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**RACP Case Studies provided to the Senate
Legal and Constitutional Affairs
Legislation Committee inquiry into the
Migration Amendment (Repairing Medical
Transfers) Bill 2019**

About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of over 17,000 physicians and 8,000 trainee physicians, across Australia and New Zealand. The College represents a broad range of medical specialties including general medicine, paediatrics and child health, cardiology, respiratory medicine, neurology, oncology, public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine, and addiction medicine. Beyond the drive for medical excellence, the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients.

Introduction

The Royal Australasian College of Physicians (RACP) is pleased to provide a supplementary submission in response to the Senate Legal and Constitutional Affairs Legislation Committee inquiry into the *Migration Amendment (Repairing Medical Transfers) Bill 2019*.

This evidence is in addition to our comprehensive submission (40 on the Inquiry website) which discusses the RACP's position on the legislation under consideration. We wish to table this document as part of our provision of evidence by Professor Niki Ellis to the Legal and Constitutional Affairs Legislation Committee inquiry hearings.

RACP members have provided deidentified case studies which demonstrate the impact of the lack of access to appropriate health care and assessment for medical transfer which was occurring before the Medevac legislation was enacted.

Impacts of unnecessary delays to access to healthcare

A 15 year old boy

A 15-year-old boy was residing as a refugee on Nauru with his family from August 2013 until October 2018, when he was finally transferred to Australia for specialist medical care, 18 months after it had first been recommended by a Children's Hospital Multidisciplinary Team.

May 2015 – May 2017

In May 2015 this boy, who is left handed, fell from his bicycle and sustained a complicated fracture to his left radius and ulna. Immediately after the injury he was noted to have limitation to the movement of his wrist and fingers.

The fracture required operative repair with the insertion of 2 metal plates. Post-operatively the movement limitation persisted. This was subsequently diagnosed clinically by a visiting orthopaedic surgeon on 24 October 2015 as a partial posterior interosseous nerve palsy (PIN palsy). This was particularly problematic as the boy is left handed and this limited his ability to write. He was referred for physiotherapy by International Health and Medical Services on Nauru. We have no clinical record of the duration or frequency of the sessions. Over the next year he was seen intermittently by the medical staff on Nauru complaining of pain in the arm.

In May 2017 he developed more severe pain in the arm which was interfering with his sleep and quality of life. He was referred by his legal team for a telehealth opinion by the [REDACTED] Hospital at [REDACTED]. A team of doctors were sourced including a paediatric neurologist, a paediatric hand surgeon, a paediatric pain specialist and refugee health specialists. The boy filled out objective pain scales and the team formed the opinion that he was suffering from significant pain interfering with his quality of life. He has significant limitation of movement of his dominant hand associated with a persisting partial PIN palsy. The recommendation was that he was transferred for urgent review by a multidisciplinary team to investigate the nature of his pain and see if the PIN palsy could be improved with surgical intervention and removal of the metal plates in his arm.

This opinion was given to the Chief Medical Officer (CMO) of Australian Border Force in [REDACTED] 2017 via teleconference with the CMO and the [REDACTED] team. The CMO at the time, [REDACTED], sought a second opinion from a visiting adult trauma surgeon employed by [REDACTED] [REDACTED], who visited Nauru. This surgeon, who was not specifically trained in paediatric surgery, stated that the boy did not need a multidisciplinary review and that he could operate on Nauru without the support of a multidisciplinary team. [REDACTED] then stated that as he had 2 opposing opinions he would seek a third arbitration opinion from the Royal Australian College of Surgeons (RACS). This opinion was obtained in October 2017 via RACS from [REDACTED] in [REDACTED]. The opinion was the same as that of [REDACTED] - i.e. that [REDACTED] required transfer for multidisciplinary assessment and possible surgical intervention with the support of a pain team (as any operation would risk a flare of his pain). Despite this, he was not transferred.

The boy became increasingly depressed, withdrawn and stopped attending school as he was unable to keep up with writing. He was seen by multiple doctors on Nauru during this time.

In August 2018, he was referred to the surgeon from [REDACTED] once again who offered operation on Nauru. The boy's father reported that the surgeon stated, "this was the only option". His father consented to the operation (although the boy did not consent). He was operated on, but only one plate could be removed as the other one was too deeply embedded in the bone. Tendon transfer surgery was also performed to try to improve the PIN palsy. Following the operation, he suffered increased pain, as had been predicted by the [REDACTED] team, and became increasingly depressed. The Republic of Nauru overseas transfer committee granted permission for his transfer for specialist care. Despite this he was not transferred.

He attempted suicide by overdose in September 2018. He then stopped eating and drinking for 3 weeks. His aim (told to the RACP member via teleconference) was to die before he turned 15 by starving himself to death. He shaved his head to see what he would look like when he was dead. He lost 15% of his body weight and became dehydrated and medically unstable. His Body Mass Index dropped to under 13. (A BMI under 14 in the context of food and fluid refusal would in Australia result in admission to hospital for inpatient treatment). Nauru did not have facilities to care for him. Multiple phone calls and emails were exchanged and eventually he was medically evacuated to Logan hospital.

His medical evacuation took place 18 months after it had first been recommended by a [REDACTED] Hospital Multidisciplinary Team - this was before the Medevac Legislation. During this time the boy suffered increasing unmanaged pain, education failure, withdrawal, depression and eventual suicidality. This highlights delays and health impacts prior to the IHAP being in place.

Since arrival he has been under the care of both the pain team and the orthopaedic team at [REDACTED]. Further surgery may be an option, but it is uncertain whether he will ever regain full function of his dominant hand. His mood and weight have improved but he will need ongoing counselling.

A 5-month-old child with osteomyelitis (bone infection) in Nauru (reported with consent)

The child's parents took him to hospital as he had a fever and they noticed he wasn't using his right hand. The child was denied care and the parents were told to return at a later date for a scheduled appointment. The child and parents returned for the appointment days later where they were advised that their child needed blood tests and x-rays. The parents were advised that blood tests could not be conducted but x-rays did occur. An x-ray report was not provided for weeks until the parent's lawyer requested the report.

The parents were advised by a visiting overseas medical team that their child could have osteomyelitis (infection of the bone) or possibly malignancy. The child was transferred to Australia after 5 weeks of Australian physician advocacy for the medical evacuation of the child for appropriate medical care. The child was subsequently seen by orthopaedic surgeons and has received appropriate management. The child is currently housed in unsuitable community detention - there is flooding in home due to plumbing issues and an open drain in backyard. This is extremely unsuitable for an infant. The housing issue has been ongoing for 10 months despite medical practitioner advocacy on this issue.

Pervasive Refusal Syndrome

Fatima was 6 years old when she came to Nauru. She had been a happy child who loved school and was a top student. By the time she was 11 years old she took to her bed, stopped eating and drinking, covered her head with the sheet, stopped washing and started wetting the bed. For months she would not or could not get out of bed and had to be carried to the toilet. She would not speak to her parents or friends. After over 5 years on Nauru, almost half her life, she had lost all hope and had lost the will to live. When she was transferred to Australia with her mother she needed nasogastric tube-feeding for a week to maintain hydration and needed a walking aid for two months to move around. She gradually began to eat, drink, wash and toilet herself and to socialise. She remained a hospital inpatient for two months and is expected to need several more months of intensive outpatient treatment.

Pervasive refusal syndrome (PRS) is a rare psychiatric condition affecting mainly children aged 7 to 15 years old, girls three times as often as boys, although the youngest child described is 4 years old. The term pervasive refusal was first used in 1991 by a British child psychiatrist Bryan Lask and colleagues to describe four girls aged between 9 and 15 with profound and pervasive refusal to eat, drink, walk, talk or care for themselves over a period of several months. The diagnostic criteria for PRS are as follows:

- Clear food refusal and weight loss
- Social withdrawal and school refusal
- Partial or complete refusal in two or more of: mobilisation, speaking, attention to self-care
- Active and angry resistance to help or encouragement
- No organic condition or other psychiatric illness

Sydney clinicians, who also saw cases, proposed now widely accepted diagnostic criteria above.