention Standards provide instruction and guidance for the care and management of immigration detainees. Rather, the Inquiry is seriously concerned about the culture and attitudes that determine the way in which these instructions and processes are applied and business is done.

There is a management attitude that does not question the instructions and processes and seems to attach little value to explaining to staff the operating context and the purpose of the instructions and processes. The attitude emphasises process and is silent on outcomes. This is dangerous in a volatile portfolio.

Rigorous rules and processes often create a false sense of security. In the case of Cornelia Rau's incarceration in prison for six months, it would be hard to fault the relevant Migration Series Instruction and the guidance it provides. The failure occurred because the requirements of MSI 244 were not adhered to and because there was no effective management oversight and no clear triggers for executive intervention.

It is essential that processes and instructions be accurate and provide guidance to operational staff trying to do their job well. Some of the MSIs seem to be unnecessarily complex, or written by lawyers for lawyers, and are difficult to understand. Some have not been updated for several years. A number of them are being reviewed and interim

instructions written, but the fundamental question of why the instructions are necessary should first be tackled.

Recommendation 7.2

The Inquiry recommends that DIMIA critically review all Migration Series Instructions from an executive policy and operational management perspective with a view to:

- discarding those that no longer apply in the current environment
- where necessary, rewriting those that are essential to the effective implementation of policy, to ensure that they facilitate and guide effective management action and provide real guidance to busy staff
- ensuring that up-to-date, accurately targeted training is delivered to staff who are required to implement the policy guidelines and instructions
- establishing regular management audits that report to executive management, to ensure that the Migration Series Instructions are up to date and DIMIA officers are adhering to them.

It would be difficult to argue with the soundness of the propositions expressed in the Immigration Detention Standards. They are not, however, a statement of requirement or a measure of performance or quality. Their weakness lies in the way they are implemented, monitored and managed and the process and practice requirements imposed—as opposed to in the shortcomings of the people responsible for applying them. In many instances the Inquiry encountered highly committed people trying to operate effectively with instructions and requirements that inhibit or prevent action rather than enable it.

Where an officer or a lower level manager believes that particular arrangements or performance measures are producing bad or negative outcomes, commonsense should prevail and the matter should be raised with executive management. This should be part of the corporate risk management strategy. Given the strength of the existing culture, though, this may not be easy to achieve.

The culture has resulted in the development of performance measures that are largely quantitative or exception based and cannot measure service quality and outcomes in any meaningful way. In particular, the

required quality of health and medical care has not been adequately defined and cannot be monitored by quantitative measures—and especially not by exception measures. Health is a critical and sensitive area for which the requirements need to be clearly defined: more meaningful performance measures and better monitoring arrangements are essential.

7.4 Structure and operations

7.4.1 Structure and cultural change

In summary, the Inquiry formed the view that the DIMIA management approach to the complexities of implementing immigration detention policy is ‘process rich’ and ‘outcomes poor’, with the predominant, and often sole, emphasis being on the achievement of quantitative yardsticks rather than qualitative measures. This approach also fails to deliver the outcomes required by government in a way that is firm but fair and respects human dignity.

Many of these practices have been in operation for a long time and seem to have given rise to an immigration detention culture that, in the opinion of the Inquiry, constrains thinking, flexibility and initiative and concentrates on functions, process and quantitative measurement to the detriment of the achievement of policy outcomes. Such a culture also dulls any sense of urgency, which is a serious weakness because every day that passes in process affects people’s lives.

The Inquiry found that most DIMIA people involved in immigration detention saw themselves as a ‘bit player’, with ‘someone else’ drawing the bits together. The fact that such a perception exists in a very sensitive policy environment should be a warning sign to the executive and serve as a call to action.

Nevertheless, although the Inquiry became aware of a number of inappropriate or defective agreements, arrangements and instructions, it is the strength of the immigration detention culture that is of greatest concern. The deficiencies in practices and procedures can be remedied, and many instructions are being amended. But the attitudes of the people who have responsibility for managing these instructions will take much longer to change. Old values and attitudes must be removed, and a new, enabling culture must be fostered.

The combination of the pressures just discussed has given rise to a culture that is overly self-protective and defensive and presents itself

as largely unwilling to challenge organisational norms or to engage in genuine self-criticism or analysis.

The answer to these difficulties is not to be found in more instructions and procedures; nor is it to be found in creating yet another division. It is the culture and attitudes that are of concern to the Inquiry. Although it could be useful to review the Migration Act with a view to removing any barriers to the exercise of sensible discretion and action, this will not change the culture.

Remedial action calls for major cultural change and attitude realignment. This is challenging for an organisation that must continue to operate throughout the reform process in a complex and sensitive environment. Implementing government policy cannot be put on hold. As an essential starting point, the new organisational focus must be clearly defined and be communicated to all staff. The reform journey will be long, and staff need and deserve a clear context in which to operate.

Reform must come from the top. Executive management must demonstrate consistent commitment to establishing new values and perspectives. These will guide the new way of doing business. On the basis of its investigations and interviews, the Inquiry considers that this is not a task solely for the current executive management responsible for immigration compliance and detention.

The Inquiry notes, however, that the problems have now been acknowledged. The Secretary of DIMIA and members of his senior executive have introduced a 'change management program' aimed at changing attitudes and the way in which immigration detention business is conducted. They are also giving consideration to the creation of a 'change management division'. The Secretary seems convinced of the need to fundamentally improve the 'practice culture' of immigration detention.

Although the Inquiry supports the broad intent of this initiative, it considers that the extensive reforms that are needed cannot come solely from within. It is difficult to see how the people responsible for failed practices, poor decisions and regrettable outcomes would have the credibility and objectivity to bring about the fundamental change of mindset that is necessary. The answer is not to be found in creating yet more structure: that itself sends the wrong message.

In spite of this, the Inquiry agrees with a recent statement by the Minister that DIMIA as a whole is, in many respects, a 'can-do'

department. She said that DIMIA ‘manages a highly successful and rapidly growing skilled migration program; it delivers the world’s third highest refugee and humanitarian intake, backed by the delivery of world-class settlement services for new arrivals’. This could suggest that the serious cultural problems the Inquiry identified within the compliance and detention areas might not be endemic to DIMIA as a whole.

Although the Inquiry was not called on to examine the corporate culture of DIMIA as a whole, the concern of some commentators is that the control-motivated culture evident in compliance and detention might now be dominant. This would need to be carefully dealt with as an integral part of the proposed implementation strategy for the reforms that are essential to the initiatives the Inquiry proposes.

In some circumstances the task of restructuring parts of DIMIA would be a matter for the Secretary. In view of the findings just discussed and the critical importance of the compliance and detention functions to the effectiveness of the Government’s immigration detention policy, the Inquiry considers that in this case the Minister should commission the Secretary to conduct the review and require the involvement of independent professional and experienced advice.

Recommendation 7.3

The Inquiry recommends that the Minister commission the Secretary of DIMIA to institute an independent professional review of the functions and operations of DIMIA’s Border Control and Compliance Division and Unlawful Arrivals and Detention Division in order to identify arrangements and structures that will ensure the following:

- DIMIA’s compliance and detention functions are effectively coordinated and integrated.
- The desired outcomes of these functions and the necessary resources—including the number and the skills profile of staff—are clearly identified before a decision is made on the structure that will best enable effective and equitable service delivery.
- The restructuring accommodates these requirements and ensures that arrangements are made to monitor and manage the high-level risks to the Commonwealth inherent in immigration detention.

- There is a seamless approach to dealing with immigration detention operations and case management.
- The aims and objectives of the Government's immigration detention policy are fairly and equitably achieved and human dignity is demonstrably respected.

7.4.2 The context for operations

The deprivation of liberty and consequent detention of individuals impinge on a basic tenet of democracy and carry with them serious responsibilities. Because of its administrative nature, the lack of any external review and the indefinite detention time frame, immigration detention entails a particular duty of care. These implications must be understood by all DIMIA people associated with exercising this power and must be reflected in the way their duties are performed.

The Inquiry found examples of poor corporate practice and deficient or improperly applied procedures sufficient to satisfy it that DIMIA's immigration detention-related performance does not currently meet the standards of care or requirements for review that should accompany the policy. Cornelia Rau might have been considered a non-citizen but she was not a non-person, and nothing in the manner of her treatment should have allowed this accusation to have any basis in fact.

Many of the deficiencies the Inquiry identified relate to the training currently given to compliance and detention officers. The approach to training seems to be ad hoc and does not adequately cover all the requisite areas. There is no accurate skills profile or skill needs database; nor is there any planned approach to induction or in-service training of sufficient quality to identify skill gaps and to prepare people for the work they are expected to do.

There is an urgent need to develop course content that provides context and better reflects the challenging environment within which staff must operate and better equips them to understand and honour their obligations.

This approach not only requires a more consistent and focused approach to ensuring fair performance of compliance and detention functions; it also requires a move away from the current quantitative training focus towards a much stronger emphasis on qualitative,

values-based training. There should be a fundamental change in focus—from inputs to outcomes.

Recommendation 7.4

The Inquiry recommends that DIMIA:

- review the current training programs for compliance and detention officers to ensure that induction and in-service programs convey an accurate and contemporary picture of DIMIA operations and adequately prepare operational and management staff for all aspects of the work they will be expected to do
- ensure that such training particularly deals with the consultation, coordination, reporting and management requirements of compliance and detention operations and shows how to manage the risks inherent in the performance of these functions
- immediately develop and implement a policy that requires that every decision to detain a person on the basis of 'reasonable suspicion of being an unlawful non-citizen' is reviewed and assessed within 24 hours or as soon as possible thereafter.

DIMIA should incorporate this policy of 24-hour review in all relevant training programs and operational guidelines to ensure that compliance officers understand the need to:

- objectively determine the reasons and facts upon which a decision to detain is made
- verify the validity of the grounds of 'reasonable suspicion' and the lawfulness of the detention
- take immediate remedial action as necessary and report the circumstances of any unresolved matter to the Identity and Immigration Status Group.

7.5 Contracting and government policy outcomes

7.5.1 The contract with GSL

The current detention services contract with GSL is flawed and does not allow for delivery of the immigration detention policy outcomes that are expected by the Government. It is onerous in its application, lacks focus in its performance audit and monitoring arrangements, and transfers the risk to the service provider. Service requirements and quality standards are poorly defined, performance measures are largely quantitative and of doubtful value, and there are financial penalties for non-compliance. This is not a basis for an effective, cooperative partnership.

In particular, the contract leaves the Commonwealth exposed to the risks inherent in the operation of immigration detention facilities. There is no indication that these risks have been recognised or that effective risk management strategies have been developed. The current audits miss the mark.

Although there can be little argument with the contract's general statements about objectives and purpose, achieving the required outputs and outcomes would be highly problematic. The contract places little emphasis on service quality or the establishment of an equitable detention environment, which are vital to the success of the Government's immigration policy. The detention environment is often volatile, but there is no incentive or freedom for the service provider to test or introduce initiatives designed to improve service quality.

In essence, the contract describes a 'master-slave' relationship, not a partnership. It works against commonsense implementation and penalises initiative. An example is DIMIA's attitude to the operating procedures that are tailored to the needs of Baxter. In response to obvious perverse behaviour and unacceptable situations created by slavish adherence to the existing generic Operating Procedures, GSL developed sensible arrangements to better focus performance, increase flexibility and improve detainee management. These changes were supported by DIMIA Baxter management, who saw the positive effects they would have on operations and the quality of detainee management.

DIMIA Canberra, on the other hand, advised GSL that its performance would continue to be measured against its compliance with the generic Operating Procedures unless it (DIMIA) had approved the site-

specific procedures. The new procedures have been under consideration since October 2004. The dilemma for GSL is that if it institutes ‘better practice’ immediately, it runs the risk of being financially penalised if the arrangements are audited. This is nonsense.

The Inquiry notes GSL’s initiative in instituting a policy that no detainee shall be placed in the Management Unit without the personal, signed authorisation of the GSL General Manager. The Inquiry has no sympathy for bad practice being promoted by nonsensical contract requirements that produce outcomes that could call the Government’s policy into disrepute. The Inquiry notes particularly the comment by the Australian National Audit Office in its 18 June 2004 report *Management of the Detention Centre Contracts—Part A*, which dealt with the DIMIA contract with Australasian Correctional Management, the previous service provider. The lessons are relevant to the current contract with GSL. The ANAO stated:

Government, citizens, and other stakeholders all expect different results from government contracting in general. Public policy advocates, interest groups and other stakeholders have additional and potentially incompatible expectations for the contracting out of detention services.

Given the complexity and volatility of the immigration detention environment, the Commonwealth is exposed to significant risks—international, national and individual. The current contract fails to manage these risks; an alternative contracting strategy could provide more effective risk identification and management. The ANAO report also states:

Better practice guidelines consistently state the case for providing reasonable operational flexibility to the provider. Specifying contracts in terms of outputs, not inputs, allows for contractor innovation and consequent efficiency gains. However, this approach is contingent upon the purchaser being able to clearly specify the outputs, including appropriate service quality measures.

The Inquiry strongly supports this view and considers that it applies equally to the current contract.

The current contract and contract management behaviour do not facilitate cooperation and partnership. They do, however, create a culture where the specified performance measures become, by default, entrenched as maximum standards because the service provider’s

focus is on ensuring compliance so as to avoid financial sanction. The nature of activity is created by the contract.

In relation to service requirements and the appropriateness of performance measures and service delivery standards, the ANAO reported:

The ANAO found that DIMIA's Immigration Detention Standards (IDS) were not clear statements of detention service requirements. Rather, key IDS listed statements and activities, and used ambiguous language to define the nature and level of service required. In addition, many of the performance measures did not specify a target that needed to be achieved or articulate the method of assessment.

It concluded:

As the IDS were derived from poorly specified standards and targets, it was difficult for DIMIA to effectively monitor ACM's performance against accepted pre-determined levels of service delivery. Based on this evidence, the ANAO formed the opinion that DIMIA's IDS were not clear statements of detention service requirements for either outputs or inputs.

Performance measures in the contract focus on exception reporting, which ignores the range of problems likely to be encountered in the management of immigration detainees. As the ANAO pointed out:

The audit found that, the majority of methods used by DIMIA to collect information were exception-based. The ANAO acknowledges that exception reporting is a standard contract management tool. However, unless underpinned by quality assurance methods, the use of exception reporting carries the risk of not identifying substandard performance until after service delivery failure has occurred.

It must be emphasised that these comments relate to the ANAO's audit and assessment of the previous DIMIA contract with Australasian Correctional Management. The Inquiry cites the report here, however, because, in its view, little has changed and lessons have not been learnt. The Inquiry was unable to avail itself of Part B of the ANAO report, which deals with the current contract with GSL, because it is under embargo and being considered by DIMIA. But it did have discussions with ANAO officials before it finalised its views.

7.5.2 A way forward

As just noted, the criticisms made by the ANAO relate to the previous contract with Australasian Correctional Management. The reality is, however, that the present contract with GSL was settled before DIMIA received Part A of the ANAO report, and many of the ANAO criticisms remain relevant to the current environment. In particular, the present contract arrangements clearly militate against the achievement of appropriate and desired outcomes at Baxter and, in the view of the Inquiry, have contributed significantly to many of the performance weaknesses the Inquiry identifies.

Many of the problems associated with operations at Baxter could be overcome if a different contracting approach were taken. In high-risk, high-visibility, high-penalty ventures some form of alliance contracting or strategic partnership can offer a way forward. Because they deal with risk, such arrangements need to be tightly and astutely managed, and they demand excellent communication and skill and trust on both sides.

In the complex and volatile immigration detainee environment a real partnership is essential. Contracting in a high-risk environment is more akin to engaging a business partner, where objectives are clarified and pursued jointly, respective responsibilities are defined, and benefits as well as risks and costs are shared. While strict in the delivery of service outcomes and outputs, the arrangements should reward initiative and innovation. They should also provide an incentive for the service provider to work more effectively.

The present contract makes provision for negotiating changes to the arrangements. In the Inquiry's view, there would be significant benefits to the Commonwealth, and to GSL, if the current contract were reviewed in the light of more than a year's experience.

As noted, DIMIA is considering the ANAO audit report on its contracting arrangements with GSL. The Inquiry urges DIMIA to seek from the ANAO a thorough briefing on the findings of that report and seek its guidance on where the most effective improvements might be made. ANAO officials told the Inquiry they would respond favourably to such an approach.

Recommendation 7.5

The Inquiry recommends that DIMIA seek from the Australian National Audit Office a detailed briefing on the findings of the ANAO report on the detention services contract with GSL, to obtain the ANAO's guidance on reviewing the Commonwealth's current detention services contract with GSL and identify where and how changes can and should be made.

The contract review should lead towards arrangements that will more effectively and fairly deliver the outcomes required by the Government's immigration policy. It is the Inquiry's view that DIMIA will need to draw on external experience and skills to identify areas for change to the contract, negotiate them with GSL, and implement and manage the outcomes.

The Inquiry proposes that a Detention Contract Management Group be established to provide to DIMIA direction and advice on the management of the contract. The Group would have membership offering a range of external expertise, with DIMIA providing guidance on immigration detention policy. The Group would guide DIMIA in managing the contract with GSL and be convened periodically and as needed. Among other things, it should draw on state government corrections experience.

Recommendation 7.6

The Inquiry recommends that the Minister establish a Detention Contract Management Group made up of external experts to provide direction and guidance to DIMIA in relation to management of the detention services contract and report quarterly to the Minister. Group members should have expertise in the following areas:

- project management in a high-risk government policy environment
- corrections management
- contracting strategy and management
- performance monitoring and management
- legal contracting and statutory reporting requirements
- management accounting and financial management.

The Detention Contract Management Group should have DIMIA representation at First Assistant Secretary level to advise on policy implications and ensure that the Group's directions are implemented effectively through new departmental arrangements.

A priority task for the Detention Contract Management Group would be to advise DIMIA on the necessary changes to the contract and guide DIMIA in its negotiations with GSL. The purpose would be to negotiate and agree with GSL changes that identify and manage the risks to the Commonwealth, clarify individual responsibilities, improve the delivery of detention services outcomes required by the Government, and place the contracting arrangements on a more practical, fairer footing for both parties.

With the guidance of GSL, the negotiations should include establishing new arrangements for contract monitoring, reporting and management that contribute value to service delivery outcomes and assist in ensuring the provision of high-quality services. The focus of activity should be quality outcomes, not audits that provide little or no added value.

Existing departmental arrangements for managing the contract will probably need to be changed to support the new directions agreed with GSL. The new arrangements should be established under the guidance of the Detention Contract Management Group, which will also advise on monitoring and reporting.

Recommendation 7.7

The Inquiry recommends that, as a priority task, the Detention Contract Management Group review the current contract for detention services and advise DIMIA, in consultation with GSL, in order to identify and agree changes in arrangements that would:

- facilitate delivery of the detention services outcomes required by the Government
- provide the basis for an effective, responsible business partnership that values and encourages innovation by GSL

- encourage GSL to carry out internal audits of its own performance and arrangements in order to maintain high-quality service delivery
- develop, in consultation with GSL, a new regime of performance measures and arrangements for their continued monitoring and management that are meaningful and add value to the delivery of high-quality services and outcomes
- agree with GSL arrangements for independent, external assessment and review as required
- provide for renegotiating arrangements for the provision of health care when the Immigration Detention Health Review Commission and the Health Advisory Panel have been established and have provided advice on new requirements
- foster a shared partnership interest in achieving effective policy outcomes to ensure that the Government's objectives and the high standards of behaviour expected by the Government are met.

8 The Examination of the Vivian Alvarez Matter

8.1 Background

The Examination of the Vivian Alvarez Matter is proceeding well under the leadership of Mr Neil Comrie. A broad analysis of DIMIA and other documentation has been completed, and interviews have been conducted in northern New South Wales, Sydney, Brisbane and Canberra. Civilian, medical, and DIMIA and Department of Foreign Affairs and Trade witnesses have been interviewed and, to date, all prospective interviewees have been prepared to speak with the Examination Team.

Although it is not expected that the Examination will be completed before at least the end of July 2005, sufficient work has been done to allow some comments and findings to be made.

8.2 Summary of events

Vivian Alvarez first came to the attention of DIMIA officers on 2 April 2001, when a social worker in, New South Wales, advised them that a physically injured and apparently destitute Filipina had been found wandering Lismore's streets. The woman was admitted to the Richmond Clinic, the psychiatric ward of Lismore Base Hospital. She claimed to be Vivian Alvarez, born on 30 October 1962 on the island of Cebu in the Philippines. DIMIA officers first interviewed Ms Alvarez on 3 May 2001.

During the next few days Ms Alvarez told differing stories about the circumstances of her arrival in Australia. Although she was moved to various medical centres, she basically remained in hospital from 2 April 2001 until a week before her removal from Australia on 20 July 2001.

DIMIA records note that on 23 April 2001 a social worker at Liverpool Hospital in Sydney advised that Ms Alvarez had become more lucid and had said she came to Australia on a spouse visa and had been beaten by her husband. Searches of relevant DIMIA

immigration databases apparently revealed no record of a Vivian Alvarez entering Australia under that name or of her possessing a spouse visa.

Between 23 April and 13 July DIMIA continued to interview Ms Alvarez and to make inquiries in order to determine her immigration status. DIMIA officers made written reference to the fact that Ms Alvarez could have been a sex slave. At present there is no indication that she ever made this claim; it seems to be an assumption on the part of a DIMIA officer.

On 7 June a DIMIA file note recorded that medical advice had been received that Ms Alvarez's rehabilitation was not progressing well and she was refusing all offers of assistance.

Three bridging visas were issued in her favour, to remove the requirement to place her in detention. The first of these was issued on 3 May 2001; the third was issued, for a period of 24 hours, on 12 July. Ms Alvarez was placed in detention on 13 July 2001, a week before her removal.

On 12 July a memo from St Vincents Hospital in Sydney informed DIMIA that Ms Alvarez had been discharged from hospital that day with 'C4-5 incomplete quadriplegia 11 to central disc herniation and ... she walks with a 4 wheel walker for safety (gait problems and hand weakness)?'.

On the same day Ms Alvarez was transported to DIMIA offices in Southport in south-east Queensland for an interview. During the interview she said she had married a Philip Smith in Cebu on 29 November 2000 and that after the marriage she was interviewed at the Australian Embassy in Manila. She said she had returned to Australia with Mr Smith some 45 days after her marriage and gave details of abusive treatment by him and having been 'kicked out' of their house. This account has not been confirmed.

DIMIA checked its ICSE, TRIM and MPMS databases and with Passports but could find no record of Mr Smith on the dates provided or any record of movement for Vivian Alvarez. Thus far it has not been possible to locate any evidence to substantiate Ms Alvarez's claim of her marriage to a Philip Smith.

DIMIA conducted a formal interview with Ms Alvarez on 13 July, during the course of which Ms Alvarez again claimed to have a visa

and, according to the DIMIA record of interview, that she ‘would like to stay in Australia and does not want to leave voluntarily’.

The same day a Request for Officer to Hold in Immigration Detention form was issued in the name of Vivian Alvarez on the basis that she was known or reasonably suspected to be an unlawful non-citizen. Ms Alvarez was then detained at the Airport 85 Motel in Brisbane from 13 July until 20 July. The file records that Ms Alvarez ‘has limited mobility and uses a walking frame to move around’. The Department of Foreign Affairs and Trade was notified that Ms Alvarez would need assistance on arrival in the Philippines.

At about this time—on the evidence of sequential file notes—a handwritten, unsigned and undated note appears in a DIMIA file: ‘smuggled into Australia as sex slave wants to return to the Philippines. Has been physically abused’. This information conflicts with that provided by Ms Alvarez during her formal interview on 13 July and has not been substantiated by the Examination Team.

The Examination Team is aware of an exchange of correspondence between the Philippines Embassy and the Honorary Consul-General in relation to Ms Alvarez’s fitness to travel.

On 19 July a number of incidents of significance occurred.

Ms Alvarez was examined by a doctor, a locum at a clinic in Spring Hill, Brisbane, who assessed her as fit for air travel.

A DIMIA manager briefed a senior DIMIA executive on the concerns raised by the Philippines Embassy and the fact that the Embassy would not issue a travel document. Later that day a travel document was issued.

An officer of the Queensland Police Service’s Missing Persons Bureau sent a faxed message to a DIMIA officer stating:

Intell currently making urgent inquiries into a Missing Person. This Missing Person is of Philippino extraction. Could inquiries please be made to ascertain if the missing person has travelled from Australia since the 18/2/01. Any info on this person would be appreciated. Missing Person Vivian SOLON @ Young D>O>B> 23/10/63 @ 30/10/63 @ 30/8/62 @ 30/10/62.

DIMIA Investigations forwarded a response to the Missing Persons Bureau, stating, ‘Departmental records show that Vivian Alvarez

SOLON @ YOUNG (30/10/62) last arrived in Australia 2/9/93. There is no record of departure since that date’.

The following day, 20 July 2001, Ms Alvarez was removed from Australia and travelled to Manila on Qantas flight QF019 in the company of a female Queensland Police Service officer, who acted solely as an escort. On arrival at Manila airport Ms Alvarez was left in the care of a representative of OWWA, a Philippines support agency.

Officers from the Missing Persons Bureau continued to make inquiries about Ms Alvarez during the remainder of 2001 and throughout 2002. Further inquiries were also made with DIMIA. In late 2002 and during 2003 the nature of the inquiries was widened and the Homicide Investigation Group and New South Wales Police became involved. The police missing persons inquiries throughout this period seem to have been extensive and thorough.

During July 2003 the Queensland Police Service asked DIMIA to make further inquiries, including citizenship inquiries, about Vivian Solon and to carry out travel checks for Solon/Young/Cook. On 20 August details (including a headshot photograph of Ms Alvarez and using the names Alvarez/Solon) provided by Queensland Police Service to Channel 9 television station was broadcast at the end of the *Without a Trace* program.

Because the Examination of the Vivian Alvarez Matter is still in progress it is inappropriate at this time to canvass further details of events in 2003 and 2004. It is clear, however, that several DIMIA officers—including executive-level officers—became aware in 2003 and 2004 that the Vivian Alvarez removed from Australia on 20 July 2001 was the person publicised on television on 20 August 2003 and she was an Australian citizen. This evidence arose in the course of interviews conducted by the Examination Team and is contained in an internal audit-style report on the Alvarez case provided to the Secretary of the Department on 11 May 2005.

8.3 The facts at issue

Although Vivian Alvarez provided a number of names to DIMIA officers during the three months preceding her removal from Australia in 2001, it is clear from DIMIA’s own records that she had claimed to have come to Australia on a visa.

Despite this knowledge, the same DIMIA records make at least two references to DIMIA officers' view that Ms Alvarez was an unauthorised, undocumented arrival who might have been manipulated by certain people for sexual purposes or had been smuggled into Australia as sex slave and 'wants to return to the Philippines'. This last, undated statement is in direct conflict with Ms Alvarez's statement in her formal interview on 13 July 2001 that she wanted to stay in Australia and did not want to leave voluntarily.

In response to the Queensland Police Service missing persons inquiry to DIMIA about 'Vivian Solon @ Young', made on 19 July 2001—the day before Ms Alvarez was removed from Australia—DIMIA sent the Queensland Police Service a message identifying the missing person, using the name Alvarez and detailing her date of birth as 30 October 1962.

DIMIA's records allowed it to advise the Queensland Police Service on the same day of the name Alvarez and to identify which of the four dates of birth listed by the Queensland Police Service in its request was correct. The date of birth quoted by DIMIA in its correspondence that day was the same as that given by Ms Alvarez when she had first been spoken to by DIMIA, on 3 May 2001. It was also the date of birth under which she was removed from Australia on 20 July.

There is no evidence to suggest that at that time any DIMIA officer involved with the removal of Vivian Alvarez was aware that the person who was removed from Australia on 20 July 2001 was an Australian citizen or a reported missing person. The Examination Team suggests, however, that the officer *should* have known and that any thorough and objective inquiry would have established this fact.

An internal DIMIA document-based audit of the Alvarez/Solon/Young files after the fact of Ms Alvarez's unlawful removal from Australia became public in April 2005 makes reference to two things of particular significance:

- First, had what is termed a 'wildcard' search been conducted on the DIMIA ICSE or TRIM databases, a match for Solon/Young would have appeared within the first 70 data matches.
- Second, although an audit of DIMIA systems for the period April to 20 July 2001 showed that the Vivian Solon/Young records were not accessed, the same audit showed that they *were* accessed twice on 23 July 2001 (three days after Ms Alvarez was removed) and once on 27 August 2001. On 24 August 2001 Vivian Alvarez's

debt to the Commonwealth for the cost of removal was written off by a DIMIA officer.

In relation to the first point, in discussions with the Examination Team in May 2005 DIMIA information technology officers acknowledged that DIMIA's IT systems are flawed, are not effectively networked, and do not have any relational database capacity. They also acknowledged that the wildcard search capacity existed in 2001 but that use of it was, and still is, discouraged because it uses too much computer power and had almost shut down the departmental training system. Some doubt exists in relation to the actual wildcard search capacity: this is further discussed in Section 8.4.1.

8.4 Initial findings

The removal of Vivian Alvarez occurred in 2001 and led to events, practices and actions in 2003 and 2004, most of which strongly corroborate and confirm the systemic nature of the problems identified in the Cornelia Rau Inquiry. An initial analysis of other cases referred to the Inquiry for examination shows that many of the same causal factors seem to be present.

The strong possibility that the same factors have contributed to the inappropriate detention of a number of other people over an extended period should give rise to serious concern.

Although the Examination of the Vivian Alvarez Matter is not complete, the Examination Team has identified a number of underlying causes that are similar to those the Cornelia Rau Inquiry finds to be of crucial importance. The causes fall into four broad categories, as follows.

8.4.1 Databases and operating systems

The problems associated with DIMIA information systems relating to immigration detention and compliance are of such magnitude that they should be subject to urgent, thorough, independent review and analysis by an experienced, appropriately qualified IT systems analyst. The review should identify the real organisational policy and operational information management requirements and assess whether these requirements can be met cost effectively by further development of existing systems under the current architecture or whether an alternative development direction is necessary.

This concern arises from the fact that the DIMIA database infrastructure is ‘siloeed’, with little connectivity between systems. Important information that needs to be linked frequently for reasons of operational effectiveness and integrity is not effectively networked and does not have an appropriate relational database capacity. The result is that there is limited search capacity.

It needs to be understood, however, that until the late 1980s data integration opportunities were limited. As a result, systems developments carried out by DIMIA were in keeping with data standards of the time and have been subject to ongoing improvement. The ICSE system itself was implemented in the mid-1990s with the aim of integrating front-counter processing systems and citizenship records. This undertaking resulted in 14 large, separate processing systems progressively being integrated into one system, with the dual purposes of improving integration of onshore client data and redressing compatibility problems.

In his statement to the Senate Estimates Committee, the Secretary of DIMIA said the following:

It is unacceptable that individuals should be disadvantaged by shortcomings in the entering of records or by systems which do not have adequate linkages. We have over the past year strongly reinforced with our officers the importance of improving our records, and our state directors have been charged with driving improvement in this area. In terms of our IT systems, we have set in train processes to integrate the detention records of the department and our detention services provider, with the aim of having a single client record for detainees, and to link DIMIA and Review Tribunal systems to ensure that data about a person’s status are up to date.

The Inquiry welcomes this commitment, but it is obvious that more needs to be done.

Recommendation 8.1

The Inquiry recommends that, as an urgent priority, DIMIA commission a thorough, independent review and analysis of its information management systems. The review should be carried out by an experienced, appropriately qualified information technology systems specialist and should aim to:

- identify the real organisational policy and operational information management requirements—particularly requirements for interconnectivity, search capacity and growth
- assess whether these requirements can be met cost effectively by further development of existing systems under the current architecture
- if not, identify the broad development parameters and indicative cost and time frame for implementation
- formulate an implementation plan for consideration by the DIMIA executive.

DIMIA staff seem to have a generally poor understanding of the capacity and functionality of departmental systems and how to search for and obtain information. For example, the wildcard search capacity was available in 2001 but, despite the obvious doubts that existed about Vivian Alvarez's immigration status, there is no evidence that any thought was given to its use. The strong indication is that most, if not all, of the staff involved, either in 2001 or in 2003 and 2004, were unaware that a wildcard capacity existed.

In its formal response to the Inquiry, DIMIA referred to a recent analysis (forwarded to the Inquiry) of the searching capacity within DIMIA systems that demonstrated that wildcard searches are not actually a feature of the system. The situation seems a little unclear. In paragraph 37 of an internal report on the Alvarez incident (commissioned by the Secretary and submitted to him during May 2005) the following statement is made:

37 If a so-called 'wild card' (no surname but 'Vivian' and 1962') search is conducted on either ICSE or TRIM, however, a large number (201) of data matches are produced including the 'Solon/Young' records (these occur within the first 70 matches). A careful and comprehensive 'trawl' through those records would at least have enlivened a capacity for officers at the time to identify that Ms Alvarez was Australian citizen Ms Solon/Young. The files do not reveal whether or not such a 'wild card' search was conducted. Even if one was, again the systems access audits show the 'Solon/Young' files were not accessed and the link was not made.

However, a minute DIMIA forwarded to the Inquiry on 30 June provided information about name-search functionality available to

DIMIA compliance officers in Australia using the ICSE and TRIPS systems, which indicates the search capacity in May 2001 was more limited. The document states that wildcard searches are not available for name searching within ICSE or TRIPS because the name-search routines ignore non-alpha characters. In particular, it seems the name search within ICSE cannot be conducted if the family name field is left blank.

On this latest advice, however, if a competent systems search—described in the earlier report as a wildcard search—had been based on ‘Vivian’ in the family name field, the Australian citizenship records for Vivian Solon/Young and the alias of Vivian Solon would have been returned, along with the correct date of birth, 30 October 1962. As the Inquiry understands the situation, on either interpretation the capacity existed in 2001 for DIMIA officers to have identified Vivian Alvarez as an Australian citizen.

The Inquiry’s conclusion that DIMIA staff have a generally poor understanding of DIMIA systems is overwhelmingly based on the statements of field and operational staff. Staff consistently spoke of difficulties they experienced in doing their jobs.

In particular, claims were made about a lack of properly focused training and inadequate systems. Frequent reference was made to the inability to make single-entry searches across related DIMIA databases, and there appeared to be a confused understanding of the systems’ capacity—even among staff with direct responsibility for management and maintenance of the systems. This situation must be redressed.

As a matter of priority, DIMIA systems should be linked to, or have well-understood authorised access to, all Immigration Review Tribunal information systems, sufficient to ensure that the names and immigration status of people whose circumstances are subject to review are readily available to DIMIA compliance officers. On an initial analysis, this deficiency appears to have been the primary cause of a significant proportion of wrongful detentions among the additional matters referred to the Inquiry.

Recommendation 8.2

The Inquiry recommends that, as a priority, DIMIA take steps to establish links or authorised access to the Immigration Review Tribunal's information systems, sufficient to ensure that the names and immigration status of people whose circumstances are subject to review are readily available to DIMIA compliance officers.

8.4.2 Training and selection

From the mid-1990s until about two years ago DIMIA compliance officers basically received no training other than on-the-job training. Many current compliance officers have had very little or no formal training for their role. As a consequence, they have only a limited understanding of the legislation they are required to enforce, the powers they are authorised to exercise, and the implications of those powers.

The current induction training package for compliance officers is inadequate. Officers with direct responsibility for detaining people suspected of being unlawful non-citizens and for conducting identity and status inquiries frequently lack even basic investigative and management skills and have an inadequate knowledge of the capability of DIMIA information systems.

There is no evidence of the existence of a corporate skills profile or any systematic selection process for compliance officers that is likely to ensure that staff considered for compliance duties have the requisite skills and personal attributes.

8.4.3 Case management

There is an almost complete lack of holistic case management. Case management is fragmented and inefficient in terms of both staff responsibility and empowerment. The current arrangements lack rigour and accountability, and there is no effective oversight and review mechanism.

8.4.4 Culture

DIMIA is a rigidly hierarchical organisation with a ‘siloes’ divisional compliance and immigration detention structure. DIMIA argued that large, distributed organisations need to rely on hierarchical organisational structures as a way of managing issues, information and outcomes. No single organisational structure is perfect, but the Inquiry is concerned that where hierarchical structures are established they must be well supported by effective communication links and information sharing and by a consultative, facilitating and enabling culture.

The Inquiry found that within DIMIA compliance and immigration detention the support arrangements were generally weak and ineffective.

There was an obvious lack of sensible staff empowerment, resulting in an almost excessive focus on and preoccupation with process. The focus seems to change only when there are adverse outcomes that DIMIA must deal with. In the Inquiry’s view, change seems to be crisis generated and not initiated by self-criticism of departmental actions, processes and outcomes.

Examples of this are the Rau Inquiry, the events generated by the Vivian Alvarez matter, and the 200 other cases referred to the Rau Inquiry. As noted, even a preliminary analysis of these additional referred cases illustrates the recurrent nature of the causal factors that appear to have given rise to the wrongful detentions. None of these factors seems to have been identified or responded to as part of normal management and quality assurance processes before this Inquiry began. Given that the cases in question span a period of some six years, this apparent lack of response is a serious concern. Effective management and oversight practices would have led to identification of the problems and ensured remedial action within a matter of weeks.

It is important to recognise, however, that the Secretary of DIMIA acknowledged in his statement to the Senate Estimates Committee that mistakes had been made. He noted that some aspects of the legislative regime are not flexible enough and that DIMIA recognises the need to further develop an organisational culture—or a set of attitudes, values and approaches—that gives greater assurance that the Department is securing outcomes that are lawful and sensible and will be found appropriate under the light of scrutiny. The Inquiry fully supports these stated objectives, but it considers that the Secretary will need independent support, as well as strong executive management support, to achieve these aims.

The tendency on the part of staff to consider that their job is done ‘if they kick it up to the next level in the chain’ or to simply ‘apply the rules’ was evident in the Rau Inquiry and is being confirmed in the Vivian Alvarez Examination. There does not seem to be wider ownership of issues and consequences; nor does there seem to be identification with DIMIA’s objectives, goals and outcomes.

A particular concern of the Alvarez Examination Team is that—even in the light of all the facts that are now publicly known about the handling of Cornelia Rau and Vivian Alvarez—a preoccupation with process and a culture of denial and defensiveness continue to exist. The Team’s concern is increased by its finding that the attitudes are not solely reflected at the operational level but also at the middle and senior executive management levels.

Throughout all aspects of both the Inquiry and the Examination there was, with few exceptions, been consistent evidence of reluctance at middle management and senior executive management levels to accept responsibility and acknowledge fault. The Secretary’s statement to the Senate Estimates Committee acknowledged fault and committed the Department to objectives the Inquiry supports.

DIMIA officers are authorised to exercise exceptional, even extraordinary, powers. That they should be permitted and expected to do so without adequate training, without proper management and oversight, with poor information systems, and with no genuine checks and balances on the exercise of these powers is of great concern. The fact that this situation has been allowed to continue unchecked and unreviewed for several years—and is still not fully understood and accepted by the executive management concerned—is difficult to understand.

There is no documentary or other evidence that any DIMIA officer personally made the decision to remove Ms Alvarez from Australia. Rather, DIMIA officers have said they acted, as a matter of course, under the provisions of the Migration Act.

In a recent formal interview a senior DIMIA executive asserted that the power to remove from Australia a person reasonably suspected of being an unlawful non-citizen 'does not require a decision' because it is required by the Act. Even when questioned about the importance of review and supervision to ensuring the propriety of any action to remove a person, the interviewee seemed reluctant to accept that supervision and review of decisions to detain and remove are crucial to good governance and operational integrity.

Such an attitude is very worrying.

Recommendation 8.3

The Inquiry recommends that DIMIA:

- develop, for all immigration detention and compliance executives and managers, a briefing program that clearly explains the need for a decision to be made to remove from Australia a person reasonably suspected of being an unlawful non-citizen and the responsibilities associated with exercising that power
- ensure that the central factors relating to removals and the implications for identity investigations and the exercising of detention powers are included in departmental training programs for compliance and removals officers
- ensure that the implications of all aspects of identity checking, detention and removals are included in the checks and balances exercised by the Identity and Immigration Status Group.

Appendix A The Inquiry's terms of reference

On 9 February 2005 the Minister for Immigration and Multicultural and Indigenous Affairs, Senator the Hon. Amanda Vanstone, issued the following terms of reference for the Inquiry into the Circumstances of the Immigration Detention of Cornelia Rau:

The Inquiry will investigate, examine and report on matters relating to the case of Cornelia Rau, including in particular the actions of DIMIA and relevant state agencies, during the period March 2004 to February 2005.

In particular the Inquiry will:

- examine and make findings on the sequence of events that gave rise to her being held in immigration detention
- examine and make findings on the circumstances, actions and procedures which resulted in her remaining unidentified during the period in question
- examine and make findings on measures taken to deal with her medical condition and other care needs during that period
- examine and make findings on the systems and processes of, and cooperation between, relevant state and commonwealth agencies in relation to identification/location of missing persons and provision of mental health services
- recommend any necessary systems/process improvements.

The Inquiry will need to request the support and cooperation of relevant state agencies.

The Inquiry will report by 24 March 2005.

On 27 February 2005 the Minister extended the time for the Inquiry and agreed to provide additional resources. An interim report was presented to her on 23 March 2005.

On 2 May 2005 a request to examine the circumstances surrounding the removal from Australia of Ms Vivian Alvarez/Solon/Young, an Australian citizen, was referred to the Inquiry by the Acting Minister

for Immigration and Multicultural and Indigenous Affairs, the Hon. Peter McGauran MP.

The terms of reference for the Rau Inquiry were extended to include the following:

In addition to your examination of Ms Rau's case, also examine and make findings on any other cases involving Australian citizens or other people lawfully in Australia who have been subject to detention or removal from Australia, which may be brought to your attention by the Minister during the life of your Inquiry into the Cornelia Rau Matter. On the basis of your findings you should recommend any necessary systems/process improvements and, if appropriate, refer any matters to relevant authorities or agencies.

Following discussion with the Minister, it was agreed that the Inquiry's report on the Cornelia Rau matter should not be delayed pending the completion of inquiries into other matters. It was decided, however, that any issues and preliminary findings identified by the Examination of the Vivian Alvarez Matter during the term of the Rau Inquiry would be taken into account and discussed in this report.

At the time of submission of the report of the Rau Inquiry, recommendations were also to be made in relation to the appropriate form of examination of other matters that might be referred to the Inquiry. These recommendations have been forwarded to the Minister separately.

Appendix B People interviewed

The following people were interviewed by the Rau Inquiry team; among those listed are DIMIA senior executives with whom formal discussions were held. More informal discussions were also held with a wide range of people and groups, including with immigration detainees at Baxter Immigration Detention Facility; these individuals are not listed here.

Administrative Review Council

Cornall, Robert—member

Creyke, Professor Robyn—member

Martin, Wayne QC—President

Harrison-Smith, Margaret—Executive Director

Australian Federal Police

Drennan, Peter—Federal Agent, National Manager, Special Operations

Russ, Jenny—Manager, Economic and Special Operations

Australian National Audit Office

Collareda, Rebecca—Senior Performance Analyst

Lack, Steven—Executive Director

Meert, John—Group Executive Director, Performance Audit Services Group

Watson, Greg—Senior Director, Performance Audit Services Group

Brisbane Women’s Correctional Centre

McCallum-Clarke, Sharon—General Manager

Collins, Scott—Acting General Manager

Holmes, Evelyn—Correctional Manager

Todd, Dr Bryan—Visiting Medical Officer

Centre for International Mental Health

Minas, Associate Professor Harry—Director

Commonwealth Ombudsman

McMillan, Professor John—Commonwealth Ombudsman

Brent, Ron—Deputy Ombudsman

Durkin, Mary—Senior Assistant Ombudsman

Masri, George—Director, Immigration Investigations

Consulate of the Federal Republic of Germany

Kessler, Thomas U—Consul-General, Melbourne

Korbes, Teresa M—Vice-Consul, Consular and Legal Affairs,
Melbourne

Raymond-Indorato, Iris—Honorary Consul, Cairns

Reising, Enis—Vice Consul, Sydney

Sulzer, Detlef—Honorary Consul, Brisbane

Woerner, Dr Claus Peter—Deputy Consul-General, Sydney

Consultant Psychiatrist to Baxter Immigration Detention Centre, Port Augusta

Frukacz, Dr Andrew—Consultant Psychiatrist, Visiting Medical
Officer

CrimTrac

Burns, Duncan—Project Manager, CPRS Project

Furry, Craig—Assistant Director, Strategic Support and
Communications

Van Lohuizen—Clifford, Director IT

Mobbs, John—Chief Executive Officer

Ovijach, Karl—Director, Strategic Support and Communications

Wray, Ian—CPRS Nationwide Policing Adviser

Detainee advocate groups: Port Augusta

Bernhardt, Stephen—Baxter visitor

Verran, Kathy—Rural Australians for Refugees

Verran, Tim—Rural Australians for Refugees

Wauchope, Bernadette—Baxter visitor

DIMIA, Canberra

Allan, Tracie—Assistant Director, Removals Policy and Operations Section

Bickford, Sharon—Removals Policy and Operations Section

Carl, Ashley—Case Coordinator, Detention Case Coordination Section

Davis, Steve—First Assistant Secretary, Unauthorised Arrivals and Detention Division

Doherty, David—Assistant Secretary, Detention Contract and Infrastructure Branch

Farmer, William—Secretary

Fleming, Garry—Assistant Secretary, Detention Policy and Coordination Branch

Godwin, Philippa—Deputy Secretary

Keenan, Annette—Director, Arrivals and Detention Centre Coordination Section

Killesteyn, Edward—Deputy Secretary

Malone, Tracey—Case Coordinator, Baxter

McMahon, Vincent—Executive Coordinator, Border Control and Compliance Division

O'Brien, Annabelle—Director, Detention Case Coordination Section

Reid, Alan—Assistant Director, Detention Case Coordination Section

Stoneley, Benjamin—Movements and Removals Officer, Compliance Officer, Brisbane

Williams, Jim—Assistant Secretary, Unauthorised Arrivals and Detention Operations Branch

DIMIA officers: Baxter Immigration Detention Facility

Heyen, Gerry—Deputy Manager

Kannis, Kaye—Manager

Lee, Narelle—Removals Officer, Case Coordinator

Ryhs-Jones, Justin—Case Coordinator

DIMIA officers: Brisbane

Holthouse, Peter—Manager, Compliance and Investigation

McCarthy, Paul—Acting Manager, Compliance and Investigation

Stone, Matthew—Compliance Officer

Watson, Wendy—Senior Inspector, Brisbane Airport

DIMIA officers: Cairns

Burke, Patimah—Regional Manager, North Queensland

Moolenschot, Aiden—Seaports Officer

Wisegibber, John—Compliance Officer

Exchange Hotel: Coen

Santowski, Brett—publican and licensee

Santowski, Roslyn—publican and licensee

Global Solutions Limited

Alchin, Stephen—Detention Services Officer

Capel, Ian—Detention Operations Coordinator

Eagle, Elizabeth—Operations Manager

Ellison, Shirley—Detainee Case Management Coordinator

Keegan, Jim—General Manager, Transport and Security Services

Keon, Alida—Detention Services Officer

Kirkhope, Benjamin—Detention Services Officer

Kotsopoulos, Hester—Detention Services Officer

Olszak, Peter—Managing Director

Paternoster, Ian—Detention Services Officer
Richards, Eric—Detention Services Officer
Ryan, Michael—National Operations Manager
Saxon, Peter—General Manager, Baxter
Shelley, Gaye—Protection Services Officer
Smith, Jason—Detention Services Officer
Tassone, Michael—Accommodation Coordinator
Tegousis, Maria—Detention Services Officer

Health Centre: Coen

Shepherd, Barbara—registered nurse

Human Rights and Equal Opportunity Commission

Ozdowski, Dr Sev OAM—Human Rights and Disability
Discrimination Commissioner

Immigration Detention Advisory Group

Alsalami, Dr Mohammed Taha—member
Aristotle, Paris AM—member
Conroy, Sister Loreto—member
Funnell, Air Marshal Ray AC (ret'd) —member
Glenny, Major General Warren AO RFD (ret'd) —member
Hand, the Hon. Gerry—member
Hodges, the Hon. John—Chair
Minas, Associate Professor Harry—member

International Health and Medical Services

Mulholland, Janelle—National Operations Manager
Norris, Vicki—registered nurse
Parkes, Tracie—Health Services Manager
Shroff, Dr Berzad—medical practitioner, Carlton Medical Services,
Port Augusta

Mental Health Council of Australia

Hickey, Professor Ian—board member
Mendoza, John—Chief Executive Officer
Nesbit, Deborah—Communications Manager
Wilson, Keith—Chair

New South Wales Department of Health: Manly Hospital

Bullock, Michael—Clinical Nurse Consultant
Ladd, Dr Dennis—Staff Specialist

New South Wales Police Service: Sydney

Bell, Murray—Detective Senior Constable, Manly Police Station
Bellemore, Pauline—Acting Commander, Hornsby Police Station
Ellis, Briana—Plain-clothes Constable, Criminal Investigations,
Manly Detectives
Hargreave, Shannon—Constable, Hornsby Police Station

Northern Beaches Mental Health Service: Sydney

James, Paula—Director, Northern Beaches Mental Health Service

Park Centre for Mental Health: Brisbane

Smith, Tamara—Psychologist, Prison Mental Health Service
Pedley, Robert—Team Leader, Prison Mental Health Service

Princess Alexandra Hospital: Brisbane

Aciu, Dr Mirciulina—Psychiatric Registrar
Cross, Dr Robyn—Psychiatric Registrar
Schneider, Dr Paul—Consultant Psychiatrist

Office of the Privacy Commissioner

Curtis, Karen—Privacy Commissioner
Pilgrim, Timothy—Deputy Privacy Commissioner

Professional Support Services

Borg, Edith—Psychologist

Hinton, Elizabeth—Clinical Director

Micallef, Adam—Psychologist

Walker, Robyn—Counsellor

Queensland Health

Hannah, Dr Dominique—Visiting Specialist, Prison Mental Health Service

Kingswell, Dr William—Director, Integrated Forensic Mental Health Service

Queensland Police Service

Anderson, Tony—Sergeant

Fitzpatrick, Dennis—Senior Sergeant

Foy, James—Acting Senior Constable

Port, Barry—Police Tracker

Rau family

Rau, Edgar—father of Cornelia Rau

Rau, Veronika—mother of Cornelia Rau

Rau, Christine—sister of Cornelia Rau

The University of Newcastle Legal Centre—lawyers for the Rau family

Religious groups: Port Augusta

Bourke, Father Paul—Catholic priest, Whyalla

Foale, Sister Anne—Sister of Mercy

Hurley, Bishop Eugene—Diocese of Port Pirie

Sealey, Sister Patricia—Josephite Sister

Royal Adelaide Hospital: Glenside Campus

Malone, Mary—Director, Glenside Campus Mental Health Service

McKenny, Dr Brian—Senior Visiting Medical Specialist in Psychiatry

Rural and Remote Mental Health Services

Fielke, Dr Ken—Clinical Director

Kelly, Dr Fiona—Director

South Australian Department of Health

Durrington, Leanne—Executive Director, Mental Health Services

Phillips, Dr Jonathan—Clinical Associate Professor, Director, Mental Health

South Australia Police

Holland, John—Senior Constable First Class, Port Augusta

Appendix C Anna's placements at Baxter

Upon arrival at Baxter Immigration Detention Facility Anna was placed in Blue One Compound and remained there until 15 October 2004. Because, it is alleged, she was behaving disruptively—walking into other detainees' rooms, being provocative to male detainees and staff, and standing naked in front of an open window, for example—she was moved to Red One B.

Anna was placed on a Red One B Behaviour Plan. This permitted eight hours' time out each day (in two-hour blocks), unlimited incoming telephone calls, but no personal or inter-compound visits.

On 25 October 2004 Anna signed a new behaviour management plan. On 30 October, however, it appears she committed a minor assault, grabbing a GSL officer by the wrist and pushing her in the back. A response team was called to restrain Anna.

On 5 November the Red One B Behaviour Plan was modified to allow personal visits, but the time out remained at eight hours a day (in two-hour blocks) between 08.00 and 22.00. In addition, Anna was allowed one outgoing telephone call a day, and incoming calls were allowed between 08.00 and 22.00. The Plan contained seven behavioural objectives, among them no assaults or threats to GSL staff, DIMIA staff or other detainees; no abusive language; compliance with instructions; no deliberate damage; and no self-harming.

On 7 November Anna refused to comply with a direction from a GSL officer and kicked the officer in the groin. She was placed in the Management Unit the next day and remained there until 12 November. During this time she was on the Management Unit Management Plan.

Anna was returned to Red One B on 12 November, with additional conditions to her behaviour management plan relating to the amount of property allowed in her room. In exchange, she was allowed one visit to Blue Compound each afternoon if she wished.

Anna was returned to Blue One on 17 November, on a new behaviour management plan, in an attempt to reintegrate her. The plan restricted her movements and required her to participate in daily social and

educational activities, with the condition that if she did not cooperate she would be returned to Red One.

On 22 November 2004 Anna was relocated to the Management Unit because she was again behaving inappropriately—entering other detainees’ rooms uninvited, leaving rubbish in the compound, taking other detainees’ cigarettes, eating other detainees’ food, using foul language in the mess and recreation rooms, and so on.

At the Management Unit Review Team meeting on 23 November Professional Support Services recommended that Anna not be held in the Management Unit and be transferred to Red One. The Review Team noted that the main problem seemed to be that no one understood how to handle her behaviour. They considered moving Anna back to Red One immediately and then to Blue One but thought this would be too unsettling for her. It was decided to leave her in the Management Unit until she could be returned to Blue One. Anna remained in the Management Unit until 30 November, when she was returned to Red One B. On 20 January 2005 she was moved to Red One A and remained there until she was identified as Cornelia Rau and released on 3 February 2005.

Anna committed minor assaults on GSL staff on 8 and 23 December 2004. On 24 December a dot-point guide to dealing with her, prepared by the Professional Support Services psychologist, was distributed to staff, noting that she was unpredictable and prone to violence without provocation.

Four attempts were made to reintegrate Anna back into Blue Compound during December 2004, but she refused to cooperate and follow protocol. Her behaviour remained disruptive and non-compliant throughout her time in Baxter, and she persisted in the attitude that she had done nothing wrong.

Shortened forms

AFP	Australian Federal Police
ANAO	Australian National Audit Office
APMC	Australasian Police Ministers Council
Baxter	Baxter Immigration Detention Facility
BWCC	Brisbane Women's Correctional Centre
COAG	Council of Australian Governments
DIMIA	Department of Immigration and Multicultural and Indigenous Affairs
<i>DSM</i>	<i>Diagnostic and Statistical Manual of Mental Disorders</i>
Glenside	Glenside Campus of Royal Adelaide Hospital
GSL	Global Solutions Limited (Australia) Pty Ltd
ICD	International Classification of Diseases
IDAG	Immigration Detention Advisory Group
IDC	immigration detention centre
IDF	immigration detention facility
IDS	Immigration Detention Standard
IHMS	International Health and Medical Services
IPP	Information Privacy Principles
MNPP	Minimum Nationwide Person Profile
MOU	memorandum of understanding
MSI	Migration Series Instruction
MURT	Management Unit Review Team
NAFIS	National Automated Fingerprint Identification System
NCIDD	National Criminal Investigation DNA Database
NEPI	National Exchange of Police Information
NMPU	National Missing Persons Unit
NNI	National Names Index
OP	Operating Procedure
PAH	Princess Alexandra Hospital
PSS	Professional Support Services
RPO	Removals Policy and Operations Section
RRMHS	Rural and Remote Mental Health Service
WWOOF	Willing Workers on Organic Farms