



OMBUDSMAN

Western Australia

Hon S G E Cash, JP
President of the Legislative Council

Hon G J Strickland, B App Sc, Dip Ed
Speaker of the Legislative Assembly

Mr President, Mr Speaker

Report on an investigation into deaths in prisons

Pursuant to section 27 of the *Parliamentary Commissioner Act 1971* (the Act) I submit, for laying before each House of Parliament, a report concerning an “own motion” investigation that I have conducted pursuant to sub-section 16(1) of the Act.

As neither House is presently sitting I will, pursuant to sub-section 27(2) of the Act, send copies of the report to the Clerks of both Houses and make the report available to the public.

A handwritten signature in black ink, appearing to read 'Murray Allen', written over a large, stylized flourish.

Murray Allen
Parliamentary Commissioner for
Administrative Investigations

15 December 2000

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GLOSSARY OF ABBREVIATIONS

ADA	Alcohol and Drug Authority
ADHD	Attention Deficit Hyperactivity Disorder
AHPU	Albany Health Promotion Unit
AIC	Australian Institute of Criminology
AIHW	Australian Institute of Health and Welfare
ALS	Aboriginal Legal Service
AMA	Australian Medical Association
ANF	Australian Nursing Federation
ARMS	At Risk Management System (Ministry of Justice)
BRAMS	Broome Aboriginal Medical Service
CCA	Corrections Corporation of Australia
CSC	Correctional Service of Canada
CWCRC	C W Campbell Remand Centre
DCS	Department of Corrective Services
DETYA	Department of Education, Training and Youth Affairs
DGR	Director General's Rules
DICWC	Deaths in Custody Watch Committee
DMSP	Drug Management Strategy Project
EED	Earliest Eligibility Date
EQulP	Evaluation and Quality Improvement Program
FCMT	Forensic Case Management Team (previously the Special Needs Team)
FTE	Full Time Equivalent
GRAMS	Geraldton Aboriginal Medical Service
HDWA	Health Department of Western Australia
HIC	Health Insurance Commission
HIV	Human Immunodeficiency Virus
IDU	Intravenous Drug Use
IIU	Internal Investigations Unit (Ministry of Justice)
IMP	Individual Management Plan
IOU	Induction and Orientation Unit (Casuarina Prison)
JJ/HIDC	Joint Justice Health/Interdepartmental Council
MOJ	Ministry of Justice
OMD	Offender Management Division (Ministry of Justice)
PASS	Prisoner Advisory Support Service
POPS	Prison Officer Promotion System
PRAG	Prisoner Risk Assessment Group
RCIADIC	Royal Commission into Aboriginal Deaths In Custody
RPH	Royal Perth Hospital
SNT	Special Needs Team (now the Forensic Case Management Team)
SURU	Substance Use Resource Unit
TOMS	Total Offender Management Solution (Ministry of Justice)
UNR	United Nation Rules (Standard Minimum Rules for the Treatment of Prisoners)
UWA	University of Western Australia
WADASO	Western Australian Drug Abuse Strategy Office
WAPOU	Western Australian Prison Officers Union
WHO	World Health Organisation
YSAC	Youth Suicide Advisory Council

OMBUDSMAN'S FOREWORD

In recent years Australians from all walks of life have died, as a result of suicide, at a rate of more than 50 per week. Quite rightly, this is a matter of immense community concern and very considerable resources are devoted to the study of the issue, the treatment of those considered to be at risk, and the counselling of those people affected by the loss of a loved one. Increasingly the subject is being discussed in frank terms in the community. In a large proportion of cases those who knew the deceased are taken completely by surprise by the suicide, but it is never, quite rightly in my opinion, suggested that those people are somehow “to blame” for not identifying the risk and “doing something” to prevent the death. The death is seen for what it is - an ultimate expression of pain that can no longer be endured and an abandonment of hope that things will get better.

On the other hand, when the suicide of a person occurs in prison custody there is often a reaction in some quarters that the death must have been preventable and that the prison authorities must have failed to do all that they could to prevent it. There is something about a death in custody that causes it to be seen in a different light from one in the community. It seems to me that this difference can be explained by the idea that when a person is deprived of his or her liberty - by being placed in the artificial, disempowering and brutal environment of a prison - the correctional authorities take on a particularly heavy responsibility for that person's wellbeing. There seems to be a presumption that those who are responsible for the care and control of a prisoner who dies in custody must be prepared to justify their discharge of that heavy responsibility - and demonstrate that they did indeed do all that they could to care for the person and that all reasonable steps that might have prevented the death were taken.

This is no bad thing, in my opinion. In Australia imprisonment is regarded as a punishment of last resort and offenders are in prison because there is no other penalty that can properly reflect the circumstances of their crimes or protect the community. However, there cannot be any doubt that many prisoners enter prison in a particularly vulnerable state - often experiencing remorse for the crime and with physical and psychological problems that are the result of traumatic pasts and drug dependencies that have frequently been significant contributory factors in their crimes. When that vulnerability is exposed to the (often extreme) pressures of prison life, the potential for further psychological harm, self harm and ultimately suicide is obvious. It follows, in my opinion, that prisoners will always be at greater risk of suicide than the community as a whole, and prison authorities must (and do) accept the duty of care that goes with that vulnerability.

Western Australian prisons are, by the standards that prevail in many parts of the world, of a good standard. We can and should expect nothing less than standards which reflect our high living standards and relative wealth, and our overriding concern for human rights and fair play. In the medium to longer term, the State's prison authorities have a record of prison deaths of all types (suicide and natural causes) that is no worse than other Australian jurisdictions, helped by a number of years in which no deaths occurred. However, the last years of the 1990s produced a significant deterioration in that record. In the five and half years between 1 January 1995 and 30 June 2000 there were 56 deaths from all causes- which represents 56% of the total deaths in Western Australian prisons in the eighteen years between 1982 and 30 June 2000 (100) and exceeds the number of deaths in the previous thirteen and a half years combined. Not surprisingly, the large increase in the number of deaths in those

years caused considerable community concern. At that time the size of the prison population was increasing rapidly (amid community agitation for more and longer prison sentences as a response to a perceived increase in crimes of violence), resulting in overcrowding of the State's prisons and the fear that the strained system was not able to cope with the situation - and that some of the deaths were a consequence of that inability.

This Report examines many aspects of the State's prison system during the 1990s, with particular emphasis on the health and other services that are provided to deal with the physical and psychological health of prisoners and the systems that were employed to manage the recognised risk of prisoner suicide. The Report sets out many instances where, in my opinion, the system as a whole failed to provide sufficient and appropriate care to prisoners, and where those failings contributed to some extent to the deaths of prisoners.

In a Report of this kind it is inevitable that much attention will be paid to the role and activities of prison staff - such as prison officers, health services personnel and prison managers. It is inevitable because these workers, particularly prison officers, share the daily lives of prisoners - every day of the year. The nature and quality of the interactions and relationships between prisoners and prison staff will be the ultimate determinant of whether we get the type of prison system that we want and need. It will influence to a very large extent whether prisoners emerge from our prisons with the attitudes and skills that may give them a better chance of not reoffending and again being committed to prison.

The quality of the relationship will also, most importantly, determine how "healthy" a prison is - and whether a prisoner with physical or psychological needs will be identified and managed in a way that reduces the risk of harm, self-inflicted or otherwise.

Working in a prison environment is a very difficult and, at times, quite thankless task. Not everyone will be suited to that type of work - either at all or for long periods. It is relatively easy for an external observer such as myself to find fault with some aspects of prisoner/prison officer relationships. I believe that I have been able to find an appropriate balance between understanding the pressures of the job and pointing out, constructively, examples of situations where the interaction has been less than helpful.

I certainly do not want to convey the impression that I believe all or most prison officers and other prison staff are unable or unwilling to have a "healthy" relationship with prisoners. That is clearly not the case. Nevertheless, as the Report discusses - and the Ministry acknowledges - there is an uncertain proportion of officers who may well be unsuited to the work. The shortcomings have, in my opinion, been aggravated by inadequacies in the prison infrastructure and systems.

The Report also contains many recommendations that, if accepted and implemented, should help to make Western Australian prisons safer and healthier places. In some ways it is very disappointing that many of the recommendations need to be made at this time - because many of them have been made before, in this State and elsewhere, in one form or another. To that extent none, or very few, of the recommendations should be seen as surprising. At the end of the day, in my opinion, a reduction in the number of prison deaths from suicide will only be achieved when prisoners -

- are housed in prisons that can adequately accommodate the numbers;
- are engaged productively in meaningful jobs (or education for those that need it) and recreational activities;
- are able to participate in appropriate and effective rehabilitative programs;
- have access to medical and other health services that are equivalent to those in the community; and when
- there is in place an appropriate system for the identification and management of those prisoners who are at risk of self harm.

Those requirements are necessary, but not sufficient in themselves. What is most important, in my opinion, is that the personnel at all levels who are responsible for the care and management of prisoners not only accept the health and wellbeing of prisoners as something that is their vital concern, but also have the willingness and the ability to make all of those factors come together. In other words, prisoner health and welfare is not simply a problem or issue for the providers of health and other “support” services in prisons; it is fundamental to what makes a “good” prison and requires the full involvement and commitment of all concerned working together.

To its credit, the Ministry of Justice also appears to have accepted these requirements and, in recent times, has worked hard at all levels to formulate strategies and to provide an environment in which they can be delivered. Some of the initiatives that are in various stages of development and implementation within the Ministry that are worth mentioning include:-

- considerable improvement and expansion of the prison infrastructure to provide more and better accommodation;
- the development of a central, specialised reception and assessment prison for male prisoners in the metropolitan area;
- improved and better resourced health services;
- a review of the prison disciplinary system and the development of a system for the early resolution of prisoner grievances;
- the development of new rehabilitative programs, in particular a program to improve prisoners’ cognitive skills that will, importantly, be accompanied by a program to improve the interpersonal skills of prison officers; and
- overall, the development of an integrated prison regime to make more constructive and “normal” the management of prisoners.

To the extent that these initiatives are already occurring, some of the recommendations in this Report may, to a degree, reflect what is already in hand. However, in my opinion one of the strongest themes to have emerged from my inquiry is that the Ministry has always been able (sometimes with the help of recommendations made externally) to identify what has been needed to be done to improve our prison system. Where the Ministry has failed, in my opinion, is in its apparent inability over the years to move beyond the awareness and planning stages to the implementation and achievement stages. Consequently, whilst I applaud the new developments within the Ministry in recent times, it seems to me that, for a period of time at least, the Ministry will have to demonstrate

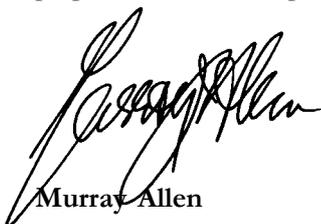
that it can achieve the outcomes that its new initiatives are designed to deliver. Prisons are hostile places and the past has shown us that achieving change within them is no easy task. It seems to me that security considerations have always prevailed over all others in this State's prisons, and reasons can always be found for not implementing some new way of doing things or for delaying the change. It would indeed be a pity if the changes that are needed in our prison system were delayed because of some perceived priority for security issues.

The recommendation I have made that is potentially of greatest impact on the system as it is presently organised is that responsibility for the control of the prison health service should not lie with the Ministry - but, rather, should be placed in the hands of a new entity which is quite separate from the Ministry. Such an entity should be funded in its own right in an amount that would enable it to plan for and provide a health service within prisons that is equivalent for all practicable purposes to health services in the community. Obviously, the Ministry would be involved in planning and other strategic matters with the new entity but, in essence, the health services within prisons would be provided by an organisation that would be seen as, and in fact would be, independent of the Ministry. The sole objective of the organisation would be the delivery of health services to patients, albeit in a prison environment. The prison system needs such an independent health service and, in my opinion, will only be able to have it with this degree of separation from the Ministry.

An unforeseen benefit of my inquiry has been to draw to the Ministry's attention to significant shortcomings in the data, statistics and general information which it collects, stores and provides to outside agencies such as my Office. It became quite clear at an early stage in the inquiry that the Ministry was unable to provide some of the information which I required, either because it was not available or was not available in a form that was easily accessible. In addition, at times I was provided with inaccurate information from sources within the Ministry which it could not subsequently identify. My questioning of information provided, and the Ministry's recognition that it was not entirely reliable, will be addressed with consequential benefits for the Ministry itself, my Office and the system as a whole.

I would like to record my appreciation to the Ministry and its senior executives as well as the many prison-based personnel who assisted my staff and me during the course of my inquiry by providing information and offering opinions. My thanks are also extended to all those who made submissions to the inquiry. In particular, I would like to thank the very many prisoners, past and present, who took the trouble to share their views about the good, bad and indifferent aspects of prison life and the prison system- and the issue of prison deaths in particular.

I also wish to acknowledge and thank all of my own staff who were in any way involved in the inquiry or in dealing with the many complaints that were received from prisoners following my visit to each prison in the course of this inquiry. I would like particularly to thank Jane Burn and Ian Cox who worked with me on the preparation of the Report.



Murray Allen

December 2000



CHAPTER 1 INTRODUCTION

COMMENCEMENT OF INVESTIGATION

DEATHS IN PRISONS - THE NUMBERS

COMMENCEMENT OF INVESTIGATION

- 1.1 In February 1998 I announced my intention to conduct an “own motion” investigation into deaths in prisons in Western Australia and the practices of the Ministry of Justice, using the power contained in section 16 of the *Parliamentary Commissioner Act 1971*. I came to that decision because of my concern that the disturbing upward trend of prison deaths in 1997 looked like continuing into 1998. In 1997 twelve people died in the State’s prisons (including one on home leave and one on home detention), which was the highest number for eighteen years. In the first five weeks of 1998 a further four deaths had occurred, (including one former prisoner who died a few days after release to bail). The trend continued, with a further eleven deaths occurring before the end of 1998 (including a prisoner who died in Graylands Hospital having never actually been taken into prison custody and another who died following release to parole) and eight deaths in 1999. Unfortunately, the first half of 2000 saw another dramatic jump in the number of deaths, with ten deaths by 30 June 2000.
- 1.2 The aim of my investigation was to look at the recommendations made as a result of various inquiries into deaths in prisons in recent years and to consider the extent to which those recommendations had been implemented by the Ministry, and the reasons for any non-implementation. The starting point for the investigation was 1 January 1991, shortly before the release of the report of the Royal Commission into Aboriginal Deaths in Custody (RCIADIC) in May that year. It was also my intention to review the issues arising from all prison deaths since then and to identify any issues not previously addressed.
- 1.3 The formal terms of reference of the inquiry were as follows:-
- (a) The extent to which the Ministry has, since the publication of the Report of the RCIADIC, implemented recommendations aimed at reducing the incidence of deaths in prisons made by the Royal Commissioners and made from time to time by the Coroner of Western Australia and any other investigatory body;
 - (b) The reasons for non-implementation of any of those recommendations;
 - (c) Whether the Ministry’s current policies and procedures and any associated training programs in relation to the identification, protection and treatment of prisoners who may be at risk and in need of protection or specialised treatment are adequate;
 - (d) Whether failure to implement any of those recommendations or any deficiency in any of those policies, procedures or training programs may have contributed to the number of deaths in prisons;
 - (e) Any other matter which arises relating to the Ministry’s administrative processes in relation to deaths in prisons.
- 1.4 I wrote to all prisoners and prison officers in the State advising them of the investigation. In addition, my staff and I visited every prison in the State (except Nyandi) at least once and interviewed hundreds of prisoners, prison officers, prison administrators, other prison staff (such as health services staff and industrial officers) and other Ministry employees. I also advertised in the media, inviting submissions from interested parties, with the result that over one hundred and eighty submissions from individuals and organisations were received.

- 1.5 When I announced the investigation I estimated that it would take eight to twelve months to complete. However, this turned out to be a significant under-estimate of the time required to carry out a thorough investigation of the issues involved, many of which are complex. Some of the factors that contributed to the task taking longer than I anticipated originally were:-
- During the course of the investigation complaints from prisoners about a wide range of issues, many of which were relevant to the investigation, increased dramatically and it became necessary to redeploy staff who had previously been involved in the investigation to deal with complaints. This was an unforeseen consequence of the investigation, which arose from the increased presence of my staff and myself in prisons and a greater awareness on the part of prisoners of the role of my Office, both of which are generally to be welcomed.
 - It also became clear that there were significant groups of people such as prison visitors, chaplains and visiting justices, who had generally not responded to my advertisements inviting submissions and I felt it necessary to actively canvass their views during the investigation.
 - The riot in Casuarina Prison on Christmas Day 1998 also temporarily diverted my staff from the investigation, since it gave rise to many complaints from prisoners about the conditions imposed at the prison after the riot, and the manner in which individual prisoners had been treated. These complaints required quick responses, necessitating further diversion of staff resources.
 - Regrettably, deaths continued to occur and it was necessary to consider and analyse the findings of Coronial inquests to identify any recurrent issues from previous deaths.
 - To its credit, the Ministry continued to explore possible causes of deaths and to introduce initiatives to deal with the problem. These initiatives had to be understood and their implications considered.
- 1.6 The investigation considered issues arising from all deaths in the State's prisons, not just those deaths due to suicide or apparent suicide. Only by doing so, in my opinion, would it be likely that we could examine the full breadth of health-related aspects of the prison system - both physical and psychological.
- 1.7 Likewise, although the investigation took as its temporal starting point the year in which the RCIADIC report was published, neither the Royal Commission's report nor this Report focus exclusively or particularly on indigenous deaths in custody. I have looked at all deaths in prisons in order to identify as many relevant issues as possible - including any issues specific to indigenous prisoners - but it is clear to me that many of the issues arising from prison deaths are applicable equally to indigenous and non-indigenous prisoners. Having said that, a report of this kind cannot fail to recognise and record the gross imbalance of the rate of imprisonment of indigenous Australians, particularly in Western Australia, when compared with non-indigenous Australians.

DEATHS IN PRISONS - THE NUMBERS

1.8 **Table 1.1** shows the number of deaths (from all causes) of persons in prison custody, between 1982 and 1999, in Western Australia and for Australia as a whole.

	Australia			Western Australia		
	I ⁽¹⁾	NI ⁽²⁾	Total	I	NI	Total
1982	4	21	25	3	3	6
1983	5	26	31	2	3	5
1984	4	27	31	3	2	5
1985	4	22	26	1	0	1
1986	1	16	17	0	0	0
1987	5	48	53	1	3	4
1988	6	36	42	2	3	5
1989	4	36	40	0	4	4
1990	5	28	33	0	3	3
1991	8	31	39	2	6	8
1992	2	32	34	0	3	3
1993	7	42	49	0	3	3
1994	11	42	53	2	4	6
1995	17	42	59	1	4	5
1996	12	39	51	2	4	6
1997	9	67	76	4	8	12
1998	9	60	69	3	12	15
1999	13	46	59	2	6	8
Total	126	661	787	28	71	99

(1) I = Indigenous prisoners
 (2) NI = Non-indigenous prisoners

Source: Australian Bureau of Statistics

1.9 It is immediately apparent from Table 1.1 that the numbers of deaths have fluctuated widely between years – at the national level from a low of 17 in 1986 to 76 in 1997, and in Western Australia from zero in 1986 to 15 in 1998. In the 18 years covered by Table 1.1, Western Australia’s total deaths (99) represented 12.6% of the total national deaths (787), but the proportion in individual years has, not unexpectedly, fluctuated. Significantly, in my opinion, Western Australia’s share of total deaths has been increasing over time. For example, taking the five-year periods of 1985-89, 1990-94 and 1995-99, the total number of deaths nationally increased as shown in **Table 1.2**.

Table 1.2 Western Australian prison deaths as a proportion of Australian prison deaths

	Western Australian deaths			Total Australian deaths			Western Australia as proportion of Australia (%)		
	I ⁽¹⁾	NI ⁽²⁾	Total	I	NI	Total	I	NI	Total
1985-89	4	10	14	20	158	178	20.0	6.3	7.9
1990-94	4	19	23	33	175	208	12.1	10.8	11.0
1995-99	12	34	46	60	254	314	20.0	13.4	14.7

(1) I = Indigenous
(2) NI = Non Indigenous

1.10 Although somewhat different proportions could be obtained by examining different groups of years, the following trends seem clear:-

- increasing absolute numbers of deaths in both Western Australia and nationally;
- Western Australia’s increasing share of the national total; and
- Western Australia’s share of the national total for indigenous deaths has exceeded the share for non-indigenous deaths.

The first of those trends is not necessarily surprising in view of the general upward trend in total prisoner numbers in Australia. Data about that increase are set out in Chapter 2 of this Report.

1.11 Given the increase in the total prison populations in Western Australia and nationally, perhaps of more importance is an understanding of the rate at which prison deaths occur – expressed as the number of deaths per 1000 prisoners. Table 1.3 shows the rate for Western Australia compared to the Australian national rate. The rates have been calculated using as the denominator of the fraction the number of prisoners at 30 June each year rather than an average daily number of prisoners over the full year – which would better reflect the number of “prisoner years.” It has been necessary to do this because no reliable average daily number is available for the whole period – due to some States in some years not collecting data on the number of indigenous prisoners.

1.12 Even the 30 June figures may be problematical because some States have had, in some years, considerable numbers of “unknowns” i.e. where it is not known if prisoners are indigenous or not. For the purposes of the calculations I have assumed that all the “unknowns” are non-indigenous prisoners – which may not necessarily be the case. To that extent some calculated rates for non-indigenous prisoners may be understated (because the denominator is a larger number than it should be) and for indigenous prisoners overstated for the opposite reason. In addition, in an environment of steadily rising prison populations, the 30 June population figure may in some cases be greater than the average daily rate taken over the whole year and, to that extent, understate the calculated rates. Nevertheless, I believe that the figures provide a reasonable approximation of the situation.

Table 1.3 Rates of death in prison custody 1982 - 1999, per 1000 prisoners

Year	National			Western Australia			National Minus Western Australia		
	I ⁽¹⁾	NI ⁽²⁾	Total	I	NI	Total	I	NI	Total
1982	n/a	n/a	2.5	6.8	3.3	4.4	n/a	n/a	2.2
1983	4.5	2.9	3.0	3.8	3.1	3.3	5.0	2.8	3.0
1984	3.9	3.1	3.2	6.1	1.9	3.2	1.9	3.3	3.2
1985	3.5	2.3	2.4	2.0	0.0	0.7	4.5	2.5	2.7
1986	0.8	1.6	1.5	0.0	0.0	0.0	1.3	1.8	1.7
1987	2.8	4.6	4.4	2.0	2.7	2.5	3.2	4.9	4.7
1988	3.3	3.4	3.4	3.8	2.7	3.0	3.1	3.5	3.5
1989	2.2	3.2	3.1	0.0	4.0	2.6	3.2	3.2	3.2
1990	2.4	2.3	2.3	0.0	2.6	1.7	3.4	2.2	2.4
1991	3.7	2.4	2.6	3.5	5.2	4.6	3.8	2.1	2.3
1992	0.9	2.4	2.2	0.0	2.3	1.6	1.2	2.4	2.3
1993	2.9	3.1	3.1	0.0	2.2	1.5	3.9	3.2	3.3
1994	3.9	3.0	3.1	2.9	2.8	2.8	4.3	3.0	3.2
1995	5.7	2.9	3.4	1.4	2.7	2.3	7.0	2.9	3.5
1996	3.7	2.6	2.8	2.7	2.7	2.7	4.0	2.6	2.8
1997	2.5	4.3	4.0	2.7	6.0	4.9	2.5	4.1	3.9
1998	2.4	3.7	3.5	4.0	7.5	6.4	2.0	3.3	3.1
1999	3.0	2.7	2.7	1.9	3.5	3.0	3.4	2.6	2.7
Average⁽³⁾	3.06	2.97	2.98	2.4	3.06	3.01	3.39	2.96	3.15

(1) I = Indigenous prisoners
(2) NI = Non-indigenous prisoners
(3) Average = 17 years 1983-1999 for national figures, 18 years 1982-1999 for Western Australia

Source: Australian Bureau of Statistics

1.13 It can be seen from Table 1.3 that Western Australia’s long term average death rates:

- **for indigenous prisoners**, is significantly lower than the National Minus Western Australian rate (2.4 deaths per 1000 prisoners compared to 3.4 deaths per 1000 prisoners): this has, obviously, been assisted greatly by the five years in which there were no deaths of indigenous prisoners in this State;
- **for non-indigenous prisoners**, is very similar to the National Minus Western Australian rate (3.06 to 2.96); and
- **for all prisoners**, is slightly less than the National Minus Western Australian rate (3.01 to 3.15).

1.14 It is against that background that my inquiry examined the situation in Western Australian prisons to better understand the circumstances of the deaths and the issues that each death highlights about prison life and the care of prisoners by the Ministry.

CHAPTER 2 THE PRISON SYSTEM

THE MINISTRY OF JUSTICE

OVERCROWDING

THE PRISONERS

THE ABILITY OF THE MINISTRY TO LEARN FROM DEATHS

THE MINISTRY OF JUSTICE

Formation

- 2.1 Until 1993 responsibility for the State's prisons, offenders and related services lay with the Department of Corrective Services ("DCS") which had been established in 1987. Headed by an Executive Director, the DCS was managed through four divisions – Prison Operations, Community Corrections, Strategic Services, and Corporate Services – with a Directorate Support Group providing specialist advice and support to the Executive Director.
- 2.2 The Ministry of Justice ("the Ministry") was established on 1 July 1993 by the passage of the *Acts Amendment (Ministry of Justice) Act*, in response to Government policy that was stated as representing a commitment to make the Western Australian system of justice more responsive to the needs of the community. Amongst other entities, the Ministry incorporated the former Departments of Corrective Services and Crown Law, and the Juvenile Justice Bureau. A Director General heads the Ministry's corporate structure, assisted by a corporate management team representing Court Services Division, Crown Solicitor's Office, Offender Management Division, Office of the Public Advocate, Parliamentary Counsel's Office, Public Trust Office, Registrar General's Office and Corporate Services. In addition, a corporate policy committee includes heads of the Aboriginal Policy and Services Branch and the Policy and Legislation Division. The Ministry also administers State Corporate Affairs and provides administrative support for the Parole Board and Supervised Release Review Board. Corporate service functions are provided in whole or in part to a number of agencies which are completely independent of the Ministry, including the Office of the Director of Public Prosecutions, Equal Opportunity Commission, Law Reform Commission and the Office of the Information Commissioner.
- 2.3 Since the creation of the Ministry, its mission statement has been – *"To ensure access to a fair and cost effective system of justice which protects the rights of individuals and is responsive to community needs."*

Offender Management Division

- 2.4 Although a number of parts of the Ministry have a role to play in the total delivery of the prison service in Western Australia, it is overwhelmingly the Offender Management Division ("OMD") that is responsible for both the day-to-day management and long-term strategic direction of the system.
- 2.5 In early 1996 the former Ministry divisions of Adult Offender Management and Juvenile Justice were amalgamated to form the OMD, thereby reflecting *"...a more collaborative approach to the treatment of prisoners."*¹ At that time the OMD consisted of seven main directorates:
- **Community-based Services** – responsible for the management of all juvenile and adult offenders subject to community-based supervision orders, whether imposed by a court or releasing authority;
 - **Health Services** – provides health services for offenders in custody;
 - **Investigations/Information Analysis** - provides a range of investigative services relating to incidents in prisons and juvenile institutions;
 - **Juvenile Offenders Custody** - responsible for managing juveniles in custody for the protection of the community;
 - **Operational Standards** – provides generic benchmark standards for prisons;

- **Policy, Programs and Projects** – responsible for divisional policy development, the delivery of rehabilitation programs and special projects; and
- **Prison Management** – includes the management of prisons throughout the state.

2.6 During 1998/99 the OMD was

“...restructured to align current and proposed custodial functions and services within a Purchaser/Provider model. This has resulted in a separation between the Offender Management Division as the “purchaser” of prison services and Prison Services as the “provider” of prison services.”²

2.7 Under those revised arrangements, the OMD is responsible for community based services, juvenile custodial services, planning and policy, service procurement, sentence management, and the internal investigations function. The Prison Services Division, and the Health Services Directorate which forms part of it, are not now - in an organisational sense - part of the OMD. Nevertheless, in this Report I will refer to the “OMD” as including the Prison Services Division and the Health Services Directorate and to “the Ministry” as encompassing the entire prison system.

2.8 It is fair to say that in the course of my inquiry I found very few people who were prepared to speak favourably about the way the OMD had operated in the past in respect of:

- strategic and tactical analysis of the kind of prison system the State needs; or
- operational management of the system, including the physical facilities, the staff of all kinds working in prisons, the policies and procedures to be applied to the management of prisoners, and, generally, the interaction between “head office” and the prisons.

2.9 Throughout the Report reference will be made to perceived - and, in my opinion, sometimes real - shortcomings of the prison system and its operational management by the OMD at various levels. Those shortcomings are not presented to sheet home some sort of “blame” for all the ills of the system. Indeed, I acknowledge readily that the past two years have seen many changes within the Ministry and OMD – both in terms of structure, personnel (particularly at senior levels) and attitudes towards addressing many of the problems. The results of these changes (many of which are also referred to in this Report) are being seen now, but much more time will be needed to redress a long period of neglect. I support wholeheartedly those initiatives – but, nevertheless, consider it appropriate to include in this Report the shortcomings which I have identified to provide a context within which the management of the OMD and the prison system as a whole over the past decade can be seen, and to assist those trying to make the changes necessary to improve our prison system.

2.10 The Smith Report in 1999 commented that the OMD had been -

“...a rather dysfunctional organisation to some extent for some time. The history – told to us by many individuals – appeared to be one where there were indications of a lack of systematic planning, a personality driven culture, the fragmentation of key officials into factions that were openly hostile to each other, a failure to make individuals accountable for their actions, a lack of management ability and vision, a lack of focus on the core business of running a Prison Service, distrust between Superintendents and Headquarters staff and vice versa, and individual power bases which often seemed to work against each other.”³

2.11 Submissions made to me by many persons involved in the prison system in differing ways were to precisely the same effect. Inevitably, many of these submissions were impressionistic, reflecting the individual’s own experiences and perceptions. I do not believe them to be less valuable for that reason, particularly in light of the consistency of the opinions expressed.

- 2.12 From outside “Head Office,” the view about the OMD and the Ministry is that it has been an unhealthy organisation containing little groups of people working in vacuums in order to – often - secure their own positions. It was frequently perceived to be riddled with factional warfare, where those who had fallen out of favour or lost power spent much of their time plotting to reverse the positions. This was said to have caused a reduction in expertise and experience and a great drop in the level of support for prison staff. The perceived growth in Head Office staff numbers was believed to have caused reductions in numbers of prison staff of all kinds and to have created a divide between Head Office and prison managers. Managers also claimed to experience obstacles, lack of money, and unethical behaviour in dealings with Head Office.
- 2.13 A person involved with a support organisation working within prisons made observations about the manner in which the prison system actually operates as opposed to the manner in which it should run. That person’s experience was that the hierarchical chain of command breaks down into a fragmented system at the prison level because individual superintendents run prisons as they see fit, ignoring directives issued under the authority of the Director General of the Ministry. Although it was not disputed that superintendents should be concerned most of all with the security and good order of prisons, it was also argued that this preoccupation, coupled with the fragmentation of authority, was part of an “*entrenched machismo culture*” in which rehabilitation was not likely to be a priority in any real sense. On the contrary, it was argued that such a culture gives rise to hopelessness on the part of prisoners which, in turn, leads to self-harm and deaths – and that a radical change of attitude was needed, involving penologists, criminologists and sociologists.
- 2.14 On a similar theme, a health services professional submitted that the Ministry has to respect and protect the individual under its care, referring to “...*rehabilitation rather than the practice of further damaging the individual’s psyche...*,” adding that -

“It is a well known psychological phenomenon that unless there is openness, accountability and supervision, the organisation runs the risk of taking on the characteristics of the client group...I have observed [the Ministry] from the highest level down mirroring much of the behaviour and characteristics of the client group...at times. [The Ministry] is not a role model for ethical and professional practice, nor does it provide a healthy environment for employees and clients.”

^The same person argued that

“...there is a large division between those who work on the ground and those who make the decisions and hold the power. It would seem that many decisions are made reactively in response to political pressure, financial concerns, protecting one’s own power base, and covering up unprofessional and unethical practice. These decisions are generally made by those who have not had training in understanding human behaviour, have not been trained adequately or at all in ‘good’ management practices, who do not understand their own psychological processes and therefore cannot be objective, and who are not open to feedback from those working with the actual client group. As a consequence, many who hold positions of power have become more and more defensive as a way of protecting themselves, their role and their status. Maybe work experience within the prison setting for the Minister and all senior management would perhaps provide a climate for greater understanding and lead to more realistic and less damaging decision making from those who hold the power. Accountability to an objective, outside observer, rather than collusion and power bases would also break up this culture of cover-up.”

- 2.15 According to some prison officers, cronyism and nepotism have been rife. The widely-held perception was that secondments or promotions were determined by who you know and who you associate with in your spare time. These officers perceive a subculture of British-born officers who play soccer and drink together, where those who are not part of the subculture do not get the same

opportunities and are not treated on merit. Several officers made reference to a “Purple Circle” and its ability to block the careers of those who were not a part of it. An alleged connection with the Western Australian Prisoner Officers’ Union (WAPOU) was also mentioned as being an alleged alliance which does not work to the benefit of all officers.

2.16 In response to my draft Report the Ministry advised me that:-

“...While the Ministry accepts that that view [expressed in paragraph 2.15] would arise during interviews conducted a few years ago, it is of the view that the factional in fighting which previously characterised the prison system has been largely marginalised. Consequently the Ministry is of the view that use of this terminology, particularly in a report of this nature, may have the adverse effect of bringing previous attitudes to the forefront and are largely counter-productive to the future well-being of the prison system in Western Australia.”

2.17 By way of illustration of the current approach, the Ministry has advised me that it has taken positive steps to ensure the integrity of the promotion system through the recent introduction of the *Prisoner Officer Promotion System (POPS)* for First Class and Senior Prison Officer positions. Essentially, POPS was formulated by representatives from prisons, Prison Services Division, human resources, the WA Prison Officers Union and the Public Sector Standards Commission to “*improve the quality, cost and timeliness of the selection process*” associated with promotions to First Class and Senior Prison Officer positions through “*a consistent approach to selection*” and “*a process that is efficient and effective.*”

2.18 POPS includes the following improvements to the promotion process:-

- validity of applications and assessments for 12 months from the completion of the selection process;
- provision of a Job Description Form for use by applicants and those assessing suitability for promotion;
- an annual requirement for staff to be assessed for their promotional suitability;
- consistency;
- the compilation of a merit-ordered list of suitable applicants from which promotional vacancies can be filled in a timely and efficient manner.

2.19 Some officers observed that the Ministry regularly made decisions without consulting ‘the people on the ground,’ frequently without realising the effect of such a practice on the morale of officers, particularly when the decisions were seen as unwise. A number of prison managers and administrators also complained of experiencing “*absolute frustration*” in trying to get adequate resources to perform what was expected of them. It was claimed that it could take weeks to get responses to letters sent to the “black hole” which is Head Office.

2.20 In common with prison administrators, prison officers complained that prisons are not allocated enough resources to perform their function. It was claimed that there is a shortage of staff in all categories; a shortage of cell accommodation; interview rooms, recreation areas, and space for staff to perform administrative tasks; and a lack of basic items such as cleaning materials, cups and bedding at some prisons. A support organisation observed that the Ministry was subject to conflicting pressures, such as the provision of services and rehabilitation on the one hand and cost minimisation on the other. Its view was that support services suffer greatly as a result, particularly as prison musters continue to rise and resources stay at the same level. Several prisoners and others made a case for increased visiting arrangements but claimed that any proposals to improve access to visits were generally declined because of the additional resources required.

- 2.21 Time and again the claim was made to me that the OMD had simply been unable, for most of the 1990s, to plan and manage a reasonable prison service that met the needs of the community and the prisoners entrusted to the Ministry's care. The constant theme was one of a system in considerable crisis in virtually every aspect of its operations and unable to extricate itself.

OVERCROWDING

- 2.22 Overcrowding of accommodation and the lack of resources to cope with it was the most commonly cited symptom of the crisis. It is abundantly clear that throughout most of the 1990s the Ministry's facilities had to house a much greater prisoner population than the planned capacity of those facilities – although it must be acknowledged that the Ministry has little control over the numbers of people committed to prison, which are more a function of levels of crime and apprehension rates, sentencing legislation and sentencing practices. Nevertheless, governments and government agencies responsible for the operations of prisons must make reasonable efforts to anticipate and plan for changes in prisoner numbers in order to provide appropriate accommodation and management regimes – even if that means the development of contingency plans that can be activated at short notice to deal with unexpected increases in an appropriate manner.
- 2.23 Western Australia now has fifteen prisons – Albany Regional Prison, Bandyup Women's Prison, Broome Regional Prison, Bunbury Regional Prison, Casuarina Prison, Eastern Goldfields Regional Prison (Kalgoorlie/Boulder), Greenough Regional Prison, the Hakea Prison complex⁴, Karnet Prison Farm, Nyandi Women's Prison (an annexe of Bandyup), Pardelup Prison Farm, Riverbank Prison, Roebourne Regional Prison, and Wooroloo Prison Farm. A further 750 bed prison, Acacia, is under construction at Wooroloo South. On 5 May 2000 the Ministry gazetted part of a former Disability Services Commission complex known as Pyrton in the suburb of Eden Hill as a minimum security prison for female prisoners. It is not known when - or if - this facility will operate as a prison because of considerable opposition to the proposal from community groups.
- 2.24 It is generally acknowledged internationally that prisons should operate at around 85% or up to 95% of capacity – to allow some spare capacity to deal with short-term fluctuations in prisoner numbers and to provide special accommodation (such as infirmary cells, observation cells etc). The Australian Institute of Criminology, the Council of Europe and the American Correctional Association have recommended to that effect. It is interesting to note, therefore, the statement by the Attorney General of Western Australia reported in the *West Australian* on 15 November 2000 that it was the Government's policy to allow a degree of overcrowding before building new prison capacity. The Attorney is reported as saying that “*The policy is for two reasons – economic and to prevent an attitude to jailing that there is plenty of room.*”
- 2.25 Prior to 1999 the Ministry's publication “*Statistical Report for the Offender Management*” set out details of average daily prison numbers compared to the accommodation available (both “Standard” and “Special”) to house those numbers. **Table 2.1** shows the situation between 1990 and 1998.
- 2.26 The picture can be looked at in another way. Using data provided by the Ministry to the *Steering Committee for the Review of Commonwealth/State Service Provision* in the form of average daily prisoner numbers and, what the Steering Committee classified as “Useable Prison Capacity,” a “Prison Utilisation Rate” was calculated as shown in **Table 2.2** overleaf.

Table 2.1 Prisoner numbers compared to available accommodation 1990 -1998

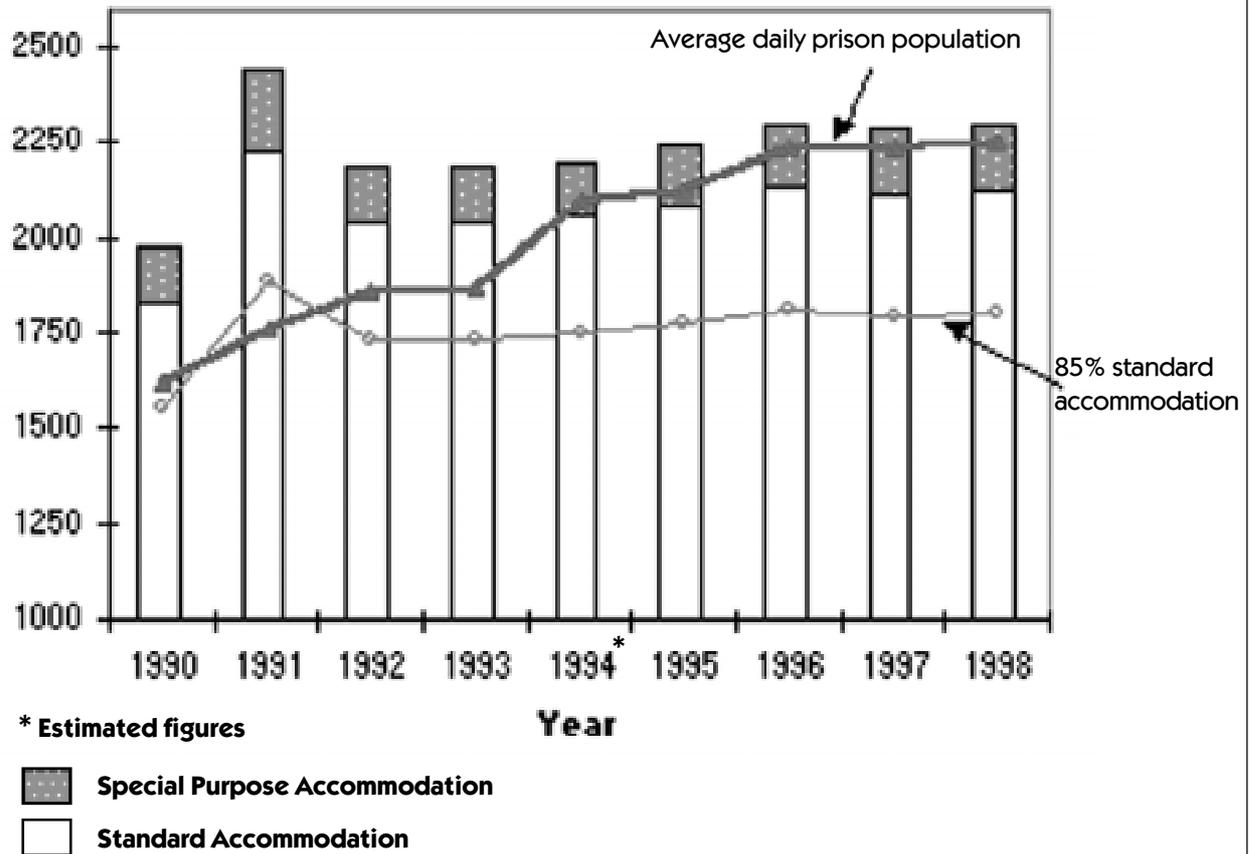


Table 2.2 Prison utilisation rates, Western Australia, 1994/95 to 1998/99

	1994/95	1995/96	1996/97	1997/98	1998/99
Average prisoner population					
- Open prisons	806	808	746	762	928
- Secure prisons	1320	1429	1485	1501	1757
- Total - all prisons	2126	2237	2231	2255	2685
Useable Prison Capacity					
- Open prisons	620	644	642	567	727
- Secure prisons	1409	1488	1522	1500	1644
- Total - all prisons	2029	2132	2164	2067	2371
Prison Utilisation Rate					
- Open prisons (%)	130.0	125.4	116.2	134.3	127.6
- Secure prisons (%)	93.7	96.1	97.6	99.5	106.8
- Total - all prisons (%)	104.9	104.9	103.1	109.1	113.22

- 2.27 Finally, I note that as at 14 April 2000 (according to information provided by the Ministry to the *Standing Committee on Estimates & Financial Operations* of the Legislative Council of the Parliament of Western Australia) the “*Designed Operational Capacity*” – 1 bed per cell - of the prisons in Western Australia was 2474 beds. On that date the “*Modified Operational Capacity*” – the capacity after additional beds have been added to cells previously designed to have only one bed - was 2973 after taking into account beds placed in quarters including hospital/infirmary cells, gymnasiums, punishment cells, observation cells and the like. This means that at that date around 500 prisoners were housed in cells which had been “modified” to accommodate additional beds. The Ministry has told me that beds placed in areas not specifically designed as cells - such as the Infirmary or gymnasium are referred to as “Overflow”.
- 2.28 It has also told me that references to overcrowding in this Report “...*more correctly reflect the Ministry’s term of Overflow rather than Modified Operating Capacity*” and that “.....*since June 1999, the Ministry has sought to standardize its use of terminology to reflect capacity and to this end utilises the terms Designed Operational Capacity, Modified Operational Capacity and Overflow. The Ministry accepts, however, the desirability of returning to a situation where prisoner numbers are within the Designed Operating Capacity.*”
- 2.29 Using the Ministry’s terminology, with a muster of 3090 and a “Modified Operational Capacity” of 3009 as at 26 October 2000, around 80 prisoners were housed in “Overflow” accommodation. In other words, there were almost 600 prisoners over and above the original “Designed Operational Capacity” of the prisons.
- 2.30 It is quite clear that, for the majority of the 1990s, the State’s prisons were overcrowded to an extent that was both unsustainable and unacceptable. It is not productive now to attempt to analyse how that situation came about; whether it might have been avoided and whether it could have been better managed. Just what impact this has had on the living and working environment within our prisons will never be fully known. However, as the *Steering Committee for the Review of Commonwealth/State Service Provision* has noted, the “*Utilisation Rate*” referred to above is not only an “*indicator of the efficiency with which private and publicly owned assets are employed.....it could also be considered an indirect indicator of quality of life and thus of offender care.*”⁵
- 2.31 I have no doubt that overcrowding of the State’s prisons placed additional strains on already stretched resources (both human and physical) with a consequential increase in the pressure on prisoners and prison staff. I also have no doubt that, for this reason, overcrowding was a contributory factor, to some degree, in some of the deaths in the 1990s.
- 2.32 In response to my draft Report, the Ministry has advised me that a report by Dear and Allan in December 1998 – *Analysis of Self-Inflicted Deaths in WA Prisons January 1990 – June 1998* – noted (at page 3), “*It was also noted that the suicide rate did not rise in concert with the level of over population in prisons.*” Having read the discussion by Dear and Allan on this issue in their report, their conclusions appear to me to be not as unequivocal. For example, at page 22, Dear and Allan state:-

“While the prison that recorded the largest level of over-population was also the prison in which the largest number of post 1996 suicides occurred, the rise in the suicide rate was at least two years after the rise in the muster. If there is a causative association between over-population and the number of suicides, then it must be a delayed effect. Perhaps it takes a while for over-population to exert an effect on prisoners’ distress levels. Maybe staff are gradually over-burdened by the high musters and their capacity to implement effective suicide prevention strategies is only diminished after a long period of over-population. However, these data can also be interpreted as indicating that there is no association between over-population and suicide rates.”

- 2.33 I would note first that my comments in paragraph 2.31 apply to the total number of deaths, not only suicide as in the Dear and Allan Report. Second, it is clear from the above quotation that the authors of this report were not totally convinced that there was no causative connection between over-population and the number of suicides and that the data could be interpreted in a different way. I am not prepared to concede that there is *no* connection between the effects of overcrowding on staff or prisoners and the number of suicides or other deaths - and my comments and observations on those strains and pressures appear throughout this Report.
- 2.34 Interestingly, I was told by a number of prison officers - and later established it to be true - that a 46-bed minimum security prison for prisoners undertaking work release and other programs that involved leaving prison on a regular basis was included in the Canning Vale complex. It has, however, never operated as a prison - despite the chronic shortage of accommodation throughout the 1990s - and has been used by staff performing a variety of administrative functions.
- 2.35 The Ministry has advised me that the facility was not used for its original purpose because of insufficient demand and because the public transport service was inadequate. The latter reason seems, at least, unconvincing. A proposal by the Ministry in 1995/96 to use the facility as minimum security accommodation apparently did not proceed because it was "*vehemently opposed by the local community.*" Whatever may have been the demand situation in the 1980s when the complex was opened, there can be no doubt that the extra accommodation was sorely needed during the 1990s. Even if a minimum security facility was opposed by the local community, it may have been possible to modify the facilities to house medium security prisoners as part of the Canning Vale Complex. It seems to me a pity that the system was deprived of accommodation that was needed desperately.

THE PRISONERS

Prisoner numbers 1982 – 1999

- 2.36 The last years of the twentieth century saw large increases in prison populations in many parts of the world. Most Australian States were not immune to this phenomenon. **Table 2.3** shows the numbers of prisoners in the five most populated States of Australia on 30 June each year from 1982 to 1999. **Table 2.4** shows the rates of imprisonment (number imprisoned per 100,000 population of imprisonable age) over the same period.
- 2.37 Although slightly different numbers and rates of imprisonment can be obtained by using average daily prisoner numbers, rather than 30 June census numbers, a number of observations can be made about the data represented by Tables 2.3 and 2.4:
- In general, both the absolute numbers of prisoners and the percentage of the population in prison have increased over the period covered, the exception being Victoria which has remained relatively stable.
 - New South Wales and Western Australia have had imprisonment rates consistently above the national average, whereas the rates for Victoria and South Australia have always been below the national average.
 - Of particular note are the increases in numbers in Western Australia in 1998/99 and Queensland between 1993 and 1999. Western Australia experienced an increase in the total number of prisoners of 29.6% between 1998 and 1999.

Table 2.3

Prison Populations 1982-1999

Year	NSW	VIC	QLD	SA	WA
1982	3719	1753	1638	812	1350
1983	3740	1996	1709	764	1503
1984	3311	1845	1881	564	1543
1985	4052	1879	1999	783	1495
1986	4166	1955	2185	810	1612
1987	4480	1956	2343	875	1627
1988	4636	2071	2374	844	1649
1989	5204	2256	2390	871	1568
1990	6276	2316	2296	931	1720
1991	7014	2310	2094	1042	1726
1992	7407	2277	2017	1152	1893
1993	7542	2272	2068	1163	2029
1994	7632	2522	2491	1348	2137
1995	7667	2467	2870	1404	2205
1996	7604	2440	3528	1475	2254
1997	7847	2643	3839	1492	2245
1998	7697	2858	4466	1385	2352
1999	8308	2923	4710	1396	3048

Source: 1982-1998, Australian Institute of Criminology, Trends & Issues, No 130, October 1999.
1999, Australian Bureau of Statistics, Prisoners in Australia 1999, June 2000

- 2.38 The above rates of imprisonment obscure the very wide divergence between rates of imprisonment for indigenous persons compared to non-indigenous persons. Although, as noted in Chapter 1, the situation of indigenous prisoners is not the main focus of this Report, it must be understood that indigenous Australians are imprisoned at rates that would not, in my opinion, be tolerated if they pertained to the whole Australian population.
- 2.39 Indigenous prisoners make up approximately one-third of Western Australia's prison population. However, Table 2.5 shows the different rates of imprisonment between indigenous and non-indigenous people at 30 June 1999 for various age groups, expressed as a rate per 100,000 of the adult indigenous population and the whole Australian adult population.
- 2.40 It must be borne in mind that the "*All prisoners*" rates shown in Table 2.5 are inflated by the inclusion in them of the indigenous prisoner statistics. Even so, it can be seen that in Western Australia indigenous persons are imprisoned at 14.2 times the rate for the population of the State as a whole. The Australian Bureau of Statistics has calculated an indigenous rate of imprisonment that is 22 times the non-indigenous rate (in June 1999, Corrective Services Australia, June quarter 1999, Series 4512.0, September 1999).
- 2.41 We saw in Chapter 1 of this Report that the rate of deaths in Western Australian prisons had not been significantly different from the national (minus Western Australia) rates (with the exception of indigenous prisoners). However, given that Australian and Western Australian prisons have consistently experienced death rates of around three deaths per 1000 prisoners, it would seem that one obvious way to reduce the number of prison deaths would be to reduce the total number of prisoners. Not only would fewer persons be exposed to the rigours of prison life but the facilities available to care for those remaining would, undoubtedly, be better able to cope.

Table 2.4 Rates of imprisonment 1982-1999

Year	NSW	VIC	QLD	SA	WA	National
1982	96.3	60.8	95.4	83.1	142.3	89.8
1983	95.6	68.1	96.9	77.0	154.2	91.6
1984	83.6	62.0	104.4	56.0	155.0	85.6
1985	100.8	62.1	108.4	76.7	146.5	94.1
1986	101.7	63.5	115.0	78.1	152.3	97.6
1987	107.2	62.4	120.3	83.4	149.2	100.8
1988	108.8	65.0	118.4	79.4	147.0	100.4
1989	120.3	69.6	115.0	80.9	135.6	103.5
1990	143.1	70.3	107.4	85.4	145.2	112.2
1991	157.8	69.2	95.6	94.4	143.3	116.0
1992	164.5	67.5	89.5	103.3	154.4	118.3
1993	166.1	67.0	89.0	103.7	163.0	119.2
1994	166.1	73.9	104.0	118.7	168.6	125.5
1995	164.8	71.8	116.6	123.1	170.4	127.3
1996	161.2	70.2	139.6	129.4	170.4	130.9
1997	163.4	74.6	149.2	130.1	165.4	134.9
1998	158.7	79.7	171.3	120.2	170.4	139.2
1999	150.1	80.6	194.0	123.9	220.2	144.7

Source: 1982-98, Australian Institute of Criminology, Trends & Issues, No 130, October 1999.
1999, Australian Bureau of Statistics, Prisoners in Australia 1999, June 2000.

Table 2.5: Rates of imprisonment, 1999, for indigenous and all prisoners

	Victoria		Western Australia		Australia	
	Indigenous	All prisoners	Indigenous	All prisoners	Indigenous	All prisoners
Males						
18 years	905.0	41.9	4074.2	361.4	2986.5	235.0
20-24 years	2634.1	296.3	9837.3	1015.9	5884.6	193.6
25-29 years	3198.5	321.9	9510.8	841.3	5917.3	611.5
All males	1754.1	130.6	5697.6	400.6	3576.0	269.8
Females						
18 years	-	3.1	522.6	30.5	99.6	12.3
20-24 years	103.4	23.8	949.8	99.5	453.6	44.7
25-29 years	300.0	27.3	1137.7	78.0	503.4	45.9
All females	86.3	9.6	617.4	32.3	277.0	18.6
All persons	903.2	73.8	3080.0	216.5	1864.4	145.2

Source: Australian Bureau of Statistics, Prisoners in Australia 1999, June 2000

Who are the prisoners ?

2.42 According to prisoners and prison officers alike, the prisoner population in Western Australia has changed in recent years. The widely held perception is that there are more young prisoners who have little self-control and self-discipline and who are harder to manage – street kids who “*don’t give a damn*” - as it was put to me. In order to assess whether there has been a meaningful change in the profile of prisoners over the last decade the data set out in Table 2.6 have been compiled.

2.43 Table 2.7 compares the position for Western Australian prisoners at 30 June 1999 and the Australian national average in relation to the age of prisoners.

2.44 In terms of the quantitative data presented in Tables 2.6 and 2.7 it would seem that Western Australia’s prisoners are not significantly different in age from the Australian averages. Similarly, the proportion of prisoners in the various categories has remained relatively constant during the 1990s, with the exception of:

- male prisoners aged under 25 years (which has declined from 37.2% in 1990 to 28.8% in 1999)
- male prisoners aged over 50 years (which has increased from 3.4% in 1990 to 6.9% in 1999)
- prisoners serving a sentence of less than one year (which has declined from 27.1% in 1990 to 16.1% in 1999) with a corresponding increase in the proportion of prisoners serving sentences of one to five years and five to ten years.

2.45 Although the quantitative data suggest that little changed in the 1990’s in terms of the profile of the State’s prisoners, it is quite clear that the *absolute* numbers of prisoners in all categories did increase. For example, in 1999 there were 278 more prisoners aged less than 25 years and 907 more prisoners with less than three years secondary education in the prison system than there had been in 1990. The latter figure may be quite significant in light of the perception referred to in paragraph 2.42.

2.46 Throughout this Report reference will be made to characteristics of prisoners - including their physical, emotional and psychological states – which should be taken into account when considering any aspect of prison life. At this point it is sufficient to refer to only a small selection of submissions made to me in the course of this inquiry. Of particular interest is the following extract from a submission made by a prisoner, based on academic work that he had carried out:-

“Prisoners are predominantly men from low social economic groups and are both violent and non-violent people. Most men are in jail for property related crime, only about 1 in 16 are in prison for violent crimes. The average prisoner is aged between 21 and 29 years, has been to prison before, is serving a sentence of between 2 and 6 years, he has a 20% chance of being an orphan, a 70% chance of having poor literacy and social skills, with a history of child abuse. This personality when placed in a prison will deteriorate further. A reciprocal situation arises whereby the prison helps to form the prisoner and the prisoners constantly redefine the prison. The intelligent criminal is very unlikely to be caught. Prisons are largely full of the uneducated social misfits with mild to severe psychological problems.”

2.47 In a similar vein, a prison chaplain commented that many, if not most, prisoners have experienced violence, sexual abuse, alienation, great deprivation of affection in childhood, lack of one or both parental figures, racial discrimination and poverty resulting in an overwhelming sense of not belonging. Although such experiences may be similar for older prisoners, the younger ones are much more likely to resort to drug or alcohol abuse and develop aggression towards society. A prison visitor used the term “*riff-ruff*” to describe the social characteristics of the typical younger female prisoner. Several interviewees made the observation that there has been an increase in the number of older prisoners and those who are psychiatrically disturbed or mentally ill prisoners, all of whom require greater resources from the system.

Table 2.6 Characteristics of Prisoners 1990–1999, Western Australia

		Prison Population on 30 June							
		1990		1993		1996		1999	
		No.	(%)	No.	(%)	No.	(%)	No.	(%)
Total prison population		1740		2038		2254		3048	
Sentenced		1550	89.1	1786	87.6	2005	89.0	2660	87.3
Unsentenced		190	10.9	252	12.4	249	11.0	388	12.7
Male – Indigenous		556	31.9	592	29.0	707	31.4	929	30.5
Male – Non Indigenous		1084	62.3	1323	64.9	1428	63.3	1892	62.1
Female – Indigenous		41	2.4	46	2.3	44	2.0	107	3.5
Female – Non Indigenous		59	3.4	77	3.8	75	3.3	120	3.9
Age									
Under 25 years	Males	647	37.2	731	35.9	758	33.6	877	28.8
	Females	34	1.9			43	1.9	82	2.7
25 – 50 years	Males	934	53.7	1199	58.8	1230	54.6	1733	56.9
	Females	61	3.5			70	3.1	141	4.6
Over 50 years	Males	60	3.4	108	5.3	149	6.6	211	6.9
	Females	5	0.3			4	0.2	4	0.1
Length of Maximum Sentence									
Less than 1 year		421	27.1	344	19.3	282	14.1	429	16.1
1 – less than 5 years		598	38.6	812	45.5	1029	51.3	1151	43.3
5 - less than 10 years		466	30.1	572	32.0	604	30.1	957	36.0
10 years or more		65	4.2	58	3.2	90	4.5	123	4.6
Educational qualifications									
Less than 3 years secondary									
	Indigenous	538	30.9	555	27.2	647	28.7	880	28.9
	Non Indigenous	807	46.4	968	47.5	1017	45.1	1372	45.0
3 years secondary									
	Indigenous	34	1.9	61	3.0	75	3.3	99	3.2
	Non Indigenous	138	7.9	199	9.8	225	10.0	318	10.4
5 years secondary									
	Indigenous	6	0.3	3	0.1	2	0.1	8	0.3
	Non Indigenous	49	2.8	42	2.1	63	2.8	70	2.3
Trade or partial trade									
	Indigenous	18	1.0	12	0.6	18	0.8	25	0.8
	Non Indigenous	114	6.6	155	7.6	158	7.0	200	6.6

Table 2.7 Average age of prisoners as at 30 June 1999

	Western Australia	National Average
Age - Mean Age		
- All males (years)	31.8	32.7
- Indigenous males (years)	29.3	29.2
- All females (years)	29.5	31.6
- Indigenous females (years)	29.2	29.7
Age - Median Age		
- All males (years)	29.0	30.2
- Indigenous males (years)	27.5	27.8
- All females (years)	27.7	29.6
- Indigenous females (years)	28.1	28.2

Source: ABS, Prisoners in Australia 1999

2.48 A prison psychologist submitted that to work with prisoners is to work with –

“Personality disorder – borderline and antisocial disorders in particular but also dependent and histrionic.

Major mental disease, most commonly drug induced psychosis but also paranoia, schizophrenia, bipolar disorder and obsessive-compulsive disorder.

It is also to work with people who are into shortcuts – to money, power, sex. You and I have been prepared to beaver away for years to get where we are, prisoners want it now and their response to delays or to no response, is to try and force the issue.

Partly due to necessity, partly to personality, prisoners use staff and visitors up. At the same time the help is despised eg a male [prison] officer in the Education centre was described to me as a mug because he would give art paper and other materials to prisoners.”

2.49 A former senior prison administrator put it this way:

“Prisons have become a dumping ground for seriously disturbed men and women who have long histories of disturbed behaviour, admission to psychiatric facilities and attempted self harm. Such people should not be in prisons as presently constituted and their management is way beyond the capacity of prison officers.”

2.50 There are, in my opinion, elements of truth in most of the above comments. It is against that background that the efforts of the Ministry and the OMD to manage the State’s prison system must be seen - particularly in relation to the physical and mental well-being of prisoners - and how the Ministry has grappled with the issue of deaths in its prisons.

THE ABILITY OF THE MINISTRY TO LEARN FROM DEATHS

- 2.51 In this preliminary chapter it is appropriate to make some general observations about how the Ministry has tried to understand why deaths - particularly those not due to natural causes - have occurred and how to improve its prevention strategies as a result of deficiencies identified following investigation of those deaths. It is quite clear to me that deaths in prisons are traumatic for all concerned - and I have no doubt that the Ministry has tried its best to counter the problem. Indeed, the Ministry has done many things in that regard - and deserves credit for doing so. I refer in this Report to those initiatives.
- 2.52 However, a continuing theme that emerged from my examination of the files relating to deceased prisoners has been the Ministry's apparent lack of coordination and, at times, commitment to not only considering recommendations made by the Coroner, the IIU and Health Services as a result of investigations into the circumstances of the death of a prisoner but also implementing those which it states it has accepted. Almost without exception, the files relating to deceased prisoners provided to me contained little or no information about responses (either positive or negative) to, or progress with, recommendations arising from those investigations. In this regard, it does not seem to me that the spirit of RCIADIC **Recommendation 124** (De-briefing sessions following a death) can be said to have been fully implemented in relation to the discussion and assessment of incidents "*with a view to reducing risks in the future.*"
- 2.53 At my request, the Ministry conducted a search of relevant files to establish the status of the recommendations made by IIU and whether any progress had been made in their implementation. I was provided with a letter from the Manager of the IIU summarising the recommendations made by IIU in relation to a number of deaths and the current status of their implementation. For the most part, the Manager was unable to provide a comprehensive answer because the files had not been returned to the IIU several months after completion of the investigations. It concerns me that a record of the Ministry's response to IIU recommendations was either not available or could not easily be found - and that many proposals appeared to have been forgotten or ignored. Two specific examples identified in the course of my inquiry illustrate the problem.

Failure to investigate concerns raised by its own staff

- 2.54 It became clear that the Ministry did not investigate or pursue a number of concerns raised by its own staff about the alleged conduct of a prison medical officer in relation to the deaths of Paul **Vincent** and Carl **Jackson**. In my view, the Ministry's inaction left an unwarranted cloud over the conduct of a Hospital Officer who was alleged by the doctor to have disregarded her instructions in relation to Mr Jackson, resulted in unresolved doubts and uncertainties in the mind of Mr Jackson's family, and a number of unaddressed deficiencies in the Ministry's administrative procedures such as the adequacy of records of telephone consultations by the on-call doctor.
- 2.55 The Ministry has advised me that it established an Investigations Review Committee in September 1999 "*to ensure the efficient, effective, appropriate and accountable management of investigations of issues affecting the operations of the Offender Management and Prison Services Divisions*" and that "*investigative matters are dealt with in a coherent and consistent manner...within an ethical and equitable framework.*" The Committee includes the Executive Director Offender Management, General Manager Prison Services and Executive Director Policy and Legislation "*reflecting the importance attached to the proper monitoring of, recording and co-ordination of investigative matters and their outcomes.*"

Failure to comply with DGR 2M(10)

- 2.56 A more disturbing omission became apparent during my examination of the files relating to Mr Jackson, when it came to light that the Ministry had not complied with DGR 2M (10). This Rule, which was promulgated in 1992 (in purported compliance with RCIADIC **Recommendation 15**), requires the Ministry to report to the Attorney General within three months of the Coroner's findings in relation to a death, setting out the Ministry's response to the findings and comments on any action taken or proposed to be taken in response to the findings. After I had raised the issue it also became apparent that the Ministry had failed to comply with this requirement in relation to a large number of deaths since the Rule was inserted.
- 2.57 Although the then Acting Executive Director of the OMD acknowledged the omission in August 1997 and indicated that he would be taking action to *"improve co-ordination within the Offender Management Division and to ensure the requirements of Director General's Rules and other policy standards are strictly satisfied,"* the report on Mr Jackson's death was not provided to the Attorney General until November 1997. The Attorney General advised me in a letter dated 11 December 1997 that the Ministry had assigned the responsibility for preparing the reports to an officer in the Policy, Programs and Projects Directorate.
- 2.58 In subsequent correspondence the Ministry informed me that, following the abolition of the Policy, Programs and Projects Directorate, the task of preparing the reports required under DGR 2M was being handled by *"temporary staffing arrangements"* and that my *"request for copies of reports on deaths in prisons, completed to date, will be attended to."*
- 2.59 In my view the Ministry's inaction and/or omissions in relation to recommendations and procedural requirements following the death of a prisoner reinforce the perception that for a part of the 1990s its response to deaths in custody, at very least, lacked co-ordination. At worst, it suggests a lack of motivation or an inability to improve its own internal procedures where the investigation of the circumstances of the death of a prisoner has highlighted administrative deficiencies. Such an approach in the past represents a wasted opportunity to improve identified deficiencies in the prison system. The Smith Inquiry into the Christmas Day disturbance at Casuarina Prison referred to the Ministry's *"reactive crisis management"*⁶ in relation to its handling of the problem of substance abuse among prisoners. To the extent that some recommendations made as a result of investigations into prisoner deaths, which appear to have been accepted, were not implemented until a number of years later and after other deaths had raised the same issues, I am inclined to agree with that assessment of the OMD's management style at the time and suspect that it permeated much of the Division's management.
- 2.60 It must be said that there has been improvement since I drew attention to the lack of reports under DGR 2M(10). A person with the specific function of coordinating the Ministry's response to recommendations following a death has been appointed. That fact, and the generally more positive and proactive approach of the Ministry to the issue in recent times means that it is not necessary for me to make a specific recommendation about this issue.

1 Ministry Handbook, 1998, p. 61

2 Ministry Handbook, 2000, p.69

3 paragraph 5.2.8.1

4 The Hakea Prison complex, which includes the former Canning Vale Prison and the CW Campbell Remand Centre, will be a dedicated centre for holding remand prisoners and for the receipt, assessment and treatment of newly sentenced prisoners.

5 2000 Report, at page 757

6 at paragraph 5.2.7.12

CHAPTER 3 HEALTH SERVICES - INTRODUCTORY ISSUES

INTRODUCTION

STANDARDS OF HEALTH CARE

ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY

DUTY OF CARE

“.....In the real world (that includes everything outside Planet BRP) everyone has to take responsibility for their own health.

Who you see to get yourself fixed/ made better and how you pay for this depends on your own decisions. Inside here it is completely different. The medical system/ staff have full responsibility for your health. Or do they? I recommend a middle approach as being far more positive and productive for all concerned. We as prisoners have no choice whatsoever on medical services. The ultimate outcomes of any procedures, treatments or non-treatments, care or advice given may well affect us for the rest of our lives. Now it seems to me that sometimes certain prisoners and medical staff get locked into confrontation. Why? Perhaps some prisoners reason that as “the system” has taken everything from them: their freedom: clothes: property: money: friends and family: and even their first name: then “they can damn well look after my health”. Their health has quite likely taken a turn for the worse under such stressful conditions as exist in jail.

Putting on a load of extra weight because of over-eating and under-exercise is no sign of glowing good health or happiness. The opposite is more the truth. The enforced idleness of “doing stuff-all/ kicking back” is usually only a benefit when done by choice, such as when on holidays. When it is enforced on you, it can be very stressful. Sleepless nights, then tensions of trying to survive yet another day in the same space as some pretty aggro and unhappy people can take a heavy toll on anyone. Even the most placid guys can get a very short fuse very easily. Trust is replaced by suspicion; truth by lies.....

So perhaps it is doubly difficult to front up as a jovial jolly patient when you don't feel well, you have made the necessary “booking” a day or so previously and then you finally get called up to wait possibly an hour or so in the cold (in winter draughty weather-exposed waiting area. However I believe the medical system suffers the same problems as many others in the “system” plus some unique ones. By that I mean they are under-funded, under-staffed, and bound up with a Mack-truckload of paper-work rules and procedures. Such an environment can be very frustrating to work in and could test the patience of even Mother Theresa. The last thing they need is some-one on-loading their general anger and aggro. It can only lead to confrontation, and certainly a less-than friendly bed-side manner!”

(Extract from the prisoner newsletter Odyssey produced at Bunbury Regional Prison, Vol 1 Issue 9, 28/8/98)

INTRODUCTION

- 3.1 Between 1 January 1991 and 30 June 2000 there were 74 deaths in Western Australian prisons, of which 23 were due to natural causes or apparent natural causes. As suggested in the above quotation, health care of, and for, prisoners is a sensitive and controversial area. It has for many years been one of the main sources of complaint to my Office by prisoners. Health-related issues were raised more consistently than any other issue in submissions to my inquiry and in interviews. Questions about the standard of health care are likely to be among the first to spring to mind when a prisoner dies. Issues involving the staff or administrative procedures of the Ministry's Health Services Directorate (which includes staff of the Forensic Case Management Team [FCMT]), nursing staff and medical practitioners, Prisoner Support Officers and the Pharmacy Department) have been raised by the Coroner, the IIU or the Ministry itself in more than half of those prisoner deaths.²
- 3.2 In May 1998 the World Health Organisation adopted a World Health Declaration which includes the following principles:

“We, the Member States of the World Health Organisation (WHO) reaffirm our commitment to the principle enunciated in its Constitution that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being; in doing so, we affirm the dignity and worth of every person, and the equal rights, equal duties and shared responsibilities of all for health.”

3.3 The relationship between the standard of a person's health and criminal activity is a matter of some debate. There is academic opinion which links poor health to heightened criminality as an indication of inability to cope with personal problems; low self-esteem and a lack of self-worth and self-respect which results in a consequential lack of respect for others. A US professor of school health claims that when schools fostered the health and well-being of children through health education programs, their academic achievements improved and behavioural problems were reduced.³

3.4 The 1981 *Report of the Royal Commission on Allegations in Relation to Prisoners under the Charge, Care and Direction of the Director of the Departments of Correctional Services and Certain Related Matters* in South Australia stated:-

“The whole health regime of prisoners in every prison system in Australia urgently needs to be re-examined. I have heard the view expressed by correctional authorities.....that inmates should have lesser, not greater access to health services than the poor and the deprived in the outside world, and I have particularly heard this view expressed in the context of psychiatric services. But if the purpose of a health system is, as I believe, to deliver services where they are most needed, then the case for a general improvement of prison medical and psychiatric services is absolutely overwhelming.”⁴

3.5 The RCIADIC also attributed the high demand for health services to the -

“environment of the prison.....Boredom, frustration and powerlessness may lead to psychosomatic illness..... An important feature of the demand for health services is that many prisoners will enter the prison system with pre-existing health problems. This in part, will be a result of neglect and in part a lack of the ability to access health services.”⁵

3.6 It is undeniable that it is a fundamental human right (reinforced by the stipulations of international conventions) that prisoners are entitled to the same standard of health care as they could expect in the community. Moreover, the health of prisoners becomes of direct and unavoidable concern to the community when they return to society.

3.7 In a media release on 16 October 1998 prior to the publication of its *Position Statement on the Health Care of Prisoners and Detainees* (the Position Statement) the Australian Medical Association (AMA) described the state of health among prisoners as “*appalling*”. Dr Sandra Hacker, the AMA's Federal Vice President and Chair of its Ethics and Public Health Committee at the time said that the health status of Australia's prison population was one of the nation's neglected problems and that prison health standards “*do nothing for a prisoner's ability to cope with every day life upon release and put other people in society at risk as well*”. The Position Statement expresses the view that:-

“Prisoners have the same right to access, equity and quality of health care as the general population. Because prisoners will return to society after their imprisonment, their health is an issue of concern to the general population. The health of prisoners is also important for the occupational health and safety of the staff of correctional facilities.”

3.8 The RCIADIC expressed the view “*...that a comprehensive prison health and medical service will go a long way towards reducing the number of Aboriginal (and non-Aboriginal) deaths in custody*”⁶ and noted that:-

“A recurring theme throughout the hearings conducted, and in the many written submissions received, is the limited resources available in the area of prisoner medical and health care. It is only in recent years that efforts have been made to improve the quality and standard of health care available in our corrections institutions.”

- 3.9 The RCIADIC reinforced its concern about the level of resourcing for prison health services in **Recommendation 328** which states:-

“That as Commonwealth, State and Territory Governments have adopted Standard Guidelines for Corrections in Australia which express commitment to principles for the maintenance of humane prison conditions embodying respect for the human rights of prisoners, sufficient resources should be made available to translate those principles into practice.”

- 3.10 A submission to my inquiry by a staff member of the Ministry’s Health Services echoed this view:-

“Appropriate resourcing and commitment to the role of Health Services in general.....will certainly not stop the occurrence of deaths in custody. However it remains my belief that appropriately resourced, committed and responsible provision of health services would contribute to an improvement in patient care and welfare, with consequent impact on reducing incidents of self harm in custody.”

- 3.11 I agree. In my view, prisoners have an inalienable right to expect the same standard of health care as they would receive in the community and it is in the interests of the community to ensure that they do so. With this principle in mind I have considered the provision of health care to Western Australian prisoners - in the context of issues arising from deaths from natural or apparent natural causes and comments and concerns raised in interviews and in submissions to my inquiry - in order to evaluate the standard of the service provided; whether it meets community standards; and whether, and in what way, it could be improved.

- 3.12 During his term of office as Home Secretary in 1910, Winston Churchill said *“The mood and temper of the public in regard to the treatment of crime and criminals is one of the most unfailing tests of the civilisation of any country.”*⁷ Based on his own personal experience, Nelson Mandela remarked that *“No-one truly knows a nation until he has been inside its jails. A nation should not be judged by how it treats its highest citizens but how it treats its lowest.”*⁸

- 3.13 Although I am aware that a significant proportion of the community may disagree with those views – in spite of, I suspect, never having been inside a prison – the importance of prisoner health to the community as a whole should not, in my view, be under-estimated.

- 3.14 In an editorial in the *British Medical Journal* in November 1998 Professor Michael Levy reinforced the importance of the provision of adequate health services to prisoners and its relevance to the community⁹:-

“Prison is a regulated but not a closed system, simply because of the numbers of people who enter, leave, and re-enter custodial institutions. So health problems in prison move between the two sides of the wall, in a seemingly chaotic manner.”

- 3.15 Professor Levy also referred to the influence of background and life style on the health of the majority of prisoners and concluded:-

“This complex of factors ensures the greatest chance of ill health, optimal conditions for infection to progress to severe disease, and minimal opportunity for early diagnosis and adequate treatment. Not surprisingly, excess prevalence of hepatitis, tuberculosis, HIV and mental illness are reported among prisoners from many countries. In fact, a prison sentence can turn into a death defying experience. And the increased risk of illness and death continues after release.

Yet the period of imprisonment could offer opportunities to improve the health of prisoners and at least minimise the risk of poorer health to the community.....Access to the prison health service may be the first opportunity to receive medical care in an otherwise disordered life.....

Regrettably, prison health care is too often the subject of criticism – either for its failings or because it is perceived as providing excessive services.When prison care is adequate the costs of providing it are questioned. Reduction of costs leads to deteriorating services which may in turn prompt prisoners to react to “inhuman or degrading” treatment.

The only protection from this is the principle of equivalence: that services to prisoners should be as good as those the state provides for the general community.

The importance of excellent health care transcends considerations of ethics and human rights: it also simply makes good sense for the community as a whole.”

- 3.16 I agree with Professor Levy’s comments. Although I do not believe that the Ministry considers that prisoners should have “*lesser access*” to health services than they would have in the community, the more important question is whether the principle of equivalence is applied in both theory and practice.
- 3.17 As a preliminary observation on the provision of health care to prisoners in Western Australia, it is of some concern that, many years after the report of the RCIADIC, similar sentiments about the adequacy and resourcing of prison health services have been expressed in submissions to me and in the course of interviews with me and members of my staff. In the course of my investigation it has been necessary, therefore, to examine similar issues and cover at least some of the same ground as that covered by the RCIADIC. It is not my intention to merely reiterate what has been said previously – although it is inevitable that there will be some repetition. Where I have found that the same problems exist, apparently for the *same* reasons as those identified in 1991, and the number of deaths in prisons has not decreased, the commitment of prison authorities in Western Australia to address a problem identified in 1991 must be questioned.

STANDARDS OF HEALTH CARE

- 3.18 All health care, whether in the community or in an institution such as a prison, is based on standards and universally accepted ethical principles. Because of the nature of incarceration and a growing awareness in the international community of the potential for abuse of people who have been disempowered by the loss of their liberty and are out of sight, it has also been considered necessary to provide prisoners with the protection of an additional framework of rules and conventions which have been formulated in response to, for example, the widespread atrocities committed during World War II and which gave rise to the United Nations Universal Declaration of Human Rights in 1948.
- 3.19 This protective framework includes the UN *Standard Minimum Rules for the Treatment of Prisoners and Procedures for the Effective Implementation of the Rules* and the work of the *Council of Europe Committee for the Prevention of Torture and Inhumane Treatment of Prisoners*. Australia has adopted *Standard Guidelines for Corrections (1996)*. Each jurisdiction has legislation governing prisons and the treatment of prisoners and may also have other standards to supplement legislative provisions. In addition there are community groups which monitor prison standards such as the AMA through its *Position Statement* - which sets out its view on the basic principles it considers pre-requisites for community-standard prisoner health care; Amnesty International; the Howard League in the UK; and the Deaths in Custody Watch Committee (DICWC) in Western Australia.
- 3.20 In addition to the *Prisons Act 1981*, *Regulations* made thereunder and *Director General’s Rules (DGRs)*, the Ministry has developed its own standards for health services - the *Standards for the Delivery of Health Services* (April 1999). The stated aim of the *Standards* is “...to ensure the health and safety of prisoners in custody in a just and humane manner” by means of “an integrated, comprehensive health service to meet the identified health needs of individual offenders and specific offender groups.”

- 3.21 As a measure of what is “*just and humane*”, the Ministry’s Standards are based on the nationally and internationally accepted principles contained in:-
- UN *Standard Minimum Rules for the Treatment of Prisoners*;
 - Australian *Standard Guidelines for Corrections* (1996)
 - Correctional Services of Canada *Standards for Health Services*;
 - Australian Council on Healthcare Standards *EQuIP Guide*,
 - the AMA’s *Position Statement*;
 - the Ministry’s *Health Services Policy Manual* which provides detailed instructions and directions for the delivery of health services to prisoners.

Prisons Act 1981

3.22 Section 38(1) of the *Prisons Act 1981*, as amended in December 1999 by the *Prisons Amendment Act 1999*, provides that “*The chief executive officer is to ensure that medical care and treatment is provided to the prisoners in each prison.*”

3.23 Under section 39, as amended in 1999, a medical officer is required to *inter alia*:-

- (a) *attend at the prison at such times and on such occasions as are specified in the terms of the medical officer’s appointment or engagement;*
- (b) *on the request of the chief executive officer, examine a prisoner as soon as practicable after the prisoner’s admission to prison and ascertain and record the prisoner’s state of health and any other circumstance connected with the prisoner’s health, as the medical officer considers necessary;*
- (c) *maintain a record of the medical condition and the course of treatment prescribed in respect of each prisoner under the medical officer’s care;*
- (g) *on the request of the chief executive officer, examine and treat a prisoner who requires medical care and treatment; and*
- (h) *on the request of the chief executive officer or superintendent, examine a prisoner.”¹⁰*

Standard Guidelines for Corrections in Australia

3.24 The principles of the UN *Standard Minimum Rules for the Treatment of Prisoners* relating to Health Services are reflected in the Australian *Standard Guidelines for Corrections 1996* at 5.66-5.84 which include guidelines for the type of service provided and the responsibility of the prison medical officer, the treatment of infectious diseases, prisoners isolated for health reasons, dental health, private health treatment, cell alarms, the prohibition of medical or scientific experimentation, the ability to maintain contact with medical services providing treatment prior to imprisonment where appropriate, inspection of food, hygiene, sanitation, clothing and bedding, the provision of psychiatric services and specialised facilities for prisoners with mental illness or intellectual disability and the organisation of the continuation of psychiatric treatment after release. The following *Standard Guidelines* are of particular relevance:-

- 5.66 *For every prison, the services of at least one qualified medical officer must be available twenty-four hours a day. This service may be on an on-call or stand-by basis. Medical services should be organised in close relationship with the general health administration in the community and must include access to a psychiatric service for the diagnosis of mental disorder. (UNR 22(1))*

- 5.67 *Prisoners who require specialist treatment should be transferred to specialised institutions or to community hospitals. Where hospital facilities are provided within a prison, the equipment, furnishings and pharmaceutical supplies must be proper for the medical care and treatment of sick prisoners, and there must be sufficient staff of suitably trained officers. (UNR 22(2))*
- 5.68 *Every prisoner must be medically examined by a suitable qualified person as soon as possible after being received into prison, and thereafter as necessary. In determining tests which prisoners must undergo the medical officer must have regard for the need to determine each prisoner's physical and mental health, as well as the safety and welfare of other prisoners in the prison. (UNR 24)*
- 5.71.1 *The medical officer has the responsibility for the maintenance of the physical and mental health of the prisoner. The medical officer should ensure all sick prisoners are seen daily, and all prisoners who complain of illness, or to whom the medical officer's attention is specially directed, are examined as soon as possible. (UNR 25)*
- 5.71a *Medical Authorities will ensure the special health needs of women and persons from the Aboriginal & Torres Strait Islander community are accommodated.*
- 5.80 *Prisoners in need of psychiatric treatment must have access to such services through the prison medical service.*
- 5.81 *Specialised facilities under appropriate professional management should be available for the observation and treatment of prisoners suffering from mental illness or intellectual disability.*
- 5.84 *Steps should be taken, by arrangement with the appropriate agencies to ensure, where necessary, the continuation of psychiatric treatment after release and the provision of social and psychiatric after-care.*

Standards for Health Services of the Correctional Service of Canada

- 3.25 The *Objective* of the *Standards for Health Services of the Correctional Service of Canada*, which the Ministry has advised me are reflected in its health service standards, is stated as:-
- “The inmate has the primary responsibility for his/her own health decisions, habits and behaviours. The CSC [Correctional Service of Canada] is responsible for ensuring appropriate, equitable and adequate access to professional physical and mental health services. These services sustain and enhance health status, contribute to the inmate's adjustment within the institution and assist them to become law-abiding citizens.”*
- 3.26 The *Principles governing the management and delivery of health services* as described in the Canadian Standards include:-
- 1. The Correctional Service of Canada will deliver essential health services comparable to provincial and community standards, notwithstanding the constraints inherent in the correctional environment.*
 - 2. Inmates will bear the primary responsibility for maintaining and improving their individual and collective health.*
 - 3. Health promotion/illness prevention will be the primary activity for health service staff...*

4. *Health services will be delivered in an effective and efficient manner and subjected to audit as well as progressive management and measurement techniques.*
5. *Incentives will be developed and applied which encourage appropriate use of health services by inmates and efficient delivery by health providers...*
6. *A multidisciplinary and holistic approach shall be implemented in the provision of health services to the inmate through his/her sentence.*

Australian Council on Healthcare Standards *EQUIP* Guide

- 3.27 The *Foreword* to the Australian Council on Healthcare Standards *EQUIP* (Evaluation and Quality Improvement Program) *Guide* states that it “*provides health care organisations with the management tools needed to focus on continuous improvement. Implementation of the program will significantly assist with the delivery of high quality care to the Australian community.*”
- 3.28 The Preface states:-

“Health care organisations have a responsibility for providing quality care. The responsibility is owed to patients, clients and their families and the general community by every individual within the organisation. With responsibility comes accountability. Health care providers must be accountable for the outcomes of care and service.”
- 3.29 The *EQUIP Guide* is “*intended to be used to establish quality systems that suit your organisation. The Guide will help the organisation focus on how well it meets customers’ needs and expectations, as well as the outcomes it achieves.*” It is “*a management tool to help health care organisations strive for excellence.*”
- 3.30 Included in the list of *Standards* in the *EQUIP Guide* are standards for the continuum of care; leadership and management; human resources management; information management; safe practice and environment and improving performance with *Guidelines* to provide direction on the application of the *Standards*.

AMA’s Position Statement on Health Care Of Prisoners and Detainees

- 3.31 The Preamble to the AMA’s *Position Statement* establishes a number of principles:-

“Prisoners and detainees have the same right to access, equity and quality of health care as the general population. Because prisoners will return to society after their imprisonment, their health is an issue of concern to the general population. The health of prisoners is also important for the occupational health and safety of the staff of correctional facilities.

Governments and prison authorities have a duty of care to all prisoners and detainees under their control, including those in private correctional facilities. The physical environment of correctional facilities influences the health of prisoners and detainees. Governments must provide basic humane standards and should strive to achieve world’s best practice in all Australian correctional facilities. Correctional facilities should accommodate the language, cultural and religious needs of prisoners and detainees. The provision of health care is potentially constrained due to the physical and social environment of correctional facilities. Prisoners and detainees may face particular health problems, both pre-existing and associated with incarceration, such as exposure to blood-borne and sexually transmitted infections, inadequate provision of a broad range of harm-minimisation measures, and lack of access to health education programs.

Correctional facilities should provide suitable health facilities with appropriate equipment and trained staff, or arrange for such services to be made available, for the continuing treatment and care of all prisoners and detainees...

...*The duty of medical practitioners to treat all patients professionally with respect for their human dignity and privacy applies equally to the care of those detained in prison, whether convicted or on remand, irrespective of the reason for their incarceration.*"

3.32 The *Position Statement* includes 'standards' for all aspects of prisoners' health care (cited as appropriate throughout this section) some of which are based on Australian *Standard Guidelines for Corrections*. It also includes a number of practices with which medical practitioners should not become involved, adopted from the Oath of Athens, (see paragraph 3.46) namely:-

- withhold appropriate medical care;
- authorise or approve physical punishment;
- participate in any form of inhumane treatment;
- participate in any form of human research or experimentation without the prisoner's consent; or
- perform body cavity searches for the purposes of obtaining evidence unless the life of the prisoner is likely to be endangered.

3.33 Essentially, a prison is a part of the community, albeit one which is isolated and where a number of freedoms available to the community in general are restricted. Imprisonment, however, should not mean that the standard of health care available to a prisoner is inferior to that which he or she was able to access prior to being imprisoned. This is summarised in the *Principles governing the management and delivery of health services* in the *Canadian Standards or Health Services*¹¹ as :-

"The Correctional Service of Canada will deliver essential health services comparable to provincial and community standards, notwithstanding the constraints inherent in the correctional environment."

3.34 In its *Position Statement*, the AMA states "Prisoners and detainees have the same right to access, equity and quality of health care as the general population.....*Correctional facilities should provide suitable health facilities with appropriate equipment and trained staff, or arrange for such services to be made available...*". The Ministry has told me that it aims for a standard of "*generally accepted medical practice*". However the standard for prison health services is described, it should embrace the basic principle that, although imprisonment will inevitably disadvantage a member of the community in a variety of ways, he or she will *not* be disadvantaged in relation to the standard of health care available.

ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY

3.35 In addition to the standards and statements of principle referred to in paragraph 3.21, the RCIADIC made a number of recommendations which could be said to represent the expectations of prisoners and the community in relation to prison health services. The text of the recommendations is set out in Appendix 1. In brief, the recommendations relating to prisoner health are as follows:-

Recommendation 140 - All cells should be equipped with an alarm or intercom system.

Recommendation 150 - Prisoner health care should be equivalent to that available to the general public; accessible and appropriate to Aboriginal prisoners and should be available 24 hours a day.

Recommendation 152 - Provision of health care to Aboriginal prisoners should be reviewed by correctional authorities in conjunction with Aboriginal Health Services to assess the standard and cultural appropriateness for Aboriginal prisoners.

Recommendation 153 - Prison Medical Services should be the subject of ongoing review in the light of experiences in all jurisdictions

Recommendation 154 - All staff of Prison Medical Services should receive training in issues which relate to Aboriginal health, including Aboriginal history, culture and life-style.

Recommendation 155 - Prison officer training should include information as to the general health status of Aboriginal people and strategies to identify persons in distress or at risk of death or harm through illness, injury or self harm.

Recommendation 156 - On admission, all Aboriginal prisoners should be subject to a thorough medical assessment with a view to determining whether the prisoner is at risk of injury, illness or self harm.

Recommendation 157 - As part of that assessment procedure, prison health staff should obtain a comprehensive medical history for the prisoner.

Recommendation 159 - All prisons and police watch-houses should have resuscitation equipment of the safest and most effective type readily available in the event of emergency and staff who are trained in the use of such equipment.

- 3.36 Importantly, the RCIADIC also included in **Recommendation 328** a statement to ensure “*the humane treatment of Aboriginal prisoners in accordance with Australia’s international obligations*”¹².
- 3.37 The 1995 Government Implementation Report states that implementation of Recommendations 140, 150, 152-6 was “*ongoing*”; that Recommendations 157 and 159 were “*implemented*”; that the guidelines referred to in Recommendation 328 had been implemented and that “*All standards from the Guidelines are being met in WA prisons*”.
- 3.38 The 1997 Government Implementation Report (published in March 1998), reported that implementation of Recommendations 150 and 152-155 was “*ongoing*”; that Recommendations 140 and 156 were “*partially implemented*”; and that Recommendations 157 and 159 had been implemented. In relation to Recommendation 328 the 1997 Implementation Report stated that “*Provision of resources to translate into practice the principles for the maintenance of humane prison conditions contained in the Standard Guidelines for Corrections in Australia*” had been “*implemented*”.
- 3.39 The Ministry has advised me that in 1997 it reported to the Aboriginal Affairs Department that Recommendations 156 and 157 were “*ongoing*”, however -

“In the 1997 Implementation Report there was some confusion of the status of particular recommendations due to the Aboriginal Affairs Department using information supplied in 1995. When the Ministry became aware that the 1995 information had been used it sought to correct the status assigned to some of the recommendations by Aboriginal Affairs Department. Unfortunately the letter sent to Aboriginal Affairs Department became an attachment to the Ministry’s response and no changes were made to Attachment One of the 1997 Implementation Report.”

The Status of Implementation of Recommendations contained in the 1997 Implementation Report was occasionally the result of an amalgamation of responses from different agencies. For instance, where a recommendation applied to more than one agency, in some cases the response of only one agency was used. This did not always accurately reflect each agency’s response.

The criteria used (1997 Implementation report, page 117 – first paragraph) in determining the status assigned to particular recommendations is also considered to be of importance in considering the stated implementation status of recommendations. This relates in the main to the ‘establishment of the process’. This did not always reflect an agency’s response.”

DUTY OF CARE

- 3.40 A study entitled “Review of Ministry of Justice Services for treatment and care of adult prisoners at risk of suicide or serious self-harm” by Kevin Howells and Guy Hall, (the Howells and Hall Report) commissioned by the Ministry in late 1997, stated at page 23:-

“As a government agency which holds its citizens in detention against their will, prisons have one of the highest levels of duty of care. As noted in the introduction of this report, this principle is now widely recognised and was emphasised by the Coroner and the Ombudsman both of whom acknowledge a greater level of public and judicial scrutiny with respect to this principle. The duty of care was also stressed by the Royal Commission into Aboriginal Deaths in Custody.”

- 3.41 In my view, there is no doubt that the Ministry is under a common law duty of care to take reasonable care for the safety of prisoners. There is ample case law¹³ to support this proposition and the Ministry is well aware of its obligations to prisoners. In addition to the common law duty of care, its obligations under universally accepted standards require that prisoners must receive an adequate health service provided by qualified health professionals. I have based my comments in this Report on the presumption that the provision of an adequate and appropriately resourced prison health services is an integral component of the Ministry’s duty of care for the safety of prisoners. In my view, the expectations of a reasonable and humane society – as epitomised in the statements by Winston Churchill and Nelson Mandela – reinforce the Ministry’s moral obligation in this regard.

- 3.42 The Preamble to the AMA’s *Position Statement* states:-

*“Medical practitioners should not deny treatment to any prisoner or detainee on the basis of their culture, ethnicity, religion, political beliefs, gender, sexual orientation or the nature of their illness. **The duty of medical practitioners to treat all patients professionally with respect for their human dignity and privacy applies equally to the care of those detained in prison, whether convicted or on remand, irrespective of the reason for their incarceration.**”* (my emphasis)

- 3.43 This principle is implicit in DGR 3B which requires prison officers in Western Australian prisons “...to facilitate access to necessary medical care for prisoners in their custody whose health is at risk irrespective of the cause of the condition requiring care...”

- 3.44 In his editorial to the *British Medical Journal* referred to at paragraphs 3.14-15 above, Professor Levy stated:-

“The more prisoners’ freedoms are limited, and the worse the general prison conditions, the greater the responsibility of the state to protect prisoners: this leads to a misunderstood principle that prisoners actually acquire rights while in custody, principally protection from harm and access to services, including health services.”

- 3.45 This seems to support the view that prisoners who have been deprived of their liberty and, to a large extent, of their ability to make decisions about their lives, may be owed a *greater* duty of care by a prison authority than they could expect in the community.¹⁴

3.46 Health professionals – nursing staff and medical practitioners – have *ex officio* a duty of care to all persons in their care based on the ethical principles of the *Hippocratic Oath*, the International Council of Nurses' *Code for Nurses* (adopted in 1973 and reaffirmed in 1991) and the statutory provisions of their registration. In addition, specific obligations towards prisoners and detainees have been formulated adding another aspect to their normal duty of care. For example:-

- the *Oath of Athens*, signed by “*health professionals who are working in prison settings*” on 10 September 1979 includes the statement:

“That our medical judgements be based on the needs of our patients and take priority over any non-medical matters.”

- the *Code for Nurses* incorporates the stipulations of the Geneva Convention in relation to prisoners, including:-

“Nurses having knowledge of physical and mental ill-treatment of detainees and prisoners must take appropriate action including reporting the matter to appropriate national and/or international bodies.”

3.47 This principle was echoed in a recent UK case – the ‘Bristol’ case – where a court determined that doctors who do not reveal their concerns about the professional standards of treatment provided by a colleague may be held collectively responsible if that colleague’s professional practices result in the death or injury of a patient.¹⁵

3.48 Although Howells and Hall acknowledged “...*the dedication, good work and commitment of staff to improving the care of prisoners at risk of self harm or suicide*” and were satisfied that the principle of duty of care had been “*recognised*” by the Ministry, they also raised questions about the content and practical application of this duty in its dealings with prisoners –

“While the principle has been established and indeed, recognised by the Ministry, the meaning or operationalisation of it is not clear. Duty of care seems to mean that everything will be done to ensure that prisoners will not harm themselves in custody. This is distinctly different from the interpretation that everything will be done to enhance the well being or welfare of prisoners.”

3.49 Howells’ and Hall’s conclusions suggest a degree of scepticism about the Ministry’s commitment to the latter interpretation. For example, at page 39 of their report they comment that the ‘blame culture’ has led to a situation where “...*the safest option is chosen by staff rather than a creative response to the needs of the individual...*” In ensuing chapters I have considered whether prison health services can be said to meet in practice the requirements and principles of the Ministry’s duty of care, its international obligations, the recommendations of the RCIADIC and community expectations.

- ¹ Bunbury Regional Prison
- ² Matters arising following the deaths of prisoners who committed suicide are dealt with in Chapter 10
- ³ Professor Phyllis Gingiss, University of Houston at a seminar on the importance of school health. Reported in *The West Australian*, 9 July 1999
- ⁴ Royal Commission 1981, South Australia. Cited by the RCIADIC at page 251, National Report Vol 3
- ⁵ At page 252, Vol 3 – interview between RCIADIC Queensland staff and a prisoner
- ⁶ paragraphs 24.4.5 and 24.5.7, page 252, Vol 3
- ⁷ During the debate on the Prisons 'Vote' in the House of Commons on 20 July 1910. Hansard Vol XIX, page 1354
- ⁸ *Long Walk to Freedom* by Nelson Mandela
- ⁹ Professor Michael Levy, Visiting Fellow to the National Centre for Epidemiology and Population Health at the Australian National University in Canberra
- ¹⁰ See Chapter 6, paragraphs 6.131-6.144 for my comments on the recent amendments to the *Prisons Act 1981*
- ¹¹ See paragraph 3.26
- ¹² See paragraph 3.9
- ¹³ *Dixon v The State of WA and Lees* [1974] WAR 65 at 71; *Nada v Knight* (Supreme Court of WA) Appeal No 71 of 1989; *Kirkham v Chief Constable of Greater Manchester* [1990] 3 AER;
- ¹⁴ See also Chapter 8 paragraph 8.14
- ¹⁵ British Medical Journal Vol 316 27 June 1998 pp1917-8



CHAPTER 4 PROVISION OF HEALTH SERVICES TO PRISONERS

INTRODUCTION

DEVELOPMENT OF HEALTH SERVICES IN WESTERN AUSTRALIA

INTRODUCTION

4.1 In Western Australia, prison health services are the sole responsibility of the Ministry which employs nursing staff, medical practitioners and psychologists in the Health Services Division under the Director, Health Services. The Ministry also pays for 80% of the time of a senior forensic psychiatrist who is employed by the Health Department of Western Australia (HDWA). A number of private sessional medical practitioners and psychiatrists are also employed under contract.

4.2 In other jurisdictions in Australia prison health services are delivered in a variety of ways, being variously the responsibility of:-

- the State correctional authority alone through the direct employment of health care providers or under contract with private providers;
- the State correctional authority and health departments jointly whereby the health department provides the service pursuant to an agreement with the correctional authority;
- the State health department or other agency alone which provides the service pursuant to a statutory charter independent of the correctional authority.

4.3 The Ministry is considering alternative means of providing health care and has discussed with its counterparts in other jurisdictions the advantages and disadvantages of the different models. It advised me that:-

- there was a growing trend to contract out health services;
- where this had been considered it was found that health service requirements must be specified exactly;
- jurisdictions where health services were provided by the government health agency had experienced problems because prisoner health was not seen to be a high priority and insufficient resources were allocated;
- the model in New South Wales differed in that health services were provided by a division of the Health Department which was dedicated to servicing prisons which meant that *“there is a clear client focus of health service provision and a good working relationship is maintained with Corrective Services.”*

During 1999/2000 the Ministry sought expressions of interest from private health providers to supply health services to prisons and considered a number of proposals.¹

4.4 This chapter provides a brief overview of the development of health services over the past decade in Western Australian prisons and the current extent of those services.

DEVELOPMENT OF HEALTH SERVICES IN WESTERN AUSTRALIAN PRISONS

Nursing and medical services

4.5 In the early 1970s a visiting medical officer (medical practitioner) conducted ‘parades’ and ‘nursing officers’ (prison officers who were qualified nurses) carried out institutional nursing duties. Following a review of services by two doctors from HDWA in 1979 improvements were made to the system for delivery of health services to prisoners. In 1980 the Prison Health Service was established under the direction of the Senior Medical Officer, and a full-time medical officer was appointed. By the end of 1981 24-hour nursing coverage, seven days a week, was available at three metropolitan prisons - Fremantle, Canning Vale and the CW Campbell Remand Centre.

- 4.6 Initially only those three prisons had a ‘dedicated’ nursing and medical service. Health services were provided to prisoners at other prisons ‘on request’ by visiting medical officers or by a local public hospital. With the greater focus on providing a ‘prison’ health service, qualified nursing staff were subsequently employed at Bandyup, Bunbury, Karnet, Pardelup and Wooroloo. Following the opening of Canning Vale in 1981 sessional doctors were appointed to assist the Medical Officer at Fremantle, Canning Vale and the Remand Centre and an additional eight nursing staff were employed. Ancillary services such as dental and optometry were provided by outside visiting specialists as required.
- 4.7 In 1982/83 the Senior Medical Officer was re-named the Medical Superintendent and a secretary was employed to assist him. The 1982 Prisons Department *Planning and Research Report* states that medical services at that time comprised a Senior Medical Officer; a part-time medical officer/general practitioner; an administrative officer; 14 nursing officers; a medical records officer; a secretary; a pharmacist and an occupational therapist.
- 4.8 The Department’s 1983/84 Annual Report noted that “*The efficiency and standard of medical service offered in prisons has been greatly enhanced by the addition of a second full-time Medical Officer, the introduction of four part-time nursing positions and an effective continuing programme of education for staff.*”
- 4.9 The second Medical Officer assumed responsibility for medical services at Bandyup but sessional visiting medical personnel continued to provide medical services to all prisons except Fremantle, Canning Vale and the Remand Centre. By 1985, all prisons except Wyndham were able to provide on-site nursing coverage to some extent.
- 4.10 There was little change in prison health services over the next five years. In 1991 the Medical Superintendent was re-named Director, Health Services to more accurately reflect his role and responsibilities. In addition, the Pharmacy Department was relocated to Canning Vale and underwent a management restructure. Also in 1991, in response to the recommendations of the RCIADIC, the number of nurses was increased; a qualified medical records officer was employed and retraining of health personnel in emergency care procedures was conducted. In June 1991 Casuarina Prison was commissioned and Fremantle Prison closed.
- 4.11 In 1992/93, in response to RCIADIC **Recommendation 153** (which recommended that Prison Medical Services should be the subject of ongoing review), an audit of prison health services was conducted. The Ministry has been unable to locate a copy of the report of this audit but it has informed me that the report identified a number of deficiencies in the quality of the services provided. As a result it was proposed to establish a joint Justice/Health Departmental Board of Management with responsibility for the delivery of health services in prisons and detention centres, reporting to the Attorney General and the Minister for Health. Following endorsement by Cabinet in January 1994 this was established as the Joint Justice/Health Interdepartmental Council (JJ/HIDC).²
- 4.12 In its response to RCIADIC **Recommendation 150** in the 1995 Implementation Report, the Ministry advised that “*Access to medical care is available on call 24 hours a day in prisons.*” The 1997 Implementation Report referred to implementation of Recommendation 150 as “ongoing”. On-site 24-hour coverage is currently available at Casuarina, Hakea and Bandyup. Full coverage at Bandyup was only introduced in 1995 following a recommendation by my predecessor.³ The on-site nursing and medical services now available in the State’s prisons are shown in **Table 4.1** overleaf:-

TABLE 4.1 NURSING AND MEDICAL SERVICES

PRISON	NURSING SERVICES		DOCTOR
	Monday-Friday	Weekend	
Albany	7.15am-8.30pm Tues, Thurs finish 8pm	7.15am-8.30pm	Tues, Thurs
Bandyup	7 days	24 hours	Mon,Tues,Thurs
Broome	7.30am-4.30pm	7.30am-12.30pm	Tues, Fri*
Bunbury	7.30am-7.30pm	8am-4pm	Wed, Fri
Casuarina	7 days	24 hours	Mon-Fri
Eastern Goldfields	8am-4pm	8am-4pm	Wed
Greenough	7am-8pm	7.30am-4pm	Mon, Wed, Fri*
Hakea	7 days	24 hours	Mon-Fri, Sat (am)
Karnet	7.30am-8pm	8.30am-4.30pm	Tues, Thurs
Pardelup	7am-3pm (1pm Fri)	Nil	Wed
Riverbank	8.30am-2.30pm	8.30am-11.30am	Wed
Roebourne	7.30am-8pm	8am-4pm	Thurs
Wooroloo	7 days	24 hours	Mon, Wed, Fri

*Medical practitioners are provided by the local Aboriginal Medical Service

4.13 Nursing services are provided by nurses employed under the Australian Nursing Federation (ANF) award at all prisons except Casuarina and Hakea, where nursing staff are known as ‘hospital officers’ and are members of the Western Australian Prison Officers Union (WAPOU)⁴. Medical services are provided by employed doctors and sessional medical practitioners. Figures provided to me by the Ministry show that the number of nursing FTE s has increased from 71.45 as at 1 July 1998 to the current level of 84.65. Sessional medical practitioners make up an aggregate of 3.5 FTEs (the equivalent of 35 sessions per week) and the Ministry has advised me that with the resources currently available Health Services has the capacity to provide another 10 sessions per week if required.

Psychiatric Services

4.14 The 1980/81 Prisons Department Annual Report noted an increase in the number of mentally disturbed offenders and those suffering the effects of substance abuse. It also commented that resources and facilities to deal with such prisoners were limited following the decline in the number of psychiatric staff from three in 1978 to one Registrar on short term appointment in January 1981.

4.15 Concerns about the continuing shortage of psychiatrists were repeated in subsequent annual reports. The 1982/83 Report stated that there was “*an urgent need for the introduction of the service of a psychiatrist who can work the hours necessary to cope with this very real problem* [the increasing number of mentally disturbed prisoners].” Psychiatric staff at that time included a part-time psychiatric registrar on secondment from the Psychiatric Registrar training course of the WA College of Psychiatrists and a consultant forensic psychiatrist. By 1983/4, a basic psychiatric service was being provided by three sessional psychiatrists. This was enhanced in 1984/85 when HDWA offered the services of a consultant psychiatrist to assist in the development of a forensic psychiatric service for prisoners.

4.16 It was agreed in the early 1990s that the Chief Psychiatrist at Graylands would provide staff for 5-6 sessions per week for prisoners. I was told that in practice, however, it was not unusual for only one weekly session to be provided and that the staff available at that time were inexperienced in prison psychiatry. Ultimately, the target number of sessions could not be met because of a shortage of trained staff.⁵

4.17 The ongoing problem of providing an adequate prison psychiatric service was discussed at length by the JJ/HIDC at its inaugural meeting on 25 October 1994. The agenda for this meeting notes:-

“The Health Department is not currently providing an integrated service on a Statewide basis. Those metropolitan services that are being delivered are inadequate with the result that a significant number of offenders with mental disorders are being managed within the prison system.....”

4.18 An addendum to the agenda stated that the Ministry’s “preferred position” was for seven psychiatric sessions per week within the metropolitan area (at Casuarina, the Remand Centre, Canning Vale and Bandyup). As a result a concerted effort was made to attract staff from other jurisdictions. By this means the Ministry acquired at its expense 80% of the time of a senior forensic psychiatrist employed by HDWA in 1995. Nevertheless, the JJ/HIDC meeting of 22 March 1996 noted:-

“The needs of offenders and the Ministry are not being met to a significant degree. Health Services does not have any funding provided for psychiatric services although this is the subject of a submission currently under consideration within the Ministry.”

4.19 The senior forensic psychiatrist referred to above, assisted by other sessional psychiatrists employed by HDWA, now provides services to prisoners as set out in **Table 4.2**.

TABLE 4.2	PSYCHIATRIC SERVICES as at November 2000	
PRISON	DAYS/WEEK	HOURS/WEEK
Albany and Pardelup	Tuesday	4 hours*
Bandyup and Nyandi	Tuesday	3.5 hrs*
<i>Plus psychiatric nurse</i>	Friday	3.5 hrs
Broome	As required*	
Bunbury	Monday	4 hrs*
Casuarina	Monday	3.5 hrs* plus 3.5 hrs
	Wednesday	3.5 hrs*
	Friday	3.5 hrs* plus 3.5 hrs
		- psychiatric registrar
	Thurs(fortnight)	3.5hrs
Eastern Goldfields	Transferred to a metropolitan prison	
Greenough	Fri (fortnight)	7 hours*
Hakea Prison <i>Including</i>	Tuesday	7 hrs
<i>Remand</i>	Thursday	7hrs
Karnet	Thurs (fortnight)	3.5 hours
Riverbank	Nil	
Roebourne	As required	
Wooroloo	Transferred to Casuarina	

*sessional psychiatrists
Figures in bold—sessions by Ministry’s psychiatrist

Psychological Services

- 4.20 Psychological Services are provided to prisoners by the Forensic Case Management Team (FCMT) (formerly known as the Special Needs Team (SNT)). The background and functions of the FCMT are dealt with in detail in Chapter 11.

Prison Health Facilities

- 4.21 In the early 1980s the infirmary building at Fremantle Prison housed the main prison medical facility, which provided “C” class hospital functions. “C” class was a term which generally applied to the provision of basic care to patients who could for the most part look after themselves, such as patients in a nursing home. The Fremantle “Hospital Dormitory” which had 23 beds was able to offer accommodation to *“the walking wounded”* under the charge of a *“wardsman”* – another prisoner. The infirmary building also included the Pharmacy⁶, the Treatment Room, the X-ray Room, a kitchen and the Occupational Therapy Section.
- 4.22 The 1984/85 Prisons Department Annual Report notes that the Treatment Room and kitchen had been renovated, but also repeated the statement made in the 1983/84 annual report that *“prevailing facilities and staffing arrangements in Fremantle Prison are inappropriate for the care of prisoners who have major psychiatric problems.”*
- 4.23 Casuarina Prison was commissioned in June 1991. It included a purpose-built Infirmary with 32 beds (two wings of 16 beds each) and four medical observation cells. It should be noted, however, that the Infirmary does **not** provide ‘hospital’ facilities - other than, for example, monitoring of prisoners who have been discharged from hospital. Prisoners requiring hospitalisation for any reason are sent to the nearest local public hospital.
- 4.24 One of the wings in the Casuarina Infirmary was intended to provide facilities for psychiatrically-disturbed prisoners. However, it was immediately taken over by the Sex Offender Treatment Unit to run the intensive residential sex offender treatment program and has been used for that purpose ever since. Consequently, the Casuarina Infirmary has a total capacity of 20 beds (including the four medical observation cells) – three less than were available at Fremantle Prison. Although a 12-bed Crisis Care Unit for at risk and other vulnerable prisoners was opened at Casuarina in April 1999, there are currently⁷ no facilities for psychiatrically disturbed or at risk prisoners at any of the other prisons.
- 4.25 None of the prisons is able to accommodate prisoners withdrawing from drugs in a discrete detoxification unit although I have been advised that the Crisis Care Unit at Casuarina could be - but is not usually - used for this purpose. Presumably the Crisis Care Unit at Hakea and that proposed for Bandyup could also be used for prisoners suffering from withdrawal symptoms.
- 4.26 Each prison has a medical centre where prisoners are seen by nursing staff, visiting medical practitioners, psychiatrists, dentists and other health service providers. Apart from minor modifications to some of the prison medical centres and the opening of a two-bed ‘hospital’ facility at Bandyup in 1995/96 there were no further additions or upgrades of health facilities until comparatively recently. The Ministry now has approval and funding to upgrade medical centres at all regional prisons with an expected completion date of July 2001. Upgrades have commenced at Pardelup (where the new facility is being constructed by prisoners using mud bricks), Broome, Roebourne and Greenough and also at Karnet and Nyandi. It is intended to involve prisoners in upgrades at other prisons. In addition, a new medical centre and Crisis Care Unit are included in the Assessment Centre at Hakea Prison and the extensive refurbishment of Bandyup will include a major upgrade of the medical centre - which is expected to be operational by July 2001. All upgrades will be based on HDWA standards.

4.27 Wooroloo District Hospital - a HDWA facility within the grounds of Wooroloo Prison - currently provides health care to both the local community and to prisoners. However, the Government announced in May 2000 that there would be a phased transition of health services for community clients to a community-based model and the transfer of responsibility for prisoner health services to the Ministry. Acacia Prison will have a 24-hour Health Centre with a three-bed Treatment Room and a Procedure Room. The Health Centre will also have one three-bed ward and four single rooms, two of which will operate as observation cells, capable of being directly supervised by nursing staff. In addition, Acacia will be equipped with a Special Care Centre consisting of a 13-bed Crisis Care Unit and a 20-bed geriatric unit.

Funding

4.28 Funding for prison health services in Western Australia is the exclusive responsibility of the body charged with the provision of custodial services (ie the Ministry) as, under section 19(2) of the Commonwealth *Health Insurance Act 1973*, prisoners are ineligible for Medicare benefits while they are incarcerated.

4.29 I have been informed by the Commonwealth Grants Commission that funding to assist in the provision of custodial services is included in the general grant to States and Territories and that it is open to a State/Territory government to use some of that allocation for the provision of health services to prisons. However, there is no guarantee (or obligation) that Commonwealth grants will be used for this purpose. Ultimately, the amount of funding made available for prison health services is at the discretion of the State/Territory government and will generally depend on the relative priority afforded to 'health' and 'security' by that government.

4.30 Prior to the appointment of Dr McCall as Acting Director General of the Ministry in late 1995, health services fell within the control of individual prison superintendents for the purposes of funding and reporting. Dr McCall believed that a decentralised prison health service under the control of prison superintendents was "*untenable*"⁸, largely because of its likely adverse effect on the independence of health service providers, and he decided to establish an independent Health Services Directorate within the Offender Management Division, reporting directly to the Director General and with a separate budget allocation, with effect from 1 July 1996. The precise figure for the 1995/96 health services budget allocation is, therefore, difficult to determine. However, on the basis of available information it appears to have been in the region of \$5.1 million, comprising an amount for Head Office and the FCMT and a sum of approximately \$3.2 million to be recouped from prison budgets.

4.31 At the same time, funding for the FCMT (which had not previously been considered a 'health' item) and for the newly established Prisoner Support Officers was brought within the budget of the Health Services Directorate. Dr McCall also approved additional funding of \$2.9 million for a Health Services Programme which provided funding for the following supplementary services and new initiatives:-

- Nursing consultancy
- Additional psychiatric and psychological staff
- Psychiatric training
- Mental health nurse
- Additional medical practitioner
- Prison Aboriginal Medical Services
- Additional nursing services
- Additional medical records support
- Staff training and development
- Purchase and replacement of medical equipment

- 4.32 The Ministry advised me, however, that there was “*considerable under-expenditure due to delays in the introduction of new services*” although the reasons for those delays are by no means clear. A further change occurred in 1997/98 with the transfer of the budget for juvenile health services to the Health Services Directorate.
- 4.33 In a statement to the Legislative Council on 31 March 1998 the Attorney General advised that “*resources for health services have doubled in just two years to a budget this year of \$8.6 million*”. The Ministry has advised me that the following budgets were available to health services (excluding health services at juvenile justice centres):-

Year	Health Budget	Daily Average Muster	Per Prisoner Funding
1996/97	\$8 454 400	2231	\$3789.5
1997/98	\$8 061 368	2254	\$3576.5
1998/99	\$9 509 416	2684	\$3543.0
1999/00	\$11 341 814	2986	\$3798.3
2000/01	\$12 247 900	3017	\$4059.6

- 4.34 The Ministry has also confirmed that it has recently received agreement from State Treasury to provide funding on a per prisoner basis to ensure that funding will increase in line with rising musters.
- 4.35 I understand that the 2000/01 figure represents approximately 8.87% of the Prison Services Budget. I have been advised that in Victoria the proportion spent on prison health services is closer to 10% but no other reliable comparative data about funding for health services in prison appear to be available. For example, the annual *Report on Government Services* published by the Steering Committee for the Review of Commonwealth/State Service Provision contains no data about health services in prisons and has not identified any specific performance indicators for health services. However, I note that the funding amounts set out in Table 4.3, when expressed as an amount per prisoner show that, in nominal dollar terms, the funding fell in 1997/98 and again in 1998/99, rising back to 1996/97 levels only in 1999/2000. In real (after inflation) terms, the reduction in funding in the years 1997/98 to 1999/2000 was even more marked.
- 4.36 In my view, it would not be safe to conclude that the real reduction in health funding per prisoner in the period 1997/98 to 1999/2000 and the substantial increase in deaths in prisons in those years is merely coincidence. Prison deaths will often be a symptom of a system under strain – and the real reduction in health funding in those years can only have exacerbated the pressure on this State’s prisons at that time.

RECOMMENDATION 4.1

That the Ministry should instigate a research project that examines funding for health services in prisons in Australian and comparable overseas jurisdictions with a view to establishing a resourcing model that reflects best practice and provides a level of prison health services that is the equivalent of health services in prisons in other jurisdictions and in the wider community.

Joint Justice/Health Interdepartmental Council (JJ/HIDC)

4.37 The JJ/HIDC was established in 1994 “to ensure the proper management and functioning of health services within Western Australian offender management settings” through its Terms of Reference, namely:-

- to determine policy for health care delivery within offender management settings in Western Australia;
- to monitor and make recommendations regarding the availability of resources for such a health service;
- to address and resolve significant problems in relation to such a health service;
- to determine priorities and strategies for health issues arising in connection with health services within offender management settings;
- to ensure that relevant standards for service delivery are developed and applied, in accordance with *Standard Guidelines for Corrections in Australia*, standards for Australian health care facilities and such other health care standards as may be agreed by the parties.

4.38 The Ministry is represented by the Director General, the Director and Manager of Health Services and the Executive Director of Offender Management; and the Health Department by the Commissioner of Health, the Chief Health Officer and the General Manager, Mental Health Division. Additional members may be co-opted for specific purposes.

4.39 Agenda items for the inaugural meeting on 25 October 1994 included:-

- the establishment of a Justice/Health Task Force “to progress operational matters consistent with the terms of reference of the JJ/HIDC”;
- a Health Services Needs Analysis;
- review of the guidelines for admission to the Frankland Unit at Graylands Hospital;
- the provision of psychiatric services⁹ to the Ministry; and
- the operation of Wooroloo District Hospital.

4.40 The Council met sporadically after the first meeting with only one meeting per year in 1995 and 1996. It was 17 months before the next meeting in August 1997 which was followed by a further meeting in December that year. Since that time, meetings appear to have become more regular with meetings in March, August and December in 1998 and 1999 and meetings in March and July with others scheduled for October and December this year. Neither the Ministry nor HDWA was able to locate the minutes for some of those meetings and little decisive action seems to have been taken –at least in the past - as a result of this forum. Other topics discussed by the Council according to the agenda/minute papers made available to me include:-

- security arrangements for hospital attendance by prisoners;
- the feasibility of upgrading the Casuarina Infirmary services;
- contracting out of prison health services;
- eligibility of prisoners for Medicare;
- HIV management strategies;
- an IT system for Health Services;
- psychiatric services;
- disease prevention, health promotion and education services;
- concerns about the independent status of Health Services;
- pharmaceutical services;
- the need to inspect, and for an audit of, prison health facilities;
- the management of prisoners with ADHD;

- charging policies;
- review of the functioning of the Council.

- 4.41 In spite of its apparent lack of positive results, HDWA has advised me that it views the Council as “*the only high level forum where issues can be discussed that impact on both Justice and Health....This in turn has resulted in more informed and better coordinated action...*”. The Council’s Terms of Reference required its functioning to be evaluated 18 months after its establishment. However, its operations have never been reviewed. I comment further on the functioning and value of the JJ/HIDC in Chapter 6.
- 4.42 As noted at paragraph 4.3 above, the Ministry has assessed proposals by private sector health service providers to deliver prison health services, including pharmacy services. My comments in Chapter 5 on issues arising from the deaths of prisoners since 1991 reflect my views on the shortcomings of the system which has been operated by the Ministry to date. I comment in Chapter 6 on the components which I believe are essential for a prison health service which is capable of offering prisoners health care provided by qualified health professionals based on generally accepted community standards of medical practice.

1 See also Chapter 6 paragraphs 6.162-6.172

2 See also paragraphs 4.37-4.41

3 24-hour coverage at Bandyup was introduced following my predecessor’s investigation into the administration of health care at that prison in 1995 (Report tabled in Parliament in November 1995)

4 See also Chapter 6 paragraphs 6.87-6.95

5 It was claimed that there was a State-wide shortage of trained psychiatrists with only four available in the public sector to service the whole community

6 See Chapter 7 for discussion of the prison Pharmacy Department

7 A Crisis Care Unit has been included in the upgrade and modification of Hakea Prison

8 Report by the Attorney General and Minister for Justice; *Hansard* 31 March 1998

9 The establishment of the Forensic Psychiatry Advisory Committee and the appointment at UWA of the Chair of Forensic Psychiatry who is also Director of State Forensic Psychiatric Services resulted from the Council’s deliberations and are seen as crucial to guide and manage the significant developments planned for forensic psychiatric services in Western Australia

CHAPTER 5 ISSUES ARISING FROM THE DEATHS OF PRISONERS FROM NATURAL CAUSES 1991-1999

INTRODUCTION

DEATHS OF ABORIGINAL PRISONERS FROM NATURAL CAUSES

EXAMINATION OF ISSUES RAISED BY DEATHS FROM NATURAL CAUSES

SUMMARY OF RECOMMENDATIONS

INTRODUCTION

5.1 As summarised in **Table 5.1** below 23 prisoners died from natural or apparent natural causes in Western Australia between 1 January 1991 and 30 June 2000.

TABLE 5.1 Deaths from natural causes or apparent natural causes 1991-2000

NAME	DATE OF DEATH	PRISON	ABORIGINAL
1991			
Edward Isaacs	25 January	Canning Vale	Yes
Francis Lord accidental death	20 April	Hospital ex Fremantle	
Bogomir Modrajan	4 May	Remand Centre	
Kerrin Foster	22 November	Casuarina	
1993			
Nicholas Ranford	20 January	Pardelup	
1994			
Graham Richards	25 January	Greenough	Yes
1995			
Ian Beach	10 March	Casuarina	
Brian Evans	5 July	Casuarina	
Keith Reynolds	29 October	Broome	Yes
Pita Young	7 December	Remand Centre	
1997			
Peter Cameron	11 January	Hospital ex Karnet on home leave	Yes
Colin Shaw	1 October	Hospital ex Casuarina	Yes
Geoffrey Lindsay	14 November	Greenough	Yes
Raymond Phillips	15 December	Remand Centre	
1998			
Winifred Michael	12 January	Hospital. ex Bandyup on bail 20/12/97	Yes
Tammy Green	13 March	Bandyup	
1999			
Norman Ackerman	4 March	Hospice ex Wooroloo	
Dwayne Rowland	5 September	Hospice ex Casuarina	
Reginald Fry	2 November	Hospital ex Canning Vale	
Gerald Woods	27 November	Remand Centre	Yes
2000			
Jason Matthews	22 May	Casuarina	
Kirk Lawson	27 May	Eastern Goldfields	Yes
Frederick Riley	7 June	Casuarina	Yes

5.2 All of the deaths have been investigated by the IIU and by police. None of the deaths after that of Mr Rowland in September 1999 has yet been the subject of coronial inquest. Recommendations and comments involving health issues and the administrative practices of health services personnel were made by the IIU and the Coroner in relation to the deaths of the following prisoners:-

- Edward Isaacs
- Francis Lord
- Graham Richards
- Keith Reynolds
- Peter Cameron
- Colin Shaw
- Geoffrey Lindsay
- Raymond Phillips
- Winifred Michael
- Tammy Green

5.3 In addition, although the prisoners (none of whom was Aboriginal) in **Table 5.2** below were found by the Coroner to have died by suicide, questions involving the administrative practices of health staff (nursing staff and doctors) were raised following investigation of their deaths.¹

TABLE 5.2		Suicide deaths raising health issues
NAME	DATE OF DEATH	PRISON
	1993	
Kenneth Summers	20 April	Casuarina
	1996	
Carl Jackson	12 January	Casuarina
Shaun Rawlings	20 October	Casuarina
	1997	
Anthony Wood	11 January	Remand Centre
Wesley Doorey	24 January	Casuarina
Noel Clarke	6 April	Casuarina
Sean Hayes	21 August	Remand Centre
	1998	
Dean Lauder	31 May 1998	Canning Vale

DEATHS OF ABORIGINAL PRISONERS FROM NATURAL CAUSES

5.4 In its paper *Australian Deaths in Custody and Custody-related Police Operations 1996* the AIC reported:-

“While there has been a minimal reduction in the total number of deaths in the year under review the alarming trends reveal that in recent years the number of Aboriginal and Torres Strait Islander people in our nation’s prisons is continuing to increase, as is their level of over-representation. Following on from this, there are critically high numbers of Aboriginal and Torres Straits Islander people hanging themselves or dying from heart disease in prison custody.”

5.5 In a paper delivered at a conference in March 1999, Vicki Dalton of the AIC drew attention to the fact that there had been 257 prison deaths nationally from natural causes between 1980 and 1998 and that over half of those had been the result of heart disease. She also referred to the fact that although Aboriginal and Torres Strait Islander prisoners had a “*particularly high level of death from natural causes (usually heart disease).....*” and that more indigenous deaths had occurred as a result of illness, “*.....the trend in more recent years has been for an increasing number of suicides, so that since 1990 the proportion of Indigenous deaths resulting from illness and suicide has been almost identical.*”

- 5.6 In its Trends and Issues paper entitled *Aboriginal Deaths in Prison 1980 to 1998: National Overview* (October 1999), the AIC reported that, of the 80 Aboriginal prisoners who died between 1990 and 1998, 35 died from natural causes. Seven of those deaths – 20% - occurred in Western Australia.
- 5.7 In 1999, one of the four prisoners who died from apparent natural causes in Western Australia was Aboriginal. Two of the three Western Australian prisoners who died from apparent natural causes between 1 January and 30 June 2000 were Aboriginal. The number of Aboriginal prisoners who have died from natural causes in Western Australia is still marginally higher than those who commit suicide – 10 deaths by natural causes compared with eight suicides (or apparent suicides) between 1991 and 30 June 2000².
- 5.8 The Ministry has made the valid comment that Aboriginal people in general – whether incarcerated or not – are at great risk from heart disease and that their mortality rate from this cause is significantly higher than that for non-indigenous people. It has also pointed out that at some prisons in Western Australia – notably Broome, Roebourne, Eastern Goldfields and Wooroloo – the prison population is predominantly (around 80%) Aboriginal. These demographics will clearly have an impact on the death rate of Aboriginal prisoners from natural causes in Western Australia when compared, for example, with Victoria where the number (and proportion) of Aboriginal prisoners is much smaller.

EXAMINATION OF ISSUES RAISED BY DEATHS FROM NATURAL CAUSES

- 5.9 This Chapter examines specific issues raised in the investigations and inquests of the deaths of Western Australian prisoners from natural causes relating to :-
- Availability of information and the quality of record-keeping
 - Quality of prison health services
 - Prison diet
 - Health facilities and equipment

Issue 1: Availability of Information and Record Keeping

- 5.10 RCIADIC **Recommendation 157** states:-

“That, as part of the assessment procedure outlined in Recommendation 156, efforts must be made by the Prison Medical Service to obtain a comprehensive medical history for the prisoner including medical records from a previous occasion of imprisonment, and where necessary, prior treatment records from hospitals and health services. In order to facilitate this process, procedures should be established to ensure that a prisoner’s medical history files accompany the prisoner on transfer to other institutions and upon re-admission and that negotiations are undertaken between prison medical, hospital and health services to establish guidelines for the transfer of such information.”

- 5.11 The issue of the adequacy of the Ministry’s record-keeping practices was initially raised following the death of Francis **Lord** in 1991, prior to publication of the RCIADIC Report. The Ministry reported in both the 1995 and 1997 Government Implementation Reports that it had implemented this recommendation. However, the recurrence of this issue in a number of deaths after the reported implementation of this recommendation raises questions about the adequacy of the steps taken by the Ministry.

(a) Availability of information

Delay in access to a prisoner's medical records - on transfer to another prison or re-entry to the prison system

- 5.12 The IIU investigation of Mr Lord's death was critical of the fact that his medical file did not accompany him when he was transferred from the Remand Centre to Fremantle on 27 March 1991 and that it had to be specially requested after his accident on 2 April 1991 (he fell from one of the landings). The delay in forwarding the file was attributed to the Easter break when the normal courier system was not operating.
- 5.13 The IIU investigator noted that it was "fortunate" that the file contained "nothing adverse...nor any indication that he suffered from "giddy" spells..." and recommended that the system needed to be "overhauled and a more efficient system put into operation to ensure prompt delivery of important documents such as medical files."
- 5.14 In August 1994 the then Acting Executive Director of the OMD issued an instruction to all superintendents drawing attention to the continuing problem of medical files not being sent with prisoners when they were transferred. She described the practice as "unacceptable" and as a "serious departure from the commitments made by the Ministry with both the Coroner and the Royal Commission into Deaths in Custody" (referring to Recommendation 157) and went on to say:-
- "The unavailability of the medical record seriously inhibits the medical management of prisoners subject to transfers and in some cases could have potentially major adverse consequences.....Every Superintendent shall put in place arrangements which ensure that medical files accompany prisoners on transfer."*
- 5.15 A similar problem arose again in 1997 in relation to Anthony Wood, whose medical file was not available when he was re-admitted to the Remand Centre after two visits to Eastern Goldfields Regional Prison for court appearances in Kalgoorlie. The delay on this occasion was attributed to the Christmas/New Year break. Because the medical file was not available at the Remand Centre, the staff who conducted the initial assessments were not aware of Mr Wood's previous psychiatric history or that he had been prescribed medication for depression.
- 5.16 The current system that should be followed when a prisoner is to be transferred between prisons requires that his/her medical file be handed in a sealed envelope by a member of the medical staff to the reception staff who should place the envelope in the bag with the prisoner's property. In addition, although a prisoner's 'Medalert' status (the level of risk presented by a prisoner in terms of his or her physical and mental well-being) is available on-line, medical staff from the transferring prison are required to send by facsimile the prisoner's 'Medalert' status and current medication chart to the receiving prison. I also understand that the number of courier services between prisons in recognition of the importance of the timely transfer of medical information has been increased.
- 5.17 Whether the absence of the information in the file contributed in any way to the deaths of either Mr Lord or Mr Wood cannot be known. Nevertheless it is an illustration of the possible outcome when there is a breakdown in the system (in both cases attributable to long public holidays). I have been told by health services staff that the transfer system works well for most of the time. In response to my draft Report, the Ministry advised me:-

“The Ministry of Justice, Health Services Division is of the view that there is not a systemic problem with the transfer of medical information. It is considered that this system works well in general, but can break down because of unforeseen difficulties on certain occasions. The Health Services Division continues to be committed to maintaining this system at appropriate and acceptable levels, and to this end it is noted that a Medical Records Committee and Quality Assurance Committee both address issues relevant to medical records and medical information transfer.”

- 5.18 I am satisfied that this is generally the case. However, the system does rely very heavily on the standard of communication between the administrative staff who make the decision to transfer a prisoner, the prison officers responsible for execution of the transfer decision and the medical staff who, for reasons of confidentiality, must provide the medical record. In this regard I have been told by prisoners that they frequently only become aware of their imminent transfer³ when they find that their gratuity or telephone account has been closed. If this is still occurring, I suggest that it is not unlikely that the procedure for the transfer of medical files may occasionally break down. Recent complaints to my Office⁴ indicate that difficulties in access to a prisoner’s medical records following transfer or re-entry into the system continue to be a problem.

Delay in access to a prisoner’s medical records – on transfer to a public hospital

- 5.19 Following the inquest into the death of Graham **Richards** in 1994 the Coroner was critical of the fact that Mr Richards’ prison medical file did not accompany him to hospital. The Coroner expressed concern that prison medical staff were limited in their ability to treat a prisoner by the extent of the information the prisoner chose to provide and suggested that it would be –

“.....helpful to both the prison medical authority and a prisoner if at the time of the initial taking of any medical history the prisoner was invited to sign a release or releases in relation to his medical history directed to any and all medical practitioners he has been treated by.”

- 5.20 The Ministry’s *Health Services Policy and Procedure 2.1* (HSPP 2.1) documents procedures for organising hospital admissions in an emergency situation but includes no requirement for the prisoner’s medical file to accompany the prisoner to hospital. The Ministry has advised me that its policy - in common with all medical institutions - is that the medical file remains within the prison system but that detailed referral forms are completed by prison medical staff who keep in contact with the receiving hospital and are able to provide any further details required by that hospital. Again the success of the system will depend on the standard of communication by health services staff. I have received no complaints about this issue.

Failure to obtain a prisoner’s previous medical records

- 5.21 The Coroner’s comments in relation to Mr Richards’ death reflect RCIADIC **Recommendation 157**, which reinforced the importance of obtaining details of a prisoner’s previous medical and psychiatric history. Although the Ministry stated in both the 1995 and 1997 *Government of Western Australia Implementation Reports* that it had implemented this recommendation, the same problem arose in the subsequent deaths of Keith **Reynolds** in 1995 and Sean **Hayes** in 1997.
- 5.22 In Mr Reynolds’ case, no attempt was made by prison medical staff at Broome Regional Prison to obtain his previous medical records from Wyndham Hospital. Although medical staff at the Remand Centre requested Mr Hayes’ records from Royal Perth Hospital (RPH) the file did not arrive until after his death and 25 days after the need to request it was noted in his prison medical file. It is not clear from the file when the request was made to RPH.

- 5.23 In 1998 I received a complaint from the mother of a prisoner who had self-harmed in Casuarina alleging that if the Ministry had obtained his previous medical records (from a prison in another State) it would have been aware of his history of self harm. With this knowledge staff would have managed her son differently and might have prevented his suicide attempt.
- 5.24 A slightly different issue arose in the investigation of the death of Peter **Cameron** who died of natural causes while on work release from Karnet Prison Farm on 11 January 1997. In response to concerns by the prisoner's family that the prison doctor who treated Mr Cameron had not read his medical notes before examining him, the doctor agreed that this was so and that "*time constraints prevented him from reading the notes prior to seeing each patient*". He added that this approach was the same with all patients regardless of whether or not they were in custody.
- 5.25 It would seem from my discussions with the Ministry that, although the value of previous medical records is accepted in principle as being of assistance – particularly if, as many prison health staff state, there is no guarantee that a prisoner will reveal all of his or her previous medical problems – the procedure in place in 1998 for their retrieval was considered cumbersome and time-consuming.
- 5.26 As a result of discussions with the Director, Health Services in the course of my investigation of the complaint by the prisoner's mother referred to above, the Director reviewed the existing procedures for obtaining previous medical histories and issued new guidelines which streamlined and simplified the procedure, particularly in relation to records held by prisons in other jurisdictions.

Prisoner's change of name not recorded

- 5.27 In the case of Kenneth **Summers** who committed suicide in 1993, the SNT staff member who interviewed him on the day of his death was unable to locate his file because his change of name by deed poll had not been noted on his records (from a previous term of imprisonment) which were filed under his previous name. The issue was not commented on by the Coroner but was reviewed by the then Manager of the SNT who concluded that the problem had arisen because of lack of communication between "others in the system" and the SNT and that the deficiency needed to be rectified.
- 5.28 The Ministry conceded that the breakdown in communication was possible in 1993 because there were at that time separate filing systems for the medical record and the offender management file. The SNT, which was not part of Health Services at that time, did not have access to the prisoner's medical record. With the amalgamation of the SNT function into the Health Services Directorate and the streamlining of the filing system so that each prisoner is allocated only one reference number, a repeat of the confusion that arose in Mr Summers' case is unlikely to re-occur.

Conclusions on Issue 1(a)

- 5.29 I am satisfied that deficiencies in the Ministry's records system highlighted by the deaths of Messrs Lord, Wood, Richards, Reynolds, Hayes and Cameron are not symptomatic of a lack of commitment to the spirit of Recommendation 157. However, continuing complaints to my Office about this issue and the obvious recurring practical difficulties lead me to the conclusion that the Ministry cannot be said to have implemented Recommendation 157 in practice. It is also quite clear that the new guidelines and protocol for obtaining a prisoner's previous medical record from the community or from another State were only introduced in 1998 as a result of my involvement following the complaint by the prisoner's mother discussed above. The effectiveness of the current system is clearly entirely dependent on the diligence of health staff and the standard of communication.

- 5.30 A possible solution might well be found in an electronic medical record system available to the whole prison system. Although I have been advised that this option has been considered by Ministry, I understand that introduction of such a system is unlikely in the immediate future on grounds of cost; the relatively small number of successful prototypes currently in operation; and the reluctance by many medical practitioners and other health professionals to record medical notes electronically. The Ministry has advised me that:-

“It is correct that it is unlikely that the Ministry will introduce an electronic medical records system. It is not entirely accurate that the system is not supported ‘on the grounds of cost’. The Health Service within the Ministry is a diverse system. It is complex because there are many providers and sources of information, both external and internal. Building complex electronic systems to support this environment can be problematic and costly, and it is considered that the risks outweigh the perceived benefits.”

- 5.31 An alternative could be the amendment of DGRs and Health Service Policies to incorporate a requirement that no prisoner may leave a prison on transfer to another prison until it is confirmed that his/her medical records are included with his/her property.

RECOMMENDATION 5.1

That the Ministry:-

- (a) in the short term, formalise the current procedure for sending a prisoner’s medical records with him/her on transfer to another prison to ensure the minimum risk of a breakdown in communication between prison staff; and**
- (b) in the medium to long term, give a high priority to the introduction of a computerised system of storing medical records to ensure that they are accessible at all prisons to authorised personnel without delay.**

The Ministry is of the view that this issue “...has been addressed, is currently formalised and works well in practice.”

(b) Inadequate record-keeping by prison health staff

- 5.32 Record-keeping by health staff is an area where there can be no doubt that accuracy and completeness are an integral part of professional responsibilities and accountability. This view appears to be reflected in *Health Services Policy 3.1* which states:-

“All patient records are legal documents. Any care of, or contact with a patient that is not documented is not verifiable and may be assumed not to have occurred. It is therefore necessary to document all relevant contact with a patient.” (my emphasis)

- 5.33 The recently amended policy repeats this statement and adds the following:-

“All documentation shall meet legal and professional standards. All forms must be approved by the Medical Records Committee before being used and filed in the medical record.

In the custodial setting, Coronial, Parliamentary Commissioner, Ombudsman, Ministerial and legal enquiries are frequent, both during and following a term of incarceration. It is essential for the wellbeing of the clients and staff that documentation is accurate and contemporaneous.”

5.34 Nevertheless, the issue of poor record-keeping was highlighted in the deaths of:-

- Carl **Jackson** - the recording of telephone consultations between the prison medical practitioner and nursing staff and the addition to medical notes after the death;
- Noel **Clarke** - the failure to note “*significant medical incidents*” in medical records;
- Winifred **Michael** - the inadequacy of consultation notes in the medical file.

Documentation of telephone consultation by on-call doctor and subsequent additions to medical records

5.35 Carl **Jackson’s** medical condition was discussed during the course of a telephone conversation between the on-call doctor and a Hospital Officer (nurse) on the night of his death. The Hospital Officer made contemporaneous notes of the conversation in the progress notes at the time but the doctor did not make her own record and subsequently added her recollection of the conversation in Mr Jackson’s notes after his death. During the investigation of Mr Jackson’s death and at the inquest there was a dispute between the Hospital Officer and the doctor over her claim that she had ordered Mr Jackson to be checked during the night. Checks were not carried out on Mr Jackson by nursing staff on the night of his death.

5.36 The IIU investigation report into Mr Jackson’s death recommended that a review be undertaken of the “*procedures for recording treatment instructions issued by doctors to Hospital Officers. Consideration should be given to the utilisation of a tape recorder to monitor the instruction and treatment required or the use of a facsimile machine to record in writing these instructions.*”

5.37 The Ministry advised me that as a result of recommendations made following Mr Jackson’s death, facsimile machines were installed in the homes of on-call doctors as a means of producing written confirmation of telephone instructions. This had, however, proved to be of limited benefit because of the reluctance of doctors to use the facilities provided. As a result, the then Director, Health Services introduced a formal policy based on the protocols in place in teaching and non-teaching hospitals to the effect that when a doctor prescribes medication or gives orders to a nurse or Hospital Officer by telephone, the information must be repeated to another nurse or, if only one nurse is available, that nurse must repeat the orders back to the doctor for verification.

5.38 In response to my draft Report, the Ministry advised me:-

“The issue of adequate documentation of medical records can perhaps best be addressed by the independent documentation by two separate nurses of the doctor’s instruction. It is rare in the community for a doctor to document telephone calls. Similarly, the Ministry has not been able to consistently implement a procedure for doctors to document telephone calls despite real efforts in this area. The Ministry is still pursuing the option of tape recording of telephone calls”

5.39 The Coroner criticised the doctor who gave the Hospital Officer advice by telephone in relation to the treatment of Mr Jackson for documenting her advice after Mr Jackson’s death and recommended that a procedure be introduced prohibiting this practice. As a result, the Ministry amended DGR 2M (*Procedure to be followed upon the Death of a Prisoner*) to require the Superintendent “*upon the reported death of a prisoner*” to “*seize and retain at the prison all records relating to that prisoner*” and to “*not permit any person to make any manner of written entry upon any document.....*”

5.40 The Ministry advised me, however, that although it agreed that *ex post facto* alteration of the record of a prisoner’s management should be avoided, this must be balanced with the need for all information relevant to a deceased prisoner to be included in the records. In Mr Jackson’s case, it believed that the doctor made the notes openly and with no intention to mislead.

- 5.41 I do not disagree with this view. Having examined the additional notes made after Mr Jackson's death, I am satisfied that the doctor did not make any attempt to imply that she had made the notes during the telephone conversation with the Hospital Officer the previous evening. As the medical record remains within the prison, it would have been impossible for her to have made the notes until she attended the prison. In my view, of greater significance is the dispute and uncertainty created by the fact that the doctor made no personal contemporaneous notes of the telephone consultation.
- 5.42 I understand from a representative of the AMA that, from a medico-legal perspective, it is considered 'best practice' that telephone consultations are recorded in subsequent notes because doctors can be held accountable for their instructions and may be sued. The Ministry has advised me that although it is aware of the AMA's view, the practice is difficult to monitor.
- 5.43 An on-call prison doctor may take calls from prison health staff while at home, at another prison or in a car en route to a prison. In such circumstances it would obviously be difficult to access a prisoner's medical records. However, the doctor's statement that she rarely took notes of telephone consultations when on-call and that she might not see personally any of the prisoners for whom she gave advice is disturbing. Although I suspect that the doctor's estimation that she took up to 500 such calls a week is an exaggeration, it is quite clear from the fact that she took no notes relating to Mr Jackson that she was in breach of *Health Service Policy 3.1* and, I would have thought, of community medical practice standards. A note in the Ministry's files on Mr Jackson recommends "*stricter guidelines for [the doctor] and others*".
- 5.44 Without notes of even half the calls the doctor claims to have routinely received while on-call, I consider that it would be almost impossible to recall the details of advice given in relation to a particular prisoner. I also presume that if the doctor did not subsequently visit the prison where the prisoner was held, she or he might never see the prisoner in question personally, and any notes of telephone consultations the doctor might make might never be recorded on the prisoner's file. If this is the case – and I believe it to be so – the Ministry's current practices may not meet either its own or community standards.
- 5.45 I accept that in general terms it is impossible to link the death of Mr Jackson with the deficiencies identified in the records. I also accept that in the context of the hundreds of records and notes made by health services staff each week, errors or omissions may be very small in number. Having considered the above examples, I am inclined to the view that the deficiencies can be attributed at least in part to the heavy workload of the majority of prison health professionals. Where a medical practitioner is responsible for shortcomings in record-keeping, it should be noted that in the metropolitan area⁵ there is only one on-call doctor after hours (plus the Director, Health Services who is on permanent call-out). I comment further on the issue of resources in Chapter 6 at paragraphs 6.75-6.85

Failure to record "significant medical incidents" in a prisoner's medical records

- 5.46 In the case of Noel **Clarke**, who committed suicide in Casuarina on 6 April 1997, there appeared to be some dispute among health staff over whether he suffered from seizures – an issue relevant to his treatment by health staff prior to his suicide and which the Coroner found "*was on his mind at the time he took his life.*" Some members of staff claimed that they had never seen him affected in this way. However, one Hospital Officer gave evidence of seeing Mr Clarke have three or four seizures which were not recorded in his medical file. The Coroner recommended that "*all members of medical and nursing staff be made aware of the necessity of recording significant medical incidents in the medical notes of a prisoner.*"

Inadequate recording of consultation notes in a prisoner's medical file

- 5.47 Winifred **Michael**, a young Aboriginal prisoner, died on 9 January 1998 in Fremantle Hospital as a result of complications arising from appendicitis. She had been admitted on 26 December 1997 shortly after her release on bail from Bandyup Women's Prison on 24 December 1997.
- 5.48 The Coroner concluded that Ms Michael had first suffered from appendicitis while she was in Bandyup *"although at that stage her clinical symptoms would have been relatively mild."* He went on to state that *"Unfortunately the only examination conducted by a doctor while she was in prison was the examination conducted by Dr ... on 23 December 1997 at which stage the deceased indicated that she was reluctant to be physically examined....."*
- 5.49 The doctor and a nurse gave evidence that Ms Michael said that she was all right and that she did not want to miss lunch. Because they did not wish to use force to conduct a physical examination, Ms Michael was allowed to leave. The doctor did not record the refusal of the deceased to be examined in the medical file.
- 5.50 The Coroner agreed that the use of force on Ms Michael would have been inappropriate, but stated *"it is important that where a reasonably thorough medical examination does not take place, that fact and the reasons for it are clearly recorded."* He was also critical of the lack of detail of Ms Michael's exact symptoms in her medical records. This was of significance in Ms Michael's case because it was alleged by prison health staff that her stomach *"cramps"* were the result of withdrawal symptoms (from drugs). The Coroner said:-
- "This case has highlighted the importance of recording symptoms complained of with precision. The use of words such as "cramps" without explanation does not assist in determining the location of any pain or in ascertaining whether the symptom is changing in severity or nature over time."*
- 5.51 The Director, Health Services advised that he was satisfied that the use of the word *"cramps"* was appropriate in the circumstances because it had been used by nursing staff who were not expected to determine the location of the pain or a change in the severity of the symptoms over a period of time.

Conclusions on issue 1(b)

- 5.52 The Ministry has acknowledged that there are deficiencies in its medical record-keeping system and accepts that there have been breaches of its *Health Services Policy 3.1*. This first came to light in 1996 with Mr Jackson's death. However, no steps were taken to address the problems until my involvement with the case through a complaint by Mr Jackson's family. It is disturbing that the Ministry did not appear to take prompt action when the deficiencies highlighted by Mr Jackson's case became known.
- 5.53 In relation to the adequacy of medical notes (highlighted by the Coroner in Ms Michael's case), having looked through a number of prisoner medical files for the purpose of this inquiry I am inclined to agree with the Coroner that the detail in some of the notes is sparse. However, given that medical notes are primarily for use by qualified health personnel, I do not feel able to comment further on the issue of the *actual* content of medical notes. The absence of details critical to an evaluation of the *quality* of care provided to a deceased prisoner is, however, of concern, particularly if there is some need to consider the reasons why a potentially life-threatening condition was not identified. (I would also have thought that if such a condition was identified by a member of the nursing staff, the prisoner in question should be referred to a medical practitioner with commensurate urgency.) In this regard, the cautionary note in *Health Services Policy 3.1* that *"....Any care of, or contact with a patient that is not documented is not verifiable and may be assumed not to have occurred....."* is obviously of significance.

- 5.54 I have discussed the issue of accurate record-keeping with the Director, Health Services who has advised me that he is far from satisfied with the standard at some prisons. I understand that he has taken steps to reinforce the importance of accurate and comprehensive notes in prisoner medical files by conducting an audit of a random sample of files and has begun to take disciplinary action if health staff do not respond to warnings about the standard of their notes.

RECOMMENDATION 5.2

That the Ministry:-

- (a) ensure that there is an efficient and effective system in place so that an appropriate record is made of every telephone consultation concerning the health care of a prisoner and that such record is placed on the prisoner's medical file; and
- (b) monitor regularly, by audit or other means, the quality of record-keeping by health services personnel and implement a strategy of action for any staff member not meeting the required standard.

Issue 2: Quality of Prison Health Services

(a) Prisoners' lack of confidence in prison health service

- 5.55 In his findings on the inquest into the death of Edward **Isaacs** (1992; Canning Vale), the Coroner commented that Mr Isaacs appeared to have no confidence in prison health services because he preferred to discuss aspects of his health problems with prison officers and prisoners rather than with health staff. Although not expressed in terms of 'lack of confidence', a reluctance to follow medical advice was noted by the Coroner in his comments on the deaths of Graham **Richards**, Keith **Reynolds**, Geoffrey **Lindsay** and Colin **Shaw**.
- 5.56 I should add that it is quite clear from the files relating to Mr Shaw and my discussions with the Ministry that considerable effort was made on the part of prison health staff, the Aboriginal Medical Service (during temporary transfers to Mr Shaw's home area), staff at Royal Perth and members of the Aboriginal Visitors Scheme to explain to Mr Shaw the seriousness of his medical condition and to encourage him to manage and treat that condition appropriately. In addition, a temporary transfer to his home area was arranged for the purpose of facilitating contact with, and counselling from, elders from his community.
- 5.57 All of the above prisoners were Aboriginal men suffering from the chronic illnesses common to many Aboriginal people, and it is possible that their reluctance to manage and treat their health problems was due to the fact that prison nursing staff - the first and most accessible point of contact for all prisoners, particularly at the regional prisons - are predominantly white and female. There is no doubt that some older Aboriginal men - particularly those from remote communities - may well feel uncomfortable discussing some of their health problems with female prison staff and may be deterred from seeking medical assistance. This presents the Ministry with a problem because of the shortage of qualified Aboriginal health professionals and nursing staff. In my view⁶, however, the situation is exacerbated by the lack of regular and comprehensive cross-cultural training made available to prison health staff. I understand that the Director, Health Services is evaluating current cross-cultural training for health staff and is examining a means of presenting the program in the prison setting rather than 'off-site'.

- 5.58 As far as medical practitioners are concerned, Aboriginal Medical Services in both Geraldton and Broome are contracted to provide services to prisoners and one might expect that personnel from those Services would be more attuned to cultural and other indigenous issues.⁷ The Ministry also advised me that “...it actually does seek out the expertise and assistance of Aboriginal health professionals. For instance, until recently the Ministry employed an Aboriginal Nurse Manager at Greenough Regional Prison. Unfortunately, this person has resigned after some 18 months in the position.”
- 5.59 Availability of medical services tailored specifically for Aboriginal prisoners in the metropolitan area is far less common and there appears to have been little involvement by local Aboriginal Medical Services in prisoner health.⁸ The Ministry has pointed out, however, that Aboriginal Medical Services – in all areas - suffer from a similar shortage of qualified Aboriginal professionals. For example, the Ministry has informed me that GRAMS has supplied 12 different doctors in the past 11 months to Greenough Prison. In spite of the difficulties, the Ministry agrees that the availability of Aboriginal health professionals is of real benefit in the provision of effective health care to Aboriginal prisoners and has signalled its intention to purchase the services of Aboriginal nurses and health workers wherever possible, particularly in areas where there are significant numbers of Aboriginal prisoners. In this regard, I note⁹ that two Aboriginal nurses from Western Australia have recently graduated from a course at the National Centre for Epidemiology and Population Health in Canberra to become two of the first indigenous epidemiologists in the country. It seems to me that the Ministry should actively seek out the expertise and assistance of such Aboriginal health professionals.

RECOMMENDATION 5.3

That the Ministry make a greater effort to encourage the involvement of Aboriginal medical services, nursing staff and health workers at all prisons to assist in making prison health services more culturally appropriate and therefore more accessible to Aboriginal prisoners.

(b) Freedom of choice of medical treatment/right to a second opinion

- 5.60 The Coroner observed in Mr Isaacs’ case that prisoners have no freedom of choice in relation to medical treatment, although he also expressed the view that prisoners could “if sufficiently resolute or articulate, ...ask to consult a medical practitioner of his or her choice.”
- 5.61 *Health Services Policy 3.8* provides that a prisoner may seek a second opinion subject to the medical officer’s approval if he or she agrees to pay for it and the medical practitioner agrees to see the prisoner in the prison. It was suggested to me by prison health staff in the course of my inquiry that there is an apparent reluctance by specialist medical practitioners to see prisoners in a prison setting and that there were considered to be security implications of allowing access by, and facilities for, outside health professionals. The Ministry disagrees with this view and has told me that, in principle, Health Services has no objection to a prisoner seeing an external doctor or his/her own doctor prior to incarceration, provided the Director, Health Services deems the consultation appropriate, the doctor is willing to attend and the prisoner agrees to bear the cost.
- 5.62 Although I have received complaints in the past from prisoners whose requests for a second opinion from outside the prison system on any health issue had been refused - even if the prisoner or his/her family were prepared to meet all the costs of the consultation – this issue no longer appears to be a cause for complaint.

- 5.63 While not entirely convinced that it is either necessary or practical to accede to all requests from prisoners for outside medical opinions or treatment, I would be concerned if the likelihood of the success of a request for a second opinion was influenced in any way by operational considerations - I suspect that this may have been the case in the past. I have no doubt that it would be of benefit to the general standard of prison health services if visits by 'outside' health professionals were both encouraged and facilitated. In my view this could reduce the professional and personal isolation felt by many health services staff and increase professional awareness of prison 'forensic' medicine as an area of specialisation.

(c) Medical confidentiality an impediment to prison officers' duty of care

- 5.64 In his remarks following the inquest into the death of Geoffrey **Lindsay** at Greenough Regional Prison in 1997 the Coroner commented on the risks of heart attacks for Aboriginal prisoners and suggested that *"it would be particularly helpful if when a prisoner is identified as being at significant risk that fact is noted on the front of the medical file."* The Coroner also recommended that:-

"Where a prisoner suffers from a life threatening illness and consents to prison officers being advised of that situation, then it would be of benefit to prison officers and the prisoner if that information was made available.....In these cases it could be beneficial for prison officers to have access to the medical alert system."

- 5.65 In 1995 my predecessor made a similar recommendation¹⁰ that prison officers should, if the prisoner consented, be given more information affecting the health of a prisoner to enable them to better fulfil their duty of care. This recommendation arose from an investigation into the procedures for the allocation of work to two prisoners at Bandyup Women's Prison who subsequently suffered miscarriages.
- 5.66 To my knowledge my predecessor's 1995 recommendation was not implemented at that time. However, in its report in September 1999 to the Attorney General on the Coroner's recommendations concerning Mr Lindsay, the Ministry advised:-

"The Medical Alert System currently provides non-confidential medical information to management staff. This includes Prison Officers.....The risk categories on the form are 'Asthma', 'Cardiac', 'Diabetes', 'Epilepsy', 'Psychiatric' and 'Self Harm Risk'. The 'On Essential Medication', 'BBCD' and 'Urgency Flag' sections of the medical Alert System are also available to Prison Officers."

- 5.67 The willingness of prisoners to consent to information about their health problems being provided to prison officers will, of course, depend on their relationship with those prison officers and the level of trust between them¹¹.

(d) The lack of routine health reviews of long term prisoners

- 5.68 The Coroner questioned the absence of periodic health reviews of long term prisoners in his findings on the death of Peter **Cameron**, who died of natural causes on 11 January 1997 while on work release from Karnet. He said:-

"In the case particularly of long term prisoners there should be periodic reviews conducted of the prisoners' overall health involving a review of the medical notes with a view to identifying heart disease, stress related conditions, dietary problems and other self-health issues."

5.69 The Ministry's files indicate that Mr Cameron had had significant contact with prison health services dating back to 1992, resulting in various tests and his referral to external medical practitioners. However, contact with health staff had been primarily initiated by him rather than as part of a general review of his health as a long term prisoner.

5.70 In its review of the Coroner's findings (dated 6 August 1998), the Ministry did not support this recommendation on the ground that it would be "*extremely expensive and not consistent with normal community standards*". The review went on to say that:-

"Long term prisoners can request medical check-ups if they desire them. However, as in the community they choose this option, it would be inappropriate to put into practice routine check-ups which could have the effect of diverting scarce valuable resources away from more needy areas."

5.71 In the course of my consideration of this issue I looked at prison statistics for the year ended 30 June 1999 and found that as at 30 June 1999 there was a relatively small number of prisoners with an expected time to serve of more than five years (including those serving indeterminate sentences) - 538 out of a total of 2660 (20%) of whom 140 (26%) were Aboriginal.¹² Significantly, eight (35%) of the 23 prisoners who died from natural (or apparent natural) causes between 1991 and 30 June 2000 (four Aboriginal prisoners and four non-Aboriginal prisoners) were serving long (or indeterminate) terms of imprisonment. It seems to me, therefore, that the introduction of periodic health reviews could have long term benefits in reducing the number of deaths from natural causes.

5.72 I am pleased to note, therefore, from its response to my draft Report that "*The Health Services Directorate supports regular medical reviews and is in the process of addressing this matter*" that the Ministry now also appears to hold this view. I understand that it has recently introduced a program for monitoring and conducting outstanding annual health reviews.¹³

RECOMMENDATION 5.4

That the Ministry include regular health reviews of certain targeted groups of high health risk prisoners, such as long term prisoners (perhaps over the age of 40) and those who have been identified as having chronic health problems as a matter of routine in a formal health management plan for each prisoner.

(e) Initial medical assessment of prisoners

5.73 Section 39(b) of the *Prisons Act 1981* provides that the prison medical officer shall –

"on the request of the chief executive officer, examine a prisoner as soon as practicable after the prisoner's admission to prison and ascertain and record the prisoner's state of health and any other circumstances connected with the prisoner's health, as the medical officer considers necessary."

5.74 *Health Services Policy 1.1* provides that all new prisoners must "*have a nursing assessment completed within 24 hours of receipt or the next time a nurse is available when there is no 7 day nursing cover*" and "*must see a medical practitioner at the next available medical clinic.*"

- 5.75 The initial assessment of prisoners on admission is an essential health management tool for the identification of medical problems. Its importance was recognised by the RCIADIC which recommended in **Recommendation 156** that all Aboriginal prisoners should be medically assessed upon initial reception to prison. Where this was not possible, an assessment should be carried out by a medical practitioner or trained nurse within 24 hours. If the initial assessment was carried out by a nurse, assessment by a medical practitioner should be provided within 72 hours.
- 5.76 A similar recommendation [3(a)] had been made in 1988 in the *Report of the Interim Inquiry into Aboriginal Deaths in Custody* (the Vincent Inquiry) which stated that:
- “The medical examination given to prisoners in Department of Corrective Services institutions upon intake should include specific tests which are reasonably necessary to detect cardio-vascular and other cardiac complications.”*
- 5.77 The Ministry has been unable to tell me whether there was any response to this recommendation at the time although it appears that there was not. I understand, however, that the current initial medical assessment procedure includes seeking details of the prisoner’s medical history including that of his/her family; blood pressure measurement; a clinical examination of the cardio-vascular system and, if necessary, an ECG and referral to a specialist.
- 5.78 At the inquest into the death of Keith **Reynolds**, the Coroner commented on the fact that he had not been medically assessed within 72 hours of his admission to Broome Prison as recommended in RCIADIC **Recommendation 156**. The Coroner noted that in 1990 primary health care services for offenders in Broome Prison - where the majority of prisoners are Aboriginal - had been provided by the Broome Aboriginal Medical Service (BRAMS) but that they had terminated the arrangement after a short period of time because they were unable to meet the service demands. Responsibility for medical services had reverted to the Broome District Hospital which is located adjacent to the prison.
- 5.79 In its response to **Recommendation 156** in the 1995 Implementation Report, the Ministry acknowledged that it was aware that the initial medical assessment of prisoners did not always take place within 72 hours of admission at Broome Prison, largely because of “*limited medical resources in regional and/or remote locations or logistical difficulties associated with very short sentences.*”¹⁴ However, the possibility of extending nursing coverage at that prison was under consideration.
- 5.80 The Ministry advised me that, following Mr Reynolds’ death, arrangements were made to increase the number of ‘doctor’s parades’ to two per week, one provided by a medical practitioner under contract from BRAMS (who is also the Broome Public Health Physician) and the second by a medical practitioner under private contract (who works at Broome District Hospital). Although it concedes that there may still be occasions when prisoners – particularly those admitted on Friday afternoons following the Magistrate’s Court – may not be medically assessed within 72 hours, this is not seen as a concern because the Nurse Manager at the prison has the discretion to arrange an additional doctor’s parade if there are large numbers who have not been seen by a doctor. In addition, if the Nurse Manager has a concern about a particular prisoner she can arrange for him/her to be transferred to Broome District Hospital.
- 5.81 The issue of the timing of the initial medical assessment also arose in the death of Winifred **Michael**. Ms Michael was admitted to Bandyup at 12.45pm on Saturday, 20 December 1997. She was called up for the morning medical ‘parade’ on Monday, 22 December but does not appear to have been seen by a doctor. In evidence to the Coroner, it was stated that Ms Michael was not seen on 22 December “... *as a result of the number of patients to be seen and the time spent examining those patients....*” She was subsequently seen by a doctor on the morning of Tuesday 23 December, although the doctor told the Coroner that Ms Michael appeared reluctant to be examined and had to be called several times.

5.82 The Coroner stated:-

“As there are good reasons for ensuring that the requirement of section 39 of the Prisons Act 1981 that every prisoner be medically examined as soon as practicable after admission to prison is complied with, in cases where a prisoner is unwilling to be examined I would recommend that consideration be given to the best means of encouraging that prisoner to consent to an examination in the interests not only of the prisoner concerned but also in the interests of other prisoners and Ministry of Justice staff who may come into contact with the prisoner.”

5.83 I understand that, as a result of the Coroner’s comments, the Ministry has amended *Health Services Policy 1.1* (relating to *Admission and Transfer of Prisoners*) as follows:-

“The following Health Services Standards apply:

- 2.4 All offenders are assessed by a nurse to determine potential health risks as soon as practicable following admission or transfer.*
- 2.5 An offender will be seen by a medical practitioner as soon as practicable following admission.*
- 2.14 All offenders receive a health status clearance prior to transfer.”*

5.84 The Director, Health Services also issued the following memorandum to all health personnel on 10 November 1999:-

“As of 10 November 1999 all new prisoners will be examined as soon as practicable after admission to prison – those who are unwilling to be examined will be encouraged to do so at a later date. All efforts will be made to examine a prisoner on admission.

Medical officers will ensure that they document the fact and the reason for it in cases where:

- Prisoners refuse to be examined.*
- A reasonably thorough medical examination cannot take place.”*

5.85 The importance of the initial medical assessment for all prisoners is obvious. I note, however, that Mr Reynolds died some eight months *after* his initial admission to prison and had received treatment and hospitalisation for a heart attack during that time. On the basis of the new arrangements now in place it seems to me that the Ministry has taken reasonable steps to ensure that prisoners are assessed as soon as possible after receipt in prison.

5.86 In relation to Ms Michael, however, it is of concern that at a ‘busy’ prison such as Bandyup a prisoner might not be medically assessed until three days after her initial admission, either because she was admitted at a weekend or because there was insufficient time for her to see a doctor at an earlier session. Given the accepted vulnerability of a prisoner at the time of admission to prison and the growing number of prisoners who arrive at the prison suffering from the effects of drugs, I consider that a doctor should be on hand to conduct the initial medical assessment as part of the reception process rather than “*as soon as practicable*”.

5.87 In my view, this may be a matter of organisation - perhaps with better communication between the prisons and the courts – rather than a cost consideration. The proposal for the initial medical assessment to form part of the new reception procedure at the Hakea Assessment and Reception Prison will, I believe, be of considerable benefit to *male* prisoners. It will not, however, assist female prisoners¹⁵ and I believe that the Ministry should modify its reception process for female prisoners as a matter of priority.

RECOMMENDATION 5.5

That the Ministry examine the possibility of including an assessment by a medical practitioner at the initial reception of all new prisoners.

(f) Treatment of terminally ill prisoners

- 5.88 Although the Coroner did not make any recommendations in relation to the medical care provided to Raymond **Phillips**, who died of natural causes in December 1997, in its report to the Attorney General following the inquest the Ministry advised its intention to “.....institute a procedure to develop a management plan in the case of prisoners who are identified as terminally ill or chronically ill. This management plan will be developed by health personnel with input from prison administration personnel.” The policy, issued in September 1999, includes the following requirements:-
- involvement of a multi-disciplinary team comprising medical, nursing, FCMT and custodial staff;
 - an assessment of the feasibility and desirability of transfer to other institutions such as Casuarina or a hospice;
 - discussion of the management and placement options with the patient;
 - documentation in the medical record and a copy to the Director, Health Services;
 - periodic review consistent with the medical condition.
- 5.89 I also note that the Attorney General formulated a policy outlining the procedure for a request for a pardon for a terminally ill prisoner to bring forward parole.
- 5.90 The Coroner was, however, critical of the Ministry’s lack of sensitivity in the final hours of his life towards Colin **Shaw**, an Aboriginal prisoner who died in RPH on 1 October 1997. Mr Shaw, who was serving a life sentence, was admitted to RPH on 30 September for emergency treatment for a respiratory problem. In accordance with usual practice Mr Shaw was placed in mechanical restraints (leg-irons) following his admission to hospital. The restraints were removed when it became necessary at one point to resuscitate him but were replaced and remained until his death the following evening.
- 5.91 The Superintendent of Casuarina Prison gave evidence at the inquest that “ordinarily the restraints would remain in place unless there was some medical need for the removal.” It appears from the Ministry’s files that the prison officer guarding Mr Shaw asked hospital staff if they needed the restraints to be removed and was advised that this was not necessary as the restraints were not impeding medical treatment.
- 5.92 The Coroner stated:-
- “I recommend that the situation in relation to mechanical restraints be reviewed so that in circumstances where it is clear that no security issue is involved and a prisoner is close to death, immediate action can be taken by prison officers attending to remove such restraints.*
- While in the present case no family members were in attendance at the time of death, it can be distressing for family members to observe a dying person who is restricted by mechanical restraints. In addition relatively early removal of these restraints would allow a prisoner to pass away in circumstances of relative dignity.”*
- 5.93 As far as I have been able to ascertain, no other terminally ill prisoner has died in hospital while restrained. I have examined the range of statutory provisions and DGRs relating to the use of restraints in the context of a prisoner in a public hospital.
- 5.94 The relevant provisions in the *Prisons Act 1981* are:-
- *Section 27* which provides for the removal of a prisoner from a prison for medical treatment;

- *Section 42* which empowers a superintendent to authorise the use of mechanical restraints where in his opinion it is necessary to prevent a prisoner injuring himself or others; upon the advice of a medical officer on medical grounds; to prevent the escape of a prisoner during his movement to or from a prison or during a temporary absence from prison;
- *Section 42(3)* which provides that where restraints are applied for more than 24 hours, “*the use and the circumstances shall be reported forthwith to the chief executive officer by the superintendent.*”

5.95 The *Prison Regulations* do not deal with the use of mechanical restraints. Practices and procedures to be followed are contained in Director General’s Rules 2C and 3K.

DGR 2C (7.1–7.2) – Removal of a Prisoner for Medical Treatment states:-

7.1 Subject to sub-rules 7.2 and 7.3 the Superintendent shall order that a prisoner being removed to a hospital or other place of treatment who is rated maximum or medium security shall be placed in mechanical restraint.

7.2 Notwithstanding sub-rule 7.1 if the particular circumstances or nature of the treatment are such that mechanical restraint is, in the opinion of the Superintendent, not required in order to maintain the charge and supervision of the prisoner, the Superintendent may determine not to use mechanical restraints.

Of particular relevance to Mr Shaw’s case, sub-rule 7.3 states:-

Notwithstanding sub-rule 7.1 if the prisoner removed from a prison under Section 27 is placed in intensive care or the medical officer treating the prisoner is of the opinion that the death of the prisoner is imminent, the prison officer assigned to take charge of the prisoner may determine that the restraints be removed. That determination shall be referred to the Superintendent for confirmation or otherwise as soon as practicable thereafter.

DGR 3K (10 and 12) – Use of mechanical restraints states:-

10. A prisoner shall not be held in restraint for any longer than is necessary to control the behaviour in the specific situation.

12. In the event that a prisoner under guard in a public hospital is transferred to intensive care, the guarding officer shall advise the Superintendent of the prison as soon as practicable. Upon receipt of this advice if the prisoner is under restraints the Superintendent shall review the need for continuing the use of the restraints and make a determination. The record as provided in sub-rule 6 [of the use and circumstances when a mechanical restraint is employed] is to be amended accordingly.

5.96 In its report to the Attorney General on the Coroner’s recommendations, the Ministry advised that it supported a review of the use of mechanical restraints where a prisoner was close to death and that the relevant DGRs were being reviewed. As a result a draft Management Instruction (CW 9) entitled *Removal of a Prisoner for Medical Assessment / Treatment* includes the following:-

“If a prisoner has been placed in intensive care or the medical officer or the doctor in charge of the prisoner’s treatment at the hospital is of the opinion that the death of the prisoner is imminent, the prison officer assigned to take charge of the prisoner:

- *shall advise the Superintendent*
- *prior to advising the Superintendent the officer may determine that the restraints be removed*
- *the determination to remove the restraints shall be referred to the Superintendent for confirmation or otherwise as soon as practicable thereafter.”*

5.97 It is quite clear to me that the legislative and procedural framework already allows for the exercise of discretion in the continued application of restraints to a prisoner and not only where there are medical reasons for their removal. In this regard I note that DGR 2C sub-rule 8.2 provides:-

*“While exercising the primary responsibility with regard to the security and continued charge and supervision of the prisoner, a prison officer shall have **due regard in the circumstances to decency, self-respect and privacy** during the course of any medical examination or treatment.”* (my emphasis)

5.98 I also note that RCIADIC **Recommendation 163** recommended that prison officers (and police officers) be provided “...with training which positively discourages the use of physical restraint methods except in circumstances where the use of force is unavoidable. Restraint aids should only be used as a last resort.”

5.99 In my view, the reluctance by officers to remove Mr Shaw’s restraints indicates a tendency to adhere strictly to ‘procedure’ and may well reflect a lack of knowledge by prison officers of the extent of their discretion. Although I accept that the potential risk to safety of hospital staff and other patients is of paramount importance when considering appropriate security measures for certain prisoners, it is hard to visualise the actual threat posed by a prisoner who had been admitted to intensive care for emergency treatment and whose condition had necessitated resuscitation. Although not diminishing the importance of security in a public hospital, this case seems to me to be a further example of security considerations being inflexibly applied to a medical situation - a subject considered later in this Report.

RECOMMENDATION 5.6

That the Ministry ensure that officers are provided with sufficient training and guidance to ensure the sensitive and proper use of their discretion in relation to the application of restraints to prisoners in public hospitals.

(g) Health services subordinate to prison administrative considerations and regimes

5.100 During the inquest into the death of Mr Shaw concerns were expressed that it was not possible to provide him with dialysis treatment in the Infirmary at Casuarina. The then Director, Health Services gave evidence that one of the reasons why there was no dialysis machine at Casuarina was because the Infirmary was “*grossly unhygienic*”. This was the result of the practice of using Infirmary beds to accommodate prisoners who were “*healthy*” because of serious overcrowding in the prison. The Director also stated that he was unable to run the Infirmary as a hospital because he was over-ridden by prison authorities who had the ultimate control over who was placed in the Infirmary. He expressed similar concerns to me in the course of my inquiry.

5.101 The Coroner said in his findings on Mr Shaw’s death:-

“I support recent steps to improve conditions in the Infirmary at Casuarina Prison. I also support the proposition that the only prisoners housed in the Infirmary should be there on medical grounds and that the Infirmary should not be used to house prisoners who are not unwell but whose placement is difficult to effect elsewhere because of high prison muster levels as was the case in early 1999. While security considerations at the Infirmary must be the responsibility of the Prison Superintendent, all other issues having a bearing on the health of patients should come within the province of the Director of Health Services.”

- 5.102 In its report to the Attorney General on the Coroner's comments in Mr Shaw's case, the Ministry advised:-

"The Ministry of Justice is of the view that in normal circumstances only prisoners with medical needs should be placed in the Infirmary at Casuarina Prison. Further it is the Ministry's view that the most appropriate manner to manage the Infirmary at Casuarina Prison is through a joint partnership between custodial and health services. To this end the placement of prisoners within the Infirmary should be at the direction of health services staff and when requested, in consultation with Prison Management."

- 5.103 A further example arose in the case of Winifred **Michael** who, according to the prison doctor, was reluctant to be examined because she did not want to miss her lunch. Meals are served at all prisons in accordance with a strict schedule. Prisoners have told me that if they are not there for any reason (including medical appointments) they would almost certainly miss out on this meal.

- 5.104 On the other hand, the Ministry advised me in response to my draft findings that:-

"It is considered to be common practice for meals to be set aside for prisoners, upon request, where the prisoner is unable to attend the meal when it is served. Examples of this include a prisoner attending an external medical appointment, inter-prison visit and official appointment within the prison."

In the instance of prisoners attending an internal medical appointment, a meal will be set aside for the prisoner upon the request of a member of the health staff to the officer supervising the medical parade. That officer will in turn contact the officer in the kitchen, to request a meal be set aside for a prisoner."

Further, Bandyup Women's Prison has instituted a process whereby, 6 evening meals are prepared each day in addition to the muster requirements, to facilitate the provision of meals to prisoners received from court at the end of the day."

- 5.105 I understand that the practice of setting aside meals for prisoners who are unable to attend at the scheduled meal time has been in place for some time and that the preparation of additional meals at Bandyup to cater for prisoners arriving late from court was instituted following the transfer of prisoner transport to CCA on 31 July 2000. Both Hakea and Casuarina set aside meals for prisoners who are attending court. Casuarina prepares additional meals for new receivals and also sets aside some cold food to cater for any additional prisoners. Hakea continues to check numbers of receivals it is likely to receive.

- 5.106 The issue of medical decisions and procedures being effectively over-ridden by medically unqualified prison staff was a recurring theme in submissions to my inquiry and is commented upon throughout this report in relation to the treatment of both sick prisoners and those identified as at risk of self harm. I am satisfied that this is a relatively common occurrence.

- 5.107 Ms Michael's reluctance to miss her lunch is not as flippant as it might sound to the uninformed nor, in my view, does it indicate that Ms Michael was indifferent to her own health. I have received complaints in the past from prisoners at Bandyup that the high musters sometimes resulted in there being insufficient food at mealtimes. I am also aware that the attitude of the prison is that meals are available only within certain times. As prisoners are not permitted to take food (other than a piece of fruit) with them out of the dining room – and may be charged with a prison disciplinary offence for doing so - it would not have been possible for a friend to save some food for Ms Michael and I suspect that, because she was a new prisoner, the officers may also not have considered that option.

- 5.108 I have been told that inflexible adherence to prison regimes resulting in prisoners missing their meals is not unique to Bandyup. For example, prisoners at Casuarina told me that they can miss out if the issue of medication in the Units conflicts with the serving of a meal. In addition, nursing staff at several prisons have told me that they are frequently required to complete their initial medical assessment of prisoners arriving late in the afternoon from court more quickly than they are comfortable with because they are pressured by prison officers to finish to fit in with prison routine. In Ms Michael's case, fear of missing her lunch may have had tragic consequences.
- 5.109 In my view, all of the above examples illustrate the low priority afforded to prisoner health care and breach the basic principle that prisoners are entitled to medical treatment of equivalent standard to that available to them in the community. The conflict between prison administrative decisions and regimes and prisoner health care is, in my view, a major impediment to the provision of an adequate health service which meets generally accepted community standards of medical practice. This issue is considered in greater detail in Chapter 6, paragraphs 6.126-147.

RECOMMENDATION 5.7

That the Ministry ensure that a culture prevails within prisons that permits health services personnel to make decisions about the health care of prisoners which pay proper regard to non-health issues but which are, essentially, based only on an assessment of what is in the best medical/health interests of the prisoner.

Issue 3: Prison Diet

- 5.110 In 1988 the Vincent Inquiry recommended that "*The diets of prisoners be reviewed to take account of special dietary requirements of Aboriginals as a preventative measure against heart disease.*" (R3(b)). It appears that the then Department of Corrective Services took little or no action to implement that recommendation.
- 5.111 The adequacy of the prison diet was subsequently considered during the inquest into the death of Keith **Reynolds**, an Aboriginal prisoner who died in Broome District Hospital in October 1995 after suffering a heart attack in Broome Prison. The Coroner observed:-

"...the current catering policy is dated the 5th September 1989 which predates the Royal Commission. It is well known that Aboriginal people are at higher risk of heart disease than other sectors of the population. In a prison environment there is the very real potential for prisoners to put on extra weight given the daily food routine and lack of exercise (recreational pursuits are optional)."

He also referred to the importance of giving proper consideration to providing appropriate, low cholesterol, low fat meals. The Ministry advised the Coroner that a dietician was appointed in November 1996 to review prison diet and recommend possible improvements.

- 5.112 The issue was raised again during the inquest into the death of Peter **Cameron** - also an Aboriginal prisoner - who died in January 1997 during a thirty-six hour home release from Karnet. In this case the Coroner recommended that the "*recent moves towards providing low-fat meals as an alternative to normal prison food be encouraged by the Ministry*". The Ministry's review of the Coronial findings, dated August 1998, referred to the progressive introduction of those initiatives.

5.113 In spite of Ministry assurances that it had implemented most of the recommendations made in the 1996 review, during my visits to prisons in the course of this inquiry I received numerous comments from prisoners and officers about the continuing absence of healthier alternatives to “normal” prison food. Both officers and prisoners complained that the ‘healthiness’ of prison food in some prisons does not meet reasonable standards and that the prison diet in general is still too high in fat. A number of officers said that they had observed a beneficial change in the behaviour and demeanour of prisoners who had a diet which was lower in fat.

5.114 In response to my request for a report on the outcome of the dietary review in late 1996/97¹⁶, the Ministry advised that the review had made ten “high priority” and eight “low priority” recommendations involving *inter alia*:-

- reduction in fat content in meat and milk;
- replacement of red meat by fish and chicken;
- provision of fruit;
- review of the system of vegetable provision;
- changes to lunch menus and preparation of evening meals;
- culturally appropriate meals.

5.115 Although I was advised in late 1998 that “All high priority recommendations have been addressed and implemented...[and] two [lower priority] have been implemented” the comments made to me during my prison visits appeared to indicate that the recommendations had not been implemented in practice at all prisons. On further enquiry, the Ministry advised me that “All high priority recommendations are being addressed” and has now advised me that 16 of the 18 recommendations “have been implemented or are in the process of being implemented”. In addition it has provided me with the following information on prisoner diets:-

“The Ministry’s catering services current practice is to provide a nutritionally balanced diet in compliance with the National Australian Nutritional guidelines. Concurrently improvements are also being made in training and the standard of food handling to be consistent with community standards and the food safe standards currently awaiting ratification by ANZEA.....”

Recent efforts to reduce the quantity of fat in all prison diets have been successful. Menus are generally in line with current external catering trends. This has included a review in cooking methods to delete the use of roux’s and include methods of cookery to allow for the extraction of saturated fats.

Considerable investment has been made in the milk packaging and processing plant. The current installation of new equipment will deliver skim and low fat milk into the system, further reducing the animal fat intake up to 24g per day.

The current menu includes alternatives to red meat, ie. chicken, fish, pasta and rice dishes now represent an increase in availability of 25 % on that of past menus.

Fresh fruit is issued daily with extra fruit issued to those prisoners confined to special medical dietary requirements, as is skim milk in fresh or powdered format. Additionally fruit based desserts have been increased in frequency.

Vegetable production has continued to develop across the system with the establishment of production gardens on new sites and continuing improvement in growing schedules to meet demand.

Cyclic menus are ratified by a qualified dietician as documented by the inspectorate report - Wooroloo August 1999 and are changed seasonally.

In April of 2000 a pilot program was introduced in four regional prisons with a high percentage of Indigenous Australians to supply one meal per week of kangaroo product with some considerable impact on associated expenditure. The introduced program has performed well with high acceptance of the product. Surveys within metropolitan prisons have shown a poor response to the introduction of Kangaroo product therefore deeming it a non-viable alternative. Notwithstanding the product is made available for days of cultural significance and at times of BBQ on an ad hoc basis."

- 5.116 The availability of an appropriate diet, particularly for Aboriginal prisoners and elderly prisoners, is clearly an integral part of managing the health problems associated with those groups of prisoners. It is also, in my opinion, a cost-effective preventative health measure. Although in my view the Ministry's response to a problem of which it been aware for more than a decade was too slow, the steps which it has taken are encouraging. On the basis that complaints about food to my Office are now almost non-existent, it would appear that the improvements have been effective.

RECOMMENDATION 5.8

That the Ministry constantly monitor the standard of prison diet and ensure that it meets the needs of those groups of prisoners for whom an appropriate diet is essential in the management of their health.

Issue 4: Health Facilities and Equipment

(a) The placement of elderly prisoners

- 5.117 In its investigation into the death of Francis **Lord**, an elderly prisoner who died from head injuries after falling from a landing at Fremantle Prison, the IIU observed that more sensitivity could have been shown in regard to his placement by allocating him a ground floor cell. He had apparently been relocated from the third floor to the first floor after a number of prisoners expressed their concern that he was having difficulty in negotiating the stairs.
- 5.118 Although prisons today do not operate on a 'landing' system, appropriate accommodation for elderly and infirm prisoners is becoming an increasing problem which absorbs considerable resources. Currently there are four cells in the Infirmary at Casuarina for geriatric and wheelchair-bound prisoners and I understand that Acacia will have a 20-bed Geriatric Unit. There are, however, no similar facilities (or plans to establish such facilities) for prisoners requiring this type of accommodation at other prisons.
- 5.119 As at 30 June 1999 there were 57 prisoners in Western Australian prisons aged 60 years or older, of whom, 32 were over 65 years. These numbers had increased from 47 and 24, respectively, as at 30 June 1998. At 30 June 1999 there were also 56 prisoners in the 55-59 year category.
- 5.120 The Ministry has also provided me with data which it has recently compiled on the age of prisoners within the system from 1994-2000. The figures are consistent with the data in Table 2.6 of this Report and show a significant increase between 1997 and 2000 in numbers in the 30-40, 40-50 and 50-60 year groups.
- 5.121 Care of the elderly is resource intensive - whether in the community, a community institution or within the confines of a prison. The general issue of the 'ageing' of sections of the prison population and the cost-implications for health services are matters which the Ministry should consider in its forward planning of health care needs. However, I am not convinced that this currently occurs to the extent that it should. For example, I understand that prisoners are frequently used at Casuarina to assist in the care of elderly and infirm inmates.

- 5.122 The Ministry is of the view that it is “*appropriate for health staff to rely on other prisoners to ‘supplement nursing resources’ and that it is considered beneficial for prisoners to have other prisoners looking after them.*” Although I am told that some prisoners enjoy and can benefit from performing that role - and provided great care is taken in their selection, can be very good at it – in my opinion it would be unacceptable if the Ministry’s capacity to provide geriatric nursing care were dependent on the availability of suitable prisoners.
- 5.123 Although the opening of the Crisis Care Unit at Casuarina has relieved pressure on Infirmery beds which were frequently used for at risk prisoners, the ‘ageing’ of the general population is already having an impact on prison admissions which include an increasing number of elderly prisoners. The planned geriatric facility at Acacia will obviously cater for elderly prisoners in the metropolitan area. However the impact of this changing demographic will need to be factored into the Ministry’s forward planning of specific types of accommodation across the system. If the data referred to above (paragraph 5.121) are collected on an ongoing basis it will obviously be of value in monitoring likely future health care needs.

RECOMMENDATION 5.9

That the Ministry include in its future accommodation plans for the prison system the likely requirement to house and care for an increasing number of elderly and geriatric prisoners and provide appropriate resources and facilities.

(b) Equipment

Resuscitation equipment

- 5.124 In the case of Shaun **Rawlings** (1996, Casuarina), the oxy viva resuscitation device was not brought to the cell by the Hospital Officers when they received the emergency call and had to be requested by them with the result that it was not available for use until twenty minutes after Mr Rawlings’ body had been discovered. Whether or not earlier availability of the equipment would have increased the likelihood of Mr Rawlings’ resuscitation is not clear. However, in his findings the Coroner recommended that the oxy viva device in each unit should be readily accessible to Hospital Officers attending all wings of the unit.
- 5.125 In his findings at the inquest into the death of Wesley **Doorey** (1997, Casuarina) the Coroner commented that the speed with which ligature compression of the neck caused unconsciousness and death emphasised the need for prison staff to be able to respond quickly in emergency situations and recommended that the Ministry make every effort to ensure that this was possible; that the defibrillator be properly maintained and replaced when necessary; and that all other necessary resuscitation equipment be readily available at all times.
- 5.126 The Ministry’s review of the Coroner’s findings in Mr Doorey’s case stated that oxy viva and air viva devices are now located in all units at Casuarina and that discussions had been held with St John Ambulance to determine the most suitable types of resuscitation equipment for use in the prison environment.
- 5.127 The Ministry recently confirmed that oxy viva and air viva units are now located in all units at all prisons but that defibrillators are available only at Casuarina and Hakea. I also understand that an electrical ambulance trolley is now in use at Casuarina. In this regard, it seems to me that **RCIADIC Recommendation 159** has been implemented. I became aware, however, that refresher training of prison officers in resuscitative measures (**RCIADIC Recommendation 160**) was significantly in arrears when I visited prisons across the State in 1998. The Ministry has advised me that rising muster levels limited the ability of superintendents to release prison officers to attend such training but that in the past 12-18 months, considerable effort has been made to address this deficiency with the result that around

350 officers have been updated in the past year. In addition, officers have been trained as instructors at several prisons and the Ministry has access to an outside facilitator. Although the situation has improved, the shortfall in training of this nature is of concern and there is clearly some way to go before Recommendation 160 can be said to be fully implemented.

- 5.128 In his findings on the death of Dean **Lauder** (May 1998, Canning Vale) the Coroner was critical of the fact that the prison officer who discovered Mr Lauder's body did not indicate that there had been a hanging in his radio call for medical assistance or that there might be a need for the defibrillator. The reason given was that the officer considered it unwise to refer to a hanging over the radio as it might be heard by other prisoners and cause alarm. In Mr Lauder's case, although the Hospital Officer who attended the cell immediately commenced resuscitation procedures, she did not bring the defibrillator which was not used until ambulance officers arrived some minutes later. The Coroner stated:-

"While I recognise that there are good reasons for not openly referring to the fact that a hanging has taken place in a radio call, it should be possible to implement a code which could alert the hospital officer to the nature of such an emergency.

I accept that in this case early use of a defibrillator would not have altered the outcome as it would appear that the deceased had already died when he was discovered, but it could have been an important factor in resuscitation efforts had the deceased been located sooner."

- 5.129 The Coroner recommended that "*a code should be developed so that hospital officers called to the scene of a hanging by radio are made aware of the situation and can make a decision as to whether or not it would be helpful to take a defibrillator immediately to the scene to assist with resuscitation attempts.*"
- 5.130 I share the Coroner's concern that the Hospital Officer called to Mr Lauder's cell was not alerted to the nature of the emergency. Prison officers are required under DGR 3B 3.1 "*...to facilitate access to necessary medical care for prisoners in their custody whose health is at risk irrespective of the cause of the condition requiring care*" (my emphasis). The failure by the prison officer to alert medical staff to the nature of the emergency involving Mr Lauder, albeit well-intentioned, might well be seen as an example of a prison security consideration (the possibility of having to deal with prisoners who were 'alarmed' or upset by the death of a fellow prisoner) being regarded as more important than the need to seek urgent medical attention for a prisoner – although I cannot conclude that this was necessarily the case. The Ministry has recently advised me that the Coroner's recommendation has been implemented at prisons where there is 24 hour nursing coverage. Because at prisons where there is no 24 hour coverage, implementation of the recommendation will require an amendment to Local Orders, the implementation process is ongoing.

RECOMMENDATION 5.10

That as a priority all prison staff be given initial or refresher first aid training, including the use of resuscitation techniques and equipment.

Emergency Cell Alarms

- 5.131 The RCIADIC recommended (**Recommendation 140**) that all cells in prisons and police watch-houses should be equipped with an alarm or intercom system which allows direct communication with prison/police officers. The Ministry did not respond specifically to this recommendation in the 1994 and 1995 *Government Implementation Reports* but the 1997 report notes that it had been "*partially implemented*". However, I understand that cells in all but minimum security prisons are equipped with emergency cell alarms.

- 5.132 There was clearly no system in Broome Prison in 1995 as - although not considered a contributory factor in the death - the Coroner commented on the lack of an alarm in Keith **Reynolds'** cell and suggested that the Ministry should "...on an ongoing basis reassess whether some form of alarm system can be installed that is still audible to officers completing night patrol duties..."
- 5.133 I understand that a system was subsequently installed at Broome although, during my visit to that prison in the course of this inquiry, prison staff expressed concern that the system was unreliable because of the effect of the tropical wet season on electronic devices; that malfunctions could not be readily fixed because of a lack of local expertise and that the system had a limited life. The Ministry acknowledged that there had been intermittent problems after the initial installation of the system and that it had, as a result, replaced the main controller unit. I have also been advised that a local company has been trained by the supplier to provide ongoing maintenance of the cell call system.
- 5.134 The issue of the recording of the activation of cell alarms in Cell Call Contact Forms and on audio-tape arose during the inquest into the death of Winifred **Michael** in relation to discrepancies in the medical condition of Ms Michael as observed by fellow prisoners and by prison health staff. The prisoners who gave evidence to the Coroner stated that Ms Michael appeared to be "very unwell" and "doubled up in pain" whereas the medical and cell call records referred simply to "cramps". The Coroner noted:-

"In this Inquest hearing Cell Call Contact Forms provided important evidence in relation to the medical condition of the deceased at night.

Accurate completion of the Cell Call Contact form may also provide important information to prison officers at the time of changes of shift etc as to earlier complaints.

Evidence at the Inquest indicated that the form is under review by the Ministry of Justice and that in the near future a new form is to be introduced for prisons throughout the State.

This review is supported and it is recommended that the following deficiencies in the present form which were identified during the hearing should be addressed –

- (a) The name of the officer who receives the call and the name of the officer who attends the cell should be clearly recorded on the form....*
- (b) The concern expressed by the prisoner should be recorded if possible in the prisoner's own words and should be in a separate section of the document from any record of any action taken by the prison officers..."*

- 5.135 The Coroner also commented on the fact that the cell call system:-

"...allows for the tape recording of conversations between prisoners who have activated the Emergency Cell Call and prison officers. These tapes, however, have not been maintained or reviewed since 1997.

In my view the recording system should be maintained and in cases of deaths in custody or deaths of prisoners after release where treatment while in custody may be relevant, the tapes should be preserved and made available as evidence. In this case if the tape recordings of the cell calls had been available, a much better appreciation of the condition of the deceased may have been possible.

In addition, the use of tape recording of cell calls may be used to check the reliability of notations on the Cell Call Contact form from time to time. Particularly with the implementation of the new form, it would be helpful to compare handwritten records with a tape recording of the actual communications."

- 5.136 In its report to the Attorney General on the Coroner's findings in May 2000, the Ministry advised that it had reviewed the Cell Call Contact Form and would introduce the revised version incorporating the Coroner's recommendations in June 2000. It also signalled its intention to instruct all prisons to utilise the facility to tape record conversations between prisoners who have activated the alarm and prison officers and to implement random checks of the new Cell Call Contact Forms in comparison with the tape recordings.
- 5.137 It seems to me that the presence of an effective and well-maintained alarm system is not only desirable in the interests of the health and safety of prisoners, it is *essential* given that the majority of units in all prisons are unmanned at night (after lockup)¹⁸. Its importance is illustrated by a complaint to my Office involving a suicide attempt by a prisoner in Casuarina – where units are generally unmanned at night.
- 5.138 In this case I received complaints from a number of prisoners about the length of time taken by officers to respond to an emergency cell call by a prisoner who woke during the night (at 1.15am) to find his cellmate hanging from a cupboard door by a bedsheet. This prisoner activated the emergency cell call before trying to support his cellmate's weight and remove the sheet from the cupboard. Having received no response within five minutes of pressing the button, he roused the prisoners in an adjacent cell who in turn woke other prisoners, all of whom pressed their cell call buttons while the first prisoner continued his efforts to save his cellmate.
- 5.139 When there continued to be no response to any of the alarms, the prisoners began shouting to attract attention. All of the prisoners involved stated that, after about twenty minutes, two prison officers appeared and started to walk towards the unit without any apparent urgency. When they got closer and realised the seriousness of the situation they called for a Hospital Officer who treated the prisoner who had attempted to hang himself. The prisoner recovered fully and his cellmate was commended for his actions.
- 5.140 On investigation, the Ministry found that there had been a malfunction in the cell call system that night (the calls registered in the unit control room were not displayed at the front gate control room). However, the malfunction does not appear to have been noticed or addressed until at least half an hour after it first occurred. In my view, there are two aspects of this case which are of concern. First, it emphasises the need for officers on duty in the front gate control room to be alert to signals on the display panel, particularly 'error' lights. Second, it illustrates the additional risks for prisoners accommodated in units which are not manned at night and that it is unsafe to place too much emphasis on technical devices in suicide prevention strategies.

SUMMARY OF RECOMMENDATIONS

That the Ministry:-

5.1.

- (a) in the short term, formalise the current procedure for sending a prisoner's medical records with him/her on transfer to another prison to ensure the minimum risk of a breakdown in communication between prison staff; and
- (b) in the medium to long term, give a high priority to the introduction of a computerised system of storing medical records to ensure that they are accessible at all prisons to authorised personnel without delay.

5.2.

- (a) ensure that there is an efficient and effective system in place so that an appropriate record is made of every telephone consultation concerning the health care of a prisoner and that such record is placed on the prisoner's medical file; and

- (b) monitor regularly, by audit or other means, the quality of record-keeping by health services personnel and implement a strategy of action for any staff member not meeting the required standard.
- 5.3. make a greater effort to encourage the involvement of Aboriginal medical services, nursing staff and health workers at all prisons to assist in making prison health services more culturally appropriate and therefore more accessible to Aboriginal prisoners.
- 5.4. include regular health reviews of certain targeted groups of high health risk prisoners, such as long term prisoners (perhaps over the age of 40) and those who have been identified as having chronic health problems, as a matter of routine in a formal health management plan for each prisoner.
- 5.5. examine the possibility of including an assessment by a medical practitioner at the initial reception of all new prisoners.
- 5.6. ensure that officers are provided with sufficient training and guidance to ensure the sensitive and proper use of their discretion in relation to the application of restraints to prisoners in hospitals.
- 5.7. ensure that a culture prevails within prisons that permits health services personnel to make decisions about the health care of prisoners which pay proper regard to non-health issues but which are, essentially, based only on an assessment of what is in the best medical/health interests of the prisoner.
- 5.8. constantly monitor the standard of prison diet and ensure that it meets the needs of those groups of prisoners for whom an appropriate diet is essential in the management of their health.
- 5.9. include in its future accommodation plans for the prison system the likely requirement to house and care for an increasing number of elderly and geriatric prisoners and provide appropriate resources and facilities.
- 5.10 That as a priority all prison staff be given initial or refresher first aid training, including the use of resuscitation techniques and equipment.

1 See also Chapter 10

2 An Aboriginal prisoner died of an overdose in 1994

3 For a more detailed consideration of prison transfers see Chapter 15

4 See my 1999 Annual Report at page 47

5 The Director, Health Services has advised me that the availability of a number of sessional GPs ensures that there are sufficient doctors to provide medical services to metropolitan prisons

6 See also Chapter 6 paragraphs 6.46-6.50 and 6.96-6.100

7 Both Mr Richards and Mr Lindsay were treated by practitioners from the Geraldton Aboriginal Medical Services

8 The issue of an appropriate health service for Aboriginal prisoners is considered further in Chapter 6 at paragraphs 6.35-6.50

9 Extract from the *West Australian* dated 13 March 2000

10 "That the Ministry of Justice review the current levels of communication between the medical and prison staff with a view to establishing an information system more in line with the spirit of the 'Pregnancy Policy' while at the same time taking in to account the requirements of medical confidentiality.

In making the above recommendation, I am conscious that it will be necessary to ensure that the needs, wishes and expectations of individual prisoners are recognised. Prisoners would need to sanction the transfer of information to staff other than medical staff and to define what information they were willing to have divulged."

- 11 The issue of prisoner/officer relations is considered further in Chapter 10, paragraphs 10.24-10.33, Chapter 11, paragraphs 11.23-11.44 and Chapter 15, paragraphs 15.17-15.30
- 12 Between 1 July 1998 and 30 June 1999, of the 3886 sentences commenced, 329 (8.5%) were for periods of 5 years or more. Twenty two of those were life or indefinite sentences. Fifty six (17%) of these sentences were imposed on Aboriginal prisoners.
- 13 See also Chapter 6, paragraphs 6.120-6.124 and Chapter 11, paragraphs 11.107-11.109
- 14 Extract from a statement by the then Manager Health Services for the inquest into Mr Reynolds' death; 16 June 1996
- 15 See Chapter 6, paragraphs 6.62-6.66 for further discussion on the provision of health services to female prisoners
- 16 The review was conducted by N Lampard and was entitled "*Dietary Issues within Western Australian Adult and Juvenile Justice Institutions*"
- 17 See Appendix 1
- 18 During those hours, unmanned units are patrolled by a small number of officers known as 'the Recovery Team'