

The Senate

Legal and Constitutional Affairs
Legislation Committee

Migration Amendment (Repairing Medical
Transfers) Bill 2019 [Provisions]

October 2019

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Contents

Members	iii
Recommendation	vii
Chapter 1 – Introduction	1
Conduct of inquiry.....	1
Acknowledgement.....	1
Structure of this report	1
Purpose of the bill	2
Background.....	2
Key provisions of the bill	3
The medical transfer provisions	4
Consideration of the bill by other committees.....	9
Note on references and terminology.....	10
Chapter 2 – Key issues with the medical transfer provisions	11
No process of return	11
Limited grounds for refusal and security issues	14
Timeframe for security advice	16
Sovereignty issues	17
Impacts on regional processing arrangements	20
Remuneration for the Independent Health Advice Panel.....	22
Alleged increase in self-harm.....	23
Adequacy of the medical transfer provisions prior to March 2019	27
Chapter 3 – Support for medical transfer provisions	35
Who should make decisions on medical issues?.....	35
Are the medical transfer provisions working as intended?.....	39
Contribution of the Independent Health Advice Panel	49
Australia's legal and human rights obligations	52

Committee view	58
Labor Senators' dissenting report	61
Australian Greens dissenting report	67
Centre Alliance dissenting report	77
Appendix 1—Submissions, additional information, answers to questions on notice and tabled documents	83
Appendix 2—Public hearing	87

Recommendation

Recommendation 1

3.104 The committee recommends that the Senate pass the bill.

Chapter 1

Introduction

- 1.1 On 4 July 2019, the Senate referred the provisions of the Migration Amendment (Repairing Medical Transfers) Bill 2019 (the bill) to the Legal and Constitutional Affairs Legislation Committee (the committee) for inquiry and report by 18 October 2019.¹
- 1.2 The Senate Selection of Bills Committee recommended that the bill be referred to examine 'the contents of the bill and allow stakeholders to inform the committee of detailed concerns'. The committee also noted that the bill repeals legislation passed in 2019 with the support of a number of parties and independents.²

Conduct of inquiry

- 1.3 In accordance with usual practice, the committee advertised the inquiry on its website and wrote to organisations inviting submissions by 16 August 2019. The committee received 104 submissions, listed at Appendix 1. The committee held a public hearing in Canberra on Monday, 26 August 2019. A list of witnesses is provided at Appendix 2.
- 1.4 Questions on notice and other material received by the committee are listed at Appendix 2. Submissions and the Hansard transcript of evidence may be accessed through the committee website.

Acknowledgement

- 1.5 The committee thanks the organisations and individuals who gave evidence at the public hearing as well as those who made written submissions.

Structure of this report

- 1.6 This report comprises three chapters as follows:
 - Chapter 1 outlines the administrative details of the inquiry, background to the inquiry, the key provisions of the bill and an overview of the operation of the medical transfer provisions.
 - Chapter 2 explores key issues with the medical transfer provisions as well as discusses the evidence received regarding the medical transfer process in place prior to 2 March 2019.

¹ *Journals of the Senate*, No. 3, 4 July 2019, pp. 78–81.

² Senate Selection of Bills Committee, *Report No. 2 of 2019*, 4 July 2019, pp. 9–10.

- Chapter 3 discusses the evidence received supporting the medical transfer provisions and the arguments presented that the provisions be retained. The chapter concludes with the committee's view and recommendation.

Purpose of the bill

- 1.7 The bill would amend the *Migration Act 1958* (the Migration Act) to repeal the medical transfer provisions, which were inserted by Schedule 6 to the *Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019*.
- 1.8 The bill also includes provisions to extend existing powers in the Migration Act to provide a mechanism for the 'return or removal' of persons transferred to Australia under the medical transfer provisions once 'they no longer need to be in Australia for the temporary purpose for which they were brought'.³
- 1.9 According to the explanatory memorandum, the government is seeking to repeal the medical transfer provisions for the following key reasons:
- there is no process for returning transferees to regional processing countries following medical assessment and/or treatment in Australia;
 - the provisions have 'broad application' and the grounds for refusal are too limited;
 - the legislation imposes impractical timeframes for making decisions; and
 - the provisions 'undermine the Australian Government's regional processing arrangements' and impinge on the sovereignty of Papua New Guinea and Nauru.⁴

Background

- 1.10 On 3 December 2018, during the 45th Parliament, crossbench members Dr Kerryn Phelps MP, Mr Andrew Wilkie MP, Mr Adam Bandt MP, Ms Julia Banks MP and Ms Rebekha Sharkie MP introduced legislation into the House of Representatives containing provisions which would facilitate the transfer of minors and other 'transitory persons' from regional processing countries to Australia for medical or psychiatric treatment or assessment (medical transfer provisions).⁵
- 1.11 The original bill did not progress past the second reading stage. However, on 6 December 2018, an amended version of the medical transfer provisions passed the Senate as Schedule 6 of the government's Home Affairs Legislation

³ Explanatory memorandum to the Migration Amendment (Repairing Medical Transfers) Bill 2019 (Explanatory memorandum), p. 2.

⁴ Explanatory memorandum, p. 4.

⁵ The Migration Amendment (Urgent Medical Treatment) Bill 2018 lapsed at dissolution of the House of Representatives on 11 April 2019.

Amendment (Miscellaneous Measures) Bill 2018, following amendments moved by Senator Tim Storer and Senator Nick McKim.⁶

- 1.12 On 12 February 2019, the Speaker of the House of Representatives reported a message from the Senate returning the Home Affairs Legislation Amendment (Miscellaneous Measures) Bill 2018 to the House of Representatives with Senate amendments, which included the medical transfer provisions.⁷
- 1.13 The Attorney-General moved to have consideration of the Senate's amendments deferred, citing possible constitutional issues with the provisions. However, opposition and crossbench members voted together against the government to bring on the immediate consideration of the Senate's amendments.⁸
- 1.14 The House then agreed the Senate's amendments with further amendments circulated in the name of the then Leader of the Opposition, the Hon Bill Shorten MP. Government members voted against the amendments but were defeated.⁹
- 1.15 The Senate agreed the House's amendments and the bill passed both houses on 13 February 2019. The medical transfer provisions have been in operation since 2 March 2019.¹⁰

Key provisions of the bill

- 1.16 The bill would repeal subsection 198B(4) and sections 198C to 198J of the Migration Act. These sections established the medical transfer provisions to create a legislative framework that provides for transfer of 'relevant transitory persons' and minors from regional processing countries to Australia for medical or psychiatric assessment or treatment on the advice of two treating doctors.¹¹
- 1.17 The bill would also repeal subdivision D of the Migration Act. Subdivision D established the Independent Health Advice Panel (the IHAP) to 'monitor, assess and report' on the physical and mental health of transitory persons in

⁶ Claire Petrie, Migration Amendment (Urgent Medical Treatment) Bill 2018, *Bills Digest No. 56*, 2018-19, Parliamentary Library, Canberra, p. 3.

⁷ *Votes and Proceedings No. 157*, 12 February 2019, p. 2052.

⁸ *Votes and Proceedings No. 157*, 12 February 2019, pp. 2054-2055.

⁹ *Votes and Proceedings No. 157*, 12 February 2019, pp. 2055-2059.

¹⁰ For the summary, full timeline, details, amendments, explanatory memoranda, and speeches, see: www.aph.gov.au/Parliamentary_Business/Bills_Legislation/Bills_Search_Results/Result?bId=r6069 (accessed 18 July 2019).

¹¹ Explanatory memorandum to the Migration Amendment (Repairing Medical Transfers) Bill 2019 (Explanatory memorandum), p. 4; Department of Home Affairs, *Fact Sheet: Overview of Schedule 6 of the Miscellaneous Measures Act 2019*, p. 1 (attached to *Submission 55*).

regional processing countries, the standard of available health services and review decisions made by the minister to refuse the approval of a transfer on medical grounds.¹²

Power to remove individuals from Australia

- 1.18 The bill would provide for the removal from Australia and/or return to a regional processing country of individuals who are brought to Australia under the medical transfer provisions. This would be achieved by amending two sections of the Migration Act. Existing subsection 198(1A) provides for the removal of unlawful non-citizens who have been brought to Australia under section 198B for a temporary purpose. The bill would amend this section to include reference to an unlawful non-citizen brought to Australia under repealed section 198C.¹³
- 1.19 Similarly, the bill would amend paragraph 198(AH)(1A)(a) to include individuals transferred to Australia under repealed section 198C. This amendment would mean that section 198AD would apply to that person. Section 198AD provides that an officer must, as soon as reasonably practicable, take an unauthorised maritime arrival to a regional processing country.¹⁴
- 1.20 The explanatory memorandum notes that this amendment would extend 'the existing return power to allow for the return to a regional processing country of those transferred to Australia under section 198C...'.¹⁵

Application of the amendments

- 1.21 The provisions of the bill would commence the day after receiving Royal Assent.¹⁶
- 1.22 The provisions of the bill would apply to unlawful non-citizens and transitory persons brought to Australia under repealed section 198C of the Migration Act before, on or after the commencement of the provisions.¹⁷

The medical transfer provisions

- 1.23 The medical transfer provisions require that before a person can be transferred, two treating doctors for the person must give an opinion that:

¹² Department of Home Affairs, *Fact Sheet: Overview of Schedule 6 of the Miscellaneous Measures Act 2019*, pp. 23, (attached to *Submission 55*).

¹³ Explanatory memorandum, p. 5, item 6 of schedule 1 of the bill.

¹⁴ Explanatory memorandum, p. 5, item 7 of schedule 1 of the bill.

¹⁵ Explanatory memorandum, p. 6.

¹⁶ Clause 2 of the bill.

¹⁷ Item 14 of schedule 1 of the bill.

- a transitory person requires medical or psychiatric assessment or treatment, and;
 - they are not receiving such treatment in the relevant regional processing country; and
 - it is necessary for them to be transferred to Australia for such assessment or treatment.
- 1.24 The framework also includes allowance for family or other persons to accompany the transferee, and provide for the transfer of minors to Australia, 'irrespective of any medical or psychiatric condition'.¹⁸
- 1.25 The treating doctors must notify the secretary of the Department of Home Affairs of their opinion and the secretary must notify the minister as soon as possible. In accordance with section 198E of the Migration Act, the minister must approve, or refuse to approve, the person's transfer to Australia no later than 72 hours after being notified. If a decision is not made within 72 hours, the minister is taken to have approved the transfer.
- 1.26 The minister must approve the transfer unless:
- the minister reasonably believes that it is not necessary to remove the person from a regional processing country for appropriate medical or psychiatric assessment or treatment; or
 - the minister reasonably suspects that the transfer of the person to Australia would be prejudicial to security within the meaning of the *Australian Security Intelligence Organisation Act 1979*, including because an adverse security assessment in respect of the person is in force under that Act; or
 - the minister knows that the person has a substantial criminal record (as defined by subsection 501(7) as in force at the commencement of this section) and the minister reasonably believes the person would expose the Australian community to a serious risk of criminal conduct.¹⁹
- 1.27 As soon as practicable, the minister must notify the IHAP if a transfer is being refused on medical grounds. The Panel then has 72 hours to conduct a further clinical assessment of the person and to inform the Minister of the findings of that assessment, including its recommendation on whether decision to refuse the person's transfer be confirmed, or the person's transfer be approved. The Minister then has 24 hours to reconsider the decision to refuse to approve the person's transfer and either confirm the decision to refuse, or approve the person's transfer. If the Panel recommends the transfer be approved, the

¹⁸ Explanatory memorandum, p. 4; Department of Home Affairs, *Fact Sheet: Overview of Schedule 6 of the Miscellaneous Measures Act 2019*, p. 1 (attached to *Submission 55*).

¹⁹ Subsection 198E(4) of the Migration Act.

Minister can only refuse the transfer on national security or character grounds.²⁰

Independent Health Advice Panel

1.28 Section 199B of the Migration Act sets out the membership of the IHAP which shall comprise:

- the person occupying the positions of Chief Medical Officer of the Department and the Surgeon-General of the Australian Border Force;
- the person occupying the position of Commonwealth Chief Medical Officer; and
- not less than 6 other members, including:
 - at least one person nominated by the President of the Australian Medical Association;
 - at least one person nominated by the Royal Australian and New Zealand College of Psychiatrists;
 - at least one person nominated by the Royal Australasian College of Physicians; and
 - at least one person who has expertise in paediatric health.²¹

1.29 The IHAP has two functions:

- a general function to monitor, assess and report on the physical and mental health of transitory persons in regional processing countries and the standard to health services provided to them (in accordance with s199A(2) of the Migration Act); and
- a specific function under s198F of the Migration Act to review a decision by the minister to refuse to approve a relevant transitory person's transfer to Australia on the ground set out in s198E(4)(a).²²

1.30 In accordance with section 199E of the Migration Act, the IHAP is required to provide a quarterly report to the minister on its operations during that three month period. A summary of that report must be tabled by the minister in both the House of Representatives and the Senate within three sitting days after the report is given to the minister.²³

1.31 The IHAP has prepared two quarterly reports since being established. For its first reporting period (2–31 March 2019), the panel comprised two members:

²⁰ Department of Home Affairs, *Fact Sheet: Overview of Schedule 6 of the Miscellaneous Measures Act 2019*, p. 2, (attached to *Submission 55*).

²¹ Section 199B of the Migration Act.

²² Independent Health Advice Panel, *First Quarterly Report*, 29 June 2019, p. 7 (tabled 19 July 2019). (That is, that the Minister reasonably believes that it is not necessary to remove the person from a regional processing country for appropriate medical or psychiatric assessment of treatment).

²³ Section 199E of the Migration Act.

- Dr Parbodh Gogna, Chief Medical Officer of the Department and the Surgeon-General of the Australian Border Force; and
- Professor Brendan Murphy, Commonwealth Chief Medical Officer.²⁴

1.32 During its second reporting period (1 April–30 June 2019), three additional members had been appointed:

- Dr Antonio Di Dio (nominated by the Australian Medical Association);
- Associate Professor Susan Evelyn Moloney (nominated by the Royal Australasian College of Physicians); and
- Associate Professor Neeraj Sing Gill (nominated by the Royal Australian and New Zealand College of Psychiatrists).

Medical transfers since 2 March 2019

1.33 The Department of Home Affairs (the department) reported on the operation of the medical transfer provisions between 2 March and 31 July 2019. During this period there have been:

- 154 notifications for medical transfer under section 198E of the Migration Act. (130 of the 154 notifications have been deemed valid); and
- 72 transitory persons from Papua New Guinea and Nauru have transferred to Australia for medical treatment, as have four accompanying family members.

1.34 The department further advised that of the 72 transitory persons medically transferred to Australia since 2 March 2019:

- three people have been admitted to a hospital for a period of more than seven days;
- one person has refused treatment;
- 14 people are receiving outpatient care; and
- 54 people are having their health concerns managed by International Health and Medical Services in detention.²⁵

1.35 At the public hearing on 26 August 2019, the department provided updated data on the operation of the medical transfer provisions:

- 167 valid notifications have been received: 112 people have been transferred to Australia, 18 applications have been refused, 19 applications have been approved with transfer pending and a number of submissions are still being drafted;²⁶

²⁴ Independent Health Advice Panel, *First Quarterly Report*, 29 June 2019, p. 7 (tabled 19 July 2019).

²⁵ Department of Home Affairs, *Submission 55*, p. 17.

²⁶ Ms Alana Sullivan, Senior Assistant Secretary, Regional processing and resettlement, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 77. Note: at the hearing on 26 August 2019, departmental officers provided two different figures for the number of people who have been transferred to Australia (111 and 112) and sought to clarify the figure on notice. Later advice

- Of the individuals transferred to Australia, no-one is currently in hospital:
 - one person has refused treatment;
 - 40 are outpatients or potential outpatients; and
 - 70 are not outpatients.²⁷

1.36 The department explained that medical transfers had occurred where regarded necessary prior to the implementation of the medical transfer provisions on 2 March 2019. Indeed, in the period from November 2012 to 31 July 2019, some 1,343 people (717 medical and 626 accompanying family transfers) had been transferred to Australia for medical treatment from offshore processing.²⁸

Referrals to the Independent Health Advice Panel

1.37 The department also submitted that as at 31 July 2019, 23 cases have been referred to the IHAP following the minister's refusal to approve transfer on medical or psychiatric grounds. The Panel recommended transfer to Australia in 10 cases and supported the minister's refusal to transfer in the other 13 cases.²⁹

1.38 At the 26 August 2019 public hearing, the department provided updated numbers of referrals to IHAP. It was reported that the IHAP considered 28 applications; ten were recommended for transfer and the minister's decision to refuse transfer was upheld in 18 cases. In relation to those 18 cases, nine applicants subsequently reapplied and eight of those have been approved.³⁰

1.39 In its first two quarterly reports, the IHAP advised the number of reviews it has undertaken for each of the reporting periods:

- for the 2 March to 31 March 2019 reporting period, the IHAP did not conduct any reviews and made no recommendations as the minister did not make a decision to refuse a transfer under 198E of the Migration Act.³¹
- for the 1 April to 30 June 2019 reporting period, the IHAP conducted further clinical assessment of 15 cases. Of those 15 cases, the IHAP recommended

confirmed that 112 individuals have been transferred to Australia. Department of Home Affairs, responses to questions on notice, 26 August 2019, (received 27 September 2019).

²⁷ Mr Michael Pezzullo, Secretary, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 79. Note: these figures total 111 which reflects the evidence given at the hearing.

²⁸ Department of Home Affairs, *Submission 55*, p. 4.

²⁹ Department of Home Affairs, *Submission 55*, p. 17.

³⁰ Ms Cheryl-anne Moy, Deputy Secretary, Chief Operating Officer, Corporate and Enabling, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 76.

³¹ Independent Health Advice Panel, *First Quarterly Report*, 29 June 2019, p. 18 (tabled 19 July 2019).

transfer to Australia for medical treatment in six cases and refused transfer to Australia for medical treatment in nine cases.³²

- 1.40 The IHAP reported each recommendation was made within the legislated 72 hour timeframe and in all 15 cases; the IHAP members reached a unanimous decision.³³

Consideration of the bill by other committees

Scrutiny of Bills Committee

- 1.41 The Senate Standing Committee for the Scrutiny of Bills drew attention to sub-item 15(1) of Schedule 1 to the bill which provides that subsection 7(2) of the *Acts Interpretation Act 1901* (Acts Interpretation Act) does not apply to the repeal of the medical transfer provisions. The scrutiny committee explained:

Subsection 7(2) of the Acts Interpretation Act provides that if an Act is repealed, then the repeal does not affect the previous operation of the Act or any rights, privileges, liabilities or obligations accrued or incurred under the Act prior to its repeal. Subsection 7(2) also ensures that any investigations or legal proceedings that were instituted prior to the repeal may continue as if the Act was still in force.³⁴

- 1.42 The scrutiny committee noted that the explanatory memorandum 'does not appear to explain why it is necessary to exclude the application of subsection 7(2) of the Acts Interpretation Act and requested an explanation from the minister, including whether sub-item 15(1) of Schedule 1 to the bill will trespass on the rights and liberties of any person.³⁵

- 1.43 The response from the Acting Minister for Home Affairs noted:

By expressly excluding the applicability of subsection 7(2) of the Acts Interpretation Act, any right, privilege, obligation or liability acquired, accrued or incurred under the medical transfer provisions, including those acquired, accrued or incurred by a relevant transitory person, will be extinguished on commencement of the Bill other than those rights preserved by sub-item 15(2)...³⁶

³² Independent Health Advice Panel, *Second Quarterly Report*, 15 August 2019, p. 9 (tabled 17 September 2019).

³³ Independent Health Advice Panel, *Second Quarterly Report*, 15 August 2019, p. 9 (tabled 17 September 2019).

³⁴ Senate Standing Committee for the Scrutiny of Bills, *Scrutiny Digest 3 of 2019*, 24 July 2019, p. 23.

³⁵ Senate Standing Committee for the Scrutiny of Bills, *Scrutiny Digest 3 of 2019*, 24 July 2019, p. 24.

³⁶ Senate Standing Committee for the Scrutiny of Bills, *Scrutiny Digest 5 of 2019*, 11 September 2019, p. 63.

- 1.44 The acting minister also posited that sub-item 15(1) 'does not trespass on the rights of any person'.³⁷
- 1.45 After considering the response from the acting minister, the scrutiny committee drew its concerns to the attention of senators and stated it 'leaves to the Senate as a whole the appropriateness of extinguishing any right, privilege, obligation or interest accrued under the medical transfer provisions inserted by the *Home Affairs Legislation Amendment (Miscellaneous Measures) Act 2019*'.³⁸

Parliamentary Joint Committee on Human Rights

- 1.46 The Parliamentary Joint Committee on Human Rights (the human rights committee) indicated concerns with a number of aspects of the bill including whether the measures in the bill are compatible with *non-refoulement* obligations and the right to an effective remedy, and the right to health.³⁹
- 1.47 At the time of adopting this report, the human rights committee had not published any further comments on the bill.

Note on references and terminology

- 1.48 In this report, references to *Committee Hansard* are to the proof transcript. Page numbers may vary between proof and official transcripts.
- 1.49 Some of the evidence referenced in this report refers to the 'medevac legislation'. This is the term which has been broadly used to refer to the medical transfer provisions.

³⁷ Senate Standing Committee for the Scrutiny of Bills, *Scrutiny Digest 5 of 2019*, 11 September 2019, p. 63.

³⁸ Senate Standing Committee for the Scrutiny of Bills, *Scrutiny Digest 5 of 2019*, 11 September 2019, p. 65.

³⁹ Parliamentary Joint Committee on Human Rights, *Report 4 of 2019*, 10 September 2019, pp. 2–9.

Chapter 2

Key issues with the medical transfer provisions

- 2.1 The Minister for Home Affairs and the Department of Home Affairs (the department) have identified a number of key issues with the medical transfer provisions introduced from March 2019 by the Home Affairs Legislation Amendment (Miscellaneous Measures) Bill 2018 (the miscellaneous measures bill). These include:
- the absence of a process for returning transferees once treatment has concluded;
 - limitations in the legislation on the criteria available to the minister to refuse a transfer;
 - tight timeframes for decisions;
 - impacts on the sovereignty of regional processing countries;
 - impacts on regional processing arrangements more broadly;
 - the lack of remuneration for the Independent Health Advice Panel (IHAP); and
 - an alleged increase in self-harm incidents.
- 2.2 The Migration Amendment (Repairing Medical Transfers) Bill 2019 (the bill) is intended to address these issues by repealing the medical transfer provisions from the *Migration Act 1958* (the Act).
- 2.3 This chapter explores the issues listed above. It then concludes by discussing evidence regarding the adequacy of the system of assessment and transfer that existed prior to March 2019.

No process of return

- 2.4 The medical transfer provisions enacted in March 2019 provide a process for transferring asylum seekers to Australia for medical assessment, medical treatment, or both. They do not include any provisions relating to returning transferees to regional processing countries following medical assessment or treatment in Australia.
- 2.5 The department submitted that the medical transfer provisions 'extend the [length of time a transferee is] in Australia as there are currently no return mechanisms to effect their removal from Australia and return to a regional processing country'.¹
- 2.6 Professor Kerry Phelp AM proposed that specific transfer provisions in the medical transfer legislation were not required because these already exist

¹ Department of Home Affairs, *Submission 55*, p. 11.

elsewhere in the Act. Professor Phelps added that 'it is a temporary transfer, so it is up to the minister whether somebody stays in Australia or is returned'.²

- 2.7 The Castan Centre for Human Rights Law (the Castan Centre) disputed the department's assertion that the medical transfer provisions limit the ability for transferees to be returned to regional processing countries. Deputy Director, Dr Maria O'Sullivan elaborated:

Whilst there is no explicit provision governing the return of this particular cohort as a matter of technical and legal requirements, as a matter of normal statutory interpretation the general removal provisions in the Migration Act would operate in relation to this cohort.³

- 2.8 The Law Council of Australia acknowledged there may be 'some ambiguity' regarding the legal basis for returning transferees, but said, according to its interpretation, those transferred under the medical transfer provisions 'can be removed and returned under the law as it stands'.⁴

- 2.9 The department's legal representative, Ms Pip De Veau, disputed the suggestion that existing provisions for return are adequate, saying:

I've seen that the Law Council...articulated some form of potential analysis around an alternative legal basis on the assumption that, because 198B is for a temporary purpose, as is the new 198C, you could then perhaps see that it's piggybacking on 198B....That was looked at in February and dismissed as a basis of a power to take back to the regional processing country.⁵

- 2.10 Ms De Veau also stated that 'the general powers under 198 were also considered' as a mechanism for returning transferees, and:

...all of the advice has been that there is a real and significant risk that if the use of these was attempted we'd find ourselves in court and probably on the worse end of the argument.⁶

- 2.11 Despite believing existing laws to be adequate, the Law Council suggested Parliament could 'remove this ambiguity by making minor technical amendments to the act', rather than by repealing the medical transfer provisions, which the Law Council opposed.⁷ Dr O'Sullivan said the Castan Centre agreed with submissions from the Law Council and the Kaldor Centre

² Professor Kerry Phelps AM, Private capacity, *Committee Hansard*, 26 August 2019, p. 15.

³ Dr Maria O'Sullivan, Deputy Director, Castan Centre for Human Rights Law, Monash University, *Committee Hansard*, 26 August 2019, p. 34.

⁴ Mr Tass Liveris, Executive Member, Law Council of Australia, *Committee Hansard*, 26 August 2019, p. 44.

⁵ Ms Pip De Veau, First Assistant Secretary, Legal, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 86.

⁶ Ms De Veau, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 86.

⁷ Mr Liveris, Law Council of Australia, *Committee Hansard*, 26 August 2019, p. 44.

for International Refugee Law (the Kaldor Centre) that any ambiguity could 'be remedied through a very simple technical amendment to the Migration Act'.⁸

2.12 Asked if it would support such an amendment, the Law Council replied:

To the extent that it's required to remove ambiguity, the Law Council is supportive of that. There's no suggestion in the Law Council's submission that the law should be used for anything other than temporary transfers for medical purposes and, to that extent, is supportive of any ambiguity being remedied.⁹

2.13 Professor Phelps, however, expressed concern about the idea of returning asylum seekers to regional processing countries after treatment.¹⁰

2.14 Witnesses from the medical sector were also concerned the bill contains provisions for return that may take decisions away from medical professionals once again. Royal Australian and New Zealand College of Psychiatrists (RANZCP) representative, Dr Kym Jenkins, elaborated:

The RANZCP is also concerned that the new bill allows for the removal of a person before medical treatment may be completed or may be adequate. We feel that decisions such as this should always be medical decisions, not ministerial ones.¹¹

2.15 The department said that two members of the IHAP, Dr Brendan Murphy and Dr Parbodh Gogna, had prior to 2 March 2019 assisted departmental officials, providing them with a considerable amount of advice regarding medical decisions. The department noted that both Dr Murphy and Dr Gogna have been taken out of the process as a result of their appointment to the IHAP.¹²

2.16 The department stressed that medical decisions have always been made by medical practitioners, and that the introduction of the medical transfer provisions did not bring about any change in this standard.¹³

2.17 The Secretary of the Department of Home Affairs, Mr Michael Pezzullo, argued that while people may be transferred for temporary purposes, returning them to regional processing countries has proven difficult. Mr Pezzullo explained:

⁸ Dr O'Sullivan, Castan Centre for Human Rights Law, *Committee Hansard*, 26 August 2019, p. 35.

⁹ Mr Liveris, Law Council of Australia, *Committee Hansard*, 26 August 2019, p. 46.

¹⁰ Professor Phelps, Private capacity, *Committee Hansard*, 26 August 2019, p. 16

¹¹ Dr Kym Jenkins, Chair, Royal Australian and New Zealand College of Psychiatrists (RANZCP) Asylum Seeker and Refugee Mental Health Network Committee, and Immediate Past President, RANZCP, *Committee Hansard*, 26 August 2019, p. 20.

¹² Ms Cheryl-Anne Moy, Deputy Secretary, Chief Operating Officer, Corporate and Enabling, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 84.

¹³ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 85.

There are currently over 320 matters before the courts which have been commenced by transitory persons in Australia—those here for medical and associated purposes—involving just under 1,000 individuals. Approximately 500 of these persons are now considered to have an effective barrier to their return, and it's anticipated that any attempts to return the remainder would result in the initiation of legal proceedings. What has commenced as medical transfer actions under various sections of the act has, over time, been transformed into legal blocking actions to keep these persons in Australia, irrespective of their medical status.¹⁴

2.18 On notice, the department confirmed that the last time a person was transferred from Australia 'to a regional processing country was on 15 April 2018'.¹⁵

2.19 Questioned about why the government has not regularly or recently returned any transferees to regional processing countries, Mr Pezzullo replied:

...there is a calculation in relation to the efficacy of seeking a removal action when one hasn't been successfully achieved for potentially two or three years...Then, over and above that—it's like a Venn diagram of problems—there is the lack of an express removal provision attached to section 198E.¹⁶

Limited grounds for refusal and security issues

2.20 The medical transfer provisions provide grounds upon which the minister may refuse a transfer to Australia, including on medical grounds (paragraph 198E(4)(a) of the Act), national security grounds (paragraph 198E(4)(b)), or because the person has a substantial criminal record (paragraph 198E(4)(c)). Refusals made on medical grounds are reviewable by the IHAP. Those made on security or criminal grounds are not reviewable.

2.21 The department submitted that the grounds for refusal available to the minister on the basis of security concerns are too limited and not in line with other parts of the Act.¹⁷ The department wrote:

The term 'security' is not defined in similar terms to the character test set out under section 501(7) of the Migration Act, and is not equivalent to an unacceptable threat to the community...Security, as defined under section 4 of the *Australian Security Intelligence Organisation Act 1979* (ASIO Act), involves the protection of Australia from specific matters. Such matters do not extend to criminal conduct generally in the same way as those identified under the character provisions of the Migration Act...The definition of security in section 4 of the ASIO Act sets a very high bar and is relatively narrow given it sits within the broader context of ASIO's

¹⁴ Mr Michael Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 68.

¹⁵ Department of Home Affairs, *answers to questions on notice*, 26 August 2019 (received 27 September 2019), [p. 7].

¹⁶ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 75.

¹⁷ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 68.

operations. The definition of security within the ASIO Act therefore may not cover all the national security concerns the Minister may have.¹⁸

- 2.22 Ms De Veau contended that 'security' is defined in section 4 of the ASIO Act, and is 'limited to espionage, sabotage, politically motivated violence, promotion of communal violence, attacks on Australia's defence system or acts of foreign of interference whether directed from, or committed within, Australia or not'.¹⁹
- 2.23 The department further contended that paragraph 198E(4)(c) limits refusal related to character to those persons with a substantial criminal record, which means the minister 'may not be able to refuse the transfer of all persons of character concern'. Persons who are currently the subject of charges or court action, or have been found guilty of offences but discharged without conviction, 'may not be captured by this ground'.²⁰
- 2.24 Mr Pezzullo argued that the medical transfer provisions prevent the department from being able to access 'the full range of tools that we have under section 501—and not just section 501(7)—that would allow us to look at broader character questions'. This means transfers may not be able to be refused for persons on grounds such as 'possession of child pornography and being charged with—not even convicted of—child sexual offences'.²¹
- 2.25 Witnesses who oppose the repeal argued the grounds for refusal were adequate. Professor Phelps proposed that the legislation contains appropriate safeguards to ensure that persons are not transferred if there are concerns around national security, 'evidence of serious criminal conduct', or 'if the minister reasonably believes that a transitory person...is a risk to the Australian community'.²² Dr Neela Janakiramanan echoed this view, adding that she believes none of the cases refused under the medical transfer provisions thus far have involved 'security issues'.²³
- 2.26 The Australian Human Rights Commission was concerned with the idea of widening the criteria for refusal, drawing the committee's attention to the legal principle that persons who have been accused but not convicted of a crime should be considered 'innocent until proven guilty'.²⁴ The Commission pointed

¹⁸ Department of Home Affairs, *Submission 55*, p. 12.

¹⁹ Ms De Veau, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 87.

²⁰ Department of Home Affairs, *Submission 55*, p. 13.

²¹ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 87.

²² Professor Phelps, *Committee Hansard*, 26 August 2019, p. 16.

²³ Dr Neela Janakiramanan, Private capacity, *Committee Hansard*, 26 August 2019, p. 9.

²⁴ Mr Edward Santow, Human Rights Commissioner, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 30.

out that refugees detained on the mainland have access to medical treatment under strict security conditions, even those convicted of crimes:

We acknowledge the very stringent protections that already exist, and what we say is that they provide adequate protection for the community while still enabling someone to be provided with urgent medical treatment.²⁵

2.27 Also arguing against the view that the medical transfer provisions unduly limit the minister's powers of refusal, Refugee Legal said:

There is significant scope under the existing legislation for refusal based on character grounds. It is actually a power held by the minister personally, so it is a personal power of the minister. Further to that, just on the security grounds issue, there have been no matters raised in relation to security at all, so I think it's a real mischaracterisation of the legislation to say that it's too narrow. It conforms with the ordinary protections under Australian law, including of the community, in relation to security or character matters. The power is vested in the minister. It is a vast power.²⁶

2.28 Ms Madeline Gleeson of the Kaldor Centre submitted that the introduction of the medical transfer provisions 'didn't repeal any of [the minister's] powers'. Ms Gleeson concluded: 'Doctors are deciding on medical care and those who need to are deciding on any character concerns. Those powers are separate.'²⁷

2.29 The department provided information on notice that indicates that, as at 26 August 2019, applications have been made for 'six individuals who are of character or security concern' to be transferred to Australia under the medical transfer provisions. None of these six were refused on security grounds, because:

...the limited nature of the character grounds upon which the Minister may refuse a transfer means the Minister may not be able to refuse the transfer of all persons of character concern.²⁸

Timeframe for security advice

2.30 The medical transfer provisions impose upon the minister a strict timeframe of 72 hours for approving transfer decisions. In addition, within that timeframe

²⁵ Mr Santow, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 32. See also: Mr Kon Karapanagiotidis, Chief Executive Officer, Asylum Seeker Resource Centre, *Committee Hansard*, 26 August 2019, p. 58.

²⁶ Mr David Mann, Executive Director, Refugee Legal, *Committee Hansard*, 26 August 2019, p. 43.

²⁷ Ms Madeline Gleeson, Senior Research Associate, Kaldor Centre for International Refugee Law, *Committee Hansard*, 26 August 2019, p. 42.

²⁸ Department of Home Affairs, *answers to questions on notice, 26 August 2019* (received 27 September 2019), [p. 9].

ASIO must 'advise the Minister if the transfer of the person to Australia may be prejudicial to security'.²⁹

- 2.31 The department submitted that the timeframe available to ASIO to provide security advice is unreasonable:

The operation of these provisions severely limits the Australian Security Intelligence Organisation's ability to provide security advice to the Minister. Such constraints have the potential to impact the quality of advice, noting full analysis is unable to be undertaken within the legislated timeframe.³⁰

- 2.32 Mr Pezzullo referred to statements by ASIO Director-General, Mr Duncan Lewis, in February 2019 that 'it's not possible within the 72 stipulated hours to conduct a security assessment' for a transferee. It was Mr Pezzullo's view that this is reason alone to repeal the medical transfer provisions.³¹

- 2.33 Mr Pezzullo went further, arguing that:

ASIO has made it amply clear that you cannot do a security assessment—as they would do for anyone crossing our border upon referral from my department—adequately in 72 hours. So whoever says there are sufficient grounds in the provisions that were passed under the miscellaneous measures, or medevac, provisions that give the minister and the Crown generally the full range of security and character powers—I regret to inform the committee, and I'm sorry to say it in these terms—is factually wrong and inconsistent with the construction of the act as it passed, was given royal assent and, therefore, modified the Migration Act.³²

Sovereignty issues

- 2.34 The department argued that the medical transfer provisions impinge on the sovereignty of Papua New Guinea (PNG) and Nauru. The department submitted:

The provisions do not expressly consider the sovereignty of Nauru and Papua New Guinea. The new medical transfer provisions require actions to be taken by Commonwealth officers in sovereign nations, to individuals under arrangements that are the responsibility of those nations.³³

- 2.35 According to the department, the provisions create a 'conflict' by mandating that Commonwealth officers remove a person from a foreign country and bring them to Australia, without reference to the 'applicable laws and procedures [to] be followed in respect to the removal of persons from [the

²⁹ Subsection 198E(4A) of the *Migration Act 1958*.

³⁰ Department of Home Affairs, *Submission 55*, p. 13.

³¹ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 77.

³² Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 87.

³³ Department of Home Affairs, *Submission 55*, p. 14.

foreign country's] territory'. As such, the provisions 'are not enforceable against the Governments of Nauru and Papua New Guinea'. However, the department confirmed that both countries 'have committed to work with the Government of Australia to administer the medical transfer provisions'.³⁴

2.36 The Government of Nauru introduced new regulations in February 2019 to codify medical transfer processes. The Health Practitioners (Overseas Medical Referrals Compliance) Regulations 2019 (OMR Regulations) and the Health Practitioners (Telemedicine Prohibition) Regulations 2019 relate to both Nauruan citizens and asylum seekers. These regulations require referrals for medical transfer to be made to a Nauruan body, the Overseas Medical Referral Committee, by medical practitioners registered in Nauru. They also prohibit:

...a health practitioner located outside Nauru from practising health and medical services using any form of telecommunications, electronic audio and video communications or any other communications with respect to any patient who is resident in Nauru.³⁵

2.37 The department reported that these restrictions are operating to require that transfer recommendations from the minister be locally re-assessed in Nauru, and the recommendation to transfer be made directly to the Overseas Medical Referral Committee by the contracted health service provider on the ground, International Health and Medical Services (IHMS), whose practitioners are registered in Nauru.³⁶

2.38 This process sets up a potential conflict of interest for the practitioners employed by IHMS, who are, according to the department, under 'significant pressure' to recommend transfers, even if they don't agree that the transfer is necessary. The department reported that 'this has resulted in increased tension between [IHMS] and local government authorities'.³⁷

2.39 In June 2019, the Federal Court ruled that medical assessment of transitory persons under the medical transfer provisions 'does not require personal engagement between the "treating doctor" and the transitory person', paving the way for remote assessments. However, the Nauruan regulations prohibit these kinds of assessments.³⁸

2.40 Ms Gleeson of the Kaldor Centre disputed the department's 'claim that medevac impinges upon the sovereignty of Nauru and PNG', saying:

I wish simply to note that, under international law, the sovereignty of Nauru and PNG prevents Australia from imposing its own laws and it

³⁴ Department of Home Affairs, *Submission 55*, p. 14.

³⁵ Department of Home Affairs, *Submission 55*, p. 15.

³⁶ Department of Home Affairs, *Submission 55*, p. 15.

³⁷ Department of Home Affairs, *Submission 55*, p. 15.

³⁸ Department of Home Affairs, *Submission 55*, p. 15.

prevents Australia from exercising government functions in the territories of those states without their consent but does not in any way extinguish Australia's obligations under both Australian and international law. Australia cannot circumvent its duty of care simply by acting outside of its territory; that is not how the law works.³⁹

2.41 Dr Jenkins from RANZCP argued that repealing the medical transfer provisions may 'put extra pressure on the medical and health staff back in Nauru and PNG...to provide medical care that they are not resourced or equipped to provide'.⁴⁰

2.42 While discussing sovereignty issues triggered by the medical transfer provisions, the department acknowledged that tensions existed with Nauru in relation to medical transfers prior to the new regime. Specifically, court ordered transfers under the pre-existing system resulted in 'strained relations with the Government of Nauru as it insists that the Commonwealth must adhere to its processes and procedures'.⁴¹

2.43 In relation to PNG, witnesses referred to reports that 'failed' and unassessed asylum seekers had allegedly been moved to Bomana, a prison complex in Port Moresby. Dr Sara Townend reported that persons involved in the medical transfer process were 'caught up' in this group, saying:

A significant number of the transitory persons in Bomana had engaged with the medevac process prior to being placed in there...There is at least one patient who had been approved who was moved to Bomana subsequent to approval for the medevac process. Since they have been in there, there are...two or three patients who have been approved subsequent to their detainment. Certainly, out of the 50 or so remaining, 33 patients have applications which we would consider that we would be able to progress because we have substantial information and prior telehealth assessments with two independent specialists.⁴²

2.44 The department confirmed that one person who has been approved for transfer under the medical transfer provisions has indeed been detained in PNG and prevented from being transferred to Australia. Senior Assistant Secretary of Regional Processing and Resettlement, Ms Alana Sullivan said:

We have requested transfer from PNG a number of times, and they have refused to approve the transfer to Australia. They have advised that they

³⁹ Ms Gleeson, Kaldor Centre for International Refugee Law, *Committee Hansard*, 26 August 2019, p. 40.

⁴⁰ Dr Jenkins, RANZCP, *Committee Hansard*, 26 August 2019, p. 20.

⁴¹ Department of Home Affairs, *Submission 55*, p. 16.

⁴² Dr Sara Townend, Private capacity, *Committee Hansard*, 26 August 2019, p. 14.

have their own medical provider. That individual has been assessed as being able to receive treatment in PNG.⁴³

- 2.45 On notice, the department provided the following additional comments about persons detained in the Bomana complex in Port Moresby:

The management of the Bomana Immigration Centre and the detention of failed asylum seekers in Papua New Guinea is a matter for the Papua New Guinea Government. The Department understands that such detention has been undertaken in accordance with the Papua New Guinea *Migration Act 1978*.⁴⁴

Impacts on regional processing arrangements

- 2.46 The explanatory memorandum to the bill states that the medical transfer provisions 'undermine the Australian Government's regional processing arrangements'.⁴⁵ The minister's second reading speech elaborates on this claim, saying that the provisions 'effectively remov[e] the ability of the Government to decide who comes into Australia'.⁴⁶

- 2.47 The department was concerned that, in applying to 'persons born in a regional processing country', the medical transfer provisions also apply to 'those born in the future', including to children born to any new asylum seekers who come by boat and are transferred to regional processing countries in the future. Further, because the provisions allow the transfer of relevant family members, along with those children, the department argued that future asylum seekers could use this as a way to get to Australia. The department submitted:

This seriously undermines the Government's border protection policies and arguably incentivises people smuggling operations.

...

The definition of a relevant transitory person also places ongoing obligations on the Minister. For example, the provisions would continue to apply to refugees permanently settled in Papua New Guinea, long after Australia's regional processing arrangement with Papua New Guinea ends.⁴⁷

⁴³ Ms Alana Sullivan, Senior Assistant Secretary, Regional Processing and Resettlement, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 72.

⁴⁴ Department of Home Affairs, *answers to questions on notice, 26 August 2019* (received 27 September 2019), p. [6].

⁴⁵ Explanatory memorandum, Migration Amendment (Repairing Medical Transfers) Bill 2019, p. 4.

⁴⁶ The Hon Peter Dutton MP, Minister for Home Affairs, *House of Representatives Hansard*, 4 July 2019, p. 296.

⁴⁷ Department of Home Affairs, *Submission 55*, p. 11.

- 2.48 World Vision submitted that, because the medical transfer provisions only apply to the existing cohort and any children they have, 'the legislation in no way creates an incentive for "people smugglers"'.⁴⁸
- 2.49 The Law Council also disputed the department's argument, pointing out that '[t]here is no pathway to permanent residency in Australia' for those transferred. The Law Council's view was that 'border management concerns' should be addressed by the fact that the Act prevents transferees from applying for any visa while in Australia, unless the minister makes a specific exception.⁴⁹
- 2.50 Professor Phelps argued that the medical transfer provisions have 'nothing to do with undermining the policy of stopping the boats' and does not undermine Operation Sovereign Borders or create a 'pull factor'.⁵⁰
- 2.51 Refugee Legal criticised comments made by the government around the time of the enactment of the medical transfer provisions, saying:
- ...the sky hasn't fallen in...nor have the boats resumed, as was clearly a concern stated by government. In fact, we've seen people being resettled to the US from Nauru and from PNG. We've seen many people being brought back for the critical medical treatment they need. What we see is not in fact the problems that those fears sought to provoke. They just haven't materialised.⁵¹
- 2.52 Mr Pezzullo conveyed the government's view that the medical transfer provisions 'sit at odds with the objectives and processes established under Operation Sovereign Borders'. Mr Pezzullo elaborated:
- It is the firm contention of the government that it is possible to support [Operation Sovereign Borders] or to support these provisions, but it is not possible to support both, as a result of the statutory requirements that were introduced into the Migration Act by way of the miscellaneous measures act.⁵²
- 2.53 Major General Furini outlined the view that the medical transfer provisions create confusion around the government's resolve:
- I think that, ultimately, we need to deliver clear and unambiguous messaging offshore to all of the potential illegal immigrants of the future. We have seen, throughout the course of [Operation Sovereign Borders] history, people smugglers peddle falsehoods and create false hope and misconstrue the policy position of the Australian government. So, the more we can be emphatic and unambiguous about our position, the better off we

⁴⁸ World Vision, *Submission 28*, p. 5.

⁴⁹ Mr Liveris, Law Council of Australia, *Committee Hansard*, 26 August 2019, p. 44.

⁵⁰ Professor Phelps, *Committee Hansard*, 26 August 2019, p. 8.

⁵¹ Mr Manne, Refugee Legal, *Committee Hansard*, 26 August 2019, p. 37.

⁵² Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 68.

will be and the easier my mission will be, in terms of delivering that deterrence message offshore.⁵³

Remuneration for the Independent Health Advice Panel

2.54 The medical transfer provisions specifically exclude remuneration for IHAP panel members. This issue was raised by submitters on both sides of the debate.

2.55 The department explained that it is able to provide secretariat support to the IHAP, including organising travel and facilitating meetings. However, attendance at IHAP meetings and associated activities are 'subject to members' ability to take leave from their paid employment or business'. Panel members are also unable to be 'indemnified by the Commonwealth', leaving members to organise their own insurance coverage.⁵⁴

2.56 In its *Second Quarterly Report*, the IHAP reported that the department had provided assistance for travel by IHAP members. The IHAP also made the following comments about insurance coverage:

The Department encourages Panel members to undertake their own assessment of the possible implications being an IHAP member may have on any existing insurance. IHAP members have requested further information and assistance from the Department regarding indemnification and insurance for IHAP members. To date, the Department has advised Panel members to consider acquiring personal or private insurance coverage and has undertaken to continue exploring options and to update Panel members accordingly.⁵⁵

2.57 The President of the Australian Medical Association (AMA), Dr Tony Bartone, was concerned that a lack of remuneration 'for the considerable time and expertise' provided by panel members represents a 'flaw' in the medical transfer provisions. However, he confirmed that the AMA does not believe this issue is 'a game-breaker', or a reason to repeal the provisions.⁵⁶

2.58 Dr Bartone provided a description of the work conducted by IHAP members:

Dr Di Dio, as an example, has performed all of that activity and due diligence, reading the case files. Of course each application could amount to many, many hundreds of pages of clinical notes that have been brought together for the brief of the application. It would take several hours to go through that meticulously for each case...I contend that the panel may in due course fatigue purely under weight of numbers or weight of

⁵³ Major General Craig Furini, Commander, Joint Agency Task Force Operation Sovereign Borders, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 86.

⁵⁴ Department of Home Affairs, *Submission 55*, p. 16.

⁵⁵ Independent Health Advice Panel, *Second Quarterly Report*, 15 August 2019, p. 13 (tabled 17 September 2019).

⁵⁶ Dr Tony Bartone, President, Australian Medical Association (AMA), *Committee Hansard*, 26 August 2019, p. 1.

obligation, because, as I say, this is all being done at the expense of their own professional day-to-day lives.⁵⁷

- 2.59 Despite the lack of remuneration, the Royal Australasian College of Physicians (RACP) reported that it had over 30 people express interest in being on the IHAP.⁵⁸ The AMA similarly argued that the lack of remuneration 'does not diminish the role the panel is playing in ensuring appropriate health care is provided'.⁵⁹
- 2.60 Witnesses did, however, argue that the government should consider remuneration for the members of the IHAP. The Royal Australian College of General Practitioners (RACGP) identified a need to provide 'adequate resourcing of the process and sufficient legal indemnity' for medical practitioners conducting assessments under the medical transfer provisions.⁶⁰ Similarly, the AMA said 'IHAP or any such body should be appropriately resourced to ensure that it carries out its functions in a way that is appropriate, timely and efficient'.⁶¹ The Law Council agreed that the panel should be remunerated.⁶²
- 2.61 When asked about what would constitute appropriate remuneration, the AMA suggested this be based on remuneration levels for involvement by medical practitioners in other Commonwealth government activities where they provide expert advice.⁶³

Alleged increase in self-harm

- 2.62 One reason provided by the department for the proposed repeal was related to the issue of self-harm among the regional processing cohort. The department argued that the medical transfer provisions have led to an increase in incidents of self-harm. This assertion was refuted by other witnesses, including Dr Phelps, Dr Janakiramanan, and Ms Gleeson of the Kaldor Centre.
- 2.63 The department submitted that incidents of self-harm among the PNG cohort saw an 'upwards trend' from late 2018 through 2019:

⁵⁷ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 3.

⁵⁸ Professor Niki Ellis, Director, and Chair, Policy and Advocacy Council, Royal Australasian College of Physicians (RACP), *Committee Hansard*, 26 August 2019, p. 22.

⁵⁹ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 2.

⁶⁰ Dr Lara Roeske, Chair, Royal Australian College of General Practitioners (RACGP) Specific Interests, and RACGP Board Director, RACGP, *Committee Hansard*, 26 August 2019, p. 20. See also RACGP, *Submission 13*, p. 2.

⁶¹ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 2.

⁶² Mr Liveris, Law Council of Australia, *Committee Hansard*, 26 August 2019, p. 44.

⁶³ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 3.

Notably, self-harm incidents increased during the parliamentary debate on the Miscellaneous Measures Act, and more significantly since the Australian Federal Election. Of the 72 transitory persons transferred to Australia under the Miscellaneous Measures Act, 39 had undertaken an act of self-harm and 19 had threatened self-harm since the implementation of the Act.⁶⁴

2.64 In addition, the department explained that the government is 'concerned that self-harm is perceived as the most expedient means of accessing medical transfer under the provisions'.⁶⁵

2.65 Professor Phelps disputed the department's claims, saying:

The incidents of self-harm related to declining mental health were increasing before medevac and was one of the reasons it was needed. The government's rhetoric and statements about repealing the legislation triggered another level of hopelessness and a new round of self-harm and suicide attempts after the last election.⁶⁶

2.66 Other submissions also disputed the government's claims about the cohort's intentions around self-harm. For example, Grandmothers Against Detention of Refugee Children submitted:

The figures will show that the distressing spate of self-harming by more than 90 people held on Manus Island began in response to the hopes for a change in refugee policy dashed by the re-election in May 2019 of the Morrison Government...To characterise the self-harm, including an act of self-immolation, as a manipulation of the system is misleading the Parliament and deserves to be called out as such by the Committee.⁶⁷

2.67 Ms Gleeson of the Kaldor Centre said historical data indicates there have been 'peaks in self-harm behaviour and mental health deterioration around critical moments', specifically around political decisions made in Australia that impact upon the regional processing cohort.⁶⁸

2.68 The department addressed the debate around the issue of self-harm at the hearing. Major General Furini said:

Senator, as you did hear earlier today from another witness, external factors do drive behaviours and attitude amongst the cohort in PNG and Nauru. Historically over time we've seen that such things as visits to the regional processing centres, public and political debate in Australia and changes to policy have all contributed to the creation of expectations, false

⁶⁴ Department of Home Affairs, *Submission 55*, p. 16.

⁶⁵ Department of Home Affairs, *Submission 55*, p. 16.

⁶⁶ Professor Phelps AM, *Committee Hansard*, 26 August 2019, p. 8, also see, Dr Janakiramanan, *Committee Hansard*, 26 August 2019, pp. 13–14.

⁶⁷ Grandmothers Against Detention of Refugee Children, *Submission 10*, p. 3.

⁶⁸ Ms Gleeson, Kaldor Centre for International Refugee Law, *Committee Hansard*, 26 August 2019, p. 40.

or otherwise, of a particular future which then in turn influences behaviours and attitudes of transferees.⁶⁹

2.69 Major General Furini also suggested that 'influential transferees are coaching others to self-harm in order to get to Australia'.⁷⁰

2.70 The department was asked to provide evidence of an increase in self-harm related to the passage of the miscellaneous measures bill. Major General Furini said:

In December 2018, about the time the bill was introduced, for example, 66 cases of self-harm occurred in Nauru, compared to 15 in December 2017, the same period a year before. In June 2019, following the election and the signal of a clear intent to push forward with the repeal of the bill, in PNG there were 101 cases of self-harm versus one for the same period in 2018.⁷¹

2.71 Dr O'Sullivan from the Castan Centre observed 'an upwards trend' in self-harm incidents, but argued that the trend 'cannot be legally linked to anything related to the medevac laws'.⁷² Mr de Kretser from the Human Rights Law Centre agreed, saying:

There is overwhelming evidence of the mental harm that's been inflicted by six long years of people being held offshore, and I don't agree with the suggestion that it's linked to the medevac laws.⁷³

2.72 On notice, the department provided the following graph to support its assertions:

⁶⁹ Major General Furini, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 69.

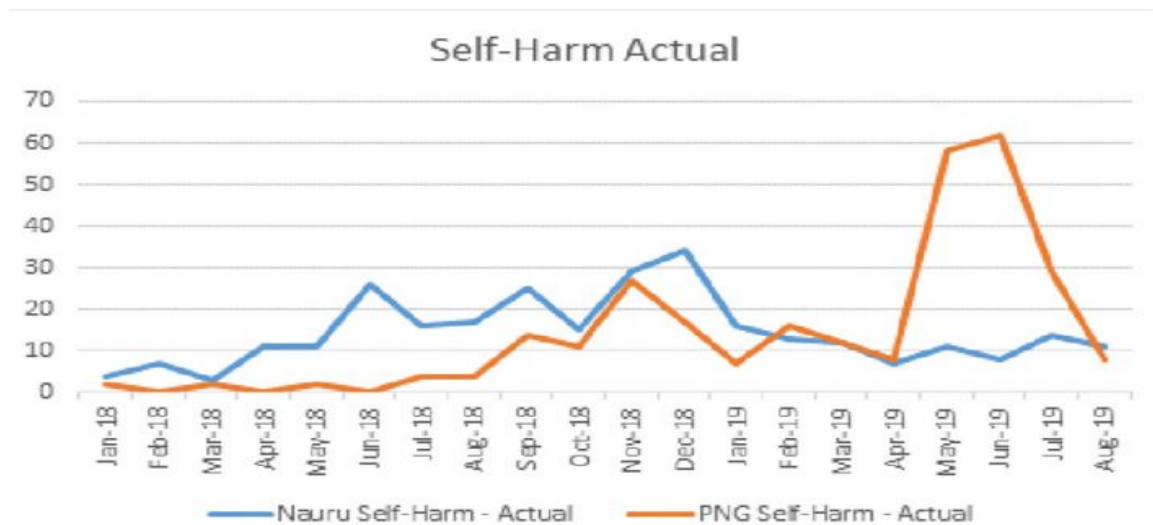
⁷⁰ Major General Furini, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 69.

⁷¹ Major General Furini, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 69.

⁷² Dr O'Sullivan, Castan Centre for Human Rights Law, *Committee Hansard*, 26 August 2019, p. 36.

⁷³ Mr Hugh de Kretser, Executive Director, Human Rights Law Centre, *Committee Hansard*, 26 August 2019, p. 36.

Figure 2.1 Graph provided by Department of Home Affairs showing the number of incidents of self-harm



Source: Department of Home Affairs, answers to questions on notice, 26 August 2019 (received 27 September 2019), [p. 2].

2.73 In addition, the department submitted:

As at 26 August 2019, 112 people had transferred to Australia under the Miscellaneous Measures provisions. In assessing this transferred cohort, it was identified that in the 11 months prior to the initial discussions in Parliament on the new medical transfer provisions (1 November 2017 – 30 September 2018) there were 18 incidents of actual self-harm involving nine individuals amongst this cohort. From 1 October 2018 to 26 August 2019, there were 121 incidents of actual self-harm involving 50 individuals in this cohort. This is an increase of 572 per cent on the previous period.⁷⁴

2.74 Doctors Janakiramanan and Townend argued that the statistics and medical reports do not indicate that self-harm rose in response to the debate and implementation of the medical transfer provisions.⁷⁵ Dr Janakiramanan added:

In fact, the medevac bill became law on 1 March, and between 1 March and the middle of May, when the election was held, the rates of self-harm were actually extremely low.⁷⁶

2.75 The doctors and Professor Phelps pointed to the federal election as a more significant factor, with Professor Phelps saying that individuals in regional processing centres are 'not trying to make a point; they're trying to kill themselves because they've lost hope'.⁷⁷

⁷⁴ Department of Home Affairs, answers to questions on notice, 26 August 2019 (received 27 September 2019), p. [3].

⁷⁵ Dr Janakiramanan, *Committee Hansard*, 26 August 2019, p. 13.

⁷⁶ Dr Janakiramanan, *Committee Hansard*, 26 August 2019, p. 14.

⁷⁷ Professor Phelps, *Committee Hansard*, 26 August 2019, p. 13.

- 2.76 The department stated that it is working with service providers to address mental health issues and self-harm by supplying 'enhanced mental health services', which include:
- more welfare support and psychology services;
 - new programs and activities;
 - more 'data and information sharing' and 'close observations' of persons deemed to be 'at risk'; and
 - more 'offshore medical accommodation'.⁷⁸
- 2.77 Additional mental health facilities have also been added at Pacific International Hospital in Port Moresby, including 'a dedicated mental health ward comprising 12 beds, with an adjoining activity room' and more mental health staff.⁷⁹

Adequacy of the medical transfer provisions prior to March 2019

- 2.78 The minister and the department proposed that the medical transfer provisions that applied prior to March 2019 (and which remain in the Act) are satisfactory for the purpose of bringing transitory persons to Australia for medical assessment or treatment.
- 2.79 Section 198B of the Act provides a power to bring transitory persons (and accompanying persons) to Australia for a temporary purpose, using restraint or force 'as is necessary and reasonable'. A 'temporary purpose' includes 'medical or psychiatric assessment or treatment'. Transfers under section 198B are 'supported by clinical advice provided by a Medical Officer of the Commonwealth'.⁸⁰
- 2.80 The department provided statistics for the numbers of people who were transferred to Australia under these provisions. From November 2012 to 31 July 2019, 1,343 transitory persons were transferred from Nauru and PNG to Australia under section 198B. This comprised 717 patients and 626 accompanying family members. In addition, 1,176 of the 1,343 persons were from Nauru and 167 were from PNG.⁸¹ As at 26 August 2019, the total figure had risen by five to 1,348.⁸²

⁷⁸ Department of Home Affairs, *Submission 55*, p. 16.

⁷⁹ Department of Home Affairs, *Submission 55*, p. 16.

⁸⁰ Department of Home Affairs, *Submission 55*, p. 10.

⁸¹ Department of Home Affairs, *Submission 55*, pp. 10-11.

⁸² Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 68.

- 2.81 On notice, the department also confirmed that, as at 26 August 2019, there were 46 requests for a transfer under section 198B 'pending outside of the medevac process'.⁸³
- 2.82 A number of inquiry participants argued that section 198B has been insufficient as a transfer mechanism because its application has been inconsistent. The Australian Human Rights Commission was concerned that 'it does not state how the power should be exercised' and that there are 'real concerns about how this power has been exercised in the past'.⁸⁴
- 2.83 The Australian Human Rights Commission elaborated on these concerns, saying that under the old provisions, transfer decisions 'often did not occur in a timely manner or in line with medical advice' and many cases led to Federal Court proceedings. In most of these cases, the Federal Court determined that 'processes for assessing individuals for medical transfer from Nauru or PNG were neither adequate nor sufficiently quick'.⁸⁵
- 2.84 Refugee Legal expressed opposition to relying solely on section 198B of the Act:
- ...because there is no clear and transparent process for section 198B to be triggered; there are no time frames for consideration of transfers, and we are aware of transfers taking months to be effected under this power; there is no clear review process, leaving desperate people to resort to complex and resource-intensive legal proceedings in the Federal Court of Australia; and crucial decisions are made by bureaucrats and politicians, not those with independent medical expertise.⁸⁶
- 2.85 Other witnesses shared these concerns, including the Castan Centre⁸⁷ and the New South Wales Council for Civil Liberties, which described the process under section 198B as 'slow, cumbersome, [and] bureaucratic'.⁸⁸
- 2.86 The Human Rights Law Centre argued that 'the transfer system in place before medevac was not working'. Mr de Kretser elaborated:
- Before the medevac law, the Human Rights Law Centre was forced to take legal action, on behalf of people who were at risk of death or serious injury, to secure transfers for medical treatment in Australia. We gathered medical reports and expert medical evidence, undertook legal advocacy for

⁸³ Department of Home Affairs, *answers to questions on notice, 26 August 2019* (received 27 September 2019), [p. 10].

⁸⁴ Mr Santow, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 27.

⁸⁵ Mr Santow, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 27.

⁸⁶ Ms Kate Fitzgerald, Lawyer, Refugee Legal, *Committee Hansard*, 26 August 2019, p. 34.

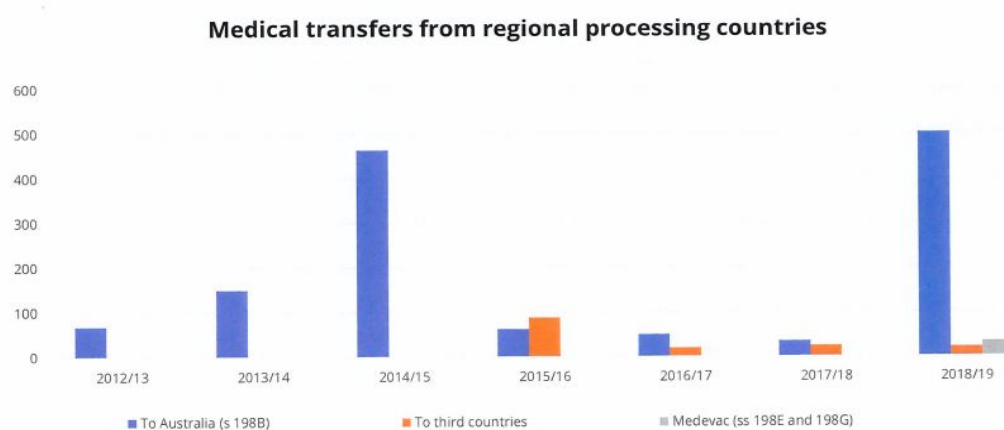
⁸⁷ Dr O'Sullivan, Castan Centre for Human Rights Law, *Committee Hansard*, 26 August 2019, p. 34.

⁸⁸ New South Wales Council for Civil Liberties, *Submission 36*, p. 7.

our clients with the government, were forced to threaten court cases and, on many occasions, were forced to bring cases in the Federal Court.⁸⁹

2.87 The Australian Human Rights Commission provided a graph with the numbers of persons transferred each year, and the country to which they were transferred:

Figure 2.2 Graph provided by the Australian Human Rights Commission showing the number of medical transfers from Nauru and Manus Island, PNG, by year



Source: *Fact Sheet 6: Medical Transfers* in the submission of the Department of Home Affairs.

The table above sets out the number of medical transfers each year from Nauru and Manus Island, PNG to:

- Australia, under s 198B of the *Migration Act 1958* (Cth)
- third countries, being either Papua New Guinea (the Pacific International Hospital at Port Moresby) or Taiwan
- Australia, under the Medevac provisions (ss 198E and 198G of the *Migration Act 1958* (Cth))

The numbers include transfers of both people receiving treatment and family members.

Source: Document tabled by Australian Human Rights Commission at the public hearing in Canberra on 26 August 2019.

2.88 The Australian Human Rights Commission observed that the dramatic drop in transfers to Australia from 2015-16 to the end of 2017-18, followed by a spike with the introduction of the medical transfer provisions, indicates that the government adopted a policy in 2015 of refusing transfers, and concluded:

...the previous regime under section 198B and the government's policy position since July 2015 were not sufficient to ensure that people received the medical care they needed.⁹⁰

Alleged delays for medical transfers under section 198B prior to March 2019

2.89 Witnesses from the legal and refugee support sectors provided evidence about delays in the medical transfer system under section 198B prior to March 2019.

⁸⁹ Mr de Kretser, Human Rights Law Centre, *Committee Hansard*, 26 August 2019, p. 33.

⁹⁰ Mr Edgerton, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 28.

Director of the National Justice Project, Mr George Newhouse, offered a case study of:

...a young man who waited two years before medevac for an urgent hand operation. After medevac was introduced, he was medevaced within 24 hours. He was being recommended for that operation by IHMS, and they were being ignored. We're told now that he will never regain the full use of his hand because of the delay. So there is delay.⁹¹

2.90 The AMA said the process prior to March 2019 was 'a bit ad hoc'. Dr Bartone provided this detailed description of the process from the point of view of doctors involved:

The IHMS was the organisation that was overseeing the provision of medical services in the refugee camps. It would make a recommendation, often discussing it with colleagues back home, and then have to go through the appropriate legal channels. That is not my area of expertise or knowledge, but suffice it to say that it was on an ad-hoc basis and there was really no clear formal process. It was all ad hoc and the oversight was at times completely lacking.

...

[F]rom feedback from doctors at the front line, that they were quite distressed at times about patients who did need to be transferred and weren't able to access the appropriate transfer. They were very, very concerned, and I know that, for some members of the medical profession performing services at that front line, it was so distressing that they had to leave that service because of that.⁹²

2.91 Dr Bartone further described the processes as 'torturous', involving 'long periods of delay'⁹³ and lacking 'the appropriate oversight'. Dr Bartone added:

There was no independent way of verifying, or not, any of the approaches or the transfers. The information wasn't being provided to the parliament in the appropriate time. This [medevac] process brings rigour to the process and information transparency to the government.⁹⁴

2.92 Many witnesses pointed to the case of Hamid Khazaei, who died after contracting an infection in his foot. The Chief Executive Officer of the Asylum Seeker Resource Centre, Mr Kon Karapanagiotidis, said:

The coroner...made it very clear that that young man who died at 24 from a foot infection should have been alive today. He set the standard. He said that if Australia is going to relocate people to an offshore camp, to an offshore prison, then the standard of medical care we should expect is the

⁹¹ Mr George Newhouse, Director and Principal Solicitor, National Justice Project, *Committee Hansard*, 26 August 2019, p. 54.

⁹² Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 3.

⁹³ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 6.

⁹⁴ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 4.

standard of care of the Australian health system. It is not normal for 24-year-olds to die of foot infections.⁹⁵

2.93 On notice, the National Justice Project provided a number of case examples it believes show that transfers were delayed against medical advice:

Figure 2.3 Graph provided by the National Justice Project showing delays in transfers against medical advice.

Evidence of delays in transfer against medical advice					
	Individual ² and their condition	Date of first medical request/recommendation for transfer ³	Transfer date to Australia	Period between first transfer request and transfer date	Legal intervention?
1	Young adult male in Nauru with chronic arthritis including in his spine (<i>ankylosing spondylitis</i>)	6 January 2015 ⁴	18 June 2019	More than 4 years and 5 months	Yes
2	Adult male in Nauru with Diabetes Mellitus Type 1 LADA; Major Depressive Disorder; severe and generalised Anxiety Disorder ⁵	9 September 2015	24 October 2018	More than 3 years	Yes
3	Pre-teen male in Nauru with broken radius and ulna; PTSD; depression and anxiety ⁶	5 June 2016	22 October 2018	More than 2 years and 4 months	Yes
4	Adult female in Nauru with major depressive disorder; borderline personality disorder; anxiety disorder; suicide ideation with suicide attempts	5 September 2016	13 August 2018	Approx. 2 years	Yes
5	Adult male in Nauru with ulnar neuropathy and complex regional pain syndrome of the left hand; major depressive disorder ⁷	16 May 2017	1 August 2019	More than 2 years and 2 months	Yes
6 & 7	Brother and sister in Nauru. Brother with Major Depressive Disorder and chronic pain. Sister with depression.	12 January 2015 ⁸	24 October 2018	Almost 4 years	Yes
8	Pre-teen male in Nauru with autistic spectrum disorder; attachment disorder; development disorder; trauma; anxiety disorder; ADHD and more	August 2017	13 August 2018	1 year	Yes

Source: National Justice Project, answers to questions on notice 26 August 2019 (received 1 October 2019), p. 2.

⁹⁵ Mr Karapanagiotidis, Asylum Seeker Resource Centre, *Committee Hansard*, 26 August 2019, pp. 55-56.

- 2.94 The Human Rights Law Centre reported that in a number of cases it worked on under the transfer provisions prior to March 2019, 'recommendations from the government's own doctors for transfers...had not been complied with'.⁹⁶
- 2.95 The department explained the process for transfers under section 198B. The department receives advice that an individual requires a medical transfer from the medical provider in PNG or Nauru. Cases are then triaged following consideration of the medical recommendation and then department and Australian Border Force officers meet and 'look at the holistic view of the transfer', which includes issues relating to accompanying persons and arrangements with PNG and Nauru.⁹⁷
- 2.96 In response to claims of deliberately delayed decision-making and transfers by the department, Mr Pezzullo said:
- We assert very strongly that in no cases have we delayed a transfer where there was an evident medical need...I strongly deny in the most forceful terms possible that I can lay before this committee any kind of strategy of prolonged, deliberate, targeted suffering...⁹⁸
- 2.97 Further, the department stated that 'as at 26 August 2019, there were 46 transfer requests (for the purposes of a transfer under section 198B of the *Migration Act 1958*) pending outside of the medevac process'.⁹⁹

Court action in relation to potential transfers

- 2.98 A number of witnesses proposed that the medical transfer provisions prior to March 2019 led to a significant amount of court action. For instance, the Australian Human Rights Commission claimed that in 2018-19, 536 people were brought to Australia for medical assessment or treatment, and 'approximately 60 per cent were transferred as a result of actual or prospective litigation'.¹⁰⁰
- 2.99 The department refuted this claim, saying:

It is not the case that the Australian government needed to be legally compelled to transfer persons from Nauru and Papua New Guinea to Australia to receive necessary health care. This is factually incorrect. Medical transfers informed by clinical advice have been available from the first day of regional processing arrangements in 2012 and will continue.¹⁰¹

⁹⁶ Mr de Kretser, Human Rights Law Centre, *Committee Hansard*, 26 August 2019, p. 38.

⁹⁷ Ms Cheryl-Anne Moy, Deputy Secretary, Chief Operating Officer, Corporate and Enabling, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 84.

⁹⁸ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 85.

⁹⁹ Department of Home Affairs, *answers to questions on notice, 26 August 2019* (received 27 September 2019), [p. 10].

¹⁰⁰ Mr Edgerton, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 28.

¹⁰¹ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 68.

- 2.100 The department submitted that out of the 1,343 transitory persons transferred to Australia under section 198B between 2012 and 31 July 2019, 'only 96 were court ordered', which represented seven per cent of the caseload.¹⁰²
- 2.101 Mr Pezzullo reported that, in relation to some of the 39 cases in which court orders were made, legal proceedings were filed despite the department informing legal representatives 'of its intention to transfer their clients prior to proceedings being filed and that transfer would occur as soon as practicable'.¹⁰³
- 2.102 The department also acknowledged another 90 cases, involving approximately 220 transitory persons, in which 'legal representatives made representations to Home Affairs seeking medical transfer, including many foreshadowing litigation'. These cases resulted in transfer to Australia under section 198B of the Migration Act 'prior to any proceedings being filed'.¹⁰⁴
- 2.103 The Human Rights Law Centre did not dispute the numbers, but disagreed with the department's characterisation of them, saying that all-in-all around '350 people—over 100 kids—were brought as a result of legal interventions'. This, Mr de Kretser said, represents a significant pro bono case workload.¹⁰⁵
- 2.104 Professor Phelps concurred that the process was ad hoc, adding there were 'no protocols for urgent transfer', or for 'triaging of cases'¹⁰⁶, and that average waiting times were over two years. Professor Phelps proposed that:
- The department had a policy of dragging medical transfer cases through the courts. Refugees and people seeking asylum lacked the resources to fight their cases, so it was up to lawyers working pro bono to take their cases—hundreds of cases. In every case the Federal Court found in favour of the original medical recommendation.¹⁰⁷
- 2.105 The Human Rights Law Centre told the committee it had been involved in legal interventions resulting in the transfer of 180 people, 'and many more were transferred through the interventions of our partners'.¹⁰⁸
- 2.106 Witnesses from the medical sector were concerned that repealing the medical transfer provisions and retuning to the old system could result in greater mortality and morbidity amongst the cohort. Professor Phelps explained 'as

¹⁰² Department of Home Affairs, *Submission 55*, pp. 10-11.

¹⁰³ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 69.

¹⁰⁴ Department of Home Affairs, *Submission 55*, pp. 10-11.

¹⁰⁵ Mr de Kretser, Human Rights Law Centre, *Committee Hansard*, 26 August 2019, pp. 40-41.

¹⁰⁶ Professor Phelps, *Committee Hansard*, 26 August 2019, p. 15.

¹⁰⁷ Professor Phelps, *Committee Hansard*, 26 August 2019, p. 7.

¹⁰⁸ Mr de Kretser, Human Rights Law Centre, *Committee Hansard*, 26 August 2019, p. 33.

doctors we fear a return to a slow, unpredictable and dangerous transfer system and further unnecessary deaths':¹⁰⁹

The fear that my colleagues and I have if we go back to the old system is that there will be other deaths. The system was broken. It wasn't working. It did not provide appropriate and timely care.¹¹⁰

2.107 The department rejected this view and argued that the pre-existing provisions and processes were a more appropriate mechanism for facilitating transfers, and said:

...our preference is to transfer under [section 198B] rather than [section 198E, which would be repealed by the bill] any day of the week...B more properly represents sovereignty of both the government and the parliament, whereas E puts transfer beyond the sovereign control of the executive.¹¹¹

¹⁰⁹ Professor Phelps, *Committee Hansard*, 26 August 2019, p. 8.

¹¹⁰ Professor Phelps, *Committee Hansard*, 26 August 2019, p. 10.

¹¹¹ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 79.

Chapter 3

Support for medical transfer provisions

- 3.1 The majority of the evidence to the inquiry argued that the medical transfer provisions enacted in March 2019 should not be repealed from the *Migration Act 1958* (the Act).¹ Inquiry participants highlighted several arguments against repeal, and therefore against the Migration Amendment (Repairing Medical Transfers) Bill 2019 (the bill), including that:
- the medical transfer provisions facilitate and support medical decisions being made by medical professionals;
 - the provisions are working as intended to ensure individuals in Nauru and Papua New Guinea (PNG) receive medical treatment;
 - the contribution of the Independent Health Advice Panel (IHAP) is beneficial, particularly its oversight, monitoring and reporting functions; and
 - repealing the provisions would adversely affect Australia's ability to meet its international legal obligations, particularly its human rights obligations.
- 3.2 This chapter discusses each of these issues in turn and concludes with the committee's view and recommendation.
- 3.3 Where this chapter refers to 'medical transfer provisions', it is referring to the medical transfer provisions enacted in March 2019 that would be repealed by the bill (as distinct from the medical transfer provisions in section 198B that applied prior to March 2019).

Who should make decisions on medical issues?

- 3.4 As outlined in chapter 1, the medical transfer provisions enacted in March 2019 stipulate that in order for a medical transfer to occur, two treating doctors must give an opinion that a transitory person requires medical or psychiatric assessment or treatment which they are not currently receiving and that transfer to Australia is necessary to enable the required assessment or treatment to occur.

¹ See, for example, Jesuit Social Services, *Submission 26*, [p. 1]; World Vision, *Submission 28*, p. 3; New South Wales Council for Civil Liberties, *Submission 36*, p. 3; Royal Australasian College of Physicians, *Submission 40*, p. 1; Maurice Blackburn Lawyers, *Submission 42*, p. 1; Refugee Council of Australia, *Submission 43*, p. 12; Australia Association of Social Workers, *Submission 57*, p. 2; Sisters of St Joseph, *Submission 72*, p. 7.

- 3.5 Evidence to the inquiry expressed support for a framework that facilitates medical decisions being made by medical professionals.² Professor Niki Ellis from the Royal Australasian College of Physicians (RACP) explained:

The medevac legislation allows medical experts to make decisions about health care for seriously ill individuals and enables Australia's independent medical oversight of a health system, contracted by the Australian government and funded by Australian taxpayers, arising as a result of Australian immigration policy.³

- 3.6 When discussing the importance of doctors playing a key role in the decision making for medical transfers, the expertise and professional standards that doctors bring to the process were highlighted. Dr Tony Bartone, President, Australian Medical Association (AMA) emphasised that 'medical practitioners in Australia...are guided and regulated by some of the strongest ethics and regulations anywhere in the world'.⁴ Similarly, Professor Ellis recognised the expertise of the medical profession:

Medical practitioners have a professional duty of care to patients and undertake years of medical training. It's therefore highly concerning when medical recommendations are overruled by persons without medical expertise.⁵

- 3.7 The Royal Australian College of General Practitioners (RACGP) said the medical transfer provisions provide:

...a process whereby skilled medical professionals undertake objective health assessments of a person and make subsequent clinical recommendations about required treatments, individuals with significant medical, surgical and psychiatric conditions can access appropriate and timely health care.⁶

- 3.8 Other inquiry participants also highlighted the importance of doctors being key decision makers in the medical transfer process.⁷ World Vision emphasised that the medical transfers legislation is 'not about resettlement, but rather about ensuring appropriate and often lifesaving medical care for refugees and asylum seekers (transitory persons, per the legislation), as

² See, for example, Australasian College for Emergency Medicine, *Submission 58*, p. 1; Cabrini Health, *Submission 68*, p. 3.

³ Professor Niki Ellis, Director, and Chair, Policy and Advocacy Council, Royal Australasian College of Physicians (RACP), *Committee Hansard*, 26 August 2019, p. 21.

⁴ Dr Tony Bartone, President, Australian Medical Association (AMA), *Committee Hansard*, 26 August 2019, p. 2.

⁵ Professor Ellis, RACP, *Committee Hansard*, 26 August 2019, p. 21; RACP *Submission 40*, p. 3.

⁶ Dr Lara Roeske, Chair, Royal Australian College of General Practitioners (RACGP) Specific Interests, and RACGP Board Director, RACGP, *Committee Hansard*, 26 August 2019, p. 19.

⁷ See, for example, Jesuit Social Services, *Submission 26*, [p. 2].

directed by qualified medical professionals'.⁸ The Castan Centre for Human Rights Law explained that a benefit of the medical transfer provisions 'is that the decision is in the hands of clinicians and is more likely to avoid unnecessary and costly litigation'.⁹

- 3.9 When discussing the importance of doctors' decisions being respected, several submitters and witnesses referred to the 2014 death of Iranian asylum seeker Hamid Khazaei and the subsequent coronial inquest in 2018.¹⁰ On this matter, Professor Kerryn Phelps AM submitted:

The coroner made a very strong recommendation that the system be changed and that doctors rather than bureaucrats or politicians make the decision about medical transfers. That's as it should be, because medical decisions should be made by people with medical qualifications. The delays that were put in place were done for political reasons.¹¹

- 3.10 The Victorian Refugee Health Network argued that the medical transfer provisions enable 'a rapid, potentially life-saving response to the health care needs' of those individuals in PNG and Nauru. Furthermore:

Because the law ensures recommendations made for medical transfer are based on the objective health assessments by highly trained medical experts, people's health needs are placed above political and policy decisions.¹²

- 3.11 Refugee Legal emphasised the medical transfer provisions 'are an effective and robust statutory mechanism which places medical expertise at the heart of decision making'. It was also noted that the provisions have allowed 'seriously ill men and women to access necessary medical treatment'.¹³

- 3.12 The Department of Home Affairs (the department) emphasised that '[d]octors and medical professionals have always been, and always will continue to be, part of the transfer system and its associated decision-making processes'.¹⁴ The

⁸ World Vision, *Submission 28*, p. 4.

⁹ Castan Centre for Human Rights Law, *Submission 48*, p. 8.

¹⁰ See, for example, Uniting Church, *Submission 14*, [pp. 5–7]; BITA Visitor's Group *Submission 17*, [p. 1]; Jesuit Social Services, *Submission 26*, [p. 2]; Dr Kevin Sweeney, *Submission 30*, [pp. 1–2]; NSW Council for Civil Liberties, *Submission 36*, pp. 3–5; Human Rights Watch, *Submission 45*, [p. 3]; Castan Centre for Human Rights Law, *Submission 48*, p. 5; Jesuit Refugee Service, *Submission 50*, p. 11; Human Rights Law Centre, *Submission 51*, p. 4; St Vincent's Health Australia, *Submission 79*, pp. 4–5; Doctors for Refugees, *Submission 89*, p. 3.

¹¹ Professor Kerryn Phelps AM, Private capacity, *Committee Hansard*, 26 August 2019, p. 10.

¹² Victorian Refugee Health Network, *Submission 59*, p. 4.

¹³ Refugee Legal, *Submission 61*, p. 4.

¹⁴ Mr Michael Pezzullo, Secretary, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 68.

department provided further details about the role of medical officers prior to March 2019:

Departmental officials do not make medical decisions; we are not medical practitioners. We do have a chief medical officer. Prior to the medevac bill's royal assent, on 2 March, the chief medical officer of the department, Dr Gogna, would provide advice and support to the medical officers of the Commonwealth, who work also in the Health Services Division. Those are the medical officers who provide advice, with IHMS [International Health and Medical Services] and the Pacific International Hospital, to determine who needs to be transferred, for what reason and for what treatment, and what receiving hospital the person should go to.¹⁵

- 3.13 It was also noted that since the commencement of the medical transfer provisions in March 2019, the role of the Commonwealth Chief Medical Officer and the departmental chief medical officer has changed given that they are now both members of the IHAP:

In terms of 2 March, the Chief Medical Officer of the Commonwealth, who is Dr Brendan Murphy, and the chief medical officer of the department, Dr Gogna, have now been removed from that ability. I can no longer use, in my line, Dr Gogna to provide me with advice in regard to how we should manage medical services on Nauru or Manus Island because he is now a part of the Independent Health Advice Panel. In terms of managing his conflict of interest as somebody who will make a decision once the minister may have declined a transfer, he is involved in that process, so it's very difficult for him also to be involved in the advisory process. The medevac legislation has taken that line, plus Dr Brendan Murphy. They are two people who we use for a considerable amount of advice, which, as you'd imagine, is why we have that position. Both of them have been taken out of the process. That being said, the medical officers of the Commonwealth underneath the health services are the people who provide the information to us in regard to the clinical referral to transfer somebody. They're the people who advise us, as they now advise the minister.¹⁶

- 3.14 The department also explained the contribution that departmental officials have made to the consideration of medical transfers which 'require a judgement to be made about resources, efficacy and Australia's interests or otherwise'.¹⁷ For example, this could include assessing whether the treatment, subject to the medical advice, could be provided in a hospital in PNG or in a clinic or hospital in Taiwan. Furthermore:

From a policy point of view, going beyond coordination of individual transfer actions, are we seeing a pattern and—this has been our experience for seven years, having lived it for the entire period in various roles—

¹⁵ Ms Cheryl-anne Moy, Deputy Secretary, Chief Operating Officer, Corporate and Enabling, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 84.

¹⁶ Ms Moy, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 84.

¹⁷ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 85.

should we perhaps be thinking about providing more systemic support in relation to particular conditions? If we're seeing presentations through the standard medical transfer assessment process of individuals, maybe there's a suggestion—to Ms Moy's earlier point—that you need to put a particular type of speciality into, for instance, the Nauru general hospital. So, as part of a team, doctors quite properly—and we really respect the role that doctors perform in our society—talk about bringing everyone together in terms of domestic care, not just medical professionals but public servants, police officers and all sorts of folks, in a team approach.¹⁸

Who should make decisions to remove people from Australia?

3.15 A related matter concerned the provisions in the bill that would extend existing powers in the Act to provide for the return or removal of persons who had previously been transferred to Australia for medical treatment.

3.16 Doctors for Refugees argued that:

...removal power should remain the responsibility of medical staff with a more complete understanding of the prognosis, management and treatment options for the patient. It is inefficient and medically unsafe to provide officers without a medical background and complete understanding of the nature of the health condition to remove persons brought to Australia for health complications.¹⁹

3.17 Dr Kym Jenkins of the Royal Australian and New Zealand College of Psychiatrists (RANZCP) expressed the view that such decisions 'should always be medical decisions, not ministerial ones'.²⁰

Are the medical transfer provisions working as intended?

3.18 During the parliamentary debate for the Home Affairs Legislation Amendment (Miscellaneous Measures) Bill 2018 (the miscellaneous measures bill) which established the medical transfer provisions, reference was made to 'an urgent medical crisis in Australia's offshore detention centres'.²¹ Inquiry participants reiterated these views to the committee noting that the medical transfer provisions were established in recognition of the health challenges faced by the population and the need to streamline the processes for transfer to Australia for medical treatment.

3.19 This section discusses the evidence received detailing how the medical transfer provisions are working in practice and considers claims that they have led to improvements in timely access to medical assessment and treatment.

¹⁸ Mr Pezzullo, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 85.

¹⁹ Doctors for Refugees, *Submission 89*, p. 2.

²⁰ Dr Kym Jenkins, Chair, Royal Australian and New Zealand College of Psychiatrists (RANZCP) Asylum Seeker and Refugee Mental Health Network Committee, and Immediate Past President, RANZCP, *Committee Hansard*, 26 August 2019, p. 20.

²¹ Professor Kerry Phelps AM, *House of Representatives Hansard*, 3 December 2018, p. 12170.

How are the medical transfer provisions working?

3.20 A view put to the committee several times emphasised that the medical transfer provisions are working as intended and should continue. Professor Phelps argued that the provisions have streamlined the process and are 'saving lives';²² the Kaldor Centre for International Refugee Law (Kaldor Centre) stated that the provisions provide 'clearer guidance of how people should be brought to the attention of the minister' and are 'fit for purpose'.²³

3.21 The Canberra Refugee Action Campaign submitted that the medical transfer provisions have 'proved effective' and furthermore:

It provides a clear framework for assessing the needs of vulnerable people and taking timely medical action where necessary. It avoids unnecessary politicisation of medical transfers from detention centres and saves taxpayer funds by reducing the legal costs incurred under the previous regime.²⁴

3.22 Drs Neela Janakiramanan, Natalie Thurtle and Sara Townend, three independent doctors who have undertaken medical assessments of refugees and asylum seekers and made subsequent applications to the minister, described the operation of the medical transfer provisions:

The assessment and application process laid out in the legislation has been utilised in a way which is respectful both to the patients and the Government. Health assessments have been rigorous, undertaken by fully qualified specialist doctors working who assess patients within their areas of medical specialty, and are conducted to Australian health standards. Doctors have fully investigated the capacity of local health services in PNG and Nauru to address the needs of the patient before recommending medical transfer. Assessments have been undertaken in volunteers' spare time, resulting in no negative impact on Australian patients.²⁵

3.23 In addition, Drs Townend and Janakiramanan explained how they have been responsible for 'data collection and the auditing of the [medical] records of the patients involved'.²⁶ The committee was advised that 'a number of medical professionals' had volunteered their time and effort to create a process for assessing referrals that would be up 'to Australian standards'.²⁷

²² Professor Phelps, Private capacity, *Committee Hansard*, 26 August 2019, p. 8.

²³ Ms Madeline Gleeson, Senior Research Associate, Kaldor Centre for International Refugee Law, University of New South Wales, *Committee Hansard*, 26 August 2019, p. 38.

²⁴ Canberra Refugee Action Campaign, *Submission 21*, p. 3.

²⁵ Dr Sara Townend, Dr Natalie Thurtle, Dr Neela Janakiramanan, *Submission 52*, [p. 5].

²⁶ Dr Neela Janakiramanan, Private capacity, and Dr Sara Townend, Private capacity, *Committee Hansard*, 26 August 2019, p. 6.

²⁷ Dr Townend, *Committee Hansard*, 26 August 2019, p. 8.

- 3.24 The committee also heard about the important coordinating role being undertaken by the Medical Evacuation Response Group (MERG). Following the commencement of the medical transfer provisions in March 2019, a number of specialist refugee organisations developed the MERG to 'create a pathway by which refugees and asylum seekers in offshore processing locations can access health assessment by independent Australian doctors'.²⁸ Professor Phelps explained that the group was established 'because the government provided no mechanism for transfer requests to be managed and there was a need for an independent, robust and efficient process'.²⁹
- 3.25 The Canberra Refugee Action Campaign referenced reports from Dr Tim McKenna, a member of the group who has visited Manus Island and Port Moresby, and has interacted with doctors who are part of MERG:
- I was deeply impressed with the calibre of these volunteers and with the organisation of MERG. This group has provided all the men with independent, trusted support and hope that their many medical problems will finally be addressed. The group also provides a medical assessment independent of Government funded doctors, but the group's assessments are also subject to independent review by the Government's panel if the Minister requests it. This is no 'two doctors from Nimbin' approach. During my July visit I saw the positive difference this group is making on Manus and in Port Moresby'.³⁰
- 3.26 When discussing the medical transfer provisions, many submissions argued that the provisions are working more effectively than the system prior to March 2019.³¹ That prior system is discussed in detail in chapter 2.
- 3.27 A key measure to demonstrate the successful operation of the medical transfer provisions referenced by submitters was the high number of approved transfer applications. The Victorian Refugee Health Network submitted:
- Since the Medevac law came into effect, over 80% of applications for transfer have been approved, demonstrating that the requirement for two doctors' medical opinions, along with the anticipated review process, has ensured that valid applications are brought before the Minister.³²
- 3.28 Professor Phelps noted that the majority of transfers have been approved by the minister in the first instance. Furthermore, 'only a handful of cases' have

²⁸ Dr Sara Townend, Dr Natalie Thurtle, Dr Neela Janakiramanan, *Submission 52*, [p. 4].

²⁹ Professor Phelps AM, *Committee Hansard*, 26 August 2019, p. 8.

³⁰ Canberra Refugee Action Campaign, *Submission 21*, p. 3.

³¹ See, for example, Human Rights Law Centre, *Submission 51*, p. 6; Refugee Legal, *Submission 61*, p. 2; Jesuit Social Services, *Submission 26*, [p. 2].

³² Victorian Refugee Health Network, *Submission 59*, p. 4.

been overturned by the IHAP and 'in the majority of cases it has upheld the Minister's decision'.³³

- 3.29 Inquiry participants argued that medical transfers are taking place in an efficient, timely and systematic way. Maurice Blackburn Lawyers submitted that the medical transfer provisions have 'successfully provided clear guidelines for how sick people can and should be assessed for treatment...[as well as providing] necessary timeframes which did not exist before'.³⁴ Furthermore, Maurice Blackburn Lawyers stated:

Importantly, the Medevac legislation provides a requirement for transparency in decision making. There are review processes in place for independent, expert reviews of Ministerial decisions, as well as setting clear processes for review by the Administrative Appeals Tribunal. This provides necessary transparency, accountability and due process which did not exist before.³⁵

- 3.30 The NSW Council for Civil Liberties supported the mandated time limits for decisions to be made for a medical transfer.³⁶ The RACP also submitted support for the legislated timeframes:

The timeframes specified within the legislation for review and response compel the Department and the Minister to act so that the patient's health is prioritised, and ensure medical decisions are reviewed by medical professionals.³⁷

- 3.31 In its second quarterly report covering operations from 1 April to 30 June 2019, the IHAP reported that it met and made recommendations on 15 cases and all recommendations were made 'within the legislated 72 hour timeframe'.³⁸

- 3.32 Section 198C of the Act enables family members to accompany individuals who are being transferred to Australia for medical treatment. Amnesty International noted that 'families are able to stay together during medical treatment',³⁹ and Maurice Blackburn Lawyers argued that 'the beneficial impact of allowing for familial support on healing and recovery cannot be understated'.⁴⁰ The Refugee Council of Australia also discussed the importance of avoiding family separation:

³³ Professor Phelps, *Submission 29*, [p. 5].

³⁴ Maurice Blackburn Lawyers, *Submission 42*, p. 6.

³⁵ Maurice Blackburn Lawyers, *Submission 42*, p. 6.

³⁶ NSW Council for Civil Liberties, *Submission 36*, p. 3.

³⁷ Royal Australasian College of Physicians, *Submission 40*, p. 4.

³⁸ Independent Health Advice Panel, *Second Quarterly Report*, 15 August 2019, p. 9 (tabled 17 September 2019).

³⁹ Amnesty International, *Submission 35*, [p. 2].

⁴⁰ Maurice Blackburn Lawyers, *Submission 42*, p. 5.

Section 198C of the Medevac legislation ensures family separation does not happen. The passage of this legislation has enabled fathers who were left behind on Nauru, sometimes for years, to be reunited with their families in Australia and see their children for the first time.⁴¹

3.33 The Human Rights Law Centre stated:

The Medevac laws are working. The laws have ensured people who are extremely unwell have better access to vital medical care. Removing a fair, transparent and doctor-led process for accessing essential, and in many cases, life-saving medical care is illogical and unnecessary. Without the Medevac laws, we are extremely concerned that the Australian Government's failure to provide appropriate and timely medical care will result in more preventable deaths offshore.⁴²

3.34 Medecins Sans Frontiers commented that the medical transfer provisions have been an effective pathway for patients from PNG; however, the medical transfer process:

...is currently handicapped in its operation for patients in Nauru by the Nauruan Government's unwillingness to authorise timely transfers or Tele-Health consultations from Australia.⁴³

What are the healthcare needs of the relevant population?

3.35 Doctors Townend and Janakiraman argued that there remains a significant 'unmet health need' among the offshore cohort and referred to an 'independent doctor-led audit' of the disease prevalence affecting the cohort of refugees and asylum seekers who have made an application for medical assessment under the medical transfer provisions. Of the 581 individuals who applied for medical assessment, 338 patients had 'adequate reliable, objective medical information' to include in the audit. Of the 338 individuals included in the study, 256 (76 per cent) were located in PNG and 82 (24 per cent) were located in Nauru.⁴⁴ It was acknowledged that the analysis applies only to this cohort of individuals and 'cannot be more broadly extrapolated to the whole group'.⁴⁵

3.36 Dr Janakiraman summarised the results:

We have found...that 97 per cent of people have physical health complaints and 91 per cent of people have psychiatric health complaints. On average, each patient has 4.6 discrete organ systems that are involved with disease. There are a number of reasons for this. Part of the reason for it is the conditions in which they have lived for the last six years. There are

⁴¹ Refugee Council of Australia, *Submission 43*, p. 12.

⁴² Human Rights Law Centre, *Submission 51*, p. 8.

⁴³ Medecins Sans Frontiers, *Submission 44*, p. 3.

⁴⁴ Dr Sara Townend, Dr Natalie Thurtle, Dr Neela Janakiraman, *Additional Documents*, August 2019, [p. 8] (tabled 26 August 2019).

⁴⁵ Dr Sara Townend, Dr Natalie Thurtle, Dr Neela Janakiraman, *Additional Documents*, August 2019, [p. 8] (tabled 26 August 2019).

certain diseases that are more common in disadvantaged populations. The second thing is because there has been no resolution to many of these health issues.⁴⁶

3.37 The department responded to the findings, noting that:

Drs Townend, Thurtle and Janakiramanan undertook something similar to a cohort study where they catalogued the health matters notified by their clients, not the entire transferee population on Manus and Nauru.

It is therefore expected that the data would indicate a statistically high-level of health matters.⁴⁷

3.38 Several witnesses expressed concern about the mental health issues being experienced by refugees and asylum seekers on Nauru and PNG.⁴⁸ Sister Jane Keogh, a member of the Canberra Refugee Action Campaign noted that 'ongoing physical pain exacerbates the mental health problems'.⁴⁹ Mr Paul Power, Chief Executive Officer, Refugee Council of Australia referred to two reports co-published with Amnesty International and the Asylum Seeker Resource Centre which analysed publicly available information from governments, international bodies, NGOs, doctors, advocates and also people who are held on Nauru and PNG:

What was clear from the information that was available in public, including from the Australian government, was really that the scale of the mental health crisis on Manus Island and Nauru was quite overwhelming. In fact, [the United Nations High Commissioner for Refugees] last year summed it up quite well when they reported that more than 80 per cent of people held on the two islands had been diagnosed as suffering PTSD, trauma or depression. This is consistent with what we've seen in Australia and other countries over more than 20 years from the impacts of long-term detention or confinement.⁵⁰

3.39 Dr Jenkins explained that length of time in detention, the uncertainty and separation 'have a very deleterious effect on people's mental health'. It was also noted that many have mental health problems prior to entering detention 'and prolonged periods of detention can only make their mental health worse'.⁵¹

⁴⁶ Dr Janakiramanan, Private capacity, *Committee Hansard*, 26 August 2019, p. 11.

⁴⁷ Department of Home Affairs, *answers to questions on notice, 26 August 2019* (received 27 September 2019).

⁴⁸ See, for example, Mr Manne, Refugee Legal, *Committee Hansard*, 26 August 2019, p. 36; Mr de Kretser, Human Rights Law Centre, *Committee Hansard*, 26 August 2019, p. 36; United Nations High Commissioner for Refugees (UNHCR), *Submission 7*, p. 5.

⁴⁹ Sister Jane Keogh, Member, Canberra Refugee Action Campaign, *Committee Hansard*, 26 August 2019, p. 49.

⁵⁰ Mr Paul Power, Chief Executive Officer, Refugee Council of Australia, *Committee Hansard*, 26 August 2019, p. 50.

⁵¹ Dr Jenkins, RANZCP, *Committee Hansard*, 26 August 2019, p. 22.

3.40 Referring to observations made by colleagues who have made multiple visits to both sites, Dr Lara Roeske from RACGP reported that the physical and psychological health of the asylum seekers is deteriorating' and what is occurring is 'a raft of physical comorbidities that are now accompanying psychological and psychiatric conditions'.⁵²

3.41 The Australian Human Rights Commission advised that 'the underlying health of asylum seekers and refugees in Nauru and PNG is precarious and that local healthcare facilities are limited'.⁵³

3.42 The IHAP assessed the physical and mental health conditions of transitory persons in Nauru in its *First Quarterly Report*:

During Quarter 1 2019 there were 5908 consultations to 237 persons provided at the Nauru Regional Processing Centre Medical Centre. 2352 consultations were provided at the IHMS Nauru Settlement Medical Centre. The commonest reason for consultation was for psychological reasons. There were a wide range of other conditions treated with no unusual pattern of disease or disability.

There were 73 admissions to 43 individuals at the RPC Medical Centre, the majority were for mental health admissions and ranged from 1-44 days.

There is an electronic medical record with updated immunisation tracking including typhoid.

There were no patterns of disease that were noted to be unusual by the panel, it was noted there was a high number of psychological presentations and mental health admissions for respite or treatment at the RPC Medical Centre.⁵⁴

3.43 The IHAP also provided an assessment of the physical and mental health conditions of transitory persons in PNG (Port Moresby and Manus Island):

During Quarter 1 2019 there were 1134 primary health consultations, 472 mental health consultations and 375 specialist consultations performed at East Lorengau Refugee Transit Centre (ELRTC) Manus. Visiting specialists in Cardiology, ENT surgery, Dermatology, Orthopaedics, General Surgery, Internal Medicine and Dental also performed consultations.

There were 21 admissions to Lorengau General Hospital for 17 individuals, there were predominately for mental health concerns. Transfers to Port Moresby occurred for a range of medical and mental health concerns.

It was noted during a number of clinical reviews that some individuals had rapid testing that was positive for typhoid, stool and water testing was negative and a community vaccination program was not required, the

⁵² Dr Roeske, RACGP, *Committee Hansard*, 26 August 2019, p. 23.

⁵³ Mr Edward Santow, Human Rights Commissioner, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 27.

⁵⁴ Independent Health Advice Panel, *First Quarterly Report*, 29 June 2019, p. 12 (tabled 19 July 2019).

Panel will continue to monitor. There are no other patterns of disease that were unusual.⁵⁵

Availability of healthcare

3.44 Representatives from peak medical bodies argued that the availability of specialist health services is limited in PNG and Nauru.⁵⁶ Dr Roeske of the RACGP advised that primary and secondary healthcare services are available. However, 'there are inadequate services available across a range of medical conditions' such as medical, surgical and psychiatric services.⁵⁷ Dr Jenkins of the RANZCP emphasised that the available facilities are likely to be insufficient 'for people with more severe mental illnesses', for example, 'people have severe depression or psychotic depression, where their physical health as well as their mental health is put at risk'.⁵⁸

3.45 Other submitters and witnesses similarly discussed the availability and adequacy of healthcare facilities in Nauru and PNG. The United Nations High Commissioner for Refugees (UNHCR) observed that '[d]espite efforts that have led to isolated improvements in the provision of care in some circumstances', there are 'many cases in which locally available services continue to be inadequate'.⁵⁹ The Refugee Council of Australia referenced its 2018 report which found that a range of health issues, many related to women's health could not be treated or managed in Nauru.⁶⁰ It also submitted:

The situation in PNG in many aspects has been worse than on Nauru. Since late 2017, the Australian Government has cut back the health care offered to people there, and shifted the responsibility of healthcare provision to local contractors and PNG's strained public health system. There has been no torture and trauma counselling since October 2017, and the number of mental health staff has halved.⁶¹

3.46 Medecins Sans Frontieres, which provided free psychological and psychiatric treatment to Nauruan nationals as well as refugees and asylum seekers in Nauru from November 2017 until October 2018, argued that the mental health services available on Nauru were not able to deal with the level of 'mental health crisis'.⁶²

⁵⁵ Independent Health Advice Panel, *First Quarterly Report*, 29 June 2019, p. 15 (tabled 19 July 2019).

⁵⁶ See, for example, Professor Ellis, RACP, *Committee Hansard*, 26 August 2019, p. 21.

⁵⁷ Dr Roeske, RACGP, *Committee Hansard*, 26 August 2019, p. 24.

⁵⁸ Dr Jenkins, RANZCP, *Committee Hansard*, 26 August 2019, p. 26.

⁵⁹ UNHCR, *Submission 7*, p. 5.

⁶⁰ Refugee Council of Australia, *Submission 43*, p. 2.

⁶¹ Refugee Council of Australia, *Submission 43*, p. 3.

⁶² Medecins Sans Frontieres, *Submission 44*, p. 3.

- 3.47 With reference to the IHAP assessments of healthcare facilities in Nauru and PNG provided in the first *IHAP Quarterly Report*, Doctors Townend, Thurtle and Janakiramanan cautioned against 'drawing any firm conclusions about the standard of care' in Nauru and PNG from the IHAP's assessment because it is unclear whether any patient outcome data, quality control or governance information or whether any feedback has been provided by patient group.⁶³
- 3.48 The department emphasised that the governments of Nauru and PNG are responsible for the healthcare of transitory persons residing in their countries under regional processing arrangements.⁶⁴ It was noted that since the re-establishment of regional processing arrangements in 2012, health services in Nauru and PNG have significantly expanded. The government has invested approximately \$197.76 million to support the delivery of primary health services on Nauru, including \$51.9 million in medical service upgrades.⁶⁵ Approximately \$194.7 million has been invested by the government to support the delivery of primary health services in PNG, including \$44.5 million for the establishment and expansion of the medical clinic at the former Manus Regional Processing Centre.⁶⁶

Nauru

- 3.49 International Health and Medical Services (IHMS), the government's contracted service provider in Nauru, provides general practitioner, nursing and mental health care clinicians seven days a week. After-hours medical staffing is also available to respond to medical emergencies. Mental health care is delivered by mental health nurses, clinicians, psychologists, psychiatrists and counsellors, including counsellors with torture and trauma counselling expertise. Specialist health services are also provided, including psychology, psychiatry, dentistry, obstetrics, radiography and pharmacy services.⁶⁷
- 3.50 According to departmental data to 31 July 2019, there were 47 contracted medical professionals in Nauru, including 12 mental health professionals, providing services to 304 transitory persons. This is a ratio of one health care professional to every six transitory persons and one mental health professional to every 25 transitory persons.⁶⁸
- 3.51 IHMS also detailed its continued presence in Nauru:

⁶³ Dr Sara Townend, Dr Natalie Thurtle, Dr. Neela Janakiramanan, *Submission 52*, pp. 3–5.

⁶⁴ Department of Home Affairs, *Submission 55*, pp. 6, 8.

⁶⁵ Department of Home Affairs, *Submission 55*, p. 7.

⁶⁶ Department of Home Affairs, *Submission 55*, p. 9.

⁶⁷ Department of Home Affairs, *Submission 55*, p. 6.

⁶⁸ Department of Home Affairs, *Submission 55*, p. 7.

As well as IHMS' continued presence (currently 59.2 Full Time IHMS Employees including 50.2 health professionals of whom nine are doctors), clinical services at the Republic of Nauru Hospital (RONH) are also available to refugees and asylum seekers.⁶⁹

3.52 In its *First Quarterly Report*, the IHAP provided an assessment of health services provided to transitory persons in Nauru:

Regarding the available services in Nauru, the IHAP believes that there are reasonable quality primary and secondary care [services]. These are supplemented on a periodic basis by the availability of specialist services namely physiotherapists, optometrists, ophthalmologists, cardiologist/internal physicians, speech and language therapists, gastroenterologist, neurologists, ENT surgeons, orthopaedic surgeons and infectious disease physicians. Special medical care is not reliably available on the island.

In respect of mental health services there are significant numbers of mental health workers but (unlike PNG) there is no access to high quality inpatient psychiatric care in Nauru and patients with severe mental illness an at high risk of suicide should be transferred to a hospital with appropriate inpatient psychiatric care.⁷⁰

Papua New Guinea

3.53 IHMS was contracted by the Australian government to provide health services in Manus and Port Moresby until 30 April 2018.⁷¹ Currently, Pacific International Hospital, as the government's contracted health service provider, provides access to certified general practitioners, nursing and mental health care through dedicated clinics. In Manus Province, the Pacific International Hospital delivers health services at the general practitioner-led clinic located at the East Lorengau Refugee Transit Centre. Health care at that clinic is delivered by medical officers, primary care nurses, a paramedic, laboratory technician, mental health nurses, psychiatrists, radiologist, general nurses and emergency trained medical officers. In circumstances when medical treatment is required that is not available in Manus, Pacific International Hospital may temporarily medically transfer transitory persons to Port Moresby for inpatient or outpatient care where a range of services are available.⁷²

3.54 According to departmental data to 31 July 2019, there were 29 contracted medical professionals in PNG, including 11 mental health professionals, providing services to 409 transitory persons. This is a ratio of one health care

⁶⁹ International Health and Medical Services, *Submission 93*, p. 2.

⁷⁰ Independent Health Advice Panel, *First Quarterly Report*, 29 June 2019, p. 14 (tabled 19 July 2019).

⁷¹ International Health and Medical Services, *Submission 93*, p. 1.

⁷² Department of Home Affairs, *Submission 55*, pp. 8–9.

professional to every 14 transitory persons and one mental health professional to every 37 transitory persons.⁷³

3.55 In its *First Quarterly Report*, the IHAP provided an assessment of health services provided to transitory persons in PNG (Port Moresby and Manus Island):

The Panel's view is that these services provide a reasonable range of primary care at the ELRTC [East Lorengau Refugee Transit Centre] with some limited secondary services at the Lorengau Hospital. Specialist medical care is not reliably available on the island. Mental health services on the island consist of psychologist, mental health nurses and a visiting psychiatrist, sufficient only for ambulatory treatment.

The Panel was impressed with the physical facilities and the range of medical and investigative services available at PIH in Port Moresby. The Panel was further impressed with the quality of cultural understanding of the two psychiatrists working a PIH. The IHAP was reasonably confident that acute inpatient mental health treatment can be provided at PIH but noted no access to Electroconvulsive therapy (ECT) or psychiatric intensive care.⁷⁴

Contribution of the Independent Health Advice Panel

3.56 As outlined in chapter 1, the medical transfer provisions established the Independent Health Advice Panel (IHAP) with two functions:

- a general monitoring, assessing and reporting function; and
- a specific function to review decisions by the minister to refuse to approve medical transfers to Australia.

3.57 Chapter 2 discusses issues relating to the remuneration of IHAP members. This section discusses the evidence received about the IHAP, with particular reference to its activities to date.

3.58 Witnesses spoke positively about the contribution and work being undertaken by the IHAP. Refugee Legal submitted that '[t]he actions by the Panel show it is an appropriate oversight mechanism and that it is necessary and appropriate that decisions of a medical nature are reviewed by an expert medical panel.'⁷⁵

3.59 The AMA recognised the level of skill and expertise of the members of the IHAP:

We have a well constituted panel. The Chief Medical Officer of Australia sits on that panel, as does Dr Gogna. They are extremely experienced doctors in their own right, through very different aspects of medical care

⁷³ Department of Home Affairs, *Submission 55*, p. 9.

⁷⁴ Independent Health Advice Panel, *First Quarterly Report*, 29 June 2019, p. 15 (tabled 19 July 2019).

⁷⁵ Refugee Legal, *Submission 61*, p. 4.

and in different theatres of medical care. They're then supported by the other stipulated members of that panel.⁷⁶

3.60 The RACP argued that the processes operating under the medical transfer provisions are 'improving the situation on a case-by-case basis' as the IHAP learns from each case, which is 'improv[ing] the system'.⁷⁷

3.61 Dr Bartone, President of the AMA, informed the committee:

From all reports, I believe that the IHAP process is working well. Applications are being brought to the panel in an appropriate manner and in an appropriate time frame, and all applications presented to the panel have been assessed and appropriately acted upon in due course. As I've said, from our point of view and from the information that we have—which obviously is not direct information—it is working as intended.⁷⁸

3.62 Dr Bartone spoke highly of the conduct of the IHAP members noting that 'under exceptionally difficult circumstances, all the doctors on the IHAP have been executing their task in the most professional, ethical and capable manner'.⁷⁹

Broad oversight and monitoring role

3.63 The AMA observed that the IHAP has been able to provide an overview of health services available in PNG and Nauru and the IHAP intends to visit to provide further assessments of the 'physical and mental health conditions of asylum seekers and refugees and the standards of health care provided'. The AMA noted that these are important functions central to the 'provision of proper and appropriate care'.⁸⁰

3.64 The UNHCR recognised the value of the IHAP in terms of transparency and accountability:

While the effectiveness of the work of the Independent Health Advice Panel will become clearer with time, this statutory oversight function is consistent with the requirement that Australia regularly monitor and review relevant conditions in Nauru and Papua New Guinea to ensure they meet international standards. By abolishing this function, the Bill would permit weaker governance and accountability in respect of the provision of health services. To describe those provisions that would be repealed by the Bill as the "medical transfer provisions" tends to minimise the importance of this monitoring and oversight function, which is independent of the legal mechanism for transfers to Australia.⁸¹

⁷⁶ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 4.

⁷⁷ Professor Ellis, RACP, *Committee Hansard*, 26 August 2019, p. 23.

⁷⁸ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 2.

⁷⁹ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 2.

⁸⁰ Australian Medical Association, *Submission 9*, p. 3.

⁸¹ United Nations High Commissioner for Refugees, *Submission 7*, p. 4.

3.65 The RANZCP supported the continuation of the IHAP with reference to its independent role 'including the perspective of psychiatry in monitoring, assessing and reporting on the health services and care provided to those in offshore detention'. Furthermore:

The panel provides a valuable referral process and safeguard for those being held in offshore detention to access health services in a timely manner, and the panel has potential to provide greater transparency in the provision of health care.⁸²

3.66 The RANZCP also suggested that 'more time is needed in order to ascertain its value' given that the 'the IHAP is such a recent innovation that it has not yet been reviewed...'.⁸³

3.67 The RACP observed that, to its knowledge, the IHAP is the only functioning current independent advisory to the department related to offshore processing:

Previous advisory groups, such as the former Detention Health Advisory Group (DeHAG, 2006-2012) and the Immigration Health Advisory Group (IHAG, 2013) and the previous iteration of the Independent Health Advice Panel (2016-2018), have not been sustained, and have not reported publicly. Other Australian healthcare oversight mechanisms, such as the Australian Health Practitioner Regulation Agency (AHPRA) and Australian health service standards do not have immediate jurisdiction/applicability in the offshore setting, however, as noted by the Queensland Coroner, the "Australian Government retains responsibility for the care of persons who are relocated, for often lengthy periods, to offshore processing countries where standards of health care do not align with those in Australia".⁸⁴

3.68 The IHAP's reporting requirements were also discussed by the RACP noting that the IHAP's summary reports must be provided to the parliament on a 'specified quarterly timeline' and the minister is required to respond within three sitting days of the summary report being tabled. In the context of the IHAP's function to monitor, assess and report on the standard of services provided to transitory persons in regional processing countries, the RACP submitted that repealing the medical transfer provisions 'will make it more difficult for the Australian Parliament and public to be able to scrutinise the adequacy of the services that are provided'.⁸⁵

3.69 The Kaldor Centre observed that when presenting the reasons to repeal the medical transfer provisions, there was 'almost no mention of the IHAP's monitoring and oversight functions' which was an unfortunate oversight 'as

⁸² Dr Jenkins, RANZCP, *Committee Hansard*, 26 August 2019, p. 20.

⁸³ Dr Jenkins, RANZCP, *Committee Hansard*, 26 August 2019, p. 20.

⁸⁴ Royal Australian College of Physicians, *Submission 40*, p. 3.

⁸⁵ Royal Australian College of Physicians, *Submission 40*, p. 5.

these functions are crucial to 'ensuring Australia meets its obligations with respect to the health and wellbeing of people transferred offshore'. The Kaldor Centre posited that '[i]ndependent oversight is a vital part of responsible and accountable governance'. The Kaldor Centre recommended that if the bill was passed, which they did not support, then 'at a very minimum...the IHAP's monitoring and oversight functions be retained'.⁸⁶

3.70 Cabrini Health suggested that IHAP's role be expanded:

The IHAP also has an important role in monitoring and reporting on health service provision and conditions in the regional processing countries. We recommend that this monitoring role be expanded to improve transparency and access for IHAP doctors to health clinics, hospital and other clinical environments in the regional processing countries so that meaningful recommendations can be made.⁸⁷

Australia's legal and human rights obligations

3.71 Evidence to the inquiry discussed Australia's legal and human rights obligations, with witnesses and submitters arguing that the Australian government has a duty of care to individuals it has transferred to regional processing countries.

3.72 The Law Council argued that:

[U]nder Australian law, as well as international law, the Commonwealth of Australia has responsibility for the health and safety of asylum seekers transferred to other countries for offshore processing and assessment.⁸⁸

3.73 The Australian Human Rights Commission advised that 'under international law, Australia has human rights obligations outside of its territory when it exercises effective control over people or territory'. Noting that the question of whether Australia exercises 'effective control' in relation to asylum seekers and refugees subject to regional processing arrangements has been considered by two parliamentary committees, the Commission:

...considers that transferring asylum seekers to third countries does not release Australia from its obligations under international human rights law. Australia must ensure adequate safeguards are in place in those countries to ensure that the human rights of the people transferred are upheld.⁸⁹

⁸⁶ Kaldor Centre for International Refugee Law, *Submission 53*, p. 8.

⁸⁷ Cabrini Health, *Submission 68*, p. 3.

⁸⁸ Law Council of Australia, *Submission 62*, p. 2.

⁸⁹ Australian Human Rights Commission, *Submission 54*, pp. 6–7.

- 3.74 Issues related to effective control and effective protection were also raised by other submitters and witnesses.⁹⁰ For example, the Human Rights Law Centre referred to the position of United Nations treaty bodies that 'the Australian Government continues to exercise effective control over [refugees and asylum seekers held in offshore detention] and is responsible for their welfare'.⁹¹ Similarly, Australian Lawyers for Human Rights argued that the government's 'actions demonstrate that it maintains effective control over the people who have been transferred to Nauru and Papua New Guinea'.⁹²
- 3.75 The Kaldor Centre argued that in exercising control and authority over refugees and asylum seekers, Australia 'has a duty of care with respect to the health and well-being of people transferred offshore to Nauru and PNG' under international law.⁹³ Ms Kate Ogg, Visiting Scholar, Kaldor Centre noted the 'UNHCR has confirmed that effective protection includes the provision of health services'.⁹⁴
- 3.76 A number of submissions contended that the Australian government, and the governments of the respective regional processing countries, share responsibility to ensure that international legal obligations are met.⁹⁵
- 3.77 The Peter McMullin Centre on Statelessness strongly disagreed with the government's position as outlined in the explanatory memorandum and argued that it is 'not sustainable as a matter of international law'.⁹⁶ The Asylum Seeker Resource Centre was also highly critical of the government's position describing the statement of compatibility with human rights 'as a cynical exercise to twist and avoid the content of its protection obligations'.⁹⁷
- 3.78 The government's position is that in general, 'Australia does not exercise the degree of control necessary in regional processing countries to enliven Australia's international obligations'. The explanatory memorandum to the bill reiterates the government's 'long-standing view' that Australia's human rights obligations 'are essentially territorial [and] persons in regional processing

⁹⁰ See, for example, Jesuit Refugee Service, *Submission 50*, pp. 3–7; Ms Kate Ogg, Visiting Scholar, Kaldor Centre for International Refugee Law, University of New South Wales, *Committee Hansard*, 26 August 2019, p. 35; Law Council of Australia, *Submission 62*, p. 15.

⁹¹ Human Rights Law Centre, *Submission 51*, p. 3.

⁹² Australian Lawyers for Human Rights, *Submission 49*, p. 10.

⁹³ Kaldor Centre for International Refugee Law, *Submission 49*, p. 1.

⁹⁴ Ms Kate Ogg, Kaldor Centre for International Refugee Law, *Committee Hansard*, 26 August 2019, p. 35.

⁹⁵ Law Council of Australia, *Submission 62*, p. 16; Kaldor Centre for International Refugee Law, *Submission 53*, p. 3; Australian Lawyers for Human Rights, *Submission 49*, p. 10.

⁹⁶ Peter McMullin Centre on Statelessness, *Submission 71*, [p. 3].

⁹⁷ Asylum Seeker Resource Centre, *Submission 56*, p. 9.

countries are outside Australia's territory'. The circumstances in which international human rights law may be engaged were outlined in the statement of compatibility with human rights:

Australia has accepted that there may be exceptional circumstances in which the rights and freedoms set out under the International Covenant on Civil and Political Rights (ICCPR) and Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) may apply to persons beyond the territory of a State party, and the extent of the obligations that a State may owe under international human rights law where it is operating extra-territorially will be informed by the degree of control exercised by the State.⁹⁸

The medical transfer provisions and Australia's international obligations

3.79 Notwithstanding the government's view that Australia's international obligations are not generally engaged with respect to regional processing countries, evidence to the committee argued that the medical transfer provisions are making a positive contribution to Australia meeting its international human rights obligations.⁹⁹

3.80 The AMA supported the view that Australia has international obligations in relation to the medical care of asylum seekers and that, in its view, having an independent oversight body, such as the IHAP, is helping Australia meeting its obligations by facilitating timely assessment and transfer of asylum seekers.¹⁰⁰

3.81 The Australian Medical Students' Association argued that the medical transfer provisions 'are consistent with international treaties to which Australia is a signatory' and furthermore:

These treaties make clear that offshore processing does not relieve Australia of its obligations under international human rights law, which include a duty of care to provide appropriate healthcare for asylum seekers undergoing processing.¹⁰¹

3.82 The Peter McMullin Centre on Statelessness argued:

Given the concrete risk of human rights violations inherent in the scheme of offshore processing, the current provisions must be maintained as they provide a safeguard to ensure the most vulnerable asylum seekers and refugees can be transferred to Australia for essential medical treatment. It is vital that an independent body, such as the Independent Health Advice

⁹⁸ Explanatory memorandum to the Migration Amendment (Repairing Medical Transfers) Bill 2019 (the explanatory memorandum), p. 9.

⁹⁹ See, for example, Australian Lawyers for Human Rights, *Submission 49*, p. 8.

¹⁰⁰ Dr Bartone, AMA, *Committee Hansard*, 26 August 2019, p. 3.

¹⁰¹ Australian Medical Students' Association, *Submission 67*, [p. 1].

Panel, has the capacity to assess individual cases in order to ensure that Australia's obligations are respected.¹⁰²

3.83 The Australian Human Rights Commission observed that the bill would limit the right to health:

There is clear evidence by the United Nations and other independent bodies that many of these people have serious health problems, especially relating to mental health. The bill would significantly limit their right to the highest attainable standard of physical and mental health. The commission considers that repealing the medical transfer provisions would be a retrogressive measure in realising their health rights. This would contravene Australia's international human rights law obligations.¹⁰³

3.84 It was recognised that the medical transfer provisions should be viewed as just one mechanism by which Australia 'ensures it is meeting its obligations with respect to the health and well-being of people transferred offshore'.¹⁰⁴ The Law Council argued that the provisions should be maintained 'as merely one tool in a toolkit...to permit people who require medical assistance in regional processing countries and can't receive it there the means to be given that medical treatment'.¹⁰⁵ The Kaldor Centre submitted:

The medevac system operates as a safety net. It only becomes relevant if and when: (i) adequate healthcare is not available locally in Nauru or PNG; and (ii) critically ill people are not otherwise identified and transferred to places where they can receive the necessary care. As such, the medevac system should be maintained as a safeguard against preventable harm, triggered only when these other two mechanisms fail.¹⁰⁶

3.85 Similarly, the UNHCR observed:

The medical provisions should not be understood as a comprehensive response to medical needs, or the primary means by which Australia should ensure the health and wellbeing of people transferred to Nauru or Papua New Guinea. Rather, the safeguards established by the medical provisions complement other measures that may provide for refugees and asylum-seekers to enjoy the rights to which they are entitled under the Refugee Convention and other relevant international instruments. These other measures include variously the general power to facilitate timely transfers to Australia and the local provision of adequate healthcare and other services, pending the realisation of durable solutions.¹⁰⁷

¹⁰² Peter McMullin Centre on Statelessness, *Submission 71*, [p. 7].

¹⁰³ Mr Santow, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 27.

¹⁰⁴ Kaldor Centre for International Refugee Law, *Submission 53*, p. 5.

¹⁰⁵ Mr Tass Liveris, Executive Member, Law Council of Australia, *Committee Hansard*, 26 August 2019, p. 45.

¹⁰⁶ Kaldor Centre for International Refugee Law, *Submission 53*, p. 5.

¹⁰⁷ United Nations High Commissioner for Refugees, *Submission 7*, p. 3.

Human rights implications of the power to return provisions

3.86 In the context of the provisions in the bill that would 'empower the Government to return persons to a regional processing country or remove persons from Australia who have been brought to Australia for a temporary purpose', the statement of compatibility notes that the bill engages the following rights:

- *non-refoulement*;
- respect for family and children; and
- rights to health.¹⁰⁸

3.87 These matters are outlined below. The statement of compatibility concludes that the measures proposed in the bill are compatible with human rights.

Non-refoulement

3.88 As outlined in the explanatory memorandum, Australia has obligations under the ICCPR and the CAT not to return a person to a country in certain circumstances. These are in addition to obligations under the *1951 Convention relating to the Status of Refugees* (the Refugee Convention). The provisions of the bill would ensure a person transferred to Australia under repealed section 198C could be returned to a regional processing countries or removed from Australia 'as soon as practicable after the Minister is satisfied that the person no longer needs to be in Australia for that temporary purpose'.¹⁰⁹ A comparable power exists in the Migration Act for individuals transferred under section 198B. The government stated it would continue to meet its *non-refoulement* obligations:

The Government takes Australia's *non-refoulement* obligations seriously, and will ensure administrative arrangements are in place to support Australia to meet its *non-refoulement* obligations to those individuals transferred under section 198C as it has done and continues to do for persons transferred under 198B. The amendments do not impact on the protections against *refoulement*, which already exist in Australia's legislation, policies and procedures. In making the amendments, the Government is not creating any new obligations or seeking to avoid obligations.

Australia will continue to meet its *non-refoulement* obligations through other mechanisms under the Migration Act, policies and procedures.¹¹⁰

Respect for the family and children

3.89 Rights relating to families and children are contained in several articles of the ICCPR and the Convention on the Rights of the Child.

¹⁰⁸ Explanatory memorandum, p. 10.

¹⁰⁹ Explanatory memorandum, p. 11.

¹¹⁰ Explanatory memorandum, p. 11.

3.90 The explanatory memorandum states:

No children have been transferred to Australia under section 198C.

The Bill supports family unity as all persons transferred under section 198B and 198C were only intended to come for a temporary purpose. The introduction of return and removal measures to support the return or removal from Australia of persons brought to Australia under section 198C is respecting families by not splitting families when returning some (those transferred under section 198B), but not all to a regional processing country or otherwise removing them from Australia. It will ensure that those transferred consistent with 'spilt family' provisions (section 198G) can be managed in the same way as the rest of the family unit subject to any reason consistent with the above obligations to depart from the practice.¹¹¹

3.91 Furthermore:

The Ministerial discretions contained within the Act for persons in Australia will not be affected and will consider the individual circumstances of the case including any international obligations, such as the best interest of affected children, where applicable.¹¹²

Right to health

3.92 The statement of compatibility states that to the extent that the provisions in the bill relate to a transitory person in Australia, the provisions may engage the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), which states:

The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

3.93 The statement of compatibility reiterates that transitory persons in Australia for a temporary purpose will continue to receive medical care in Australian medical facilities which is an arrangement, in the government's view, consistent with Article 12 of the ICESCR. Furthermore:

The Bill will not affect the existing provisions for the temporary transfer of transitory persons for medical treatment in a third country. Section 198B provides a standing authority for individuals in need of medical care not available in the regional processing country to be brought to a third country, including Australia, for medical treatment.¹¹³

¹¹¹ Explanatory memorandum, p. 12

¹¹² Explanatory memorandum, p. 13

¹¹³ Explanatory memorandum, p. 13.

Committee view

- 3.94 The committee acknowledges the strong and passionately held views expressed in evidence to this inquiry. The committee has carefully considered all the evidence provided to it, and has listened to all sides of the debate.
- 3.95 The committee considers that the medical transfer provisions enacted in March 2019 are unnecessary, and that those provisions have significant flaws. These flaws include:
- the absence of a process for returning transferees;
 - the imposition of strict grounds for refusal, which are not in line with other parts of the Act;
 - an unrealistic timeframe for assessing security and character concerns; and
 - a lack of remuneration for Independent Health Advice Panel members.
- 3.96 Between 2007 and 2013, prior to the introduction of Operation Sovereign Borders, over 1,200 men, women and children died at sea attempting to come to Australia by boat. The government has implemented a series of policies to stop the people smuggling trade and since the start of 2014, there have been no recorded deaths at sea. Operation Sovereign Borders has been effective, and its integrity must be maintained.
- 3.97 The medical transfer provisions restrict the government's ability to assess transfer requests on a case-by-case basis and make decisions in Australia's national interest. The provisions also impinge on the sovereignty of PNG and Nauru by dictating the terms upon which transfers must be made, with no flexibility to accommodate the legislative frameworks, procedures and processes of those countries.
- 3.98 Of particular concern to the committee is the fact that the medical transfer provisions impose strictly limited grounds for refusal in relation to security and character concerns. The committee understands the minister has already been forced to approve the transfer of six individuals who were 'of security or character concern', because the concerns did not meet the strict grounds upon which the minister may refuse a transfer under the provisions.¹¹⁴
- 3.99 The committee acknowledges evidence received advocating for the medical transfer provisions to be retained. While recognising that there are circumstances that necessitate medical transfer from regional processing countries, the committee considers that the arrangements in place prior to March 2019 were appropriate and working effectively. Importantly, these processes incorporated medical assessment by medical professionals, while also ensuring the minister had the appropriate powers to refuse applications on security and community safety grounds. They also facilitated medical

¹¹⁴ Department of Home Affairs, *answers to questions on notice, 26 August 2019* (received 27 September 2019), [p. 9].

transfers without impinging upon the sovereignty of regional processing countries, or unduly limiting the government's ability to protect the community and maintain the integrity of Australia's border protection policies.

- 3.100 These medical transfer processes would continue under section 198B of the Migration Act following repeal of the March 2019 medical transfer provisions. The committee highlights that from November 2012 to 31 July 2019, 1,343 individuals (717 medical and 626 accompanying family transfers) were transferred to Australia for medical treatment under these provisions, with only 39 cases involving 96 individuals being court ordered.
- 3.101 The committee notes concerns raised about the health status of refugees and asylum seekers and the availability of health services in regional processing countries. The governments of Nauru and PNG are responsible for the healthcare of transitory persons residing in their countries under regional processing arrangements, and the Australian Government has invested significantly in the upgrade and delivery of health services in both countries.
- 3.102 The committee does not believe that repealing the medical transfer provisions would impact Australia's ability to meet its international obligations in relation to the right to health. Repealing the provisions would not compromise access to medical services for the regional processing cohorts in PNG and Nauru.
- 3.103 As such, the committee considers that the Senate should pass the Migration Amendment (Repairing Medical Transfers) Bill 2019 as soon as is practicable.

Recommendation 1

3.104 The committee recommends that the Senate pass the bill.

Senator Amanda Stoker
Chair

Labor Senators' dissenting report

- 1.1 This bill, like several other bills to amend the Migration Act introduced in the 46th Parliament, is solely an expression of the Government's political agenda.
- 1.2 The bill's provisions are not necessary to maintain or improve the existing border protection system, under which asylum seekers who arrive in Australia by boat and without valid entry documents are detained and processed offshore.
- 1.3 Even the name of the bill is seriously misleading, because it refers to a problem that does not exist.
- 1.4 The medical transfer provisions of the Migration Act, the so-called medevac law introduced earlier this year, do not need to be "repaired".
- 1.5 They are working well, as expert witnesses have attested in evidence to the committee.
- 1.6 Labor supported the enactment of these provisions so that sick people could get the medical care they need, and because the Minister for Home Affairs retained the discretion to refuse transfers on grounds of national security or serious criminality.
- 1.7 That is still the case.
- 1.8 When the provisions were introduced, the Government claimed that they were a green light to people smugglers and would result in a new surge of boat arrivals.
- 1.9 That has not happened.
- 1.10 We argued that it was possible both to maintain rigorous border surveillance and security and to fulfil Australia's obligation to provide full and appropriate medical care for people detained in Australian-funded facilities.
- 1.11 That is what the operation of the medevac law has demonstrated.
- 1.12 These transfer provisions have shown that it is not necessary to resort to cruelty, the abuse of asylum seekers' rights and the flouting of Australia's international obligations in order to maintain a strict border protection regime.
- 1.13 The Minister for Home Affairs, Peter Dutton, has claimed that restoration of the previous medical transfer system is necessary to prevent an influx into Australia of undesirable persons, including rapists and pornographers.
- 1.14 This contention is as spurious as the notion that medevac sends a green light to people smugglers.
- 1.15 Even before medevac, the Government was transferring significant numbers of people from Nauru and PNG to Australia.

- 1.16 As Mr Dutton's department noted in its submission to the committee, from November 2012 to the end of July 2019 there were a total of 1343 transfers (717 medical and 626 accompanying family).
- 1.17 There has been no spike in sexual and other crimes because these 1343 people entered Australia, and there is no reason to suspect that the medevac process is likely to cause the predicted increase either.
- 1.18 The Government's own practice in the matter of transfers has been inconsistent. Two Rwandan refugees who went to the US, and who had been accused of murdering tourists, were accepted into Australia as part of the US refugee swap deal.
- 1.19 Under medevac, the essential change from previous medical transfer arrangements is that the medical profession has the primary responsibility for assessing the need for transfer, as is appropriate.
- 1.20 Before the medevac law was enacted, transfers were authorised solely by the Home Affairs Minister or the Immigration Minister, and those who wished to challenge the ministers' decisions had to do so in court.
- 1.21 By seeking to repeal the medevac law, the Government is effectively trying to undermine the role of medical profession and to question their independence.
- 1.22 As the Human Rights Commissioner at the Australian Human Rights Commission, Mr Edward Santow, said in evidence:

The current law enables a medical transfer where two or more treating doctors believe it is necessary. The minister can refuse a transfer on medical, security or community safety grounds. [Independent Health Advice Panel (IHAP)] can review the minister's decision but only on the ground of medical necessity. IHAP cannot challenge the minister's decision if it relates to security or community safety. In other words, as the government retains primary control over medical transfer decisions, the commission considers that the bill is not necessary to achieve the stated aim of ensuring the integrity and efficacy of the regional processing framework and returning decision-making power to government.¹

- 1.23 Mr Santow commented on the likely consequences of returning to the previous system for medical transfers, if the bill is passed:

Before the introduction of the current medical transfer provisions, decisions to transfer a person for medical reasons often did not occur in a timely manner or in line with medical advice. In many cases, Federal Court proceedings were needed to secure urgent medical transfers. The Federal Court found the processes for assessing individuals for medical transfer from Nauru or PNG were neither adequate nor sufficiently quick. As you have heard this morning, one deeply concerning case involved 24-year-old Hamid Khazaei, who contracted a leg infection that was not properly

¹ Mr Edward Santow, Human Rights Commissioner, Australian Human Rights Commission (AHRC), *Committee Hansard*, 26 August 2019, p. 27.

treated on Manus Island. Despite medical advice that he receive treatment in Australia, the Australian government refused to do so. He was taken instead to Port Moresby, where delays in critical care led to him suffering a major heart attack. This precipitated his transfer to the Mater Hospital in Brisbane, where he was declared brain dead and his life support was withdrawn.

If this bill is passed, medical transfers will be subject to the previous section 198B regime. We know the underlying health of asylum seekers and refugees in Nauru and PNG is precarious and that local healthcare facilities are limited. By making it more difficult for these people to obtain timely and appropriate health care, this bill would have a significant negative affect on their right to health. The commission considers this is not justified under international law.²

- 1.24 At the time of writing, 132 people have been transferred to Australia under the medevac provisions, and all of these transfers were explicitly approved by the Minister for Home Affairs, Peter Dutton, the Minister for Immigration, Peter Coleman, or by ministerial-appointed doctors.
- 1.25 Of this number, 23 were transferred after being initially refused by the ministers. These individuals were only transferred to Australia after assessment by the Independent Health Advice Panel – the expert panel of doctors appointed by the minister.
- 1.26 Only one case has been rejected on security or character grounds.
- 1.27 The Independent Health Advice Panel includes some of Australia's most highly qualified and experienced medical practitioners, including the Commonwealth's Chief Medical Officer Professor Brendan Murphy; the Surgeon-General of Australian Border Force Dr Parbodh Gogna; Australian Medical Association (AMA) representative and the AMA's ACT President, Dr Antonio Di Dio; Paediatric health expert Associate Professor Susan Moloney; and Royal Australian and New Zealand College of Psychiatrists representative Associate Professor Neeraj Singh Gill.
- 1.28 As the president of the Australian Medical Association, Dr Tony Bartone, said in evidence to the committee:

From all reports, I believe that the Independent Health Advice Panel process is working well...I haven't seen any of the applications that have come before the panel, However, I am led to believe that all the cases that have been brought to the panel have been meritorious and worthy of consideration, and the panel's assessment has been duly followed through. In that respect, I have nothing but faith in the process, and the outcomes, and its execution by the panel.³

- 1.29 Labor is confident that the Australian people can see through the Government's political rhetoric on this issue.

² Mr Santow, AHRC, *Committee Hansard*, 26 August 2019, p. 27.

³ Dr Tony Bartone, President, Australian Medical Association (AMA), *Committee Hansard*, 26 August 2019, p. 2.

1.30 The need for the transfer system introduced by the medevac law reflects the baleful consequences of the Government's failure to resettle people who have been held in offshore processing centres for up to six years.

1.31 Dr Neela Janakiramanan, one of the lead doctors implementing the medevac transfer provisions, provided the committee with the results of a health audit of asylum seekers in PNG and Nauru:

So 581 patients have written to us and said that they have unmet health needs. We have obtained the medical records or conducted direct teleconference health assessments for 338 of those patients. Those direct telehealth assessments range in time from 50 minutes to 170 minutes in length, so they are significant health consultations.

We have gone through these medical records and documented the current health conditions that these patients have. Where there was any uncertainty about whether a diagnosis could be made it was not coded for. These are diagnoses that are based on standard diagnostic criteria and standard objective test findings—things like x-rays. If there's a broken bone, you can see it. It's very straightforward.

We have found—and I will reiterate the numbers—that 97 per cent of people have physical health complaints and 91 per cent of people have psychiatric health complaints. On average, each patient has 4.6 discrete organ systems that are involved with disease. There are a number of reasons for this. Part of the reason for it is the conditions in which they have lived for the last six years. There are certain diseases that are more common in disadvantaged populations. The second thing is because there has been no resolution to many of these health issues.

So even though \$400 million has been spent by the department on providing healthcare services to patients in Papua New Guinea and Nauru, as far as we can tell from the submission that the department has made there has been no audit of the outcomes that these services have actually provided. If we funded an Australian health service that delivered these sorts of outcomes, it would be shut down immediately. The numbers are absolutely gobsmacking.⁴

1.32 The audit results are a shocking indictment of the way this Government has conducted the offshore processing of boat arrivals.

1.33 The system was never intended to consign people into indefinite detention with little or no hope of permanent resettlement. But that is what it has become.

1.34 In this situation, it is not surprising that health outcomes for the asylum seekers in offshore centres continue to deteriorate.

1.35 The need for a medical transfer system that gives due weight to medical assessments, which the medevac law has created, has been abundantly confirmed.

⁴ Dr Neela Janakiramanan, *Committee Hansard*, 26 August 2019, p. 11.

- 1.36 No matter how much money is spent to ameliorate life in an unhealthy environment, the result is likely to be unhealthy people.
- 1.37 As Professor Kerry Phelp, a former AMA president and one of the architects of the medevac law, said in evidence to the committee:
- You say that the government say they've spent a lot of money. We can spend a lot of money on something that is not appropriate. For example, if you don't have a culturally and linguistically appropriate psychiatric service, you are not going to be able to treat people with serious mental illness—mental illness which is created by the situation from which people quite often have fled, whether that be persecution or torture or war, and then they are detained indefinitely with no understanding of what their future might be or if indeed they have a future. They then become more unwell and have to fight through lawyers whom they have not met and are working on a pro bono basis to try to get them to a country where they can receive appropriate care. This is not the way that Australia should be treating people seeking asylum.⁵
- 1.38 The Government, however, has ignored these independent medical assessments.
- 1.39 Despite the clear evidence that the combination of turnbacks and offshore processing has stemmed the flow of boats, the Minister continues to try to incite fears in the wider community about a new influx of boat arrivals.
- 1.40 Labor is deeply concerned about the Minister's reputation as the boy who cried wolf, and what that will mean for the Department he leads.
- 1.41 The Minister must be held to account for his continuing mismanagement, and his attempt to wind back the clock on medical transfer must be rejected.

Recommendation 1

- 1.42 That the bill not be passed.**

Senator the Hon Kim Carr
Deputy Chair
Labor Senator for Victoria

Senator Anthony Chisholm
Labor Senator for Queensland

⁵ Professor Kerry Phelp AM, *Committee Hansard*, 26 August 2019, p. 10.

Australian Greens dissenting report

- 1.1 The Australian Greens would like to thank everyone who made a public submission and/or public representation to this inquiry.

Seeking asylum in Australia

- 1.2 Seeking asylum in Australia is legal under both Australian and international law. As submitted by the Law Council of Australia (the Law Council):

asylum seekers and refugees have committed no illegal action by virtue of coming to Australia by boat for the purpose of seeking asylum.

- 1.3 The Parliamentary Library, in its 2015 research paper 'Asylum seekers and refugees: what are the facts?', found:

There is no offence under Australian law that criminalises the act of arriving in Australia [irrespective of their mode of arrival] or the seeking of asylum without a valid visa.

Rights of people seeking asylum from Australia

- 1.4 As submitted by the United Nations High Commissioner for Refugees (the UNHCR), all people who seek asylum in Australia are owed:

rights to which they are entitled under the Refugee Convention and other relevant international instruments.

- 1.5 This convention and other relevant international instruments provide not only for the rights of people seeking asylum, but also the receiving state's duty of care.

Australia's duty of care

- 1.6 Numerous submissions from legal experts and others raised the matter of Australia's duty of care for people it has transferred and detained offshore. As submitted by the UNHCR:

The physical transfer of asylum-seekers from Australia to Papua New Guinea and Nauru does not extinguish Australia's legal responsibility for their protection...the primary responsibility for providing protection rests with the State from which asylum is sought.

- 1.7 This is because, as submitted by the Andrew and Renata Kaldor Centre for International Refugee Law (the Kaldor Centre):

the arrangements with Nauru and PNG do not meet the conditions for full 'transfer' of legal responsibility for those affected and their futures.

- 1.8 What's more, this duty of care is, according to the Kaldor Centre, 'non-delegable'.

- 1.9 Australia's duty of care for people it has detained offshore is a legal obligation of both domestic and international laws. This duty of care, as submitted by the

Kaldor Centre, has been acknowledged by the Minister and the Commonwealth in cases brought before the Federal Court.

Sovereignty

1.10 Due to multi-state arrangements between the Commonwealth of Australia, Papua New Guinea (PNG), and the Republic of Nauru (Nauru), issues regarding sovereignty have been raised. On this matter, the Kaldor Centre found no conflict regarding Australia's duty of care obligations, and the sovereignty of other State actors, referring to Bromberg J stating that:

he 'would expect that the Commonwealth is subject to a duty of care in many situations which have the capacity to touch on relations with sovereign states' and that '[t]here can be no general rule against the existence of a duty of care owed by the Commonwealth simply because the existence of the duty may give rise to a possibility of some impact on Australia's relations with other sovereign states'.

Health data

1.11 After 11 months working on Nauru, Médecins Sans Frontières (MSF) released its 2018 report *Indefinite Despair: The tragic mental health consequences of offshore processing on Nauru*. This report presented independent medical data demonstrating extreme mental health suffering of detainees due to Australia's policy of indefinite offshore processing. It found:

the mental health suffering on Nauru is among the most severe [it] has ever seen around the world, including in projects providing care for victims of torture...Close to half (47%) of the 64 Nauruan patients seen by MSF had psychosis...[and that] in total, 135 (65%) refugee and asylum seeker patients seen by MSF had suicidal ideation and/or engaged in self-harm or suicidal acts...[including] children as young as nine.

1.12 This corresponded with two 2016 reports: one by Amnesty International that conditions the conditions were 'tantamount to torture', causing 'severe mental anguish'; and another by the U.N. Special Rapporteur for the Human Rights of Migrants which described the detention as 'cruel, inhuman and degrading'.

1.13 The latest data on the health of refugees and asylum seekers in offshore detention comes from Drs Townend, Thurtle, and Janakiraman, who are three of the lead doctors implementing the medevac transfers as part of the Medical Evacuation and Response Group (MERG). Through their assessments of individuals and audits of records they have found the burden of the last six years on the physical health of refugees and asylum seekers detained offshore by the Australian Government to be significant. Of the cases reviewed by MERG, as submitted to this inquiry by Townend et al., they found:

- 97 per cent have a confirmed physical ailment;
- On average each patient has 4.6 distinct physical ailments, with the maximum counted in a single patient being 15;
- 91 per cent experienced one or more psychiatric health problems;

- 57 per cent have been actively considering suicide;
- The great majority of patients (88 per cent) are experiencing both physical and psychiatric health problems.

On-island health services

1.14 It has been argued many times, and by many experts and NGOs, that the health services on PNG and Nauru, including those funded and/or provided onshore by the Australian Government, are ill-equipped and unable to cope with the clinical needs of people detained offshore by the Australian Government.

1.15 As submitted by the Castan Centre, the UN High Commissioner for Human Rights has stated:

Among the myriad of actors that provide services to the migrants, private security and other service providers have reportedly failed to facilitate access to health care in a number of instances.

1.16 In its submission to this inquiry, MSF noted:

There are...no acute inpatient treatment facilities [in Nauru], nor is there a permanent psychiatrist amongst the Ministry of Health staff. Patients who pose a risk to themselves or others are detained by police.

1.17 As submitted by Townend et al.:

Upgrades to the Republic of Nauru Hospital are noted by the monetary expenditure on them, and not by reference to their quality or suitability for use.

1.18 A similar lack of appropriate healthcare exists in PNG too. In East Lorengau the Shamrock Compound is used to accommodate refugees and asylum seekers who have self-harmed. This compound is a former police barracks, which is guarded by non-clinical staff. According to Townend et al., this compound has been used to accommodate at least 17 mentally unstable men at a time.

1.19 The Independent Health Advice Panel (IHAP) stated in its first quarterly report, which was completed without external membership, that it was impressed with the facilities at the Pacific International Hospital (PIH) in Port Moresby. However, Townend et al. argue:

it is not clear whether the panel has been provided with, or asked for, any outcome data from PIH; whether they have been provided with, or asked for, any quality control or governance information for PIH; or whether the panel has engaged any patient groups for feedback about the services provided, which would be the standard of care at an Australian institution were it being evaluated. For these reasons, in our view **the IHAP's statement that they were impressed with the PIH facilities should be treated with caution** [emphasis added].

A failed pre-medevac process

1.20 It is Australia's pre-medevac process for medical transfers of offshore detainees that has led to the need for medevac legislation. As submitted by the Kaldor Centre:

If Australia acts promptly to identify people with critical health needs and ensure they are appropriately met – be it in Australia or elsewhere – the medevac system will not come into play.

1.21 But the critical health needs of this cohort were not met by the Australian Government prior to the medevac legislation being enacted. The Australian Government created living conditions for people in offshore detention that could only further traumatise an already vulnerable cohort, which led to local health services being overwhelmed. As submitted by MSF:

Despite the number of healthcare staff on [Nauru] the reality is that it cannot meet the need as shown by the ongoing health crisis, and the number of transfers to Australia in the past 9 months.

1.22 The Australian Government also repeatedly ignored recommendations from its own contracted medical staff regarding medical transfers. Put simply by the Human Rights Law Centre (HRLC):

Despite [its] clear legal responsibility, the Australian Government has demonstrated that it cannot be relied upon to act on medical recommendations appropriately and in good faith when decisions about care are left entirely to Ministerial discretion.

1.23 Witnesses to this inquiry have raised numerous examples of people in offshore detention whose treating doctors had recommended a medical transfer, only to have those recommendations ignored by the Australian Government. These medical recommendations would sometimes be ignored by Government for many years. In the 2018 case *EWB v Minister for Home Affairs*, Justice Thawley of the Federal Court noted that:

the Minister did not respond to a single letter that had been written requesting the urgent transfer of the applicants from Nauru and indicating that proceedings would be commenced.

1.24 According to the Kaldor Centre:

There was no clear statutory guidance for how people in need of urgent medical care should be brought to the attention of the Minister, nor how decisions about such transfers should be made. There was no requirement that transfer decisions be made by people with appropriate medical qualifications, nor that they respond to identified clinical needs.

1.25 The HRLC submitted:

the Australian Government's failure to transfer seriously unwell people held on Manus and Nauru to Australia for treatment meant that those people were forced to take legal action to access appropriate medical care.

- 1.26 As submitted by the HRLC, every single court case compelling the Australian Government to transfer a detainee for urgent medical care that couldn't be provided offshore was successful. Sometimes medical transfers would be authorised without court proceedings, but only after lawyers intervened and threatened legal action. Legal actions resulted in over 340 people being transferred for serious and unmet medical needs.

Court proceedings

- 1.27 The pre-medevac transfer process was not only a lengthy process, but also a costly process. As submitted by the Law Council:

prior to the commencement of the Medevac Law, the only means of compelling the transfer of an asylum seeker requiring medical treatment was to commence injunctive proceedings in court. Such proceedings were unnecessarily adversarial, time and resource-intensive. The Medevac Law avoids the significant amount of resources that were previously expended by the pro bono legal community, the Government and the Federal Court of Australia in dealing with claims for medical transfer on behalf of refugees and asylum seekers. It provides a more efficient process achieving the same result, and avoids potentially life-threatening delays.

- 1.28 The costs of these lengthy legal processes are to community, government, and life.

Cost to community

- 1.29 Numerous witnesses have provided this inquiry with evidence that the pre-medevac process for urgent medical transfers involved significant legal costs and resources. One significant benefit of the medevac process is that medical decisions are now made by independent medical professionals, which avoids the need for costly litigations. As submitted by the Law Council:

The Medevac Law avoids the significant amount of resources (which could be elsewhere better allocated) that were previously expended by the legal community, the Government and the Federal Court of Australia in dealing with claims for medical transfer on behalf of refugees and asylum seekers.

Cost to Government

- 1.30 The pre-medevac process also resulted in substantial legal costs for Government, as it fought in court against individual applications for urgent medical transfers. Costs borne by the Government have been provided, under scrutiny, to the Legal and Constitutional Affairs Committee. These include the following excerpts from the Hansard:

Ms de Veau: It looks like in 2017-18 [the legal costs, how much the department has spent in court opposing applications to transfer people out of our offshore detention system here to Australia] was in the vicinity of \$275,000. This is legal expenses in relation to medical transfer interlocutory proceedings. From July to September—so year to date to the end of

September, first quarter—it looks like it's in the vicinity of \$480,000. So that's a total of \$753,000 (Supplementary Estimates, October 2018).

Ms de Veau: ...for the current financial year—so, July 2018 to 31 January—the figure is \$1.373 million [spent by the department in the courts to prevent transfers of people from Manus Island and Nauru] (Additional Estimates, February 2019).

Cost to life

- 1.31 The greatest cost of the pre-medevac process for urgent medical transfers, which could result in litigation that lasted for years, was to life: the lives of people under Australia's duty of care. As submitted by the HRLC:

The Australian Government's failure to provide access to appropriate medical care has led to tragic consequences. Twelve people died in offshore detention before the Medevac laws were passed. Most of those deaths involved untreated physical or mental health conditions and included cases in which the Australian Government ignored medical advice recommending urgent transfer to Australia.

Medevac legislation works

- 1.32 Against this backdrop of detainee deaths in custody, unprecedented numbers of children with resignation syndrome, and untold human misery, an amendment (sheet 8619) to the Home Affairs Legislation Amendment (Miscellaneous Measures) Bill 2018 was moved by Senators Storer and McKim, which passed both houses. This amendment introduced what we now refer to as medevac legislation, which the Migration Amendment (Repairing Medical Transfers) Bill 2019 seeks to repeal.
- 1.33 Under this medevac legislation, a transfer on medical grounds needs to be recommended to the Minister by two (2) doctors. The Minister then has 72 hours to approve or refuse this recommendation. A refusal can be issued on security and/or character grounds, or on medical grounds (except when a minor). If the refusal is made on medical grounds, this decision is then referred to an eight-person medical panel—the IHAP—which has a further 72 hours to review the case.
- 1.34 If the panel supports the doctors' recommendation for a transfer, this decision goes back to the Minister, who can still refuse on security and/or character grounds. If there are no security and/or character grounds on which to refuse a transfer, the transfer recommended by both the attending doctors and medical panel is approved.
- 1.35 As part of the medevac legislation, the independent MERG was established to oversee the triage of people in offshore detention in need of urgent medical care. MERG is made up of caseworkers, counsellors, and lawyers from non-governmental organisations who work directly with medical professionals.

- 1.36 According to Townend et al., doctors conducting medical assessments of people in offshore detention make their assessments in regards to the patient's medical needs, and the capacity of local health services to meet these needs. Where a patient has a problem relating to a single organ or specialty field, a medical specialist in that organ or field is allocated to make the assessment.
- 1.37 Where patients have a major presenting problem related to a single organ system, then a specialist who is an expert in that organ system is most appropriate to undertake the assessment and provide their medical opinion.
- 1.38 The need and success of medevac legislation can be demonstrated by the number of approvals that have occurred under it. As submitted by Townend et al.:

As of Thursday August 15 [2019], 121 patients have been approved for medical evacuation. This indicates the level of unmet health need among the cohort of refugees and asylum seekers still in PNG and Nauru. A majority of approvals have been given by either the Minister for Home Affairs or the Minister for Immigration...Only twenty-two applications were referred to IHAP. Eight of these applications have been approved for medical transfer by IHAP, and fourteen patients were not approved for medical transfer.

- 1.39 As noted by numerous submissions, rather than replace the pre-2019 medical transfer process, what the medevac laws have done is improve the pre-existing process by putting in place clear timeframes for decisions based on expert medical advice to ensure urgent medical care is provided when needed for people detained offshore and owed a duty of care by the Australian Government. Moreover, as submitted by the Law Council:

the Medevac Law overcomes the existing adversarial approach to medical transfers...[with medical recommendations] based on giving appropriate weight to the views of qualified and objective medical professionals, as a key element of decision-making, reflecting Australia's common law and international obligations.

Depoliticising medical evacuations

- 1.40 A critical outcome of the medevac legislation, both from medical and policy perspective, is the depoliticisation of the medical transfer process. Although the Minister still has oversight medical transfers, the medevac legislation has depoliticised the process by ensuring decisions regarding healthcare for offshore detainees are made by independent medical professionals, not bureaucrats or politicians.
- 1.41 As submitted by Townend et al., as lead doctors working with the MERG:
- The medical assessments we have undertaken [under medevac law] are independent, and absent of any broader advocacy agenda.
- 1.42 This view is echoed by the Kaldor Centre, which submitted the medevac legislation:

minimises the risks of delay, uncertainty, and politicisation of medical decisions.

- 1.43 In the Queensland Coroner's inquest into the death of Hamid Khazaei, an Iranian asylum seeker who died of sepsis and cardiac arrest from a leg infection, the Coroner found:

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.

- 1.44 As demonstrated by submissions to this inquiry, the medevac legislation and its medical evacuation process is overwhelmingly supported by Australia's peak medical and legal organisations.

Standard operating procedures

- 1.45 Medical experts have also noted that medical transfers provided under medevac legislation are consistent with standard practices within Australia. As submitted by Townend et al.:

Doctors are required by the Australian Health Practitioners Regulation Agency Code of Conduct for Medical Professionals to ensure that patients are referred for appropriate care...In Australia, the balance is typically in favour of transferring patients where there is an indication that might be required, rather than waiting until a patient is catastrophically unwell before escalating their care provision.

- 1.46 Townend et al. also noted that the use of telehealth by medical practitioners to remotely assess patients, and the use of medical records and test results without physical examinations to inform recommendations for complex care is commonplace in Australia.

Ministerial oversight

- 1.47 The medevac legislation does not remove ministerial oversight, or introduce additional risks to national security or public safety. As submitted by the Law Council:

The Minister can prevent a transfer where he or she reasonably suspects that a transfer would be prejudicial to security, or where the person has a substantial criminal record and he reasonably believes that the transfer would expose the community to a serious risk of criminal conduct...[and] the Minister ultimately retains the discretion as to whether a person is detained in the community or in a detention centre.

Temporary transfer

1.48 Medevac legislation only provides offshore detainees with a temporary transfer to Australia, for so long as that person requires medical care that cannot be provided by offshore medical facilities. As submitted by the Law Council:

any transitory person who is brought to Australia from [a regional processing centre] once again becomes an unlawful non-citizen and must be detained under section 189 of the Act. This detention must continue until the time of removal from Australia.

1.49 As submitted by the Castan Centre:

an unauthorised maritime arrival brought to Australia from a regional processing country for a temporary purpose under section 198B must be removed from Australia and taken to a regional processing country once they no longer need to be in Australia for the temporary purpose.

1.50 These legal opinions are supported by the Department of Home Affairs. On 22 October 2018, Secretary of the Department of Home Affairs, Mr Michael Pezzullo, told the Senate Standing Committee on Legal and Constitutional Affairs:

Upon transference to Australia, and there's something in the order of over 600 people here on temporary transfers, the law states quite clearly that when their period of treatment is concluded they're expected to return. So we try to make that clear to people. We don't want to create a situation where people think that medical transference to Australia is a pathway to residency, because that could incentivise the kinds of perverse behaviours...so medical transfers are not a solution to the migration challenge or migration issue of one day finding these people permanent homes under our Migration Act. Under the laws this parliament has passed they can't settle here in Australia.

Conclusion

1.51 The medevac legislation has saved lives, and delivered people health care they had previously been deliberately deprived.

1.52 The government's refusal to transfer sick people from offshore detention to Australia under previous arrangements caused death, mental anguish and untold suffering among refugees and people seeking asylum.

1.53 The medevac repeal Bill shows that the government puts political imperatives ahead of people's medical needs.

1.54 They have made the crass calculation that some lives are worth sacrificing for broader political outcomes, despite their legal and moral obligations.

1.55 This calculation should be intolerable in a liberal democracy like Australia.

1.56 Decisions about medical care should be made by medical experts, not politicians or bureaucrats.

Recommendation 1

1.57 The recommendation of the Australian Greens is that this bill should not proceed.

**Senator Nick McKim
Greens Senator for Tasmania**

Centre Alliance dissenting report

- 1.1 The medical transfers regime created through the "Medevac" law is working as intended, to allow for independently-assessed and timely transfers of patients from offshore detention to Australia for treatment of chronic and complex conditions.
- 1.2 The evidence presented at the inquiry demonstrates the current law complements the department's pre-existing transfer regime—which has too often been slow and overly-bureaucratic—but rightly puts the ultimate decision of whether a sick refugee needs to be medically transferred in the hands of medical professionals, not a bureaucrat within the Department of Home Affairs.
- 1.3 The clinical reviews conducted under the Medevac process have also enabled Australian doctors to properly assess and understand the burden of disease in asylum seekers and refugees in Papua New Guinea and Nauru – and the inquiry into this bill heard it has shocked many.
- 1.4 Dr Neela Janakiramanan from the Medical Evacuation Response Group (MERG) told the inquiry:

Some of our doctors have worked extensively in refugee camps in various parts of the world, and they call us up to debrief because they say that what they are seeing in terms of the health burden is absolutely shocking and the worst thing that they have ever seen.¹
- 1.5 Until the Medevac laws came into play in March 2019, medical transfers were secured under section 198B of the *Migration Act 1958*, which gives an officer the power to bring a transitory person to Australia for a temporary purpose, including medical or psychiatric assessment or treatment. However, this did not provide for a transparent, speedy and medically-led transfer process.
- 1.6 The Australian Human Rights Commissions said:

...we also had concerns about the structure for the process under 198B previously, where ultimately the decision was being made by someone at first assistant secretary level within the department rather than by medical officers who have knowledge of what is required in a medical sense.²
- 1.7 Evidence from refugee groups and the medical profession, including doctors on the ground, was that the department's pre-existing system was inadequate, unpredictable, litigious and so distressing that some doctors had stopped working in the field.

¹ Dr Neela Janakiramanan, private capacity, *Committee Hansard*, 26 August 2019, p. 14.

² Mr Graeme Edgerton, Deputy General Counsel, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 31.

It was all ad hoc and the oversight was at times completely lacking...I know, from feedback from doctors at the front line, that they were quite distressed at times about patients who did need to be transferred and weren't able to access the appropriate transfer. They were very, very concerned, and I know that, for some members of the medical profession performing services at that front line, it was so distressing that they had to leave that service because of that.³

- 1.8 Before the Medevac laws, a number of medical transfer requests were only secured after cases were brought to the Federal Court or a legal case was threatened.
- 1.9 Based on figures provided by the Department of Home Affairs submission, it appears legal intervention occurred in about 17% of the 717 medical transfers that have occurred over almost seven years.
- 1.10 In its submission, the Department said 717 individuals and 626 accompanying relatives (a total of 1343 people) have been transferred to Australia and third countries for medical treatment since November 2012. About 1098 transferees remain in Australia and no-one has been returned from Australia to a regional processing country since April 2018.⁴
- 1.11 Of these, 37 cases involving 96 people were transferred as a result of court orders. As the department acknowledged in its submission, lawyers persisted with some of these court cases because the transfer was not happening quickly enough.
- 1.12 In a further 90 cases involving 220 people, the Department reviewed and approved transfer requests after lawyers had foreshadowed legal proceedings.⁵ That indicates a flawed system, where lawyers regularly needed to flex their muscle in order to secure the treatment doctors had recommended.
- 1.13 The Human Rights Law Centre stated it participated in 48 pro-bono cases brought to the Federal Court between December 2017 and February 2019—some of them on weekends or at night due to urgency⁶—for 'serious medical conditions including psychosis, sepsis, encephalitis, resignation syndrome and pregnancy complications in which the life of the unborn child and mother were put at risk'. All were successful, and resulted in the transfer of more than 340 people.⁷

³ Dr Tony Bartone, President, Australian Medical Association, *Committee Hansard*, 26 August 2019, p. 3.

⁴ Major General Craig Furini, Commander, Joint Agency Task Force Operation Sovereign Borders, Department of Home Affairs, *Committee Hansard*, 26 August 2019, p. 75.

⁵ Department of Home Affairs, *Submission 55*, pp. 10–11.

⁶ Mr Hugh de Kretser, Executive Director, Human Rights Law Centre, *Committee Hansard*, 26 August 2019, p. 33

⁷ Human Rights Law Centre, *Submission 51*, p. 5.

- 1.14 Twelve people died in offshore detention in the five years before the Medevac laws were passed, and patients recommended for medical transfer averaged a wait of two years, and up to five years, before transfer was secured.⁸
- 1.15 According to an audit of medical records of Medevac applicants, conducted by Dr Janakiramanan and her MERG colleague Dr Sara Townend, **97 per cent** of the refugees and asylum seekers on Nauru and in PNG have significant physical health issues and **91 per cent** have significant mental health issues.⁹ Given this is an independent and objective assessment from trained doctors, these are staggering numbers and they demonstrate why the Medevac laws were needed, and why they remain important.
- 1.16 According to Dr Townend's evidence, some of the presenting health conditions have arisen through detention (for instance, a large number of patients with kidney stones due to poor diet and hydration) and other conditions have become chronic because they were not well managed from the outset (for instance poorly or untreated fractures leading to limb deformity).¹⁰

As a clinician, often those clinical files are heartbreaking to read because you see the recommendations of the doctors over and over again—that this patient requires transfer to an appropriate facility for a specialist procedure or test—from 2015.¹¹

- 1.17 The inquiry heard that the standard of healthcare offered in PNG and Nauru can be inadequate, particularly for serious cases. This was highlighted in the preventable death of Hamid Khazaei in 2014, whose death began with a leg infection which spiralled into sepsis due to lack of antibiotics and his woeful care in PNG and ended with his death shortly after his delayed transfer to Brisbane.¹²
- 1.18 The first quarterly report from the Independent Health Assessment Panel (IHAP), created under the Medevac laws, gives a recent snapshot of the health services in PNG and Nauru. It noted while general healthcare services are 'reasonable', the mental health facilities in Nauru in particular are not up to the job for the high number of psychological presentations and mental health admissions.

In respect of mental health services, there are significant numbers of mental health workers but (unlike PNG) there is no access to high quality inpatient psychiatric care in Nauru and patients with severe mental illness

⁸ Asylum Seeker Resource Centre, *Submission 56*; Human Rights Law Centre, *Submission 51*, p. 4

⁹ Dr Neela Janakiramanan, Dr Natalie Thurtle and Dr Sara Townend, *Submission 52*.

¹⁰ Dr Sara Townend, private capacity, *Committee Hansard*, 26 August 2019, p. 12.

¹¹ Dr Townend, *Committee Hansard*, 26 August 2019, p. 13.

¹² Mr Edward Santow, Human Rights Commissioner, Australian Human Rights Commission, *Committee Hansard*, 26 August 2019, p. 27; Mr Kon Karapanagiotidis, Chief Executive Officer, Asylum Seeker Resource Centre, *Committee Hansard*, 26 August 2019, pp. 55–56.

and at high risk of suicide should be transferred to a hospital with appropriate inpatient psychiatric care.¹³

- 1.19 The IHAP noted some asylum seekers in PNG had tested positive for typhoid. It also noted that specialist medical care is not readily available on Manus and that, while there were mental health services for people who can walk themselves to a clinic, there was no access to psychiatric intensive care or electro-convulsive therapy in PNG.¹⁴
- 1.20 The Medevac laws have worked to secure timely transfers of patients with established clinical need—as intended. In fact, the only witnesses at the public committee hearing who supported repealing the Medevac Laws through this bill were those from the Department.
- 1.21 Over the period from March to the end of July 2019, 72 people were transferred to Australia under the Medevac laws (with four accompanying family members) and a total of 154 people had applied. A further 54 people (at least 9 of them accompanying family)¹⁵ were transferred under the pre-existing provisions of the Act.¹⁶
- 1.22 The IHAP steps in to review transfer applications which have been rejected by the Minister and, within 72 hours, assess whether there is an overriding clinical need and approve the transfer. The Minister can only overturn these based on national security or character concerns.
- 1.23 According to the Department, the panel reviewed 23 refusals between March and the end of July and overturned 10 cases, recommending them for transfer.
- 1.24 None of the 154 applications made by July have been knocked back by the Minister on national security or character grounds.
- 1.25 The IHAP also provides an independent monitoring function of the available health services and standard of care on Nauru and PNG and this would be lost if the Migration Amendment (Repairing Medical Transfers) Bill 2019 was passed and the Medevac laws repealed.
- 1.26 **Looked at objectively, the Medevac laws do no harm and only do good—at the very least sitting in complement to the pre-existing transfer provisions under s198B.**
- 1.27 It is important to note that the Medevac laws have not "restarted the boats".

¹³ Independent Health Advice Panel, First Quarterly Report, tabled in Parliament 4 July 2019, p. 3.

¹⁴ Independent Health Advice Panel, First Quarterly Report, tabled in Parliament 4 July 2019, p. 4.

¹⁵ Independent Health Advice Panel, Second Quarterly Report, p. 6.

¹⁶ Department of Home Affairs, *Submission 55*, p. 4 and p. 17.

1.28 It is important to note that the Medevac laws only apply to people who are already in PNG and Nauru and don't create a "pull factor" for future arrivals. It does not provide a pathway to settlement in Australia.

1.29 In fact, doctors and lawyers gave evidence to the inquiry that, should the laws be repealed, there would be a risk of worsening physical and mental health outcomes and an increased risk of death and disability for those in PNG and Nauru.¹⁷

Removing a fair, transparent and doctor-led process for accessing essential, and in many cases, life-saving medical care is illogical and unnecessary. Without the Medevac laws, we are extremely concerned that the Australian Government's failure to provide appropriate and timely medical care will result in more preventable deaths offshore.¹⁸

1.30 The government and department have not advanced sufficiently solid grounds for abolishing the Medevac laws. The Department argued that the narrow character grounds may not capture everyone of concern but witnesses countered that potential risks can be mitigated.

1.31 For instance, those transferred to Australia for medical treatment are detained while they are onshore, and the Minister decides whether this is in the community or in a detention centre. As stated by the Law Council, 'this means that any potential risk posed to the Australian community will be managed in practice'.¹⁹

1.32 Other witnesses noted that the scare tactics and fears raised by the Government after the Medevac reforms were passed have not come to pass.

All of the scaremongering and all of the rhetoric about flooded hospitals, blown out waiting lists and opening the doors to people of bad character coming to Australia—none of it was ever true. Nor is it true that the medevac legislation has encouraged an increase in episodes of self-harm. The incidents of self-harm related to declining mental health were increasing before medevac and was one of the reasons it was needed.²⁰

The sky hasn't fallen in with the 1,084 people who've been brought back and nor have the boats resumed, as was clearly a concern stated by government. In fact, we've seen people being resettled to the US from Nauru and from PNG. We've seen many people being brought back for the critical medical treatment they need. What we see is not in fact the

¹⁷ For example, the Royal Australian and New Zealand College of Psychiatrists, *Submission 60*; also see *Committee Hansard*, 26 August 2019, p. 15, p. 20, pp. 22–23, p. 27, p. 34 and so on.

¹⁸ Human Rights Law Centre, *Submission 51*, p. 8.

¹⁹ Mr Tass Liveris, Executive Member, Law Council of Australia, *Committee Hansard*, 26 August 2019, p. 44.

²⁰ Professor Kerry Phelps AM, *Committee Hansard*, 26 August 2019, p. 8.

problems that those fears sought to provoke. They just haven't materialised.²¹

1.33 The laws are working. They are supported by the people at the frontline of decision making for medical transfers—doctors themselves—and have not resulted in any of the negatives with which the Government sought to scaremonger and frighten the Australian public.

1.34 In light of all this, it makes no sense to repeal the Medevac laws and, indeed, to do so potentially and needlessly puts these already vulnerable people at risk.

Recommendation 1

1.35 Centre Alliance recommends that the bill not be passed.

Senator Stirling Griff

Centre Alliance Senator for South Australia

²¹ Mr David Manne, Executive Director, Refugee Legal, *Committee Hansard*, 26 August 2019, p. 37.

Appendix 1

Submissions, additional information, answers to questions on notice and tabled documents

Submissions

- 1 Mr Robert Whiting
- 2 Ms Sarah Robertson
- 3 Catholic Diocese of Darwin
- 4 Miss Diana Boyd
- 5 Ms Lanie Stockman
- 6 Mr Andrew Blanckensee
- 7 United Nations High Commissioner for Refugees
- 8 Dr Timothy Macnaught
- 9 Australian Medical Association
- 10 Grandmothers Against Detention of Refugee Children
- 11 Australian Lawyers Alliance
- 12 Caroline Davis
- 13 Royal Australian College of General Practitioners
- 14 Uniting Church
- 15 Ms Angela Mawbey
- 16 Ms Marie Wood
- 17 BITA Visitor's Group
- 18 Bega Valley Rural Australians for Refugees
- 19 Yass Rural Australians for Refugees
- 20 Ms Cathy Picone
- 21 Canberra Refugee Action Campaign
- 22 Ms Frederika Steen
- 23 Professor Caroline de Costa AM
- 24 Ms Eileen O'Brien
- 25 East Gippsland Asylum Seekers Support Group
- 26 Jesuit Social Services
- 27 Northern Victoria Refugee Support Network
- 28 World Vision Australia
- 29 Prof Kerry Phelp
- 30 Dr Kevin Sweeney
- 31 Dr Tanya McIntyre

- 32 Mr Shaun Hanns
- 33 Refugee Advocacy Network
- 34 Ms Sue Todd
- 35 Amnesty International Australia
- 36 NSW Council for Civil Liberties
- 37 Ms Julie Marlow
- 38 Refugee Action Collective Illawarra
- 40 The Royal Australasian College of Physicians
- 41 Australian and New Zealand College of Anaesthetists
- 42 Maurice Blackburn Lawyers
- 43 Refugee Council of Australia
- 44 Medecins Sans Frontieres Australia
- 45 Human Rights Watch
- 46 Bayside Refugee Advocacy and Support Association
- 47 Refugee Advice and Casework Advocacy (Aust) Inc.
- 48 Castan Centre for Human Rights Law
- 49 Australian Lawyers for Human Rights
- 50 Jesuit Refugee Service
- 51 Human Rights Law Centre
- 52 Dr Neela Janakiramanan, Dr Natalie Thurtle and Dr Sara Townend
- 53 Kaldor Centre
 - 53.1 Supplementary to submission 53
- 54 Australian Human Rights Commission
 - 54.1 Supplementary to submission 54
- 55 Department of Home Affairs
- 56 Asylum Seekers Resource Centre (ASRC)
- 57 Australian Association of Social Workers
- 58 Australasian College for Emergency Medicine
- 59 Victorian Refugee Health Network
- 60 The Royal Australian and New Zealand College of Psychiatrists
- 61 Refugee Legal
- 62 Law Council of Australia
- 63 Mr Les Bohm
- 64 Ms Rose Costelloe
- 65 Ms Anna Sande
- 66 Blue Mountains Refugee Support Group Inc
- 67 The Australian Medical Students' Association
- 68 Cabrini Health

-
- 69 Ms Charmaine Rodrigues
70 A/Prof Hasantha Gunasekera, The University of Sydney
71 Peter McMullin Centre on Statelessness
72 Sisters of St Joseph
73 Ms Kimberly Matousek
74 Dr Maila Stivens
75 Mr Robert Richter QC and Mr Max Costello
• 75.1 Supplementary to submission 75
76 Ms Noel Pratt
77 *Name Withheld*
78 Mr Grant Mistler
79 St Vincent's Health Australia
80 Mr Peter Morris
81 Ms Bonnie Cassen
82 Ms Lauren Honcope
83 Mrs Linda Cusworth
84 Ms Peta Hughes
85 Mr Chris Welch
86 Miss Renee Thomas
87 Australian Hellenic Council
88 Mrs Zainab Clark
89 Doctors for Refugees
90 Dr Michael Dudley
91 Professor David Isaacs
92 Dr Helen Young
• 92.1 Supplementary to submission 92
93 International Health and Medical Services
94 Mrs Helen Fox
95 *Confidential*
96 *Confidential*
97 *Confidential*
98 *Confidential*
99 *Confidential*
100 *Confidential*
101 *Confidential*
102 *Name Withheld*
103 *Confidential*
104 *Confidential*

Additional Information

- 1 Additional information provided by the Royal Australian College of General Practitioners - 'The mental health of refugees and asylum seekers on Manus Island'

Answer to Question on Notice

- 1 Human Rights Law Centre, answers to questions on notice, 26 August 2019 (received 13 September 2019)
- 2 Royal Australian and New Zealand College of Psychiatrists, answers to questions on notice, 26 August 2019 (received 13 September 2019)
- 3 Department of Home Affairs, answers to questions on notice, 26 August 2019 (received 27 September 2019)
- 4 National Justice Project, answers to questions on notice, 26 August 2019 (received 1 October 2019)
- 5 Department of Home Affairs, answers to questions on notice, 26 August 2019 (received 30 September 2019)

Tabled Documents

- 1 Document tabled by Dr Sara Townend and Dr Neela Janakiramanan at the public hearing in Canberra, 26 August 2019
- 2 Document tabled by Australian Human Rights Commission at the public hearing in Canberra, 26 August 2019
- 3 Document tabled by the Royal Australasian College of Physicians at the public hearing in Canberra, 26 August 2019

Appendix 2

Public hearing

Monday, 26 August 2019

Committee Room 2S3

Parliament House

Canberra

Australian Medical Association

- Dr Tony Bartone, President

Professor Kerry Phelps AM, Private capacity

Dr Neela Janakiramanan and Dr Sara Townend, Private capacity

Royal Australian College of General Practitioners

- Dr Lara Roeske, Chair, RACGP Specific Interests and RACGP Board Director

The Royal Australasian College of Physicians

- Professor Niki Ellis, Director, Chair Policy and Advocacy Council

Royal Australian and New Zealand College of Psychiatrists

- Dr Kym Jenkins, Chair of the RANZCP Asylum Seeker and Refugee Mental Health Network Committee

Australian Human Rights Commission

- Mr Edward Santow, Human Rights Commissioner
- Mr Graeme Edgerton, Deputy General Counsel

Castan Centre for Human Rights Law

- Dr Maria O'Sullivan, Senior Lecturer

Human Rights Law Centre

- Mr Hugh de Krestler, Executive Director
- Ms Josephine Langbien, Lawyer

Kaldor Centre

- Ms Madeline Gleeson, Senior Research Associate
- Ms Kate Ogg, Visiting Scholar

Refugee Legal

- Mr David Manne, Executive Director
- Ms Kate Fitzgerald, Lawyer

Law Council of Australia

- Mr Tass Liveris, Executive Member
- Ms Leonie Campbell, Deputy Director of Policy
- Ms Georgina Costello, Chair, Migration Law Committee

Canberra Refugee Action Campaign

- Sister Jane Keogh, Member

Refugee Council of Australia

- Mr Paul Power, Chief Executive Officer

Asylum Seekers Resource Centre

- Mr Kon Karapanagiotidis, Chief Executive Officer
- Mr Michael Hoey, Triage Manager, Medical Evacuation Response Group

National Justice Project

- Adjunct Professor George Newhouse, Director & Principal Solicitor
- Ms Emma Hearne, Senior Solicitor

Amnesty International Australia

- Dr Graham Thom, Refugee Advisor

Medecins Sans Frontieres Australia

- Mr Paul McPhun, Executive Director
- Mr Jon Edwards, Head of Advocacy and Public Affairs
- Dr Beth O'Connor, Psychiatrist
- Ms Beatrice Barbot, Field/Project Coordinator

Department of Home Affairs

- Mr Michael Pezzullo, Secretary
- Ms Cheryl-ann Moy, Deputy Secretary, Chief Operating Officer, Corporate and Enabling
- Major General Craig Furini, Commander JATF OSB
- Ms Kaylene Zakaroff, Group Manager, Immigration Detention
- Ms Pip De Veau, First Assistant Secretary, Legal
- Ms Alana Sullivan, Senior Assistant Secretary, Regional Processing and Resettlement