New South Wales
Council for Civil Liberties

NSWCCL SUBMISSION

Senate Legal and Constitutional Affairs Legislation Committee

Migration Amendment (Repairing Medical Transfers) Bill 2019

August 16, 2019

Contact: Dr. Martin Bibby, (02)9484.3963 Mobile 0415 511 617

ozbibby1@hotmail.com

About NSW Council for Civil Liberties

NSWCCL is one of Australia's leading human rights and civil liberties organisations, founded in 1963. We are a non-political, non-religious and non-sectarian organisation that champions the rights of all to express their views and beliefs without suppression. We also listen to individual complaints and, through volunteer efforts, attempt to help members of the public with civil liberties problems. We prepare submissions to government, conduct court cases defending infringements of civil liberties, engage regularly in public debates, produce publications, and conduct many other activities.

CCL is a Non-Government Organisation in Special Consultative Status with the Economic and Social Council of the United Nations, by resolution 2006/221 (21 July 2006).

Contact NSW Council for Civil Liberties

http://www.nswccl.org.au
office@nswccl.org.au
Correspondence to: PO Box A1386, Sydney South, NSW 1235
Phone: 02 8090 2952
Fax: 02 8580 4633

The New South Wales Council for Civil Liberties (NSWCCL) thanks the Legal and Constitutional Affairs Legislation Committee for its invitation to make a submission concerning the Migration Amendment (Repairing Medical Transfers) Bill 2019.

In view of the gravity of what is proposed in this bill, with people's health and even lives at risk, NSWCCL seeks to give evidence to the Legal and Constitutional Committee directly.

The Migration Amendment (Repairing Medical Transfers) Bill 2019 (the Bill) does three things:

1. It repeals the provisions that were inserted into the Migration Act (the Act) by Schedule 6 of the Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019 (the medical transfer provisions). This will mean that the arrangements for very sick people in a regional processing country will revert to those that were in place before February this year—the arrangements that saw Hamid Khazaei lose his life to a curable illness, and Omar Masoumali lose his because of delays in treatment. Others have had their lives set at risk by unconscionable delays.

2. It will also mean that the Minister will have power to prevent more people, who may never have been convicted of a crime, from being brought from offshore detention to Australia. This in turn will mean that some people, against whom there are only suspicions, will be denied the medical attention they urgently need.

3. It will require that a person who has been brought to Australia under the medical transfer provisions be sent back to a regional processing country once the person no longer needs to be in Australia for the purpose for which they were brought here, *whether or not that purpose has been achieved*. This will mean that persons who were severely mentally ill and were brought to Australia for a cure will be returned to the regional processing country where they were made ill, once the emergency is over, whether or not they have been cured. And that in turn is likely to have the outcome that they again become severely ill, or worse.

None of these outcomes is at all acceptable. The Bill should be rejected.

A. Reverting to the former arrangements.

One great benefit of the changes that were made in February was the setting of time limits for decisions to be made. As illustrated below, there was a clear need to fix the bureaucratic processes involved in arranging for people who were seriously ill to be brought to Australia.

1. The case of Hamid Khazaei—layers of bureaucracy in two countries.

No one who has read the Coroner's report on the death of Hamid Khazaei could consider the arrangements that were in place at that time—at the end of last year—satisfactory. Consider the following—and remember that the request for a transfer was marked 'urgent':

> Ms Gow explained that she was the first DIBP officer involved in the transfer approval process. She referred requests for transfer to the Director of Health Operations, Amanda Little, who would then send it to the Assistant Secretary, Paul Windsor. It was finally sent to the First Assistant Secretary, John Cahill, for approval.[1]

Note that none of these persons is medically qualified.

Ms Little's evidence was that she was in meetings between 1230 hours and 1700 hours. She told Ms Gow that she would be in meetings, and "normal practice would be that she could have – she could call me if she needed to at any time."[202] Ms Little expected Ms Gow's email notification about the transfer to find its way to her inbox at some point.[2]

> The RMM sat unread in Ms Little's inbox from approximately 1230 hours on 25 August 2014, until she returned from her meetings sometime around 1700 hours. By the time Ms Little checked her emails and saw the transfer request, any prospect of making the 1730 flight had passed as safe flights at night off Manus Island could not be guaranteed. Having regard to logistics, even if DIBP had approved the movement request in the early evening, Mr Khazaei would not have left Manus Island until the morning of 26 August 2014.[3]
> Ms Little reviewed the contents of the RMM prepared by Ms Zhai. She decided that she needed to seek clarifying information with respect to "the availability of pathology services, the availability of antibiotics supply and stock and, basically, those matters.[214] Ms Little was not satisfied of a number of things, some of which included that there was the occurrence of, or the risk of sepsis, or that a transfer to Lorengau hospital should be ruled out.[215] At 1802 hours, Ms Little emailed Dr Renshaw outlining these matters, as follows:
> "Hi Anthony,
>
> I have received this urgent request for transfer to POM for inpatient treatment of cellulitis of this Transferee's leg. I am wondering why this can't be managed at Lorengau Hospital? From my understanding this would require IVI antibiotics, which could be done either as an inpatient or as an outpatient / or perhaps at the IHMS clinic. The NOC is for antibiotic treatment not sepsis.
> The NOC states "There is a lack of microbiological investigative diagnostics. This limitation, compounded with the lack appropriate antibiotic treatment, will lead to progression of this infective process. This client has exhausted all antibiotic treatment that is available on Manus Island..." which appears to be the reason for transfer.
> Grateful if you could clarify what this means:
- Regarding "a lack of microbiological investigative diagnostics"; If blood cultures are needed: are these able to be collected and processed at Lorengau / sent to POM for

[1] Coroners Court of Queensland: Inquest into the Death of Hamid Khazaei, July 30, 2018 §131
[2] §143

[3] §405

sensitivities? Similarly processing of swabs. Logistically this should be easier than sending a person with escorts for results that will take several days

- • Regarding "lack appropriate antibiotic treatment": I'm not sure what this means – first line treatment should be quite common antibiotics, with several options available pending sensitivities. Even using something "unusual" should be able to be managed locally
- • Regarding "This client has exhausted all antibiotic treatment that is available on Manus Island." Is there a supply issue that we are unaware of? Again, these should be brought in rather than the person being transferred if this is the case.
  DIBP staff on island are being pushed for this urgent transfer in the next 18 hrs however I don't have adequate information to be able to escalate at this point if this is still warranted.
  Regards,
  Amanda.[4]

And perhaps the most damning, from the evidence of Dr Dennett:

> Yeah?---We usually do not recommend transfers to Port Moresby. However, experience has shown that the department was very reluctant to bring patients to Australia, and we knew that if we – if we recommend transferring to Australia, it would not be approved. So we knew that a transfer would not be approved, so – and this patient was not well, so in his best interest – in his best interest, we considered that it would be not the best option at the time, but it would be a step up in an upgrade of care, and that's why we put that to the department. [5]

The corner's own findings reinforce the points.

> It appeared that the medical staff were working primarily to clinical imperatives while the DIBP officers were working primarily to bureaucratic and political imperatives to keep transferees on Manus Island, or in PNG. The evidence demonstrates that this process resulted in crucial information, i.e. the importance of getting Mr Khazaei on the flight at 1730 hours, being missed, or not passed on accurately or clearly enough.[6]

And:

> I accept Dr Little's evidence that the decision to transfer a patient to a higher level of medical care is a clinical one, to be made on a clinical basis.... However, the process put in place by the DIBP to approve medical transfers was overly bureaucratic and lacked clear written procedures….It was only when an air ambulance was requested that the process was expedited. Where the request was for a commercial flight, as in this case, the approval had to negotiate at least four departmental employees before it was approved.[7]…

Mr Kahzaei's transfer to Port Moresby was further delayed by the need to obtain a visa from the Papua New Guinea Government.

---

[4] §150
[5] §185
[6] §404
[7] §409

2. Since July 2018

After the inquest into the death of Mt. Khazaei, the processes were supposed to have been improved. However, the delays remain, and in some cases are far worse. The Refugee Council of Australia reports:

> The process previously relied heavily on cooperation from Home Affairs Department and resulted in highly taxing and resource intensive court cases that spanned months and years.
>
> The Minister and the Department were forcing us to go to court to get severely ill people to Australia for medical treatment.'

On February 8 this year the Asylum Seekers Resource Centre reported on a study of 49 de-identified critically sick people.

> Over half of the cases in the sample, 25 people have been recommended for medical transfer by IHMS, who employ Australian Government appointed physicians for medical treatment, are still awaiting transfer. The majority have been waiting for 2 to 3 years, with some Overseas Medical Requests made by clinicians more than 5 years ago. Patients' conditions have escalated in severity and complexity in the meantime.
>
> People experiencing physical and mental health symptoms that require urgent medical treatment range from young adults to people over 60.
>
> People suffer from a wide range of treatable physical illnesses such as cardiac and respiratory conditions, kidney stones, abdominal conditions like gastritis, internal and external infections, joint conditions, gynaecological and urological conditions and chronic and acute pain conditions.
>
> Mental health conditions include repeated incidents of self-harm and suicidality, mood disorders and symptoms relating to ongoing trauma and post trauma.
>
> Data shows when the first diagnosis of a physical condition is medically neglected, people develop mental health conditions over time parallel to intensifying physical symptoms.[8]

3. The Minsters' arguments.[9]

i. The lack of need for the medical transfer provisions.

[8] Asylum Seeker Resource Centre, February 8, 2019.

[9] There is clearly a source document underlying the Second Reading Speeches of the Minister for Home Affairs (in the House of Representatives) and that of the Minister for Finance, Charities and Electoral Matters (in the Senate). The latter's text has also been scrambled in the version on the Parliament House website.

Both minsters assert that 'There was never a need for Labor's law. The government's existing medical provisions have brought over 900 people from the RPC in both locations to Australia to receive medical attention.'[10]

We have refuted this point. The pre-existing processes were, slow, cumbersome, bureaucratic and cost at least one life, and contributed to the death of Omar Masoumali. (Masoumali set himself on fire, but his transfer to Australia was delayed, and he died in Brisbane hospital several days later.) Australians, and the refugees involved, have been fortunate that in spite of the delays, there have been no more deaths for this reason. The condition of many refugees, however, has worsened while they were denied transfer.

ii. An increase in self-harm.
The Ministers both assert that 'The Department of Home Affairs has advised me that since the Migration Amendment (Urgent Medical Treatment) Bill was first introduced by the former member for Wentworth in December 2018, there has been a marked increase in self-harm behaviours in regional processing countries. Many of these acts are undertaken for the explicit purpose of manipulating the system and gaining access to our country. This bill removes the motivation for transferees to engage in this dangerous behaviour.'[11]

This argument depends on how the transferees allegedly made their purposes explicit, and how many there were. No evidence has been made publicly available as to whether the people harming themselves actually said why they had done so. It is incumbent upon the Department to provide details of how they came to the conclusion that the acts were undertaken for the purpose alleged. It is noted that if individuals had confessed that they had self-harmed for the purpose of being brought to Australia for treatment, this would have removed the likelihood of their remaining in Australia following treatment. In any case, it is strange that they waited till after the passage of the medical transfer provisions if the pre-existing law was perfectly adequate, as the two Ministers assert.

If, instead, it is being *inferred* that the increase in self-harm was caused by the change in the law, then the Minsters, whoever wrote this script, and the Department, are committing the post hoc ergo propter hoc fallacy. (Because a followed b, it does not follow that b caused a.) There could be many other reasons for an increase in self-harm since February this year, amongst them, dashed hopes at the re-election of the Government.

But let us suppose the "Department's" assertion is true.[12] We would need to know how many instances there have been explicitly for the purpose of taking advantage of the medical transfer provisions, and how that compares with the harm done by the extensive delays in treatment. How is the risk of self-harm to be weighed against the deaths of Mr. Khazaei and Mr. Masoumali?

B. Changes in the Minister's powers.

Mr. Dutton made the following assertions:

[10] In the same wording in both reports.
[11] Also in the same wording.
[12] Who actually averred it?

'The government has significantly less powers to prevent the transfer of a person of bad character under Labor's medevac law, or 'bring them all here law', than under any other process. In fact, the Minister has more power to stop individuals coming on a tourist visa than to stop those with bad character that seek to be transferred under Labor's medevac law, or 'bring them all here' law.

'There are currently people in PNG and Nauru who are charged with crimes against children, and are being investigated for the supply of illicit drugs or have posted terror related information online, and the government, under Labor's law, has no discretion to prevent the transfer to Australia of these individuals.'[13]

This argument is unfounded and untrue.
Let us first clear one falsehood out of the way.[14] The medical transfer provisions do not comprise a 'bring them all here' law. All *minors* were to be brought here (though not if they had substantial criminal records, or were the subject of an adverse ASIO assessment[15]—but they are all here now anyway. Adults can only be transferred if a treating doctor assesses that the person requires medical or psychiatric assessment or treatment, and their transfer is necessary for them to receive that treatment.[16] And, as with minors, 'if the Minister reasonably suspects that the transfer of a person to Australia would be prejudicial to security within the meaning of the Australian Security Intelligence Organisation Act 1979, or the Minister knows the person has a substantial criminal record, as defined by subsection 501(7) of the Migration Act' (that is to say, they have been sentenced to at least 12 months' imprisonment, where the 12 months may be made of lesser sentences for more than one offence) he can prevent the transfer.[17]

So who are the people that the Minister wishes to keep in offshore locations? They are not caught by subsection 501(7) of the Migration Act, for those people are excluded from the medical transfer provisions, by paragraph 198E(4)(c). That means they have not been sentenced for twelve months, for a single crime, or for two or more lesser crimes for which their sentences add up to 12 months.[18] They have not even been found unfit to plead, but been detained, or found not guilty because of unsoundness of mind and been detained.

So we must turn to subsection 501(6). Under the medical transfer provisions, people who fail the character test under that subsection are not required to remain in offshore locations, if they are seriously ill and cannot be treated in those locations. Who are they?

Four of the categories in subsection (6) catch people whom the Minister merely suspects of wrongdoing. One of those does not require any wrongdoing at all—it is a mere matter of association.[19] Others do not require that anybody *at all* has been convicted.

---

[13] Mr. Dutton's version.
[14] To her credit, senator Sisela omits this assertion.
[15] S.198D, subsections (1) and(3).
[16] Subsection.198E(b).
[17] S.198E(4)(c).
[18] Migration Act paragraphs 501(7)(c) and (d). A shoplifting offence may incur such a penalty, or graffiti. Or two lesser offences, one of each.
[19] Paragraphs 701(6)(b) and (ba).

Then there are four categories that merely involve a *risk* of criminal, or just disruptive behaviour.

Then there are those who are just held not to be of good character. This may be, but need not be, because of a criminal record.[20] Presumably though, any criminal record has not incurred sentences adding up to 12 months' imprisonment, for then subsection (7) would apply. These are not serious criminals.

Finally, there are people who have been charged with serious offences overseas, whether or not they have been convicted.

So why are these of such concern that the Ministers wish to repeal the medical transfer provisions?

As we noted, if persons had been convicted of the more serious offences listed, they would have received a sentence of more than twelve months, and subsection (7) would apply. *So we are talking about people with trivial offences, or people who have been accused and are not found guilty, or are just suspected, or in the case of the general conduct accusation, are not suspected of any actual offence at all.*

So what do the Ministers say?

> There are currently people in PNG and Nauru who are charged with crimes against children, who are being investigated for the supply of illicit drugs, or who have posted terror related information online, and the government has no discretion to prevent their transfer to Australia.

Three questions should be asked.
1. Why is it thought appropriate to keep Australians safe by taking them to PNG or Nauru, and presumably making the citizens of those countries unsafe?
2. Why are people being held indefinitely on suspicion, when within Australia that would be against the law? Should they not be tried, or released?
3. When such persons are seriously ill, and there are not the facilities, the expertise or the equipment to treat them in PNG or Nauru, what is supposed to happen to them?

The answer to the first is straightforward. It is a piece of international immorality.[21]
The answer to the second is a failure to respect people's rights.

There is no nice answer to the third. If the people are lucky, they may spontaneously recover. But, if, as is more likely, they deteriorate, presumably they will die.

Of course, the Minister could make an exception, once they deteriorate, and have them permitted to come here after all[22]. *But that would make nonsense of his case*.

[20] 501(6)(c)
[21] Notably, Australia takes a contrary, inconsistent, position when its own citizens have or are suspected to have committed terrorist offences overseas.

C. The lack of provisions to return people to regional processing countries.

If people are prone to serious psychological illnesses because of the traumata they have suffered and the trauma we have subjected them to, they may be helped to recover. But if they are returned to captivity on Nauru, or its near equivalent on Manus Island, they are very likely to relapse.

The Royal Australian and New Zealand College of Psychiatrists supports this view, as does the Australian Psychological Society.

> Asylum seekers and refugees are among the most vulnerable and marginalised people in our community, many having experienced torture, trauma and other catastrophic events prior to displacement and flight. Of all migrant groups, asylum seekers and refugees are the most vulnerable to mental and physical ill health with common mental health disorders twice as high in refugee populations in comparison with economic migrants. Asylum seekers and refugees are at particular risk of developing a range of comorbid psychological disorders including post-traumatic stress disorder (PTSD), anxiety, depression and psychosomatic disorders. Contributing factors include previous traumatic experiences including torture, persecution, displacement and loss as well as life-risking journeys involving forced migration, cultural bereavement, culture shock, discrepancies between expectations and achievements, and/or non-acceptance by a new nation.[23]
>
> Many mental illnesses, including PTSD, are complex to treat and often unresponsive to primary interventions. They require specialist therapeutic interventions, resources and independent treatment settings which are not available in Australian immigration detention centres..[24] Young and Gordon found that approximately one-half of the detained refugee group who completed the Harvard Trauma Questionnaire reported PTSD symptoms and that, on clinician-rated measures, one-third of children, adolescents and adults suffered with clinical symptoms requiring tertiary outpatient assessment.[25]

---

[22] Hopefully, without bureaucratic delays.

[23] Bhugra D, Gupta S, Bhui K, Craig T, Dogra N, Ingleby J, Kirkbride J, Moussaoui D, Nazroo Newman L, Proctor N, Dudley M (2013) Seeking asylum in Australia: immigration detention, human rights and mental health care. *Australasian Psychiatry* 21: 315–20. , J, Qureshi A, Stompe T, Tribe R (2011) WPA guidance on mental health and mental health care in migrants. *World Psychiatry* 10(2): 2–10.

[24] Ashcroft R (2005) Standing up for the medical rights of asylum seekers. *Journal of Medical Ethics* 31: 125–6.

[25] Young P, Gordon MS (2016) Mental health screening in immigration detention: A fresh look at Australian government data. *Australasian Psychiatry* 24(1): 19–22.

> Furthermore, prolonged or indefinite detention itself is known to contribute to adverse mental health outcomes as a result of prolonged exposure to factors including uncertainty, lack of autonomy, deprivation of liberty, dehumanisation, isolation and lack of social support.[26] The prolonged uncertainty created by a system of indefinite detention is a major factor in increasing hopelessness, mental deterioration and the persistence of mental disorder.[27] Self-harm and suicidal behaviour have become endemic in detention facilities amid well-documented allegations of the exposure of asylum seekers and refugees in detention to sexual and physical assault and abuse, and conditions which are tantamount to cruel and degrading treatment.[28] An international systematic review from Campbell Collaboration confirmed the deleterious effects of detention on the mental health of asylum seekers and refugees.[29]
>
> *Harms to well-being accumulate during detention and the longer a person is held in detention, the higher their risk of developing or worsening mental ill health*. Mental health conditions are unlikely to respond to treatment until key stressors are removed from the patient's life. While people continue to be held in difficult, often re-traumatising conditions and with an uncertain future, mental disorders are likely to persist or worsen.[30]

And the Australian Psychological Society, as reported by the Refugee Council of Australia:

> Many people came into detention with pre-existing injuries and trauma. This has been compounded by a widespread deterioration of the mental and physical health of the people detained as a result of the offshore detention conditions. Twelve people have died in offshore detention to date. The inquiry into the case of Hamid Khazaei showed that he died as a direct result of the Australian Government's refusal to follow medical orders.

---

[26] United Nations Committee Against Torture (2014) Concluding observations on the combined fourth and fifth periodic reports of Australia. United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, CAT/C/AUS/CO4-5.

[27] Newman L, Proctor N, Dudley M (2013) Seeking asylum in Australia: immigration detention, human rights and mental health care. *Australasian Psychiatry* 21: 315–20.

[28] Australian Human Rights Commission (2013) *Asylum seekers, refugees and human rights: Snapshot report*. Sydney, Australia: AHRC, Australian Human Rights Commission (2015) 'Use of force in immigration detention facilities.' Available at: www.humanrights.gov.au/sites/default/files/document/publication/Factsheet-on-use-of-force-in-immigration-detention-facilities.pdf (accessed 25 August 2016), Amnesty International (2016) *Amnesty International Report 2015/16*. London: Amnesty International Ltd.

[29] Filges T, Montgomery E, Kastrup M, Jørgensen AMK (2015) *The Impact of Detention on the Health of Asylum Seekers: A Systematic Review*. Available at: www.campbellcollaboration.org/library/the- impact-of-detention-on-the-health-of-asylum-seekers-a-systematic-review.html (accessed 6 October 2016).

[30] Royal Australian and New Zealand College of Psychiatrists, Position Statement 46: The provision of mental health services for asylum seekers and refugees, September 2017, pp. 2f.ld

There has been an epidemic of self-harm, suicides and suicide attempts, some of which have even been made by young children. In 2016, UNHCR found that 88% of people on Manus Island were suffering from depression, anxiety and/or post-traumatic stress disorder.
The medical facilities on Manus Island and Nauru are grossly inadequate for dealing with this crisis. Furthermore, the Australian Government has made drastic cuts to the support services and monitoring previously in place.

Thus the omission of provisions to ensure the return of people to offshore detention is not a weakness of the medical transfer provisions, but a strength. The Ministers' proposals are either profoundly immoral, or they are futile.

Recommendation: All three proposals under the Bill should be condemned, and the Bill itself should not be passed.

This submission was prepared by Dr. Martin Bibby on behalf of the New South Wales Council for Civil Liberties.

Therese Cochrane
Secretary
NSW Council for Civil Liberties

Contact in relation to this submission Dr Martin Bibby: email ozbibby1@hotmail.com; tel 02 9484-3963, mobile 0415 511 617.