

PAPER

Is Australia engaged in torturing asylum seekers? A cautionary tale for Europe

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ABSTRACT

Australian immigration detention has been identified as perpetuating ongoing human rights violations. Concern has been heightened by the assessment of clinicians involved and by the United Nations that this treatment may in fact constitute torture. We discuss the allegations of torture within immigration detention, and the reasons why healthcare providers have an ethical duty to report them. Finally, we will discuss the protective power of ratifying the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment as a means of providing transparency and ethical guidance.

Australian immigration detention has been identified as perpetuating ongoing human rights violations.^{1–7} Concern has been heightened by clinicians involved and by the United Nations that the treatment of asylum seekers in detention does in fact constitute torture.^{2–7} Additionally, the introduction of the Border Force Act 2015 makes advocating for patients difficult, and potentially illegal, as those doing so now put themselves at risk of 2 years incarceration. This severely hampers transparency. The medical communities' response to this, in part, has been to endorse a joint statement calling for the ratification of the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).⁸ The OPCAT is a United Nations treaty which has been left unratified by successive governments since Australia became a party to it in 2009. Implementation of the OPCAT would allow for monitoring of places of detention by domestic and international bodies, thus increasing transparency and acting as deterrence to human rights violations in the first instance.⁵

The situation in Australia is particularly important when seen in the broader context of the humanitarian crises in Syria which is forcing people to seek refuge throughout the Middle East and Europe. Australia's mandatory detention regime, with an emphasis on deterrence, is being promoted by the likes of Australia's former Prime Minister, Tony Abbot, with some evidence that he is being listened to.⁹ This now includes the Prime Minister of the UK, David Cameron, calling for the European Union to adopt Australian styled and inspired immigration policies.¹⁰

In what follows, we will discuss the allegations of torture within immigration detention, and the reasons why healthcare providers have a duty to report them. Finally, we will discuss the protective power of ratifying the OPCAT and the health

sectors call for its ratification as well as the current consideration of a boycott.

IS TORTURE OCCURRING IN AUSTRALIAN IMMIGRATION DETENTION CENTRES?

There is increasing evidence that Australia is engaged in torturing asylum seekers.^{1–7} There are allegations of situations, circumstances and actions that also constitute cruel and unusual punishment throughout Australian immigration detention.

Submission 95 to the Parliamentary Select Committee on the Recent Allegations relating to Conditions and Circumstances at the Regional Processing Centre in Nauru¹ details allegations made by guards on Nauru of waterboarding, familiar to most as a torture technique that simulates drowning used by the Central Intelligence Agency (CIA) in places like Guantanamo bay. This practice has drawn heavy international condemnation.¹¹

'Zipping' is also alleged. It is described as tying an individual to a metal bed frame with cable ties, the bed is then thrown into the air causing injury to the bound individual when the frame crashes to the ground.¹

There is significant commentary regarding conditions in detention, as well behaviours endured by asylum seekers, bearing the hallmarks of torture with asylum seeker detention itself having been characterised as 'cruel and unusual punishment'.^{2–5}

Dr Peter Young, former mental health medical director of International Health and Medical Services—the private company contracted to provide medical services in immigration detention—stated that:

If we take the definition of torture to be the deliberate harming of people in order to coerce them into a desired outcome, I think it does fulfil that definition.²

The use of force feeding during hunger strikes, restraints used for deportation and the incarceration of children are examples of these phenomena.³ The indefinite nature of the detention, the use of numbers to refer to human beings and the harsh physical conditions of the camps add further to this picture.

The United Nations special rapporteur on torture has found Australia to be in breach of the United Nations Convention Against Torture.⁴ In this example, The United Nations special rapporteur on torture, Juan Mendez, revealed an allegation that two asylum seekers on Manus Island, referred to as Mr A and Mr B, allege they were tied to chairs by security staff and threatened with



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'physical violence, rape, and prosecution for "becoming aggressive"' if they refused to retract statements they had made to police about the murder of a fellow detainee, Reza Barati, during riots on Manus Island detention centre.^{4 12}

Details of sexual assault and exploitation have also been described in a Select Committee Report to the Australian Parliament.¹³ The report states that 'evidence to this committee demonstrates that the conditions within the RPC on Nauru can never be guaranteed to an acceptable standard to protect the human rights of asylum seekers'.¹⁴

These events are taking place within the more well-documented substandard conditions of detention.¹⁻⁷ The lack of access to respectable standards of medical care has been recognised by peak Australian health bodies and belatedly by the Australian Medical Association as constituting 'state sanction child abuse'¹³ and elsewhere as torture.^{2 15}

Knowledge of the conditions of asylum seeker detention and the suffering that it causes raises important questions about the duties of healthcare professionals. Does it follow that they have obligations to report torture as well as cruel and unusual punishment, even if there are penalties for making such reports? In what follows, we will suggest that such a duty does in fact exist, and describe its basis.

DO HEALTHCARE PROVIDERS HAVE A DUTY TO REPORT ABUSIVE TREATMENT?

Secrecy: at the core of human rights abuse

In general terms, regimes that commit human rights abuses are marked by secrecy and a lack of accountability.^{5 7} Poor documentation, the denial of facts and the creation of an historical vacuum are common place in highly oppressive regimes, so that the suffering of victims remains a kind of fantasy, which is difficult to prove. As well, it ensures that in the future no recompense or apology can be given to the victims.^{5 7} It is, therefore, of great concern and significance that the frameworks which enshrine human rights and protect asylum seekers have long been absent in the Australian immigration detention setting.^{3 5-7}

In this way, those who control the collection and dissemination of information, in this case successive Australian governments extinguish evidence of the suffering of those in the present and silence their voices for all time. It is in this silence that policies which undermine human rights facilitate substandard care, child abuse and now, perhaps, more active and egregious examples of torture, such as those seen in Submission 95 to the Senate Inquiry.¹

WHAT THEN IS THE ROLE OF SECRECY AND HOW DOES IT IMPACT THE PROVISION OF CARE IN DETENTION?

In all other Australian healthcare environments, the law and professional guidance ensure that there are high standards of reporting, record keeping and vigilance. Immigration detention, however, is marked by a lack of this type of accountability. There is a documented history of issues having been raised by medical practitioners working within the system for years without progress let alone resolution.⁵⁻⁷ Indeed, conditions appear to be worsening.

Significantly, the lack of transparency and informally sanctioned breaches of ethical practice are now accompanied by new laws that explicitly prohibit medical and healthcare practitioners from reporting, other than through demonstrably failed internal channels.⁶ This has appeared most egregiously in regard to child abuse in asylum seeker detention as seen through the Moss review and a Senate inquiry.¹⁶ The reporting of child abuse as exposed through these processes must be understood in the

context of the Australian parliament voting down a motion to make the reporting of child abuse mandatory within immigration detention. The mandatory reporting of child abuse is standard practise internationally.⁷

WHAT THEN ARE THE LIMITATIONS IMPOSED ON HEALTHCARE PROVIDERS' ABILITY TO REPORT?

For years, there have existed significant barriers to advocating for patients in immigration detention including perceived risk to one's professional standing and the actual risk to employment and hence ability to support one's self and dependants.^{6 7} There also exists a risk of being falsely accused of unethical conduct by powerful persons.¹⁷ These barriers to whistleblowing on the conditions of detention have been compounded by the introduction of the Border Force Act, a new law which was passed in July 2015.

Most significantly, Section 42 of the Border force Act entitled 'Secrecy' states that:

1. A person commits an offence if:
 - A. the person is, or has been, an entrusted person;
 - B. the person makes a record of, or discloses, information;
 - C. the information is protected information.¹⁸

Breaking this new law carries a two-year prison term.^{7 18}

Nonetheless, on the day the Border Force Act came into effect, over 40 'entrusted persons' spoke out in the form of an open letter. It stated:

We have advocated, and will continue to advocate, for the health of those for whom we have a duty of care, despite the threats of imprisonment, because standing by and watching sub-standard and harmful care, child abuse and gross violations of human rights is not ethically justifiable.¹⁹

Senior legal counsel from across the country has shown concern about the legislation and its potential to create a 'chilling effect'. Speaking up about abuses puts individuals in a position where they might need to defend themselves in court, at risk of imprisonment. This acts as a significant deterrent.^{20 21}

The situations that might put someone at jeopardy are surprisingly mundane. Special Counsel George Newhouse released a series of hypothetical case vignettes which included the examples of:

A doctor working in a public hospital that has been managing a patient from a detention centre. This is an interesting clinical case that after deidentification is presented in a clinical meeting.

And

A doctor is at a social gathering where someone says that asylum seekers are really economic migrants. Without revealing the detail of any individuals, aspects of asylum seekers experiences in their countries of origin and their journey to Australia are related by the doctor.²⁰

WHY DO HEALTHCARE WORKERS HAVE SPECIAL DUTIES?

With these barriers and deterrents to reporting and addressing human rights in detention, one might come to ask what necessitates that healthcare workers report and work to ameliorate human rights abuses.

The Declaration of Tokyo gives us some guidance when it states that:

The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures, whatever the offense of which the victim of such procedures is suspected, accused or guilty, and whatever the victim's beliefs or motives, and in all situations, including armed conflict and civil strife.²²

This guidance is underpinned by the distinctive position of healthcare providers. For example, access to information and asylum seekers themselves in detention is severely limited. As this access is restricted, those detained are more vulnerable to abuse. Healthcare workers despite this are afforded access. They can, therefore, be powerful agents of change, working to ensure that healthcare and human rights of people are respected.

One of the philosophical underpinnings of this obligation is based on the idea that knowledge and the ability to change another person's destiny create duties towards her. The relationship between vulnerability and responsibility can be examined when considering a passenger on a plane, and the duties owed to him by the pilot. We might think that a pilot has a professional duty to her passengers, or reciprocal duties based on payment for her services. However, the fact that the passengers are especially vulnerable to the pilot's actions also creates certain special responsibilities.²³

We argue that it is this vulnerability that is part of the basis from which a duty of care is established between doctors and their patients. The role of doctors and other healthcare providers in detention is vital to maintaining any semblance of human rights, in particular the right to health, as other systems that uphold this right are absent. Seeking asylum leaves one particularly vulnerable; there must accordingly be a proportionate duty of care.

One way in which these duties might be fulfilled in the immigration detention setting is through the act of witnessing which involves speaking out against harmful practices, by those whom have seen them first hand. This shows victims of these injustices that they have not been abandoned. Additionally testifying to the outside world and advocating for the world community to bring about change fuels human solidarity in the face of tragedy and contributes to the focusing of international attention.²⁴

This action, however, is not ethically inconsequential. Bearing witness by healthcare professionals presents a 'dual loyalty' conflict, whereby such persons are asked to subordinate the patient's interests to the state or to their employer, thereby violating his or her human rights.²⁵ The healthcare provider therefore finds him or herself in potential breach of a contractual obligation to remain silent. Briskman and Zion have suggested that there are four ways in which dual loyalty conflicts of this kind might be managed. They state that:

One group provides services as required by their employing body with little questioning of moral dilemmas. A second group is more overtly aware of the conflicts and works in a mildly subversive manner to provide the best possible care available within a harsh environment. A third group retreats by relinquishing employment in the detention setting. A fourth group is activist in intent and actions.²⁶

It is our belief that neither denial of subversion (strategies 1 and 2) have had any effect in changing the nature of detention, and that even those who no longer work on Nauru and Manus Island have an obligation to speak out. This obligation is based on the general duty to uphold the rights of others, and the specific duties ascribed to healthcare providers, set out in international codes, and in codes governing specific healthcare disciplines, which privilege, above all, the well-being of the patient.

Moreover, Leslie London suggests that it is important that practitioners have institutional support when acting in the best interests of their patients in such circumstances. He states that:

Critical is the need to look more broadly at the institutional context in which ethical behaviours are facilitated or obstructed, and what steps can be taken to enable practitioners to make the best ethical choices when faced with conflicts of dual loyalties.²⁷

Apart from guidance from individual medical colleges, in what follows we suggest that the ratification of the OPCAT would provide official mechanisms that support individual practitioners in upholding the rights and well-beings of patients in detention.

REASONS FOR RATIFYING THE OPCAT

Allegations of torture, a long documented history of human rights violations, the testimony of health professionals acting as whistleblowers and the work of the Australian Human Rights Commission have all shone an intense light on the urgent need for transparency.^{1-7 13-16 28 29}

This transparency needed for the safety of asylum seeker and for the safety of those that interact with them, from their jailers to their doctors, and would provide a way forward for those involved to speak openly about what they have seen, and a formal mechanism for such reports to be acted upon.

Such transparency can be provided through the ratification of the OPCAT.^{5 30}

The OPCAT is a United Nations treaty that Australia has signed up to through the Joint Standing Committee on Treaties, thus ostensibly having bipartisan support. It has provision for the monitoring of places of detention by domestic and international bodies through the establishment of a National Preventive Mechanism (NPM). An NPM is a system of regular visits and reporting undertaken by independent bodies. NPM assessments inform legislation and intervention, as well as act as deterrents in their own right. The transparency this provides should in and of itself act as a deterrent to human rights abuses.^{5 28} The rationale being that if there is a likelihood of abuses being detected and thus those perpetrating them being held accountable, then a disincentive and thus aversion to carrying out acts of abuse can be established.

A call for the ratification of the OPCAT has gone out to the medical community.⁵ The response is heartening and clear. The health sector is deeply concerned about the situation in immigration detention and indeed in all situations where persons are deprived of their liberty. To this effect, multiple peak health bodies have endorsed a statement calling for the ratification of the OPCAT. As far as the authors are aware, there has been no other statement with such broad representation from across the health sector on a single issue. It includes medical colleges, federal allied health and nursing bodies.⁸

What remains is for legislative change to bring Australia into line with its promise to the international community through the United Nations. The OPCAT's NPM needs to be established to ensure transparency in places of detention thus deterring human rights violations. Ad hoc and reactive solutions should not be employed when a best practice and comprehensive approach is achievable, and indeed required. There has been substantial work completed to facilitate ratification.²⁹ Alongside this, legislative review of the Border Force Act needs to occur, in particular Section 42, with an aim to removing all doubt that advocacy and disclosure in the public interest is not an offense punishable by incarceration.

Other measures to address the human rights and health problems in immigration detention have been raised. These include the transfer of care to state health services, the shutting of irredeemable centres on Manus and Nauru, a moratorium on the returning of children from medical care back to immigration

detention (and the provision of health services through non-government organisations (NGOs)),³⁰ Because of the severity of the situation and the inability to engage in ethical medical practice, a boycott is also being discussed (D Berger. Doctors must not work in Australia's immigration detention centres under the current conditions. *BMJ* forthcoming).^{6 30 31}

Europe is contending with the largest migration since the Second World War resulting from the Syrian crisis.⁷ The authors in the strongest terms counsel others against following on the same path as Australia, least the same mistakes and unjustifiable suffering come to be repeated.

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