Letter of Concern

International Health and Medical Services

For review by

International Health and Medical Services Management and Executive

Summary

This letter is our response to a request by the Medical Director of the health service provided by International Health and Management Services (IHMS) at Christmas Island Immigration Detention Centres (CI IDC). The Medical Director requested that we outline our concerns regarding the standard of medical care and practices at CI IDC.

These concerns include the numerous unsafe practices and gross departures from generally accepted, medical standards which have posed significant risk to patients and caused considerable harm.

This letter is based on accounts of Australian medical practitioners employed by IHMS to provide primary care to the people detained at the CI IDC. It is supported by evidence wherever possible, consisting of documentation and case reports.

The concerns outlined in this letter include:

The **Health Induction Assessment (HIA)** process is performed in a way that neglects patient care and dignity. The condition of patients casts doubt on their capacity for informed consent. During HIAs, medical aids and essential medical information critical to care are removed, resulting in negative consequences for patients. Assessments are not fit for purpose and are rushed due to unnecessary time pressures. This results in medical problems not being detected.

Rapid processing has resulted in the abandonment of previously established standards to ensure unsuitable patients were not transferred to medically risky offshore facilities. Patients are now being cleared on the basis of an ineffective assessment and without pathology.

Inappropriate reallocation of doctors away from clinics to perform more of these clinically unreliable assessments results in the deterioration of chronic disease and delayed treatment of acute illness.

Patients requiring urgent transfer to the mainland are languishing in the centre resulting in unnecessary suffering and further deterioration.

Management interfere with doctor's clinical autonomy in referring these patients. Gross inefficiencies in this process include extended periods in which no patients are transferred and cases of patients returned following transfer without receiving definitive care.

With poor standards of paediatric care, children with chronic illnesses are ineffectively managed and deteriorate during long waits for transfer. The absence of any comprehensive child health program or access to paediatric specialists jeopardises child safety

Antenatal care is performed far below any accepted Australian standard and places pregnant women and their children at unnecessary risk of harm.

Chronic diseases are monitored and treated in an ineffective and poorly executed manner.

People with disabilities are not safely managed within the CI IDC facilities and despite this are not transferred in a timely manner to a place of appropriate care.

Acute care, especially emergent care is limited and medico-legally fraught due to the lack of insurance cover despite the medical officer having an established duty of care.

Preventative measures for common infectious diseases are insufficient.

Facilities are not fit for purpose and **medical supplies are poorly managed** with frequent shortages impacting on clinical care. The dispensation and prescription of medications are performed in an unsafe and substandard manner.

An **ineffective electronic health system** with multiple errors, each of which constitutes a significant risk to patient safety. The processes are not intuitive and present a prohibitive administrative burden.

Clinical risk management is lacking in response to frequent, systematic deficiencies.

A **conflict of interest** exists, as a result of IHMS' relationship with the Department of Immigration and Border Protection that can influence decisions regarding patient care. Decisions made by IHMS do not appear to have always been made in the best interest of patients.

The **shifting of responsibility** between the DIBP and IHMS is likely to result in neither party acting appropriately in regards to patients.

As a result of the above issues, people in CI IDC are unnecessarily put at risk of harm.

IHMS has been contracted to deliver primary healthcare broadly comparable to an Australian standard. However, the above list of issues demonstrates that IHMS is not maintaining standards and is likely compromised by its relationship with the DIBP, resulting in adverse outcomes for patients.

Even when mitigating factors, such as the remote location and the practical limitations imposed by the DIBP, are considered, many aspects of the IHMS health service fall well below accepted standards for clinical practice and are unnecessarily dangerous.

The majority of the concerns detailed have been expressed repeatedly, in some cases over a period of years, to IHMS management with poor responses that have allowed unsafe practices to continue.

As medical practitioners, we have mandatory reporting obligations when faced with a reasonable belief that departure from accepted professional standards is placing the public at risk.

We ask that that IHMS provide the undersigned with a detailed response to the various concerns expressed in this document within 7 days, (as noted in section 3.4.3).

We ask this due to concerns that practicing under the current circumstances is unsafe, unethical, poses a risk to our medical registrations and may require mandatory reporting.

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1.0 Processes and Systems

1.1 Health Induction Assessments

1.1.1 Introduction

Health Induction Assessments (HIA) are conducted to determine whether a person is sufficiently medically stable to be placed in an immigration detention centre[1]. They are performed as part of a broader 'induction' process coordinated by the Department of Immigration and Border Protection (DIBP, formally DIAC). The 'induction' process lasts approximately eight hours[T].

The process includes:

- consent to medical treatment
- public health questionnaire
- nursing observations
- health assessment (performed by medical practitioners)
- mental state examination (performed by nursing staff)
- phlebotomy
- chest x-ray.

A number of other processes unrelated to healthcare are also performed by non-IHMS staff [T].

There are several issues surrounding the conduct of HIA at Christmas Island (CI).

1.1.2 Poor condition of patients

The condition of people arriving at CI often complicates the HIA process. Most new arrivals arrived at CI by boat – a journey which usually takes between 3 – 5 days, with some people at sea for several weeks [T,2].

Most have been subject to the following conditions:

- cramped and exposed conditions
- periods of limited or no food and water intake
- motion sickness
- sleep deprivation
- severe sunburn
- poor hygiene due to a lack of washing facilities
- clothing soiled with urine and faeces due to a lack of toilets.
- skin infection colloquially known as "Boat Rash" (see appendix 1).

T,2

1.1.2.1 Patient dignity compromised

Medical staff have frequently noted that allowing new arrivals to remain in this state, in addition to putting them through an induction process lasting in excess of eight hours is an affront to human dignity 2,T,I1,I2.

Article 10 of the *International Covenant on Political and Human Rights* states

> "All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."

3

The arrivals frequently express their embarrassment at their state. They apologise for the smell and filth they are covered in. Despite the heat, women especially often cover up and swelter even when medical staff indicate that by doing so they will have increased perspiration and further compound any existing dehydration T.

1.1.2.2 Essential Care Neglected

There has been an ongoing push by medical staff to provide arrivals with access to showers, food, drink and a change of clothing before processing I1, I2. There have even been issues with no access to baby formula I2.

The Federal Government's Australian Human Rights Commission (AHRC) outlines the standard for 'Meeting immediate basic needs' in *Human Rights Standards for Immigration Detention 2013* (section 8.6):

> "Detainees are offered a shower and clean clothing if necessary, food and drink, and a hygiene pack containing essential items (eg. Toothbrush), if necessary."

This standard is derived from The International Covenant on Civil and Political Rights (ICCPR) section 10 and the International Covenant on Economic, Social and Cultural Rights sections 11 and 12 [4,5,6].

1.1.2.3 Inadequate response to the neglect of basic needs

This concern has been recognised by management on CI. Management have advised medical staff that their concerns were raised with Department of Immigration and Border Protection (DIBP, formerly DIAC)[I1,I2,I3,T]. Despite this, every person to arrive on CI has continued to undergo this process with at least some aspect of their essential care neglected[T,I1,I2,I3].

1.1.2.4 Capacity for consent to medical treatment

Arrivals usually experience sleep deprivation, and in some cases a complete lack of sleep, during their journeys [T,I1,I2,I3,2]. This raises the issue of fatigue and if the new arrivals have the capacity for consent. Consent is acquired en masse through translation in documents written in English which the asylum seekers most often cannot read [T].

1.1.3 Loss of medicines, medical aids and medical documents

During processing, new arrivals are separated from their belongings, including essential medical documents, medications and medical aids before seeing a doctor [T].

1.1.3.1 Patient medications not easily accessible by doctors

If an asylum seeker states they take medications (note – they frequently neglect to mention they do even on direct questioning), it can be a time-consuming and often unsuccessful exercise to find the medications and any medical documentation. This includes antenatal ultrasound scans, test results, health summaries and specialist letters[T].

The fact that it is possible to get medications and medical documentation from customs as they process the arrivals belongings is only discovered if the individual medical officer has the initiative to attempt it in the first place [T].

1.1.3.2 Destroyed medications not documented

There is no attempt to document the medications being destroyed; the process is as crude as two nurses sitting popping pills out of blister packaging into a large bin [T]. Without documentation, it becomes very difficult to determine what medications a patient has been prescribed in the past and can have significant impacts on the safety of their management plans.

1.1.3.3 Destroyed essential medications not available on island

Another difficulty faced is that some of the destroyed medications are not stocked by IHMS. This means that some new arrivals go without medication until it can be sourced, which can be weeks [T,C1,C4].

1.1.3.4 Loss of essential medical documents

The same fate is held for medical records, imaging and specialist letters which a new arrival may have brought with them. Attempts to retrieve these documents after the induction process are usually unsuccessful [T].

1.1.3.5 Loss of medical aides

Spectacles and hearing aids are also confiscated. They are very difficult to recover without significant efforts from medical staff. A single replacement

hearing aide has not been seen by any undersigned doctor working for IHMS [T,C2,C3].

1.1.3.6 Failure to address issues of lost and destroyed items

Medical staff have repeatedly raised their concerns with management on CI to address these serious problems, including trying to find a way to keep medications and medical paperwork with individuals until they see a doctor during induction. There have been repeated complaints about medications being destroyed. In some instances, destruction of medications has begun before health inductions have finished [T,I1,I2,I3]

It has been suggested by medical staff that arrivals should be given an opportunity to retrieve their medical aides, spectacles, hearing aides and prosthetic limbs from confiscated baggage, during the induction process. This suggestion has not been adopted or been effectively communicated [T,I2].

1.1.4 Integrity of health induction assessments

1.1.4.1 Impact of poor condition on HIA integrity

Clinical measurements reflect the poor condition of patients through tachycardia, hypotension and fevers. These abnormal readings cannot provide an accurate baseline, so further obfuscate obtaining a representative assessment of any individual [T].

The impact of deconditioning on their mental state is also likely to impact on their ability and willingness to participate in full history taking during health and mental state assessments and confound any information gathered.

1.1.4..2 Impact on missing medication data and medical documentation on HIA integrity

This process results in a loss of medical information vital to the safe and effective provision of medical care. This is a serious patient safety issue which can result in essential medications being ceased and inappropriate or

unsafe management plans being put in place in the absence of a complete medical history [T,C1].

1.1.4.3Impact of time pressure and working hours on HIA integrity

HIAs are carried out in a time-pressured environment. Following discussion at a meeting, medical officers agreed that at least 20 minutes was required with the patient to perform an adequate assessment, if there are no findings [T].

However, large numbers of patients are processed daily. Some doctors are required to perform up to 90 assessments in a single eight-hour shift (~5 min each). Time pressures are compounded by the need for translators and for relevant data to be entered into the health information system. Time pressures and unsafe working hours can also impact on the quality and safety of assessments made by fatigued medical practitioners [T,I2,I3,].

The impact of time pressures on HIAs is further explored in the section "Rapid processing".

1.1.4.4 HIA Standards

HIAs, including the Form 26, are usually completed in accordance with *Instructions for medical and radiological examination of Australia visa applicants* [7]

1.1.4..5 HIAs do not meet Panel Doctor standards

As per the *Instructions for medical and radiological examination of Australia visa applicants,* issued by the Department of Immigration and Citizenship, Health Policy Section, Canberra, Australia, March 2009, the following procedures are required, but are not performed at HIAs on Christmas Island [T,7].

- Dipstick urinanalysis for persons 5 and older (and for under 5 if indicated). If the urine dipstick indicates then for further urinalysis including serum creatinine and glucose [7].

- In the event that a cardiac condition that is unstable or progressive, symptomatic, complicated or likely to impact the applicant's they need to be referred to a cardiologist or appropriate. The cardiologist's assessment should address history, diagnosis, clinical examination findings, treatment needs and expected prognosis. The report should be attached to form 26 for submission [7].
- In the event that neurological conditions or symptoms are elicited they should be refer to a neurologist for assessment to complete the HIA [7].
- Breast examination should be offered to all women over the age of 40[7].
- Under endocrine examination if any of the following are found a thyroid function test must be performed
    - dipstick proteinuria
    - reduced visual acuity
    - hypertension
    - angina pectoris
    - peripheral sensory loss and foot ulcers
    - vascular bruits
    - weak peripheral pulses
    - focal neurological signs.

[7]

Pending results, the patient may require an endocrinologist to complete the HIA documentation.

- If there is a hearing impairment, the communication skills that are used by the applicant need to be assessed, that is, lip-reading, signing, reading or writing. All hearing impaired applicants require formal audiological assessment, as well as a report from a specialist that details their abilities and special needs, for example, speech therapy, hearing-aids and surgery. If the applicant has a cochlear implant, it should be documented whether age-appropriate

pneumococcal and meningococcal vaccinations have been administered and the dates of administration recorded. [7]

[7]

1.1.5 HIAs during periods of increased boat arrivals

1.1.5.1 Cancellation of clinics

In periods of frequent boat arrivals medical officers are usually shifted from clinics to perform HIAs. This means clinics are without doctors and for 'emergencies only' [T,I4].

Patients have been confined without access to any alternate health service. They are denied access to appropriate health care during these periods [T].

1.1.5.2 Delay in medical treatment

The reallocation of doctors is unsafe, as experienced in July-August 2013 when clinics were stripped to skeleton staff for weeks on end [T,I4.] This resulted in the deterioration of patients with chronic illness and the late treatment of acute presentations. One doctor described entering Lilac camp to be surrounded by patients begging for treatment. The crowd included pregnant women and mothers with unwell children [T].

1.1.5.3 Delay in specialist referral and mainland transfer

As a consequence, when the backlog of patients in clinics is finally attended to, many patients requiring urgent transfer for specialist assessment are identified that should have been referred much earlier.

1.1.5.4 Unhealthy and unsafe working conditions

During these periods, excessive pressure has been placed on medical staff to perform unreasonable overtime and work unhealthy and unsafe hours. Management have stated at formal meetings that neither the DIBP nor IHMS are willing to fund any additional staff, even when existing services have been overwhelmed to the detriment of patient care [I2].

1.1.6 Error prone nature of compromised HIAs

HIAs as performed currently have a poor record of successfully detecting pathology. This is noted when patients with no finding through their HIAs are seen in clinics later with significant pathology that was present at the time of induction. One example includes a man with a dislocated paralysed atrophied left arm, which was not identified during HIA [13,T]

1.1.7 Summary of the HIA process

The process is clinically unreliable and creates the loss of important and often irretrievable health information. It results in the loss of essential medical aids and destruction of essential medications. These outcomes endanger the health of patients.

HIAs, as carried out by IHMS, are not fit for purpose and unreliable. They cannot and should not be relied upon for any reasonable assessment of a person's health [13,T].

1.1.8 Key recommendations (A)

A1) That Asylum Seeker's Human Right to dignity be upheld in accordance with Australian and International Treaties and Law through the induction process. They should be provided with:

- A shower and hygiene cares
- A change of clean clothes
- Water
- Food
- Adequate rest, including sleep.

A2) Patients should be seen with all their documentation and medications.

A3) No person should complete the induction process without their existing medical equipment or aides.

A4) The integrity of HIAs should be maintained. Any changes should be based on evidence of patient benefit or absence of harm.

A4) In times of demand, the safety of patients should always be kept as a priority. Clinics must be reasonably staffed at all times.

A5) Safe working hours and conditions should be secured for all staff working with IHMS.

1.2 Rapid Processing

1.2.1 Introduction

Migration Legislation Amendment (Regional Processing and Other Measures) Bill 2012 has led to the development of 'rapid processing' of new arrivals to CI within brief, nominated timeframes to allow for expedited transfer to offshore facilities at Manus Island and Nauru[8].

1.2.2 Concern regarding transfers

Many doctors have expressed concerns regarding the rushed medical clearance of individuals by IHMS as fit to be transferred to Offshore Processing Centres. It has been established by management that the medical services at these centres are limited and operate well below Australian standards[T,I2,I3,I4]. Recent UNHCR reports also expressed concern regarding the poor living conditions on both sites and the medical risks associated with the level of services and remote, tropical nature of the centres [9.10].

1.2.3 Medical risks associated with Manus Island and Nauru

1.2.3.1 Manus

Residents are housed in crowded and leaking tents in hot and wet tropical conditions [10.] WHO rates PNG as having the lowest health status in the Pacific region, with poor life expectancy and high rates of multidrug-resistant TB and malaria [10,13]. Representatives from the PNG nurses association have described the health system as 'understaffed and under-equipped' and can no longer 'effectively meet the need of the people'[11,13]. Considering these limitations, it seems unlikely IHMS will be able to rely on the local health system for support with complex and acute medical conditions.

1.2.3.2 Nauru

The UNHCR report on Nauru describes poor living conditions in crowded, hot tents[9]. Consistent access to clean drinking water has also been questioned [9,12,13].

Pregnant women and children are being transferred to Nauru. The Minister for Immigration has given assurances that these groups will be provided appropriate care in the Nauruan health system, with IHMS support [55].

However, according to a 2012 UNICEF report, Nauru's mortality rate for children under 5 is over 40 times higher than Australia's[56]. Furthermore, a pregnant detainee in Nauru with suspected twins recently required transfer to Brisbane for management of her high-risk pregnancy, which could not be provided for in Nauru [C35].

The Nauruan health system's ability to support IHMS in obstetric management and the treatment of complex medical problems is in doubt. The UNHCR report describes medical services provided in Nauru as 'limited' and several other patients have required evacuation to Australia for specialist care[11,13].

1.2.4 Responsibility to perform appropriate screening

Because of these harsh conditions, IHMS should treat its responsibility of medically clearing these people carefully.

According to the UNHCR, IHMS stated in June 2013 that the PNG Government mandates that asylum seekers must be in good health prior to transfer. IHMS assured the UNHCR that these (pre-departure) assessments were thorough[10].

However, since this time, expected processing time for transfer off CI has been gradually reduced from 7 days[I8] to 48 hours[T,I8,14], which makes performing thorough assessments difficult.

1.2.4.1 RACP concern regarding safety of 48 hour timeframe

The Royal Australasian College of Physicians (RACP) states that this tight timeframe means it is unlikely that asylum seekers arriving by boat will receive adequate medical assessment, meaning they could face "significant health issues" once transferred.

Speaking to Guardian Australia, the RACP president elect, Professor Nicholas Talley, said it would be "incredibly difficult" to "appropriately and properly asses people who are coming from all sorts of other parts of the world in such a timeframe".

> "A number of these people will have acute or chronic illnesses and they need to be assessed," Talley said. [53]

As HIAs represent a major hurdle in the processing of new arrivals, IHMS has been under great pressure from the DIBP to ensure assessments are completed within the nominated timeframes[I8,T,]. In order to do this, IHMS has compromised the quality of the HIAs and are inappropriately using them to approve transfers to offshore sites.

1.2.5 Standards abandoned to achieve DIBP processing time targets

Several aspects of the health induction assessments have been compromised.

Assessments initially included:

- urinalysis,
- blood glucose level (finger-prick),
- full blood count and LFT's
- vital signs
- height, weight and head circumference (children only).

Patients with abnormal results were flagged as not fit for transfer to offshore facilities, according to guidelines drafted by the medical director[I9].

Results were divided into three categories of risk.

- Category 1- Not for offshore processing (for example, pregnant women and children under 7 were considered unfit for transfer to offshore centres)
- Category 2- Not for transfer until sufficiently investigated (for example, gross haematuria[urine test] and hyperglycaemia [fingerprick blood test])

- Category 3- Fit for transfer

In regards to TB screening, all abnormal chest x-rays and reports required review by a TB specialist, prior to patients being declared fit for transfer. Transfer practices in June 2013 reflected these guidelines[I9].

However, with increasing pressure from the DIBP to improve processing time, these standards were abandoned.

In July 2013, blood sugar levels and urinalysis were cut from the process entirely, resulting in many category 1 & 2 patients not being detected [T].

By September 2013, abnormal blood results including moderate neutropenia [C5] (category 2) were declared fit for transfer without investigation (72 hour processing), as were pregnant women (category 1), and now patients are sent offshore without blood results at all (48 hour processing)[I10]. As the TB specialist is not available at weekends, the medical director is now taking on the responsibility of clearing chest x-rays at these times, and has declared patients as fit for transfer that were later flagged as high risk by the TB specialist and recommended for isolation [C30].

1.2.6 HIAs inappropriately used to approve transfers to offshore sites

As discussed, the brief and compromised health assessments have poor sensitivity for detecting significant medical problems. Prior to rapid processing this was somewhat acceptable, as patients would undergo a period of surveillance within the detention centre in which abnormal results were followed up and any medical problems could be detected and/or further assessed by medical officers in clinics.

Doctors were advised by management that their assessments were not being directly used to justify medical clearance for transfer to offshore sites[I2].

However, in the context of rapid processing, this is no longer the case. The decision to medically clear an individual is now based exclusively on the HIA, vitals and chest x-ray recorded at their induction, with no period of surveillance or follow up[I3,T].

1.2.7 Flawed discharge health assessments for transfers to offshore centres

The medical clearance for transfer to offshore centres is officially documented in Discharge Health Assessments. These assessments are currently completed by reporting nurses with input from the Medical Director. Medical officers have a number of concerns regarding this process.

Firstly, certifying medical clearance is not usually within the scope of practice for a registered nurse.

Secondly, even with medical director input, the decision to flag an individual as fit for transfer is a poorly informed one. Neither the Medical Director or reporting nurse have seen the patient and are basing the decision on a flawed and often incomplete HIA process with poor sensitivity in detecting significant medical problems.

1.2.8 Consequences of rapid processing with inadequate HIAs

The combination of rapid processing and the downgrading of HIA standards has numerous negative consequences for patients.

1.2.8.1 Inappropriate transfers

Groups of individuals were approved as 'fit for transfer', even though they did not meet IHMS' own guidelines from a few months ago[I9].

This list includes

- Patients referred to the mainland for urgent specialist attention [C6]
- Patients with visual impairment or other disabilities [C6, C7]
- Pregnant women (including with suspected twins [C35]) and children under seven sent to Nauru [C7,]

1.2.8.2 Unknown risks to safety and appropriate follow up

Transfers that occur with so little information can result in unsuitable individuals being moved offshore. There have been assurances made by IHMS

management and Minister Morrison that patients will be followed up on arrival[54]. However, this may be as limited as a brief nursing assessment (according to IHMS management at a staff meeting) [I3]. Furthermore, considering the difficulties, delays and frequent errors in the process of executing and following up tests and results on Christmas Island, it seems unlikely that patients will experience timely or appropriate care once transferred to these substandard offshore sites. There have also been assurances that patients with abnormal results will be returned to the mainland. However, this remains unsafe, as even if a patient is returned to Australia, the transfer itself can constitute a risk to patient safety.

1.2.8.3 Public health risk to offshore sites

The rushed and inappropriate medical approval of transfers to Manus Island also constitutes a significant public health risk, of infectious conditions such as TB, to offshore sites. On more than one occasion TB has failed to be detected within 48 hours by the limited HIA process[T,C8]. Additionally, CXR results have been entered into the medical information system as 'normal' incorrectly and potentially not identified within 48 hours [TI].

1.2.8.4 Immunisation errors

There are other negative consequences associated with rapid processing. Immunisations are rushed in order to establish vaccination prior to transfer offshore. This has resulted in multiple vaccination errors, such as the administration of live vaccines to pregnant women[C9] and patients with inter-current illnesses. Furthermore, these patients are flown offshore to places of risk before these immunisations have had time to take effect[15].

1.2.8.5 Blanket prescribing

Additionally there is an issue with the prescribing of malaria prophylaxis. It is done through a process of blanket prescribing to hundreds of people without the prescribing doctors ever seeing their patients. The process relies entirely on a HIA to have picked up any contraindications [T]. The drug is contraindicated in patients that report hypersensitivity to either atovaquone or proguanil hydrochloride (active constituents of Malarone) that is not enquired about during HIAs. Another contraindication is renal impairment,

which is typically asymptomatic until very severe, and yet no testing of renal function is currently performed on any patient without 'clinical signs'.

1.2.9 Conflict of interest

It seems unlikely that the dramatic change in practice observed in the face of time pressures from the DIBP is based on any evidence of benefit or lack of harm that may result. Rather it appears that IHMS is making decisions that compromise patient care as a result of their conflict of interest with the DIBP.

1.2.10 Medico-legal implications

Furthermore these decisions place medical and nurse practitioners at great medico-legal risk, a fact that goes uncontested by management at staff meetings and yet has not been addressed. Management states that the Department of Immigration are accepting all responsibility. However, no third party has the power to absolve health practitioners of their duty of care to patients and we must all adhere to AHPRAs code of conduct.

1.2.11 Key recommendations B

B1) That rapid processing is refused on the basis of safety and due diligence.

B2) That HIAs are not used as a sound basis for determining the fitness or otherwise of a person to be sent to an offshore processing centre.

B3) That an entirely separate assessment takes place to assess an asylum seeker's fitness to tolerate the conditions at an offshore processing centre.

B4) That investigations are given time to be properly assessed in a clinical context with the patient present so as to make a more reasonable and reliable assessment.

B5) That important and relevant pathology is reinstated.

B6) That conditions such as pregnancy, that were previously considered not fit for transfer to offshore centres, are not cleared for transfer.

1.3 Medical Transfers

1.3.1 Introduction

Patients requiring specialist attention on Christmas Island are referred by medical practitioners for transfer to mainland facilities.

However, the process involved to have a patient considered for medical transfer is increasingly convoluted, time consuming and problematic [T,appendix 1].

1.3.2 Human Rights Standards

Human Rights Standards for Immigration Detention 2013, section 14.15 requires that:

Each detainee has access to the services of specialist medical practitioners as well as psychiatric, dental, optical and radiological diagnostic services, on medical referral. Prostheses and aids required by a detainee, such as glasses or wheel chairs, are made available on the recommendation of medical staff.

[4]

1.3.3 Prolonged delays in transfer of unwell patients

Medical Practitioners triage referrals in three categories of urgency (1 -3).

The most urgent, Category 1, require transfer in two weeks. However, this is frequently inappropriate as there are a multitude of medical conditions which require more urgent attention.

Despite this, few Category 1 patients leave before four weeks and some wait at least as long as two months. There have been periods of time where no patients have left the island despite needing immediate tertiary attention. These periods of time have extended up to four weeks (according to the CI Medical Director)[T,l6].

1.3.4 Interference in referrals by management

It is routine for the Medical Director to down-categorise referrals without consulting either the patient or the referring doctor, constituting an infringement on the clinical autonomy of medical practitioners working at

Christmas Island. There is in fact a column on the medical transfer list set aside for re-triaging by the Medical Director [T,I6].

1.3.5 Consequences of prolonged delays

During these delays, medical staff attempt to manage these often complex and painful conditions with ad hoc and temporising measures. The waiting time is indeterminate and no advice can be given as to when a person is to leave for definitive care. This results in medical staff being unable to effectively counsel patients and increases patient distress and anxiety, frequently exacerbating mental illness [T].

The conditions can be so severe that they risk life-threatening deterioration. Cases include an individual with an imminent risk of sepsis from surgical pathology [C10], complications of a pacemaker insertion in a child[C11] and fevers in a patient with undifferentiated immune-compromise [C12].

1.3.6 Patients transferred to mainland and then returned to Christmas Island without specialist review

Patients have been transferred to the mainland for treatment (after a lengthy wait) only to be returned to Christmas Island after having an appointment made and not actually seen by the specialist required. This further administrative delay is cruel, unsafe and inefficient[C13].

1.3.7 Patients referred, not added to transfer list

Due to widespread problems with data management at IHMS, many referrals are lost and patients languish in detention without appropriate specialist care. They repeatedly see GPs who mistakenly believe that because a referral has been made it is in progress. This is an ongoing issue despite repeated warnings from medical staff [C36, C37.]

1.3.8 Case Reports

Please refer to the following case reports for examples of the consequences encountered as a result of inappropriate delays

C14, C7, C15, C16, C13, C34, C36

Conclusion

The prolonged delays experienced by patients requiring urgent transfer for specialist attention result in significant suffering and further harm.

1.3.9 Key recommendations (C)

C1) All patients requiring medical treatment not available on the island should be transferred to the mainland within reasonable time frames

C2) The urgency of referrals by medical practitioners must not be interfered with unless by another doctor who has more recently assessed the patient.

C3) Patients should be provided estimates of their waiting times.

C4) Patients transferred to the mainland should receive the treatment required before being returned to Christmas Island

C5) All referrals must be added to the transfer list. Systems should be put

1.4 Facilities, equipment, medication stock

1.4.1 Introduction

For medical and nursing staff to provide adequate health care it is essential they have access to appropriate facilities, equipment and medications. However, there are inadequate levels of facilities and equipment in Christmas Island Detention Centres.

1.4.2 Standards

The HRISD has the following relevant provisions:

14.2 Provision of medical treatment

The physical facilities for health services within immigration detention facilities are an adequate size and allow the provision of health care in conditions that maintain privacy and respect for human dignity.

14.3 Equipment

Immigration detention facilities have adequate and appropriate medical equipment.

All medical and safety equipment (including the resuscitation kit) is used, checked, cleaned and maintained in line with relevant standards of regulatory bodies. Staff understand how to access the equipment and use it effectively.

14.7 Pharmacy and safe distribution of medications

Each immigration detention facility has an adequate supply of medications that are commonly required by detainees. Detainees are properly advised

concerning the benefits and risks of medications, and the self-administration of medication.

Medicines are stored, handled and dispensed safely and securely in line with relevant state or territory legislation.

[4]

1.4.3 Medication shortages

There are frequent periods where supplies of basic medications are exhausted such as cephalexin, bicillin, paracetamol and oxycontin [T].

1.4.4 Equipment shortages

Consumable such as IV fluids and lines, needles and syringes, scalpels, speculums and suture kits and more have frequently been unavailable when required by staff during busy clinics [T].

1.4.5 Facility limitations

The clinic at Aqua has only one room where a medical officer can see a patient. This limits the ability to see patients and contributes to the difficulty in meeting the demand in that compound. The Lilac facility has no bed and no computer [T].

1.4.6 Medication Dispensing

The current dispensing practice is for patients to queue for each dose of their medication. This consumes vast amounts of both patient and nurse time. Depending on the site, a person could be queuing for up to 2-3 hours for each dose. With some medications requiring four times a day dosing, some people are spending their entire day waiting for medications

This impacts on compliance and therefore patient safety, as well as secondary effects such as absences from parenting, family and other responsibilities.

1.4.7 Key recommendations (D)

D1) Management have been promising lock boxes for patient's medications for months. This would be an excellent solution to the queuing problem and should be executed as soon as possible.

D2) Systems should be put in place to ensure the continuous availability of medicines and consumables

D3) Facilities should be brought up to standards

D4) Patients with chronic illness currently residing in poorly equipped facilities such as Aqua/Lilac should be moved to centres that can properly accommodate their needs.

1.5 Health informatics

1.5.1 Introduction

The medical information systems and online processes required to perform medical officer duties are complex, time consuming and error prone.

1.5.2 Training

Medical officers almost without exception arrive on Christmas Island with no training on how to use the counter intuitive software and complex IT processes. Instead they are required to learn on the job, during which time frequent errors are made. This effect is compounded by the short contracts offered by IHMS (as short as two weeks).

1.5.3 Patient identification errors

Patient identification details are frequently subject to data entry errors which are not corrected including date of birth, name, age, language spoken and location. This is despite repeated attempts by detainees to get these details corrected.

1.5.4 Problematic medical transfer referral procedure

The administrative burden to make a medical transfer referral is prohibitively high. The process is continuously changing with new forms and procedures. At the end of October, it required twelve, time consuming steps (see appendix 1 for details).

Referrals represent a significant time cost for busy medical practitioners, who receive no formal training in this onerous and technically convoluted task, which is prone to errors.

1.5.5 Mainland transfer referral errors – case report

One such error involves an entry in the master transfer list that listed a patient as having returned a positive HIV test - the name and the boat ID for that entry did not match the abnormal result, and when the medical record of either the name or the boat ID were inspected, neither had

returned a positive HIV test. This leaves the possibility of an unidentified HIV positive patient that has not been appropriately referred for specialist input[12].

1.5.6 Ineffective & substandard systems for follow up of test results

Pathology and radiology reporting systems are not up to standard and constitute a risk to patient safety and a potential source of patient harm.

The standard for general practice edition 4 Criterion 1.5.3 Systems for follow up of tests and results is not met for the following reasons[17]:

- Requests for pathology and imaging routinely go missing and have no method of tracking.
- Results are not reliably scanned into electronic systems.
- Patients frequently have specimens and phlebotomy collected several times for the same test. The specimens seem to simply disappear.
- There is no system to flag that a new result has arrived.
- It takes significant time to locate results. This is a result of the multiple places within the computer system that results are stored and the three pathology companies utilised by the service (The numbers to which are not readily available).
- Results are located too late to be of use, resulting in doctors becoming discouraged from ordering pathology.
- Even results for notifiable diseases like hepatitis B and C can take upwards of 3 months to be addressed. For example, a man was advised of positive hepatitis C result three months after his blood test.

1.5.7 Citrix disconnections

Chiron is reliant on a Citrix connection which can disconnect frequently leaving Chiron, email and other essential software inaccessible for up to 30 minutes.

1.5.8 Issues with health information system - Chiron

The health information system currently being used is Chiron 2. IHMS staff members frequently complain regarding its hindrance to the task of patient care. It has many design flaws, some of which are described below.

1.5.8.1 Dual records

On the creation of a patient file a Siebel party ID is generated. It is a parent file of two patient entries, in which staff can enter information independently. The two entries are merged sometimes days after initial generation of a patient record. This effectively creates a temporary dual record. For the period of time where two exist, accessing one record will not show all the patient information (contained in the second record). This problem is not widely understood by people using the system.

1.5.8.2 Limited diagnostic list

Diagnosis is not a free text box and the options available do not give adequate scope to accurately describe the pathology seen in practice. In addition, once a "reason for attendance" has been selected in Chiron it is not possible to change it. Hence the only way to alert people to incorrect diagnoses is to put a note in the warning box. Given the nature of the drop down box system, it is very easy to click on a diagnosis adjacent to the correct one, hence this problem does not occur that infrequently.

1.5.8.3Appointment booking

The process of booking an appointment takes multiple steps which require navigating menus and data entry. This process can be error prone with appointments not made if specific entries are not made. This process was abandoned for a period for an even more complex system involving Excel spreadsheets.

1.5.8.4 No multitasking capability

Once an entry has been started, there is no ability to review test results, medication charts or other scanned documents. If the user needs to review any results, charts or documents, the record must be cancelled and the user must start again. . To overcome this issue, a second Chiron application must be opened (not well understood by staff).

1.5.8.5Loss of data

Entries can be inexplicably “lost” by Chiron ,with previously filled data boxes becoming void of any text.

1.5.8.6New system

A new system (Apollo) is being rolled out but it is not certain if this will be an improvement or address any of the discussed problems. Given the failure of IHMS to address the abundant and critical issues with Chiron it seems unlikely that any response to similar problems with Apollo will be appropriate.

1.5.9 Key recommendations (E)

E1) Administrative tasks such as mainland referrals should be simple and time efficient.

E2) All staff should have formal training in the use of the health information software and other procedures necessary for patient care.

E3) A new system should be implemented to collate and action pathology and radiology results in a timely fashion without error.

E4) The specific issues raised above must be adequately addressed in Apollo and an ongoing review and improvement process with clinician feedback sought

1.6 Medication prescribing and dispensing

1.6.1 Introduction

The medication prescribing process is fundamentally flawed and exposing patients to unnecessary risk.

Adverse events are common and these issues are not new. Many of these points were raised at least two years ago and none have been resolved [I1,I2,I3,I13].

1.6.2 Multiple medication records

Currently there are two separate medication records for every patient; an electronic record which shows any prescriptions made through Chiron (the current health information system), This is printed to form the paper record from which medications are dispensed. This results in the following issues:

- When a medication is cancelled, it is frequently cancelled on either the paper chart or the electronic one, but rarely both. This leads to continuation of medications which have been ceased.

- When medications are changed on Chiron a new paper copy is printed, resulting in the old medication chart being removed from the patient's dispensing folder. This chart is usually lost and means that there is no way to check the dispensing history. It is infrequently scanned into Chiron.

- It is possible for patients to be given the same medications, twice, from two versions of the same chart if old medication charts are left in the dispensing folders

- If a change to medications is made on a paper chart it is lost to and invisible from the electronic chart.

1.6.3 Multiple charts in multiple folders

For the convenience of dispensing nurses and Serco there are multiple folders for medication charts - 'red' for critical medications and 'white' for non-critical. This has the following risks:

- Patients have had one chart in each folder.
- Patients can be administered multiple or incompatible medications.
- Patients may miss medications because of this.

As patients are not allowed to self-administer and there is inadequate access to interpreters during medication dispensing, patients can be unaware what medications they are being given. Incidents have arisen where patients deny they are meant to be on certain medications and have been given them regardless or incorrect medications being given, such as a non-diabetic receiving Metformin.

1.6.4 Dispensing of expired medications

Additionally, there have been numerous incidents of medications continuing to be dispensed well beyond the expiration of their prescription. This is an unsafe practice not in keeping with accepted standards. If a prescription has expired, it must not be dispensed and should trigger a medication review.

1.6.5 Prescribing errors within Chiron

The mechanics of actually prescribing a medication within Chiron are dangerous.

- Only the trade names of most medications are printed, but best practice requires generic names to be printed. This is a significant point of confusion for nurses administering medications. Medication charts must be printed, the trade name crossed out by hand and then the generic name hand written.
- Chiron provides a field for dosing instructions where free text can be entered. This text is not printed on the paper copy that is actually used for dispensing medication.

- The primary patient identifier used (boat number) does not appear on the printed medication chart. This is hand written afterwards.
- When a dosing frequency is not selected, Chiron automatically selects 'TID' as the dosing frequency.
- Currently Chiron provides an option to prescribe a medication indefinitely. It is poor practice to prescribe any medication indefinitely.
- The 'strength' field that is displayed on the electronic prescription is not printed on the paper copy. This can result in inadvertent overdose, for example in the case of antibiotic syrups of varying strengths being prescribed only in 'mls'.

1.6.6 Failure to respond to problems with prescribing

These problems are well known to IHMS as staff have repeatedly informed IHMS about the issue over a number of years. Despite this, no solutions to ensure patient safety are evident.

1.6.7 Unsafe prescribing practices requested of medical practitioners

Medical officers are frequently requested by nurses to 'sign off' re-printed medication charts that have run out of room to record dispensing.

This means medical officers are often requested to sign off on another doctor's prescription, for a patient they most likely don't know or for a medication whose indication is also unknown.

This is unsafe due to the possibility of adverse events resulting from the prescribed medication. Doctors would also be liable due to a lack of due diligence [16,17,18].

1.6.8 Dispensing errors related to lack of interpreters

As patients are not allowed to self-administer and there is inadequate access to interpreters during medication dispensing, patients can be unaware of which medications they are being given. Incidents have arisen where patients deny they are meant to be on certain medications and have been given them regardless or incorrect medications having been given, such as a non-diabetic receiving Metformin [T].

1.6.9 Conclusion

The errors within IHMS' medication processes are manifold, represent significant risk to patients and likely constitute medical negligence.

1.6.9 Key recommendations (F)

F1) Deficiencies within the systems responsible for the prescribing and dispensing of medications should be addressed immediately with processes put in place to ensure the safety of patients.

1.7 Patient Identification

1.7.1 Background

It has become a culture within IHMS and other stakeholders to refer to people in the centres exclusively by their boat numbers, both in person and between colleagues. This practice is both dehumanising and degrading. Photo identification badges have helped, but the text is too small to allow familiarisation with names.

1.7.2 Case report

Patients have also expressed their distaste for this practice. There is an example of a Muslim asylum seeker that has drawn the Jewish Star of David onto his shirt with his identification number written underneath it.

1.7.3 Key recommendations (G)

G1) There should be a widely published and reinforced policy within IHMS of using patient's preferred names.

G2) This could potentially be achieved simply by investing in stick-on name tags which would be provided at induction. Replacements should be available at all IHMS clinics and staff would encourage patients to use.

1.8 Clinical Risk Management

1.8.1 Introduction

A cornerstone of delivering high quality health care is the implementation of a formal ongoing review and improvement process whereby critical or high potential incidents ("near misses") are recorded and examined so that they may be prevented in future.

1.8.2 Standard

The RACGP Standards for Health Services in Australian Immigration Detention Centres address this specifically in Standard 3.1 - Safety and Quality.

> *Criterion 3.1.2 - Clinical risk management system - relates to a systematised attempt to improve patient safety. It has two key indicators:*
>
> - *our medical and clinical staff can describe the process for identifying and reporting a slip, lapse or mistake in clinical care*
> - *our medical and clinical staff can describe an improvement we have made to prevent slips, lapses and mistakes in clinical care from recurring*
>
> *"If the health service does not make improvements after identifying a slip, lapse or mistake, patients may be exposed to an increased risk of adverse outcomes, and the staff may be exposed to an increased risk of medicolegal action. An example of this situation is where a clinically significant test result is not communicated to the patient or adequately followed up; the health service knows about this, and yet makes no attempt to prevent a recurrence"*

1.8.3 Failure to maintain effective risk management system

Few IHMS medical officers undergo any formal induction and few are aware of any formal incident notification process. There is no regular, ongoing audit process that is open to medical officer involvement. Numerous, companywide, systematic flaws remain unaddressed after several years (section 1.6) High potential incidents continue to occur with alarming frequency (section 1.5) with little attempt to prevent them occurring again in the future (section 2.3). It seems unlikely that RACGP Standard 3.1 - Safety and Quality, is currently being met on Christmas Island.

2.0 Areas of clinical concern

2.1 Paediatrics

2.1.1 Introduction

The delivery of effective health care to the hundreds of children and adolescents detained at Christmas Island IDC should be a priority for IHMS.

The UNHCR states that children and adolescents require special care and assistance for a number of reasons [19].

- Children are vulnerable. They are susceptible to disease, malnutrition and physical injury.
- Children are dependent. They need the support of adults, not only for physical survival, particularly in the early years of childhood, but also for their psychological and social well-being.
- Children are developing. They grow in developmental sequences, like a tower of bricks, each layer depending on the one below it. Serious delays interrupting these sequences can severely disrupt development.

This demographic is also at risk due to negative past experiences, such as torture and trauma, which can impact on their physical and psycho-social well-being for years to come[19].

2.1.2 Advocacy against indefinite detention

There has been widespread consensus that the detention environment is both unsuitable for children and a contravention of human rights.

RACP states: "Detention of children is a contravention of Australia's responsibility under the United Nation Convention of the Rights of the Child."[20]

It also states: “The detention environment has the potential to cause long-term damage to psychosocial and emotional functioning, especially in children who have experienced torture or trauma.”[20]

In light of this, both the RACP and the RANZCP have called for “an immediate end to the practice of detaining children,” and asked for “their placement in the community, unless there are special circumstances preventing this that are in the best interest of the child”. [20]

As a medical service provider, with an established duty of care to these children, it is IHMS’ responsibility to effectively as possible advocate on their behalf and in their best interests.

It is clear this means advocating for their immediate removal from the detention environment. This should be the starting position and be vigorously defended when approaching any negotiating on the care of these minors.

Instead there appears to be a culture of acceptance within IHMS of the mandatory detention of children. Indeed, IHMS appears complicit in plans to detain children and adolescents on Christmas Island long term (indefinitely), despite warnings from key medical bodies such as the RACP regarding the likely consequences of prolonged detention in this vulnerable group.

2.1.3 Paediatric health care needs

To compound this further, the medical care currently provided for children and adolescents is inadequate. There is minimal preventative care and no regular monitoring of child health. In fact, there is no discernable, overarching child health policy available or in use on the Island.

2.1.4 Appropriate standards

There are no specific guidelines on delivery of healthcare to children in detention. However, examination of recommendations by respected medical and human rights bodies suggest a broader and more pro-active health care

program for children should be provided at Christmas Island Immigration Detention Centre (CI IDC).

The 'Convention on the Rights of the Child' states that parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services (article 24)[21]

The health care needs of each child in immigration detention should be regularly monitored, and preventive health programs implemented where required[22].

The RACP states that:

> "It is highly likely that early comprehensive medical assessment of refugee children and young people, and rapid identification of their needs, will produce better health outcomes and will be cost effective[23]."

2.1.5 Paediatric health areas of concern

The RACP publication '*Towards better health for refugee children and young people in Australia and New Zealand*' provides some clinical considerations for the provision of health care in this demographic, and has been used to inform the following areas of child and adolescent health care that are particularly lacking[23].

2.1.5.1 Chronic medical/surgical conditions

Chronic paediatric medical or surgical problems require specialist management beyond the scope of general practice, and are poorly managed at CI IDC. This problem is exacerbated by unnecessary waiting times for mainland transfer and specialist review [C1, C11, C17, C18.]

A paediatrician occasionally visits the island to service the island community and can provide support to the centre if time allows. However, there is no effective referral system in place to ensure patients requiring review are seen, so this rarely happens.

2.1.5.2Infectious diseases and immunisations

Infectious diseases in children such as malaria, blood born viruses and common parasitic infections such as schistosomiasis and strongyloides are not routinely screened for or empirically treated. All of the above can have significant impacts on child health and development [23,24,25].

2.1.5.3 Nutrition

Nutritional deficiencies (ie lack of iron, vitamin D) in asylum seeker groups are common and carry significant consequences[23,26]. There are no screening measures to detect these cases at CI IDC.

2.1.5.4 Dental care

Dental care within the Christmas Island IDC is variable with a single dentist arriving once every three months. Formal, preventative dental care strategies are not evident.

2.1.5.5 Growth and development

There are no reliable or consistent tests of visual acuity or hearing for children within the camp.

Children may not have had access to newborn screening programs, such as hearing tests or had access to optometry services.

Some children arrive with hearing aids or corrective lenses. These are sometimes confiscated, lost or their script may be changed and not replaced. This results in numerous children within the camp living with visual/hearing impairment[C2,C19.] This has well documented impacts on development as well as on social functioning and mental health [27,28].

Physical growth and development also remains unmonitored. Children with failure to thrive are easily missed with no established protocols for regular monitoring of physical development.

In fact, none of the scheduled physical and developmental assessments that would normally occur in the community (typically by a Maternal Child Health Nurse), occur at Christmas Island IDC[29,30].

2.1.5.6 Adolescent health

Adolescents, particularly unaccompanied minors, represent a high-risk group for mental illness such as depression, anxiety and PTSD. They frequently have backgrounds of rape, torture and trauma. This is certainly true for the adolescents on Christmas Island [C20,C21].

However, limited treatments are available and cannot remove the ongoing exacerbating factor of indefinite, mandatory detention[23,32,]. Of marked concern is the lack of functioning adolescent health programs or health education.

2.1.5.7 Mental health

The deleterious effect of indefinite detention on children and adolescents has been well established[26]. Children within the camp have demonstrated signs of acute stress including enuresis and marked behaviour changes [c22.] However, despite this evidence there are no effective systems in place for detecting children at risk. Furthermore, there are no child specific mental health services on the island (ie no paediatric psychologist, or psychiatrist)

2.1.5.8 Education

The links between education and health have been well-established [32] and is a protective factor for resilience[23]

At present, children take turns attending the local school (as few as 12 places available in the primary school) and unaccompanied minors are excluded from the limited high school classes provided in family camps[33].

The HRSID in section 16.2 "Children's education" states the standard as being:

If detained, children continue with their education. Primary school education is compulsory and secondary schooling is available. Older children no longer attending school should have access to other educational opportunities such as vocationally-oriented training. Wherever possible, children's education takes place within the Australian community. Where education is provided within the facility, it is of a standard and quality equivalent to that offered in Australian schools for students with special needs such as English-language instruction.

Parents are consulted about the education of their children and, where possible, offered a choice of schools such as religious schools.

IHMS must advocate for the provision of formal education for all children and adolescents under its care.

2.1.6 New Services

IHMS management has advised staff that new services for children and unaccompanied minors are being developed. This includes an eight-week educational course for unaccompanied minors. This is a step in the right direction, but no replacement for formal schooling.

2.1.7 Key recommendations (H)

H1) IHMS should be strongly advocating for the removal of all children and adolescents from detention.

H2) Paediatricians (RACP) and education specialists should be consulted regarding the best model of care for children within the centre.

H3) A Maternal & Child Health Nurse should be employed to undertake all the usual monitoring of growth and development that would occur for a child on the mainland.

H4) Audiologists and optometrists should be made available for all children.

H6) Missing hearing aids should be replaced as soon as possible and those who need aids provided for.

H7) Experts on the impacts of detention on children should be consulted for advice regarding the best screening method to detect children at risk within the camp, and appropriate treatment.

H8) Access to child psychologists and visiting child psychiatrists.

H9) Visiting speech pathology and occupational therapy should also be considered.

H10) IHMS should insist on the adequate provision of educational services to the children and adolescents under their care.

2.2 Antenatal Care

2.2.1 Introduction

Antenatal care provided by IHMS is unsafe and inadequate and does not comply with Australian standards.

2.2.2 Failure to meet Standards

The 'Doctor's Handbook' distributed to new doctors on Christmas Island states that

> *"Antenatal care is handled per standard practice"*[I14].

However, none of the following guidelines are currently met by IHMS.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) have the following guidelines with respect to antenatal care

> *All women, irrespective of their geographical location, resources or chosen model of antenatal care, are entitled to informed prenatal screening and diagnostic testing for foetal abnormalities or genetic conditions that may impact on the future life and health of their baby.*
>
> *Pre-pregnancy counselling for inherited genetic conditions is of particular importance in patients where the possibility of pre-implantation diagnosis is available*[34].

The guidelines go on to say:

> ***1.1. Screening***
> *At pre-pregnancy or early in the antenatal period counselling should address:*
> *· A detailed clinical assessment of any particular risk factors for fetal abnormalities or familial genetic conditions.*

· Prospective parents option for maternal serum screening and nuchal translucency assessment to evaluate the risk of chromosomal abnormalities, irrespective of maternal age.

· Screening for thalassaemia syndromes in at-risk populations.

· Availability of carrier status screening for genetic conditions of perceived high prevalence or consequence.

· A mid-trimester ultrasound for fetal structural abnormalities.

34

2.2.3 Lack of ultrasonography services available in detention

Of particular concern is the absence of any antenatal ultrasound scan (USS), which poses a risk to the woman, her unborn children and the mental health of their families in an already at-risk population.

Ultrasounds are essential for the following

- Obstetric emergencies such as vaginal bleeding and suspected ectopics
- Routine morphological scans.

The Christmas Island '*Doctor's handbook'* agrees that *"Nuchal and morphology scans need to go to Perth."* However, these have not been provided even with high risk pregnancies [C35], or following exposure to a teratogen or potential iatrogenic harm [C9, C14, C24.],

There is a direction from IHMS to send patients to CI hospital for USS. However, there are usually no ultrasonographers available, as they only visit every few months and cater primarily for local residents. Locals of CI are also flown to the mainland for routine and emergent ultrasounds.

2.2.4 Reliable access to termination of pregnancy

Access to termination is not available within a reasonable timeframe and not prioritised accordingly – even in the event of iatrogenic harm and exposure to teratogens with consequential mental health harm.

2.2.5 Gestational diabetes

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) state that :

> *Current evidence suggests that there is a benefit in reduced perinatal morbidity in screening for and treating gestational diabetes mellitus.*
>
> [36]

2.2.5.1 No screening for gestational diabetes

Despite this, there is no effective screening for gestational diabetes. Gestational diabetes has serious potential consequence for the mother and the foetus. This includes birth complications due to high birth weight and delivery complications to hypoglycemia and impaired glucose regulation of the neonate after birth. It is also associated with long term risk of type 2 diabetes mellitus for the mother.

2.2.6 Duty as a medical services provider

HRSID section 14.9 on women and girls states there should be pre and post-natal services and accommodation are available for women who need them[4].

IHMS has failed its duty as a medical service to appropriately provide for pregnant women and their families.

2.2.7 Key recommendations (I)

I1) Pregnant women under the care of IHMS should receive antenatal care in accordance with RANZCOG guidelines.

I2) This includes access to ultrasonography when required and for morphological scans.

I3) Women requesting termination need to be counselled accordingly and transferred in a timely fashion.

2.3 Chronic disease management

2.3.1 Diabetes

Diabetes is a common chronic disease with long term health consequences if not managed well. They require frequent, consistent and reliable measurements of their blood sugar levels to guide insulin dosing and a consistent, low GI diet[37].

2.3.1.1 Diet

Human rights standards for immigration detention 2013, Australian human rights commission 12.1 provision of food states that

· *Appropriate meals are provided where it is established that a special diet is required for medical reasons*

[4]

There have been frequent requests for palatable, diabetic diets. However, the only healthy options are unnecessarily bland (compromising compliance) and contain high GI carbohydrates, such as white rice.

2.3.1.2 Blood sugar monitoring and insulin administration

Documentation of blood sugars is poorly performed within the centres. Levels are often taken intermittently and irrespective of meals. This is in part due to the inadequacies of insulin related documentation.

IHMS have been provided with standardised subcutaneous insulin forms to improve safety and better manage diabetes, but they have yet to be put into practice[38].

Insulin dosing times can be unreliable, with some patients receiving their nocte doses as late as 0100 (i) and unusual practices are occurring, such as extracting insulin from insulin pens into a syringe for administration.

2.3.2 Warfarin

A similar issue occurred with patients on the anticoagulant drug Warfarin. Due to ineffective procedures in place to obtain timely blood results, patients were receiving inappropriate doses of the drug resulting in very high and very low levels of anticoagulation, placing them at high risk of death/disability from haemorrhage or stroke[39, C25]

In short, IHMS was unable to provide the service required for safe anticoagulation.

Furthermore there was poor clinical governance regarding this issue. Instead, staff were forced to develop their own, variable dosing charts and, only when bedside INR testing equipment was suggested repeatedly by staff members, was this relatively cheap and simple solution considered.

2.3.3 Key recommendations (J)

J1) Evidence-based systems should be put in place to ensure the safe provision of medical care to patients with chronic disease.

J2) A diabetic nurse should be employed to oversee and provide continuity and education to diabetic patients.

J3) Improved clinical governance is required from IHMS to respond to deficiencies reported by staff.

2.4 Disabilities

2.4.1 Introduction

Christmas Island Immigration Detention Centre is unsuitable for any person living with significant intellectual or physical disability. The detention environment exacerbates their burden of care and the facilities and medical services provided are inadequate to accommodate their needs.

2.4.2 Limitations to facilities and services

- There are no slings, hoists or other manual handling tools.
- Mobility aids are limited in number, poorly fitting and often broken.
- Lost/broken prosthesis and medical aids are not replaced/repaired.
- There are no communication aids or appropriate stimulation activities.
- Food provided may pose high aspiration risk.
- Most require multidisciplinary, specialist assessment and tailored equipment not available on site.

2.4.3 Impact of detention environment

The burden of care within the centre falls on families who often have no other support networks available. The stressors of living in the detention environment can exacerbate strain on carers [C25,]. Individuals with intellectual and dual disabilities also struggle with the stressors of the detention environment, and can deteriorate with mood disorders, difficult behaviours and exacerbations of prior mental illness [C2,C16].

People with serious disabilities, such as cerebral palsy, can deteriorate quickly when unwell, sometimes requiring emergent, high level tertiary care that the local hospital is not able to provide[40].

2.4.4 Failure to advocate for people with disabilities

Despite this, multiple people with significant disabilities have been kept on Christmas Island and even sent to offshore facilities [C25,C26]. Medical staff have continuously advocated for their removal from Christmas Island. In more than one instance, these people have suffered considerably as a result of their ongoing incarceration in unsuitable conditions.

2.4.5 Key recommendations (K)

K1) All persons with disabilities should be immediately reviewed by medical officers.

K2) Medical officers should be given the option of declaring these individuals as unsuitable for the detention environment. (note this is currently an option in the HIA online paperwork but doctors have been instructed not to click to the box).

K3) These patients should then be immediately transferred to a location with suitable facilities and supports.

K4) Any person with a disability that remains on the island should be frequently reviewed, with their needs updated and attended to on an ongoing basis, whilst awaiting transfer to the mainland.

2.5 Acute care and Resuscitation

2.5.1 The provision of acute care

Whilst CI hospital provides support for critically unwell patients, most people requiring emergent care are provided for by medical officers at a level beyond what is reasonably expected at a general practice level of care.

2.5.2 Challenges to the provision of acute care

The detention facilities are under-resourced and understaffed for the provision of such care. This is particularly true after hours when nursing staff are not available to monitor patients longitudinally due to responsibilities at other clinics. This is compounded by the remote location of Christmas Island.

Furthermore, while crash trolleys are available, including defibrillation equipment in clinics, many of the medical and nursing staff do not have up-to-date training in Advanced Life Support.

2.5.3 Concern regarding liability

IHMS is contracted to provide basic life support only. As a result, their insurance does not provide cover for medical officers if they proceed ALS.

2.5.5 Key recommendations (L)

L1) Expectations regarding emergent care should be clarified.

L2) IHMS should move to the delivery of advanced life support, but all staff must have sufficient training.

L3) Staffing must be adjusted to allow for emergency management without compromising the care of other patients.

2.6 Infectious diseases and physical environmental

2.6.1 Introduction

The close living conditions in the camps provides an excellent environment for the transmission of communicable diseases such as upper respiratory tract infections and gastroenteritis. Scabies and lice are also a frequent presenting problem in all Christmas Island clinics.

2.6.2 Response to outbreaks

While isolation strategies have been improving for gastroenteritis, the response continues to be reactionary. There are limited preventative exercises such as education campaigns or hand hygiene measures.

Scabies is treated on a case-by-case basis with no apparent correlation made between infested rooms or bedding, likely resulting in infection of subsequent residents.

2.6.3 Sexually transmitted infections

Medical practitioners have noticed high rates of sexually transmitted infections such as syphilis in the Christmas Island Detention Centres (particularly the single adult male unit at North West Point). Apart from access to condoms, medical officers are not aware of any formal preventative health strategies in place to reduce the transmission of these infections.

2.6.4 Key recommendations (M)

M1) Hand hygiene education and the provision of Chlorhex hand wash at food areas and shared bathrooms.

M2) IHMS to support SERCO in identifying rooms with a history of scabies for thorough eradication plan.

M3) Preventative health programs should be put in place for infectious diseases.

2.7 Age determination

2.7.1 Request to refer for age determination

In late October 2012, the Medical Director sent an email to medical staff, followed by an announcement at the all staff meeting at North West Point Immigration Detention Center, requesting medical staff to refer individuals for age assessment.

2.7.2 Human right's position on age determination

The HRSID section 19.1 "Decisions to detain children and families" states:

> *If a young person's age is in doubt, a suitably qualified and trained interviewer with the consent of the young person and their guardian or other independent adult conducts an age assessment interview. Any age assessment process applies the principle of the benefit of the doubt and is conducted in a manner that ensures the protection of the best interests of the child. X-ray or other scientific evidence is not used as evidence that a young person is an adult.*

[4]

2.7.3 Professional bodies position on wrist x-ray age assessment.

On 19 August 2011, a letter was sent to the then Minister of Immigration and Citizenship Chris Bowden. The letter was signed by the following bodies :

- The Royal Australasian College of Physicians,
- The Royal Australian and New Zealand College of Radiologists,
- The Australian and New Zealand Society for Paediatric Radiology
- The Australasian Paediatric Endocrine Group

The wrist x-ray age assessment process was condemned. The letter stated:

"We advise you that these methods are unreliable and untrustworthy when used as criminal evidence in a court of law, and unethical when used by

medical practitioners in situations when their use is for administrative purposes." [44]

2.7.4 Wrist x-ray assessment

It is unclear if wrist x-ray assessment is still part of the age assessment process. It should be made clear especially if medical officers are being asked to refer patients for it.

2.7.5 Conflict of interest and scientifically unsound

It seems unreasonable to ask medical officers to refer patients for this unscientific examination.

There is also a clear conflict of interest as these assessments are frequently not in the patient's best interest and compromise their trust.

Section 8.11 of the *AHPRA good medical practice; A code of conduct for doctors in Australia* is relevant here. [18]

"Patients rely on the independence and trustworthiness of doctors for any advice or treatment offered. A conflict of interest in medical practice arises when a doctor, entrusted with acting in the interests of a patient, also has financial, professional or personal interests, or relationships with third parties, which may affect their care of the patient."

2.7.6 Key recommendations (N)

N1) IHMS should refrain from requesting that doctors refer patients for age assessment

N2) If x-ray assessments are still in practice, IHMS should strongly advocate against their use

3.0 Accreditation, Conduct and Ethics

3.1 RACGP accreditation

3.1.1 Introduction

The clinics on Christmas Island are accredited by the RACGP. There are 2 standards which could be applicable when considering accreditation of clinics by the RACGP

- RACGP Standards for General Practice (SGP)[16];
- RACGP Standards for Immigration Detention Centres (SIDC).

3.1.2 Failure to meed RACGP standards

The following is a non-exhaustive selection of criterion for accreditation under these standards which IHMS on Christmas Island does not meet.

- SGP Criterion 1.4.2 Clinical autonomy for general practitioners

Medical officers are not free to refer directly to specialists. Instead all referrals are corralled and prioritised centrally through the Sydney office. The triaging is then controlled by unknown persons that have never met the patient. It is not even certain if medical practitioners are doing the triage.

Referrals can be and are frequently down triaged. This system also compromises Section 3 of the AMA Code of Ethics (2004)[43]

- SGP Criterion 1.5.3 Systems for follow up of tests and results

As discussed under health informatics:

- SGP Criterion 1.6.1 Engaging with other services and SIDC Criterion 1.6.1 Engaging with other services

Christmas Island has almost no allied health input despite a great need for it.

- SGP Criterion 1.7.1 Patient health records

As discussed under health informatics:

- SGP Criterion 5.1.1 Practice facilities
- Our practice facilities are appropriate for a safe and effective environment for patients and the practice team.

As discussed under health informatics

- SIDC Criterion 1.4.2 Clinical autonomy for medical, clinical and allied health staff

As discussed under code of conduct and ethics

- SIDC Criterion 1.5.4 System for follow up of tests and results

As discussed under health informatics.

3.1.3 Key recommendations (O)

O1) IHMS should use the RACGP standards to assist in the systematic identification of problems within its service and rectify them accordingly.

3.2 Conduct and Ethics

3.2.1 Introduction

Ethical practice of medicine is core to the integrity of all doctors and health services and an essential part of good medical practice.

3.2.2 Conflict of Interest

We have concerns that decisions made by IHMS regarding the provision of care to patients have been compromised by their relationship with the DIBP. As a result, these decisions are not always in the best interest of the patient.

In regards to conflicts of interest, the AHPRA code of conduct states:

> *'Multiple interests are common. They require identification, careful consideration, appropriate disclosure and accountability. When these interests compromise, or might reasonably be perceived by an independent observer to compromise, the doctor's primary duty to the patient, doctors must recognise and resolve this conflict in the best interests of the patient.'*[18]

Section 3 of the AMA Code of Ethics (2004) outlines the importance of professional independence and argues that to provide high quality healthcare, doctors must safeguard clinical independence and professional integrity from increased demands from society, third parties, individual patients and governments[43].

> *If you work in a practice or institution, place your professional duties and responsibilities to your patients above the commercial interests of the owners or others who work within these practices* [43].

3.2.3 Concerning statements of IHMS management regarding risk

At a doctors' meeting at the end of September 2013, a discussion was initiated by the acting site manager (IHMS) about 'doctors being paid to accept the risk". The risk in question seems to be the risk of negligent medical practice and the provision of sub-standard care.

3.2.3.1 Code of conduct as it relates to financial inducements

This concept of payment for risk is clearly in conflict with AHPRA's code of conduct. The AHPRA code of conduct for doctors in Australia section 8.11.9, broadly paraphrased, states that you should not allow commercial dealings and financial interests to compromise the care you provide[18].

IHMS must therefore not put its doctors or itself in a situation where financial inducement means that its care for patients is compromised.

3.2.4 Shifting of responsibility

In response to complaints by staff regarding the poor delivery of care, management have frequently responded that the DIBP is accepting of risk, thus allowing doctors to practice with indemnity.

However, no third party can absolve any practitioner of their primary responsibilities to the patient or to their registration body (AHPRA).

Furthermore, at the September doctors' meeting, the acting site manager expressed a view that IHMS was set up so the Australian Federal Government could divest itself of risk from the lack of appropriate care provided to asylum seekers. He went on to say there will one day be a royal commission into what is taking place on Christmas Island. He suggested we document well [T].

These statements went uncontested by other members of management present.

This shifting of responsibility between the DIBP and IHMS is likely to result in neither party acting appropriately in regards to the welfare of patients.

3.2.5 Key recommendations (P)

P1) IHMS must ensure that decisions made regarding the health of patients are always in the patient's best interest, despite any demands from third parties, such as the DIBP.

P2) IHMS management should understand that no third party can absolve medical practitioners of their duty of care.

P3) IHMS should be aware that payment does not absolve medical practitioners of their duty of care. Neither does receipt of payment in any way acknowledge some unsaid transaction of risk for fiscal reward.

P4) IHMS should seek clarification of the responsibilities of IHMS and the DIBP to ensure patient care is not compromised. This division of responsibility should be made available to medical practitioners.

3.3 Informing the Department of Immigration & Border Protection

3.3.1 Introduction

IHMS has a responsibility to ensure that key stakeholders, such as the DIBP, are well informed.

3.3.2 Immigration Health Advisory Group

The Immigration Health Advisory Group (IHAG) was established to provide independent advice to the DIBP on the health needs of asylum seekers and newly settled humanitarian entrants.

3.3.2.1 Failure of IHMS to ensure IHAG well informed

It was concerning to note that on a tour with IHMS staff during a recent IHAG visit (October 2013), representatives were not introduced to a single medical practitioner working in a clinical role[13]. Considering the fact that most practitioners working at the time had serious concerns about practices on the island, it is likely that the IHAG representatives did not obtain a full understanding of the issues at hand.

3.3.3 Informing the Minister for Immigration

Decisions made by Minister Morrison have direct and significant impacts on the health and wellbeing of our patients. Whilst we are aware IHMS reports primarily to the DIBP, the following statements by Minister Morrison suggest that he is poorly informed regarding the current health situation on Christmas Island.

1. Regarding the presence of two unaccompanied minors detained on Manus Island

   "*At my press conference today I stated that I understood there were no unaccompanied minors currently located on Manus Island as I had*

been under the impression they had been transferred to an alternate facility,"

"I can subsequently confirm that there are still two unaccompanied minors on Manus, who were transferred there by the previous government. I have instructed that they be relocated to Christmas Island as soon as possible."

IHMS would have been aware of these two minors and that their presence on Manus Island was considered unacceptable.

[52]

2. According to The Guardian, Minister Morrision's response to RACP concerns regarding risks associated with 48 hour medical assessments was:

"The immigration minister, Scott Morrison, says he is satisfied that the government's new 48-hour turnaround target to move asylum seekers offshore for processing allows for adequate medical assessments, despite expert groups arguing otherwise. "

This is not the case, as evidenced in Sections 1.1 and 1.2

Minister Morrison went on to say:

"Inoculations as I understand it have always been done on Manus Island anyway."[54]

Immunisations are performed on Christmas Island prior to departure. Their hasty implementation resulted in administration of live vaccines to pregnant women.

3. In regards to a woman diagnosed with twins, transferred to Nauru.

"This is why I'm stressing to you, I strongly suggest that the media should more thoroughly interrogate the sorts of claims that are being represented to you. That is a classic example. This suggestion that there has been a pregnant woman with twins on Nauru is simply not true."

At the time of her transfer to Nauru, this woman was considered to be carrying twins.

3.3.4 Key recommendations (Q)

Q1) IHMS should ensure that IHAG representatives are fully informed. This should include discussions with clinical staff without interference.

Q2) IHMS should take steps to ensure the minister is well informed.

3.4 AHPRA Registration

3.4.1 Introduction

AHPRA is the body for registering health practitioners in Australia. It is of concern that practitioners working within IHMS may be putting any registration they have with AHPRA at risk, by participating in unethical conduct and in gross departures from clinical standards.

3.4.2 The role of a Medical Officer

The circumstances detailed in this document make it a practical impossibility for medical officers to practice in a way that is consistent with standard practice. This departure from standards places the public at risk.

According to the guidelines for mandatory notifications (AHPRA, 2013), Medical practitioners have mandatory reporting obligations to AHPRA when faced with a reasonable belief that departure from accepted professional standards is placing the public at risk[43].

The guidelines go further to state that:

...making mandatory notifications under the National Law is consistent with professional conduct and a practitioner's ethical responsibilities.

As a result of these responsibilities and the various issues discussed in this letter, it is possible that all practitioners working on Christmas Island have mandatory reporting requirements to AHPRA.

3.4.3 Response Expected

We the undersigned ask that IHMS provide us, as soon as possible (not more than 7 days) a response to the concerns detailed in sections 1.1-1.3, 1.5-1.6, 2.1-2.4, 2.7

We ask this due to concerns that continuing to practice under the current circumstances may constitute a breach in AHPRA's code of conduct and require mandatory reporting.

5.0 References

T Testimony

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6.0 Appendix

1

It has contributing factors of skin degradation from salt accretion, abrasions and exposure to urine. These irritations are colonised resulting in a purulent and exudative series of superficial lesions with surrounding cellulitis on affected areas; commonly the lower limbs, buttock and back[3].

2

The following is a step by step process required at the end of October

1) Open the s:\ (if it is infact accessible from your workstation)
2) Find a template and ensure it is the most up to date version (7 versions) by correctly clicking through 7 file folders with no clear logic or guide as to where is might be found unless you already know that it is there.
3) Open the spreadsheet
4) Transfer patient details and clinical data
5) Save to a file folder 7 folders down using a specified format identifying the patient and category
6) Open email and send a copy to 3 addresses or more if relevant (ie TB/antenatal nurse)
7) Find a referral template which is as of yet is only located amongst received emails
8) Write a referral
9) Print referral and sign
10) Scan referral into Chiron (unreliable as to whether it is retained)
11) Check the master transfer list over the next few days to ensure it is not lost in the process
12) Follow up patients that despite all this get lost