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STATE OF TORTURE LAW IN AUSTRALIA

SUMMARY: A discussion on the applicability of the Torture Law Provisions of the Divison 274 of the Australian Criminal Code Act 1995 (Cth) on offshore medical-related torture incidents. Also, consider its inter-operability with Division 268.10, the ICC Rome Statute Crime Against Humanity of Enslavement. Presents the methodology to implement the Division 274 provisions in a situation of doctor occasioning medical malfeasance on offshore asylum-seeker patients. With legal-laypersons in mind, the article explains the use of doctor-patient contract to identify the breach of legal duty.

Friends, just before the 2022 Christmas break, we have been discussing the DIBP and IHMS healthcare contracts, also as regards the doctor-patient contract in the common law. Before we pick up those issues, I would first discuss the current state of Torture Law in Australia. This discussion is essential in understanding how DIBP/ABF have applied control measures in the offshore enslavement process. In addition, there has never been a legal precedent for criminal prosecution in Australia as regards Torture Law. In comparison, the proper legal determination was made by the High Court of Australia on Slavery Law in "Queen vs Tang" in 2008 [#6].

PART- I. TORTURE: THE US CASE LAW COMPARISON

In determining whether the authorities have commissioned the crime of slavery, the procedure is as follows:

=> When an asylum-seeker has been `denied` or `deliberately rendered ineffectual` medical treatment, the Commonwealth Government, the IHMS and its GPs have violated the law of torture;
=> When such medical intervention by DIBP/ABF has restricted the freedom of movement for that asylum-seeker, the corresponding DIBP/ABF conduct has violated slavery laws. The IHMS and its GP may also be violating slavery laws.

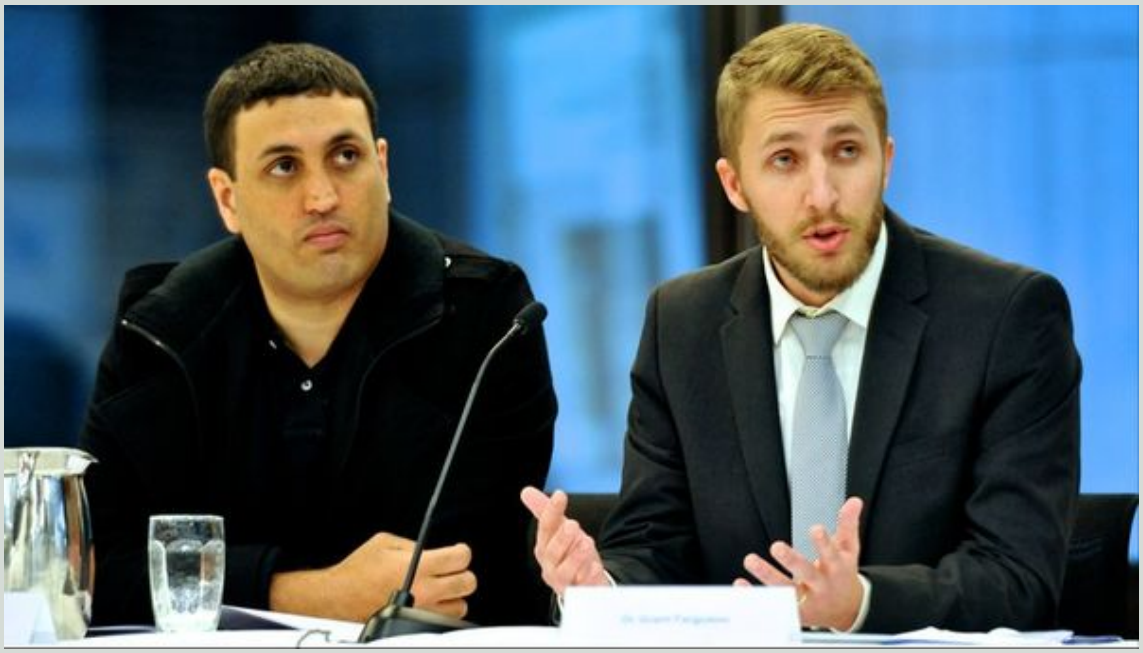
The legal consideration for torture in offshore detention has been undertaken, with a direct analogy from the US case laws of prisoners. I have recorded a summary of findings in Sections VIII & IX of [#2] in 2021. In sum, if the detaining authorities showed (1) deliberate indifference to the (2) serious medical needs of the person (prisoner), the crime of torture is committed [#3]. Furthermore, the standard test for authorities showing deliberate indifference:

(1) knows of a prisoner's need for medical treatment but intentionally refuses to provide it;
(2) delays necessary medical treatment based on a non-medical reason;
(3) prevents a prisoner from receiving needed or recommended medical treatment; or
(4) persists in a particular course of treatment in the face of resultant pain and risk of permanent injury [#4].

The test above is adequate to determine whether the medical-related torture occurred in offshore detention centres.

TORTURE IN LAYPERSONS' UNDERSTANDING

We can vividly recall the whistle-blowers -- Dr(s) Young, Sanggaran and Ferguson amongst them -- as early as 2014-2015 telling us that there has been torture in offshore detention. Of course, these doctors have first-hand experience treating asylum-seeker patients and witnessing the conduct of DIBP/IHMS in offshore settings. But these medical doctors aren't lawyers, and therefore we cannot expect them to explain the torture in proper legal terms. Why then, our legal paternity were failing to recognize the existence of torture offshore at that time ?



Dr Sanggaran and Dr Ferguson at The 2014 Inquiry on Children in Detention.

Actually, I was pretty surprised in 2021 that I came across these US legal documents on torture that are so readily accessible and directly relevant to offshore detention. Why was everyone keeping silence on torture taking place offshore ? We -- Australians -- do need to have a hard look at ourselves!

THE TORTURE IN GRANULAR AUSTRALIAN COMMON LAW

One of the reasons, perhaps, could be that Australian common law is too technical. In the situation of torture, one must interpret the cases that took place at offshore detention in the "granular" common law, which is not a trivial task.

For example, in the case of Faysal Ahmed, for two years, the IHMS-GPs (allegedly) had given the pain-killer Panadol every time he went to the clinic for excruciating stomach pain. Isn't the

authorities "(4) persist in a particular course of treatment in the face of resultant pain and risk of permanent injury" ? Such conduct, in fact, is deliberately rendering ineffectual treatment to a person in detention. In US case laws, this is sufficient to conclude the authorities have tortured this detainee. As for Australian common law, this may not be sufficient for the judge to conclude the authorities had commissioned the torture of the detainee.

Friends, I would pause the discussion here and redirect you to the practical case in the United States of "Williams vs Vincent" (https://casetext.com/case/williams-v-vincent) [#5]. It was a case of US prisoner Nathan Williams, who had been incarcerated in Green Haven Correctional Facility in the City of New York in 1969. The tale has it that while prisoner Williams was queuing for lunch, another inmate attacked and cut his right ear. The prison hospital refused to stitch his ear back and threw it into bin (A). On making a complaint about the medicare he received, the Green Haven prison officials put him in solitary confinement for 22 days without medication (B).

Our readers, sure, would immediately connect this case with the situation of Faysal Ahmed:(A) He was given The pain-killer Panadol for the severe stomach pains; (B) When he complained about null treatments he was receiving for his heart pain and chest problems, he was sent to the psychiatric ward, VSRA. These are (A) "deliberate indifference caused an easier and less efficacious treatment to be consciously chosen by the doctors;" (B) "knows of a prisoner's need for medical treatment but intentionally refuses to provide it."

Next, I shall try to project these cases within the context of Australian Torture Law.

PART - II. CURRENT STATE OF TORTURE LAW IN USA & AUSTRALIA

Friends, in the previous posting on 18/2/2023, I introduced the story of the US prisoner Williams in the Green Haven Correctional Facility in 1969. In September 1969, Williams was queuing for lunch another inmate attacked and cut his right ear. The prison hospital refused to stitch his ear back and threw it into bin (A). On making a complaint about the medicare he received, the Green Haven prison officials put him in solitary confinement for 22 days without medication (B). Prisoner Williams was subsequently transferred to another facility in June 1970. In April 1973, Prisoner Williams put forward a pro se (self-represented) complaint against the Green Haven prison hospital officials at the District Court. The District Court dismissed his case on technical grounds, but the appeal court reversed it.

PROHIBITION OF TORTURE IN THE USA AND AUSTRALIA

Both in the United States and Australia, the origin of laws relating to the torture of prisoners or of the persons being held in custody by the government authorities can eventually trace back to the English Bill of Rights of 1689. For the United States of America, the Eighth Amendment of the US Constitution (The US Bill of Rights, 1791) prohibits the government from imposing upon its citizens "excessive bail, excessive fines, or cruel and unusual punishments" [#7]. But, of course, the framers of the Australian constitution in 1901 had opted not to include the US-style Bill of Rights and seemed quite content with the 1689 English Bill of Rights for their newly formed federation. As a result, the Australian constitution would not directly protect us

from the government's torture, but we must turn to the Australian Criminal Code Act (Cth, 1995) Division. 274, for protection. Current Torture Law in Australia was introduced in 2010 under Rudd/Gillard government, which has limited conformity with the UN Convention Against Torture [#8].

In regards to medical-related torture, we have seen the expression used in US case laws such as [authorities showing] "deliberate indifference to serious medical needs of (prisoner)" and "persists in a particular course of treatment in the face of resultant pain and risk of permanent injury". But, we cannot find the precise legal texts in the Eighth Amendment of US Constitution or US Criminal Code 2340A, which says:

> *(1) "torture" means an act committed by a person acting under the color of law specifically intended to inflict severe physical or mental pain or suffering (other than pain or suffering incidental to lawful sanctions) upon another person within his custody or physical control;*

These US case law texts, "deliberate indifference ...etc", come from the judicial interpretation of the US Constitution and US Criminal Code 2340A. The caution is that the Australian domestic courts will not adopt such legal language directly.

A GLASS HALF-FILLED

Academics have questioned the sincerity of Australia's effort to implement UNCAT in 2010 [#8, pp.236]. Such question of sincerity has been long-standing since Australia signed up the ICCPR in 1972 and never having time to adopt into domestic legislation. Observing the government's implementation of UN Convention Against Torture, it notes [#8]:

> *..... All of these measures indicate a strong emphasis upon parliamentary sovereignty and Parliament's role in assessing Australia's human rights obligations and excluding a prominent role for direct judicial interpretive development giving effect to the non-derogable right of freedom from torture and cruel, inhuman and degrading treatment or punishment ..... The Act's domestic criminalisation of torture is therefore grounded within that parliamentary/executive model of ... human rights protection and promotion, and the present government's rejection of a statutory charter of rights.*

I believe Australia's signing and ratifying of UN Human Rights treaties have been of decorative and not substantive commitment. In that sense, Australia has yet to sincerely adopt these UN Human Rights treaties, as these laws remain out of the reach of ordinary people who need protection. As for the UN Convention Against Torture, Australia adapted as far as practically possible. But, the insincerity here is filling the glass in half, not expecting others who need can fill the rest. Without any Australian case law on torture, the plaintiff (initiator of legal action) must reach out for a detailed interpretation of the code.

MEDICAL-RELATED TORTURE AT OFFSHORE

In our example case of Williams v Vincent [#5], the two specific torture-related incidents identified as:

> *(A) The prison hospital refused to stitch his ear back and threw it into the bin;*
> *(B) The prison officials put him in solitary confinement without medication.*

Incident (B) has a more straightforward application and leaves it out for now. Incident (A) is more interesting for our offshore medical care issues. Let's examine the situation of prisoner Williams and the doctor at Green Haven Correctional Facility in an ordinary commonsense manner.

The medical care for a prisoner by his arrest is solely the responsibility of detaining authorities. The prison doctor must and must be able to discharge his duty per the usual medical practitioners' code of ethics [#9]. As such, the prison doctor must treat and advise in the best interest of the patient Williams. As Williams requests his severed ear reconnected, the prison doctor must adequately advise the patient on possible options based on medical judgment. The prison doctor must also choose reasonable best treatment options for Williams, including the referral to the specialist hospital. It appears that Williams made a reasonable request to reconnect his ear, which was endorsed by the appeal court justices [#5]. In this case, the prison doctor has shown deliberate indifference in choosing "an easier and less efficacious treatment plan" than otherwise being available.

In the next post, we speculate on what we might do if the case of Williams were to present to Australian courts. -- Cheers, NetIPR.

PART - III. WILLIAM'S CASE IN AUSTRALIAN COMMON LAW

Friends, we are looking at details of the US Prisoner Williams case [#5] to decipher legal contents within the context of Australian common law. In Williams' case, the prison doctor accorded an "easier and less efficacious treatment plan" to Williams had violated the torture law. In normal circumstances, a doctor paying little attention to the patient can cause medical malpractice. In the circumstance of a person in detention, however, such medical malpractice must be construed as torture. Of course, we frequently heard stories of offshore doctors treating severely ill asylum-seekers by dispensing only Panadol. (NB: Nothing wrong with Panadol, but the doctors repeatedly dispense that medicine, all the time and over the period).

In Williams v Vincent [#5], the prison doctor (i) failed to advise Williams on possible treatment options based on medical judgment. The prison doctor also (ii) failed to provide reasonable best treatment options for Williams, including the (iii) referral to the specialist hospital. The US appeal court indicated the prison doctor's conduct could be construed as torture. Let us assume Williams' incident has occurred in the Australian detention environment and then postulate the legal implications in Australian common law.

INDIVIDUAL FOCUS, LEGAL PRECEDENT AND REASONABLENESS

The common law focuses on individual rights and responsibilities. Under common law, "everybody is free to do anything, subject only to the provisions of the law" [Para. 2.42-2.50, #10]. In the case of Williams, the prison doctor is responsible for ensuring his patient receives the best treatment and provides independent advice. A doctor's conduct toward their patient is governed by the doctor-patient contract [#11], regardless of the doctor working in a detention environment.

The common law courts observe the doctrine of legal precedent, also known as "stare decisis" [#12]. Therefore, a presiding judge on a given case will not make a "radical" and "unprecedented" judgement primarily based on natural justice. In other words, the court must not allow itself to be radically catapulted into a new legal domain -- that would be unconstitutional. When making decisions, a judge must be impartial to both parties and observe the legal precedent. Because of the legal precedent doctrine, the court uses strict legal language. The human rights and legal languages used in other jurisdictions are unacceptable to Australian common law courts.

Therefore, if the plaintiff Williams were to appear before Australian common law court and then pleaded that the prison doctor had been "deliberate indifference to him" and had chosen "an easier and less efficacious treatment plan", the judge wouldn't doubt the authenticity and honesty of Williams' claim. But because Williams did not plead his case by the language of the court and under Australian legal precedent, the judge would probably have to "dismiss the case without prejudice". The judge must be impartial at trials and cannot "fill the gaps" for Williams' claims.

Reasonableness has been the most critical factor in decision makings of the judge. At the hearing, a judge would listen to both parties' pleadings of facts and assess whether the claims are reasonable. The judge will also evaluate the credibility of the witnesses. The judge would then make a reasonable decision based on the facts before him. A judge's reasonableness is not influenced by public opinion or other factors.

COMMON SENSE AND COMMON LAW

Therefore, for prisoner Williams, the proper remedy for receiving an "easier and less efficacious treatment plan" has been to take direct legal action against the treating doctor and the prison management. Doctors are mandatorily required to act under their standard code of ethics. As such, a doctor must treat and advise in the patient's best interest. Any doctor compromising their time-honoured code of ethics is committing an insidious crime. The doctor violating the code of ethics breaches their legal duty imposed by common law. Under common law, the doctor-patient contract regulates doctors' conduct toward the patient, and this area of law is usually known as medical negligence laws.

During last year (2022), we have made substantial efforts to understand basic criminal law concepts, common law patient rights and doctor-patient contracts [#11]. In Part-3 of [#11], we've learnt that the crime would be committed if "a person" acted in violation of a law prohibiting it or omitted to act in violation of a law ordering it. The omission to act becomes a crime when:

(1) there is a statute that creates a legal duty to act,
(2) there is a contract that creates a legal duty to act, or
(3) there is a special relationship between the parties that creates a legal duty to act.

In the case of Williams, the prison doctor is under a legal duty imposed by (2) the doctor-patient contract. The doctor-patient contract is usually not in written form but binding as soon as a patient submits themself to the doctor for the treatment [Part-4, #11]. In the previous note, using our common sense understandings, we concluded the prison doctor had given Williams "an easier and less efficacious treatment plan" because:

(i) failed to advise Williams on possible treatment options based on medical judgment;
(ii) failed to provide reasonable best treatment options for Williams, and
(iii) failing to refer to the specialist hospital.

High Court of Australia summarises a doctor's legal duty in the case of Rogers vs Whitaker (1992) as [#13]:

> "*5. ... the law imposes on a medical practitioner a duty to exercise reasonable care and skill in the provision of professional advice and treatment. That duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment"; it extends to the examination, diagnosis and treatment of the patient and the provision of information in an appropriate case. It is of course necessary to give content to the duty in the given case. (citations omitted)*"

In the following section, we shall look at a similar case of medical negligence in Australia which Williams can directly refer to as the legal precedent. Be aware that our human rights law discussion is now moving into proper common law areas.

GULAB KHAN V MATTHEW RATHJEN [2016] NSWDC 139 [#14]

Mr Khan, a university graduate with Master in Information Technology, works as a console operator at Caltex Service Station at Five Dock, Sydney. At approximately 10.00pm on 16 October 2011, a man holding 30cms knife entered the Service Station and approached Mr Khan. Fearful of being stabbed, Mr Khan grabbed the knife's blade and struggled with his attacker. Mr Khan sustained several lacerations to his left hand.

The police and ambulance attended the scene. At that time, Mr Khan had no Medicare, and opted not to go to the hospital. Mr Khan's employer, who did not wish to report the incident to Work Cover, brought him to Five Dock Medical Centre the next day. The GP had examined the hand injury on Mr Khan, but had not adequately tested individual movements of the fingers.

Following the GP examination, the nurse put the histoacryl glue on the wounds and gave the tetanus shot. The GP had seen Mr Khan at a follow-up appointment.

As it turned out, the knife wound was deeper and Mr Khan's left-middle finger tendons were severed. As a result, Mr Khan's finger is now permanently damaged. Mr Khan filed a lawsuit against the GP at Five Dock Medical Centre. The judge Mahony of District Court considered the case.

DOCTOR'S DUTY IN GRANULAR COMMON LAW

As quoted above, a doctor's duty is a "single comprehensive duty" to examine, diagnose and treat the patient and provide information. Common law requires that one must give the content to that duty in each case. In Para (3) of [#14], Mr Khan's lawyer had outlined the detailed contents of GPs duty, i.e. heads of medical negligence, as follows:

(a) "Failing to recognise the severity of the plaintiff's injuries on 17 October 2011 and to appropriately attend to the plaintiff's injuries on 17 October 2011;
(d) Failing to properly examine the plaintiff's left middle finger for damage to tendons, nerves and blood vessels on 17 October 2011;
(f) Failing to refer the plaintiff to a hand surgeon and/or to an emergency department at a hospital...
(h) Failing to refer the plaintiff for imaging and/or other necessary investigations to assess the nature and extent of his injuries on 17 October 2011 ....

Judge Mahony accepted all of the above as GP breaching his legal duty [#14].

> *266. I am therefore satisfied .... that the defendant breached his duty of care to the plaintiff on 17 October 2011, by failing to properly assess and diagnose the plaintiff's injuries, which led to a further failure to refer the plaintiff on to a hand surgeon and/or to an emergency department at the hospital for review of ... tendons. That breach was compounded on 25 October 2011 when the defendant again re-examined the plaintiff and failed to refer him as outlined above.*

Therefore, when describing the doctor's breach of duty at Australian courts, not sufficient simply to allege the doctor had chosen an "easier and less efficacious treatment plan". Williams must allege the detailed and specific content of that duty, with possibly already known heads of medical negligence. In this example, a doctor's failure to make proper referrals is identified as a form of medical negligence and a breach of legal duty [#14].

In sum, the common law has a reputation for being cumbersome and difficult to understand by laypersons. Nevertheless, as this prisoner Williams' torture case demonstrated, the common law is not entirely out of the reach of our understanding. I hope this example case will serve as a methodology to bring offshore torture cases to Australian courts. -- Cheers, NetIPR.

PART - IV. IDENTIFYING LAYERS, SCOPE AND BREACH OF HEALTHCARE DUTY

In the previous three parts, I explained how we could utilise a doctor-patient contract to invoke the torture law in a complex detention environment. In this regard, I used the case of US prisoner Williams[#5] to demonstrate the relevant legal methodology. Generally, a patient (prisoner) can obtain the legal remedy for medical malpractice by tort or contract laws [#15]. In offshore medical-related cases, the approach via doctor-patient contract is most suitable for our purpose. On invoking the torture law, we will limit our use of the doctor-patient contract only so far as to ascertain whether a doctor has breached their legal duty. Starting from the doctor's omission of duty, one must project the legal responsibility for other entities such as IHMS and DIBP.

The doctor-patient contract is a well-established legal principle in medical negligence laws. Common law judges have used the doctor-patient contract for decades in numerous cases.

Although the doctor-patient implied contract is well known to common law jurists, it has been a new concept for refugee activists and asylum-seekers. I, therefore, focus this discussion on this contract for more details.

CHARACTERISING LEGAL RELATIONSHIP: THE LAYERS IN HEALTHCARE DUTY

In Part-3 of "Doctor-patient Contract in Common Law (2022)"[#11], I discussed how to divide the layers of healthcare responsibility in offshore settings. I repeat the discussion here with a proper characterisation for the legal relationship of each layer to an asylum-seeker patient. In so doing, we can ascertain each contractual layer has owed healthcare duty to the asylum-seeker patient.

=> the provider-subcontractor-doctor has an employment contract with IHMS. That provider-doctor also has the doctor-patient implied-unwritten contract when treating the asylum-seeker patient. The subcontracted provider-doctor can either be a physician (GP) or a psychiatrist.

At this layer, the doctor-patient contract has primacy since the common law overwrites all other contractual considerations of the doctor [#16]. Meaning: any doctor coming to work at the detention centre, regardless of their employment status with IHMS, must observe the common law doctor-patient contract. Any breach of that contract will attract personal legal liability for the doctor.

=> the provider-contractor-IHMS has a contractual duty on health care of offshore asylum-seekers stipulated by written contract terms with Commonwealth/DIBP.

The contractual duty of IHMS require the detainees to provide healthcare services "to a standard broadly commensurate with health care available to people in the Australian community through the public health system."[#17]. At offshore settings, the standard of

health care required is Australian standards. This point has been discussed in detail in Part-3 of "Sec. IX. Medivac Related Torture at Offshore Centers (2021)"[#2]. Any breach of this contractual duty will attract legal liability for IHMS.

=> the provider-contractor-Broadspectrum has a contractual duty in care, including health care, of asylum-seekers that has been stipulated by written terms of contract with DIBP.

Broadspectrum is contractually required to follow the standard duty of care in offshore detention centres [#18]. Any breach of that contractual duty attracts criminal liability for detention guards and Broadspectrum.

Be aware that the contract terms described in FOI references [#17] & [#18] are adequate only for this analysis. For judicial standards, i.e. to supply to the court, we may need further detailed contract documents. That is because Commonwealth and IHMS/Broadspectrum contracts for Manus and Nauru may vary over a period of time with the versions or forms [#17].

=> the provider-DIBP has an overall non-delegable duty on health care of offshore asylum-seekers.

The Commonwealth has the overall duty to provide health care to offshore asylum-seekers. Although the asylum-seekers are in other sovereign states, i.e. PNG and Nauru, the Commonwealth Government of Australia have a special relationship with the offshore asylum-seeker [#19], where DIBP has the legal duty to act. On this point, the legal precedent has already been set in the landmark judgment of S99/2016 for all offshore cases. On the one hand, the federal court in 2005 had a position on the Commonwealth having non-delegable duty of care to immigration detainees on shore. My inference from other sources is that the decision was legally correct also for offshore, but it may still be open to the High Court challenges.

EVALUATING THE SCOPE OF HEALTHCARE LEGAL DUTY

In many ways, we can compare the operational mode for IHMS clinics on Manus Island and Nauru to any common medical centre in the suburbia of Sydney or Melbourne. These are small dispensary clinics with few GP and occasionally psychiatric working on the roster, and the medical centre keeps individual patient records. The consulting GP can check the logs when the patient presents and make a further referral for tests and diagnoses and to specialists.

In 2022, we examined the scope of doctors' contractual duties in Part-4 of "Doctor-patient Contract in Common Law"[#11]. Three categories of legal duty are imposed upon the treating doctor and the healthcare providers in general. The first primary legal duty imposed on the doctor is to "advise and treat the patient with reasonable skill and care". That duty is a "single comprehensive duty covering all the ways in which a doctor is called upon to exercise his skill and judgment"[#13]. The primary legal duty demands that the doctor use "reasonable skill" and "reasonable care" when treating and advising the patient. That "reasonableness" is to be determined only by the presiding judge.

The contract will also impose a second legal duty on the doctor regarding patient information. The doctor and all healthcare providers must respect the patient's privacy in person and observe the confidentiality of the patient's information. The source of that contractual duty has, for example, in Australia, originated from the Privacy Act 1988 (Cth), where a doctor had acquired information from the patient to advise and treat. Hence, all healthcare providers must not use that patient information for other purposes.

The third legal duty for the doctor, the fiduciary duty, had also arisen while treating the patient. The doctor's fiduciary duty can arise from (1) in the process of the patient reposing their trust in the doctor and (2) the patient utilising the doctor's agency in the treatment. Australian courts do not accept that a doctor, by social status or profession, would automatically owe a fiduciary duty towards their patient. The courts consider fiduciary obligations to arise because a doctor must act in the patient's interests. The courts would consider fiduciary duty for a doctor erected from the discharge of the primary duty on their patient to "advise and treat with reasonable skill and care". The fiduciary duty also is applied to all healthcare providers.

IDENTIFYING BREACH OF DUTY: CATCH IF FAILS

At this stage, we can look at few examples of medical malfeasance to identify a breach of duty. Most of us, of course, are neither lawyers nor medical doctors. But when we read the internet messages and other media reports from the refugees and activists, we sense that the treating doctors and IHMS/DIBP "have not done their jobs properly". On the one hand, the reports by professional journalists and presentations made by whistle-blowers over the years convey the same message, "IHMS and DIBP had not done their jobs properly". The question: Have we actually been seeing the underlying incidents that could be the breach of legal duties through those messages? That is a possibility. Remember, these messages, in general, are legally imprecise to use as evidence. On the other hand, journalist reports were legally "pruned" out of factual references that could be used as incriminating evidence on someone or something. Nevertheless, we may use our discernment in any situation to identify potential legal breaches.

The following examples are not made out in reference to a specific cases or incidents. But I've drawn these examples out of my memory from the repeated messages over the years.

In one instance, the Manus Island detainee who suffered severe stomach pain was repeatedly given " panadol " over dozen visitations for the same symptoms. The GP did not refer the patient to further tests or specialist examination. We can identify the GPs' conduct as breaching their legal duty. The doctor-patient contract requires the doctor to use "reasonable skill" and "reasonable care" to "treat" and "advise" the patient. In this instance:

-> The GP has not used reasonable care to check the patient's medical records;
-> The GP failed to take into account repeated symptoms;
-> The GP has not used reasonable skill to treat illness;
-> The GP failing to make a referral to specialists;
-> The GP failed to make a referral for further tests and diagnosis.

If the fact and evidence have shown that the GP has made a referral for further tests and

diagnosis and to the specialists, the IHMS and DIBP have breached their duties.

In other instances, the GPs working at detention centres (Manus, Nauru & Onshore) are dispensing mentally ill patients with medications such as Zoloft & Diazepam, "repeatedly" and over a "long period". This conduct breaches doctors' duty because only psychiatrists have the necessary skills to treat mentally ill (psychiatric) patients.

Psychiatrists (as opposed to psychologists) are specialists who have a degree in medicine and additional qualification in psychiatry. Usually, the doctor (GP) needs another five years of studying psychiatry to become a psychiatrist. The GP can not have the skill of a psychiatrist. Therefore, in the above instances, the GP has breached the doctor-patient contractual duties.

-> The GP doesn't have the necessary skill and, therefore, is reckless in treating a mentally ill (psychiatric) patient;
-> The GP fails to appreciate the psychiatric illness;
-> The GP is failing to refer the patient to a specialist (the psychiatrist);
-> The GP has not used reasonable care dispensing anti-psychotic medications for a long period, which may cause medication addiction in the patient.

From the above two examples, I have demonstrated how a layperson may identify the breach and potential breach of the legal duty by medical doctors. Our next task is to chain-up this breach with torture and slavery laws.

PART - V. JUSTICIABILITY AND INTER-OPERABILITY OF DIV. 274 TORTURE LAW:

Friends, since February 2023, we have been endeavouring to connect the torture and slavery laws of the Criminal Code Act 1995 (Cth) with offshore medevac incidents. The Australian Parliament in 2010 enacted Div. 274 Torture law with "Extended Geographical jurisdiction -- Category D". The Division 274 Torture of Criminal Code Act 1995(Cth), therefore, applies to the incidents that occurred on Manus Island of PNG and Nauru.

Torture offences are applicable as crimes against humanity with Div. 268.13 of the Criminal Code Act 1995 (Cth). Historically, the laws enacted under Div. 268 Crime Against Humanity have originated from the international humanitarian law foundation, the Geneva Convention (1949) [#8]. On the other hand, Div. 274 Torture Law originates in the international human rights law foundation, United Nations Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment (1987). This post will look at the compatibility of operating Div. 274 of Australian domestic torture law with Div. 268.10 Crime Against Humanity Enslavement. The Div. 274 Torture Law focuses on protecting individuals within Australian domestic polity, contrasted with the Div. 268, which has broader international applications.

THRESHOLD COMPATIBILITY OF DIV.274 AND DIV. 268.10

In Section IV. "Slavery and ICC Legal Threshold (2021)" [#2], I discussed the ICC's requirement for a higher threshold in considering slavery crimes. The 1998 ICC Rome Statute focuses on the "slavery" proper and leaves out "... practices similar to slavery". Therefore, the ICC is only mandated to exercise its jurisdiction on the "slavery" proper but not on the "practices similar to slavery". Consequently, the ICC could only act upon having the proof, under the principle of complementarity, of the perpetrator exercising any or all powers attaching to the rights of ownership over the (enslaved) person(s), in a 'chattel-like' comprehensive manner. This higher threshold requirement for ICC was due to the contracting states' desire to avoid international intervention in less severe "slavery-like" conditions.

By the irony of legal fate, the Div. 274 torture laws also have provisions set for a higher threshold. Specifically, when the Australian Parliament adept 1987 UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment in their domestic legislation in 2010, a strict and narrower definition for torture has been used. Such adaption has resulted in Division 274 provisioning only for torture. The other activities conducive to torture -- i.e. Cruel, Inhuman or Degrading Treatment -- were not criminalised. As such, Division 274, in principle, has the inter-operability with ICC enslavement law provisions, i.e. Div. 268.10.

Juxtaposition: The Division 270 Australian domestic slavery law, which also has extended geographical jurisdiction category--D, is set for a lower threshold. For example, Wei Tang, the operator of Melbourne Fitzroy Night Club, had been convicted of "debt-bondage slavery" under slavery-like category [Para.4, #6]. Therefore, Wei Tang cannot be charged with crime against humanity under Div. 268.10 of ICC enslavement laws.

COMPULSORY FOR ICC INVOLVEMENT

Australia has exclusive responsibility for the policy of offshore detention and the consequent crimes that have taken place. Most detention contractors -- i.e. Broadspectrum, IHMS and the Australian employees -- are Australian entities and, therefore, amenable to the Division 274 torture provisions. However, some IHMS-GPs working at the detention centres are not Australian nationals. The Australian domestic courts have no jurisdiction to prosecute these foreigners. On the one hand, overseas entities, such as hospitals in Nauru and PNG, that are likely involved in the perpetration of crime cannot be prosecuted under Australian laws. Therefore, there will be instances of Australia unable to "genuinely carry out prosecution" due to jurisdictional limitations. Thus, the United Nations and ICC must intervene in those criminal cases.

Considering the complexity of the international political environment, we, the public, must adopt diversity in our legal approach. The Div. 274 torture laws focus more on justiciability for Australian courts in such a complex environment. Therefore, the two approaches offered by Div 286.10 enslavement and Div 274 Torture can complement each other to reach the best result.

ROBUSTNESS OF DIV. 274 TORTURE LAW PROVISIONS

The existing Torture law, Div. 274 that conforms with UN Convention Against Torture "UNCAT", was enacted in 2010 and replaced the older version. Features directly adopted from UN Convention are:

-> the concept of torture requires a certain threshold of suffering that mental as well as physical suffering is included;
-> the act of torture has to be inflicted intentionally that the torture must be inflicted for a prescribed purpose;
-> the infliction of pain and suffering be done by or at the instigation of, or with the consent of, a public official or other person acting in an official capacity.

Australian Criminal Code Act 1995(Cth), Sections 274.2 of (1) and (2) reflect the above features of UNCAT [#20].

PERPETRATOR (DEFENDANTS)

In 274.2(1), A person (the perpetrator) commits an offence if the perpetrator (a) engages in conduct that inflicts severe physical or mental pain or suffering on a person (the victim);
In 274.2(2), A person (the perpetrator) commits an offence if the perpetrator (a) engages in conduct that inflicts severe physical or mental pain or suffering on a person;

Here, the term "perpetrator" represents an entity or individual. At the court, the perpetrator(s) will be referred to as defendants: IHMS-GP (individual), IHMS (Healthcare Company) and DIBP (Commonwealth Department). "Engages in conduct" means the defendant has done "an act against the law proscribing it" or "omitted to do the act that prescribed by the law". For example, a medical doctor who breached the duty imposed by the doctor-patient contract reaches this requirement. Similarly, the IHMS or DIBP, acting against the advice of doctor, that failed to transfer an offshore patient to Australia will meet this requirement.

INTENTION AND PURPOSE OF CONDUCT

In 274.2(1)(b) the conduct is engaged in:

(iii) for the purpose of intimidating or coercing the victim or a third person; or
(iv) for a purpose related to a purpose mentioned in subparagraph (i), (ii) or (iii); and

When DIBP/IHMS failed to transfer the offshore patient, the defendant (DIBP) engaged in this conduct for the purpose of coercing the asylum-seeker patient to remain in the offshore camp.

Or, in the case of the IHMS-GP breaches the doctor-patient contract, the defendant (GP) has engaged in conduct for the purpose related to coercing an asylum-seeker patient to stay in the offshore camp.

In 274.2(1)(b), the conduct is engaged in for any reason based on discrimination of any kind.

The DIBP has implemented a policy for offshore asylum-seekers to receive reduced healthcare standards. That policy is discrimination against all other Commonwealth government immigration detainees who, by law, must receive Australian standards of healthcare.

DESIGNATION OF AN OFFICIAL

In 274.2(1)(c) & 274.2(2)(c) the perpetrator engages in the conduct:
(i) in the capacity of a public official; or
(ii) acting in an official capacity.

The IHMS-GPs, other healthcare workers and detention guards on Manus Island and Nauru are working in an official capacity. Also, a Commonwealth government employee engaged in the conduct is a public official.

ABSOLUTE LIABILITY

In 274.2 (3) Absolute liability applies to paragraphs (1)(c) and (2)(c).

An offence in this Division does not allow any legal defence. It is strongest provision for criminal liability. A superior's order cannot be a legal defence.

EXCLUSION OF LAWFUL SANCTIONS

It is unlikely the Australian Parliament would allow to remove or reduce the healthcare of any person in detention. However, it is arguable that some matters might arise from "inherent or incidental" to lawful operations. In any case, Subsection 274.2(4) will not apply to the proven instances of officials showing "deliberate indifference to serious medical needs" of asylum-seeker patients.

EXTENSION OF CRIMINAL RESPONSIBILITY: AIDING, ABETTING AND PROCURING IN CRIME

Those who attempt, complicit or participated in torture are criminalised through Pt. 2.4 of Criminal Code Act 1995 (Cth). This is not explicitly written in texts of Div. 274, but apply through general provisions of Criminal code [#8].

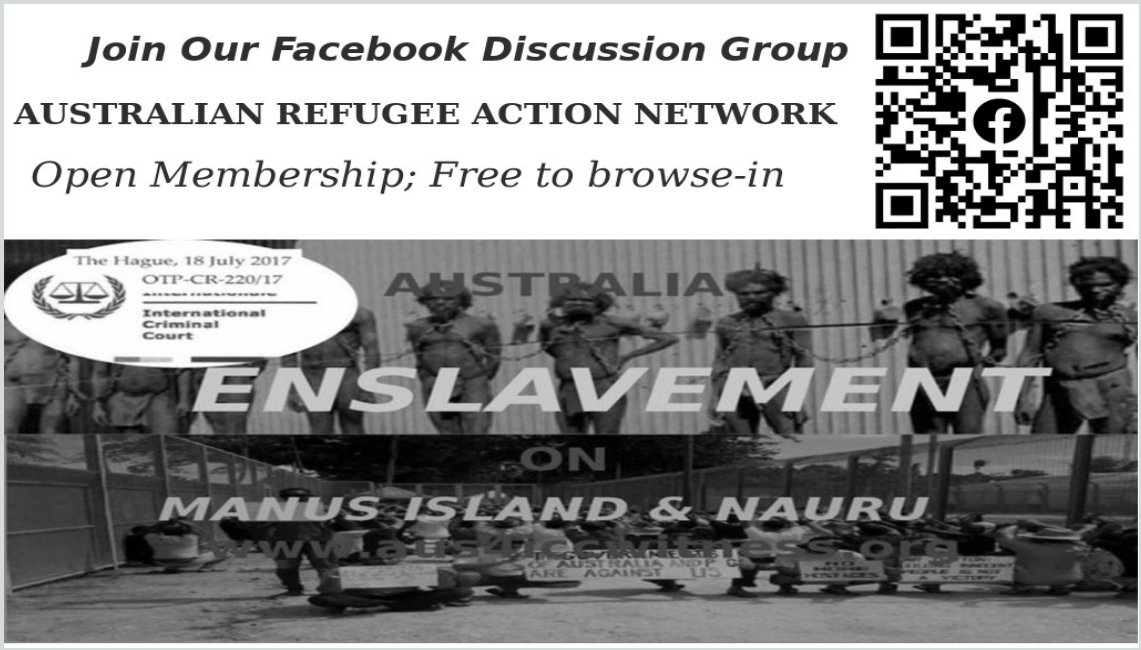
Part 2.4 -- Extensions of criminal responsibility.
s 11.1(1) Attempt
A person who attempts to commit an offence is guilty of the offence of attempting to commit that offence and is punishable as if the offence attempted had been committed;
s 11.2(1) Complicity and common purpose
A person who aids, abets, counsels or procures the commission of an offence by another person is taken to have committed that offence and is punishable accordingly;
s 11.2 A (1) Joint Commission
If:

(a) a person and at least one other party enter into an agreement to commit an offence; and
(b) either
(i) an offence is committed in accordance with the agreement ... or
(ii) an offence is committed in the course of carrying out the agreement ...
the person is taken to have committed the joint offence referred to in whichever of subsection (2) or (3) of [Division 11] applies and is punishable accordingly.

WILL DIV. 274 TURNS ON THE WHEEL OF JUSTICE ?

The Division 274 Torture has been criticised as "not nearly good enough" or "glass-half filled". However, the robustness of provisions in this Division is quite noticeable. Furthermore, this Division's justiciability has been greater than Division 268.13 Crime Against Humanity Torture. Hopeful that we can unravel the crimes of detention slavery by utilising Division 274 Torture. Much homework still needed to be done, of course.

-- U Ne Oo, Network for International Protection of Refugees.



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