NAURU REVIEW 2013

EXECUTIVE REPORT OF THE REVIEW INTO THE 19 JULY 2013 INCIDENT AT THE NAURU REGIONAL PROCESSING CENTRE

8 November 2013 **Keith Hamburger AM**

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Disclaimer:

This Review Report has been prepared in good faith, exercising due care and attention and is based on:

- Information derived from interviews of DIAC officers, staff of Nauru Regional Processing Centre (RPC) service providers, officials from the Government of Nauru including Nauru Police Officers and members of the interim Joint Advisory Committee (iJAC) established to oversee the implementation and operation of the RPC
- A thorough review of documents and other information provided by DIAC and Nauru RPC service providers and
- The professional knowledge, training and experience of the reviewer.

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1. Executive Report

1.1 Background

On 19 July 2013 a serious incident, a riot, occurred at the Nauru Regional Processing Centre (Nauru RPC) resulting in the destruction of the majority of infrastructure. There were 543 transferees accommodated at the Nauru RPC at the time of the incident. It is estimated that the loss and damage from the incident was in excess of $60 million.

This review of the 19 July 2013 Nauru incident, was established under Terms of Reference (TOR) to determine exactly what the facts were, to make those facts available to any relevant authorities and to ensure that the Department of Immigration and Citizenship (DIAC) gets clear recommendations on any systems improvements that can be made to help avoid similar incidents from happening in the future.

The Nauru RPC was established as a matter of urgency from August to September 2012. This followed the former Australian Government's agreement to the recommendations of the *Expert Panel on Asylum Seekers* (August 2012). The recommendations included re-establishing immigration facilities, including on Nauru, in the form of Regional Processing Centres. This formed part of a regional approach to help combat people smuggling and prevent asylum seekers risking their lives at sea. The Australian Government entered into a Memorandum of Understanding with the Government of Nauru regarding the operation of the Nauru RPC on 29 August 2012 (the MOU).

Establishing a regional processing centre on Nauru, another sovereign country, involved a significant level of complexity in implementing the required administrative arrangements. Further, the Nauru election in June 2013 contributed to the inability for both Australia and Nauru to have in place the administrative measures envisaged under the MOU to make rules and to provide powers in relation to security functions at Nauru RPC.

The Government of Nauru passed two pieces of legislation, the *Refugees Convention Act 2012* and the *Asylum Seekers (Regional Processing Centre) Act 2012*. While the operation of the Nauru RPC was to be fully funded by the Australian government, the legislation provided for the processing of the Nauru RPC transferees to be conducted by the Government of Nauru.

Clause 11 of the MOU states, *'The Commonwealth of Australia will make all efforts to ensure that all persons entering Nauru under this MOU will depart within as short a time as is reasonably necessary for the implementation of this MOU.'*

An interim Joint Advisory Committee (iJAC) was established under the terms of the MOU in relation to the transfer and assessment of persons in Nauru. The iJAC was established to oversee the implementation and operation of the Nauru RPC. The committee is co-chaired by Australian and Nauru officials and members have expertise in a range of relevant disciplines.

The Department contracted three key service providers to assist in the operation of the Nauru RPC:

- ***Transfield Services*** for garrison, operational and maintenance services including asset management, transport, supplies and logistics and catering with a sub-contractor responsible for security services working in partnership with a local security company
- ***The Salvation Army*** for client welfare and engagement services including education, programs and activities, community engagement and religious services; and
- ***International Health and Medical Services (IHMS)*** for health and medical Services including doctors, nurses, psychologists, paramedics, counsellors and psychiatrists.

These service providers began work at the Nauru Regional Processing Centre on 5 September 2012. The first 20 asylum seeker transferees from Christmas Island arrived at Nauru on 14 September 2012 and were accommodated in tents.

1.2 The 19 July 2013 Incident

At the time of the 19 July 2013 incident at Nauru RPC there were 543 transferees accommodated at the RPC. On the morning of that day there was intelligence suggesting the possibility of a significant protest taking place.

At 1330hrs around 50 to 60 transferees were involved in initial protests demanding to speak to Nauruan Government officials. The threat level was raised, with the garrison service provider and the Nauruan police force preparing for possible action.

Over the following hours some self-harm attempts and on-going large protests occurred and non-essential staff were evacuated. Protesting transferees were reported chanting ‘freedom’ and ‘Nauru Guantanamo’. Staff at the RPC were negotiating with the protesting transferees in an attempt to deescalate the situation. The transferees’ concerns related to refugee status processing delays, delays relating to Claims Assistance Provider (CAPS) lawyers arriving at Nauru and transferees wishing to speak to Government of Nauru officials.

At 1800hrs some transferees were reported to be removing railing bars in preparation for the incident and at 1900hrs property was reported as being damaged in the centre. At around 1900hrs the then Director of Police was stood down and a new Director of Police was appointed. At around this time, large crowd movement increased in the centre and at 1943hrs large numbers of transferees pushed down temporary fencing and a large number of transferees were observed picking up weapons and throwing rocks.

At 1947hrs police in full riot gear formed a line to contain the transferees at the RPC and they were attacked by various makeshift missiles.

Garrison service provider staff had no Personal Protection Equipment (PPE). Police Officers had PPE including, helmets, vests, shields and batons. Rioters were armed with various makeshift implements.

Police and security officers repelled three concerted wave attacks where they were struck repeatedly by the aforementioned implements. All the evidence is that during these assaults police and security staff acted with considerable restraint and courage. At around this time, acts of arson were occurring including significant fires being lit at the RPC.

At 2100hrs local men arrived at the RPC to assist security staff and police but they were separated from the rioting transferees by the authorities. The intensity of the riots then subsided and the Nauruan Police convinced the locals to disperse. At 2130hrs fires continued to burn in the centre. A large number of transferees ceased rioting at around this time and some surrendered.

The Nauruan Police then charged 153 transferees for rioting, unlawful assembly and property damage. A considerable amount of the existing infrastructure was destroyed by the fire including all of the permanent accommodation at the RPC, at an estimated cost of over $60 million. Five transferees were admitted to the Hospital of Nauru for treatment.

The fact that the incident was contained and stabilised without loss of life or even serious injury, in the experience of the reviewer in similar incidents of this scale, was a remarkable outcome and a credit to all the staff involved.

1.3 Causes of the 19 July 2013 Incident

Concerning causes, a number of consistent themes emerged during the review. No one factor caused the incident, but rather a variety of factors combined to trigger the 19 July 2013 riot.

a. Transferees had been advised in March 2013 that their refugee status determination (RSD) process would be completed within four to six months. The incident occurred nearly four months after processing commenced and no RSD decisions had been handed down.

b. An incident that created agitation among the transferees included a misunderstanding following a meeting with the claims assistance provider (CAPS) where transferees apparently interpreted comments in a way that led them to believe that the legal assistance program was to be discontinued in August 2013. CAPS claim that they did not contribute to this misunderstanding. This was further exacerbated by the CAPS lawyers subsequently not arriving as expected on 18 July 2013 due to a flight delay.

c. Evidence conclusively identified an ongoing mood of frustration and uncertainty building within the Nauru RPC transferee group. The transferees were increasingly uncertain about their future and frustrated by a lack of clarity around dates for their RSD processing and resolution. Further discontent is attributed to inconsistent and inaccurate messaging to transferees. Examples where shortcomings in messaging had occurred were identified which increased transferee frustration.

d. There was a failure to have all of the administrative measures in place as envisaged in the *Asylum Seekers (Regional Processing Centre) Act 2012*. The created ambiguity around governance and operational command issues at the RPC.

e. The Nauru RPC was not a secure centre. It was designed as an ‘open centre’ with very little physical security. There was some limited provision for behaviour management facilities to deal with transferees who may become non-compliant

from time to time. When a cohort of transferees became violently non-compliant, this 'open centre' style did not provide for the capacity to segregate and control transferees.

Security was to be provided under a dynamic security model where security staff were mobile within the centre and engaged proactively and regularly with transferees. This model was further supported by active welfare case management, quality accommodation, health, medical and food services and recreational opportunities, including excursions during daylight hours away from the Nauru RPC. Buildings were of light construction typical for open and low security environments. These operational assumptions underpinning the Nauru RPC's operational model could not effectively deal with the riotous behaviour of transferees on 19 July, 2013.

1.4 Risk Management at Nauru RPC

The review has identified a range of significant issues that should have been subjected to a holistic risk assessment prior to the construction and opening of the Nauru RPC. This is not to say that individual risk assessments were not done by individual providers on Nauru or that risk was never discussed in various meetings. However, a holistic professional risk assessment process at the start of the project was a critical missing element. Such a risk assessment was essential to guide decisions relating to infrastructure and operations and to mitigate *duty of care* risks, particularly in the highly complex and risk prone regional processing environment.

A holistic risk assessment process would have included setting objectives for and clearly documenting the Nauru RPC operating concept or model and identification of the risks to these objectives. The assessment would have identified risk mitigations and controls and provided a basis for decision making as to the most appropriate operational arrangements, infrastructure and governance.

Given the large numbers of transferees accommodated at Nauru RPC, as a matter of urgency the review recommends that a comprehensive expert driven and holistic risk assessment be conducted. The risk assessment should focus on safety and security concerning the post incident environment at Nauru RPC.

1.5 'Open Centre' Approach

Clearer decision making was required in relation to the most effective operational and infrastructure model for Nauru RPC. The reviewer finds that a 'one model fits all' 'open centre' approach catering for up to 900 transferees on one site would have failed a duty of care test having regard to safety and security issues. A duty of care risk assessment approach would most likely have pointed to risk mitigation involving multiple sites with various grades of accommodation ranging from open through to medium and high security.

Concerning multiple sites, relevant DIAC officers advised that they recognised in the early stages of considering options for Nauru RPC infrastructure that multiple sites would be of benefit. However, there were challenges in the procurement of land on Nauru which restricted the ability to acquire additional sites for RPC facilities, particularly in a short time frame. This resulted in the unsatisfactory outcome of all transferees being accommodated on the one 2.8 hectare site.

The reviewer believes that concepts such as 'administrative detention' and 'open centre' should never be used to drive a 'one model fits all' approach to infrastructure to house asylum seekers. Infrastructure must reflect operational need under the umbrella of duty of care to provide a safe working environment for staff and a safe and humane living environment for asylum seekers having regard to analysis of the demographics of the cohorts to be accommodated, including their risk profile.

In terms of the risk profile of transferees, the Hawke – Williams *Independent Review of the Incidents at the Christmas Island and Villawood Immigration Detention Centres* (31 August 2011) identified five elements required to maintain good order in an immigration facility. These elements included, *'physical security, including infrastructure that accommodates the placement of detainees with varying degrees of security risk and vulnerability risk profiles…'* and *'ongoing intelligence and analysis concerning potential risks.'*

The review found that had the assumption in relation to winding up tent accommodation at Nauru OPC been challenged (in the context of a risk assessment), then a potential outcome would have been to:

a) Maintain the existing tent camp for a defined period with improved amenity and safety precautions and

b) Ensure a high-level DIAC project team assisted by Government of Nauru representatives and external specialists develop an effective operational and infrastructure response for the Nauru RPC.

This approach may have led to better ownership of the Nauru RPC by both governments and a shared sense of urgency to achieve outcomes, particularly around issues such as land use, legislative policy and administrative arrangements.

The reviewer is of the opinion that during the efforts to rebuild on Nauru following the incident there was insufficient operational consideration as to whether there needed to be significant changes to the Nauru RPC infrastructure as a consequence of what happened in the incident and the identified risks.

Any further planning around the development of new infrastructure and security arrangements at the Nauru RPC should ensure these two factors are jointly considered. Duty of care, safety and security considerations should be paramount to any further operational planning for Nauru RPC.

1.6 Governance and Outsourcing

With regards to governance responsibilities at Nauru RPC, there appears to have been a belief within DIAC that the outsourcing of functional responsibility for Nauru RPC operations to service providers, particularly in the security area, negated the need for robust accountability systems for the delivery of a safe and secure environment by DIAC. The review also found the oversight of service provider performance to be lacking.

1.7 DIAC Operational Leadership, Organisational Structure and Intelligence Handling

The review found evidence of a lack of decisive operational leadership in relation to emerging issues in the lead up to the July 2013 incident at the Nauru RPC.

The review found impediments in DIAC's organisational structure and the need to have in certain key National Office positions people who have strong leadership capacity and experience in high risk operational environments.

There was intelligence available prior to the incident that afforded reasonable and credible information to suggest that a non-peaceful disturbance was likely to occur. However, the daily reports provided to relevant sections in DIAC National Office from the Nauru RPC regarding the 'mood of the centre' did not appear to match the emerging reality. The reports consistently indicated that the centre was 'calm' and that the threat level was low, yet individual intelligence reports produced at the same time stated that there were underlying tensions and potentially concerning developments.

The review has found that the failure to respond effectively to the available intelligence is a symptom of failings in governance and risk management relating to the Nauru RPC.

The review has found that effective systems and structures do not appear to be in place in the relevant division of the DIAC National Office to communicate and manage key operational and strategic risks that reach across the three key delivery areas of services, infrastructure and operations that impact on regional processing centres.

1.8 Incident Response

Concerning the 19 July 2013 incident, the review has found that a structured and decisive response to the incident was greatly inhibited by:

- Risks and assumptions relating to contingency planning not being tested with the Government of Nauru
- Governance weaknesses due to the envisaged *Administrative Measures* not being fully in place which in turn led to a lack of Nauru RPC rules
- An associated lack of clarity relating to the powers of police and security officers in performing duties within the Nauru RPC and
- A lack of capacity of emergency response services.

The review has found that lack of clarity relating to the powers of police and security officers in performing duties within the Nauru RPC was a significant issue. This impacted on decision making by security officers and police during the civil disobedience that occurred in the hours leading up to the incident. The outcome of this lack of clarity was that no pre-emptive exercise of authority was undertaken by police in the lead up to the incident. There was no attempt to either diffuse the situation by warning demonstrators of the adverse consequences to them of continued escalation of their behaviour or to apply force to contain those who were inciting the civil disobedience.

The then Director of Police's opinion, founded in legal advice available to him, was that the demonstration in the lead up to the riot was a 'peaceful protest' as no criminal offences were being committed and therefore police could not be committed to assist in de-escalation and/or to confront the protesters.

The reviewer is not persuaded on the available evidence that it was the case that the demonstration was peaceful.

The then Director of Police was stood down by order of the Government around the time the riot commenced.

By the time the Director of Police had been stood down the circumstances had escalated to such a level that it appears it would not have been feasible for safety reasons for police to enter the Nauru RPC in an endeavour to quell trouble makers and restore order. It can be said with certainty that, at this point, the opportunity to protect the existing infrastructure was lost.

In relation to what could have been done the reviewer explored a number of 'what if' questions. However, in all the circumstances where a considerable lack of clarity existed in relation to powers to act the reviewer is not prepared to 'second guess' the decisions taken by those involved in their response to the incident.

The review recommends that the 'use of force' powers of both the garrison service provider and the Nauruan Police Force at the Nauru RPC are clarified and then operationally documented.

The previous comment about the lack of capacity of emergency response services is in no way a criticism of the Government of Nauru or their emergency services. It relates to the fact that very complex infrastructure housing hundreds of people has emerged with little notice in a small island community without a commensurate increase in the administrative, social and emergency infrastructure to service it.

The review has found that the relevant officers at the DIAC National Office did not undertake a sufficient assessment of the incident or put in place post incident operational support for Nauru staff. Evidence from these officers suggested there was an assumption that everything was in order on Nauru and relevant DIAC staff on Nauru 'seemed to be handling it okay'. The review has found it difficult to verify this assumption based on the limited amount of information sourced by relevant DIAC National Office staff regarding the incident.

A recommendation has been made in this report that DIAC improves its capacity for effective crisis response interventions following serious incidents, including post incident assessments.

1.9 Staffing Issues

The review has found that staffing levels were adequate for the Nauru RPC 'open centre' design while transferees were exhibiting compliant behaviour. However, staffing was inadequate to deal with large scale non-compliant behaviour that occurred during the 19 July 2013 incident. This was due to the large number of transferees that were accommodated within the infrastructure and the 'open centre' design of the infrastructure. It is very difficult to staff an RPC of this particular design to maintain order during a large scale disturbance.

Concerning transferee management, there were some service provider performance issues at the Nauru RPC, particularly during its early months of operation. This is to be

expected in a complex facility in a remote location. However, there is evidence that these were not dealt with promptly or decisively by relevant officers in the DIAC National Office.

The training of staff has been found to be generally adequate and appropriate. However, a need was identified to focus on improved 'messaging' to transferees. iJAC drew attention to this need in its April 2013 report relating to progress with the Nauru RPC.

1.10 Executive Report Conclusion

The speed involved to get the Nauru RPC operational within a short period of time compromised the proper assessment and planning required for the safety and security of the facility. The findings and recommendations in this report provide guidance for DIAC to remove or minimise the risk of this happening again.

In a review of this nature where a forensic analysis is conducted of a significant catastrophic incident there will be critical findings and naturally there will be emphasis upon these in consideration of the report. However, what should not be lost sight of is the context in which staff of DIAC and the Nauru RPC service providers were operating.

The review has found that DIAC was faced with the challenge of responding with extreme urgency to a government policy imperative to combat people smuggling and prevent asylum seekers losing their lives at sea. DIAC officers and Nauru RPC service providers worked long hours under significant pressure to achieve a functioning RPC in a short time frame in another sovereign country where there were limited resources.

The Nauru RPC is a very complex facility and establishing it required a high level of administrative, physical, logistical and staffing infrastructure to provide for the humane, safe and secure servicing of the needs of the transferees in a challenging environment.

The review calls in to question the decision making approach that led to the infrastructure and operational outcomes that ultimately failed in the face of a violent riot by transferees. This calling in to question is founded in the professional experience of the reviewer in operations of this nature, the evidence available from a forensic analysis of the circumstances and of course with the benefit of hindsight.

The review does not call in to question the professionalism, dedication, hard work and courage of DIAC and Nauru RPC service provider staff. These staff worked above and beyond the call of duty to establish the facilities on Nauru in a very short period of time, ensured that no lives were lost in the 19 July 2013 incident, contained and quelled the riot and then reaccommodated transferees within 72 hours of the incident. Officers at all levels were placed under immense pressure and they responded with their best efforts, often above the call of normal duty. They are to be commended for their efforts.

The criticism in this review of the approach around infrastructure and operational protocols should not be read in terms of failings by individual officers. It also needs to be considered in the context of a complex and rapidly developing policy challenge requiring an urgent operational response. However, DIAC officers were constrained by a lack of access to high level operational input and some organisational structural impediments to guide their response to the emergency they were faced with.

The reviewer places on record his appreciation of the frank, open, constructive and courteous approach adopted by everyone interviewed in relation to the incident under review. It was obviously a very challenging experience for all concerned, yet all showed commitment to learning from the experience to enhance future arrangements. More detailed findings and analysis can be found in the detailed report and findings of this review.

2. Report recommendations

Recommendation 1
That operational protocols are developed for regional processing centres around the concept and application of 'duty of care' to residents and staff at RPCs. Further that concepts such as 'administrative detention' and 'open centre' not be used to drive a 'one model fits all' approach to infrastructure to house asylum seekers.

Infrastructure should reflect a duty of care focus and provide a safe working environment for staff and a safe and humane living environment for asylum seekers with regards to the demographics of the transferee cohorts and including their risk profile. A duty of care approach would necessitate various grades of accommodation ranging from open through medium and high security rather than a single approach.

Recommendation 2
That the position descriptions for key positions within the Departmental organisational structure dealing with regional processing centres are reviewed to ensure that:

- *There are no impediments to urgent holistic responses to operational objectives and requirements under the current arrangements between operations, infrastructure and services divisions of DIAC.*
- *Key positions in DIAC National Office relating to regional processing centres are designed for people who have leadership capacity in high risk operational environments.*
- *The governance framework for regional processing centres has adequate regard to the outsourced service provider model including capacity for robust operational audit and investigations with high level operational risk assessment.*
- *Crisis response interventions following serious incidents can be mobilised quickly.*

Recommendation 3
That DIAC initiates a review of the fire response capacity in the tent sites where transferees are now accommodated by a qualified organisation or person.

Recommendation 4
That the 'use of force' powers of both the garrison service provider and the Nauruan Police Force at the Nauru RPC are clarified and then operationally documented. The powers of the Nauruan Police Force to enter the facility to restore order during non-peaceful protest actions (and what constitutes a non-peaceful protest) also needs to be clarified as a matter of priority to ensure police have the appropriate powers to deal with unrest and a full understanding of their capacity to deescalate potentially serious incidents.

Recommendation 5
That the Australian Government work with the Government of Nauru to strengthen the administrative arrangements at the Nauru RPC.

Recommendation 6
That the suitability of garrison service provider officers having powers as 'reserve police' is further assessed regarding governance, proposed duties, training, suitability and associated risk.

Recommendation 7
That an urgent comprehensive expert driven risk assessment focussed on safety and security is conducted concerning the post incident environment at Nauru RPC.

Recommendation 8
That documented and agreed guidelines or protocols for communication with transferees are developed to ensure staff who interact with transferees provide appropriate and accurate information to transferees.

Recommendation 9
That the effectiveness of the recently implemented performance management framework for service providers at the Nauru RPC is tested against the experience from the 19 July 2013 incident.

Recommendation 10
That the relevant area within DIAC urgently develops a project plan to deal with the following priorities arising from the findings in this report:

- *Directing and supporting operations on Nauru and Manus Island.*
- *Taking charge of the post incident environment at Nauru RPC having regard to issues identified in the post incident environment section under the response to TOR 6 in this report.*
- *Reviewing the current arrangements for intelligence gathering, synthesising data and for implementing informed, timely and decisive responses.*
- *Undertaking a holistic risk assessment of the detention and regional processing arrangements currently existing on each island.*
- *Achieving a common understanding by all staff involved in detention operations of the concept of duty of care and responsibilities and accountabilities attaching to this in terms of their work as outlined in Recommendation 1.*

3. Terms of Reference

The terms of reference for this review are as follows:

On Friday 19 July 2013 an incident occurred at the Nauru Regional Processing Centre involving violence and extensive property damage by residents of the Centre. Criminal charges under the law of Nauru have been laid, or are in the process of being laid, against more than 100 individuals.

The review is to investigate and report on key issues raised by that incident, in particular:

- to determine exactly what the facts were;
- to ensure that those facts are available to any of the authorities for any action that would take place as a result; and
- to ensure that the Department gets clear recommendations on any systems improvements that can be made to avoid what has been alleged, from happening in the future.

This will involve assessing:

TOR 1

the adequacy of infrastructure, staffing and client management in maintaining appropriate security at the Centre;

TOR 2

the effectiveness of the communication and coordination between the Department and service providers;

TOR 3

the extent of any prior indicators or intelligence that would have assisted in the prevention or management of the incident;

TOR 4

the clarity of roles and responsibilities in managing security at the Centre and in managing the incident;

TOR 5

how breaches of security were achieved, what access occupants of the Centre had to tools to assist with such breaches and, if relevant, how such access occurred;

TOR 6

the appropriateness of the response measures taken to the incident; and

TOR 7

the adequacy of training and supervision of staff of the department and of service providers.

Any material obtained by the review that may be of assistance to relevant authorities in managing actual or possible criminal charges is to be made available to those authorities.

The review may make recommendations to strengthen relevant arrangements at the Centre and prevent recurrence of any similar incident in the future.

The review is to commence immediately and report to the Secretary of the Department of Immigration and Citizenship by 30 September 2013, with a progress report provided by 16 September 2013.

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