Visit to Darwin Alternative Places of Detention
December 6th-8th, 2013

Darwin Detention: Damaging Children

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Executive Summary

With 338 children currently detained across three detention facilities, Darwin holds more refugee and asylum seeker children than any other mainland location. Further to this Darwin’s Alternative Places of Detention (APODs) have – in recent months – become a maternal health holding unit for asylum seeker women. With no public information available about the maternal and infant health care for asylum seekers in Darwin, ChilOut thus saw Darwin as a priority, and visited in November 2013. We hold grave concerns about a variety of risks to which children, pregnant and new mothers in these facilities are exposed.

ChilOut’s position on children in immigration is clear. There should always be a presumption against detention, there should not be remote, mandatory nor indefinite detention of any child seeking protection. Knowing however, that the policy of the day is a complete antithesis to any model that focuses on the best interests of the child, ChilOut conducted this Darwin detention visit. We hoped to gain a thorough understanding of the system in place, assess efforts to mitigate harm to children within a damaging system and to make pragmatic recommendations for change.

To this end, ChilOut was accompanied by Professor Caroline deCosta and Dr Emma Adams. Professor de Costa has 39 years experience in the practice of obstetrics and 36 years in the area of obstetrics research. Dr Adams – a fellow of the Royal Australian and New Zealand College of Psychiatrists – is a psychiatrist with a special interest in the mental health of mothers and infants.

ChilOut’s Chair, Dianne Hiles and Campaign Director, Sophie Peer along with Professor deCosta and Dr Adams attended a day of formal meetings and facility tours with the Department of Immigration and Border Protection (DIBP), Serco, International Health and Medical Services (IHMS) and Maximus. In addition we met with detained families as well as external Darwin stakeholders.

We toured Wickham Point, Blaydin Point and the Darwin Airport Lodge (DAL), but did not visit the Northern Immigration Detention Centre as it does not hold children.

Our International Obligations
As a signatory to the Convention on the Rights of the Child Australia has certain responsibilities.

Convention on the Rights of the Child – Article 3
In all actions concerning children … the best interests of the child shall be a primary consideration.

Convention on the Rights of the Child – Article 22
… a child who is seeking refugee status … whether unaccompanied or accompanied … [shall] receive appropriate protection and humanitarian assistance…

Detaining children violates their basic human rights. But when they are housed in locked facilities such as those in Darwin, as the Convention states, it is incumbent upon their caretakers to make their best interests a primary consideration.
Children subjected to abuse, torture or armed conflicts should recover in an environment which fosters the health, self-respect and dignity of the child.

Many children in detention have fled active war zones, and depriving them of liberty does not promote their recovery from such experiences. As many reports have shown, detention compounds trauma.

Constitution on the Rights of the Child – Article 37(b)
No child shall be deprived of his or her liberty unlawfully or arbitrarily. The arrest, detention or imprisonment of a child shall be in conformity with the law and shall be used only as a measure of last resort and for the shortest appropriate period of time.

Australia’s mandatory detention regime is fundamentally flawed. While it imprisons children as a first resort and for indefinite periods of time, it contravenes international law and common sense morality. Children should not be locked up. Ultimately the government must recognise this and legislate to prevent the implementation of policies that breach Australia’s legal and moral obligations.

The immigration detention regime does not keep children safe and presents significant risks to their ongoing wellbeing.

Darwin in Context: In Australia today at least 1153 children are held in locked indefinite detention. Over 100 children are detained on Nauru. They will never be resettled in Australia, even if found to be refugees. Australia is the only Refugee Convention signatory to have a policy of mandatory, indefinite detention for asylum seekers.

“They can call me illegal, but don’t call my baby illegal”

- Pregnant mother speaks about her first child who will be born into detention.
1.1. Darwin Recommendations

Darwin facilities presented certain issues which need to be addressed by our Government, the Minister for Immigration and Border Protection and the agencies involved. Our recommendations relating specifically to our visit of Darwin but pertinent to any site holding children, babies and pregnant women are:

1. Families should never be separated. A woman should be relocated to the mainland as soon as her pregnancy is confirmed, at this time she should be accompanied by her partner and any children she may have.

2. As soon as expectant mother arrives to Australia, a hospital booking visit is provided and her ante-natal care commences by qualified health professionals.

3. The immediate employment of two midwives via Royal Darwin Hospital whose specific workload is asylum seeker women. If numbers of pregnant women increase, the resourcing of healthcare provided must be reviewed. This should be a DIBP cost paid to NT Health / RDH.

4. IHMS in Darwin to immediately recruit a GP with a Diploma in Obstetrics (at minimum) to be employed on site. The same should apply in any other location that becomes such a maternal health detention unit.

5. Increased communication and an agreed, shared care plan for ante/post natal care developed between local hospital / IHMS and DIBP. Serco to be made completely aware of the logistics and requirements of this agreement.

6. Medical staff involved in clearing a mother and baby to be sent to Christmas Island, Nauru or Manus Island be provided with a full and transparent understanding of the healthcare situation in these locations. No transfer is made without full medical recommendation.

7. At an absolute minimum, no transfers to Christmas Island or Nauru should take place until the mother has had her 6 week post-natal check and GP / midwife is confident that baby is feeding well, any lactation issues are resolved.

8. Antenatal and postnatal care for detained women reflect best practice community standards as prescribed by Australian College of Midwives and Royal Australian and New Zealand College of Obstetricians and Gynaecologists

9. All medical appointments be attended by an in-person qualified interpreter taking into account cultural / gender issues.

10. All medical services should be culturally accessible. This includes mental health care. Simply presenting for a scheduled check up may not address needs.

11. More thorough mental health screening is required for all detained asylum seekers. If the clinical recommendation is that the person / family unit should no longer be in secure detention, then this must be acted upon.

12. Early childhood development experts be involved in the development (and perhaps administering) of programs provided on-site for children under school age and school holiday programs.

13. Detention staff working with children (eg providing the only available early childhood development activities) should have qualifications that mirror Australian community standards.

14. Mothers should be provided with sufficient maternity items that consider cultural needs.

15. Babies should be provided with at least six complete changes of clothes suitable to weather and air-conditioning. More should be available on request.
1.2. General Recommendations

In its 2011 Christmas Island Report ChilOut called for general changes to policy or legislation to institute the following across the detention network:

1. Develop alternative accommodation facilities
2. Develop criteria for the need to detain or release children
3. Apply a time limit to the detention of children
4. Develop a risk-based determinant framework
5. Institute a detention review process that can be enforced
6. Institute an alternative Guardian for children in detention
7. Create a unified, national code of mandatory reporting
8. Remove the discriminatory treatment of children who arrive by boat

As at 2013 none of these changes have been implemented. Though more facilities that detain children are now called “Alternative Places of Detention (APODs)” that does not make them alternative in any way.

Further to the still unmet 2011 recommendations our recent detention visit leads to the following recommendations:

i. The reinstatement of the Independent Health Advisory Group or similar comprising independent practitioners with a range of expertise. Most definitely including but not limited to, infant and child psychiatry, childhood development, obstetrics, midwifery and children’s health.

ii. The standard of healthcare in the detention network must be commensurate with best practice Australian community standards.

iii. If the Government is intent on maintaining long-term detention, family situations should be taken into account and people held in the Australian city that their children / spouses are known to live in.

If the Government intends to keep people detained long-term, contractors and DIBP must put in place health care plans, education, recreation and activity programs that take this into account. Specialists must be brought in to develop and run these.

“It would have been better if I fell in the ocean and sharks ate my body. That is better than this.”

- Mother in-front of her two children. They have spent 14 months in three different detention facilities.
2.1. CHILOUT INTRODUCTION

ChilOut is a not-for-profit community group advocating for the release of children from immigration in detention in Australia. Established in 2001, the group has since toured almost every detention facility which holds children.

ChildOut aims to hold Australia accountable to its commitment to the Convention on the Rights of Child, which states Australia should in all cases take into account the best interests of the child, above all other considerations.

The premise of our organisation and the foundation of this report was reiterated by the United Nations in 2013 when it was clearly stated that detaining asylum seeker children was never in the best interests of that child and called on states to “expeditiously and completely cease the detention of children on the basis of their immigration status.”

2.2. APODs – Alternative Places of Detention

For over a decade ChilOut has continually stated that no child should be detained. Governments have responded by creating so called “Alternative Places of Detention” (APODs). In some cases they’ve simply rebranded detention facilities as APODs, making no other changes. Even where cosmetic, or greater changes have been made ChilOut has long rejected the use of this terminology. The Darwin Airport Lodge, Wickham Point and Blaydin Point, for example, are all detention facilities. Each facility denies a person their freedom, they are not an alternative to detention. There are usually some physical delineations between APODs and Immigration Detention Centres (IDCs) where single adult men are predominantly held. We address this issue further in section 5.2 relating to the recently designated Wickham Pt “APOD”.

The number of people detained in each mainland APOD do not appear in Department of Immigration and Border Protection (DIBP) statistics, despite ChilOut and other agencies requesting this information for many years. Rather, a figure for Christmas Island “APOD” and a grouped figure for “mainland APODs” are released irregularly.

2.3. PURPOSE OF VISIT and DELEGATION

ChilOut attempts to visit all detention facilities holding children and does so as funding permits. With 338 children currently detained across three detention facilities, Darwin holds more refugee and asylum seeker children than any other mainland location.

Further to this, in recent months Darwin’s APODs have become a maternal holding unit. There has been no public information pertaining to maternal and infant health care for asylum seekers, nor any sense of the overall environment facing women and babies in this precarious position ChilOut deemed Darwin a priority.

In addition, around 50 pregnant women are held in detention in Darwin. The majority of expectant mothers have been transferred from Christmas Island and arrived by boat after 19 July. After they give birth and have clearance they will be sent back to detention on Christmas Island and potentially on to Nauru or Manus Island.

ChilOut conducted this Darwin visit to gain a thorough understanding of the detention system in place, assess efforts to mitigate harm to children within a damaging system and to make pragmatic recommendations for change.

To this end, ChilOut was accompanied by Professor Caroline de Costa and Dr Emma Adams. Neither was visiting in a clinical role but both used their respective expertise to observe, make in-depth inquiries and provide purely health focused – not asylum policy focused – insights.

Caroline de Costa, Professor of Obstetrics and Gynaecology of the Clinical School at James Cook University School of Medicine, Cairns Campus. BA (USyd), MBBS (London University), FRCOG

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2 NB: acknowledge and commend AMJ article but ref fact it is 2011 figures, before this practice was underway
(Fellow of the Royal College of Obstetricians and Gynaecologists), FRANZCOG (Fellow of the Australian and New Zealand College of Obstetricians and Gynaecologists), FRCS (Glasgow), MPH (USyd), PhD. Caroline has 39 years experience in the practice of obstetrics and 36 years in the area of obstetrics research. She has been a specialist obstetrician and gynaecologist for 32 years. Caroline has practiced in Papua New Guinea and Australia since 1980. Caroline has extensive experience of practice in women’s health in Papua New Guinea. She is one of very few Australian obstetricians with direct clinical experience of medical practice and detention on Nauru having visited and worked on the island for AusAid in 2003 during Australia’s first so called ‘Pacific Solution’.

Dr Emma Adams is a psychiatrist with a special interest in the mental health of mothers and infants. Dr Adams is a fellow of the Royal Australian and New Zealand College of Psychiatrists and has a Masters degree in Perinatal and Infant Mental Health. She has worked in clinics in Canada and Australia and her recent focus has been on Aboriginal and Torres Strait Islander mental health through a community controlled health service. Currently Dr Adams is in private practice in Canberra.

ChilOut’s Chair, Dianne Hiles and Campaign Director, Sophie Peer also attended the visit which involved a day of formal meetings and facility tours with DIBP, Serco, IHMS and Maximus. In addition we met with detained families, local health professionals and relevant community members. We toured Wickham Point, Blaydin Point and the Darwin Airport Lodge (DAL), but did not visit the Northern Immigration Detention Centre as it does not hold children.

2.4. FORMAL DIBP / SERCO / IHMS INVOLVEMENT

ChilOut was taken on formal tours of Darwin’s three APODs, the Darwin Airport Lodge (DAL), Wickham Point and Blaydin Point, with the full knowledge and involvement of all agencies, Serco, the DIBP and IHMS as well as Maximus. We had meetings with on-site staff, including those in senior positions. In addition we completed necessary forms to meet with families who wished to meet us.

Over four days in Darwin we received conflicting information from different sources. We presented each anomaly to DIBP, Serco and IHMS in writing and provided ample response time to clarify the information and reach recommendations that were most useful to all involved.

None of the agencies responded.

Required response time had passed and ChilOut contacted all three agencies again, DIBP then responded stating:

The department and its service providers take the care of detainees seriously, and will carefully consider any recommendations and follow-up on issues in line with Government policy.
3.1. WHO IS DETAINED IN DARWIN?

Of the 338 children detained in Darwin, eight are unaccompanied minors aged 15 –18, we believe all eight are boys. Of these, two are in Darwin to receive medical treatment and arrived after 19 July (meaning they can be transferred to Christmas Island and then on to Nauru or Manus Island at any time).

Since our visit to Darwin, we believe at least three babies have been born and another 40 are due in coming weeks. The majority of these women and children have arrived since 19 July 2013 and as such, face indefinite detention on Christmas Island, Nauru or potentially Manus Island. This Government has repeatedly stated they do not intend to send families and children to Manus Island.

It was explained to us that it has become operational practice to bring a pregnant woman to Darwin for scans, health checks for her unborn baby without the rest of her family. We met pregnant and new mothers in Darwin who are currently forcibly separated from their husbands/partners and other children (who have been left detained on Christmas Island). This practice is causing great distress to mothers in an already stressful situation and no doubt anxiety to fathers and the unnecessary suffering and anguish of young children who may have never previously been separated from their mothers and cannot comprehend where she is and when or if she will return.

Even with the Government’s harsh ‘no exceptions’ policy that leaves families detained indefinitely in remote locations, this practice of forcibly separating families has no place. It is entirely contrary to current practice in the care of women and children in Australia itself.

The entire family unit could be transferred together to Darwin (or other mainland locations) whilst the individual/s receive necessary medical treatment and then all transferred back to Christmas Island together once mother and child are cleared for return.

This would be far more economically prudent than the current practice which can involve up to six privately chartered flights, all at enormous taxpayer expense. ChilOut understands that DIBP has also caused other family separations between Perth and CI as well as Adelaide and CI, whilst individuals receive medical treatment. This practice is unnecessarily cruel.

Over recent weeks most people have been moved from the DAL to Wickham Pt and Blaydin Pt. Approximately 80 people remain detained at the DAL, using only one of the three compounds available which have a combined capacity of 435 people. The majority of pregnant women and new mothers have been moved to Blaydin Point which is around 40 minutes drive from the Royal Darwin Hospital.

Those remaining at the DAL arrived in Australia before 19 July 2013 and their fate is unclear; some may be eligible for Bridging Visas (if the Minister recommences issuing these), Community Detention or some may be ‘screened out’ and returned to their country of origin. We have concerns about access to independent legal advice and the pressures of indefinite detention leading people to take ‘voluntary return’ packages. The same pressure of arbitrary detention noted by the UNHCR on recent visits to Nauru and Manus Island are also evident in Darwin where many people are approaching seven months of detention without any progress of their protection claims.

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3 UNHCR monitoring visit to the Republic of Nauru, 7 to 9 October 2013
4.1. OBSERVATIONS ACROSS ALL DARWIN APODs

Overall, the conditions of mandatory and arbitrary detention within a “return-orientated environment”, delays in RSD processing and the absence of clear durable solutions, if left unaddressed, will inevitably have a detrimental impact on the physical and psycho-social health of asylum seekers, particularly vulnerable individuals.

ChilOut understands that the lease on the DAL ends in June 2014. Given the huge capacity of Wickham Pt and Blaydin Pt (2050 people in total4) as well as the Government’s stated intention to keep people indefinitely on Christmas Island and send others offshore, including children and families, ChilOut presumes but cannot confirm that the DAL lease will not be renewed. Whilst ChilOut is opposed to indefinite immigration detention, it must be noted that the physical environment of the DAL, the lowered fences, proximity for community engagement and the overall layout are far less oppressive than at Wickham Pt and Blaydin Pt.

4.2. Accommodation

Accommodation at each site is in converted shipping containers 6m x 2.4m. The internal configuration of bunk beds / double bed / single bed can be altered as needed. Some rooms have a kitchenette, we are advised that no microwaves are available for use in rooms. Rooms feature a small dining table, families can take plastic chairs from common corridor areas, there is a television mounted on the wall, a small wardrobe, a small fridge and small bathroom consisting of shower, toilet and basin. A large family can have two adjacent rooms, no interconnecting doors and it was explained to us that one parent would be in each room and that service providers felt “this was working well”. Staff advised there were no age restrictions on using bunk beds. We did not observe guard-rails on top bunks. This is contrary to the nationally available standard advice.5

4.3. Communication / Recreation

None of the Darwin APODs have private phones or computers. Phones are wall mounted in outdoor public corridors. Computers are in rooms with no booths / dividers or means for having a private Skype call for example. There are booking appointments and scheduled operating hours to use the internet. Many asylum seekers raised concerns about internet access. Some sites have half hour booking times, some have 1 hour. There appear to be ample computers, especially given that the facilities are currently under capacity. We were advised by asylum seekers that internet speeds are slow and much of the session is spent waiting. There are concerns that internet times are not useful for Australian eastern business hours (contacting lawyers and the like) nor for contacting family members overseas (Skype, real time chat etc). It is completely unclear to us why computer rooms cannot be open for use from 8am – 9pm with booking sessions to facilitate shared use. Communication, contact with family, lawyers and a connection to the outside world are essential for the mental health of asylum seekers. The rooms are air-conditioned, the climate is very hot, we urge Serco and DIBP to consider increasing the availability of computers / internet access.

A concern long raised in relation to Australian detention facilities is that phones and computers exist but have been out of order. We were advised by service providers that all of the telephones and computers across the three APODs were in working order.

4 Department of Immigration and Border Protection website accessed 16 December 2013
5 Child Accident Prevention Foundation of Australia, 2011 Parent’s Guide to Kidsafe homes. Downloaded 16 December 2013,

Falls are the most common cause of injuries to children.
The most common injuries from falls are head injuries and fractures.

Safety Steps to Prevent Falls:

Bunk Beds:
Make sure bunk beds have guard rails, a fixed ladder and the Australian Standards tick of approval.
Children under nine should not sleep in the top bunk bed
Each site has a library consisting of multi-lingual books and a relatively large selection of books in English. All are small spaces, with some room for relaxation but if there were more than 2 families in any library it would become noisy and cramped. The need for indoor recreation is essential given the Darwin climate and the fact that accommodation rooms are so small. Library opening times vary across sites, some are for 2 x 2hr sessions on weekdays, others have scheduled times for school children to do homework, one we were advised was drop-in anytime.

Each site offers art and craft activities. Blaydin Pt and Wickham Pt have woodwork rooms and rooms with sewing machines. At Blaydin Pt these rooms were very small and although contained much equipment, it was difficult to see how more than a few people at a time could use the facilities. Similar spaces at Wickham Pt were spacious and well equipped. Although it was noted that culturally many people are more comfortable engaging in such activities by sitting on the ground, there were no facilities to allow this. We observed people using makeshift items to sit comfortably whilst they work. Some low stools and cushions would be a simple remedy to this.

Interaction with the wider community is dependent on geography. A long standing local group, DASSAN conduct regular visits to the DAL and have commenced some to Blaydin Point as personal friends have been transferred there. Wickham Pt and Blaydin Pt are approximately 50 minutes drive from the Darwin CBD compared with 15 minutes to the DAL, to which many visitors ride their bicycles, this presents an immediate barrier. Formal excursions outside of Wickham Pt and Blaydin Pt are more restrictive than from the DAL. For example there are religious excursions each Sunday, restrictions are in place so that religious buildings can accommodate the local population as well. People detained at the DAL spoke of ample visiting time, a chance to share in communal prayer and food. For people forced to Wickham Pt and Blaydin Pt, there is less time spent at such outings and on the weekend we were there, people were forced to leave before sharing in important aspects of their religious observance.

We were told of an ongoing partnership between Serco and NT Multicultural Centre and NT Arts.

We have been unable to confirm the number of people involved in such activities or their frequency. We understood some programs to be of 5 week duration and that programs would recommence in 2014. Whilst we were in Darwin there was a local art exhibition in which a handful of asylum seekers had works displayed and were being taken to the public gallery to see the show. Most artworks we saw in the detention facilities were signed with the artist’s name and their boat ID.

There are limited off-site escorted excursions, we were specifically explained one from the DAL only for women. Serco advised that this CBD visit involves one of their officers and up to 15 “detainees”. It appears that such excursions are not available to women detained at Blaydin Pt or Wickham Pt.

At no site were children observed to be wearing hats, it was around 35 degrees on the day of our formal visit. There was no sunscreen on walls for use, no signs encouraging such actions. We are advised that hats and suncream are provided to all “detainees”.

The forms we were required to sign and the Occupational Health & Safety briefings at each site for our formal tours were very thorough. It was a requirement that we wear closed toed shoes. Officers wear army style boots. We observed several male asylum seekers using gym equipment, including 20kg+ dumbbells wearing only thongs.

Given Darwin’s population, there are limited religious buildings and communities for asylum seekers to interact with and understandable restrictions on those that are there. For example, the local mosque can only accommodate 50 asylum seekers for Friday prayers, so they can ensure that they are comfortably and safely also meeting the needs of the local and visiting population. We asked Serco and DIBP to confirm whether, given this fact and given the understanding that hundreds more people could be detained in Darwin, if there were plans for increased religious spaces within Darwin’s “APODs” and whether external religious figures would be brought in to conduct weekly services across all religions - no response was provided.
4.4. Staffing / Operational Issues

Maximus is the company contracted to care for unaccompanied minors. As such staff are only on-site at Blaydin Point where 8 unaccompanied children are currently being detained. If required, these staff can be utilised at other sites. For example if parents are at the hospital for the delivery of a new baby and other siblings require care. These staff are employed in a welfare capacity to assist children without parents in getting ready for school, taking part in activities but are not the delegated guardians of the children. This role falls to a prescribed DIBP staff member in Darwin. We have sought but not received clarity from Maximus about the level of training and qualifications their staff have in working with adolescents who have experienced trauma, may be depressed and at times have attempted suicide or engaged in self-harm behaviour.

Maximus are not the guardians of these children, this role falls to a prescribed DIBP staff member in Darwin. That this person can be the “guardian”, “consent giver” for medical procedures and the like and also the representative “imprisoner” of this child is ethically incompatible.

Many asylum seekers, including unaccompanied children can act as “volunteer interpreters” inside the detention network. Given the power relationship between asylum seekers and the authorities detaining them the ethics of this are highly questionable. The delegated guardian for unaccompanied children is a locally employed DIBP official. How can this person be the ‘guardian’, ‘consent giver’ and representative of the organisation delegated to detain that child? What debriefing, support, mental health care plan is available to children who are translating sensitive information? What cultural / gender care is taken in making these arrangements?

We observed that children were not adequately included in medical decision-making, nor given sufficient information regarding their medical conditions nor treatment options. An unaccompanied minor divulged to us that he required medical treatment. It quickly became apparent that he had been given very conflicting information about his condition and was not aware of the options available to him indicating serious gaps in the system. IHMS, Maximus and the delegated DIBP guardian all have a communication as well as duty-of-care role to play in such situations.

Across the whole detention network if a child is with a relative aged 21 or over they are not eligible to receive Maximus case assistance. This means that a 23 yr old becomes the sole carer for his 15 yr old brother. There is no support provided to that 23 yr old to carry out this task despite the indefinite detention pressures he himself is trying to cope with. As one young man told us “I cannot be just his brother, but I also cannot be his mother and his father. We have no support in here.”

It was observed (and is understandable) that bilingual and multilingual staff working in detention facilities are called upon to be much more than general officers, they play a welfare role, a child and parental support role. What training, support, supervision and de-briefing is available to these staff for such tasks? We were advised that the staff who ran playgroups for 0-4yr olds were “community support workers”. The standard of training required in Australian daycare facilities should be a bare minimum requirement for such employees in the detention network. However, due to the mental health needs of these detained children, the extra assistance of an early childhood expert with experience in infant mental health, in particular, being able to recognise and intervene with “red flags” such as emotional and behavioural difficulties and things like trauma play is vital to reduce the suffering of these young children.

NT Police are on-site in each APOD as Immigration Liaison Officers. The role was explained to us as being to get people used to and comfortable with Australian authorities and laws. Police are in uniform but without weapons.

The shift of language from calling asylum seekers “clients” to calling them “detainees” was most definitely in evidence. Some staff described their reluctance to use the term “illegals” and shared with ChilOut their concerns that the next company refresher course may include the directive to
use this term. There was clear instruction to our delegation that Serco employed “officers” not guards.

ChilOut witnessed many occasions when numbers as opposed to names are used to address and identify asylum seekers. Individuals for whom we had submitted visit forms (including full names) could only be found at Blaydin Pt by providing their ID number, Serco’s visit sheet to be checked off did not even list names. Perhaps the most alarming use of numbers not names was in the new medical area. On the back of consultation room doors are lists of people’s boat IDs without a name even noted adjacent, presumably to be ticked off for the regular check-ups people are provided. Numbers are ticked off for meals, these sheets do have a name and photograph listed as well. Every asylum seeker we met knew their number, that of their friends, and some introduced themselves to ChilOut using their ID number. Parents were concerned that their new babies did not have ID numbers and wondered how they ‘existed’ in the detention system.

Each site uses plastic cutlery for every meal which is thrown away. Plates and cups are plastic but are re-usable. No site appeared to be using solar power and we could not locate recycling bins for our own rubbish. The climate in Darwin requires constant air-conditioning to prevent mould. This means that the two thirds of facilities not in use, and for which there is no projected short-term use, are constantly air-conditioned.

Pregnant women described having insufficient maternity items. One woman showed us pants that she was forced to fold down as her belly expanded and was told a loose skirt was not an option as a visitor had already provided her with one skirt and ‘this was enough’. There are basic needs that must be met by service providers if pregnant women are to be detained in this manner. Having to ask for such items seems to be just another deliberate step in removing any autonomy and eroding dignity. We met families with newborn babies who had been issued with one and two pairs of baby pants respectively. Given the number of wet nappies expected by healthy babies in a day this is completely inadequate.

The issue of breast pumps is noted in the medical section below 6.3. However from an operational perspective, the delay in providing such an item illustrates the unclear delineation between IHMS, Serco and DIBP.

Clarity has not been provided by any agency but we presume that an item could be recommended from a health perspective by IHMS, purchase would need DIBP sign off and the item would be issued by Serco. How a decision is made regarding a personal property item vs detention owned is not clear to us, we have asked this in relation to breast pumps.

No family had been issued a baby change-mat despite the very hot conditions and risks of infection. Baby baths were provided for use in the room’s showers.

Some families were provided with second-hand strollers which they were concerned were dirty.

ChilOut observed signs notifying asylum seekers that they needed to be in their rooms for 11pm and 5am room checks. Other signs stress the importance of reasonable bed times for different age groups of children. Families explained to us that they were woken at least two, up to four times per night by an officer doing a head count. People explained to us that they were required to respond verbally “two” etc. Having a thorough understanding of the physical environment and the constant presence of Serco, we cannot see why the converse cannot be done - checks of corridors, communal spaces etc. Being woken from your sleep, having your children woken, already having sleep difficulties as it is known so many detained people have - these room checks seem to be yet another unnecessary cruelty. We sought clarity from agencies on this practice but received no response.
4.5. Food

The catering contract in Darwin is with private company, Trepang.

“Snacks” available in between meal times are the same instant noodle pots we have seen inside detention facilities for years. ChilOut was on-site as primary school children were returning to detention in the afternoon. The mess hall contained self-serve dispensers of four very brightly coloured drinks and instant noodle pots. At one site, there was a self-serve fridge containing milk, bread and condiments as well as tea, coffee and milo. We were told the fridge was re-stocked four times per day and included fruit, but there was none there at the time of our visit. We did observe fruit available at all sites during our formal visit, there were four options. Asylum seekers later advised us that on days when there are no external, formal visitors, only one type of fruit is available to them. We put this inconsistency to Serco and DIBP but received no clarity.

No Darwin “APOD” has capability for parents to prepare meals for their children. This option is available elsewhere in the Australian detention network. All baby food is processed, pre-packaged in jars / packets. We observed two savoury and two sweet varieties of food in storerooms along with formula and cereal. Bottles and formula are given to mothers as they arrive ‘home’ from hospital with their new babies. Formula is not an on-request item but a standard issue and no staff member we spoke with seemed to even comprehend that this was at odds with the World Health Organisation (WHO) recommendations about promoting and supporting breast feeding.6

The WHO code includes guidance for “health facilities and health professionals”, given the fact that these women have no choice in health care provider and that the detention environment must unfortunately also serve as their maternal healthcare provider, we believe the WHO code applies in this case to DIBP, Serco and IHMS. In addition, we did not observe any sterilisers at any detention location and although clarity was sought, none was provided by agencies involved as to whether sterilisers were provided with bottles. It was explained to ChilOut that if a mother required a bottle to be heated in the middle of the night, she could find an officer and request it.

Pregnant women and new mothers expressed concern about their diets and worried that it was not nutritious enough to provide for optimum health for them and their babies. We were advised that many meals were too spicy, that there was not a balance of food provided across a week and that for lunches in particular people ticked off their names but did not eat.

ChilOut is advised that a “nutritionist” checks off the meal plans. We have asked for clarity as to whether this person visits the detention sites, understands the physical restrictions and emotional and mental stress people are under. In addition does this person have training to work in the areas of infants, children, pregnant women and across many cultures? A senior member of a service provider agency told us there were difficulties around children eating the meals provided. The staff member advised us this was “cultural” and then noted it was seen as a “welfare” issue for those staff to assist with. No reference was made to meal plan changes that fit with the varying developmental stages of children at different ages.

6 https://www.breastfeeding.asn.au/who-code

The WHO Code

1 Health facilities and health professionals do not have a role in promoting breastmilk substitutes
2 Free samples of breastmilk substitutes or items that promote breastmilk substitutes should not be provided to pregnant women, new mothers, or health facilities
3 Health risks to infants who are artificially fed, or who are not exclusively breastfed, should be highlighted through appropriate warnings and labelling
4.6. Education

There is an arrangement with four local primary schools (one for students with special needs), one pre-school, a middle school (years 7-10) and a secondary level school where 16 and 17 year olds attend “night classes”. These night classes run from 2:30pm - 6:30pm, clearly not the allocated amount of lesson time provided to mainstream 16/17 year olds to undertake a full curriculum of work.

There is no early childhood education or equivalent for the many children detained under the age of 4. ChilOut was formally advised that a playgroup exists on each site. Most families were not aware of this, one family described that an hour per week of playgroup was available at one site.

There is no option of childcare, playgroup or developmental activities that provide parents with any respite or are tailored to the anxiety, depression and stress affecting both children and parents. We were shown “playrooms”, at no facility did we witness children playing in these rooms despite there being many children under the age of 4 wondering about corridors and along pathways.

There was ample evidence that the playrooms at each site are little if ever used – stacks of toys still in plastic wrapping, toys that no sign of ever having been used.

ChilOut was advised that school holiday programs are prepared in conjunction with NT Department of Education. No-one was able to detail for us what these were and there are no education specialists for any level of childhood development employed at the facilities or brought in over the holiday periods. The already very stressful environment is compounded for parents and children with the coming seven-week school holiday break being very hot and wet.

Teaching English as Second Language (TESL) classes are provided on site for adults and there are classes specifically for children under 5yrs. We met one teacher on-site who explained that parents can bring their children to some classes.

“They can call me illegal, but don’t call my baby illegal”

pregnant mother speaks about her first child who will be born into detention.
5.1. Darwin Airport Lodge (DAL)

Compared to the other Darwin “APODs”, this site is less prison-like. Whilst clearly still 24 hour detention, and no alternative to detention, there is a more relaxed feel to this facility. This sentiment is echoed by those who have been moved from the DAL to Wickham Pt or Blaydin Point.

We were advised of 36 children detained at this site.

The facility is right next to Darwin airport and within a relatively easy distance to Darwin’s CBD and suburbs. It is about a 15 minute commute to RDH.

The “playroom” here is a single shipping container of 6m x 2.4m, it was explained to us that around 15 children at a time (with a parent) would use the room. The room is open two days per week from 10:00am - 11:30am. Given the complete lack of child centric care in the whole facility it is unclear why this playroom cannot be available and appropriately staffed with trained professionals from 9am - 5pm. With the centre so under capacity yet still a lot of young children held here, it would seem logical that a larger space could be dedicated to a playroom.

There is a pool on-site at this facility.

The IHMS office is open 8:00am - 8:45am, 7:30pm - 8:15pm and essential medications are issued at 9pm. Appointments can be made a day in advance if required.

Internet is available 8:00am - 9:30am and 8:00pm - 9:00pm.

5.2. Wickham Point

The classification of this facility as an “APOD” appears to be very much by name only. There are electric fences (perhaps they are switched off, but they are still signed as electrified), all the way around, 20 foot high double perimeter of fencing, considerable series of locks, gates and blocked off areas giving the whole environment a very overbearing, prison-like feeling. Officials advised that there are attempts to “soften” the environment. A very difficult task if the fencing, caged walkways and other harsh infrastructure is to remain in place.

We were advised there are 590 “detainees” in the three compounds and that 175 of these are children. One compound is for single adult males (SAMs) and extra fencing has been put up in order to meet operational requirements that the SAMs are not using common areas at the same time as family groups and unaccompanied children. Even the SAMs are now taken to be held in an APOD as opposed to Immigration Detention Centre (IDC). We are aware of families separated across the compounds.

ChilOut toured only the ‘Surf’ compound the other two are named ‘Sun’ and ‘Sand’, we were advised that each are identical in terms of infrastructure. The compound we saw had an area described to us by officials as the ‘community hub’. This comprised a covered concrete area with table tennis, the canteen, a hairdressing / beauty salon, a multipurpose room where around ten school aged children were dancing (we visited during school hours), the small library and computer room.

There is one centralised kitchen for the whole site and three separate dining rooms. There are 40 computers per compound.

The visit room at this site, whilst the facility was apparently well under capacity was small to the point of being unsafe. Private conversation, comfort and any sense of reprieve from the usual detention setting was completely missing from this small, stark, noisy room. Once a few visits were underway in the allocated time slot, people had to clamber over chairs to reach a cup of water.
5.3. Blaydin Point

On many occasions ChilOut was advised that much infrastructure on this site was “purpose built” and the facility was “state of the art”. Once on-site it was clear that much of the site is exactly the same as the other Darwin APODs. Accommodation is again in shipping containers of 6m x 2.4m. Yes there are many new areas and facilities such as a woodwork room. However, many spaces are already cramped and the whole site lacks any sense of safety and softness. The ‘community hub’ as it was described was already over-run with people and the facility is presently well under capacity. A room being used for entertainment was full with about 20 people using it, an undercover area with pool tables etc was incredibly noisy and appeared crowded with about 50 people milling about. It is completely unclear how such spaces, the only communal, user directed recreation areas out of the weather, will cope if the facility detains the numbers it can apparently cater for.

There are approximately 80 children detained here including 8 unaccompanied minors. Maximus staff are based onsite at this Darwin location only, as their contract is for the provision of ‘care’ to detained unaccompanied children.

The visiting room is incredibly small given the number of detainees expected to be held at this facility. It is a long, not under cover walk for both visitors and clients to use this room.

Items in this room were either still in their packaging or looked brand new. It is unclear whether they existed prior to ChilOut’s visit. There were no basic supplies in the room until we requested them, tea, cups, plates etc.

There is a huge open hanger style shed designed to “process” onshore boat arrivals and a separate area of the compound in which to detain these people whilst they are being health checked. None of this area is in use, nor likely to be in the near future, but air conditioning / fans are on in all rooms to prevent the mould likely to develop in Darwin’s climate.

There is a pool on-site at this facility. Serco advised us that the library is open Monday - Friday on a “come and go basis”. Playgroup is said to be available for one hour per day on weekdays. No family we met with was aware of this being the case.

This facility has a new, outdoor covered self-serve snack area. We are advised it is re-stocked by the caterers four times/day with bread, milk, condiments, milo, tea, coffee and fresh fruit. There was no fruit in this area at the time of our tour.

The IHMS clinic is open 7am - 9:30pm Monday - Friday, there is a triage phone and a pharmacy counter.

“At least at home we knew we would be hung or shot and who the enemy was. Here they slowly torture us, they hurt our minds.”
6.1. HEALTH CONCERNS ACROSS ALL SITES

Research conducted into the impacts of asylum seeker health needs on the Royal Darwin Hospital was published on 16 December 2013. The research utilises 2011 data, since that time the pressure on local health services has only increased.

“Our data show that there was a high prevalence of unmet health need, particularly relating to psychiatric morbidity, and limited access to primary health care services, for immigration detainees in Darwin in 2011.”

Given all of the healthcare issues outlined below, ChilOut is certain of the need for an increase in independent health advice to the Government, Department of Immigration and the agencies involved, not reduced involvement. The recent Government decision to abolish the Independent Health Advisory Group (IHAG) leaves us even more concerned about basic health care provisions for asylum seekers. The Australian Medical Association (AMA) has recommended;

“A national statutory body of clinical experts independent of governments should be established with the power to investigate and advise regarding the health and welfare of asylum seekers and refugees”

6.2. Mental Health

It must be noted that mental illness cannot be ‘treated’ inside detention rather there will be management of resulting and compounding issues. There are mental health staff on-site and asylum seekers have regular appointments with IHMS staff. One staff member told the ChilOut delegation “there are the mental health issues people arrive with and then there are the ones they acquire whilst they’re here.” The harmful impacts of detention are well documented and most people detained in Darwin are approaching six / seven months in detention and have realised (although not received formal briefing after the decision to disallow Temporary Protection Visas) that they could face another seven months locked up. Staff conducting ChilOut’s formal visit recognised that people’s mental health deteriorated with increased time in detention and that the facilities they operated were now holding “long-term detainees”.

A child psychiatrist comes to Darwin from Perth every 3 weeks. It is unclear whether this person’s expertise is in perinatal, infant, child or adolescent mental health and we are unsure of whether there are mental health staff onsite with training in these areas. We were informed that there is a fairly high turnover rate of staff in all areas of the detention network, including in the mental health team. The use of independent mental health and child specialists coming in with a supervisory and debrief role could be of use.

It was confirmed to us by IHMS that there is no mental health screening of children under the age of 4. This is an incredibly concerning fact given there are in Darwin a growing number of young children who have spent the majority of their lives locked up and exposed to many traumas.

The impact of room checks and broken sleep are a concern from a general and mental health perspective.

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"There is an incorrect, but widespread belief that young children are not affected by trauma and do not notice or remember traumatic events. Often people remark ‘but she was only a baby when it happened’ or ‘if we don’t mention it he will forget about it’, with the belief that this reduces or removes any impact of events. However, trauma can have a serious effect on babies, toddlers and preschool children. In fact, anything that affects older children and adults can also affect very young children. As children are dependent on others for care and safety and their brains and bodies are still developing, they are much more vulnerable to trauma than adults. Events that occur in a young child’s life, particularly the first few years, influence their immune system; how they express and manage their feelings; behaviour and stress; how they form relationships; their communication skills; their intelligence and functions like body temperature and hormone production.”
6.3. Maternal & Infant Health

There was a clear DIBP decision to bring more than 50 pregnant women from Christmas Island to Darwin. There was never a suggestion that they would give birth inside the detention facilities. Yet there also appears to have been little, if any, DIBP consultation with Northern Territory Health ahead of even shortly after the decision was taken. We are unsure as to whether other mainland locations were considered and whether health professionals were engaged at all in reaching the decision that Darwin would be a suitable location. Melbourne and Sydney have far more hospitals, more experience in issues of refugee health and in some instances have labour wards that are not under as much pressure as that of RDH. Private discussion with staff working in RDH reveals that they have had no increase in numbers of midwives/doctors with obstetric experience to cope with the increased numbers of births. There are increasing numbers of deliveries in RDH even without those of asylum seeker women and the greatly increased workload is causing enormous stress to RDH staff as well as impacting on the care that can be provided to all women attending the maternity unit.

**ChilOut notes that since our visit, a meeting has been held between DIBP, IHMS and RDH. We very much hope that the recommendations put forward by health professionals have been promptly acted upon and that the issues outlined in this report are rectified with improved communication, extra resourcing and perhaps consideration of alternative locations for these births. We are also aware of women in third trimester pregnancy being transferred in recent weeks (without husbands) from Christmas Island to detention in Inverbrackie.**

The operational aspects of giving birth for asylum seeker women in Darwin left us very concerned. Women are routinely escorted by Serco to the RDH having never been seen at the hospital before, usually without even a call ahead to let the labour ward know to expect a woman about to give birth. The women are usually without any medical files and most often without an interpreter, a telephone interpreter is used, even in the case of explaining to a first time mother that an emergency cesarean section is recommended. Once at the labour ward and given the number of babies due within a relatively short amount of time and the presence of husbands / partners – who are also under Serco escort, there is an overbearing presence of Serco officers at the hospital. Two are required for the spouse, one for the woman and of course the officers are coming and going as “detainees” come and go for treatment, appointments, Serco shifts change etc. The result is many, often men, outside delivery suites, outside labour wards and in other parts of the hospital. The issue has been raised in the past by hospital staff as one that has an adverse impact on their workplace and the comfort of patients, visitors and staff.

The birth of a baby is recorded by RDH but the mother is not provided with any formal documentation that could lead to her baby having a recognisable identity.

Putting aside any controversy and Ministerial concern around the recent case of Latifa and baby Ferouz in Brisbane, a birth certificate does not equate to citizenship and is a basic requirement that Australia should be issuing to these babies.

The post-natal care of asylum seeker women in Darwin is not in keeping with Australian community standards.

We were advised that there are three general practitioners (GPs) providing care for all asylum seekers (Male and female, adults and children) but none of these has any obstetric qualifications and it would appear that their clinical experience of antenatal and obstetric care is limited. This is by no means a criticism of these doctors – many GPs in Australia do not have such training or experience. However there is clearly an urgent need for one or more doctors with such qualifications to provide care to pregnant women. We were told that a doctor with obstetric qualifications had been briefly employed by IHMS in Darwin but was only there for around one week. It is unclear whether another doctor with such experience is being actively recruited.

ChilOut was advised by IHMS that there are two midwives employed by them in Darwin. One of these is a male registered nurse, we sought clarity as to whether he was employed specifically as a
midwife but we received no response. Not one pregnant woman we met (some of whose babies were due in a matter of weeks) nor any new mother we met, could recall being seen by any health professional at a detention facility who identified themselves as a midwife. All knew the role of a midwife and we confirmed that they had not been seen by the male Registered Nurse and perhaps not known that he was a midwife.

If there was community standard postnatal care (provided by a registered midwife employed by the local hospital), mothers would be supported to breastfeed in line with World Health Organisation recommendations. These staff could provide input to meal planning for pregnant and new mothers. These staff would be in a position to speak more freely than the detained parent in terms of requesting that babies be issued with sufficient clothing, that items such as change-mats and slings are offered. Postnatal care in line with that offered to women in the general Australian community would certainly involve mothers receiving lactation advice and assistance. ChilOut met two new mothers who were clearly in need of assistance in feeding their babies and who had both been told by IHMS staff to hand express, neither had success with this option. Other mothers said they simply began to use the bottles and formula they were issued when their babies were born. Providing postnatal care would prevent simple problems becoming more serious and requiring more complex medical care or even hospital admission of a child; this is the basic principle of primary care.

Thus having such care available in the “APOD” clinics would make financial as well as medical and ethical sense; the same is true of routine antenatal care were it to be provided by one or two registered midwives in the “APOD” clinics.

It is unclear as to whether all asylum seeker women detained in Darwin are provided with screening such as the Edinburgh Postnatal Depression Scale. This is standard post-natal practice throughout Australia, if it is being done in immigration detention, we are unclear what if any intervention results from a low score. Depression and detachment in new mothers is evident even to the untrained eye.

ChilOut did not sight any sterilisers and no service provider would confirm whether these are available or not for families using bottles. A service provider advised that if a parent wanted a bottle heated up in the middle of the night he or she would need to leave their room, find an officer and ask them to do it. For those bottle fed babies headed to Christmas Island we are not aware of whether or not sterilisers are provided there but we note that many asylum seekers in Darwin
and elsewhere that facilities on CI are extremely unhygienic and bathroom areas particularly unclean.

A six-week check up for both mother and child is considered standard in the Australian community. Women and babies are being transferred from Darwin to Christmas Island when the baby is 4 weeks old and access to midwifery care on CI is not known. While Darwin is a hot and crowded environment we believe that CI (and the Regional Processing Centers on Manus Island and Nauru) are even more so. These are not suitable environments for very young babies and the risk of infections is high. Again it makes financial as well as medical sense to try and prevent the development of serious medical conditions in infants (and mothers) rather than have to transfer and treat people on the mainland once they are actually seriously unwell. Every one of these indefinitely detained mothers is at great risk of post-natal depression given the levels of anxiety and depression amongst detained asylum seekers, stresses of knowing their new baby faces indefinite detention and that the most basic of parenting decisions are taken out of their hands by virtue of the environment they are locked in to.

In addition to maternal and neonatal health, other individuals with medical needs are also being transferred from Christmas Island to Darwin’s detention facilities (and others to Perth and Brisbane). Again, there does not appear to have been prior consultation or discussion with relevant local health professionals as to areas of healthcare they are able to fit within their current resourcing models.

Time and again it was reiterated to us how state of the art and desirable the new facilities at Wickham Pt and Blaydin Pt are and that this was the justification for moving people from the less overbearing environment of the DAL to these more prison-like facilities.

Certainly, ChilOut was shown brand new facilities equipped with new medical equipment. This is of course a positive and if people are to be detained, provision of primary health care in line with community standards is an essential. No matter how state of the art a facility is, staff with appropriate training are needed and a system operating on the foundation of people’s names not ID numbers and personal care is required. In addition, an approach to healthcare based on actually providing care and being culturally accessible is essential.

ChilOut’s observations and the accounts provided by asylum seekers lead to serious concerns that basic primary healthcare is not being provided inside Darwin’s three “APODs”. For many years asylum seekers have advised that presenting to IHMS with a host of issues renders the standard response that people should take panadol and water. An unaccompanied child described being in pain and taking so many panadol tablets he felt dizzy.

As the case study below illustrates, there are concerns about the level of training and expertise of onsite medical staff. A detained asylum seeker, even a first time mother, has no other medical option besides the person at the detention facility clinic (if it is open). The asylum seeker cannot ring a health hotline, cannot go to the pharmacy or seek the opinion of a recommended GP. The frontline health staff have a huge responsibility and in the instance we witnessed at the Blaydin Pt detention facility, did not come even close to meeting this.

“There is no word to describe this (ongoing detention). If I say bad it is not enough, if I say awful it is not enough. There are just no words”
Whilst visiting families over the weekend of 7/8 December 2013, ChilOut witnessed a 12 day old baby put in a potentially high-risk health situation due to the lack of basic health care provided to her. As we were chatting with the family in the visiting room, the baby’s nappy was changed (on a change mat which we removed from it’s plastic wrapping, no family has been provided with change mats for their rooms). On the baby’s groin were lesions clearly evident to even the untrained medical eye and another on the baby’s finger which looked infected.

The parents explained that they had taken the baby to the IHMS nurse over recent days for regular weighing etc and that they had pointed out the lesions but were told the baby was fine and no treatment was required. Dr Adams and Professor deCosta of the ChilOut delegation were not visiting in a clinical capacity but could also not ignore the issue in front of them. As such Professor deCosta offered to escort the parents to the IHMS clinic on-site. Serco initially said this was possible and then retracted the permission.

This led, Dr Adams and Professor deCosta to provide a hand-written note for the parents to present to medical staff on duty.

ChilOut was assured by Serco that an interpreter would be available for the parents when they went to the clinic. Later this information was altered and we were told that if the clinic staff deemed it necessary, a phone interpreter would be used. The baby’s mother spoke no English and the father, only a little, not sufficient to be given medical information about his first child.

The family returned to the visiting area a very short time later and we were informed that the nurse did not remove the baby’s clothes at all and simply advised the family without the use of any interpreter that ‘all was fine and they should return on Monday when a GP would be available’. It was Saturday afternoon. Already the baby had not been sleeping well and was observed to be feeding almost constantly. It was only through ChilOut leaving the secured section of the facility, using phone contacts we had that a GP was sent to the detention facility to look at the baby.

Clearly there is no second option available to parents in this position. They cannot duck down to the medical centre, pharmacist and are not provided with details of the free medical hotline available to families in the community. The period from infection, to fever to serious illness can be very short in the case of a tiny baby. The medical needs of this child were most certainly not met by the frontline and only healthcare option available to this family.

“In any Australian hospital, any neonate (newborn baby under 4 weeks) presenting is taken seriously and will not leave the hospital until seen by a more senior doctor as it is well understood that the clinical conditions of newborns can deteriorate quickly”
- Dr Adams.

We understand that since our involvement the baby has received follow up GP care, the RDH has been involved and the baby is not unwell. In addition, we insisted that the mother be provided with lactation assistance and a breast pump (she had told IHMS staff that she was having difficulties and was advised to hand express which was not going well for her).

We are assured by service providers that this mother now has a pump and the advice required to accompany this and that if needed, other mothers will have the same access. Despite the 50+ pregnant women, many new babies, pre-term births and very stressful conditions in which to successfully breastfeed - pumps were not already available on-site prior to ChilOut’s visit. We sought, but did not receive, clarity as to whether a mother would be able to take this pump with her to Christmas Island and / or Nauru. The question of sterilisers being provided with the pumps was also not answered by DIBP, Serco or IHMS.
CONCLUDING OBSERVATIONS

A recommendation that we acknowledge to be unrealistic but one that will become increasingly essential is that every single on-site staff member with client interaction be trained in dealing with torture / trauma and in working with children at risk. Each and every interaction, from running an activity, being asked for panadol, watching a child play - can all involve the need for intervention, referral to mental health specialists, be an in-road for a conversation about someone’s wellbeing or be a sign of something requiring attention all easily missed by the untrained person. Currently Serco staff receive some training by the mental health staff, by no means is this sufficient to meet the complex needs of children enduring long-term detention and their anxious parents.

At every turn we were struck by the sheer madness of the whole system. Each and every day it causes harm to people then follows a flurry of ineffective activity aimed at mitigating the harm. There is immense irony in the need for 150+ baby gates we saw stacked on pallets outside Blaydin Pt - keeping a child safe inside the very environment that damages him or her. Beside the gates were piles of plastic baby baths exposed to Darwin’s summer storms and searing heat meanwhile a woman on Christmas Island hopes to keep hold of her baby whilst standing in a dirty, shared shower. Toys still in plastic wrapping are neatly stacked up whilst children stare emptily in the sandpit. There are huge numbers of staff, extra prescription medications for people, brand new health clinics, air conditioning running 24/7 even in rooms not utilised for months on end. None of this is necessary, there are far more humane, far more cost effective ways of accommodating this relatively small number of people.

The whole system needs a child-centric overhaul. If children are to be detained for one year or more of their lives (or even for a few months), there must be staff with necessary expertise, programs with a development focus. Overall we were told time and again that service providers want decisions to be “parent-led” and senior staff repeatedly explained away issues as being “cultural differences”. There appeared to be no acknowledgment whatsoever that parents’ sense of agency, their dignity was taken from them. That the system itself destroys the family unit and makes pro-active parenting nearly impossible. There appear to be many expectations placed on parents but no support or room for them to play their role. Children are witnessing the mental anguish of their parents, parents are unable to work, no adult is furthering their education, a parent cannot even make their child’s breakfast. No amount of one-hour tai-chi sessions (with a male volunteer teacher) is going to cancel out these factors.

It was evident that there were a number of individuals working within the detention network in Darwin who are genuinely attempting to provide a level of care to asylum seekers. There is simply no way even the most well-intentioned staff could give a child or adult what they require in this environment. There was great care taken to ensure that our delegation did not refer to Serco officers as “guards”, there are staff called “vocational trade officers”, the NT Police regularly referred to people’s lives in the community. There is a complete disconnect between the reality that is indefinite immigration detention ruining people’s lives and the cognitive dissonance used to mask the truths and make people’s daily jobs bearable.

“We are between the sky and the sea. They just leave us hanging”