

# Chapter 11

## Children with Disabilities in Immigration Detention

### Contents

---

<b>11.</b>	<b>Children with Disabilities in Immigration Detention</b>	<b>523</b>
11.1	What are the rights of children with disabilities in immigration detention?	524
11.2	What policies were in place to ensure that children with disabilities enjoyed their rights in detention?	526
11.2.1	Department policy	526
	(a) Immigration Detention Standards	526
	(b) Commonwealth disability legislation	527
	(c) Monitoring	527
	(d) Payment arrangements with ACM	528
	(i) Case 1: Port Hedland	528
	(ii) Case 2: Curtin	529
11.2.2	ACM policy	530
11.2.3	State disability standards and arrangements with State disability authorities	531
	(a) Case 1: Port Hedland	532
	(b) Case 2: Curtin	532
11.2.4	Findings regarding policies on provision of services to children with disabilities	533
11.3	Was there early identification of disabilities for children in detention?	534
11.3.1	Case 1: Port Hedland	535
11.3.2	Case 2: Curtin	537
11.3.3	Findings regarding early identification	537
11.4	Was there appropriate case management for children with disabilities in detention?	538
11.4.1	Case 1: Port Hedland	539
11.4.2	Case 2: Curtin	541
11.4.3	Findings regarding case management	543
11.5	Was there appropriate support for parents of children with disabilities in detention?	543
11.5.1	Case 1: Port Hedland	544
11.5.2	Case 2: Curtin	545
11.5.3	Findings regarding support for parents	547

11.6	Was there appropriate physical access, aids and adaptations for children with disabilities in detention?	548
11.6.1	Case 2: Curtin	549
11.6.2	Findings regarding physical access, aids and adaptations	551
11.7	Was there appropriate education for children with disabilities in detention?	551
11.7.1	Case 1: Port Hedland	553
11.7.2	Case 2: Curtin	556
11.7.3	Findings regarding education	557
11.8	Were there appropriate recreational activities for children with disabilities in detention?	557
11.8.1	Case 1: Port Hedland	558
11.8.2	Case 2: Curtin	559
11.8.3	Findings regarding recreation	559
11.9	Were appropriate steps taken to transfer or release children with disabilities from detention?	559
11.9.1	Case 1: Port Hedland	561
11.9.2	Case 2: Curtin	561
11.9.3	Findings regarding release and transfer	564
11.10	Summary of findings regarding the rights of children with disabilities in detention	565
	Endnotes	568

## 11. Children with Disabilities in Immigration Detention

---

One of the underlying goals of international and Australian laws relating to children with disabilities is to provide the highest possible level of support and assistance in the least restrictive way. Laws, policies and programs should be designed to ensure that children with disabilities have the opportunity to participate, to the maximum extent possible, in all aspects of the general community.

By definition, the detention of children poses barriers to achieving integration within the general community. Furthermore, the challenging task of providing appropriate services to children with disabilities in the community becomes even more difficult when children are in immigration detention. However, by legislating for the mandatory detention of children, including children with disabilities, the Commonwealth assumes the responsibility of ensuring that those children get at least as good care and opportunities to achieve their full potential, as they would in the community.

The Department of Immigration and Multicultural and Indigenous Affairs (the Department or DIMIA) submission to the Inquiry refers to two families in detention with children with serious disabilities, as examples of how the detention system can provide care to such children.

The first family (Case 1) includes two boys and a girl, aged 6, 11 and 13 on arrival, with aspartylglucosaminuria (AGU), an intellectual disability. The children are cared for by their mother and older sister.<sup>1</sup> The family arrived in Australia in August 2000 and were detained in the Port Hedland detention centre until they were transferred to Villawood detention centre on 1 September 2003. The family were released on permanent refugee protection visas in December 2003, after three years and four months in detention.

The second family (Case 2) includes a boy with cerebral palsy. He was 14 when he was detained in November 2000. The boy came to Australia with his two brothers, who were 10 and 15 on arrival, and his mother. The family were detained in Curtin until it closed in September 2002 when they were transferred to Baxter. The family were released on permanent refugee protection visas in October 2003, after two years and eleven months in detention.

## A last resort?

The Inquiry uses the same families as the Department to examine whether children with disabilities have been provided with timely, appropriate and effective services and opportunities consistent with Australia's international responsibilities.<sup>2</sup> The Inquiry required the production of documents relating to the provision of care for these children and their parents and explored the situation of these families with the Department in some detail during the Inquiry hearings in December 2002.<sup>3</sup>

These two cases are representative of the Department's efforts to meet the special needs of children with serious disabilities during the period investigated by the Inquiry. However, the Inquiry has also included information regarding the treatment of other children with disabilities where appropriate.

The questions addressed in this chapter are:

- 11.1 What are the rights of children with disabilities in immigration detention?
- 11.2 What policies were in place to ensure that children with disabilities enjoyed their rights in detention?
- 11.3 Was there early identification of disabilities for children in detention?
- 11.4 Was there appropriate case management for children with disabilities in detention?
- 11.5 Was there appropriate support for parents of children with disabilities in detention?
- 11.6 Was there appropriate physical access, aids and adaptations for children with disabilities in detention?
- 11.7 Was there appropriate education for children with disabilities in detention?
- 11.8 Were there appropriate recreational activities for children with disabilities in detention?
- 11.9 Were appropriate steps taken to transfer or release children with disabilities from detention?

There is a summary of the Inquiry's findings at the end of the chapter.

### **11.1 What are the rights of children with disabilities in immigration detention?**

The *Convention on the Rights of the Child* (CRC) is very explicit about the special efforts that must be made to ensure that children with disabilities have access to services designed to promote the maximum possible integration in the community.

1. States Parties recognise that a mentally or physically disabled child should *enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.*

2. States Parties recognise the right of the disabled child to special care and shall encourage and ensure the extension, subject to available resources, to the eligible child and those responsible for his or her care, of assistance for which application is made and which is appropriate to the child's condition and to the circumstances of the parents or others caring for the child.

3. Recognizing the special needs of a disabled child, assistance extended in accordance with paragraph 2 of the present article shall be provided free of charge, whenever possible, taking into account the financial resources of the parents or others caring for the child, and shall be *designed to ensure that the disabled child has effective access to and receives education, training, health care services, rehabilitation services, preparation for employment and recreation opportunities in a manner conducive to the child's achieving the fullest possible social integration and individual development*, including his or her cultural and spiritual development.

*Convention on the Rights of the Child, article 23*  
(emphasis added)

The long-term mandatory detention of children with disabilities imposes obvious barriers to participation and integration into the general community. This suggests that the principle that children be detained as a matter of last resort and for the shortest appropriate period of time (article 37(b)) is of particular importance to children with disabilities. Indeed, the United Nations High Commissioner for Refugees (UNHCR) Detention Guidelines recommend that asylum seekers with physical and mental disabilities should only be detained:

on the certification of a qualified medical practitioner that detention will not adversely affect their health and well being. In addition there must be regular follow up and support by a relevant skilled professional. They must also have access to services, hospitalisation and medication counselling etc., should it become necessary.<sup>4</sup>

Furthermore, the 'best interests' principle in article 3(1) requires the Commonwealth – including the Parliament and the Department – to consider whether, and how, children with disabilities in detention can fully enjoy their rights under article 23.

The threshold for satisfying article 23 is high. Not only does it seek to promote integration into society, article 23(3) reinforces that children with disabilities are to be provided with the extra assistance they need to enjoy all other rights in the CRC. For example, they must have '*effective access to*' the appropriate health care services (article 24(1)), education (article 28(1)), and recreational activities (article 31). In most cases this will mean that children in detention should enjoy at least the same health care, education and recreational opportunities as those available to children with disabilities in the community.

Article 23(2) also recognises that parents of children with disabilities may require additional support. This reflects the general obligation in article 18(2) which requires Australia to 'render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities'. Single parents are likely to need greater support, as is the case with the two families discussed in this chapter.

Children with disabilities also have the right to enjoy, to the maximum extent possible, a healthy environment which fosters development and rehabilitation and reintegration from past torture and trauma (articles 6(2) and 39) as well as the right to be treated with respect for their inherent dignity while in detention (article 37(c)). Furthermore, article 22(1) of the CRC requires that appropriate assistance be given to ensure that the special needs of asylum-seeking children with disabilities are addressed.

## A last resort?

Finally, the principle of non-discrimination in article 2(1) of the CRC requires that there be no discrimination against children with disabilities whether or not they are in detention. The UN *Standard Rules on the Equalization of Opportunities for Persons with Disabilities* also upholds the principle of equality for children with disabilities, as does the *Declaration on the Rights of Disabled Persons* and the *UN Declaration on the Rights of Mentally Retarded Persons*.<sup>5</sup>

## 11.2 What policies were in place to ensure that children with disabilities enjoyed their rights in detention?

### 11.2.1 Department policy

The Commonwealth, through the Department, is ultimately responsible for ensuring that all children with disabilities who are in immigration detention enjoy their rights under the CRC. It is the Department's responsibility to decide who should and should not be in detention under Australia's laws. However, generally, under the contract with the detention services provider, the Department relies on it to provide most of the day-to-day services.

The severe nature of the disabilities of the children in the two case studies discussed in this chapter has meant that they have required a high level of services, which is costly. This has led to some blurring of the role and responsibilities between the Department and Australasian Correctional Management Pty Limited (ACM) as discussed below.

#### (a) Immigration Detention Standards

The Immigration Detention Standards (IDS) in the detention services contract with ACM did not specifically address the provision of care to children with disabilities but provided generally that:

The individual care needs of detainees with special needs are identified and programs provided to enhance their quality of life and care.<sup>6</sup>

The Department Managers' Handbook states that:

[C]hildren who experience intellectual or physical disability may require additional help and support to enable them to benefit from participating in relevant activities.<sup>7</sup>

The Department states that the provision of services for children with disabilities has evolved over time:

I think that it would be fair to say that the Department takes its duty of care towards children with disabilities particularly seriously and some of the processes that may have been in place earlier on have evolved since the beginning of – well late 2000, 2001 to the point now where I believe that we have something that is more robust in place than we did at that time.<sup>8</sup>

The more evolved policy appears to be the one described in the Department's submission:

Child detainees with disabilities are provided special care and assistance on entry into immigration detention facilities through the development of case management plans. Services are required to be tailored to suit the child's individual health, educational and recreational needs. Where possible, this includes the provision of lodgings that specifically accommodate the physical needs of the child...

In addition to addressing the medical condition, other factors considered by the facilities' health professionals include:

- possible enrolment at local schools;
- education programs;
- religious studies;
- recreational activities; and
- external excursions (depending on local arrangements).

The role and assistance of the parents is assessed at the same time, and the parents are asked to contribute to the process and agreed management plan for their child. Once finalised, necessary resources can be allocated to ensure the child is able to commence the program as soon as practicable.<sup>9</sup>

### **(b) Commonwealth disability legislation**

The Commonwealth *Disability Discrimination Act 1992* (DDA) prohibits direct and indirect discrimination against people on the ground of their disability. The DDA binds Commonwealth and State government agencies as well as individuals and private companies.

Section 52 of the DDA provides a general exemption from discrimination on the grounds of disability in relation to the provisions of the *Migration Act 1958* (Cth) and its administration. The Inquiry is of the view that while the provision allows for discrimination in the granting of visas on the basis of disability, it does not amount to a blanket exemption in relation to the treatment of people, detainees and staff, in the course of the operation of detention centres. Such an approach is clearly supported by the objects and purposes of the DDA.<sup>10</sup>

Furthermore, the *Disability Services Act 1986* (Cth) highlights the importance of promoting services to persons with disabilities in order to assist them to fully integrate into the community.<sup>11</sup>

### **(c) Monitoring**

As set out in Chapter 5 on Mechanisms to Protect Human Rights, the Department has a responsibility to monitor ACM's compliance with the IDS. At a Contract Management Group meeting in April 2001, the Department 'highlighted the importance of providing appropriate care for people with special needs in detention'.<sup>12</sup> The Department requested that ACM provide the Department Managers in each detention centre with a list of all the detainees with disabilities and information on the management plans put into place. In turn, the Department Managers were to forward the information to DIMIA's Central Office on a monthly basis.

## A last resort?

In October, November and December 2001, the Department Manager at Curtin noted that a father had difficulty coping with his daughter who had 'possibly borderline cerebral palsy'.<sup>13</sup> He notes that the father 'has on occasion required counselling in relation to his obligations' and requested that ACM 'include in management plan speech therapy and signing'.<sup>14</sup> The identical words were repeated in each monthly report, indicating that there had been little progress, or little attention paid to the progress, regarding this family.

However, nowhere in the above reports is there any mention of the child with cerebral palsy discussed in Case 2. There is no mention of him or his family until the March 2002 Department Manager report, which details the crisis point when the mother relinquished care of her child (see section 11.4.2 below).<sup>15</sup>

As for the family in Case 1, the Port Hedland Department Manager makes no mention of them in her reports until November 2001.<sup>16</sup>

Consistent reporting by Department Managers on the situation of children with disabilities appears to have begun after November 2001, around the time this Inquiry was announced.

### **(d) Payment arrangements with ACM**

The cost of providing support for a child with disabilities can be extremely high. In the Australian community many of the costs associated with support services are met by State and Commonwealth service providers. However, as set out below, neither the Department nor ACM regularly engaged those government service providers, and it was therefore left to them to provide and pay for the individual care needs.

While the care for children with 'special needs' was generally contemplated by the contract between ACM and the Department, it appears that neither foreshadowed the extent and cost of services that might be required to provide appropriate care to children with significant disabilities. This issue is discussed primarily in the context of the provision of care for the boy in Case 2, who has cerebral palsy. However, it was also an issue regarding education for the children in Case 1.

#### **(i) Case 1: Port Hedland**

A letter from the Department to ACM in November 2001 deals with a payment request in relation to education of the children with intellectual disabilities:

I refer... to [ACM's] request that DIMA approve in principle costs associated with the provision of special schooling for the children.

I do not consider that such approval is required from DIMA as the provision of education for all children in immigration detention facilities is incorporated into the Detention Agreements... As such it is the responsibility of ACM both to provide education (including catering to special needs) at the facilities and to fund any associated costs...<sup>17</sup>

As described in more detail in section 11.7.1 below, it appears that there was no education specifically directed to the children's needs until May 2002, almost two years after their arrival, when an ACM teacher concentrated exclusively on them. Even then, that teacher had no specific training in educating children with disabilities. It is of concern to the Inquiry that this delay in providing special education may have been related to cost concerns. However, ACM denies that there is any connection between the cost of services and their provision.

### (ii) Case 2: Curtin

The Department described the dilemma as to who would pay for disability support services as follows:

[W]e're talking here about a situation where, as we've identified, the child is profoundly disabled and we are now in a situation where, as I understand it, the mother is not able to care for the child, or wasn't for a good proportion of this year, able to care for the child in the way that she had previously and that required round the clock care by some other specialist staff. I think it is quite reasonable that the services provider might want to discuss with us something that was well outside the scope of the contract in the beginning when I think, frankly I don't think either the people, any of the people negotiating the contract in the first instance envisaged that we may have a profoundly disabled child.<sup>18</sup>

In April 2002, ACM had estimated that the cost of caring for the boy was \$372,218.25 a year, and asked for reimbursement for at least part of the cost.<sup>19</sup> In June 2002, ACM had not received any reply from the Department and threatened to 'dump the child on DIMIA's doorstep':

This afternoon [the Department's Deputy Manager] was advised by the ACM Manager that unless ACM received an immediate response to their request for additional funding for the care of the child they (ACM) would be dumping the child on DIMIA's door step tomorrow morning. ACM Manager advised that this direction had come directly from [ACM Managing Director]. [He] also instructed ACM manager to contact DCD [Department for Community Development] and advise them of the intention to dump the child.<sup>20</sup>

In August 2002, more than a year and a half after the child's arrival, ACM noted that the Department had verbally agreed to meet costs for ACM staff providing services at the previous Contract Operation Group Meeting but that no formal correspondence had been received.<sup>21</sup> In September 2002, the Department wrote to ACM stating that the daytime supervision was within the scope of the contract and therefore the Department would only pay for the overnight care and supervision.

Also in September 2002, a doctor at the Port Augusta Hospital noted that:

Normally I would organise for him to see physio, OT and speech for assessment of needs as well as involving [the Crippled Children's Association of South Australia] and Orthopaedics for management of contractures. I understand this cannot be done through the state system unfortunately.<sup>22</sup>

## A last resort?

This emphasises the considerable financial and logistical burden that was placed on the Department and ACM to provide care that is normally arranged by the State authorities.

In October 2002, ACM wrote to the Department stating that it was 'not responsible for the ongoing care of a child in detention and as such should not be required to meet the costs of caring for a child on a long-term basis'.<sup>23</sup> The Department confirmed that as at October 2002, the issue of who pays for what had still not been resolved.<sup>24</sup>

The Department states that the negotiations as to costs 'in no way has affected the actual care that has been provided to the child for that period [starting March 2002]'.<sup>25</sup> ACM also denies that cost influenced the level of care provided to the boy.<sup>26</sup> As set out below, the Inquiry acknowledges that from March 2002 the level of care provided to the boy was very intensive and to that extent cost disputes may not have affected the level of care. Nevertheless, the Inquiry remains concerned that the lack of clarity as to who would pay the costs of caring for this child may have been a factor in the 16-month delay in providing this level of care. Neither ACM nor DIMIA have provided any other convincing explanation for the delay.

### 11.2.2 ACM policy

There does not appear to have been any specific ACM policy regarding the special care of children with disabilities. However, in May 2002 ACM issued a policy relating to special needs resulting from 'a significant medical or psychiatric illness, or developmental disability' which stated that:

Where a detainee's illness or disability may impact on the detainee's housing, program assignments or transfer, the appropriate health care staff will see the detainee and the detainee's assignment will be governed by written medical orders.<sup>27</sup>

The ACM policy on special care needs for minors generally notes that:

4.1 When a minor is admitted into the Centre, the Nurse will interview the child's parents and child to determine the special needs of the child. Factors to be addressed include the possible enrolment at local schools, education programs, religious studies, recreational activities and external excursions....

4.3 Once a plan has been agreed with the parents, necessary resources will be allocated to ensure the child is able to commence such activities as soon as practicable.<sup>28</sup>

The former ACM Health Services Coordinator, employed at Curtin from late 1999 to early 2002, told the Inquiry that 'there was never any coherent policy by ACM or DIMIA for the care of the disabled'.<sup>29</sup>

### 11.2.3 State disability standards and arrangements with State disability authorities

Each State has developed disability services standards which help define what standards should be provided to people with disabilities. In Western Australia, where the children in the case studies were detained, the Disability Services Commission (DSC) published the Disability Services Standards (the Standards) pursuant to the *Disability Services Act 1993 (WA)*. One of the guiding principles in the Standards is that disability services be provided in the 'least restrictive way'. The Standards define this concept to mean:

The provision of services which are appropriate to people's need, while allowing them as much freedom of choice, independence and opportunity as possible.<sup>30</sup>

This reflects article 23 of the CRC which requires special measures to encourage active participation and integration into the community. The Standards are not reflected or referred to in either ACM or Department policy documents.

In addition to developing the Standards, State disability authorities provide comprehensive services designed to assist children with disabilities and their families. While it is clear that service providers throughout Australia face serious challenges in meeting the demand for services, the Inquiry was concerned to ascertain whether the Department or ACM had taken steps to seek advice from and involve those State authorities in the care of children with disabilities in detention. The Department told the Inquiry that:

No arrangements or agreement exist between the Department and State or Commonwealth disability agencies relating to access to, and funding or payment for, disability assessment, treatment and rehabilitation for children in Australian immigration detention facilities.<sup>31</sup>

The Department also states that it is ACM's responsibility to make such arrangements:

Where disability agencies are engaged for the purpose of providing access to disability assessment, treatment and rehabilitation for child detainees, they are engaged by Australasian Correctional Management (ACM) on a case by case basis.<sup>32</sup>

The Western Australian Government confirmed that there were no formal agreements with the Department to provide services to children with disabilities in detention. It emphasised that the WA Government could not provide any services without a formal agreement and payment:

In order for the [Disability Services] Commission to provide services such an agreement would need to be in place, and this agreement would need to provide for a formal notification by DIMIA identifying the children with disabilities and their families who are in need of services and support. It would require an assessment by the Commission as to the needs and the possible services that could be provided and the cost of those services and

## A last resort?

it would also require that the cost of those services be met by the Commonwealth.

It is important to highlight the importance of the Commonwealth meeting the costs and services that could be provided to children with disabilities and their families.<sup>33</sup>

The South Australian body that provides disability services to children, Child and Youth Health, also indicated that there were no arrangements to provide support services to children with disabilities in Woomera.<sup>34</sup>

However, the children in both Case 1 and Case 2 have had some contact with the Western Australian child welfare authorities (rather than the disability authorities). The relationship between the Department and child welfare authorities is discussed more generally in Chapter 8 on Safety and Chapter 9 on Mental Health.

### (a) Case 1: Port Hedland

On the evidence available to the Inquiry, the first contact made with DSC occurred 22 months after the family arrived in Port Hedland. DSC, rather than ACM or the Department, initiated the visit and even then only after a conversation with this Inquiry. The Department's Port Hedland Manager reported that:

The reason for the visit was because the children had been brought to their attention by HREOC and they were following this up.<sup>35</sup>

In the correspondence available to the Inquiry, DSC stated that it would be willing to 'assist in any way'.<sup>36</sup> However, the Department Manager was of the view that DSC 'concluded that [the three children] were not disabled enough to qualify for any service from the Commission'.<sup>37</sup> It is unclear on what basis the Manager came to this conclusion; however, there is no evidence of any further contact between DSC, the Department or ACM in relation to these children.

The Department did have some contact with the State child welfare authority (as opposed to DSC) regarding the relationship between the mother and the children (see section 11.5.1 below).

### (b) Case 2: Curtin

In March 2001, four months after the family's arrival, the senior occupational therapist at the Derby Regional Hospital noted that she had consulted DSC for advice on the most appropriate seating system for the boy with cerebral palsy.<sup>38</sup>

The first contact with the child welfare authority, the Department for Community Development (DCD), was a year later, in March 2002.<sup>39</sup> DCD became involved with the care of the child after the mother declared that she was no longer able to cope and passed over responsibility for the child to the detention staff (see sections 11.4.2 and 11.5.2 below).

At the same time, DCD suggested that the Department contact DSC. DCD's case management notes state:

DIMIA to follow up whether Disability Services Commission could assist in planning and assessment of [the boy's] needs.<sup>40</sup>

A margin note states that 'ACM can initiate this', but the first record of any contact is where DCD notes that it, rather than ACM or the Department, contacted DSC in April 2002 in order to arrange for a communication device for the boy.<sup>41</sup> This occurred 17 months after the boy arrived at the Curtin detention centre.<sup>42</sup> It appears that, amongst other things, he had no communication device until after that time. This evidence suggests that neither DSC nor DCD had been involved in the assessment of the child or the case management planning until March 2002.

The South Australian child welfare authority, Family and Youth Services (FAYS, within Department of Human Services)<sup>43</sup> were contacted in December 2002, when the boy had been detained at Baxter for three months. They were called in to discuss 'the services and assistance [the boy] is receiving from ACM staff due to [his mother's] current inability to cope with caring for him due to his special needs'.<sup>44</sup>

FAYS agreed to contact the South Australian Disability Services about 'possible additional service provision'. FAYS also contacted the Crippled Children's Association of South Australia (CCA) which was willing to provide an assessment 'in order to establish what ongoing therapy, equipment needs may be required and if "home support" is needed'.<sup>45</sup> The boy became a registered client of the CCA in March 2003.<sup>46</sup>

FAYS monitored the care of the boy regularly from December 2002 onwards. In April 2003, FAYS noted that the family was satisfied with the level of care being provided but recommended the purchase of some new equipment, including a 'fully functioning stroller'.<sup>47</sup>

### **11.2.4 Findings regarding policies on provision of services to children with disabilities**

The Inquiry finds that neither the Department nor ACM had any formal policies that clearly set out the procedures and responsibilities for the care of severely disabled children at the time that the children in Case Studies 1 and 2 required assessment and service coordination.

Furthermore, there were no formal arrangements between either ACM or the Department, and State disability authorities. They did not routinely or promptly draw on their expertise when children with disabilities arrived into detention centres. However, there was some consultation with child welfare authorities when parenting became a child protection issue.

The absence of clear policies as to who would take responsibility for the considerable effort, cost and consultations required for the care of children with serious disabilities affected many aspects of their lives.

These issues are explored further throughout this chapter.

### 11.3 Was there early identification of disabilities for children in detention?

The UN Committee on the Rights of the Child has highlighted the importance of early identification of disabilities to ensure that the necessary care is provided.<sup>48</sup>

The Department's submission states that:

The initial health screening of detainees on entry to an immigration detention facility provides for the early detection and treatment of disabilities in child detainees. Children are screened for evidence of physical and/or mental disability, as well as other developmental or learning impairments.<sup>49</sup>

The Department provided figures to the National Ethnic Disability Alliance (NEDA) stating that there were 16 children with disabilities in detention on 5 February 2002 (4.2 per cent of children in detention).<sup>50</sup> The Department states that on 30 April 2002 there were nine children in detention with disabilities.<sup>51</sup>

The South Australian Department of Human Services (DHS) gave evidence that, in Woomera, there were children with disabilities who had not been appropriately identified by the detention centre staff. DHS were of the view that the health staff were not using the guidelines used in Australia to identify children with disabilities and the staff did not have the experience needed to apply those guidelines properly. DHS states that the consequence is that:

Certainly children arrive at the Migrant Health Centre after release with disabilities that have not been identified during detention.<sup>52</sup>

However, evidence from DHS also suggests that some children may have been sent to Adelaide for assessments. For example:

We've also had one child with unexplained paraplegia and he was in Woomera Detention Centre for some months before he was sent to Adelaide for assessment. I know he was granted a TPV while he was in the Women's and Children's Hospital.<sup>53</sup>

Several disability organisations also expressed concern about the ability of the Department and ACM to properly identify children with disabilities, including the Multicultural Disability Advocacy Association (MDAA) and NEDA.<sup>54</sup>

MDAA described the consequences of failing to identify disabilities to include the following:

- poor health;
- development of patterns of movement and behaviour that inhibit functional patterns;
- impaired learning and development;
- increased physical deterioration (especially for children with cerebral palsy)...;
- increased need for adaptive/specialised equipment which is costly and ongoing ...;

- increased communication and behavioural support needs (especially for children with autism or intellectual disability) ...;
- increased financial costs re long-term 'burden of care', on the caregiver, the community and future government agencies;
- family breakdown/severe stress/severe impact on other siblings in the family;
- long-term social/emotional problems;
- nutritional/diet concerns/consequences in non-identified children with disabilities can also involve the development of Type 1 diabetes (especially in under-nourished communities); the increased rate of oesophageal cancer in Iranian populations; the impact of vitamin A deficiencies in refugee populations (eg, vitamin A deficiencies resulting in blindness; vitamin D deficiencies resulting in rickets and often prevalent in Asian populations)...<sup>55</sup>

### 11.3.1 Case 1: Port Hedland

The evidence available to the Inquiry suggests that the exact nature of the disability of the three siblings in Port Hedland – a lysosomal storage disease<sup>56</sup> – was not determined until two years after their arrival in Australia.<sup>57</sup> The Department states that:

this particular disability that these children, as I understand it, that these children have, is not something that's easy to diagnose and it has been a process that's taken some time for the medical experts to be able to eliminate certain suspected names for the disability and to be able to identify in particular what we now believe to be the actual disability that these children have.<sup>58</sup>

The Department has cited evidence that only one in 500,000 Australians have the disease.<sup>59</sup> ACM, on the other hand, cites evidence that only 30 people in the world, outside Finland, where there are more than 200 cases, have the disease.<sup>60</sup> One of the studies cited by the Department also states that the average age at which children are diagnosed with this particular disease is 9.7 years, and the median age is 2.7 years old.<sup>61</sup> Both ACM and DIMIA argue that it is therefore understandable that it took some time to properly diagnose these children.

It is not necessary for the Inquiry to determine whether the evidence cited by the Department or ACM regarding the prevalence or difficulty of diagnosing the disease is correct because the concern in this case is not just that it took a long time to diagnose, but that there is no evidence of serious efforts to commence the diagnostic process until seven months after this family's arrival in Australia. Furthermore, there was slow follow-up once the process had commenced.

In any event, if the studies are correct it must be remembered that two of the children were well over 9.7 years old on arrival (11 and 13) and the study cited by the Department states that there is a strong correlation between the age at diagnosis, severity of the disease and life expectancy.<sup>62</sup> It is therefore possible that the delay in diagnosis may have contributed to increased problems for the children in the future.

## A last resort?

One possible reason for the delay in commencing the diagnostic process is that the family was in separation detention for the first seven months in Port Hedland.<sup>63</sup> The Inquiry was concerned that the Department may have taken the position that it was unnecessary to determine the illness of these children if they were to be returned back to their home country. However, the Department disputed that this would have any effect on the care provided.<sup>64</sup>

A teacher formerly employed at Port Hedland told the Inquiry:

Their disability has never been formally assessed. After your Inquiry was announced late last year [November 2001], there was another panic attack about this family and there were weekly meetings about this family as well as about what was going to be done with them and so on and so forth. ... We don't even know what is wrong with them so we couldn't even ask people who were qualified for help or assistance to know what is suitable for these – what learning material is suitable for these children.<sup>65</sup>

The following chronology sets out the documentary evidence provided to the Inquiry regarding the efforts made to obtain an accurate assessment of the cause of the children's disabilities and their corresponding needs.<sup>66</sup>

---

### Case 1: Chronology of disability assessment

---

August 2000	Family arrive in Australia and initial assessments are conducted. Records identify that the 13-year-old has 'delayed development' and the 11-year-old has 'intellectual impairment', but lists no health problems for the 7-year-old. <sup>67</sup> Family kept in separation detention for seven months.
March 2001	Paediatrician assesses developmental status and suggests that 'Fragile X' is a possible diagnosis. Further tests ordered. <sup>68</sup> Results not provided to the Inquiry.
June 2001	Medical records of the mother note that two of the children are 'mentally challenged'. <sup>69</sup>
August 2001	One of the boys attends Perth hospital and sees a doctor without an interpreter. Further tests are ordered. <sup>70</sup>
November 2001	Letter from the Department to ACM regarding payment for care notes a diagnosis of Fragile X Syndrome. <sup>71</sup> Inquiry announced.
December 2001	ACM psychologist discusses possible needs assessment of children with mother <sup>72</sup> and tests girl's IQ. <sup>73</sup> Psychologist emphasises importance of obtaining an accurate assessment. <sup>74</sup>
March 2002	Department notes that another ACM psychologist assesses that: <i>the intellectual disability problems of the family are well beyond the capacity of the Centre to deal with. They need a dedicated team of ID specialists working to best practice and that cannot occur here. There has been no official diagnosis of Fragile X and [psychologist] does not know where that comes from. The children need a diagnosis of the ID problems and a program of specialist therapeutic care.</i> <sup>75</sup> Disability Services Commission offers to 'assist in any way'. <sup>76</sup> However, Department Manager states that DSC has found they are 'not disabled enough to qualify for any service from [DSC]'. <sup>77</sup>

April 2002	Department Manager notes need for much more comprehensive program for the children. ACM provides a plan including recommendations for detailed assessments, genetics testing and a therapeutic program by an occupational therapist. There are notes of tensions between ACM and the Department over the plan. <sup>78</sup> Psychologist states that mother and sister should be told of results of genetic testing as soon as possible. <sup>79</sup>
June 2002	ACM doctor requests a 'definitive diagnosis' from an external doctor. <sup>80</sup> Inquiry visit to Port Hedland.
July 2002	External paediatrician identifies some screening tests that can be 'pretty simply done' to diagnose the condition. He orders those tests for one of the boys. <sup>81</sup>
August 2002	A cytogenetics report for one of the boys states that screening for Fragile X is negative. <sup>82</sup> Paediatric registrar suggests children may suffer from a metabolic storage disorder and orders further tests to 'assist in the diagnostic process'. <sup>83</sup> Results show final diagnosis of aspartylglucosaminuria. <sup>84</sup> Children referred for audiology assessment. <sup>85</sup>
September 2002	Children referred for speech pathology assessment. <sup>86</sup>
November 2002	Minister writes to Inquiry noting final diagnosis. <sup>87</sup>

---

### 11.3.2 Case 2: Curtin

The medical records concerning the boy in Case 2 begin four days after his arrival at the detention centre. Within a month, the medical records and a referral to the occupational therapist note the boy's cerebral palsy.<sup>88</sup> He first saw a physiotherapist six weeks after his arrival and an occupational therapist eleven weeks after his arrival.<sup>89</sup> They agreed with the diagnosis of cerebral palsy.<sup>90</sup>

Nevertheless, not all of the relevant baseline tests were conducted at this time. For example, while there is some evidence of ongoing dental and psychological care,<sup>91</sup> several of the May 2002 management strategies note that dental, optical, hearing, speech and bone density assessments, as well as skeletal x-rays, needed to be done.<sup>92</sup> ACM states that a full psychiatric assessment occurred in April 2002, a social work assessment in May 2002 and a psychological assessment in June 2002 – long after the child arrived in the detention centre.<sup>93</sup> Further, in June 2002, a doctor at Derby Hospital stated that he would order chest, hip and spine x-rays for the boy, 'as baseline investigations,' which indicates that they had not yet been performed.<sup>94</sup>

### 11.3.3 Findings regarding early identification

There is no evidence of any guidelines regarding the assessment of children with disabilities at the time the families in Case 1 and 2 were detained. There were no formal arrangements, nor any routine or prompt consultation with State disability authorities which have the special expertise to assist in the process of identifying disabilities.

## A last resort?

In Case 2, where the source of the disability is clear, the initial identification process was relatively prompt. However, broader baseline testing took much longer to occur.

The pursuit of an accurate diagnosis for the children in Case 1, who had more complicated disabilities, was extremely slow. The Inquiry does not accept the suggestion by the Department and ACM that the rarity of the disability excuses the delay in diagnosis. Despite the observable developmental delays, it took seven months to commence the medical diagnosis process of the three children and insufficient attention was paid to the follow-up of that process. Once a decision had been made in June 2002 (22 months after their arrival) to seek a 'definitive diagnosis' from an external doctor, the condition was diagnosed within two months.

### **11.4 Was there appropriate case management for children with disabilities in detention?**

The Department recognises its obligations to provide individualised care to children with disabilities:

Services are required to be tailored to suit the child's individual health, educational and recreational needs.<sup>95</sup>

NEDA is also of the view that:

The best outcome for children with disabilities will be achieved through addressing their individual needs via specific intervention programs that are incorporated into their daily routine which include the education of their care-givers.<sup>96</sup>

An ACM psychologist highlighted that the first step for developing a case management plan is to identify the problem:

The importance of assessment cannot be understated. Much of the solution to any problem [lies] in defining it accurately. In order to provide genuinely meaningful and effective management of a child with an [intellectual disability], it is necessary to obtain an accurate and comprehensive understanding of that child's general abilities and deficits.<sup>97</sup>

As set out above, there were sometimes substantial delays in commencing the needs assessment process. This created even longer delays in implementing a holistic strategy to address those needs.

However, some of those difficulties may have also been caused by the absence of staff with sufficient expertise in the remote detention centres. MDAA suggests that 'mainstream health professionals do not usually have the expertise in disability required'.<sup>98</sup> The Department has not stated that it has specially trained staff on site. However, a former ACM doctor, who worked at Woomera between October 2000 and the end of June 2001, stated that children with disabilities did receive appropriate care:

I assessed quite a few of them. ... There were some who, two or three who were completely deaf, weren't speaking. One was five years old. Another was two years old. Another was seven. And they were all referred

appropriately to the ... Women's and Children's Hospital, in Adelaide, and given the appropriate treatment. There were a couple of children with very severe birth defects, and sometimes we marvel at how they came across, or severe birth defects, and they had what our children would have had. Sometimes they had it even more rapidly because we pressured them very hard, because the Woomera detention centre was not a place to have these children, with severe birth defects.<sup>99</sup>

### 11.4.1 Case 1: Port Hedland

As set out below, in her reports until April 2002, the Department Manager at Port Hedland consistently noted dissatisfaction about the quality of the case management plans intended to address the needs of the three children.

The Department's version of events at the Inquiry hearings in December 2002 paints a more positive picture of the care being provided to the children than that of the Department Manager. The Department explained that the absence of documentation supporting their version demonstrated that the management of children was an evolving process that was increasingly sophisticated over time.<sup>100</sup> The Inquiry cannot assess management strategies that have not been documented, and on that basis prefers the view of the Department Manager on the ground.

---

#### Case 1: Chronology of Case Management

---

August 2000	Family arrive in Australia and initial health assessments are conducted.
March 2001	Commence 'behaviour modification' plan with ACM counsellor. No mention of addressing intellectual disability needs. <sup>101</sup>
June 2001	Nurse notes that mother 'has a very difficult time with her children, two are mentally challenged and difficult at the best of times. She also endures hostility from other residents who are intolerant of her children's behaviour'. <sup>102</sup>
Nov 2001	Department Manager notes failure to assess or address the special needs of the children and suggests involvement of WA Family and Community Services and DCD. <sup>103</sup> ACM note the need to create a behaviour modification plan in conjunction with health team, teachers and guards. <sup>104</sup> Psychologist asked to draft a document on how to manage children with special needs. <sup>105</sup> Inquiry announced.
Dec 2001	Department Manager states that the children's needs are 'still not being met'. <sup>106</sup> Delay in creating management plan is due to priority of unaccompanied minor management plans. <sup>107</sup> Medical notes state that 'management are in the process of formulating management plan for whole family'. <sup>108</sup>
Feb 2002	Department Manager states that children's needs are being addressed. <sup>109</sup>
March 2002	Department Manager believes that children's needs 'are still not being met adequately. ACM is very slow to produce suitable and implement management plans'. <sup>110</sup> ACM psychologist discusses behaviour management program with family <sup>111</sup> then drafts it. <sup>112</sup>

## A last resort?

April 2002	Department Manager states that behaviour management program should be a 'much more comprehensive plan of action that gives them structure and routine, and urgently'. <sup>113</sup> A new plan is produced. <sup>114</sup>
	No evidence of any further management plans.
June 2002	Inquiry visit to Port Hedland.

---

The ACM medical records provided to the Inquiry indicate that the primary concern about these children related to the disruptions caused by their behaviour. The records do not connect the behaviour problems and the intellectual disability.

While a behaviour modification plan may be of considerable value to the children as well as the family, such a plan should be integrated into an individual program plan which addresses wider issues of education, personal development and social integration into the community. It appears that this process commenced in November 2001, when the medical records note that a 'program to modify the behaviour of [the] family' would be created in conjunction with the officers, nurses, counsellor, education and recreation staff.<sup>115</sup>

By December 2001, the children were beginning to become involved in a variety of activities, such as painting a wall, which helped to develop some motor skills and made the children easier to care for.<sup>116</sup>

In March 2002, a 'behaviour management plan' was created. During the public hearings, the Department explained that 'behaviour management plans' in fact referred to 'case management plans':

I think we also need to be careful about the use of the term 'case management' because I think there is – as we referred to earlier in the evidence from the Department, there has been an evolution of the way that we approach the management of individuals with special needs and others in the Department. I think the term case management is something that we have become more used to using towards the end of that year, but the information that I have available to me here is that a behaviour management plan for some members of the family was in place from 25 March [2002]...

I think that what we are seeing here is some quite intensive management of the case from early on in their time in detention and some appropriate action being taken to manage their condition.<sup>117</sup>

The program entailed weekly sessions with the psychologist as follows:

- one 45-minute counselling session with mother
- one 45-minute behaviour management session with the two boys
- one 45-minute family dynamic session with mother and three children.

In addition, the plan contained recommendations for further assessments by health professionals, plus the design of occupational therapy sessions and daily living programs.<sup>118</sup>

The records suggest that by June 2002, the behaviour management program was no longer being implemented. The mental health nurse recorded at that time that the children's mother was angry, distressed and worried about one of her sons.<sup>119</sup>

The children were frequently observed by the High Risk Assessment Team (HRAT). However, as noted in Chapter 8 on Safety, the HRAT scheme was more focussed on monitoring the physical safety of the children than their developmental needs. Therefore, while this may have been a useful strategy to protect the physical safety of the children in the detention environment, it is not a measure that is designed to encourage their development and participation in meaningful activities. Nevertheless, the records indicate that ACM detention officers played a part in teaching the children appropriate behaviours, such as shaking hands with strangers rather than hugging them.<sup>120</sup>

### 11.4.2 Case 2: Curtin

The case management of this boy with clearly identifiable disabilities occurred in two stages with a large gap of time in between. Shortly after his arrival, the boy's needs were assessed and staff developed a care strategy in close liaison with occupational therapists, physiotherapists and others at the local hospital.<sup>121</sup>

In March 2001, the ACM paediatric nurse noted that she had the responsibility to liaise with the education and welfare departments regarding the boy's behaviour management and implement a multi-disciplinary program.<sup>122</sup>

However, within a few months some difficulties arose regarding the mother's level of involvement in his therapy (as discussed below). ACM states that it 'attempted to support the mother in caring for the boy rather than usurp her care'.<sup>123</sup> However, the documents available to the Inquiry suggest that the mother's lack of engagement led to some frustration in ACM staff with the result that they appear to have stepped back from actively providing services to the boy over the course of 2001.

In May 2001, ACM management overrode the judgment of its Health Services Coordinator who had recommended that the family move to a metropolitan detention centre because Curtin was not set up to meet the major needs of this child.<sup>124</sup> The reply from ACM's Centre Manager at Curtin put operational considerations above medical considerations:

Whilst I appreciate your professional medical opinion that a transfer may be, in the medical sense, a help [to the boy's] development I must point out that operationally there is no requirement for a transfer.<sup>125</sup>

However, on 5 July 2001, after a further recommendation from his health staff to relocate the family, the ACM Centre Manager wrote in the margin that 'discussions are also underway to relocate this family. DIMIA for comment'.<sup>126</sup> The following week, the ACM Health Services Manager again recommended transferring the family to a metropolitan detention centre as they could not be adequately cared for at Curtin.<sup>127</sup>

## A last resort?

In August 2001, the Health Services Coordinator states that a health support officer with experience in disability services attempted to liaise with the psychologist, nurses and school teachers to develop a new program. He notes that the boy's mother halted this process.<sup>128</sup>

The Department Manager noted that it had provided ACM with an opportunity to move the family to Villawood in October 2001:

ACM were given the opportunity six months ago to have the family transferred to Villawood where more appropriate care would be available for the child. They refused to agree to this.<sup>129</sup>

ACM denies that this offer was ever made and states that it was the Department Manager who vetoed the transfer, as 'he was convinced [the mother] was "using" her son's disability and care requirements for personal gain'.<sup>130</sup>

In February 2002, ACM reported that the child was 'under a programme with the Minor Liaison Officer, counsellor and nurse to maximise his potential, physically and mentally'.<sup>131</sup>

In March 2002 the boy 'was put into the care of ACM by his mother after she found it too difficult to cope with his care'<sup>132</sup> giving rise to the financial dispute set out above. At that time the Department Manager mentioned the boy for the first time in his monthly Manager's reports. He observed that there had been serious problems regarding the boy's case management since the time of his arrival:

In reviewing this case it is apparent that ACM have not developed an appropriate program to focus on the individual needs of both the child and the mother. Had the needs of the mother been addressed 18 months ago when she arrived at Curtin it is likely that she would not have reached the stage that she is now at where she is psychologically not able to cope with her disabled child.<sup>133</sup>

In March 2002, the WA child welfare agency, DCD, became involved in developing a case management plan. At that time ACM and DCD developed a comprehensive strategy, which included recommendations for physiotherapy, occupational therapy and education.<sup>134</sup> An ACM psychologist with psychology and special education training also helped to develop a case management strategy.<sup>135</sup> In late July 2002, intensive physiotherapy and speech therapy began.<sup>136</sup>

The records indicate that a case management strategy appears to have continued at least until September 2002, when the family was transferred to Baxter detention facility.<sup>137</sup>

When the Inquiry visited Baxter in December 2002, the boy was accompanied by a carer. ACM told the Inquiry in September 2003 that it continued to provide 24 hours a day, seven days a week carers and other management strategies while the boy was at Baxter in 2003.<sup>138</sup>

### 11.4.3 Findings regarding case management

According to the Western Australian Disability Service Standards, each person with a disability should receive 'a service that is designed to meet, in the least restrictive way, his or her individual needs and personal goals'.<sup>139</sup>

The Inquiry recognises the significant improvements in the Department's commitment to providing individualised case management of children with disabilities over 2002. However, these improvements occurred long after these children with disabilities began to be detained. The Inquiry therefore finds that the Department failed to ensure the prompt development of comprehensive individual case management strategies that address the specific developmental needs of children with disabilities during the period of the Inquiry. There has been insufficient consultation with State disability authorities and other experts, who are otherwise available to children in the community, to assist in the process.

Regarding Case 1, the Inquiry finds that there were ad hoc efforts by individual staff members over 2001 and 2002. However, on the evidence available to the Inquiry there was still no comprehensive plan which addressed the individual needs of the children in the areas of health care, education, recreation and other developmental issues by the end of 2002.

Regarding Case 2, the Inquiry finds that there were efforts to create a case management plan on arrival. However, within six months ACM staff were of the view that the child could not be properly cared for in Curtin and the mother became disengaged in the process. The Department Manager was of the view that there was no appropriate case management plan for the child or his mother. These circumstances culminated in the mother handing over the child in March 2002.

In March 2002, the child welfare authorities were called in for assistance and an appropriate case management plan was developed. The Inquiry finds that a high level of service was provided pursuant to this plan. However, the Inquiry is extremely concerned that it took 16 months of detention before this level of service was provided. In the Inquiry's view this delay unnecessarily compromised the development of the child and the psychological health of his family.

## 11.5 Was there appropriate support for parents of children with disabilities in detention?

Chapter 9 on Mental Health demonstrates that the detention environment can have a serious impact on the ability of parents to fulfil their role as carer. This is even more the case for parents of children with disabilities due to the additional needs of their children. For example, a parent seeking to care for a child with disabilities in the community would likely seek assistance from specialist doctors, nurses, advocacy groups and State disability agencies. They would need to obtain specialist equipment and access specialist schools or units within community schools. They are also likely to seek the support of other parents in a similar situation. In the detention environment, these options are not always available and therefore parents

## A last resort?

are not necessarily in the position to make the decisions that they believe are in the best interests of their child.

The Department recognises that parents should actively participate in the decisions concerning their children:

The role and assistance of the parents is assessed [on entry], and the parents are asked to contribute to the process and agreed management plan for their child.<sup>140</sup>

The Department also acknowledges that parents of children with disabilities may need some support in order to carry out that role:

[P]arents play a role in the management of their children in detention facilities and that in particular for families with disabilities – children with disabilities – it was important to ensure that they were supported.<sup>141</sup>

In July 2001, the Department Manager at Villawood noted that insufficient respite care was provided to parents of another child with cerebral palsy, since 'ACM have relied on parental supervision over a 24 hour period, seven days per week'.<sup>142</sup>

Case 1 and Case 2 highlight the enormous pressures that the detention environment places on the mental health of carers of children with disabilities. They also demonstrate the difficulties in providing parents with appropriate support within that environment. Many of those difficulties stem from the deprivation of liberty itself, which restricts access to facilities like support groups.

In neither Case 1 nor Case 2 is there a father to assist in the care of the children. However, in Case 1, the children's sister (aged 19 on arrival) has an equally important carer role as their mother. In Case 2, both the boy's brothers (aged 10 and 15 on arrival) also have a role, but the mother is primarily responsible for the boy's care.

### 11.5.1 Case 1: Port Hedland

From January 2001, there are fairly detailed records of the difficulties that the mother of the three children in this family with disabilities was having in coping with her children's needs.<sup>143</sup> She was also having some trouble dealing with the reaction of other detainees to her children.<sup>144</sup>

The mother and children were frequently put on a HRAT watch.<sup>145</sup> The close supervision by detention staff may have relieved some of the pressure on the mother and assisted in the protection of the children. However, HRAT does not provide proactive coping strategies for parents.

In April 2001, the medical records note that 'a behaviour modification program' would start with the counsellor and that this would include family counselling.<sup>146</sup>

The WA Family and Community Services (FACS) were brought in to consult with the mother regarding the discipline of her children in March 2001, December 2001 and May 2002.<sup>147</sup> Evidence as to what exactly the counsellor or FACS recommended

for the mother was not available to the Inquiry. However, the ACM Child Liaison officer did provide the mother with some guidance as to appropriate disciplinary strategies in December 2001.<sup>148</sup> Also in December 2001, the ACM psychologist discussed 'positive parenting strategies' with the children's mother.<sup>149</sup>

From February 2002, both the mother and the eldest daughter saw the ACM counsellor more regularly and in April a behaviour management plan was created proposing appropriate support.<sup>150</sup> The counsellor stated that:

[B]oth [the mother and the sister] appear to be unable to stop the cycle of negative behaviours, even though this behaviour pattern is [affecting] their progress in school and life in general. The family are unable to restrain [the two boys] without support.<sup>151</sup>

It is unclear for how long the management plan was pursued. However, the medical records indicate that the difficulties continued well after the creation of that plan.

In July 2002, the ACM psychologist stated the following about the mother and eldest sister:

My concerns with the [name removed] family are not for the three children with special needs, but for their mother and older sister, as my reviews (weekly, when I was at the centre) indicate that it is they who are displaying signs of lowered mood and general deterioration in presentation.<sup>152</sup>

### 11.5.2 Case 2: Curtin

ACM and the Department were of the view that the primary responsibility for the boy with cerebral palsy lay with his mother. The Department stated the following at the hearings:

notwithstanding the Department's duty of care, which extends to all detainees including the members of this family... the child arrived with his mother and there was obviously a competent adult able to take care of the day-to-day needs of the child in question.<sup>153</sup>

While it is clearly the case that this mother had primary responsibility for her children, while in detention she had to rely on the Department and ACM to assist her in providing the care and facilities she needed. It appears that there was some dispute between ACM and the Department as to who should pay for this assistance:

ACM wishes to remind DIMIA that under the current contract parents are responsible for the care of their children whilst in detention. ACM is not responsible for the ongoing care of a child in detention and as such should not be required to meet the costs of caring for a child on a long-term basis.<sup>154</sup>

In any event, the child's mother had such difficulty coping with his care that she handed him over to detention staff in March 2002, 16 months after their arrival in Australia.<sup>155</sup> The Curtin Department Manager notes that one of the likely causes of this dramatic act was the absence of a case management plan for the child and his mother.<sup>156</sup>

## A last resort?

The mother's continuing detention and visa rejection also had an impact on her ability to cope with her child with disabilities and other two children.<sup>157</sup> ACM summarises the pressures as follows:

There is no doubt that caring for a severely disabled child in detention is a difficult physical and emotional task for a single mother particularly given the range of other emotional issues associated with seeking asylum. There is also no doubt that these pressures contributed to the mother's withdrawal. The boy's mother was however quite uncooperative...<sup>158</sup>

The primary documents provided to the Inquiry give a detailed record of the difficulties facing the mother and her reluctance to take full responsibility for the care of her son. However, prior to March 2002, there is very little record of any comprehensive plan to provide the boy's mother with respite care or to help her develop coping strategies. In endeavouring to determine what led her to leave her child, the Inquiry asked the Department to explain what it had done to ensure support for the extra needs of the boy's mother:

[O]n 7 February 2001, the ACM counsellor began counselling processes with the mother of this family and there was ongoing counselling support provided. I also understand that on 22 May 2001 there was also a meeting, I think, with the psychologist in which, as I think I mentioned earlier, parenting strategies were discussed with the mother of the child. On the 4th of April [2002], there was also a referral made for the mother. However, she declined to take advantage of that offer and of ongoing care in relation to the health and welfare that was provided from the centre.

So I think that there has been support provided to the family over time. As I mentioned, the ongoing counselling that started back in 2001. So that support from welfare staff members within the centre and as we've said, we've also been seeking advice from external specialists in relation to the conditions for the children and no doubt that information would be passed on to the mother of the child as well.<sup>159</sup>

The medical reports in February 2001 suggest that:

Maybe group meeting of Teacher, counsellor, paediatric nurse etc. could be organised to develop some strategies to assist this mother in coping alone with 3 young boys along with other stressors.<sup>160</sup>

Moreover, a case management plan in February 2001 indicates that parenting education programs were arranged by the ACM medical centre.<sup>161</sup> However, there is no indication of what those programs were and how long they went for.

By the beginning of March 2001 the medical records note that a management strategy had been developed, however there is no evidence of what that strategy involved.<sup>162</sup> Nevertheless, the medical records indicate that the mother had regular contact with the medical staff.

In May 2001, the psychologist notes that 'the mother was ... instructed in positive parenting strategies and agreed to commence their implementation'.<sup>163</sup> ACM states that in October 2001 'nursing staff offered the boy's mother regular respite and kept up his physiotherapy and play'.<sup>164</sup>

However, it appears that these measures were of limited effect. When DCD assessed the situation in March 2002, they recommended that the mother be put under psychiatric care for depression, and to commence appropriate therapy. They also recommended that the mother 'be supported in caring for [her son] at a pace that is comfortable to her'.<sup>165</sup> A further report notes that:

Psychiatric Assessment to take place as soon as possible – her mental health may be impacting on her ability to make any commitment to [her son].<sup>166</sup>

A psychiatric report in April 2002 states that:

Recently [the boy's mother] started to feel 'psychologically tired'. When asked to explain this, she found it difficult but agreed that it contained elements of depression, stress, a feeling of wanting to give up and general unhappiness. It is this state of feeling that has led her to refuse to look after [her son] who requires 24 hours supervision. She insisted that she loves him...but felt that he is getting bigger and that she would need assistance to care for him wherever she was. She feels he will ultimately need to be looked after in a special setting and come home to her two or three days per week.<sup>167</sup>

The Department recognised that the mother should 'not be considered as having abandoned her son but rather as a parent requiring respite care'.<sup>168</sup> ACM took active control of the care of the child from this time, giving the mother the respite she needed.<sup>169</sup> However, this did not fully address the stressors facing the mother.

A report from DCD notes that the boy's mother 'has been struggling' and that she said that as 'long as I am here my psychological state will not get better and therefore I could not care for [my son]'.<sup>170</sup> The same report notes that she had obtained some support by talking about her problems with another detainee. The social worker notes 'coping strategies within the detention environment' should be developed. One of those strategies was to help her find work within the detention facility. It appears that this did occur. However, the problems were still ongoing in August 2002,<sup>171</sup> despite full time care of the child by ACM staff.<sup>172</sup>

The family was transferred to Baxter on 7 September 2002, where the boy received ongoing care until they were granted permanent refugee protection visas 13 months later. The boy's mother was apparently participating more fully with his care there.<sup>173</sup>

### 11.5.3 Findings regarding support for parents

Cases 1 and 2 demonstrate that the normal pressures placed upon parents with children with disabilities are exacerbated in the detention environment. Support systems available to families with children with disabilities in the community are not available to families in detention, for example there is no access to other parents who experience the stresses of supporting children with disabilities.

Further, families in detention face the additional stressors that come with the detention environment and deprivation of liberty (see further Chapter 9 on Mental Health). This combination of factors increases the risk of serious breakdowns in the family unit, impacting both on the care provided to children with disabilities and other children in the family. This highlights the inherent risks in the long-term detention of children with disabilities.

## A last resort?

However, the Department has an obligation to ensure that the support provided to parents in detention is effective to protect their health and the health of the children. Despite efforts by individual staff to provide counselling and respite, there has been a failure to address the needs of parents in a comprehensive and effective manner. This is demonstrated by the continuing problems faced by the mothers in Case 1 and Case 2.

### **11.6 Was there appropriate physical access, aids and adaptations for children with disabilities in detention?**

The Building Code of Australia and Australian Standards guide design for access and mobility including access for children and adolescents with physical disabilities. Disability organisations have been concerned about the level of compliance with these standards in detention centres:

The buildings are demountable with stairs leading to a door, which would make it impossible for a child in a wheelchair for example to negotiate independently. Furthermore [People With Disabilities] notes that in some detention centres particularly those in remote areas that the ground surface is very dusty and uneven. This would also contribute significantly to the lack of accessibility to children with disability.<sup>174</sup>

Children with physical disabilities which restrict mobility require the appropriate aids to ensure their maximum development (for instance wheelchairs, eating aids, special shoes), and buildings should be designed to cater to their needs. Moreover, children must be provided the appropriate assistance to use those aids:

Appropriately equipping children addresses safety issues, enhances functioning, assists in pain relief, and stops or lessens further physical complications, such as bone fusion, reduced lung capacity, dislocated hips or arms, and swallowing problems. Ultimately, this reduces the long-term financial and social costs which can be associated with a disability.

In the short-term lack of access to facilities decreases mobility and physical and social function and contributes to continued dependence in self-care and community living skills. In the long-term, it limits overall learning, development and independence; inhibits social interactions/environmental opportunities; and discriminates against/denies the disable[d] the basic right to be 'included' with others.<sup>175</sup>

A doctor working at Woomera in August 2001 and January 2002 described a situation where a young boy was forced to go to the women's bathroom because there was nobody other than his mother to help him:

There was one particular case of a child in a wheelchair when I was at the centre in August [2001]...This meant that the child was now in a very vulnerable situation because it was culturally, totally inappropriate for him to enter the shower blocks or the toilet blocks with his female mother which I found to be a very frustrating and distressing situation to deal with and certainly the mother found it almost impossible to deal with and he required a great deal of support, of course, because he simply could not walk.<sup>176</sup>

The March 2001 Port Hedland Department Manager report notes that ACM ‘attempts where possible to accommodate families with small children and the elderly or handicapped on the ground floors’ of the two storey accommodation blocks.<sup>177</sup>

### 11.6.1 Case 2: Curtin

ACM states that:

the need to care for a child with a disability as significant as [this boy] was an unusual occurrence and there was some delay in identifying all the necessary aids and equipment. However, ACM provided effective care... The issues concerning costs did not arise until March 2002. It is the case that additional equipment was purchased after this time. Nonetheless [the boy] had received the highest possible standard of care since his arrival at Curtin and despite the dispute between ACM and DIMIA cost was not a relevant factor...<sup>178</sup>

The boy was moved around in a baby stroller for the first seven months of his detention there. As the Human Rights Commissioner noted:

[In early 2001] I saw her pushing a pram with a child in it and having real difficulty doing it, because it was a near desert situation – there were plenty of pebbles on the ground.<sup>179</sup>

ACM states there was a wheelchair available in the health centre but the boy’s mother chose to use the stroller instead.<sup>180</sup> It is unclear to the Inquiry why the mother would have refused a wheelchair if it was appropriate for her child.

ACM states that a wheelchair was ordered in January 2001 and arrived in June 2001.<sup>181</sup> It also suggests that a wheelchair was provided to the child (along with a beanbag and play mat) in December 2000.<sup>182</sup> However, the primary records suggest that it was not until February 2001, three months after the family’s arrival at Curtin, that the child was assessed by an occupational therapist regarding his wheelchair needs. She recommended the purchase of a particular chair in March 2001.<sup>183</sup> The same week, an ACM nurse recorded a conversation with the boy’s mother about when she would bring her child to the clinic for his ‘stimulation therapy’ session:

[The mother] stated that she had no chair for [the boy] to bring him to the Clinic. She also said that ACM will buy [him] a wheelchair – “So where is it?”. I asked her was the pram broken – she said it was too small for [the boy] and his legs were cramped. I suggested that perhaps if she had money she could purchase a chair for [him].<sup>184</sup>

The ACM psychologist assessed the boy on 22 May 2001 and noted that ‘currently there is no means of transporting [him]’ as the stroller was still broken.<sup>185</sup> A ‘Special Needs III Baby Jogger’ was delivered on 25 May 2001.<sup>186</sup>

The Baby Jogger was different to the wheelchair recommended by the Occupational Therapist in March 2001. The Department states that the manufacturer of the Baby Jogger was consulted because the recommended wheelchair was not immediately available from Derby Hospital.<sup>187</sup> An ACM nurse states that she consulted Baby

## A last resort?

Jogger because she thought the recommended wheelchair would not be practical, but that she would seek the input of the occupational therapist as to the suitability of the jogger.<sup>188</sup>

In March 2002, the psychologist noted that the boy's mother requested a bedrail to stop him falling out of bed.<sup>189</sup> Modifications were made to a donga (demountable sleeping quarters) where the boy was being temporarily housed at that time 'to accommodate his needs re assisted showering etc'.<sup>190</sup>

In April 2002, an occupational therapist noted that the Baby Jogger was inappropriate to the child's needs because it was too small for him and lacked a solid base for postural support. She stated that this had already been mentioned in an earlier occupational therapy report.<sup>191</sup> The therapist recommended a wheelchair similar to that recommended in March 2001. Another physiotherapist noted 11 other items as 'Equipment Requirements' for the boy.<sup>192</sup> On 19 April it was agreed that a vacant donga would be converted to accommodate his 'personal care, physical therapy and educational needs'.<sup>193</sup>

The records show that in May 2002 ACM requested quotes for cutlery, slings, a patient lifter and other items.<sup>194</sup> On 7 May 2002, ACM purchased the wheelchair, tilting bed and mobile shower commode.<sup>195</sup> The wheelchair arrived in early June 2002, as did a device to assist with walking ('Maywalker'). The tilting bed arrived in July.<sup>196</sup>

DCD contacted the Disability Services Commission regarding a communication system for the boy and suggested that the Department or ACM organise referral to a speech pathologist for assessment.<sup>197</sup>

It is clear that the purchase of these items and the provision of round-the-clock care greatly assisted the boy. However, it is disappointing that it took more than 18 months to make this investment. It also highlights the difficulties that the boy's mother must have faced in the absence of all these aids. For example, it must have been quite difficult for her to feed and bathe her son without the required equipment for such a long time.

The boy's accommodation at the Baxter facility was purpose built and offered substantial improvements to this family:

At the Baxter facility we have the capacity to provide particular accommodation units that are designed for people with disabilities. These units include wheelchair access and particular configurations in the units themselves that are more suitable for use with people with disabilities who may have equipment that they need to use in the accommodation unit...

It is my understanding that the facilities at Baxter where the child is now accommodated with his mother and siblings is better suited to meeting the needs of his particular condition in that disabled unit.<sup>198</sup>

However, in April 2003, FAYS reported that the boy's stroller was again unsatisfactory, as it was:

...reportedly fraying near the seat and as a result the carers are unable to position him correctly. In the long term, this could be detrimental to his physical health. It is vital that [he] be provided with a fully functioning stroller.<sup>199</sup>

The Inquiry is unaware whether a new wheelchair was provided.

### **11.6.2 Findings regarding physical access, aids and adaptations**

The Inquiry rejects ACM's submission that the boy with cerebral palsy 'received the highest possible standard of care from the time of his arrival at Curtin'.<sup>200</sup> For the first seven months of detention the boy's mother struggled with a pram unsuited to his needs to move him around. In May 2001, the pram was replaced with a special needs 'Baby Jogger', which was different to what was originally recommended by the occupational therapist. While the Baby Jogger may have been purchased with the appropriate advice, in April 2002 an occupational therapist noted that the Baby Jogger was unsuitable. In June 2002, a wheelchair similar to the one originally recommended in March 2001 was purchased.

The Inquiry finds that after March 2002 the boy was provided with a bed, eating utensils, shower commode and other aids and adaptations that were appropriate to his needs. There were also substantial improvements in the facilities provided after his transfer to Baxter in September 2002.

However, the Inquiry is extremely concerned about the long delay in providing the appropriate aids and adaptations necessary to assist the boy achieve appropriate developmental levels.

## **11.7 Was there appropriate education for children with disabilities in detention?**

As Chapter 12 on Education sets out in some detail, education is a fundamental right of all children. In the case of children with disabilities, the standard of education offered should be equivalent to that available to children with disabilities in the community. This would usually mean that the children would be best catered for by attending external schools that provide such facilities. These may either be specialist schools or general schools with special needs support. There is a specialist school in Port Hedland. Furthermore, most general schools in Australia's capital cities are required to provide appropriate facilities, including special education support.

In October 2002, the boy in Case 2 was 'to be enrolled in a special needs school' in Port Augusta; however, he did not commence attending the school until 1 August 2003.<sup>201</sup> The children in Case 1 began attending the special needs school in Port Hedland at the start of the 2003 academic year. To the Inquiry's knowledge this is the first time that this has occurred in relation to any child with disabilities in detention. The children were also enrolled in local schools with special needs units when they were transferred to Villawood detention centre in September 2003.<sup>202</sup>

## A last resort?

The National Ethnic Disability Alliance states that:

Children with disability, particularly those with cognitive disability, require a program that is designed to meet their specific needs to ensure that they are equipped with basic life skills and enough independence during their transition into the community. Without this, children with disability will require additional support and assistance which means additional costs.<sup>203</sup>

The Department's submission states that the management plan for a child must be tailored to suit the child's individual educational needs.<sup>204</sup> The first step in designing such a plan is to obtain an assessment by teachers with special training in the area. The Inquiry has not seen any evidence of routine and early assessment of children with possible cognitive difficulties. A case management plan for a child at Woomera noting possible cognition problems suggests that 'in an Australian school situation this child would be referred to an educational psychologist for assessment'.<sup>205</sup>

The ACM Education Coordinator at Woomera suggested that some teachers might have had special needs training but there was no dedicated teacher:

MR WIGNEY (INQUIRY COUNSEL): What about, for example, children with – who were developmentally delayed or had development difficulties? Were there sufficient or adequate resources ...

MS LUMLEY (ACM EDUCATION OFFICER): Well, we had a – we had a child with an intellectual disability. Sometimes, they can be integrated into the normal classroom and that's good for socialisation. Other times, they might need assistance.

INQUIRY COUNSEL: But were there any teachers trained in the provision of special education for such –

ACM EDUCATION OFFICER: Some of the teachers may have done extra training in special needs but we didn't have a solely special needs teacher, as such, no.<sup>206</sup>

The Department states that while special needs teachers were not routinely employed this does not mean that:

a properly qualified teacher could not provide the level of education needed or provide meaningful activities to all participants in the spirit of inclusive education.<sup>207</sup>

While this may be correct in theory, Case 1 and Case 2 demonstrate that in practice the teachers were not equipped to cater to the children's educational needs, nor were they provided with special education support, as is often the case in the outside community. Furthermore, there appear to have been impediments to gaining access to special schools when ACM staff identified difficulties that they were having in providing appropriate education within the detention centres.

The former ACM Health Services Coordinator at Curtin described the difficulty in obtaining permission to send a child with a hearing impairment to the Derby school:

We had another child who was deaf and I had great trouble getting DIMIA to allow this child into Derby where the school actually had someone trained in education of the hearing impaired child unlike the Curtin school. DIMIA refused this to happen citing they did not have a memorandum of understanding with the primary school. This is despite the fact that the high and primary school were on one site, with one administration ... and the teacher in question happy to take the child.

The little girl was around 5 years old and arrived sometime late in 2001. ACM school were reluctant to do anything with this child. They insisted that a nurse take the child to school as if she was a medical case requiring supervision. The senior teacher ... was most uncooperative. When the school did take the child she sat in class for an hour with colouring pencils while routine classes carried on. Then she went over to the recreation office where she watched videos (no subtitles) with other kids for an hour and then played under supervision for an hour. This was recorded as a three hour education session for the girl.<sup>208</sup>

### 11.7.1 Case 1: Port Hedland

In January 2001 at least one of the three children was going to the ACM school in separation detention for three hours a day.<sup>209</sup> In March 2001, it appears that all three children were being taught but only for two hours a day.<sup>210</sup> Furthermore there were no specialist teachers or curriculum for these children.

In October 2001, 14 months after the family arrived, the Child Liaison Officer was trying to facilitate the girl's return to the on-site school (as she had not been attending) and considered special education classes.<sup>211</sup> In December 2001 and again in February 2002, it appears that ACM staff were encouraging the children to go to the on-site school. The records also show that there was intermittently some resistance from their mother, possibly because of teasing by other children.<sup>212</sup>

According to the Department's Manager, one of the children attended the on-site school about 60 per cent of the time in the month of November 2001, but the other two did not attend at all.<sup>213</sup> According to a teacher employed at Port Hedland, the reason for erratic attendance was that the children in this family had 'been banned from the school in the compound ... because of behavioural difficulties'.<sup>214</sup>

Another teacher working at Port Hedland described the challenges of teaching these children:

It was left up to me to set simpler work for them. There were two support detainees in the class that I was teaching in and we just tried to keep them going with very simplified work and quite often the other children would rile the smaller boy as it was very easy to do that and he would jump on tables and start screaming out and run round the classroom. It was very difficult to know what to do, I guess. After a while I developed some techniques. It took time. But it was another area – it was yet another level to deal with in that classroom and the people working with me were untrained. They were very

## A last resort?

humane and very good with the children, excellent actually, but they weren't trained in any – in that specialist area.<sup>215</sup>

According to the Department Manager at Port Hedland, the 'needs of intellectually disabled residents [had] still not been assessed or addressed' in November 2001.<sup>216</sup> This was the first time she had mentioned the children in her Manager's reports to Central Office.

In December 2001, 16 months after the family's arrival, a special education teacher visited the detention centre to advise ACM staff as to the type of program the children needed.<sup>217</sup> The Department Manager stated that:

The special needs of the three intellectually disabled children still not being met. Meeting with special education teacher elicited some useful ideas and suitable plans were subsequently devised by the psychologist. These have not been implemented however due to lack of personnel with suitable language skills.<sup>218</sup>

In January 2002, the ACM psychologist set out three options for providing appropriate education to the children with intellectual disabilities:

The option that is the most ideal (but also the most difficult) is that of a community based educational facility that is specifically designed and geared to teach appropriately sized groups of children with special needs. While this option will always be difficult, I feel that it should nonetheless be perused [sic] and exhausted before exploring the next two options... Option two is to construct a special needs school within the centre... Given the already under-resourced nature of the school, I feel that this option would never come to pass. Another practical and perhaps even more important shortcoming of this option however would be the excessively small class size (only two-three students) and essentially the total lack of social skills development opportunities... The third option is that of integration into existing classes which is the option that I suggest for the [three children] (especially as [one of them] is already in a mainstream class).<sup>219</sup>

In January 2002, the youngest of the children was attending the on-site school but there were problems with managing his brother's behaviour.<sup>220</sup> In February, both boys were attending the on-site school on a regular basis.<sup>221</sup> However, in March the Department Manager reiterated her view that ACM was taking too long to produce and implement plans for these children, because of understaffing.<sup>222</sup> In April, the Manager noted that 'there is an ongoing problem that their need for special education and training is not being addressed'.<sup>223</sup>

The difficulties in providing appropriate education to these children were made clear in a memo from the ACM Programs Manager to the ACM Centre Manager. He set out a range of other options, including enrolment in the local special education school:

It is difficult, under present circumstances, to devise an education plan for these children. Each requires a carer, at all times, for education to be a success. ... Each appears to have an intellectual disability. ... Educationally, it is best if trained staff work with these children. One option is for the children

to attend the Special Education Class at South Hedland, if this were possible. Another option is to employ a special education teacher, or aide, at the [detention] Centre. There are volunteers offering to work with the children.<sup>224</sup>

In May 2002 the other children at Port Hedland started going to the local Catholic school. The school did not have a special education teacher or program but permitted ACM to use a spare room so that the three children could leave the centre and mix with other children during recess.

An ACM teacher accompanied the three children to the local Catholic school for half a day. However, he did not have any special education training.<sup>225</sup> He tried to contact State schools in Port Hedland that had special education teachers in order to obtain some guidance:

He hopes that he can get some input from one or other, even if it's just a couple of days a week that special ed teacher spends with them.<sup>226</sup>

For two to three weeks in June 2002 the ACM teacher was assisted by a voluntary special needs teacher's assistant for two to three hours a day.<sup>227</sup> In July 2002, the teacher reported on the education progress of the children. He stated that the decision to teach the children at the school 'has been partially successful':

In the longer term it's likely to be counterproductive – these children have unmet special needs...

I persist with the view that **the children belong in a Special School setting**...the most urgent needs are **ESL assessments and Education development testing**. If the education authorities are unwilling to take these responsibilities I recommend that funding be sought and the test undertaken as soon as possible.

In the interim Centre Management needs to build on the good work the children have begun by continuing their schooling...under the care of a Special Education teacher assisted by a suitable carer.<sup>228</sup>

From July-September 2002, the children's mother apparently prevented them from going to the Catholic school, possibly related to concerns over their safety.<sup>229</sup> By December, the children were again attending the local Catholic school<sup>230</sup> with their older sister assisting the teacher.

Despite the persistent urgings of the teacher, there is no evidence that a special education teacher was provided, nor that the educational assessments he suggested were conducted until the start of the 2003 school year when the children started attending the local special needs school in Port Hedland.

It is unclear why there was a delay in enrolling the children at this school. The Department stated that it had made several unsuccessful efforts at enrolling the children at the Port Hedland special needs school but did not provide reasons for the failure.<sup>231</sup> ACM states that the Principal of the school refused to accept them but gave no reasons for that refusal.<sup>232</sup> Evidence from the Western Australian Government suggests that it expected to be paid for the attendance of any children from the detention centres even though it would be provided at no cost if the children

## A last resort?

had appropriate visas.<sup>233</sup> It may therefore be that cost was the barrier to the children's access to the special needs school.

During the Inquiry's December hearing, the Inquiry asked the Department to assess whether appropriate education had been provided to the children:

INQUIRY COUNSEL: ... accepting for present purposes that the Department and ACM did offer the best available services open to them to offer in this detention environment, the point is that the best available at the time was not good enough to adequately deal with ... these disabled children. That is the point, isn't it?

MS McPAUL (DIMIA ASS SEC (UNAUTH ARRIVALS)): Well, I would accept that it is not part of the State curricula for special education. So to that extent I accept broadly what you are saying.<sup>234</sup>

### 11.7.2 Case 2: Curtin

In December 2000, the ACM Education Co-ordinator notified the Programs Co-ordinator that the boy with cerebral palsy had special education needs and outlined a program of 25 minutes at school, 30 minutes of play group and 30 minutes of reading group, all accompanied by his mother.<sup>235</sup>

There is a detailed education program dated March 2001, with 20 minutes a day of special education, approximately 35 minutes where he would join the mainstream class in the ACM school within the detention centre, playgroup with the other children, 10 minutes of optional reading and half an hour of therapy in the medical clinic.<sup>236</sup> There is no evidence of how long this program was pursued.

The next document in the Inquiry's files regarding education of this child is dated March 2002 when DCD suggested that:

ACM to consider increasing [the child's] participation in schooling. [He] would be participating in full time education (with the extra assistance of a One to One Worker – employed by the Education Department) – if he was in the community – the Curtin School would more than likely need to employ an educational assistant for [him]. The school to devise educational activities appropriate to [his] needs.<sup>237</sup>

It appears that the boy did start attending the on-site ACM school for two hours a day in order to interact with other children, but there was no special curriculum for him.<sup>238</sup> In June 2002, DCD noted that there was still no special curriculum:

Full time schooling curriculum to be designed specifically for [the child's] educational needs.<sup>239</sup>

ACM's Daily Activity Sheets noted increasing attendance at educational activities from June to August.<sup>240</sup> However, in August 2002, Department staff noted that there had been nothing done to implement DCD's recommendation to develop a special program:

All I can suggest for this that this be a matter discussed with his new carer at Baxter who will be responsible for his program and that it be considered in

amongst his swimming, physio, medical needs, excursions and other activities designed for his development and care.<sup>241</sup>

In October 2002, the ACM Baxter Case Management Plan notes that the boy is to be enrolled at the special needs school near the detention centre, 'to be commenced on twice weekly structured days'.<sup>242</sup> In July 2003 the boy had still not been enrolled. The Department states that there has been some resistance from parents of other children at the special school but it expects that this barrier to enrolment would soon disappear.<sup>243</sup>

A July 2003 assessment by the Crippled Children's Association notes that it would benefit the boy:

to have access to a customised educational program and specialised equipment designed for children with special needs to help him develop his physical and cognitive skills to their full potential. As there is limited space available and a restricted range of social opportunities, it is difficult for [him] to have these opportunities in the detention centre however he would have more opportunities to access these in a special school environment.<sup>244</sup>

### 11.7.3 Findings regarding education

The Inquiry finds that the Department has failed to ensure that children with disabilities are provided with an education adapted to their specific needs. There have been insufficient staff with the appropriate qualifications and support to develop and implement an education strategy within the detention environment. Furthermore, there have been inadequate efforts to enrol the children in external schools which have the appropriate staff and facilities for children with disabilities.

The Inquiry is particularly concerned about the very long delay in obtaining appropriate education for the children in Case 1. On the evidence before the Inquiry, it took 14 months before special education classes for these children were considered and two and a half years before they started attending the special needs schools in the local community.

Regarding the boy in Case 2, as at July 2003, external agencies were still recommending the implementation of a special education program. On 1 August 2003 he commenced attending a special needs school in Port Augusta.<sup>245</sup>

## 11.8 Were there appropriate recreational activities for children with disabilities in detention?

As set out in Chapter 13 on Recreation, recreational activities have a vital role to play in children's development. While children with certain disabilities may be able to join the activities provided to other children on occasion, they may also require specially designed programs. Moreover, they may require additional assistance to participate in the programs designed for other children. For example, it may be necessary to provide additional supervision in order to allow children with a disability to participate in excursions or participate in games with defined rules.

## A last resort?

The Department states that services must be tailored to suit a disabled child's individual recreational needs and that external excursions are considered by detention centre health staff.<sup>246</sup>

### 11.8.1 Case 1: Port Hedland

ACM states that the three children in this family enjoyed a variety of recreational activities including, picnics, swimming, movies, shopping, art classes, shell collecting and walks outside the detention centre.<sup>247</sup> However, ACM has not provided the dates on which these activities began or the frequency with which these activities took place other than to say they occurred 'regularly' or 'whenever possible'.

The primary documents before the Inquiry do not note specific recreational activities until March 2002. This does not mean that they did not occur prior to that time, but it does suggest that if these activities did take place it was not documented in the children's case management plans.

The ACM Programs Manager described the following recreational activities plan for the children in March 2002:

Special consideration is currently made for the children, to some extent. Games and art/craft materials are supplied to the children. They join some of the after-school activities.

Organised, simple games and sports for all children, but occasionally aimed at the abilities and interests of these particular children, may be helpful.

They have been welcome to attend the Saturday morning movie and popcorn session for children. [One of the children's] current behaviour should preclude him from attending without a carer.<sup>248</sup>

The Department's submission, dated May 2002, states that the three children with intellectual disabilities:

have recently been enrolled in Riding for the Disabled classes. This experience will assist with socialisation skills for the children, as well as provide a break for their carers.<sup>249</sup>

During the hearings the Department indicated that the riding class was 'an eight week course that actually commenced some time earlier in May [2002] and probably finished some time in June'.<sup>250</sup> However, the Department Manager reports indicate that the children were participating in August and September 2002.<sup>251</sup> In any event, the children did not attend every session, sometimes because their mother would not permit them to go, and other times because ACM did not have the staff to take them.<sup>252</sup> The ACM psychologist reported the horse riding program a 'resounding success'.<sup>253</sup> However, it was not an ongoing activity.

In July 2002, the psychologist reported that the children had done woodwork classes 'aimed at developing improved motor functioning and spatial awareness (and of course to have fun)'.<sup>254</sup> The medical records indicate that there were some efforts

to involve them in painting in order to better manage their behaviour (see section 11.4.1 above). The children also participated in a sausage sizzle outside the centre in June 2002.<sup>255</sup>

### 11.8.2 Case 2: Curtin

Although there is some evidence of a program to encourage the boy to play in a variety of positions, hold a spoon, reach for objects unassisted, and so on, in January 2001, this was occupational therapy rather than recreational activity.<sup>256</sup> In June 2001, the Health Service Coordinator discussed the possibility of daytime excursions to give the boy's mother some respite.<sup>257</sup> However, once again, the records provided to the Inquiry demonstrate that a planned recreational program only began in earnest after March 2002.

At that time, DCD recommended that the Department and ACM 'explore options for daily walks other than around the compound' and that 'activity based opportunities...be devised so that the family can spend time together (eg weekly outing if possible)'.<sup>258</sup> He started recreational outings from March 2002, although with a carer rather than his mother.<sup>259</sup> ACM also went to some effort to make staff and a vehicle available for family outings and gave them a television and video cassette recorder.<sup>260</sup>

The Daily Activity Sheets from April to August 2002 indicate that the boy attended four of the excursions provided to other children in the centre, all of which were during July, to the local swimming pool.<sup>261</sup>

### 11.8.3 Findings regarding recreation

As discussed in Chapter 13 on Recreation, the deprivation of liberty itself limits the recreational activities available to children with disabilities in immigration detention.

The Inquiry finds that there have been some discrete events, like Riding for the Disabled, arranged for the children in Case 1. However, this event occurred after they had been in detention for more than 18 months and it lasted approximately eight weeks. The Inquiry also finds that children with disabilities were permitted to attend some of the recreational activities provided to other children. However, these efforts were insufficient to amount to a recreational program that addressed the special needs of children with serious disabilities in detention for long periods of time.

## 11.9 Were appropriate steps taken to transfer or release children with disabilities from detention?

Much is known about the ill-effects of institutional settings on people with disability. It is widely agreed that those settings have negative effects on people with disability in terms of their health, emotional, intellectual and social developments.<sup>262</sup>

## A last resort?

Both ACM and the Department suggest that children in immigration detention enjoyed access to superior disability services while in detention than they might have obtained if they were in the community. While the Inquiry readily acknowledges that many children in the community with disabilities might have trouble accessing the full complement of services, the Department has a responsibility to ensure that children in detention are provided with the highest attainable standard rather than the lowest common denominator. This is because the family's freedom to seek out the best services – be it health, education, recreation or moral support – is taken away by detention. Furthermore, their arguments ignore the psychological harm caused by detention.

Many of these difficulties are the result of deprivation of liberty itself, which is why international law is so clear in providing that detention of children, and especially children with disabilities, be a matter of last resort (see further section 11.1 above on international law).

The importance of liberty for children is emphasised not only by article 37(b) of the CRC, but by article 23 which talks about maximising the ability of a child to participate in the general community. The UNHCR Detention Guidelines recommend that children with disabilities only be detained if there is a medical certification that detention will not impact on their well-being and the Australian Disability Services Standards require that disability services be provided in the 'least restrictive way'.

As Chapter 6 on Australia's Detention Policy explains, the Department has two options for removing children from a detention centre prior to the grant of a protection visa.

First, the Department can issue a bridging visa on the grounds of 'special health needs'. It is the view of the Inquiry that once children with disabilities have been identified, they are likely to be obvious candidates for such bridging visas. However, the Department states that:

while it is unfortunate that children are held in immigration detention, it is usually in their best interests (including if they are disabled) to remain with their parents [in detention].<sup>263</sup>

As discussed more fully in Chapter 6, a proper interpretation of the 'best interests' principle leads to the conclusion that it will usually be in the child's best interests to be released from detention *with* their parents. However, the current bridging visa regulations make it extremely difficult to bring about such a result.

Nevertheless, the Department has a second option available to it, namely the transfer of children and their parents to alternative places of detention in the community. The Department states that the reason it has not transferred the children with disabilities out of detention centres is that any alternative place must have 'a commensurate level of service, security and welfare as in the detention facility' and no such place has been located for these families.<sup>264</sup> Given the difficulties that the Department faces in providing care to the families in detention, it is surprising that an appropriate alternative has not been identified, especially when at least one of the families has close relatives in the community.

### 11.9.1 Case 1: Port Hedland

The Inquiry has not received any evidence that the Department made efforts to arrange for a bridging visa or transfer this family to an alternative place of detention in the community. This is particularly disappointing in light of the fact that the mother's sister lives in Sydney.

The first record of requests by the children's mother to be moved to Sydney is noted in the medical records in April 2002.<sup>265</sup> At the same time there is a note that a letter will be written 're transfer to another Centre where there are facilities to help with her children'.<sup>266</sup> She repeatedly requested appointments with the Department to ask to be moved to Sydney near her sister.<sup>267</sup>

The Department acknowledges that it was aware of the family ties. Moreover, it has stated that the presence of contacts in the community is one of the factors considered when a detainee asks to be moved from one detention facility to another.<sup>268</sup> The Department must also have been aware that there was more ready access to disability expertise in Sydney than in Port Hedland. However, the Department was unable to shed any light on why this family was not moved except that:

...there are a very large number of people who would probably prefer to be accommodated in Villawood and that is just simply not possible. Villawood has a fairly high capacity at the moment and is primarily used for managing the compliance program, compliance pick-ups from the New South Wales and to some extent Queensland jurisdictions. So you know, there are a number of different factors there that we have to balance up in terms of questions about where individual families might be located...<sup>269</sup>

The Department eventually changed its mind and on 1 September 2003, the family were transferred to Villawood detention centre.<sup>270</sup> The family was released on permanent refugee protection visas in December 2003.

### 11.9.2 Case 2: Curtin

As noted above, in May 2001, an ACM Health Services Manager recommended that the family move to a metropolitan detention centre because Curtin was unable to meet the needs of the child. While acknowledging that such a transfer 'may be, in a medical sense, a help for [the boy's] development', ACM management refused to do so due to operational considerations.<sup>271</sup> ACM states that the final decision rested with the Department Manager at Curtin, who refused to allow the transfer to go ahead (see section 11.4.2 above).

In March 2002, the Department Manager at Curtin noted that ACM had been emphasising 'having the child taken into care within the community'.<sup>272</sup> The Department acknowledged that March 2002, after the mother had left the boy in the care of ACM and the Department, was:

the first time that the Department probably, given the changed circumstances of the family in the centre, were seriously looking for other possibilities for the care of the child in some kind of a supported community arrangement.<sup>273</sup>

## A last resort?

In May 2002, the Department Manager at Curtin proposed five options regarding the care of this child:

1. Child is placed in a community facility and other family members are moved to an IDC in a metropolitan location;
2. Child is placed in a community facility and other family members are placed in an alternative place of detention within the community close to disabled child accommodation;
3. Child is placed in a community facility and other family members remain in an IRPC facility;
4. Representations made to authorities in [country of origin] to give consideration to forced return of family to [country of origin];
5. Entire family including the disabled child remains in an IRPC facility and ACM are assisted financially to provide care for the child utilising available community resources.<sup>274</sup>

The proposal notes that there are many difficulties with obtaining community placement for the child, including the absence of available places for children with disabilities. The Department also referred to the fact that:

DCS have advised that it will be impossible to place this child in the local community of either Derby or Broome. He will be a difficult placement, given his degree of dependence. Community placements in the best of circumstances are very difficult to achieve and waiting times run into years.<sup>275</sup>

Moreover in metropolitan centres, even though:

[F]oster care options do exist for foster children but in cases of profound disability, it is a very big ask of any other person to take on. It is extremely difficult for the welfare authorities to find a suitable placement that we could take advantage of.<sup>276</sup>

The May 2002 proposal also states that:

[T]he family would be very difficult to manage in an alternative place of detention and would definitely present a flight risk as they have exhausted all avenues to remain legally in Australia.<sup>277</sup>

When challenged as to the likelihood that a family with a child with such profound disabilities would be a flight risk, the Department did not address the specific characteristics of the family, but it gave the more general response that:

[O]nce families are not able to achieve the migration outcome they'd hoped for by coming to Australia as unauthorised boat arrivals or other unauthorised arrivals, the likelihood or propensity for absconding does increase with the advanced stage of processing and the number of determinations that have been made that the family have not been found to be refugees.<sup>278</sup>

The proposal concludes that option 5 – keeping the family in detention with increased financial support to ACM – appears to be the only viable one. The final recommendation is that the boy 'remain within the detention environment unless other reasonable options for placement in the community become available'.<sup>279</sup>

In June 2002, a social worker from DCD stated that she believed:

that this family should be released from detention and placed into the community as soon as possible....the family's breakdown and stressors is a direct result of the detention environment.<sup>280</sup>

A Departmental Minute in June 2002 suggested that the Department had made attempts to find 'suitable placement in the community' but was unsuccessful.<sup>281</sup> The Minute also stated that 'this option could be explored further following the family's relocation to Baxter'.<sup>282</sup>

In August 2002, 21 months into the family's detention, DCD wrote to the Department recommending the family's urgent release from detention:

The Department [DCD] has been involved with this family since March 2002 and is very concerned about their well being. Of particular concern is the deteriorating emotional and physical health of the children. It is strongly recommended that this family should be released from detention and placed in the community as soon as possible.<sup>283</sup>

The Department responded to DCD with an outline of the steps it had taken to develop coping strategies for the child and the rest of the family and then stated:

While the Department is willing to explore possible options for places for alternative detention, it would be necessary to establish that any community placement would be at least consistent with the level of support and access to services currently available to the family.<sup>284</sup>

The Department appeared to be suggesting that the child was better off in detention than in the community. However, it went on to suggest that the possibility of alternative detention might be discussed with the South Australian Government after the child was moved to Baxter.

The Inquiry also explored whether the Department had given any consideration to moving this family to a metropolitan detention facility:

I think the situation with this particular family group, as with the other family with disability – disabilities – that we've already discussed, is that very careful consideration needs to be given to changing the arrangements that might be in place and while we accept that the process of providing services and management plans to these individual families has improved over time, one of the features to provide successful management of these cases is to enable the families to live in an environment that is familiar, that is understood by the children and disruption through moves that might be operationally convenient to the Department from one compound or one centre to another would need to be carefully weighed up against the effects that that might have on the children themselves.<sup>285</sup>

The May 2002 proposal from the Department's Manager at Curtin, which considered the best place to move the family on its closure, went through the pros and cons of Port Hedland, Woomera and Baxter. It did not consider the metropolitan centres.<sup>286</sup> In any event, after 22 months in detention at Curtin, the boy and his family were

## A last resort?

moved to Baxter. They were detained there for a further 13 months, until they were granted permanent refugee status in October 2003.

### 11.9.3 Findings regarding release and transfer

The Inquiry finds that the Department has failed to promptly pursue the available options for releasing or transferring children with disabilities from remote detention centres. As set out in Chapter 6 on Australia's Detention Policy, the Inquiry recognises that the criteria for granting bridging visas are extremely narrow, making it difficult to arrange for release on such visas. However, the Department has always had the possibility of transferring the family to an alternative place of detention in the community or, at the very least, to metropolitan detention centres with greater access to disability support services.

The Department failed to explore the possibility of transfer outside the facility regarding the family in Case 2, until 18 months after they had been detained. The family were released in October 2003, 35 months after they were detained.

Furthermore, in Case 1 the Department appears to have put 'operational considerations' above both the mother's desire to be near her sister in Sydney and the increased access to disability services in Sydney. In September 2003, more than three years after their arrival, they were transferred to Villawood. The family were released in December 2003, 40 months after they were detained.

The Department has suggested that one of the reasons it did not pursue the option of release on a bridging visa or alternative detention in the community is because the children received better services in detention than they would have in the community. The Department highlights the scarcity of resources for Australian children with disabilities in making this argument. ACM have also submitted that the services provided to the children in Case 1 and Case 2 over 2002 and 2003 are at least as good as the services that can be accessed by most families in the community with similar needs. Putting aside the inappropriateness of the delay in providing those services, the Inquiry is of the view that these arguments fail to take account of the following factors.

Firstly, detention per se limits the ability of children with disabilities to participate and integrate with the general community as required by article 23 of the CRC. The Department itself seems to recognise the limitations in the context of Case 2:

INQUIRY COUNSEL: ... Do you think that the conditions in which this child has been detained since November of 2000 have been such as to ensure that he has enjoyed a full and decent life in conditions which have ensured his dignity, promoted his self-reliance and facilitated his active participation in the community?

DIMIA ASS SEC (UNAUTH ARRIVALS): Look, I think to the fullest extent possible under the circumstances, that has been the case.<sup>287</sup>

Secondly, detention restricts the choices available to parents to seek the services that address the best interests of their children. The Inquiry readily acknowledges that the services available to families in the community may be scarce. However,

those families have the freedom to assess and lobby for the highest attainable care for their children and the most appropriate support for themselves. Families in detention do not have this option; they have no choice but to rely on the Department and ACM to provide for their children. As seen above, this has not always resulted in the best possible outcome for their children.

Thirdly, detention not only takes away certain choices from parents, it impacts on the mental health and coping mechanisms of parents and their children (see further section 9.3.4 in Chapter 9 on Mental Health). While this is an important factor for all children and parents, it can have a disproportionate impact on families with children with disabilities.

### **11.10 Summary of findings regarding the rights of children with disabilities in detention**

The Inquiry finds that there has been a breach of articles 2(1), 3(1), 6(2), 18(2), 23, 24(1), 28(1), 37(b) and 39 of the CRC.

In Chapter 6 on Australia's Detention Policy the Inquiry finds that Australia's mandatory detention laws, as administered by the Commonwealth, have resulted in the long-term detention of unauthorised arrival children, whether or not they have disabilities. Long-term detention creates particular difficulties for the care of children with disabilities. The Inquiry finds that the Department failed to address the needs of those children, within the confines of Australia's mandatory detention laws, in a manner that protects their rights under the CRC.

The Inquiry recognises that providing care to children with disabilities in detention is an extremely challenging task and that many individual staff members have done the best they can to assist these children. The Inquiry also acknowledges that, soon after the announcement of this Inquiry in November 2001, the Department started to focus greater attention on the development of management strategies, resulting in improvements in the quality of care. However, the Department has been responsible for children in detention for more than a decade.

When the children in the two case studies arrived in the Port Hedland and Curtin detention centres in August 2000 and November 2000 respectively, there were no systems in place to ensure routine and prompt consultation with State disability and child welfare authorities with the expertise to assist in the identification and management of children in detention with potential or observable disabilities. Furthermore, there does not appear to have been any use of the established State services standards to guide their service provision. This resulted in substantial delays in both these important areas.

The systemic failures in the management of children with disabilities in detention are reflected in the two case studies in this chapter. The children who are the subject of those case studies have serious disabilities with high needs, yet for most of the time that they were in detention these children and their families did not receive the services required to ensure that their special needs were met.

## A last resort?

On the evidence before the Inquiry, by the end of 2002 there was still no comprehensive case management plan and implementation strategy that adequately addressed the needs created by the intellectual disabilities of the children in Case 1. Regarding the boy with cerebral palsy in Case 2, there were efforts to create a plan on the boy's arrival but within six months staff were of the view that the boy could not be properly catered for in Curtin and the mother became disengaged. The services offered to the boy tapered off, culminating in the mother leaving the child in the hands of detention staff in March 2002. At this time State child welfare authorities became involved in the child's case management strategy and an appropriate plan was implemented.

There were also substantial delays in providing the appropriate aids and adaptations to the boy in Case 2. He was pushed around in a pram for the first seven months of his detention. There was also some concern about whether the 'Baby Jogger' that replaced the pram in May 2001 was best suited to his needs. In June 2002, a new wheelchair was purchased. Furthermore, it was only in March 2002 that the boy received appropriate eating utensils, bed, shower commode, communication devices and other aids and adaptations appropriate to his needs. The facilities improved further in September 2002 when the boy was transferred to Baxter.

The Inquiry therefore finds that the Department's failure to ensure a 'full and decent life' for these children 'in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community' resulted in a breach of article 23(1) of the CRC. The Department also failed to provide the special care and assistance required by these children to ensure that they had effective access to education, health care services, aids and adaptations and recreational opportunities 'in a manner conducive to the child's achieving the fullest possible social integration and individual development, including his or her cultural and spiritual needs', as required by article 23(3). The Department's failure to provide appropriate levels of care to these children also breaches article 24(1), which requires that all children enjoy access to health care services to enable their enjoyment of the highest standard of health.

The Inquiry acknowledges that many of the stresses facing the mothers of the children were related to the detention environment itself. It was therefore very difficult for staff to provide the psychological treatment needed. Nevertheless, the Department has the obligation to ensure that the additional support needs of parents with children with disabilities are directly addressed. The Inquiry finds that, despite the efforts of staff to provide counselling to the mothers of these children in detention, there was no comprehensive plan of support sufficient to address their additional needs. In Case 2, the heightened pressures that come with detention, combined with a lack of support, led to a complete breakdown in the mother's ability to be primary carer of her children. This amounts to a breach of article 23(2) which requires that assistance be provided to those responsible for the care of a child with a disability and article 18(2) which requires appropriate assistance for parents in the performance of their child-rearing responsibilities.

The Inquiry acknowledges the efforts of on-site teachers to provide some education to the children in Case 1 especially. However, these teachers did not have special

education training nor were they provided with special education teaching support. Despite the inability of the internal school system to accommodate these children, in Case 1 it took 14 months before special education classes were considered and two and half years before they received education from appropriately qualified teachers. This occurred when they began attending the local school in Port Hedland which had a special needs stream. Prior to this time their education failed to address their special needs and fell well below the standard of education offered to similar children in the community. Regarding Case 2, in July 2003, external agencies were still recommending the implementation of a special needs education program. The boy commenced attending an appropriate school in August 2003.

The failure to provide the special education required by these children results in a breach of article 23(3). There has also been a breach of articles 2(1) and 28(1) which require that all children be provided with the appropriate level of education on the basis of equal opportunity and without discrimination on the basis of their disability or immigration status. Although the children in these two case studies were able to attend internal schooling for some of the time in detention, there were insufficient measures taken to ensure that they could benefit from this schooling to the same extent as children without disabilities.<sup>288</sup> In addition, while the children in Case 1 were permitted to use a classroom at the local Catholic school, neither they nor the boy in Case 2 had access to external schools that provided an education appropriate to their needs until 2003. Accordingly they did not enjoy education on the basis of equal opportunity as compared to either the other children in detention or children with similar needs in the community.

Discrete events, like Riding for the Disabled, were offered to the children in Case 1 after 18 months in detention. Furthermore, children with disabilities were permitted to attend some of the recreational activities provided to other children in the centre. However, these opportunities were inadequate to address the recreational needs of the children. The failure to provide targeted recreational (as opposed to therapeutic) opportunities for a substantial period of their time in detention is likely to be connected to the failure to produce comprehensive case management plans addressed to their specific needs. This results in a breach of article 23(3) which requires assistance to be provided to ensure that children have access to, and receive, appropriate recreational opportunities.

While the Inquiry acknowledges that providing the appropriate level of services to children in detention is a challenging task, especially when the children are in detention for long periods of time in remote areas, it is within the power of the Department to seek the prompt release or transfer of children with disabilities from those areas.

The Inquiry finds that the Department failed to promptly pursue the option of releasing the children on a 'special needs' bridging visa, or into alternative care in the community or, at the very least, to transfer the children to metropolitan centres where access to disability services is greater. It appears that operational considerations resulted in a three-year wait before transferring the family in Case 1 to Villawood in Sydney in September 2003. They were released from Villawood detention centre on permanent refugee protection visas in December 2003. The

## A last resort?

family in Case 2 was released on permanent refugee protection visas, after almost three years in detention, in October 2003. These circumstances amount to a breach of article 37(b) of the CRC which requires detention for the shortest appropriate period of time. In the circumstances of these children, their continued detention was not, in the Inquiry's view, appropriate.

Further, the Inquiry finds that Australia's detention laws and the manner in which they were administered by the Minister and Department – both in terms of the length and location of detention, and the care provided to the children – failed to ensure 'to the maximum extent possible' the development of the children, in breach of article 6(2). There has also been a failure to ensure that children with disabilities enjoy an environment that fosters their recovery and reintegration from past trauma in accordance with article 39.

The Inquiry also finds that the length of their detention and the failure to provide these children with the appropriate level of care, demonstrates that the best interests of these children was not a primary consideration in all decisions concerning them. The Inquiry therefore finds that article 3(1) of the CRC was breached in relation to these children. The extent to which the system of mandatory detention itself reflects a failure to make the best interests of children a primary consideration is considered further in Chapter 17, Major Findings and Recommendations.

The circumstances outlined above must also be taken into account in considering whether the conditions of detention are such to satisfy the right to be treated with the inherent dignity of the child in accordance with article 37(c). This is also discussed in Chapter 17.

---

## Endnotes

- 1 They were also accompanied by their grandfather and uncle. Untitled document listing family's personal details and relationships to one another, (N5, Case 7, pp96-7).
- 2 See further DIMIA, Transcript of Evidence, 4 December 2002, p79.
- 3 See in particular, DIMIA, Transcript of Evidence, 4-5 December 2002.
- 4 UNHCR, *UNHCR Revised Guidelines on applicable Criteria and Standards relating to the Detention of Asylum Seekers*, 1999, guideline 7, 'Detention of Vulnerable Persons'.
- 5 *The Declaration on the Rights of Disabled Persons* and the *UN Declaration on the Rights of Mentally Retarded Persons* are scheduled to the *Human Rights and Equal Opportunity Commission Act 1986* (Cth).
- 6 IDS, 1998, 9.1, [www.immi.gov.au/detention/det\\_standards.htm](http://www.immi.gov.au/detention/det_standards.htm). The revised IDS attached to the detention services contract signed on 27 August 2003 are more detailed in their provision of services to children with disabilities. However, those IDS were not operational throughout the period of the Inquiry.
- 7 DIMIA, Managers' Handbook, Section 4.12, Issue 3, 30 April 2002, para 6.
- 8 DIMIA, Transcript of Evidence, Sydney, 4 December 2002, pp83-84.
- 9 DIMIA, Submission 185, pp69-70.
- 10 See also Multicultural Disability Advocacy Association (MDAA), Submission 122, p10.
- 11 Department of Human Services (DHS), Submission 181, pp34-35.
- 12 DIMIA, Contract Management Group Minutes, 19 April 2001, (N1, Q4, F4). See further Chapter 5 on Mechanisms to Protect Human Rights for a description of Contract Management Group and Contract Operations Group meetings.
- 13 DIMIA Curtin Manager Reports, October 2001, November 2001, December 2001, (N1, Q3a, F5).

- 14 DIMIA Curtin Manager Report, November 2001, (N1, Q3a, F5).
- 15 The Department provided the Inquiry with Curtin Department Manager Reports beginning in the first quarter of 2001, (N1, Q3a, F5).
- 16 The Department provided the Inquiry with Port Hedland Department Manager reports beginning in the first quarter of 2001, (N1, Q3a, F5).
- 17 DIMIA Director, Detention Operation Section, Letter, to ACM General Manager Detention Services, 5 November 2001, (N5, Case 7, p442).
- 18 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p62.
- 19 ACM Curtin Programs Coordinator, Memo, to DIMIA Curtin Manager, 19 April 2002, (N5, Case 2, p534).
- 20 DIMIA Curtin Manager, Email, to DIMIA Central Office, 20 June 2002, (N5, Case 2, p1662).
- 21 ACM Detention Services Monthly Report, Health Services Monthly Report, August 2002, p76.
- 22 Medical Practitioner, Port Augusta Hospital and Regional Health Services, Report, 20 September 2002, (N5, Case 2, p414).
- 23 ACM Managing Director, Letter, to DIMIA Assistant Secretary, Unauthorised Arrivals and Detention Services, DIMIA Central Office, 10 October 2002, (N5, Case 2, p1671).
- 24 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p63.
- 25 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p62.
- 26 ACM, Response to Draft Report, 5 September 2003.
- 27 ACM Health Services Operating Manual, Policy 6.6, Decision Making – Special Needs Detainees, Issue 2, 9 May 2002, para 4.3, (N1, Q8, F9).
- 28 ACM, Policy 16.1, Special Care Needs for Minors and Unaccompanied Minors, Issue 4, 12 August 2001.
- 29 Michael Hall, Submission 288a, p1.
- 30 DSC, Disability Services Standards, June 2001, Glossary, at <http://www.dsc.wa.gov.au/content/publications.asp#15>, viewed 25 November 2003.
- 31 DIMIA, Information Required, (N4, Q10, F9).
- 32 DIMIA, Information Required, (N4, Q10, F9).
- 33 Western Australian Government, Transcript of Evidence, Perth, 10 June 2002, p34.
- 34 DHS, Submission 181, Appendix 3, Child and Youth Health, p68.
- 35 DIMIA Port Hedland Manager, Facsimile, to DIMIA Deputy Secretary, 27 June 2002, (N5, Case 7, p438).
- 36 DSC, Letter, to DIMIA Port Hedland Manager, 19 June 2002, (N5, Case 7, p424).
- 37 DIMIA Port Hedland Manager, Facsimile, to DIMIA Deputy Secretary, 27 June 2002, (N5, Case 7, p438).
- 38 Derby Health Services, Letter, to ACM Curtin Nurse, 29 March 2001, (N5, Case 2, p958).
- 39 DCD, Acting Executive Director Community Development and Statewide Services, Letter, to DIMIA Assistant Secretary, Unauthorised Arrivals and Detention Services Branch, 1 August 2002, (N5, Case 2, p1681).
- 40 DCD, Case Notes, 25 March 2002, (N5, Case 2, p489).
- 41 DCD, Summary of Visit and Recommendations, referring to DCD contacting DSC on 4 April 2002, (N5, Case 2, p486).
- 42 DCD, Summary of Visit and Recommendations, 28 June 2002, (N5, Case 2, pp1682-3).
- 43 The Department of Human Services (DHS) is responsible for child protection and child welfare in South Australia. Family and Youth Services (FAYS) is the section of DHS that manages these responsibilities.
- 44 DHS, FAYS, Memo, to DIMIA Baxter Deputy Manager, 16 December 2002. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p182.
- 45 DHS, FAYS, Memo, to DIMIA Baxter Deputy Manager, 16 December 2002. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p182.
- 46 The Crippled Children's Association of South Australia, Planning Report, 17 July 2003. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p190.
- 47 DHS, FAYS, Memo, to DIMIA Baxter Deputy Manager, 1 April 2003. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p187.
- 48 United Nations Children's Fund (UNICEF), *Implementation Handbook for the Convention on the Rights of the Child*, United Nations Publications, Geneva, 2002, p335.
- 49 DIMIA, Submission 185, p69.
- 50 NEDA, Submission 210, p5.
- 51 DIMIA, Submission 185, p69.
- 52 DHS, Submission 181, Appendix 3, Child and Youth Health, p67.
- 53 DHS, Transcript of Evidence, Adelaide, 1 July 2002, p91.
- 54 See MDAA, Submission 122; NEDA, Submission 210.
- 55 MDAA, Submission 122, p11.

## A last resort?

- 56 Aspartylglucosaminuria (AGU).
- 57 Minister for Immigration and Multicultural and Indigenous Affairs, Letter, to Human Rights Commissioner, 20 November 2002.
- 58 DIMIA, Transcript of Evidence, Sydney 4 December 2002, p84.
- 59 DIMIA, Response to Draft Report, 10 July 2003, referring to TKT Europe, Epidemiology of LSD, [http://www.tkt5s.com/html/lysosomal/lys\\_epidemiology.html](http://www.tkt5s.com/html/lysosomal/lys_epidemiology.html), viewed 11 November 2003.
- 60 Katri Puhakainen, How day nursery can support a child who has an AGU disorder, Abstract, <http://www.kirjasto.jypoly.fi/opin/abstract.asp?aidee=189>, viewed 11 November 2003.
- 61 DIMIA, Response to Draft Report, 10 July 2003, referring to TKT Europe, Epidemiology of LSD, [http://www.tkt5s.com/html/lysosomal/lys\\_epidemiology.html](http://www.tkt5s.com/html/lysosomal/lys_epidemiology.html), viewed 11 November 2003.
- 62 DIMIA, Response to Draft Report, 10 July 2003 referring to PJ Meikle, JJ Hopwood, AE Clague and W F Carey, Prevalence of Lysosomal Storage Disorders, <http://aborn.webring.tripod.com/Medical/Lysosomal.html>, viewed 11 November 2003.
- 63 Separation detention is an area fenced off from the rest of the detention centre. Unauthorised arrivals are usually kept in separation detention until they are interviewed in response to a request for asylum. See further Chapter 7 on Refugee Status Determination.
- 64 DIMIA, Transcript of Evidence, Sydney, 4 December 2002, p85.
- 65 Katie Brosnan, Transcript of Evidence, Perth, 10 June 2002, p47.
- 66 Note that DIMIA stated that records held at State hospitals may demonstrate further care. DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p4.
- 67 ACM Port Hedland, Health Profile Forms for the three children, 24 August 2000, (N5, Case 7, pp199, 273, 341).
- 68 Paediatrician, East Pilbara Health Service, Letter, to ACM Port Hedland Health Service Coordinator, 2 March 2001, (N5, Case 7, pp82-84).
- 69 ACM Port Hedland, Medical Records, 1 June 2001, (N5, Case 7, p13).
- 70 Renal Physician, Royal Perth Hospital, Letter, to ACM Port Hedland Medical Practitioner, 9 August 2001, (N5, Case 7, p331).
- 71 DIMIA Director, Detention Operation Section, Letter, to ACM General Manager Detention Services, 5 November 2001, (N5, Case 7, p442).
- 72 ACM Port Hedland, Medical Records, 7 December 2001, (N5, Case 7, pp17-18).
- 73 ACM Port Hedland, Medical Records, 7 December 2001, (N5, Case 7, p212).
- 74 ACM Port Hedland Psychologist, Approach to Managing Children with suspected/identified Intellectual Disabilities, Memo, to ACM Port Hedland Programs Manager, 5 December 2001, (N3, F15).
- 75 DIMIA Port Hedland officer, Email, to DIMIA Port Hedland Manager, 27 March 2002.
- 76 DSC, Letter, to DIMIA Port Hedland Manager, 19 June 2002, (N5, Case 7, p424).
- 77 DIMIA Port Hedland Manager, Facsimile, to DIMIA Deputy Secretary, 27 June 2002, (N5, Case 7, p438).
- 78 DIMIA Port Hedland Manager, Email, to DIMIA Port Hedland officer and DIMIA Central Office, 2 April 2002.
- 79 ACM Port Hedland Psychologist, Memo, to DIMIA Port Hedland Manager, 4 April 2002, (N5, Case 7, p106).
- 80 ACM Port Hedland, Medical Practitioner, Facsimile, 'Referrals of Genetically challenged family', to external medical practitioner, 11 June 2002, (N5, Case 7, p74).
- 81 Paediatrician, East Pilbara Health Service, Letter, to ACM Port Hedland Medical Practitioner, 25 July 2002, (N5, Case 7, p333).
- 82 King Edward and Princess Margaret Hospitals, Perth, Pathology report, 20 August 2002, (N5, Case 7, p316).
- 83 Paediatric Registrar, East Pilbara Health Service, File Note, 29 August 2002, (N5, Case 7, p72).
- 84 King Edward and Princess Margaret Hospitals, Perth, Pathology report, 7 August 2002, (N5, Case 7, p318).
- 85 ACM, Response to Draft Report, 1 October 2003, pp18-19.
- 86 ACM, Response to Draft Report, 1 October 2003, p18.
- 87 Minister for Immigration and Multicultural and Indigenous Affairs, Letter, to Human Rights Commissioner, 20 November 2002. See also DIMIA, Transcript of Evidence, Sydney, 5 December 2002, pp9-10.
- 88 ACM Curtin Medical Practitioner, Letter, to Occupational Therapist, Derby Regional Hospital, 8 December 2000, (N5, Case 2, p989); ACM Curtin, Medical Records, 8 December 2000. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p6.
- 89 ACM Curtin Health Clinic, Memo, to Physiotherapist and Occupational Therapist, Derby Regional Hospital, 10 September 2001, (N5, Case 2, p944). The Memo refers to the boy's initial assessment

- by the hospital's physiotherapist on 15 December 2000 and the occupational therapist on 17 January 2001.
- 90 Senior Physiotherapist, Derby Regional Hospital, Facsimile, to ACM Curtin Health Services Coordinator, 20 December 2000, (N5, Case 2, pp981-983).
  - 91 See for example ACM Curtin, Medical Records, January 2001 to January 2002. ACM, Response to Draft Report, 1 October 2003, Attachment 44, pp10, 23, 29, 37, 39.
  - 92 ACM Curtin, Detainee Management Strategies, 20 May 2002, (N5, Case 2, p498). See also ACM Curtin, Detainee Management Strategies, 17 April and 29 May 2002. ACM, Response to Draft Report, 1 October 2003, Attachment 44, pp136, 152.
  - 93 ACM, Response to Draft Report, 1 October 2003, p21.
  - 94 Paediatric Registrar, Derby Regional Hospital, Report, to ACM Curtin Medical Practitioner, 18 June 2002, (N5, Case 2, pp1693-4).
  - 95 DIMIA, Submission 185, p69.
  - 96 NEDA, Submission 210, p11.
  - 97 ACM Port Hedland Psychologist, Approach to managing children with suspected/identified intellectual disabilities, Memo, to ACM Port Hedland Programs Manager, 5 December 2001, (N3, F15).
  - 98 MDAA, Submission 122, p21.
  - 99 Dr Bernice Pfitzner, Transcript of Evidence, Sydney, 16 July 2002, pp9-10.
  - 100 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p16.
  - 101 ACM Port Hedland, Medical Records, 6 April 2001, (N5, Case 7, p203). See also DIMIA, Transcript of Evidence, Sydney, 5 December 2001, pp6-7.
  - 102 ACM Port Hedland, Medical Records, 1 June 2001, (N5, Case 7, p13).
  - 103 DIMIA Port Hedland, Manager Report, November 2001, (N1, Q3a, F5).
  - 104 ACM Port Hedland, Medical Records, 12 November 2001, (N5, Case 7, p210).
  - 105 ACM Port Hedland Psychologist, Response to complaints/allegations made by [name removed], Memo, to ACM Port Hedland Acting Health Services Coordinator, 1 July 2002, (N3, F15).
  - 106 DIMIA Port Hedland, Manager Report, December 2001, (N1, Q3a, F5).
  - 107 DIMIA Port Hedland Manager, Email, to DIMIA Central Office, 16 December 2001, (N5, Case 7, p441).
  - 108 ACM Port Hedland, Medical Records, 3 December 2001, (N5, Case 7, p17).
  - 109 DIMIA Port Hedland, Manager Report, January 2002, (N1, Q3a, F5).
  - 110 DIMIA Port Hedland, Manager Report, March 2002, (N1, Q3a, F5).
  - 111 ACM Port Hedland Psychologist, Memo, to DIMIA Port Hedland Manager, 4 April 2002, (N5, Case 7, p104).
  - 112 DIMIA Port Hedland Manager, Email, to colleagues, 2 April 2002.
  - 113 DIMIA Port Hedland Manager, Email, to colleagues, 2 April 2002.
  - 114 ACM Port Hedland Psychologist, Behaviour Management Program, to DIMIA Port Hedland Manager, 2 April 2002, (N5, Case 7, pp109-110).
  - 115 ACM Port Hedland, Medical Records, 12 and 21 November 2001, (N5, Case 7, p210).
  - 116 ACM Port Hedland, Medical Records, 6 and 19 December 2001, (N5, Case 7, pp 212, 284, 409, 410).
  - 117 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p6.
  - 118 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, pp13-14.
  - 119 ACM Port Hedland, Medical Records, 5 June 2002, (N5, Case 7, p34).
  - 120 ACM Port Hedland Psychologist, Response to complaints/allegations made by [name removed], Memo, to ACM Port Hedland Acting Health Services Coordinator, 1 July 2002, (N3, F15).
  - 121 ACM Curtin Medical Clinic, Memo, to ACM Curtin Centre Manager, 5 March 2001, (N5, Case 2, pp962-83).
  - 122 ACM Curtin, Medical Records, 9 March 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p18.
  - 123 ACM, Response to Draft Report, 5 September 2003.
  - 124 Michael Hall, Submission 288a, p1. See also ACM Curtin Health Services Coordinator and Registered Nurse, Memo, to ACM Curtin Centre Manager and DIMIA Curtin Manager, 24 May 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p64.
  - 125 ACM Curtin Centre Manager, Memo, to ACM Curtin Health Services Coordinator, 6 June 2001, (N5, Case 2, p948).
  - 126 ACM Curtin Health Services Coordinator, Memo, to ACM Centre Manager, 27 June 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p66.
  - 127 ACM Curtin Health Services Coordinator, Proposal, to Centre Manager, 13 July 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, pp67-8.

## A last resort?

- 128 ACM Curtin Health Services Coordinator, Memo, to ACM Curtin Acting Centre Manager, 29 August 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p69.
- 129 DIMIA Curtin, Manager Report, March 2002. (N1, Q3a, F5). See also DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p42.
- 130 ACM Managing Director, Letter, to DIMIA First Assistant Secretary, Unauthorised Arrivals and Detention Division, 22 October 2002. ACM, Response to Draft Report, 1 October 2003.
- 131 ACM Curtin Acting Health Services Co-ordinator, Letter, to ACM National Operations Manager Detention Services, 1 February 2002, (N1, Q8, F9).
- 132 DIMIA Curtin, Manager Report, March 2002, (N1, Q3a, F5).
- 133 DIMIA Curtin, Manager Report, March 2002, (N1, Q3a, F5). ACM disagrees with the Department Manager's assessment: ACM, Response to Draft Report, 5 September 2003.
- 134 DCD, Reports, 25 March 2002 and others undated, (N5, Case 2, pp474-5, 486-90).
- 135 ACM Curtin Psychologist, Memo, to ACM Curtin Centre Manager, 27 March 2002, (N5, Case 2, pp938-939).
- 136 ACM, Response to Draft Report, 1 October 2003, p22.
- 137 See, for example, DIMIA Port Hedland officer, Email, to DIMIA Central Office, 3 August 2002, (N5 Case 2, p1689).
- 138 ACM, Response to Draft Report, 5 September 2003.
- 139 DSC, Disability Services Standards, June 2001, at <http://www.dsc.wa.gov.au/content/publications.asp#15>, viewed 25 November 2003.
- 140 DIMIA, Submission 185, pp69-70.
- 141 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p48.
- 142 DIMIA Villawood, Manager Report, July 2001, (N1, Q3a, F5).
- 143 See for example ACM Port Hedland, Medical Records, 13 January 2001, 1 June 2001, 23 April 2002 (N5, Case 7, pp8, 13, 25).
- 144 ACM Port Hedland, Medical Records, 21 March 2002, (N5, Case 7, p21).
- 145 ACM Port Hedland, Medical Records, 4 February to 18 March 2001, (N5, Case 7, pp8-10).
- 146 ACM Port Hedland, Medical Records, 6 April 2001, (N5, Case 7, p203).
- 147 ACM Port Hedland, Medical Records, 12 March 2001, 3 December 2001, 2 May 2002, (N5, Case 7, pp10, 17, 28).
- 148 ACM Port Hedland, transcript of meeting between ACM Port Hedland Intelligence Manager, ACM Port Hedland Child Liaison Officer and the children's mother, with the assistance of an interpreter, 3 December 2001, (N5 Case 7, pp428-32).
- 149 ACM Port Hedland, Medical Records, 10 December 2001, (N5, Case 7, p18).
- 150 ACM Port Hedland Psychologist, Progress Report on Behaviour Management Program, to DIMIA Port Hedland Manager, 4 April 2002, (N5, Case 7, pp104-110).
- 151 ACM Port Hedland Psychologist, Progress Report on Behaviour Management Program, to DIMIA Port Hedland Manager, 4 April 2002, (N5, Case 7, p105).
- 152 ACM Port Hedland Psychologist, Response to complaints/allegations made by [name removed], Memo, to ACM Port Hedland Acting Health Services Coordinator, 1 July 2002, (N3, F15).
- 153 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p43.
- 154 ACM Managing Director, Letter, to DIMIA Assistant Secretary, Unauthorised Arrivals and Detention Services, 10 October 2002, (N5, Case 2, p1671).
- 155 ACM Curtin, Detainee Management Strategies, 30 May 2002, (N5, Case 2, p502).
- 156 See above, DIMIA Curtin, Manager Report, March 2002, (N1, Q3a, F5).
- 157 ACM Curtin Psychologist, Mental Health Assessment, 26 March 2003, (N5, Case 2, p174).
- 158 ACM, Response to Draft Report, 5 September 2003.
- 159 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p49.
- 160 ACM Curtin, Medical Records, 30 November 2000, 26 February 2001, (N5, Case 2, pp22, 24).
- 161 ACM Curtin, Detainee Management Strategies, 27 February 2001, (N5, Case 2, p185). See also DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p52.
- 162 ACM Curtin, Medical Records, 7 March 2001, (N5, Case 2, p25).
- 163 ACM Curtin Psychologist, Psychological Assessment Report, 22 May 2001, (N5, Case 2, p164).
- 164 ACM, Response to Draft Report, 5 September 2003.
- 165 DCD, Report, 25 March 2002, (N5, Case 2, pp418-419).
- 166 DCD, Report, undated, (N5, Case 2, p417).
- 167 Chief Psychiatrist, Mental Health Division, Health Department of Western Australia, Psychiatric Report, 13 April 2002, (N5, Case 2, pp130-6, 523-7). See also DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p54.

- 168 DIMIA Central Office officer, Minute, to DIMIA Director, Detention Operations, 7 June 2002, (N5, Case 2, p1660).
- 169 ACM Baxter, Detainee individual management strategies, undated, (N5, Case 2, p237).
- 170 DCD, Report, undated, (N5, Case 2, p416).
- 171 See also ACM Curtin Nurse, Memo, to ACM Curtin Health Services Coordinator, 13 August 2002, (N5, Case 2, pp144-145).
- 172 ACM Curtin Medical Practitioner, Letter, to Derby Regional Hospital Paediatrician, 16 August 2002, (N5, Case 2, p922).
- 173 DIMIA Baxter, Manager Report, September 2002, (N4, Q1, F1).
- 174 People with Disabilities NSW, Submission 24, p13. Note that they have not been to detention centres but based comments on photographs of Woomera on the HREOC web site.
- 175 MDAA, Submission 122, p18.
- 176 Dr Annie Sparrow, Transcript of Evidence, Perth, 10 June 2002, pp74-75.
- 177 DIMIA Port Hedland, Manager Report, January-March 2001, (N1, Q3a, F5).
- 178 ACM, Response to Draft Report, 5 September 2003.
- 179 HREOC, Transcript of Evidence, Sydney, 5 December 2002, p40.
- 180 ACM, Response to Draft Report, 5 September 2003.
- 181 ACM, Response to Draft Report, 5 September 2003.
- 182 ACM, Response to Draft Report, 1 October 2003, p20. See, however, ACM Curtin Paediatric Nurse, Letter, to ACM Curtin Welfare Officer, 8 February 2001, which suggests that the bean bag had not arrived in February 2001, (N5, Case 2, p1008).
- 183 Senior Occupational Therapist, Derby Regional Hospital, Letter, to ACM Curtin Paediatric Nurse, 29 March 2001, (N5, Case 2, p958). See also ACM Curtin, Medical Records, 7 February 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p12.
- 184 ACM Curtin, Medical Records, 25 March 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p19.
- 185 ACM Curtin Psychologist, Psychological Assessment Report, 22 May 2001, (N5, Case 2, p164).
- 186 ACM Curtin, Stroller Management Plan, signed by mother and ACM Curtin staff, 25 May 2001, (N5, Case 2, p1003). See also DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p42. See further, ACM, Curtin, Medical Records, 25 May 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p26.
- 187 DIMIA, Response to Draft Report, 10 July 2003.
- 188 ACM Curtin Paediatric Nurse, Letter, to ACM Curtin Centre Manager, 12 April 2001, (N5, Case 2, p969).
- 189 ACM Curtin Psychologist, Report, 13 March 2002, (N5, Case 2, p398).
- 190 ACM Curtin, Revised Management Plan, 3 April 2002, (N5, Case 2, p7).
- 191 Occupational Therapist, Derby Regional Hospital, Occupational Therapy Report, 10 April 2002, (N5, Case 2, p528).
- 192 Physiotherapist, Derby Regional Hospital, Physiotherapy Report, 10 April 2002, (N5, Case 2, p531).
- 193 ACM Curtin Programs Coordinator, Memo, to DIMIA Curtin Manager, 19 April 2002, (N5, Case 2, p533).
- 194 Derby Health Services, Facsimile, to ACM Curtin, 3 May 2002; Paramedical Supplies Australia, Facsimile, to ACM Curtin, 21 May 2002, (N5, Case 2, pp1009-17).
- 195 Glide Rehabilitation Products, Delivery docket, to ACM Curtin, 7 May 2002, (N5, Case 2, p1053). ACM Curtin Programs Coordinator, Memo, to DIMIA Curtin Manager, 19 April 2002, notes the necessity of these items and others. ACM, Response to Draft Report, 1 October 2003, Attachment 44, pp180-1.
- 196 ACM, untitled document. ACM, Response to Draft Report, 1 October 2003, Attachment 35, p5.
- 197 DCD, Report, undated, (N5, Case 2, p421).
- 198 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p41.
- 199 DHS, FAYS, Acting Supervisor Woomera/Baxter Response Team, Memo, to DIMIA Baxter Deputy Manager, 1 April 2003. ACM Response to Draft Report, 1 October 2003, Attachment 44, pp187-8.
- 200 ACM, Response to Draft Report, 5 September 2003.
- 201 ACM Baxter, Revised Management Strategy, 9 October 2002, (N5, Case 2, p996); ACM, Response to Draft Report, 5 September 2003; DIMIA, Response to Second Draft Report, 17 December 2003.
- 202 ACM, Response to Draft Report, 1 October 2003, p19.
- 203 NEDA, Submission 210, p12. See also MDAA, Submission 122, p15.
- 204 DIMIA, Submission 185, p69.
- 205 ACM Woomera, Detainee Individual Management Strategies, undated, (N2, Q4, F3).

## A last resort?

- 206 ACM, Transcript of Evidence, Sydney, 4 December 2002, p47.
- 207 DIMIA, Response to Draft Report, 10 July 2003.
- 208 Michael Hall, Submission 288a, p1.
- 209 ACM Port Hedland, Health Profile Form, 3 January 2001, (N5, Case 7, p200).
- 210 East Pilbara Health Service, Letter, to ACM Port Hedland Health Coordinator, 2 March 2001, (N5, Case 7, p255).
- 211 ACM Port Hedland, Medical Records, 19 October 2001, (N5, Case 7, p209).
- 212 ACM Port Hedland, Medical Records, 18 December 2001 and 18 February 2002, (N5, Case 7, pp18, 20).
- 213 DIMIA Port Hedland Manager, Email, to DIMIA Central Office, 16 December 2001, (N5, Case 7, p441).
- 214 Katie Brosnan, Transcript of Evidence, Perth, 10 June 2002, p47.
- 215 Rose O'Connor, Transcript of Evidence, Perth, 10 June 2002, p46.
- 216 DIMIA Port Hedland, Manager Report, November 2001, (N1, Q3a, F5).
- 217 DIMIA Port Hedland Manager, Email, to DIMIA Central Office, 16 December 2001, (N5, Case 7, p441).
- 218 DIMIA Port Hedland Manager Report, December 2001, (N1, Q3a, F5).
- 219 ACM Port Hedland Psychologist, Memo, Management of Children with Intellectual Disabilities, to DIMIA Port Hedland Manager, 23 January 2002, (N3, F15).
- 220 DIMIA Port Hedland, Manager Report, January 2002, (N1, Q3a, F5).
- 221 DIMIA Port Hedland, Manager Report, February 2002, (N1, Q3a, F5).
- 222 DIMIA Port Hedland, Manager Report, March 2002, (N1, Q3a, F5).
- 223 DIMIA Port Hedland, Manager Report, April 2002, (N1, Q3a, F5).
- 224 ACM Port Hedland Programs Manager, Memo, to ACM Port Hedland Centre Manager, 27 March 2003, (N5, Case 7, pp354-355).
- 225 DIMIA Port Hedland Manager, Email, to DIMIA Central Office, 29 May 2002, (N5, Case 7, p439).
- 226 DIMIA Port Hedland Manager, Email, to DIMIA Central Office, 29 May 2002, (N5, Case 7, p439).
- 227 ACM Curtin Teacher, Memo, to ACM Curtin Centre Manager and DIMIA Curtin Manager, 8 July 2002, (N5, Case 2, p419); DIMIA, Response to Draft Report, 10 July 2003.
- 228 ACM Curtin Teacher, Memo, to ACM Centre Manager and DIMIA Manager, 8 July 2002, (N5, Case 2, p420-421) [emphasis in original].
- 229 DIMIA Port Hedland, Manager Reports, July 2002, August 2002, September 2002, (N4, Q1, F1).
- 230 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p20.
- 231 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, pp20-21, 23.
- 232 ACM, Response to Draft Report, 1 October 2003, p19.
- 233 Western Australian Government, Transcript of Evidence, Perth, 10 June 2002, p38.
- 234 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, pp23-24.
- 235 ACM Curtin Education Co-ordinator, Memo, Special Needs Student, to ACM Curtin Programs Co-ordinator, 13 December 2000. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p53.
- 236 ACM Curtin, school timetable, undated, (N5, Case 2, p967).
- 237 DCD, Report, 25 March 2002, (N5, Case 2).
- 238 On his involvement in educational activities see, for example, ACM Curtin, Detainee Management Strategies, 21 March 2002, (N5, Case 2, p428) and ACM Curtin Education Officer, Memo, to ACM Curtin Centre Manager, 9 April 2002 (N5, Case 2, pp471-2).
- 239 DCD, Summary of Visit and Recommendations, 28 June 2002, (N5, Case 2, p1682).
- 240 DCD, Report, 28 June 2002, (N5, Case 2, pp1123-1345).
- 241 DIMIA Central Office, Email, to DIMIA Woomera Centre Manager, 20 August 2002, (N5, Case 2, p1695).
- 242 ACM Baxter, Detainee Management Strategies, 9 October 2002, (N5, Case 2, p996).
- 243 DIMIA, Response to Draft Report, 10 July 2003.
- 244 The Crippled Children's Association of South Australia, Planning Report, 17 July 2003. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p192.
- 245 DIMIA, Response to Second Draft Report, 17 December 2003.
- 246 DIMIA, Submission 185, pp69-70.
- 247 ACM, Response to Draft Report, 1 October 2003, p19.
- 248 ACM Port Hedland Programs Manager, Memo, to ACM Centre Manager, 27 March 2003, (N5, Case 7, pp354-355).
- 249 DIMIA, Submission 185, p70.

- 250 The children's riding classes commenced on 11 May 2002 and were to run for eight weeks. DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p28. See also ACM Port Hedland, Incident Report, 15 May 2002, (N5, Case 2, p505).
- 251 DIMIA Port Hedland, Manager Report, August 2002, September 2002, (N4, Q3a, F1).
- 252 DIMIA Port Hedland, Manager Report, August 2002, September 2002, (N4, Q3a, F1).
- 253 ACM Port Hedland Psychologist, Response to complaints/allegations made by [name removed], Memo, to ACM Port Hedland Acting Health Services Coordinator, 1 July 2002, (N3, F15).
- 254 ACM Port Hedland Psychologist, Response to complaints/allegations made by [name removed], Memo, to ACM Port Hedland Acting Health Services Coordinator, 1 July 2002, (N3, F15).
- 255 ACM Port Hedland, Counsellor Contact, 3 July 2002, (N3, F15).
- 256 Senior Occupational Therapist, Derby Health Services, Report, 17 January 2001, (N5, Case 2, pp934-937).
- 257 ACM Curtin Health Services Coordinator, Memo, to ACM Curtin Centre Manager, 27 June 2001. ACM, Response to Draft Report, 1 October 2003, Attachment 44, p66.
- 258 DCD, Report, 27 March 2002, (N5, Case 2, p443).
- 259 See for example DIMIA Curtin officer, Email, to DIMIA Central Office, 3 August 2002, (N5, Case 2, pp438, 1689).
- 260 ACM Curtin, Revised Management Plan, April 2002, (N5, Case 2, pp4, 7, 8).
- 261 For example see ACM Curtin, Daily Activity Sheet for [name removed], 11 July 2002 (N5, Case 2, p1278); ACM Curtin, Daily Activity Sheet for [name removed], 10 July 2002 (N5, Case 2, p1282).
- 262 MDAA, Submission 122, p20.
- 263 DIMIA, Response to Draft Report, 10 July 2003.
- 264 DIMIA, Response to Draft Report, 10 July 2003.
- 265 The Mental Health Nurse noted: 'All her requests have focussed on DIMIA and her wish to be moved to Sydney'. ACM Port Hedland, Medical Records, 23 April 2002, (N5, Case 7, p24).
- 266 ACM Port Hedland, Medical Records, 23 April 2002, (N5, Case 7, p25).
- 267 See for example, ACM Port Hedland, Medical Records, 25 April, 30 April, 13 May 2002, (N5, Case 7, pp26, 27, 30).
- 268 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, pp32-34.
- 269 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p35.
- 270 DIMIA, Response to Second Draft Report, 17 December 2003.
- 271 Michael Hall, Submission 288a, p1. See also ACM Curtin Centre Manager, Memo, to ACM Health Services Manager, 6 June 2001, (N5, Case 2, p948).
- 272 DIMIA Curtin, Manager Report, March 2002, (N1, Q3a, F5).
- 273 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p58.
- 274 DIMIA Curtin Manager, Email, to DIMIA Central Office, 3 May 2002, (N5, Case 2, pp1656-1659).
- 275 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p64.
- 276 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p65.
- 277 DIMIA Curtin Manager, Email, to DIMIA Central Office, 3 May 2002, (N5, Case 2, pp1656-1659).
- 278 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p66.
- 279 DIMIA Curtin Manager, Email, to DIMIA Central Office, 3 May 2002, (N5, Case 2, pp1656-1659).
- 280 DCD, Report, 28 June 2002, (N5, Case 2, pp1682-1683).
- 281 DIMIA Detention Operations Section officer, Minute, to DIMIA Director, Detention Operations Section, DIMIA Central Office, 7 June 2002, (N5 Case 2, pp1160-1).
- 282 DIMIA Detention Operations Section officer, Minute, to DIMIA Director, Detention Operations Section, DIMIA Central Office, 7 June 2002, (N5 Case 2, pp1160-1).
- 283 Acting Executive Director, Community Development and Statewide Services, DCD, Letter, to DIMIA Assistant Secretary, Unauthorised Arrivals and Detention Services Branch, 1 August 2002, (N5, Case 2, p1681).
- 284 DIMIA Assistant Secretary, Unauthorised Arrivals and Detention Services Branch Letter, to Acting Executive Director Community Development and Statewide Services, DCD, August 2002, (N5, Case 2, p1655).
- 285 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p42.
- 286 DIMIA Curtin Manager, Email, to DIMIA Central Office, 3 May 2002, (N5, Case 2, pp1656-9).
- 287 DIMIA, Transcript of Evidence, Sydney, 5 December 2002, p46.
- 288 See Chapter 12 on Education for an analysis of the quality of internal education provided to children without disabilities in these centres.

