



Monday 19th December 2016

Doctors for Refugees' submission to Senate Legal and Constitutional Affairs Committee into serious allegations of abuse, self-harm and neglect of asylum seekers in relation to the Nauru Regional Processing Centre and any like allegations in relation to the Manus Regional Processing Centre.

Committee Secretary
Senate Legal and Constitutional Affairs Committee
PO Box 6100
Parliament House
Canberra ACT 2600
Legcon.sen@aph.gov.au

Doctors for Refugees (D4R) is an organisation, registered with Office of Fair Trading NSW, whose members are Australian doctors, medical students and other concerned Australians. D4R campaigns for better health outcomes for refugees and asylum seekers.

D4R works to improve access to medical advice and treatment for refugees and asylum seekers in Australia, immigration detention centres (IDCs) and offshore regional processing centres (RPCs) on Nauru and Manus Island. D4R is engaged in advocacy for those currently kept in indefinite Immigration detention. A High Court challenge led by D4R is also underway to remove the threat of prosecution of those who speak out about the deleterious conditions in detention centres as a result of the Australian Border Force Act (ABFA).

D4R doctors conduct independent medical case analysis with liaison between IDC health service provider International Health and Medical Services (IHMS), individual asylum seekers and their advocates. Medical records are provided by IHMS upon receipt of written consent from individuals. Mainland Australian health professionals provide clinical recommendations for patients and D4R submits these to IHMS.

For the formulation of this submission, D4R used information provided with consent by individuals currently, or previously living in RPCs on Nauru and Manus Island.

D4R advocates for the immediate end to offshore processing, institution of a transparent, timely and accountable procedure for asylum seeker processing regardless of their mode of arrival to Australia, with the immediate return of all children in detention to Australia.

Table of Contents

INTRODUCTION.....	3
SUMMARY OF SUBMISSION	3
RECOMMENDATIONS:	4
RESPONSE TO TERMS OF REFERENCE.....	7
A. THE FACTORS THAT HAVE LED TO THE ABUSE AND SELF-HARM ALLEGED TO HAVE OCCURRED ON NAURU AND MANUS ISLAND.....	7
<i>4.1. Violation of human rights through indefinite detention with</i>	<i>7</i>
<i>4.2. Inadequate healthcare provision: systemic failure to meet basic obligations, delays and abject disregard for medical standards.</i>	<i>12</i>
B. HOW NOTIFICATIONS OF ABUSE AND SELF-HARM ARE INVESTIGATED.....	17
C. THE OBLIGATIONS OF THE COMMONWEALTH GOVERNMENT AND CONTRACTORS RELATING TO THE TREATMENT OF ASYLUM SEEKERS INCLUDING THE PROVISION OF SUPPORT, CAPABILITY AND CAPACITY BUILDING TO LOCAL NAURUAN AUTHORITIES.....	20
D. THE PROVISION OF SUPPORT SERVICES FOR ASYLUM SEEKERS WHO HAVE BEEN ALLEGED OR BEEN FOUND TO HAVE BEEN SUBJECT TO ABUSE, NEGLECT OR SELF-HARM IN THE CENTRES OR WITHIN THE COMMUNITY WHILE RESIDING IN NAURU.....	20
E. THE ROLE AN INDEPENDENT CHILDREN’S ADVOCATE COULD PLAY IN ENSURING THE RIGHTS AND INTERESTS OF UNACCOMPANIED MINORS ARE PROTECTED.	21
F. THE EFFECT OF PART 6 OF THE AUSTRALIAN BORDER FORCE ACT 2015.....	22
CONCLUSION.....	23
REFERENCES.....	24

Introduction

As of August 30, 2016, there are 873 people in Manus Island RPC and 396 people in Nauru [1]. D4R has 219 active cases of individuals who have self-referred to D4R for medical assistance. 106 individuals are on Nauru, 82 on Manus Island, 26 in Australia, 4 in Port Moresby and 1 on Christmas Island.

Summary of Submission

D4R appreciates the opportunity to present in response to the terms of reference, with particular emphasis on:

- (a) The factors that have led to the abuse and self-harm alleged to have occurred on Nauru and Manus Island which primarily are:
 - Violation of human rights through indefinite detention via the restrictions of autonomy, personal freedom and the denigration of individuals.
 - D4R would like to make special reference to children in detention who suffer abuse and have engaged in self-harm and
 - Inadequate healthcare provision with systemic failure to meet basic obligations, delays and abject disregard for medical standards.

- (b) How notifications of abuse and self-harm are investigated

D4R will briefly address the remaining terms of reference, with evidence limited by the lack of transparency of IDCs and their medical processes.

D4R will not address in detail the final term of reference (f) because the High Court challenge against the Australian Border Force Act 2015 is currently in proceedings.

Recommendations:

D4R makes the following recommendations:

a. With regards to human rights and mitigating the detrimental effects of Detention

- The express end to arbitrary indefinite mandatory detention
- In the situation where mandatory detention must occur for security or public health reasons, individuals in detention be treated with respect and dignity, afforded their fundamental human rights and detained for the shortest period of time possible.
- An independent and transparent procedure for reporting and investigating abuse, neglect and self-harm in detention centres including the RPCs of Nauru and Manus island, and ongoing events or threats to those living in the Nauru and Papua New Guinea community

b. With regards to providing adequate medical care:

(i) Mental health -

- Individuals with objective evidence of deteriorating mental health because of their prolonged detention immediately removed from detention.
- The treating medical team to demonstrate hyper-vigilance and expeditious responsiveness where there is risk of self-harm, suicide, or deteriorating mental health.
- Admission to a psychiatric facility of those individuals who are not receiving adequate psychiatric care both in IDCs and the community to mitigate the risk of suicide. It is understood such a facility is not available at RPCs and individuals should be urgently transferred to Australia (within 24 hours).
- Urgent (within 24 hours) transfer of all paediatric patients who express self-harm or suicidal intent to Australia for specialist paediatric psychiatric treatment.
- Compliance with Australian Mental Health Act (MHA) with regards to the involuntary detention and treatment of persons with mental illness.

(ii) Meeting standard codes of practice

(reference to Australian Medical Board's code of conduct items):

Transfer of Medical Records:

- 8.4.7 Promptly facilitate the transfer of health information when requested by a patient
- In accordance with the Office of the Australian Information Commissioner (OAIC): Process and provide medical records within 30 days. (More promptly if the case is an urgent or serious threat to the individual, or public's safety).

Uphold the duty of medical professionals to ‘protect and promote the health of individuals and their community’ through meeting accepted professional standards and acting in the best interests of their patients [2, 3]:

- 2.2.6 Provide treatment options based on the best available information
- 2.2.8 Support the patient’s right to seek a second opinion
- 2.2.9 Consult and take advice from colleagues when appropriate
- 2.2.10 Make responsible and effective use of the resources available
- Use evidence-based treatment, referral to specialist services as required and timely transfer to Australia when specialist services are not available at RPC.
- Prompt sourcing of further medical advice and implementation of an alternative management plan when an individual fails to respond to treatment.
- Senior health staff be responsible for ensuring delayed referrals are monitored, addressed and a preventive treatment plan instituted for early detection of deterioration. Documentation of such a plan in the clinical file and all correspondence with the Department of Immigration and Border Protection (DIBP) regarding the patient’s medical care be documented and explained to the patient.

Where a medical professional is practising in a way that significantly departs from accepted professional standards, practitioners are under legal obligation through mandatory notification requirements to report this to the Australian Health Practitioner Regulation Authority [3].

Specific mention of the obligation of Senior Medical officers and Medical Directors to comply with the Medical Board of Australia Code of Conduct items regarding:

- IHMS Senior Medical Officer or Medical Director should maintain responsibility for ensuring individuals in the care of IDCs with complex medical conditions receive best possible medical care. This includes adherence to MBACC items:
 - 5.2.2 Upholding the patient’s right to gain access to the necessary level of healthcare and, whenever possible, helping them to do so.
 - 5.2.3 Supporting the transparent and equitable allocation of healthcare resources.
 - 5.3 Ensuring expertise and influence is used to protect and advance the health and wellbeing of individual patients
 - 6.2.4 Ensuring that systems are in place for raising concerns about risks to patients
 - 6.2.6 Taking all reasonable steps to address risk if there is a possibility patient safety may be compromised. [2]

In particular, if the Senior Medical Officer or Medical Director is aware a patient is unable to access necessary medical care due to interference by DIBP or other stakeholders, it is within their responsibility to ensure this is reported, escalated and actions taken to mitigate risks to the patient.

c. With regards to interference by other stakeholders including the DIBP

- DIBP should not influence autonomous clinical decision making of the treating medical team, including referrals to specialists and admission to hospital.
- Clinical decisions including referrals to specialist services not available in Nauru or Manus Island should be autonomous and not subject to approval by non-clinical decision-makers.

With regards to children in detention:

- The immediate removal of all children from immigration detention
- Institution of an independent legal guardian for all unaccompanied minors
- Institution of an independent children's advocate
- All children treated with dignity and care.
- All children given the right to healthy development: physical, mental and spiritual wellbeing, education, cultural expression, protection from violence and a safe, nurturing home.
- All children given the opportunity to recover from past trauma
- All children with chronic medical conditions including mental illness, developmental disorders, intractable illness or pain receive early paediatric assessment. This presumably means transfer to Australia to access specialist paediatric, multi-disciplinary services.
- All employees and contractors for the Australian Government are entrusted persons and should be subject to child protection laws. Independent investigation by child protection authorities and / or the police is warranted in all cases of suspected child abuse.
- Failure to comply warrants police investigation.

With regards to revision of the ABFA

- Amendment to enable all people to speak freely and without threat or intimidation about the conditions and situation in IDCs as long as it does not compromise confidentiality and privacy of the individual.
- Retrospective inclusion within the amendment to ensure those who have previously spoken out are exempt from prosecution.

Response to Terms of Reference

a. The factors that have led to the abuse and self-harm alleged to have occurred on Nauru and Manus Island

It is asserted that abuse and self-harm on Nauru and Manus is caused, or perpetuated by the following factors inherent to the current mandatory detention regime:

1. Violation of human rights through indefinite detention with:
 - Restrictions to autonomy, personal freedom and the denigration of individuals with
 - Special reference to children in detention and
2. Inadequate healthcare provision: systemic failure to meet obligations of care, delays and abject disregard for medical standards.

4.1. Violation of human rights through indefinite detention with

4.1.1. *Restrictions to autonomy, personal freedom and the denigration of individuals*

As at 31st August 2016, the average time an individual spends in Australian immigration detention is 454 days [1]. 436 people have been held in immigration detention for over 2 years [4]. Detention conditions are purposefully harsh, degrading and in some circumstances also a means of torture [5]. The detention environment contributes directly to psychological distress and is reflected by 3-17 times higher suicide rates in detention centres compared to the Australian community [6]. Similarly, rates of mental illness are higher in detained individuals, than non-detained refugees with similar pre-migration exposure [7]. Inarguably, there are extremely high levels of depression, anxiety and post-traumatic stress disorder in asylum seekers detained by the Australian Government [8-10].

Recommendation:

- The express end to arbitrary indefinite mandatory detention
- In the situation where mandatory detention must occur for security or public health reasons, individuals in detention be treated with respect and dignity, afforded their fundamental human rights and detained for the shortest period of time possible.

D4R has 58 active cases (26% of all cases) where severe and deteriorating mental health is the primary reason for referral. This number excludes cases where the individual has co-morbid mental illness but the primary reason for referral is another medical condition. More than 30% involve suicide attempts as the primary reason for referral, with two self-immolations.

The following case is an example of an individual who sought political asylum in Australia and despite exposure to trauma pre-departure, had no pre-existing mental illness but developed severe mental illness with suicidal ideation during and as a result of prolonged detention.

*(Name redacted) is **an adult** in Papua New Guinea. His clinical file begins at induction to Manus Island RPC in November 2013 and documents no pre-existing physical or mental illness. (Name redacted) showed consistent engagement with self-care activities such as group walking, relaxation classes and Torture and Trauma counselling for the first 24 months of detention. He was seen once in 2013 by a psychologist for nightmares with mild anxiety but did not require medical treatment. Over the following two years, he presented intermittently with concerns about deteriorating physical health including untreated dental pain, undiagnosed hand pain and worries for the safety of his family who remain in . In August 2015 he was transferred to the Manus Island transit centre and saw a series of doctors without formal diagnoses made for his physical ailments. A psychiatrist documents in May 2016 that he now suffers reactive depression with self-harm intent.*

*D4R received referral from a concerned advocate for this **adult** on the 17th of May 2016 because he expressed desire to self-immolate. An urgent request for his medical file was sent to IHMS on the 26th of May 2016. After multiple attempts to access his file from IHMS, a complaint was made by D4R to the Office of the Australian Information Commissioner (OAIC) under the Freedom of Information Act (FOI). Following this, (name redacted)'s file was received on the 25th of July 2016. The last documentations in his file following the psychiatrist's report are entries from 2nd of June 2016 to 14th of July 2016 where the mental health team report he did not attend his appointments. There is no documented effort made by health workers to determine why despite a high risk of suicide. His advocate advises that he continues to express suicidal ideation and D4R have informed IHMS of this on several occasions.*

The Australia Mental Health Act (MHA) provides explicit State legislative guidelines for the management of people who are mentally ill. These include the 'best possible care and treatment' in line with professionally accepted standards. Such standards for health practitioners include:

- Formal assessment and documentation by a doctor, psychiatrist or approved mental health worker of suicide risk.
- Written safety plan provided to the individual, their caregivers and other relevant stakeholders with the patient's consent.
- Regular suicidal risk monitoring (by a doctor, or approved mental health worker) until it diminishes and where this fails (such as patient non-compliance) an alternative plan instituted which may include voluntary or involuntary, psychiatric hospital admission or community treatment order under the MHA [11, 12].

As demonstrated in the case example, IHMS has failed to meet these standards of care. IHMS continues to fail to respond to requests by D4R for formal medical update on the individual's condition since the 14th of July 2016. His advocate advises D4R that he continues to express a desire to self-immolate.

Recommendations:

- Individuals with objective evidence of deteriorating mental health because of their prolonged detention immediately removed from detention.
- The treating medical team to demonstrate hyper-vigilance and expeditious responsiveness where there is risk of self-harm, suicide, or deteriorating mental health.
- Admission to a psychiatric facility of those individuals who are not receiving adequate psychiatric care both in IDCs and the community to mitigate the risk of suicide. It is understood such a facility is not available at RPCs and individuals should be urgently transferred to Australia (within 24 hours).

4.1.2. Special reference to children in detention

Children in IDCs experience multiple forms of child abuse including neglect, deprivation from stimulation and social connectivity, exposure to harsh environmental conditions and harm to their health, development and dignity [13]. The Moss Review found that “there were both reported and unreported allegations of sexual and other physical assault” in relation to children on Nauru [14]. The review found that between October 2013 and October 2014, 17 children engaged in self-harm, the youngest being 11 years old. The Senate Select Committee on the Recent Allegations relating to Conditions and Circumstances at the RPC in Nauru determined in 2015 that ‘Nauru is neither a safe nor an appropriate environment for children and that they should not longer be held there’ [15].

Normal protective factors for children exposed to abuse include being with their parents and having a safe, predictable environment [16]. In IDCs, the disintegration of parents’ authority and declining parental mental health profoundly undermine the parental role, leaving children with little protection or comfort [8].

(Name redacted) lives on Nauru. His mother was diagnosed with severe depression and has attempted suicide on several occasions. She is disengaged from her son and he has withdrawn from her. She is unable to tolerate his touch, sometimes even his presence and says so frequently in front of him. Subsequently, his behaviour has deteriorated, as has the mental health of his father who is now the primary caregiver.

Recommendation:

- The immediate removal of all children from immigration detention

All individuals in detention represent a vulnerable population, however children with mental illness in detention are particularly at risk. Australia ratified the Convention on the Rights of the Child in 1990 where Art 24(1) provides that all children have the right to the highest attainable standard of health [17]. In Nauru, children are unlikely

to receive services that meet their complex needs and their prolonged detention has permanently impaired their psychological wellbeing [18].

The following case outlines the history of a child with a treatable surgical condition and preventable co-morbid mental illness where his medical care was presumably obstructed by DIBP and not effectively escalated by IHMS so that he now suffers severe mental illness with psychosis and is of high suicide risk.

(Name redacted) was child upon his arrival to Nauru in September 2013 and assessed as having “mild PTSD symptoms.” His father took him to Torture and Trauma counselling and he initially coped well. In April 2014, IHMS doctor and psychologist noted he was being bullied because of a speech impediment. He was referred to a paediatric psychiatrist. The psychiatrist noted “speech production disorder” and referred to an Ear Nose and Throat surgeon (ENT) for assessment of reduced tongue movement. In May 2014 the child presented with a dental infection and later that month represented after assault by another child at school. The psychologist noted “he is teased daily about his speech impediment.” A “high priority referral” unsigned in his case file is dated June 2014. His father presents to IHMS multiple times over 3 months to check this referral - psychologists and multiple general practitioners confirm an existing referral and note escalating this to the Senior Medical Officer on Nauru several times.

(Name redacted)’s father submitted a complaint through Transfield services regarding the delayed specialist review and received written reply from the Health Services Manager on the 13th of May: “I do not have a date for specialist to visit Nauru at this time. (Name redacted) is on the waiting list and we will notify you when we have a date for this service.” On the 22nd of May 2014 the Senior Medical Officer for IHMS on Nauru submitted a Recommendation for Medical Movement from Nauru to Australia for oral surgery and speech therapy to the Area Medical Director. D4R does not have documentation following this to explain why no transfer occurred.

7 months later, in December 2014 an IHMS medical officer at the Republic of Nauru Hospital (RONH) documents “advised no operation for tongue tie is indicated. There is clear evidence that tongue tie operation does not improve speech.” Unfortunately, while surgical management of tongue-tie is controversial, indications for possible surgery include articulation problems, psychological problems and periodontal disease - all present in this case [19]. Standard treatment for tongue-tie and speech problems is a collaboration between paediatric ENT specialists with speech pathologists (neither available on Nauru)[19]. D4R does not have clinical notes between this time and April 2015 when an IHMS psychologist wrote to the Health Services Manager on Nauru that “(name redacted) had a tongue untied not long ago.”

The psychologist also wrote in 2015 that “his speech is very poor, due to this he reported being severely bullied by his peers and he is no longer attending school... communication difficulties, enuresis and suffering from bullying reinforced his self-hatred, as a result his self-esteem is non-existent in my opinion. Conceptually his sleep deprivation, social exclusion and detention

fatigue create more anxiety, severe depression and suicidal ideations...at the moment I worry for his prognosis.” 11 months later, in March 2016 (name redacted) attempted to strike him-self with a knife and Nauru police noted knife slashes on the walls. Upon arrival to hospital (name redacted) stated “I am tired of life.. I want to die.” In May 2016 a psychologist documents “ (name redacted) had disclosed suicidal ideations ... he would set himself on fire.”

In April 2016 the Nauru Settlement Clinic child and adolescent psychiatrist had a phone call with a psychiatrist at the RONH who reported “a psychotic episode” and commenced him on anti-psychotic medication. The psychiatrist writes that he discussed this with the medical team who requested offshore management for close monitoring of suicidal ideation, and treatment by a speech pathologist. No documentation of a transfer request by senior medical officers is found in his file.

On the 4th of July 2016 (name redacted) is referred by an IHMS psychiatrist for transfer to Australia or a third country for inpatient treatment (“which has an accessible hospital providing child psychiatric specialist services with capability, expertise and experience with childhood psychosis”) of a presumed first episode depressive psychosis (despite this being the second documented event). He writes that (name redacted) “was found by his father having tried to hang himself from a fan with a computer cord” and hearing voices telling him to kill himself. This referral was updated further on the 7th of July and the psychiatrist writes that “(name redacted)’s mental condition is reported to have further deteriorated over the last day with ongoing psychotic symptoms...receiving psychiatric care requires time and forward planning to ensure bed availability. IHMS are requesting urgent approval to allow for forward planning of ongoing management.” He was finally transferred to Melbourne on the 9th of July 2016, three months after the first psychiatrist highlighted suicidal risk and need for inpatient treatment.

This case highlights several areas of concern:

- The child did not received standard, nor evidence-based treatment for tongue-tie and paediatric mental illness that includes multidisciplinary assessment, examination of comorbid diagnosis, individual cognitive behavioural therapy and / or psychotherapy.
- Suicidal intent in the paediatric population requires urgent (within 24 hours) management by a specialist paediatric psychiatrist.
- His delayed transfer time (for both speech disorder and deteriorating mental health) demonstrates extreme medical negligence.

Recommendation:

- Use appropriate medical standards of care including evidence-based treatment, referral to specialist services as required and timely transfer to Australia when specialist services are not available at RPC.
- Senior health staff be responsible for ensuring delayed referrals are monitored, addressed and a preventive treatment plan instituted for early detection of deterioration. Documentation of such a plan in the clinical file and all correspondence with DIBP regarding the patient's medical care be documented and explained to the patient.
- DIBP should not influence autonomous clinical decision making of the treating medical team, including referrals to specialists and admission to hospital.
- Urgent (within 24 hours) transfer of all paediatric patients who express self-harm or suicidal intent to Australia for specialist paediatric psychiatric treatment.

D4R asserts that all children in IDCs have been and continue to be abused through the failure of the Australian government to provide an appropriate, safe and supportive environment for them to reside. Similarly they continue to experience the emotional abuse of activities inherent to the infrastructure and functioning of the IDCs, that restrict their movements, denigrate, intimidate and discriminate [20].

Guardians for unaccompanied children have the 'primary responsibility for the upbringing and development of the child'[17]. It is pertinent to note that the Minister for Immigration and Border Protection as the legal guardian of 'non-citizen' unaccompanied minors is the perpetrator of the abuse and neglect of these children.

Recommendations:

- An independent legal guardian for non-citizen unaccompanied children be appointed
- All children treated with dignity and care.
- All children given the right to healthy development: physical, mental and spiritual wellbeing, education, cultural expression, protection from violence and a safe, nurturing home.
- All children given the opportunity to recover from past trauma

4.2. Inadequate healthcare provision: systemic failure to meet basic obligations, delays and abject disregard for medical standards.

D4R requests medical records from IHMS in accordance with FOI [4]. Frequently these requests are not answered and consequently, D4R has made 50 complaints to OAIC since June 30 2016, of which 3 cases involve children. The longest waiting

time for medical records has been 300 days (10 months) and two other records at 270 days (9 months), all requiring multiple correspondences between D4R and IHMS.

The OAIC recommends that acknowledgement of receipt of a request for medical records should occur within 14 days, while total processing time should not exceed 30 days [4]. In recent weeks, the DIBP has denied multiple requests for notes because of their concerns that signatures on consent forms did not match those on their records - it has taken 70 days (10 weeks) for DIBP to review these signatures and inform D4R of their concerns.

One of the paediatric cases where D4R has not received the clinical file 135 days since the OAIC complaint was made, involves a child with an infectious disease (*Schistosoma Japonica*) which D4R was informed was inadequately treated. The infectious disease poses both a serious risk to the child's growth and the public safety of all those in close contact on Nauru. IHMS has been informed of this and has still not released the medical file.

Recommendation:

- In accordance with the Medical Board of Australia's Code of Conduct (MBACC) 8.4.7: Promptly facilitate the transfer of health information when requested by a patient.[2]
- In accordance with OAIC: Process and provide medical records within 30 days. (More promptly if the case is an urgent or serious threat to the individual, or public's safety).

Following review of medical files, D4R sends medical recommendations to IHMS for cases where investigations, referral and treatment are lacking. It is frequent that these recommendations are ignored.

*(Name redacted) is a **child** with suspicious lymphadenopathy in the neck. Basic investigations suggested extra-pulmonary tuberculosis (TB). Clinical Professor in Paediatric Infectious diseases, recommended transfer to Australia for further specialist investigation. In particular, review of alternative diagnoses such as lympho-proliferative disease, Syphilis, or Yaws. The **child** was not transferred. It should be noted that Syphilis is a sexually transmitted disease and suspicion of such a diagnosis in a child needs urgent attention. It is also pertinent to note that children would not be exposed to the tropical bacteria causing Yaws were they in Australia and not detained on Nauru.*

*Three years ago, a **child** on Nauru was assessed by an IHMS psychiatrist who was concerned about possible "significant developmental delay" with impaired speech and fine motor skills. His parents requested assistance from D4R and this year his medical notes were reviewed by Child and Adolescent psychiatrist Dr . He stated that (name redacted) has "a complex history of global developmental delay and more recently regression*

*in speech and language skills.” D4R strongly recommended immediate transfer of the child to Australia for specialist services. To date, the **child** has not received specialist paediatric developmental assessment or treatment.*

Acknowledging the limitations of access to comprehensive primary care and medical specialists on Nauru, D4R provides volunteer mainland general practitioners and specialists who review the medical records and give medical advice. D4R frequently does not receive a response from IHMS to this correspondence, nor updates on the progression of the patient’s clinical condition without frequent requests, if at all. Intuitively it seems economical for IHMS to utilise the insights of these volunteer and specialist health professionals.

Recommendation:

- D4R recommends IHMS comply with MBACC with particular respect to items:
 - 2.2.6 Providing treatment options based on the best available information;
 - 2.2.8 Supporting the patient’s right to seek a second opinion;
 - 2.2.9 Consulting and taking advice from colleagues when appropriate;
 - 2.2.10 Making responsible and effective use of the resources available [2]

The following are three paediatric cases that highlight significant departures from accepted professional standards and where IHMS does not meet their professional code of conduct. This includes failing to:

- 2.1.2. Formulate and implement a suitable management plan
- 2.1.3 Facilitate coordination and continuity of care
- 2.1.4 Refer a patient to another practitioner when this is in the patient’s best interests
- 2.2.6 Provide treatment options based on the best available information (both evidence and treatment guidelines appear to have been ignored in this case)
- 2.4.4 Give priority to investigating and treating the patient on the basis of clinical need and effectiveness of the proposed investigations or treatment [2]

*(Name redacted) is a **child** living on Nauru. She was seen six times by doctors for right maxillary sinus pain and examined under full sedation by a dentist three times between March and April 2016. The dentist documented in April 2016 a possible diagnosis of “?maxillary sinusitis.” She has taken six courses of prescribed antibiotics and requires daily analgesia. A facial Xray was done in May 2016, which a RONG medical officer documented as normal but D4R has not been provided the formal written report (despite requests). It should be noted that sinus Xrays are rarely helpful and computed tomography scans (CTs) of the sinuses are indicated for patients failing medical therapy, or those with atypical disease such as unilateral symptoms [21]. Despite*

persistent, debilitating symptoms she has not received assessment by an ENT surgeon, nor a CT of her sinuses. D4R has corresponded with IHMS on many occasions regarding this child. IHMS insists that the diagnosis is dental abscess despite no response to multiple antibiotics and documentation by doctors in her medical record of:

“right maxillary pain and swelling,”

“swelling in right maxillary area,”

“tenderness right frontal area,”

“Ax: maxillary sinusitis” (the diagnosis by doctors on 3 separate attendances)

(Name redacted) is a child who has been in detention with his family since 2013. His childcare in had concerns with hyperactivity disorder. In October 2015 IHMS psychologist on Nauru described a “very energetically charged child with odd posture and gait, poor eye contact and lacking functional impulse control.” He recommended formal developmental assessment for Autism Spectrum disorder. In February 2016 another IHMS psychologist recommended psychiatry referral for persistently poor social skills. Once again in April 2016 a third IHMS psychologist recommended developmental assessment by a child psychologist with a special interest in psychometric testing. There is no evidence in his case file of these recommended referrals occurring and no developmental assessment has been done.

(Name redacted) is a child on Nauru who sustained fractures in both forearm bones on the left side, his dominant hand, in May 2015. After reviewing his X-rays, D4R recommended orthopaedic surgical assessment and open reduction with internal fixation (ORIF). The recommendation was dismissed by IHMS. After X-ray images appeared in the Australian media, ORIF was arranged. Notably this involved flying an Australian orthopaedic team to Nauru, at great expense, to perform surgery in June 2015, a delay of one month following the original injury.

In November 2015, a medical officer at the RONH noted that “patient was not seen and evaluated by physiotherapist!!! No physiotherapy was done since my referral last August.” 12 months later, (Name redacted) experiences severe arm pain and impaired function of his dominant hand. (Name redacted)’s mother informed D4R that an orthopaedic surgeon was flown from Australia one month ago but the “surgery room was not ready for operation.”

Recommendations:

- All children with chronic medical conditions including mental illness, developmental disorders, intractable illness or pain receive early paediatric assessment. This presumably means transfer to Australia to access specialist paediatric, multi-disciplinary services.
- All individuals who fail to respond to initial treatment receive review of alternative diagnoses and prompt correspondence for second opinion.

As a result of the lack of transparency from DIBP and IHMS, it is often unclear why medical recommendations are ignored or denied, but presumably clinical decisions are intercepted and obstructed by other authorities. The following are two examples of patients who did not receive treatment for serious medical conditions despite appropriate medical recommendations from IHMS.

*(Name redacted) is **an adult** who has suffered Post Traumatic Stress Disorder (PTSD) following the riots at Manus Island RPC in February 2014. He was physically assaulted and witnessed the murder of Reza Barati. (Name redacted) developed nocturnal enuresis attributed to PTSD despite no investigation into organic causes conducted.*

In November 2015, the attending IHMS general practitioner documented a plan to “arrange a Urology teleconference to ensure there are no further investigations required from a clinical POV..” An external referral for Urology review was completed on the 5th of December 2015. According to his clinical record, he has not received further specialist assessment despite recommendations by IHMS doctors.

*(Name redacted) is **an adult** in Papua New Guinea with chronic back pain. MRI in 2015 showed a significant abnormality and a neurosurgeon recommended surgical treatment. On the 22nd of February 2015, a Melbourne neurosurgeon wrote “I have discussed (name redacted)’s situation with my senior Neurosurgery colleagues at Hospital in Melbourne, as well as senior administration. We concur and are happy to provide the requisite high level care needed by (name redacted) given his medical and surgical circumstance.” D4R has been advised that he did not receive surgery.*

D4R requested his medical file in June 2016 that was rejected by DIBP for missing a signature on a portion of the form unrelated to his consent. Legal advice to D4R is that the initial consent form was adequate under FOI. A further consent form was sent in August and in November, 5 months after the

original request his records were received. These records however only document to December 2015.

Recommendations:

- Clinical decisions including referrals to specialist services not available in Nauru or Manus Island be autonomous and not subject to approval by non-clinical decision-makers.
- The IHMS Senior Medical Officer or Medical Director should maintain responsibility for ensuring that individuals in the care of IDCs with complex medical conditions receive best possible medical care. This includes adherence to MBACC items:
 - 5.2.2 Upholding the patient's right to gain access to the necessary level of healthcare and, whenever possible, helping them to do so.
 - 5.2.3 Supporting the transparent and equitable allocation of healthcare resources.
 - 5.3 Ensuring expertise and influence is used to protect and advance the health and wellbeing of individual patients
 - 6.2.4 Ensuring that systems are in place for raising concerns about risks to patients
 - 6.2.6 Taking all reasonable steps to address risk if there is a possibility patient safety may be compromised. [2]

In particular, if the Senior Medical Officer or Medical Director is aware a patient is unable to access necessary medical care due to decisions made by DIBP or other stakeholders, it is within their responsibility to ensure this is reported, escalated and actions taken to mitigate risks to the patient.

b. How notifications of abuse and self-harm are investigated

The information D4R receives from individuals on Nauru and Manus suggests a reluctance to report abuse for fear of retaliation, negative implications for their asylum claims and further victimisation. It is understood that prior to release of individuals into the Nauru and Papua New Guinea community, reports of abuse were directed to the security contractors (eg. Wilsons, Serco security). There is a self-evident conflict of interest if the accused is a Wilsons employee, or an Australian government representative.

Because of the lack of independent reporting procedures, notifications of abuse and self-harm presumably under-represent the real numbers.

The murder of Reza Barati during the riots on Manus Island in February 2015 illustrated the legitimate danger refugees and asylum seekers face in protesting their detention.

D4R is not aware of formal processes for notification of self-harm within IDCs, nor on Nauru or Manus. Notifications and liaison with external agencies should be documented within the medical record, as would be protocol for health workers in Australia. D4R has not seen this consistently occur.

D4R is aware of multiple refugees and asylum seekers who report abuse by employees of IDCs. The following are three examples of individuals who reported abuse by IDC workers to D4R. D4R has not been able to access the file for the final example of a young adult who self-immolated despite multiple requests and complaint under FOI.

(Name redacted) is an adult currently living in the Nauru. In 2015, she was hospitalised in mainland Australia with depression and suicide attempts during pregnancy. Five months post-natal, she advised D4R that she was forcibly returned to Nauru. (Name redacted)'s account of the transfer is summarised as follows:

Woke at 6am handcuffed in bed and officers in the room. She was wearing undergarments and officers would not allow her to put on her clothes prior to driving to the airport. Officers took video footage of her during the drive. Dragged onto the plane sustaining scratches on elbows, knees and back of neck. Photographs demonstrate an abrasion on one knee, bruising above the right elbow and three large bruises on the upper back. She was not permitted to breastfeed her son between 6am to 5pm. Her husband was transferred in a different vehicle.

In March 2015, a young child (name redacted) was hit by a rock allegedly thrown by a Wilsons security guard resulting in a cracked tooth. Attending primary health nurse writes "Parents of child stated they feared for their safety and asked to stay at OPC1. Family was placed in SAA overnight." A psychiatrist notes "he has nightmares, nocturnal enuresis and is not his usual self after his tooth was broken by a stone thrown by a guard"

(Name redacted) was an unaccompanied minor when she first arrived in Australia. It was noted in Brisbane transit centre that she was depressed and suicidal. D4R was told that she was on "high security check" (monitored 24-hours by a guard for suicide risk). Allegedly she was transferred from Brisbane to Nauru against her will and witnesses have reported to D4R that she was dragged across the courtyard of the detention facility screaming in protest. Shortly after returning to Nauru she self-immolated.

In addition, D4R is aware of claims sexual assault and abuse of children, where entrusted persons including healthcare workers are informed but do not escalate investigation.

*In the clinical record of a young female living in Nauru on the 20th of December 2013 she is quoted as saying "I don't feel safe here, somebody was raped here..."
"...the adults and children are doing bad things in the toilet block."*

The mental health nurse taking the history notes action: "encouraged client to report safety concerns to Serco." There is no evidence in the clinical file that the health worker escalated own investigation into claims of sexual assault, including possible child abuse.

It should be noted that under Australian State legislations, failure to report a 'reasonable belief' of child sexual abuse to the police is a criminal offence.

Recommendations:

- All employees and contractors for the Australian Government are entrusted persons and should be subject to child protection laws. Independent investigation by child protection authorities and / or the police must occur in all cases of suspected child abuse.
- Failure of Australian healthcare workers and other entrusted persons to comply with mandatory reporting requirements warrants police investigation.
- An independent and transparent procedure for reporting and investigating abuse, neglect, self-harm and criminal conduct in detention centres including the RPCs of Nauru and Manus island, and ongoing events or threats from those living in the Nauru and Papua New Guinea community.

In addition, all Australians deemed at risk of harming themselves or others are subject to State-based governance regarding the involuntary detention, or hospital admission for treatment of mental illness. It is understood that individuals deemed at high risk of self-harm in offshore RPCs are frequently placed under 24-hour watch by security guards rather than admitted to a medical facility. The involuntary nature of this form of 'treatment' is secondary to their involuntary detention by DIBP. The MHA explicitly outlines that individuals should receive effective care with the least restriction of their liberty, interference with their rights, dignity and self-respect [22]. Australians have the right to appeal decisions made under the MHA and seek representation from an independent lawyer, psychiatrist and liaison, or advocacy organisations to ensure their autonomy is protected. Asylum seekers in offshore detention have historically been unable to access legal counsel and are presented with a coercive consent form by IHMS upon arrival. The IHMS "Consent relating to your medical record" form states: *"You do not have to provide consent for any aspect of your health care, however it may limit the Commonwealth of Australia's ability to fully consider your health status when determining placement options and the progression of your immigration outcome."*

There is no appreciable reason why individuals in immigration detention are not afforded the same human rights and protections as Australians that include the right to

make an informed decision about their medical treatment and seek independent advice when needed.

Recommendation:

- Compliance with Australian MHA with regards to the involuntary detention and treatment of persons with mental illness.

c. The obligations of the Commonwealth Government and contractors relating to the treatment of asylum seekers including the provision of support, capability and capacity building to local Nauruan authorities.

Unfortunately, the Australian government and IHMS are not forthcoming with information regarding the conditions, or services available at the RONH.

D4R is frequently advised by IHMS that individuals are receiving appropriate treatment when this is not the case. In addition, IHMS has advised D4R that individuals treated at the RONH or Pacific International Hospital (Port Moresby) frequently return from admissions, or treatment at these facilities without paperwork provided to IHMS. D4R confirms that written documentation of hospital admissions or treatment is typically absent from the medical records released by IHMS. IHMS consequently has little knowledge of what transpired and what conditions require ongoing management. Inarguably this practice is dangerous.

With regards to Nauru health services, it is understood it is limited by the availability of comprehensive primary care and medical specialists. We understand there are no paediatric sub-specialists such as paediatric psychiatrists, allied health services including Nauruan psychologists, speech pathologists, or physiotherapists. Given that individuals leaving Nauru RPC to live in the Nauru community are now a uniquely afflicted group as a consequence of their prolonged detention, it is imprudent to expect the Nauru health service to meet their complex needs.

Nauruan people themselves do not have access to Australian quality primary or specialist care. Improving capacity for Nauru is a worthy endeavour, however asylum seekers and refugees should not be a commodity in this transaction.

d. The provision of support services for asylum seekers who have been alleged or been found to have been subject to abuse, neglect or self-harm in the Centres or within the community while residing in Nauru.

Once again, processes for the treatment of asylum seekers and provision of support services to those who have been abused, neglected or self-harmed are not transparent. D4R has been notified by individuals of multiple incidences of alleged abuse of asylum seekers and refugees now residing in Nauru.

The following are excerpts from a summary provided by a D4R volunteer medical specialist regarding the assault, then psychiatric and behavioural decline of **an adult** living in the Nauru community:

(Name redacted) was assaulted returning from work on the 5th of March 2016. Struck over the back of the head with 'something sharp' (possibly a machete)...Assaulted again the following day at home by the same assailants. Soon after this event he began experiencing regular headaches... developed hallucinations...mood/personality disturbance... Commenced on high doses of antipsychotic and anti-depressant medications with minimal improvement. Transfer to Australia recommended for ECT (electroconvulsive therapy).

Under the Work Health and Safety Act 2011 (WHS Act), the Commonwealth has a primary duty of care to ensure the health and safety of both workers and 'other persons' at all Commonwealth workplaces including overseas RPCs. 'Other persons' encompasses residents, visitors and any individuals on site, and therefore includes detained individuals [22]. D4R asserts that the Commonwealth has not fulfilled its duty of care to ensure the health of asylum seekers is maintained and in fact utilises offshore centres that exploit the inherent hazards of remoteness, environmental exposure to heat, organic substances, tropical disease and psychosocial deprivation. As the compliance authority, Comcare is responsible for conducting investigation into whether the Commonwealth and its contractors have aligned with WHS legislation and has failed to do so.

e. The role an independent children's advocate could play in ensuring the rights and interests of unaccompanied minors are protected.

It is to be noted that D4R recommends the immediate release of all children from immigration detention in Australia and offshore.

The Australian Human Rights Commission has raised concerns about the Immigration Minister's conflict of interest between administering the mandatory detention regime, granting visas and transferring children to Nauru with his legal guardianship of unaccompanied minors [23]. It is undeniable that the best interests of the child are not of primary consideration. There have been repeated recommendations for an independent guardian, which have been consistently ignored [18].

In Australia, child protection is governed by State legislation and where a child is known to be in an abusive environment, healthcare workers are legally required to report so that nominated child-centred agencies are mobilised to ensure the child's wellbeing. However, the welfare of children in detention is not systematically monitored and safety mechanisms cannot be activated from detention centres that are under federal jurisdiction [24].

Furthermore, both Australia and Nauru have failed to ratify their obligations under the Optional Protocol to the Convention against Torture to provide a National Preventive Mechanism (NPM) as an independent monitoring body for conditions in the Nauru RPC. An NPM would lessen the likelihood that particularly vulnerable groups such as children, disabled persons and those with mental illness experience ill-treatment [25].

An audit of ‘all allegations of sexual abuse, child abuse and other criminal conduct’ reported to the Australian Human Rights Commission, the Moss Review and the Select Committee on conditions and circumstances of Australia’s RPC in Nauru has been recommended. However, the Australian Government responded that ‘alleged criminal conduct in Nauru is a matter for Nauruan authorities’[15]. This disregards that the majority of incidences of self-harm, abuse and neglect occurred within the closed Nauru RPC overseen by (sometimes perpetrated by) the Australian government and its contractors.

Recommendations:

- Institution of an independent legal guardian for all unaccompanied minors
- Institution of an independent children’s advocate

f. The effect of Part 6 of the Australian Border Force Act 2015

D4R is aware of many general practitioners and medical specialists who feel threatened by Part 6 of the ABFA 2015 and subsequently are unwilling to document their experiences in detention centres. We are also aware that many of our consulting doctors and specialists who provide their medical advice on cases are unwilling to disclose their names because of the tangential risk of prosecution by association with the detention centres and the ABFA.

Despite the recent amendment to the ABFA to exclude health professionals from prosecution, all other professionals and contractors including teachers, social workers and administrators remain at risk. Similarly, those health professionals who spoke out prior to the date of the amendment remain in a precarious position.

D4R continues the High Court challenge against the ABFA to enable people to speak about concerns for the wellbeing of refugees and asylum seekers on Nauru and Manus without intimidation.

Recommendation:

- Amendment to enable all people to speak freely and without threat or intimidation about the conditions and situation in IDCs as long as it does not compromise confidentiality and privacy of the individual.
- Retrospective inclusion within the amendment to ensure those who have previously spoken out are exempt from prosecution.

Conclusion

The Australian government's Immigration policy denies individuals their fundamental human rights to seek asylum and to enjoy liberty, safety and respect. There is intent to deter others from coming by boat through the harsh treatment of those who remain on Nauru and Manus.

Deprivation, despair and loss of hope are the recurring themes in the requests D4R receives from those in detention.

D4R asserts that individuals categorically have not received adequate healthcare in offshore detention and continue to receive substandard care. The wall of secrecy and obstruction from IHMS and DIBP represents obscene negligence and a wilful denial of humane, economic and practical alternatives.

REFERENCES

1. *Immigration Detention and Community Statistics Summary*. 2016 30th October 2016]; Available from:
<http://www.border.gov.au/ReportsandPublications/Documents/statistics/immigration-detention-statistics-31-aug-2016.pdf>
2. *Good Medical Practice: A Code of Conduct for Doctors in Australia*. 2014, Medical Board of Australia: Australia.
3. AHPRA, *Guidelines for Mandatory Notifications*, in *National Board guidelines for registered health practitioners*, A.H.P.R. Agency, Editor. 2014.
4. Comissioner, O.o.t.A.I., *APP Guidelines*. , A. Government, Editor. 2014.
5. *Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, U. Nations, Editor. 2011: Geneva.
6. Steel Z., S.D., *The mental health implications of detaining asylum seekers*. Med J Aust, 2001. **175**: p. 596-599.
7. Bronstein I., M.P., *Psychological distress in refugee children: a systematic review*. Clinical Child and Family Psychology Review, 2009. **14**(1): p. 44-56.
8. Mares S., N.L., Dudley M., Gale F., *Seeking refuge, losing hope: parents and children in immigration detention*. Australas. Psychiatry, 2002. **10**: p. 91-96.
9. Silove D., S.Z., Watters C., *Policies of deterrence and the mental health of asylum seekers*. JAMA, 2000. **284**: p. 604-611.
10. Mares, S., *The mental health of children and parents detained on Christmas Island: Secondary analysis of an Australia Human Rights Commission Data Set*. Health and Human Rights Journal, 2015(Papers in Press).
11. Gordon M., M.G., *Risk assessment and initial management of suicidal adolescents*. Australian Family Physician, 2014. **43**(6): p. 367-372.
12. GPMHSC, *Suicide prevention and first aid*, in *The General Practice Mental Health Standards Collaboration*, RACGP, Editor.
13. *Report of the Consultation of Child Abuse Prevention 29-31 March 1999*, W.H. Organization, Editor. 1999, WHO Geneva: Geneva.
14. P., M., *Review into recent allegations relating to conditions and circumstances at the Regional Processing Centre in Nauru*. 2015.
15. *Response to the report of the Select Committee on Recent Allegations relating to Conditions and Circumstances at the Regional Processing Centre in Nauru: Taking responsibility: Conditions and circumstancces at Australia's Regional Processing Centre in Nauru.*, A. Government, Editor. 2015.
16. D., S., *The psychosocial effects of torture, mass human rights violations and refugee trauma: toward an integrated conceptual framework*. . J Nery Ment Dis, 1999. **187**: p. 200-207.
17. *Convention on the Rights of the Child*. 1989.

18. *The Forgotten Children: National Inquiry into Children in Immigration Detention*, A.H.R. Commission, Editor. 2014.
19. Isaacson, G.C., *Ankyloglossia (tongue-tie) in infants and children*. UpToDate, 2016.
20. WHO, *Child abuse and neglect by parents and other caregivers*, in *The Global Campaign for Violence Prevention*, W.H. Organisation, Editor. 2014.
21. *Therapeutic Guidelines: Respiratory (eTG July 2016 Edition)*, ed. T. Guidelines. 2016, State of Victoria: Therapeutic Guidelines Limited.
22. *Mental Health Act 2007 - NSW Legislation*, in No. 8. 2007, <http://www.legislation.nsw.gov.au/-/view/act/2007/8/chap3>: Australia.
23. *Information about children in immigration detention*. 2016; Available from: <https://www.humanrights.gov.au/information-about-children-immigration-detention>.
24. Zwi KJ., H.B., Dossetor D., Field J., *A child in detention: dilemmas faced by health professionals*. MJA, 2003. **179**.
25. *UN torture prevention body urges Nauru to set up detention monitoring mechanism*, U.N.H.R.O.o.t.H. Commissioner, Editor. 2015, OHCHR.