

CHAPTER 6 EVALUATION OF THE PERFORMANCE OF PRISON HEALTH SERVICES

INTRODUCTION

THE HEALTH NEEDS OF PRISONERS

ARE PRISONER HEALTH NEEDS MET?

INSUFFICIENT RESOURCES

LOW PROFILE OF HEALTH SERVICES

LACK OF COMPREHENSIVE FORWARD PLANNING

OTHER FACTORS

SUMMARY OF CONCLUSIONS

SUMMARY OF RECOMMENDATIONS

INTRODUCTION

6.1 As long ago as 1978 the Nagle Royal Commission in New South Wales recommended that:-

“..in all cases the appropriate test for the provision of medical and other health care should be whether it is necessary for the health of the prisoner. Prisoners should receive the same medical and health care as a private citizen. The cost of such provision is no answer to necessity.” (my emphasis)

6.2 The Ministry’s *Standards for the Delivery of Health Services* (April 1999) state that the aim of its health services 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....”

6.3 Although not specifically stated in that mission statement, the underlying - and universally accepted - principle by which prison health services are measured is that they should be equal to that available to the community. That means that cost and logistical difficulties created by the prison environment should not generally be used as justification for not providing that equality of service.

6.4 A large proportion – possibly the majority - of submissions to my inquiry raised concerns about the standard and adequacy of prison health services. An equally large number of issues were also raised in the course of interviews with prisoners, prison officers, prison health staff and outside organisations. It is quite clear from the issues identified in individual prison deaths and the number of comments about prison health care in submissions and interviews that there are wide-ranging concerns among prisoners and health services staff about the adequacy of health services. Only one prisoner said that he thought the health service was “*excellent*”.

6.5 I must emphasise, however, that I have not interpreted the absence of compliments about the service as significant. What is significant is that there were relatively few complaints about *individual* prison health staff other than a number of comments about verbal abuse and rough treatment by unidentified Hospital Officers at Casuarina and the complaints about a former prison doctor referred to in Chapter 5. Most prisoners were concerned about the adequacy and accessibility of the health services available to them rather than the quality of those that were provided.

6.6 Health services staff were also concerned about the adequacy of the services that they were able to provide and frequently expressed the view that, in the long term, a shortfall in ‘*quantity*’ would eventually impact on ‘*quality*’. Taking this a step further, I agree with the view expressed in a submission¹ that “.....*appropriately resourced, committed and responsible provision of health services would contribute to an improvement in patient care and welfare.....*”

6.7 The consistency of the theme in submissions and interviews that prison health services are “*starved*” of funding and under-resourced led me to consider this issue closely in order to establish whether there was substance to this view. Having considered and explored the range of services provided to prisoners and the way in which those services are provided, I have reached the conclusion that health services have been for the most part under-resourced and under-staffed primarily because prisoner health care has been, and still is to an extent, in reality, considered of lesser importance than prison operations and security issues by some sectors of prison administration.

- 6.8 It is unclear whether the Ministry accepts in principle the view expressed by the Nagle Royal Commission that “*The cost of such [equal to community standards] provision is no answer to necessity*”. What is quite clear is that health services have to compete with security considerations for the scarce ‘corrections’ dollar and have frequently come off second best. Competition becomes fiercer because an assessment of the ‘performance’ of the prison system tends to be measured from the negative aspect of the number of escapes and the number of prisoner deaths - rather than from the more positive aspect of successful rehabilitation resulting in a reduced rate of recidivism and a generally healthier and more manageable prison population. In this regard, I note RCIADIC **Recommendation 328**² that “*sufficient resources be made available to translate the principles [of Standard Guidelines for Corrections] into practice*”. In other words, it is not enough to say that the principles of the *Standard Guidelines* and the RCIADIC recommendations have been implemented if funding and resources are inadequate to permit those principles to be reflected in everyday service reality. The recent increase in funding for health services referred to in Chapter 4 – Table 4.3 and paragraphs 4.33 and 4.34 – is therefore a welcome improvement.
- 6.9 Security within prisons may be the emphasis demanded by society - and I am not suggesting that the escape of an offender who has been sentenced to a term of imprisonment for the protection of society should not be of concern. However, the fact is that most prisoners are released to the community at some stage and, in my view, whether they continue to present a risk to society *after their release* should be of equal concern to the community. I interpret ‘risk’ to include not only risk of re-offending but also health risks. Ultimately, society bears the cost of prisoner health care to a very large extent, whether it is provided during a term of imprisonment or after release.
- 6.10 In relation to the importance of prisoner health to the community, HM Chief Inspector of Prisons (UK) wrote in the introduction to his 1998 discussion paper entitled “*Patient or Prisoner?*”:-
- “Prisoners are entitled to the same level of health care as that provided in society at large. Those who are sick, addicted, mentally ill or disabled should be treated, counselled, and nursed to the same standards demanded within the National Health Service. **Failure to do so could not only damage the patient but also put society at risk.**”* (my emphasis)
- 6.11 Later in the same paper³ the Chief Inspector noted:-
- “Health for the individual is part of the overall quality of life and health for everyone. Every penal establishment is a small part of the wider local community, which should be seen as an organic whole. Health standards affect all who work and live within the establishment. Staff, prisoners, visitors and contractors all contribute to the overall well being of each other....*
-A prisoner’s health and health care before offending has an impact on what happens in prison, both to the individual prisoner and more widely. A prisoner’s health care in prison can, for example, for those with mental disorder or substance abuse, be a major factor in their well being and chances of re-offending on release. However obvious those statements, they emphasise the interdependence of health care in prisons and in the wider community.....”*
- 6.12 I agree entirely with this view. I also believe that the successful rehabilitation of an offender is as important to the safety and welfare of the community as the security of that offender within a prison. In this regard I consider it significant that in 1998/99 almost *two thirds* of Western Australia’s prisoners had served one or more previous prison sentences as shown in **Table 6.1** on the next page:-

Table 6.1 Previous Sentences for Prisoners 1998/99

No. of Previous Sentences	Aboriginal	Non-Aboriginal	Total	% of Total Prisoners
0	343	943	1286	36 (37)*
1	211	342	553	15 (15)
2	168	208	376	11 (10)
3-5	329	302	631	18 (17)
6-10	282	148	430	12 (13)
11-15	125	37	162	5 (5)
16-20	45	7	52	1.5 (2)
21-25	18	1	19	0.5 (0.5)
26 and over	24	0	24	1 (0.5)
Total	1545	1988	3533	

*The figures in brackets are the % of total prisoners for 1997/98

6.13 An analysis of these figures shows that:-

- 1318 prisoners (38%) had served 3 or more sentences
- 647 prisoners (20%) had served 6 or more sentences
- Of the 257 prisoners (8%) who had served 11 or more sentences, 212 (82%) were Aboriginal

6.14 In my view, the ‘health’ of an offender in its broadest sense⁴ will make a significant contribution to his or her chances of successful rehabilitation. However, the figures in Table 6.1 appear to indicate that a large proportion of prisoners reoffend. In this chapter I set out the reasons why I believe that the Ministry’s Health Service does not meet the health needs of its patients.

THE HEALTH NEEDS OF PRISONERS

6.15 Prison health staff have told me, and it is widely acknowledged, that prisoners as a group have probably the worst health of any group in the community due to, *inter alia*, background and life-style; a generally low level of education; lack of employment; physical, sexual or mental abuse; a perception of low self-worth; and lack of appreciation of the importance of health to their overall wellbeing. Many offenders entering the system do not know how to manage or improve their general health and present prison health services with a wide range of health problems - some of which are chronic or life-threatening or a risk to the health of other prisoners and staff.

6.16 Within the general prison population there are also particular types of prisoner with special health needs whose management and treatment are likely to require specialised medical services involving more extensive care and facilities and significantly higher expenditure. These include the elderly; Aboriginal prisoners; substance abusers; female prisoners; long term prisoners; those with communicable and chronic diseases such as HIV/AIDS and Hepatitis C; and prisoners who are psychologically or psychiatrically disturbed.

- 6.17 The fact that these groups of prisoners present a range of health problems which are likely to absorb a disproportionate amount of the health services budget does not absolve the Ministry from accepting and discharging its responsibility to treat offenders who are admitted to prison with serious pre-existing conditions, even if that involves the employment of more staff and a commensurate increase in the allocation of health services funding. The treatment of small but costly prisoner groups cannot be compromised by lack of funding nor can it compromise the provision of health services to other less-demanding groups of prisoners.
- 6.18 In terms of my inquiry it is significant that all the ‘costly’ groups could also be considered ‘high risk’ either in terms of self harm and suicide or simply to the extent that their poorer physical health increases the likelihood of their dying while incarcerated.
- 6.19 Of the 65 prisoners who died in prison between 1991 and 31 December 1999³ from either suicide or apparent suicide, natural causes or accident, **40** fell into one or more of the special needs groups -
- 5 were aged 48-50
 - 1 was aged 51-62
 - 6 were aged 63-74
 - 14 were Aboriginal, of whom 4 were aged 41-45
 - 11 were known to have a history of substance abuse to a greater or lesser degree;
 - 14 were long term prisoners – (7 serving 5-10 years; 7 serving indeterminate sentences)
 - 11 of the above fell into two or more groups

Each group presents health services with slightly different problems.

‘Elderly’ prisoners

- 6.20 Care of the elderly is resource intensive and potentially very expensive because of the range and intensity of treatment needed to deal with health problems associated with ageing. The ‘ageing’ of Australia’s population generally is already having an impact on prison admissions which include an increasing number of elderly offenders. Moreover, the growing trend towards longer prison sentences means that prisoners are ‘growing old’ while incarcerated.
- 6.21 In a paper examining the implications of elderly inmates for prison authorities⁶ released in May 1999 the AIC stated:-
- “The number of prisoners over 50 years of age is increasing – either because people are entering prison relatively late in life, or because they are serving longer sentences and growing old in prison.*
- This poses new challenges for Australian correctional administrators. Older prisoners may be expected to experience more health problems than their younger counterparts, and the cost of keeping them in custody will be that much greater.”*
- 6.22 The paper compares the cost of health care for elderly inmates as “second only to providing care for HIV/AIDS sufferers” and as “of the order of three times more expensive than required for the care of younger inmates. Kidney failure, advanced heart disease, lung cancer from increased smoking and other cancers are far more prevalent among the elderly than the young and middle-aged.”

- 6.23 At the same time there is also an indication that the life-style of some offenders may result in problems usually associated with the process of ageing at a much earlier stage. An American study⁷ noted this phenomenon in 1993 and suggested that “.....*although chronologically [these] inmates may be 55 years old, biologically their bodies are often much older.*” In the case of Aboriginal prisoners, there appears to be a premature onset of health problems which normally affect non-Aboriginal people much later in life.⁸ In this regard it is not unreasonable to consider Aboriginal prisoners in their mid 40s as ‘elderly’ for the purposes of their health.
- 6.24 It appears that there has been little research conducted on the issue of ‘elderly inmates’ in Australia nor is there information available on approaches taken by Australian correctional authorities to deal with the problem. However, studies in the United States and Europe describe the “*specialised care*” provided to elderly inmates, as including “*chronic care clinics, preventive care and increased frequency of physical examinations. In addition, more than half the correctional departments in the United States report that special nutrition/dietary care and housing and the use of inmate aides to provide non-medical assistance, are available to elderly inmates in particular jurisdictions.*”⁹
- 6.25 In summary, the AIC paper emphasises that there is a need for research in this area to “*identify the gaps in service provision to this increasingly (and often disproportionately expensive) group of inmates*”. It stresses not only that “*...failure to anticipate such population and cost increases may place further constraints on correctional budgets in the near future...*” but also that, as stated by the AMA in the Preamble to its Position Paper, “*elderly ex-prisoners may go on to contribute to the caseloads of community health and welfare systems*” if not properly treated while in prison.
- 6.26 The AIC’s prediction of an ageing prison population is confirmed in its paper - “*Australian Corrections: Main Demographic Characteristics of Prison Populations*”, released in April 2000 – which reports that there was an increase in the median¹⁰ age of prisoners between 1988 and 1998 from 28.2 to 30.0 years for males and from 28.7 to 29.8 years for females. During the same period there had been an increase in the median age of admission to prison from 26.8 to 28.4 years for males and from 27.9 to 28.9 for females.
- 6.27 The age group which showed the greatest increase for male prisoners was for those aged 35 and over, with a significant increase in those aged 60 and over. The percentage of males aged under 25 had decreased and the 25-34 year group had remained relatively stable. Although there was a similar increase in the number of female prisoners in the 34-54 age group, the research found an increase in females aged 19 and under over the ten years from 1988-98 but a decline in those aged 20-34.
- 6.28 On the basis of its research the AIC found that the increase in the median age appeared to be attributable to an increase nationally in the median expected time to serve rather than the median length of sentence (which had declined) and that prisoners are being admitted at older ages. On the age of admission, the AIC commented “*This finding has important implications as it suggests that significant shifts in the length, duration and intensity of criminal careers may have occurred during the ten years of this study.*”
- 6.29 I note that this issue was also raised in a submission by the Director of the New South Wales Legal Aid Commission to the New South Wales Legislative Council Select Committee on the Increase in Prisoner Population on 19 October 2000 in relation to the likely need for “*nursing home accommodation*” for prisoners serving lengthy life sentences.¹¹
- 6.30 There are currently four beds in the Infirmary at Casuarina for elderly or disabled prisoners and three prisoners who are considered ‘geriatric’. Although I understand that the opening of the Crisis Care Unit at that prison has relieved pressure on Infirmary beds for ‘at risk’ prisoners, the need for some prisoners - such as the elderly or disabled - to be housed permanently in the Infirmary inevitably reduces its capacity to house other sick prisoners. It also raises the question of placement if the number of elderly and/or disabled prisoners exceeds four. I understand, however, that health care facilities at Acacia will include a 20-bed Geriatric Unit.

- 6.31 The Ministry has also advised me that it has undertaken a “*cohort study of age groups in Western Australian prisons. The trend of each age is potentially more useful for planning purposes than the median age of the prisoner population. These trends will continue to be monitored by the Health Services Directorate and factored into planning for continued health service delivery.*” To assist in the care of the three geriatric prisoners in the Casuarina Infirmary, the services of the Aged Care Assessment Team (ACAT) are utilised to assess each prisoner and provide a management plan for their future care.
- 6.32 As noted in Chapter 5, the Ministry has found that the numbers of older prisoners – in the 40-60 age groups has increased significantly since 1997. If this trend continues – and there is more evidence that it is likely to than not – there are significant implications for prison health services in terms of the nature of service required, resources and accommodation.
- 6.33 In addition to the requirement for special facilities, the AIC also argues that “*Careful staff recruitment and selection for sensitivity to the unique requirements of elderly inmates should be an important consideration for correctional administrators. Many people may not have the aptitude or the essential skills needed to manage elderly people.*” Other than the employment of a number of staff with a mental health background, it does not seem to me that the Ministry has given consideration to the employment of specialist aged care staff.
- 6.34 In relation to the aged care unit at Acacia the Ministry has advised me that:-

“...the preferred model of assessment at Acacia will encompass a broader notion of “aged care” which is not driven by the date of birth of a person but rather the medical problems associated with ageing. It is noted that Aboriginal people tend to experience ageing related to medical problems at a younger age than non-Aboriginal people. This is reflected in the assessment process CCA will provide at Acacia.

In respect of older prisoners CCA will:

- provide a comprehensive assessment on admission of all prisoners who appear to fit this category;*
- provide quarterly medical examinations for Aboriginal prisoners from age 50;*
- provide quarterly medical examinations for non-Aboriginal prisoners from age 60; and*
- a specific unit for aged prisoners who cannot reasonably be accommodated elsewhere.*

The unit will provide ground floor accommodation in close proximity to the Health Centre. Nursing support and medical assistance will be readily available.

Special fixtures and fittings of assistance to the frail and infirm will be provided throughout the Unit and assistance with cleaning, washing and cooking will be provided by staff and/or prisoner peer support program.

Aged prisoners will be allocated to a case manager (counsellor) who will ensure that the prisoner’s IMP [Individual Management Plan] reflects assessed needs and that the prisoner is provided with appropriate opportunities for involvement in work, education, programs and recreation.

CCA is currently involved in discussion with Aged Care Services (Australia) to be involved in providing ongoing support for elderly prisoners, post-prison after care and staff training in the special needs of the elderly.”

Aboriginal prisoners

- 6.35 Recent¹² Australian Bureau of Statistics figures stated that the death rate for Aborigines was up to seven times higher for all age groups than that of the total Australian population from 1995-97. The figures showed that of the Aborigines who died in that period, 53% of men and 41% of women were aged under 50 and that circulatory disease, injury, respiratory disease, cancer and diabetes were the main causes of death. It was also claimed that Aborigines had a higher death rate than their indigenous counterparts in New Zealand and North America.
- 6.36 At a 1998 Aboriginal health symposium in Perth, the late Dr Charles Perkins referred to the widening gap between Aboriginal and non-Aboriginal health and quoted from a 1997 report to the effect that the death rate of Aboriginal males (in the general population) aged from 20-35 was eight times higher than that of non-Aboriginal males of similar age. He attributed the problem partially to an apparent lack of confidence by Aboriginal people in 'mainstream' medicine and urged the establishment of more Aboriginal Medical Services - which he believed took a more holistic approach to the health of individuals because they were closer to the community and appreciated the importance of culture and other social issues.
- 6.37 The facts and the statistics on the poor health of Aboriginal people are irrefutable. It is, therefore, inevitable that Aboriginal offenders are more (although not exclusively) likely to be admitted to prison with a wide range of serious health problems – diabetes, heart disease, kidney problems, asthma, alcohol and smoking-related diseases and deafness. This is especially so of Aborigines in the 40-45 age group but could also be expected in a much younger age group than for non-Aboriginal offenders.
- 6.38 Consequently, as discussed in Chapter 5 (at paragraphs 5.4-5.8), the statistics show that Aboriginal prisoners die from natural causes at a much higher rate than their non-Aboriginal counterparts. Twenty three prisoners died from natural or apparent natural causes between 1 January 1991 and 25 June 2000. Ten of the total were Aboriginal. Six were relatively young men (aged from 35-46) who died of heart attacks (Edward Isaacs, Keith Reynolds, Graham Richards, Peter Cameron, Geoffrey Lindsay; an unexpected heart attack is also the suspected cause of death of Gerald Woods whose death has not yet been subject to inquest). A seventh, Colin Shaw, was 41 and suffered from many of the health problems common to indigenous Australians. He died from complications associated with diabetes.¹³
- 6.39 In the same way that young white males on remand or in the early part of a sentence of imprisonment are generally considered to be at highest risk of suicide and self-harm, there can be little doubt that Aboriginal prisoners are likely to present prison health services with the highest risk of serious life-threatening health problems.
- 6.40 The AMA's *Position Statement* includes a special section (Clauses 11.2 - 11.5) relating to the health care of Aboriginal and Torres Straits Islander People which states:-

“Aboriginal and Torres Straits Islander prisoners should be ensured access to Elders and to relevant representatives of their communities to address their beliefs and needs.

Aboriginal and Islander cultural beliefs and practices which relate to health and health services must be respected in the design and implementation of Aboriginal and Islander health care programs in all correctional facilities.

Medical and other health professionals involved in the provision of services to Aboriginal and Islander people in correctional facilities should at all times be aware of, and sensitive to, Aboriginal and Islander culture.

Appropriate, on-going, orientation courses in Aboriginal and Islander culture should be conducted for all health workers in correctional facilities.”

- 6.41 In terms of the size of the problem, Aborigines represent a substantial proportion of the population of most prisons in Western Australia and nationally. Eighty percent of prisoners in prisons such as Broome, Roebourne and Greenough and 60-70% at Eastern Goldfields are likely to be Aboriginal. The fact is that caring for this 'special needs' group of prisoners with potentially poorer health than the rest of the prison population is both cost and labour-intensive and also presents the Ministry with a range of cultural problems. Significantly, it also offers the opportunity for the Ministry to undertake a primary role in the delivery of health education and preventative programs designed to deal with the health problems of indigenous prisoners. The Ministry *must* take that reality into account in planning and resourcing prison health services.
- 6.42 The issue of general health care provided to Aboriginal prisoners, was the subject of RCIADIC **Recommendation 152** -
- “Corrective Services in conjunction with Aboriginal Health Services should review the provision of health services to Aboriginal prisoners and have regard tothe extent to which services provided are culturally appropriate for and are used by Aboriginal inmates.....”*
- 6.43 It seems to me that Recommendation 152 raises two questions when evaluating prison health services. First, are they adequate to meet the health needs of Aboriginal prisoners? Second, are health services staff properly trained to ensure that the service provided is sufficiently culturally appropriate so that Aboriginal prisoners will want to utilise it?
- 6.44 In the 1995 *Government Implementation Report*, the Ministry responded that implementation of this recommendation was “ongoing” and that it had undertaken an audit of health services utilisation “as a precursor to the medical needs analysis review.” It was, however, unable to provide me with a report on the outcome of this audit or on the action – if any - it has taken as a result. The 1997 Implementation Report describes the review of the provision of health services to Aboriginal prisoners by “Corrective Services and Aboriginal Health Services” as “ongoing”. I am not aware of any specific action which has been taken by the Ministry in relation to health services for Aboriginal prisoners and I am not convinced that sufficient attention is paid to this group of ‘special needs’ prisoners in terms of future planning or staff training. The Ministry has advised me that it endeavours to employ Aboriginal health staff wherever possible (in line with RCIADIC **Recommendation 178**) and I acknowledge that the shortage of qualified Aboriginal health professionals is also a problem faced by Aboriginal Medical Services and by HDWA.
- 6.45 Although no findings of lack of care have been made in the inquests into the deaths of Aboriginal prisoners from natural causes, the Coroner made the observation that some appeared not to have confidence in, or feel sufficiently comfortable with, the prison health service. This was perhaps a surprising finding in relation to prisoners at Greenough where medical services have been provided by the Geraldton Aboriginal Medical Services for some time. I have, however, been told that reluctance on the part of some Aboriginal men (particularly those from remote communities) to discuss medical problems with *prison* health staff may stem from the fact that prison nurses are predominantly white and female.
- 6.46 Although I am pleased to note that the extent of training available to all prison health services staff has been significantly increased during the past year, in my view, the general shortage of Aboriginal health staff working in the prisons and the difficulties the Ministry seems to encounter in recruiting Aboriginal nursing staff and health workers emphasise the need for a greater focus on awareness of Aboriginal cultural issues and health problems endemic among Aboriginal prisoners.

- 6.47 Alternatively, the Ministry could take a different approach by encouraging Aboriginal community groups which already provide health services to Aboriginal people in the community to take a more active role in providing health services to prisoners. For example, the objectives of the Aboriginal Medical Service in Perth (now known as Derbarl Yerrigan Health Services) are to provide “*an Aboriginal community controlled holistic health care network which develops, promotes and maintains Aboriginal People’s physical, spiritual, social, economic and cultural well-being.*”¹⁴ During the course of my inquiry the Executive Director and personnel of Derbarl Yerrigan expressed both willingness and enthusiasm for greater involvement in prison health services. However, the current lack of resources and a certain amount of hostility from some prison staff (both health staff and prison officers) experienced from their prior limited involvement had deterred them from making more positive overtures to the Ministry. I understand that the Director Health Services has recently discussed ways in which the expertise of Aboriginal Medical Services might be more widely used in the delivery of health care to prisoners and is encouraged by the positive response.
- 6.48 Similarly, the *Albany Health Promotion Unit* (AHPU), a health programme of the Southern Aboriginal Corporation based in Albany and funded by the Health Department’s Office of Aboriginal Health, provides health education and health promotion services for Aboriginal people in communities of the great southern region. The philosophy of the AHPU is that “*Health promotion is the process of enabling people to prevent illness, improve the quality of life, prevent premature deaths, improve their health status, have control over their health and lifestyle.*” The AHPU’s aim is to “*promote culturally appropriate healthy life style behaviours in all Aboriginal people.*”¹⁵
- 6.49 The Coordinator of the AHPU told me that the Unit would be willing and able to do more at Albany Prison than the current occasional provision of self-esteem programmes which, I note, have been requested by the Aboriginal Visitors or by the prison Education Officer and not by health services staff. The Director, Health Services has also approached the AHPU on this issue and has told me that the matter is under discussion.
- 6.50 It seems to me that increased involvement by Aboriginal community health units such as Derbarl Yerrigan and the AHPU would go a long way to implementing the spirit of RCIADIC Recommendation 152. I also suggest that those groups may be able to provide a valuable source of training for prison staff.

Prisoners with a history of substance abuse

- 6.51 This issue is dealt with in some detail in Chapter 12 of this Report. For the purposes of this chapter it is sufficient to note that the number of young substance abusers being admitted to prison is growing; that they form a high risk group in terms of both vulnerability to self harm and health problems associated with substance abuse and that the nature of some of those problems - such as HIV and Hepatitis A, B and C - is also of grave concern to prison staff and fellow prisoners. Prior to publication of its *Position Statement* in October 1998, the AMA cited the following statistics:-

*“60-83% of inmates have an alcohol/drug problem
20-25% use heroin and 64-69% share needles
33-66% are Hepatitis C carriers¹⁶
34-46% have been exposed to Hepatitis B
more than 70% smoke while 33-44% use marijuana ”*

6.52 A recent report released by the AIC on 4 May 2000 demonstrates the links between illicit drug use and crime based on information gathered from people detained in police lockups in Queensland, New South Wales and Western Australia (East Perth). It found that:-

- 43% of detainees whose most serious charge was a property offence tested positive for opiates;
- 75% of detainees tested positive to one or more illicit drugs;
- Cannabis was most commonly detected with 62% of men and 56% of women;
- Overall, opiates were the second most common with 39% of men and 22% of women;
- Around 33% of all detainees said that they had sold drugs for money;
- 50% said that they had been arrested before in the past 12 months;
- 17% reported that they had been imprisoned during the past 12 months

6.53 The report also found that the rate of positive tests at the lockups in Sydney was almost double that in Western Australia and Queensland. Although both Queensland and Western Australia showed lower levels of opiates there was a relatively high number of positive results for cannabis.

6.54 In terms of actual numbers, prisoners suffering the effects of substance abuse are by far the biggest 'special needs' group entering the prison system. The Smith Inquiry said that the problem was so extensive that it would be safer to presume that a young offender entering the prison system used illicit substances than that he or she did not. At page 27 of his findings on the death of Winifred Michael the Coroner noted:-

“At this Inquest hearing evidence was given to the effect that up to 80% of new prisoners may be suffering from withdrawal symptoms.”

6.55 A significant factor in relation to prisoner health – in addition to the increased risk of self harm and suicide by prisoners in withdrawal – is, as stated by the Coroner in Ms Michael's case:-

“This case has highlighted the fact that withdrawal symptoms may mask or be similar to symptoms caused by serious illness.....”¹⁷

6.56 The Ministry estimates that there are approximately 200 prisoners in the system who are Hepatitis C carriers although it realises that the exact figure is difficult to estimate because screening is voluntary. The Director, Health Services has told me that the prevalence of Hepatitis C among prisoners is increasing and is likely to have a significant impact on prison health services because of the long term health implications of infection. On the basis of existing data, it is estimated that 5-10% of Hepatitis C carriers will develop liver failure or liver cancer. Both these conditions require intensive nursing care. These figures may also mean that 20-60 prisoners may experience liver problems in the next ten years. If 10% of those needed hospitalisation while in prison, two to six additional infirmary beds would be required. However, as much of the treatment of Hepatitis C affected patients can be performed on an 'outpatient' basis, the predicted number of extra beds is thought to be the 'worst case scenario'.

6.57 The proportion of those developing life-threatening consequences of exposure is small but given the numbers of prisoners with the infection and the large numbers of prisoners who reoffend and return to prison, the long term impact on the provision of health services could be substantial. This is clearly an area for which the Ministry will need accurate and regular data and which it will need to properly monitor on an ongoing basis.

- 6.58 In spite of the size – and seriousness - of the problem of substance use affected prisoners, there are no special detoxification facilities at *any* prison in Western Australia. Prisoners with serious physical withdrawal symptoms entering Casuarina may be placed in the Infirmary and those considered at greatest risk of self-harm may be housed in the Crisis Care Unit. Similarly, the Crisis Care facilities soon to be commissioned at the Hakea Reception Centre and those planned for Bandyup may also serve this purpose. Nevertheless, because of the limited facilities at Casuarina and Hakea and the lack of facilities at other prisons – and until the facilities are available at Bandyup - it is more likely that a prisoner suffering withdrawal symptoms will receive medication for the symptoms and remain in his/her own (usually shared) cell.
- 6.59 There is currently a limited methadone program for certain categories of prisoner (those who are either HIV positive; pregnant; or on short term remand and who had been participating in a methadone program in the community prior to being imprisoned). Until recently, counselling or rehabilitation programs for those with a substance abuse problem have been concentrated at the end of the sentence largely, I am told, because of limited resources and funding. I understand that this situation is now changing and that programs are available for remand prisoners with the general aim that rehabilitation programs will be provided throughout a prisoner's sentence.
- 6.60 Moreover, due to lack of time and resources, it is also not the practice of the FCMT to routinely see prisoners in withdrawal unless they have been assessed as 'at risk' of suicide or self harm.¹⁸ As far as I am aware, very few members of the health services staff are experienced in substance abuse issues or treatment and there is little opportunity for training in such issues provided by the Ministry.
- 6.61 The management of substance abuse is a highly cost-intensive health issue which, as far as I can see, currently receives very little special funding – funding was provided for the Naltrexone Treatment Pilot Program. To my knowledge there is also no proposal in the Ministry's future plans for additional facilities or the provision of specialised staff other than those who provide pre-release substance abuse programs. The Ministry has, however, commissioned the development of a range of new drug treatment strategies which are nearing completion.

Female prisoners

- 6.62 The number of female prisoners as a proportion of the total prisoner population is both nationally and at State level significantly smaller than for their male counterparts. The AIC reported in its most recent paper on prison demographics that the national ratio had remained relatively stable at 5.3% in 1988 and around 5.7% in 1999. However, in a submission this year to the New South Wales Legislative Council Select Committee on the Increase in Prisoner Population, the AIC reported that the number of Indigenous women prisoners nationally had increased by 148% between 1988 and 1998 – from 105 to 261 and that the rate of Indigenous women's imprisonment had increased by 36.9% from 162.8 per 100,000 in 1988 to 223 per 100,000 in 1998.
- 6.63 The ratio in Western Australia as at 30 June 1999 for female prisoners as a proportion of the total prison population, was somewhat higher than the national average at around 7% of the total (186 sentenced (92 Aboriginal) and 41 unsentenced (15 Aboriginal)) and had increased from 5.3% in 1988 (94 sentenced and 14 unsentenced)¹⁹. As at 30 June 2000, female prisoners represented 8% of the total prison population in Western Australia (201 sentenced prisoners (72 Aboriginal) and 47 unsentenced (21 Aboriginal)). It seems to me that, because they form such a small proportion of the overall prison population, it is more likely than not that female prisoners have become to a considerable extent the forgotten minority. The continued increase in the number of female prisoners will require a distinct shift in future planning, particularly in the regional prisons.

- 6.64 I have frequently been told that health service requirements are greater at a prison such as Bandyup because women tend to utilise health services more frequently than men. This view is supported by the experience of community health services, which suggests that women of all age groups are more health-conscious and visit a doctor more frequently than their male counterparts. Pregnancy, of course, brings with it a range of additional needs. The health problems of female prisoners are frequently exacerbated by the effects of substance abuse and the fact that a large proportion entering the prison system have a history of physical and sexual abuse.
- 6.65 Given that this is the case, the health facilities available to female prisoners are, in my view, inferior to those provided in the male prisons. For example, it was only after my predecessor's inquiry into health services at Bandyup in 1995 that 24-hour nursing coverage was introduced and a two-bed infirmary established. There are currently neither designated crisis care nor detoxification facilities - although the 'infirmary' beds can be used for this purpose. Ante-natal care is provided at the prison by prison health staff although prisoners are routinely reviewed by King Edward Memorial Hospital staff prior to delivery at that hospital. Post-natal care is provided within the prison by prison nursing and medical staff. Bandyup also has a nursery for mothers and children up to the age of 12 months. At regional prisons which house female prisoners there are no health services, facilities or programs with a female focus. The new health care facilities proposed in the refurbishment of Bandyup will be a welcome - but long overdue - improvement in the conditions for women prisoners at *that* prison.
- 6.66 I have not specifically discussed the provision of health care to female prisoners elsewhere in my report because particular 'female' health issues were not raised in the investigation of the deaths of Winifred Michael and Tammy Green. Nevertheless, as a small, identifiable group of 'special needs' prisoners, health services for female prisoners are in my view in great need of expansion and improvement. This is particularly so in view of the increasing number of female offenders entering the system. As indicated above, the number of female prisoners more than doubled between 1988 and 1999.

Long term prisoners

- 6.67 The National Prisoner Census conducted on the night of 30 June 1998²⁰ reported that in Western Australia 433²¹ (21%) of a total of 2054 prisoners had an expected time to serve of five years or more. Of those, 110 (5.3%) were Aboriginal. Of sentences commenced in the year to 30 June 1998, 8.9% were of more than 5 years' duration (247 out of a total of 2774), of whom 57 (23%) were Aboriginal.²²
- 6.68 The census for the following year (conducted on the night of 30 June 1999) shows that the number of prisoners with an expected time to serve of five years or more in Western Australian prisons had increased to 533²³ although the percentage was actually smaller than in 1998 - 20% of a total of 2660 prisoners. One hundred and forty (5.2% of the total) were Aboriginal.²⁴ Of the sentences commenced in the year to 30 June 1999, 329 (8.5%) of 3886 were for periods of 5 years or more, of which 22 were life or indefinite sentences. Fifty six (17%) of the total number of long term sentences were imposed on Aboriginal prisoners.²⁵ As far as health service resourcing is concerned it is the actual numbers of prisoners, rather than the percentage, which is significant.
- 6.69 During the period reviewed in my inquiry, 11 prisoners who died either by suicide, apparent suicide or from natural (or apparent natural) causes were serving sentences of five years or more and nine were serving indeterminate sentences (27% of the total of 74 deaths from all causes between 1 January 1991 and 30 June 2000). With the current trend towards longer sentences, the prison system is likely to see an increasing number of prisoners who are serving longer sentences and who will inevitably become susceptible to the health problems associated with ageing and the general problems of being in prison for a lengthy period of time.

- 6.70 Some commentators observe that long term prisoners provide the ‘balance’ in the prison system. They know the system; have accepted that prison is going to be their ‘home’ for a lengthy period of time and play a valuable role in ‘calming’ down younger prisoners to the overall benefit of the whole system. On the basis of the extremely useful input to my inquiry by a number of long term prisoners I am sure that this the case.
- 6.71 However, not all long term prisoners are able to accept prison as ‘home’. As one prisoner wrote in a submission “*at any time people hit rock bottom and every person handles their low times differently*”. In fact, although they may well provide the ‘balance’ in the system, it is universally accepted that instead of becoming resigned to their fate, some long term prisoners present one of the highest risks of suicide when feelings of hopelessness about the present and the future become predominant.
- 6.72 It seems to me that the knowledge that certain prisoners will remain in the system for some years provides the prison authorities with both the responsibility - and the ideal opportunity - to monitor that prisoner’s health and provide a structured program of health education and preventative strategies. This does not occur in any systematic way at present. I have been told by prisoners and prison officers that a prisoner with a long sentence was quite likely, after an initial orientation, to be told “*see you in ten years*” or whenever pre-release activity begins – the onus being on the prisoner to initiate action in relation to his/her health education and employment needs.
- 6.73 This approach was aggravated by the Ministry’s previous position that regular routine health reviews for long term prisoners are too expensive and would not occur in the community. That was a short-sighted approach to the health management of long term prisoners and ignored the obvious benefits - in both welfare and cost terms - for the prisoner, the prison system and the community. I am pleased that the Ministry now takes a different view. I also understand that the Ministry’s new Integrated Prison Regime, incorporating a revitalised Case Management system, will improve the situation for long term prisoners.

RECOMMENDATION 6.1

That the Ministry:-

- (a) **monitor the level of accommodation and service required by special needs groups of prisoners particularly those suffering the effects of substance abuse; those with a psychiatric disorder; and female prisoners (particularly those in regional prisons) and ensure that its future accommodation plans include adequate facilities for their placement and care.**
- (b) **enhance its current health services for Aboriginal prisoners by:-**
- **initiating formal discussions with community health groups such as Derbarl Yerrigan Health Services and the Albany Health Promotion Unit with a view to encouraging and establishing their greater involvement in the provision of health services to Aboriginal prisoners; and**
 - **providing adequate funding to enable the Ministry to take advantage of and co-ordinate any specialist services, advice and training that Derbarl Yerrigan and other Aboriginal health groups may be able to provide to prison staff.**
- (c) **provide routine health reviews for long term prisoners as part of a structured and certain sentence plan which includes education, employment and rehabilitation programs.**

ARE PRISONER HEALTH NEEDS MET?

- 6.74 Although I am not suggesting that health staff do, or are likely to, treat a prisoner other than as an individual, the question of the cost involved and the resources and facilities available will inevitably be a factor in the extent and the quality of the treatment provided. This is not entirely unreasonable because, as in every other public sector agency, there are budgetary limitations. However, what is of concern to me is that the budget allocated to health services does not seem to take into account the actual *needs* of prisoners in the system or the resource implications of treating a significant number of prisoners with extensive and possibly resource-intensive health problems. It is only comparatively recently that the Ministry has taken into account the budget implications for health services of a simple increase in prison musters!
- 6.75 In my view there are a number of factors which have limited the Ministry's ability to provide an efficient and effective prison health service which meets community standards. Broadly, these factors are:-
- Insufficient resources
 - Low priority of health services
 - Lack of forward planning capacity

INSUFFICIENT RESOURCES

- 6.76 RCIADIC **Recommendation 328** recommended that "*sufficient resources should be made available to translate those principles [in the Standard Guidelines for Corrections in Australia] into practice.*" In my view, the Ministry has for a number of years failed to implement this recommendation in practical terms because of shortages of suitably and appropriately trained staff and adequate facilities; and the lack of structured and ongoing health education and preventative strategies and regular health reviews for certain prisoner groups.

Shortage of staff

- 6.77 I have reached the conclusion that the current health staff establishment is insufficient to provide both the range of services required by prisoners and the standard of service necessary to meet community standards.
- 6.78 In November 1998, the then Director, Health Services advised me that as at 1 July 1998 there were 71.45 (FTEs) nurses and 3.8 (FTEs) medical officers and stated that:-

"It would be beneficial if there were more nurses in the system.

The benefit would assist in providing a comprehensive health screening and greater health education to prisoners with the objective of generally improving the overall health status of the population.

The current nursing services provided are not used as efficiently as they might and this can be related to several issues which include:

- *Difficulty in recruiting permanent suitably qualified nurses*
- *Limited or delayed access to prisoners related to prison routine and security issues which take priority over health*

- *Inefficient communication systems including computer information and communication with prison operations eg timely notification regarding movements*
- *Amount of nursing time taken to issue a continual increase in prisoners' medication."*

- 6.79 He also advised me in November 1998 that a national shortage of nurses had a greater impact on prison nursing than in other fields because of a tendency for nurses to prefer to work via agencies so that they can choose their shifts and area of work. As a result, "...Prisons do not rank highly in this nurse directed employment environment even though there is a higher level of pay offered and paid orientation available..." He said that there were even greater problems in finding suitable staff for regional prisons which are forced to rely on casual and agency staff which "... leads to fragmented services and extra pressure upon permanent staff."
- 6.80 In view of the situation, the then Director expressed the view that the Ministry may need to look at other options such as increasing the level of clerical support to relieve nursing staff of administrative duties and considering the employment of enrolled nurses. He attributed the difficulty in recruiting medical practitioners to the uncompetitive remuneration offered and the cumbersome, uncoordinated and protracted recruitment process.
- 6.81 Although the Ministry has more recently advised me that the current number of nursing FTEs has increased to 84.65 and that "*staffing levels have been maintained at a close proximity to the allocated FTE...*", I understand that the difficulty in recruiting nursing staff remains in spite of a recent pay increase, largely because of the national shortage of nurses and the poor profile of prison nursing.
- 6.82 The situation regarding medical practitioners in the metropolitan area was critical throughout 1999 with only 3.8 FTEs available assisted by an insufficient number of sessional GPs. Although there are now only 3.5 FTEs – which equates to 35 sessions per week, the number of additional sessional doctors now available to Health Services means that it would be possible to hold an additional 10 sessions per week if there was the demand and the level of service to all prisons in the metropolitan area is now greatly improved, with additional sessions at Bandyup and Hakea. I understand that the greater interest is due, at least in part, to the Ministry's decision to offer remuneration comparable with that available to doctors in the community. Medical services are provided at the regional prisons by local practitioners under contractual arrangements; the local Aboriginal Medical Services provides primary care at Greenough and one practitioner in Broome.
- 6.83 In his 1995 report on health services at Bandyup my predecessor suggested that "*...the Ministry should consider putting in place a mechanism whereby the provision of extra staff could be triggered by a significant increase in the number of nursing contacts...*" because "*...these figures might provide a more accurate basis for the provision of extra staff than the number of prisoners per se which may not necessarily reflect the general health care requirements of prisoners in Bandyup at any one time.....*"²⁶
- 6.84 Twenty-four hour nursing coverage was introduced at Bandyup in May 1996 as a result of my predecessor's inquiry. However, there is still no mechanism whereby an increase in staffing levels is triggered by a rise in muster levels or the number of nursing contacts - although I understand that nurse managers have the discretion to increase nursing hours if they consider it necessary. An increase in the number of doctor's parades – as indicated above - is also becoming more possible with the greater availability of sessional medical practitioners.
- 6.85 In my view, there is no doubt that health services are under-resourced in terms of staff establishment. Although this may be due, in the case of nurses, to the national shortage and the perception that prison nursing is unattractive, I suggest that there may be a number of ways in which this field of nursing could be made more desirable.

- 6.86 From my observations, health services staff cope with a heavy workload in order to fulfil the routine health needs of prisoners. There is little time, if any, to become involved in health education and preventative medicine or alternative therapeutic initiatives, and very little opportunity to acquire new skills or expertise. The lack of clerical support at some prisons; the time spent in issuing an increasing amount of medication; and the absence of the FCMT and Prisoner Support Officers at weekends²⁷ place additional demands on nursing staff, possibly at the expense of nursing duties, and certainly limit the ability of nurses to become involved in health education – an essential role in my view and one which could add variety to the work and may increase job satisfaction. In addition, raising the profile of prison nursing generally as an accepted area of specialisation through greater association with teaching institutions could have a beneficial, although more long term, effect.

RECOMMENDATION 6.2

That the Ministry consider the following strategies to address the shortage of nursing staff:-

- (a) promotion of prison nursing as a specialised field of expertise which should be accredited and taught as a unit in the tertiary nursing qualification;**
- (b) the greater involvement of trainee nurses in prison nursing to increase awareness of the range of skills required in this field of expertise and similar encouragement of medical students from teaching hospitals to increase community involvement and awareness;²⁸**
- (c) introduction of a structured career development program for staff by including training and the acquisition of additional qualifications in a continuing education model similar to that available in other professions; and**
- (d) given that the nursing community is small and shares experiences, commitment to improvement of its profile as a ‘good employer’ by addressing the concerns of its staff that they are under-valued, not appreciated and are more likely to be blamed than receive support.**

Suitable and appropriately trained staff

- 6.87 As well as the provision of adequate facilities and health education and preventive programmes, the AIC also argued in its paper on the health needs of elderly inmates that:-

“Careful staff recruitment and selection for sensitivity to the unique requirements of elderly inmates should be an important consideration for correctional administrators. Many people may not have the aptitude or the essential skills needed to manage elderly people.”

- 6.88 Apart from the obvious requirement of appropriate qualifications, I have been told that ‘suitability’ includes the requirement that a prospective ‘prison’ nurse must be able to cope with the unique pressures of working in a prison and be able and willing to accept the role of ‘mother figure’ (a term used by some nurses during interviews) accorded them by many prisoners who are seeking someone to talk to who is not a prison officer.
- 6.89 In relation to the issue of suitability, a number of problems caused for the system by the employment of nursing staff at Casuarina, Canning Vale and the Remand Centre under the WAPOU Award rather than under the ANF Award that applies to staff at all other prisons have been drawn to my attention by health staff of all levels.

- 6.90 I understand that the anomaly developed from the time when ‘nursing’ services were provided by prison officers at Fremantle based on the military ‘orderly’ model. The same model was adopted for Canning Vale when it was commissioned in 1980 and, although it had been intended that nursing staff at Casuarina would be members of the ANF and ‘nurses’ in the strict sense of the word, this did not occur when the prison opened in 1991. WAPOU membership was extended to cover nursing staff at Casuarina, who are known as Hospital Officers.
- 6.91 It has been put to me in numerous submissions that the Hospital Officers at Casuarina and Hakea are perceived to be associated more with prison officers than with health staff because they can (and do) charge prisoners with disciplinary offences. This seems to be the case although their job description and function is exactly the same as that of ANF nurses. In support of this view, I regret to say that complaints I have received about the conduct of nursing staff tend to be levelled against Hospital Officers, some of whom are alleged to verbally abuse prisoners and occasionally treat prisoners roughly. I have also been told that the problems associated with 12-hour shifts are equally applicable to WAPOU Hospital Officers who are employed on that basis.
- 6.92 The difficulties caused by the WAPOU membership of Hospital Officers are not new and have been the subject of a number of reviews. An audit of prison health services completed in 1992 by a consultant attached to the HDWA found:-

“Nursing services are provided by Registered Nurses employed under two different awards - the WA Prison Officers Award at Casuarina, Canning Vale and the Remand Centre, and the Australian Nursing Federation Award at all other prisons. This dichotomy is causing immense problems, many of which have been reported previously.

Available evidence suggests that ANF nurses are delivering a professional service which is cost efficient. Many of them work part time so that they are on duty only when required. Use is made of casual staff for relief as necessary. Overtime is minimal, as is sick leave. The nurses take responsibility for their own staff development, whether in work time or not. On the whole, the nurses exhibit a community health focus, with an emphasis on health promotion and education.

Unfortunately, the same cannot be said for the Hospital Officers. The following issues are contributing to a service from them that is basically less effective and considerably more expensive:

- The inability to use part time and casual staff*
- Limited (and recent) acceptance of the use of agency staff to cover long term absences*
- High levels of sick leave with no establishment cover*
- The necessity to cover absences with overtime*
- High levels of overtime and double shifts contribute to stress and fatigue. Tired people make mistakes*
- The apparent necessity for a consensus decision on the way staff will be deployed. In effect, the Senior Hospital Officer is unable to make such management decisions.*
- Some staff have undertaken no staff development in years. It is doubtful whether their competencies would be acceptable or registerable outside the prison system.*

- *Their dual roles as prison officers and nurses is a difficult one. The two roles are philosophically different and to some extent, mutually exclusive. It is evident that some of the Hospital Officers find it difficult to reconcile the two, particularly those who have joined the service more recently. On a more practical note there is anecdotal evidence that prisoners regard them more as prison officers than nurses, that the prison officers see them as “medics” and have little appreciation of their training and qualifications, and that their orientation to their role as prison officers is patchy. They complain of little input into decisions, little response to complaints or suggestions, no praise or positive feedback. Some of these complaints appear justified, but the reality may be that their militant attitude and their aptitude to involve the Union immediately in any dispute works against a more participative management style.*
- *On the whole, their nursing role appears far more reactive than in other prisons, with little emphasis on health education or health promotion. There is also a much more laissez-faire attitude to the giving and recording of medications.*
- *Nursing is a basic and front line aspect of health services, and the efficient and effective delivery of nursing services is of paramount importance to the operation and utilisation of the service as a whole. For the most part, nurses employed under the ANF Award are delivering a service which meets current standards. However, the nursing service being provided by the Hospital Officers is divided and antagonistic and meets less standards. It is not cost effective and does not provide value for money. With resources so limited, it is hard to see how the continued use of this dual system of employment can be justified.”*

- 6.93 The issue was also discussed in the *Review of the Statewide Forensic Psychiatric Services of Western Australia* conducted in 1995 by Professor Harding of the Crime Research Centre at UWA and Dr O’Brien of the South Australian Mental Health Service. This review recommended that “*consideration be given to standardising nursing awards and conditions of practice for nurses working within the prison environment.*”
- 6.94 A 1998 review of nursing services at Casuarina commissioned by the Ministry found that health staff at that prison were generally resistant to change and were “*militant*” in their attitudes. It noted with concern that professional issues quickly became industrial issues because the prison officer aspect of the role of hospital officer became the primary focus. This led to a more punitive approach by some Hospital Officers who seemed “*captured by the prison culture*”.
- 6.95 The continuing difficulties at Casuarina are of concern, particularly if, as seems to be the case, the problems highlighted in the 1992 review still remain eight years later²⁹ in spite of a big turnover in staff in recent times. I understand that the Ministry tried (albeit unsuccessfully) to address this issue prior to the opening of Casuarina in 1992. Although I appreciate that it is a potentially sensitive industrial relations issue because of the pressure on health services arising from high musters and staff recruitment difficulties, I would have thought that the Ministry could ill afford the sort of problems highlighted by the 1992 review and clearly still prevalent today. The final comment of the 1992 reviewer that “*it is hard to see how the continued use of this dual system of employment can be justified*” seems to me just as valid today and to warrant urgent action.

RECOMMENDATION 6.3

That the Ministry as a matter of priority develop a strategy for the employment of all nursing staff under the ANF award as part of a strategy to encourage a cultural change and to enhance the independence of health services from operational staff.

Training

- 6.96 It is quite clear that there are very few health staff with specialised areas of expertise in substance abuse, aged care or Aboriginal health issues, nor does the Ministry offer extensive training in those fields, despite their obvious relevance to prison nursing. I suspect also that – at least in the past - for those staff members who were motivated to specialise there would have been little reward in terms of career development in the prison system.
- 6.97 Lack of training and the opportunity for professional development was raised by the majority of staff who spoke to my inquiry at the commencement of my inquiry in 1998. This was largely attributed to the fact that there was insufficient funding for training and that staffing levels were inadequate to provide relief staff to cover for those undergoing training.
- 6.98 **RCIADIC Recommendation 154(a)**³⁶ endorses the importance of training “.....to ensure that staff have an understanding and appreciation of those issues which relate to Aboriginal health, including Aboriginal history, culture and life-style so as to assist them in their dealings with Aboriginal people.” In my view, the provision of appropriate staff training in all areas of the prison system is integral to the welfare of both prisoners and staff. In spite of the significant efforts of the current Director, Health Services to address this shortcoming, the cumulative effect of inadequate training over the years has produced a number of undesirable results:-
- It emphasises the view that prison health services and those who provide them are of lesser importance in the total scheme of things. This lowers morale and reduces the motivation to progress professionally. It also enhances the feelings of isolation from fellow professionals in the community and can produce an adverse effect on the standard of service available to prisoners.
 - It decreases the attractiveness of prison nursing as a field of expertise and makes the Ministry a very poor competitor in the competition for scarce nursing staff.
 - It reduces the range of skills available within the prison health service and lowers the standard of service, especially if the Ministry is not prepared to address the shortfall by bringing in those services from the community. The consequence is that the particular needs of certain groups of prisoners are not met and the risk of the death of one of those prisoners is increased as a result.
 - Lack of training in cultural issues is of particular significance in the treatment of Aboriginal prisoners. If, as appears to be the case, there is a chronic shortage of Aboriginal health staff in the community, then in my view the Ministry has no option but to provide funding for intensive and ongoing training in this field, both clinical and cultural.
- 6.99 The Ministry has advised me in its response to my draft report that the recent Nurses Agreement will give prison nursing staff parity within 18 months, commencing from June 2000. It has also advised me that Health Services is in the process of developing an annual training calendar for associated staff. The range of training programs for health staff has recently been comprehensively increased and now includes:-
- a Documentation and Skills Update course through Curtin University – 15 staff from Casuarina and Hakea have attended and a further five staff are scheduled to attend;
 - CPR training for nurses due or overdue for the course was completed in July 2000. All other nursing staff will complete the training by the end of the year. From January 2000, CPR has been considered a “core competency” and nurses will be required to update these skills on an annual basis;

- the opportunity for nurses to undertake further study relevant to their work will be funded by Health Services on the basis that these courses are undertaken in their own time. There are also, however, a number of courses run during ‘Ministry’ time such as a Health Assessment course at Curtin University and training in mental health;
- mental health training, conducted by an external body, is now presented within the prison to enable more staff to attend;
- staff have also attended an Emergency Nursing Skills and the International Forensic Nursing Conference and the Director, Health Services organised a weekend conference for all health care and associated staff covering areas of topical interest.

6.100 The steps the Ministry has taken to significantly increase the level of training for health staff is encouraging – if long overdue. Of particular concern to me in the context of this inquiry is the obvious shortfall in the provision of CPR training and refresher training and the disturbing implication that, prior to January 2000, CPR was not considered a “core competency” for prison nursing staff. I would have thought that this was an area in which CPR competency has always been essential.

RECOMMENDATION 6.4

While acknowledging that the Ministry has taken steps to significantly increase the level of training for health staff, that it regularly review its current training programs for health staff in consultation with staff and HDWA in order to evaluate their relevance and adequacy; to identify any deficiencies and to formulate appropriate strategies to rectify those deficiencies.

Shortage of facilities

- 6.101 I or my staff visited all prison medical centres during the course of the inquiry and considered many of those facilities to be of minimum standard. We found that most prison medical centres afford little privacy to prisoners consulting nursing staff or adequate security for staff. Waiting areas are uncongenial and filing and storage facilities are inadequate. We noted a disturbing potential for breaches of confidentiality in the Infirmary at Casuarina where Hospital Officers working on prisoners’ medical files share office space with prison officers in the ‘control room’. This co-location tends to raise the ‘prison officer’ profile of Hospital Officers and increases the perception that they are not independent.
- 6.102 In spite of repeated assertions made to me by many prison health professionals that the health of prisoners is generally much worse than that of the general community, particular those suffering the effects of substance abuse, there are currently only 20 ‘infirmary’ beds available for sick male prisoners at Casuarina and only two for sick female prisoners. This number will, of course, increase with the commissioning of Acacia later this year. By comparison, there were between 22 and 26 infirmary beds at Fremantle Prison in 1991 (although at one stage six of those beds were allocated to prisoners suffering from infectious diseases and HIV) in spite of a much lower muster level in 1991.
- 6.103 As discussed in Chapter 4, the Ministry has sought and received funding for extensive upgrades of health care facilities at all of the regional prisons and at Bandyup and Karnet. It is expected that those upgrades will be completed within the next three years. In addition, the new Assessment Centre at Hakea includes a new health care centre (including a Crisis Care Unit) and Acacia will have a seven-bed ward, a Crisis Care Unit and a Geriatric Unit.

- 6.104 However, as mentioned previously the only cells designed to meet the special needs of the elderly or disabled in the prison population are located in the metropolitan area. There are **no** *dedicated* facilities for those suffering the effects of substance abuse. The facilities designed for psychiatrically disturbed prisoners at Casuarina house ‘well’ participants in the residential Intensive Sex Offender Treatment Program. There are currently no other facilities for this group of prisoners in the prison system other than the Crisis Care Units at Casuarina and Hakea and those planned for Acacia and Bandyup.
- 6.105 There are **no** special facilities at all for female prisoners who are disabled, elderly, suffering the effects of substance abuse, are at risk or are psychiatrically disturbed – other than the two beds currently in the ‘infirmery’ at Bandyup and the Crisis Care Unit in the planned refurbishment - because the limited ‘aged care’ and ‘disabled’ beds, the Infirmery and the crisis care units are located in male prisons. Female prisoners who are suffering the effects of substance abuse, are at risk or psychiatrically disturbed are generally housed in medical observation cells located in the punishment block at Bandyup. As there appear to be no proposals for other dedicated facilities for female prisoners at other prisons I suspect that the demand for beds in the proposed crisis care unit at Bandyup will far outweigh the number to be provided.
- 6.106 In my view, in spite of the long overdue upgrades of prison medical centres, the lack of facilities for special needs groups of prisoners remains a problem. The lack of accommodation for these groups of prisoners engenders other problems - such as prisoners in need of special accommodation being housed in units which are unmanned at night - which create obstacles for the proper provision of health services to prisoners. In this regard I note that the AMA’s *Position Statement* states:-
- “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.”*
- 6.107 Although I am aware that by far the most costly remedy of deficiencies in health services for special needs groups of prisoners is the provision of appropriate facilities, in my opinion, the shortage of such facilities casts doubt on the Ministry’s claim that prison health services meet community standards and that it has implemented RCIADIC **Recommendation 328**. My recommendation 6.1(a) deals with this issue.

Lack of structured and ongoing health education and preventative strategies

- 6.108 The Ministry has told me that it bases its standards of health care in part on the *Standards for Health Services* of the Correctional Service of Canada which include the following in its “*Principles governing the management and delivery of health services*”:-
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.***
(my emphasis)
- 6.109 The Ministry’s apparent lack of commitment to pro-active health education and preventative programs at the time was discussed by the JJ/HIDC at its meeting of 22 March 1996. The Minutes state:-
- “Benefits are available to the community from development of structured health programs embracing primary, secondary and tertiary preventative strategies to deal with:*

- *drug and alcohol abuse*
- *mental health (eg self harm and suicide, chronic psychoses)*
- *infectious diseases (eg HIV/AIDS, Hepatitis B and C, Sexually Transmissible Diseases)*
- *nutritional/lifestyle/metabolic diseases (including diabetes, respiratory disease and cardio-vascular disease)*
- *cancers*

Such programs are virtually absent in the Ministry and their establishment must occur in close collaboration with a wide range of public and private health care providers and the Health Department of W.A. (my emphasis)

The basis under which these programs are developed and/or acquired for offenders will need to be determined by the Joint Council. A submission to the Joint Council on this issue is currently being drafted but the development of these programs will be expedited over the three months before the Council's next meeting."

- 6.110 The next JJ/HIDC meeting was not held until 18 August 1997 – some 16 months later - but the issue of preventative programs and education services does not appear to have been discussed at that meeting. Some progress was made, however, in the establishment of the *Blood Borne Communicable Disease Program* to which funding of \$174 000 was allocated in 1997/98. The program, which commenced in December 1997, was contracted out to the AIDS Council and the Hepatitis C Council of Western Australia and provided education for prisoners and staff in “*Keeping Safe*” from infections while in prison - with a focus on Hepatitis B, C and HIV, safe sex, safe drug use, alternatives to IV drug use, tattooing and information on sexually transmitted disease. Immunisation against Hepatitis B was also made available. The success of the program was noted at the JJ/HIDC meeting on 30 March 1998. There appears to have been little or no progress in the introduction of the other education initiatives discussed by the JJ/HIDC in 1996.
- 6.111 There also appears to be little capacity within the Ministry's current health budget for the development and running of other health education and preventative programs in spite of the success and popularity of the very few that have taken place - such as a health education program at Bandyup run by Derbarl Yerrigan Health Services and a pilot drug program run by Holyoake involving prisoners and their families at Canning Vale.
- 6.112 The management of the range of health problems presented by ‘special needs’ groups involves treatment, possibly long-term medication, testing, monitoring, special diets, exercise and regular review, all of which absorb staff resources and money. In my view, the allocation of additional funding to provide services to meet the needs of these prisoners is an obligation which the Ministry must fulfil as part of its duty to provide adequate health services to its ‘patients’.
- 6.113 I also believe that it is ‘false economy’ for the Ministry to use the cost of providing a comprehensive and structured programme of health education and preventative measures as a barrier to meeting what I consider to be one of its obligations. I base this conclusion on the wide support for the view, expressed in the course of my inquiry by prison health staff, prison officers and prisoners, that the introduction of such measures could, in the long term, reduce the cost of providing an effective health service for prisoners; increase their chances of rehabilitation and also produce consequential long term benefits for the prison system and the community.

6.114 In its paper on elderly prisoners, the AIC stated that it is:-

“.....particularly important that correctional systems address issues of diet, exercise and smoking with ongoing preventive programs. While ageing cannot be stopped, many of the consequences can be minimised or delayed, resulting in considerable financial savings to correctional systems. Elderly inmates should have access to a comprehensive and systematic health care program that encompasses education and preventive care as well as treatment of ailments and disorders in order to address both the special needs and high costs associated with this group of inmates.”

6.115 It seems to me that this statement could apply generally to all prisoners, especially those identified as having ‘special needs’. At a meeting in April 1998³⁰ the Council of Europe *Committee of Ministers to Member States* adopted a recommendation “*Concerning the Ethical and Organisational Aspects of Health Care in Prison*” which noted the following:-

“.....respect for the fundamental rights of prisoners entails the provision to prisoners of preventive treatment and health care equivalent to those provided to the community in general.”

6.116 In the Appendix to that Recommendation the Council stated:-

“Sociotherapeutic programmes should be organised along community lines and carefully supervised. Doctors should be willing to co-operate in a constructive way with all the services concerned, with a view to enabling prisoners to benefit from such programs and thus to acquire the social skills which might help reduce the risk of recidivism.”

6.117 In my view, the Ministry should actively promote health programs relating to healthy diets; the effects of smoking and ‘Quit’ programs; the management of heart disease, diabetes, depression, and stress; dealing with domestic violence; alternatives to drugs and alcohol; and relaxation techniques and exercise. These programs should, as far as possible, replicate those conducted in the community but should also include programs designed to meet the special needs of prisoners. Ideally, presentation of the non-clinical programs would involve prison officers and possibly suitable prisoners who could receive accreditation for those skills. The use of health promotion programs available through community organisations and health providers, particularly through Aboriginal Medical Services, could have the additional benefit of ‘normalising’ prison health for both prisoners and staff. The Ministry has advised me that it has incorporated a range of programs such as those mentioned above in its proposed health service structure and that it has costed provision of the programs if privatisation of the delivery of health services does not occur.

6.118 In my opinion, health education and preventative strategies are an effective means of teaching prisoners how to accept responsibility for the management of their own health with obvious consequential benefits for improving life skills, general self-management and rehabilitation. Moreover, I believe that the Ministry has an obligation to provide such programs as part of its commitment to providing health services to some of the special needs groups discussed above. The current ‘crisis management’ approach to all aspects of health services is, in my opinion, hazardous for prisoners and prison staff; detrimental to the spirit of health services staff; leaves society and the families of prisoners at risk and is not cost-effective.

6.119 Although I am conscious of the scarcity of the ‘health dollar’ in prisons, it seems to me that, with a little lateral thinking and imagination, an expanded model of prison health care could reap significant benefits for prisoners and the system as a whole. Promotion of health education as a valid component of prison nursing may also add a variety to the daily routine which could enhance job satisfaction and increase the morale of the staff. In my view the long term benefits for all parties and the prison system as a whole have the potential to produce a more efficient and more cost-effective health service.

Lack of regular health reviews for certain prisoner groups

- 6.120 As discussed in Chapter 5 the Coroner commented on the benefit of providing prisoners, particularly long term prisoners, with regular health reviews in his findings following the inquest into the death of Peter Cameron in April 1998. The Ministry did not support the Coroner's view at that stage on the ground that it "*could have the effect of diverting scarce valuable resources away from more needy areas*". As a result regular health reviews were not conducted as a normal part of prisoner health services. In my view that omission was short-sighted.
- 6.121 The Ministry has subsequently advised me that the "*Health Services Directorate has recommended regular health reviews. A preliminary audit of this function revealed omissions to this regular health review. Consequently, two projects have been scheduled to commence in October 2000. The principal project is intended to identify and rectify omissions with respect to the annual health assessment. The second project is a quality audit of certain nursing functions through the review of medical records in certain specified areas.*" Obviously, this is a step in the right direction but, on the basis of the Ministry's advice, I am not satisfied that what is proposed will address either the Coroner's concerns or my own.
- 6.122 The AMA's *Position Statement* at Item 8.8 includes the requirement for "*systematic, ongoing, health review for each individual prisoner or detainee*" based on its view that:-
- "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."*
- 6.123 As I am frequently told by prison health staff, prisoners as a group are considered to have the worst physical – and possibly mental/psychological - health of any social group. That being so, in my opinion it is simply short-sighted and dangerous for the Ministry to fail to regularly monitor the health status of certain high risk prisoner groups, even if it entails greater cost.
- 6.124 In my view, health monitoring and regular routine reviews of long term prisoners, particularly Aboriginal prisoners, could have significant long term benefits. Such a system, in conjunction with a comprehensive range of health education programs could be a *cost-effective* exercise for the community as a whole and could certainly reduce the risk of an unexpected death. I would also suggest that regular review of the health of long term prisoners could serve as a means of evaluating the success of any health education or preventative medicine programs provided in order to assess future requirements.

RECOMMENDATION 6.5

That, for consistency with community initiatives and in the interests of improving the general health of prisoners and the occupational safety of prison staff, the Ministry develop, fund and implement a comprehensive range of health education and preventative programs utilising the expertise of appropriate community organisations and selected prison staff and prisoners.

LOW PRIORITY OF HEALTH SERVICES

- 6.125 I have reached the inescapable conclusion that prison health services are a low priority in terms of resources, funding and prestige. However, in terms of commitment to reducing deaths in prisons, the physical and mental well-being of prisoners is the cornerstone in any effective preventative strategy.
- 6.126 The Ministry has introduced a number of initiatives in the past two years, primarily in relation to suicide and self harm, to address the problems which it believes have caused the increase in the number of deaths in recent years. Although there has been an increase in the nursing coverage at certain prisons and in the availability of medical practitioners, it seems to me that any change in the overall nature and quality of general physical health care has been minimal. In my opinion, in order to make real improvements in this area, a quantum cultural change in the system's attitude towards the importance of prisoner health care in the maintenance of the "good government, good order and security" of prisons³¹ and in the rehabilitation of prisoners will be necessary before the principle of "equivalence" can be said to be achieved in prison health services. Attention to the following areas would be a positive step towards that cultural change.

Funding

- 6.127 I observed in Chapter 4 (paragraph 4.35) that health service funding on a per prisoner basis declined in 1997/98 and 1998/99 before reverting (in nominal terms) to the 1996/97 levels in 1999/2000. It is quite clear to me from submissions, interviews and from my own observations that prison health services were for many years under-funded. This has resulted in increased pressure on all health services staff; inappropriate placement of prisoners and increased risk of a death; and the need for health staff to tailor health care to fit in with prison procedures and regimes. The general impression I have is that the 'system' considers that health staff should be able to do more with less and that if there is a shortfall which results in an aspect of a health service for prisoners being not as good as it should be, then that is one of the disadvantages of being in prison. This is, perhaps, surprising as I am quite sure that the death of a prisoner affects all staff and that all staff are clearly concerned about the risk of exposure to communicable diseases and infections.
- 6.128 It seems to me that, in reality, health services staff do what they can with the funding available and that reasonable needs which cannot be serviced - such as those outlined in this chapter - are eventually seen as 'luxuries'. In my view, the lack of these services and facilities through consistent under-funding results in a prison health service which may not reach generally accepted community standards of medical practice. More funding is urgently needed.

Independence and prestige of Prison Health Services

Independence

- 6.129 Adherence to the principle that prison health services staff should be independent and should base their medical judgements "on the needs of [our] patients and take priority over any non-medical matters"³² appears to me to be an essential (and obvious) component of any prison health service which claims to be equivalent to that available in the community. This view was reflected in RCIADIC **Recommendation 153(c)** which recommended that "whatever administrative model for the delivery of prison medical services is adopted, it is essential that medical staff should be responsible to professional medical officers rather than prison administrators."
- 6.130 This view was echoed by HM Chief Inspector of Prisons who stated in his discussion paper "Patient or Prisoner"³³ :-

“It is encouraging that the [UK] Prison Service Health Care Standards refer to prisoners as patients throughout. The need for security and discipline can cut across the perception of individuals as patients. There will clearly always be tension over this issue, because health care providers will clearly demand that those requiring services are recognised as patients. How else can prisoners voluntarily accept the care that they so often desperately require?”

6.131 In this regard recent amendments to the *Prisons Act 1981* are of concern. In Chapter 3 I referred to amendments to sections 38 and 39 of the Act which provide for the appointment and responsibilities of the prison medical officer.

6.132 Previously, section 38(1) of the Act provided:

“The chief executive officer shall nominate for each prison a prison medical officer or a medical officer who shall be responsible for the medical care and treatment of every prisoner in that prison.”

whereas the amended section 38(1) now provides:-

“The chief executive officer is to ensure that medical care and treatment is provided to the prisoners in each prison.”

6.133 Previous section 39 of the Act required the medical officer to *inter alia*:-

- (a) attend at the prison at such times and on such occasions as **the chief executive officer may direct;**
- (b) examine every prisoner as soon as practicable after his admission to prison and ascertain and record the state of health of the prisoner and any other circumstance connected with the prisoner’s health, as he considers necessary;
- (c) maintain a record of the medical condition and the course of treatment prescribed in respect of any prisoner under his care;
- (g) examine and treat every prisoner in the prison who requires medical care and treatment; and
- (h) examine **such prisoner** as the chief executive officer or superintendent may require.” (my emphasis)

This section was repealed and was replaced by the following:-

- (a) attend at a 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 circumstances 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;
- (h) **on the request of the chief executive officer or a superintendent**, examine a prisoner. (my emphasis)

6.134 Although not necessarily intended, the amendments to sections 38 and 39 seem to me to shift the focus of responsibility for medical care and treatment away from the medical officer and towards the chief executive officer. In spite of the Ministry’s assurance that delegation of the chief executive officer’s responsibility for medical care to the Director, Health Services under section 8 of the *Prisons Act* is sufficient to allay any concerns in this regard, it seems to me that the perception created by the legislation - which is more obvious than the delegation - could have an adverse impact on the current tenuous independence of prison health services.

- 6.135 In addition, it seems to me that the inclusion of the words “*on the request of the chief executive officer*” in amended ss.39(b) and 39(g) could cast doubt on the Ministry’s practical compliance with United Nations *Standard Minimum Rules for the Treatment of Prisoners*. For example, UNR 22(1) states that “*the services of at least one qualified medical officer must be available twenty-four hours a day.*” UNR 24 requires that “*Every prisoner must be medically examined by a suitable qualified person as soon as possible after being received into prison, and thereafter as necessary.*” (my emphasis). There is no suggestion in either rule that the availability of a medical practitioner or the examination of a prisoner by a qualified person is subject to the direction or the request of a non-medically qualified chief executive officer.
- 6.136 Similarly, UNR 25(1) provides that “*The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.*” I am not convinced that the wording of the recent amendments makes it unequivocally clear that “*sick prisoners*” and “*all who complain of illness*” will be seen “*daily*”. In fact, under previous sections 38 and 39 not all sick prisoners or those who complained of illness were seen daily because only Casuarina and Hakea have routine daily ‘doctor’s parades’.
- 6.137 I would have thought that access to a doctor should depend solely on the prisoner’s state of health as judged by the doctor and not be dependent on a “*request*” by a third party. In this regard I note that the Council of Europe *Committee of Ministers* in the Appendix to *Recommendation No. R (98) 7* states at paragraphs 19 to 21:-

“Doctors who work in prison should provide the inmate with the same standards of health care as are being delivered to patients in the community. The health needs of the inmate should always be the primary concern of the doctor.

*Clinical decisions and any other assessments regarding the health of detained persons should be governed only by medical criteria. **Health care personnel should operate with complete independence within the bounds of their qualifications and competence.*** (my emphasis)

Nurses and other members of the health care staff should perform their tasks under the direct responsibility of the senior doctor.....”

- 6.138 In response to my draft report the Ministry advised me:-

“The Ministry does not attempt to ensure all sick prisoners are seen by a doctor daily, rather that prisoners who require such attention should be seen daily by a health professional. This is consistent with the Standard Guidelines for Corrections in Australia (5.71) which state that “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.....”

- 6.139 In its response, however, the Ministry omitted the final part of Guideline 5.71 which continues – “*...and all prisoners who complain of illness, or to whom the medical officer’s attention is specially directed, are examined as soon as possible*”. I suppose it is possible to interpret 5.71 as meaning that the medical officer could delegate his responsibility to a member of the nursing staff – in line with the practice of triage³⁴ - but I question whether either Guideline 5.71 or the Ministry’s interpretation of it is in accordance with either the wording or the intent of UNR 25(1) which specifically states:-

“The medical officer shall have the care of the physical and mental health of the prisoners and should daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.”

6.140 The point of my comments on this issue – and those of the Council of Europe in relation to *Recommendation R (98) 7* - is that, in the prison environment with its endemic culture, there is a real danger that security and operational issues will always be considered more important than prisoners' health needs, resulting in difficulties for health staff. In my opinion, at least in the past, if there was any integration of health and operations in Western Australian prisons, health was certainly not an equal partner. The situation may have improved in the past year but, in my view, while integration is an ideal to aim for, nothing less than an equal partnership will result in a better prison health service.

6.141 It is also of concern to me that new subsection 39(h) provides that the medical officer must examine a prisoner if requested to do so by the chief executive officer or a superintendent. It does not specify that that prisoner requires medical care and treatment as in previous section 39(h) (by use of the word “*such*”) and could potentially leave a medical officer open to becoming involved with a prisoner for non-medical reasons in breach of his/her ethical principles.

6.142 The Ministry provide the following response on this issue:-

“All requests by prison staff regarding medical duties are referred to the Director Health Services. In practice this protects those health staff who for their own reasons may not wish to become involved in the collection of specimens or examination of prisoners but allows those staff who have no objection to do so. This follows the community standard which in regional and remote communities allows medical staff to refuse requests by police to undertake legal duties.”

6.143 In my view the Ministry's response highlights the difficult position in which many prison health staff find themselves and it is perhaps not surprising that some prisoners are unwilling to give prison health staff their total confidence if the same staff may decide to become involved in the obtaining of evidence in relation to an offence for which the prisoner could be punished in some way. More specifically, I note that the *Position Statement* of the International Council of Nurses on the *Nurse's Role in the Care of Detainees and Prisoners* states “*Nurses employed in prison health services do not assume functions of prison security personnel, such as body search for prison security reasons.*” I also note that the AMA's *Position Statement* provides that:-

5.2 *Medical practitioners should not perform body cavity searches to obtain evidence or to retrieve substances for evidentiary purposes.*

5.3 *Medical practitioners may perform body cavity searches on non-consenting prisoners or detainees only when, in the opinion of the attending medical practitioner, the life of the prisoner or detainee is likely to be endangered.”*

6.144 No doubt the purpose of the change in focus in the legislation is to reflect the new purchaser/provider model which the Ministry has adopted. However, in my view, the amendments seem to have the potential to further reduce the independence of prison health services and to create conflict with the ethical principles of medical practitioners who are obliged to provide health care regardless of the circumstances of the patient. *Recommendation No. R (98) 7* referred to above also states:-

“Recognising that the medical practitioner in prison often faces difficult problems which stem from conflicting expectations from the prison administration and prisoners, the consequences of which require that the practitioner should adhere to very strict ethical guidelines;

Considering that it is in the interests of the prison doctor, the other health care staff, the inmates and the prison administration to proceed on a clear vision of the right to health care in prison and the specific role of the prison doctor and the other health care staff;

Considering that specific problem situations in prisons such as overcrowding, infectious diseases, drug addiction, mental disturbance, violence, cellular confinement or body searches require sound ethical principles in the conduct of medical practice.....”

Prestige

- 6.145 If prison health services are considered a lower priority in terms of funding and resources and in comparison with security considerations, it becomes all too easy for either prison health services staff to be ignored or over-ridden or for them to be ‘captured’ by the system. Throughout this report I have given examples of situations drawn to my attention where health care has become subordinate to prison operations. These include:-
- health staff are frequently not consulted or sufficiently involved in the decision-making process in new initiatives;
 - decisions about the placement of prisoners in the Crisis Care Unit or in a medical observation cell and how long they should remain there are frequently made by prison administrative staff and prison officers without consulting health professionals or in spite of differing advice;
 - nursing staff are placed under pressure by prison officers to tailor nursing duties to fit in with prison operations e.g. rushed initial assessments when prisoners arrive from court at the end of a shift; mealtimes and lockup times may interfere with the issue of medication at the appropriate time; the mid-day lockdown at Casuarina is unproductive ‘down time’ for nursing staff;
 - a shortage of officers for an escort may result in the cancellation of outside hospital appointments regardless of the inconvenience it may cause. It seems from complaints to my Office that this remains a problem after transfer of the responsibility for prisoner transport to CCA;
 - low prison officer staffing levels at night mean that it may be problematical to escort a prisoner to hospital after hours. The Ministry has advised me that it is normal practice to call an ambulance if there is an after hours emergency and a prison escort is not possible or appropriate. This is obviously the common sense approach but prison officers at Bandyup told me during the course of my inquiry that there have been occasions in the past when they did not feel they could call an ambulance to transport a prisoner to hospital;
 - low prison officer staffing levels may mean that nursing staff are not provided with sufficient personal security in medical centres;
 - nurses can be charged by prison officers for minor breaches of prison procedure.
- 6.146 Inevitably, constantly being relegated to ‘second best’ or having their clinical judgements over-ridden or ignored must have an adverse impact on the morale of prison health staff. This in turn affects the Ministry’s ability to retain nursing staff or medical officers or to recruit new staff and impacts on the quality of service provided. In my opinion, the working conditions of health services staff and their status within the system need to be improved and enhanced to preserve their independence and in the interests of the health and well-being of prisoners.

RECOMMENDATION 6.6

That the Ministry:-

- (a) ensure that the health of prisoners receives, and is seen to receive, the same level of commitment as prison operations; and,
- (b) take steps to improve the working conditions of health services staff and enhance their status within the system with the aim of emphasising their independence and raising the standard of health services generally.

LACK OF COMPREHENSIVE FORWARD PLANNING

- 6.147 In its research paper on elderly inmates, the AIC suggested that correctional administrators should utilise the knowledge of medical/health care staff during planning for housing, program development and security classification for this group of prisoners. In my view this suggestion is relevant to the planning of *all* health-related matters.
- 6.148 In spite of a growing awareness of the increasing age of prisoners; the growing number of offenders with substance abuse problems; and the rapidly deteriorating facilities at Bandyup, the warnings of prison administrators and health professionals of the likely increased pressure on accommodation and the need for specialised facilities, the Ministry has only very recently taken steps to address the deficiencies.
- 6.149 It is acknowledged that, in the past, the Ministry's computer system was not capable of producing the level of statistical data needed to monitor changes and trends in the characteristics of new prisoners and the existing prisoner population, nor to evaluate the effectiveness of programs and other initiatives. For example, the Ministry was unable to provide me with basic statistical data about incidents of self harm or the effectiveness of its risk assessment procedures without conducting a time-consuming manual search of prisoner files.
- 6.150 It appears from the Minutes of the JJ/HIDC that the Ministry had been aware of the problem for some time but took no action to either update or replace the technology until comparatively recently. For example, the Minutes of the meeting of the JJ/HIDC held on 22 March 1996 state:-

"Lack of appropriate clinical and management information systems is a substantial impediment to the effective delivery, appraisal and planning of health services to offenders. It has precluded useful ascertainment of public health services utilised by offenders and impedes appraisal of options and determination of priorities for service modification and development.

The Joint Council had instructed the previous Director of the Ministry's Health Services to proceed with procurement of appropriate information systems. This has not occurred as the Ministry was not willing to release funds for purchase.

Funding for health services information systems has not yet been resolved."

It would appear from the Minutes of subsequent meetings that the JJ/HIDC did not discuss this issue again. However, a new system known as TOMS (Total Offender Management Solution) was developed and Phase 1 of TOMS has recently been introduced.

- 6.151 In interviews with me and my staff, however, prison and health staff expressed some doubts about the ability of the new system to provide the detail required to produce a comprehensive prisoner profile for the purposes of planning future accommodation requirements and evaluating the effectiveness of programs. At this early stage of implementation it is not possible to comment on the adequacy of the data capture capability of the new system. It is to be hoped that it has been designed with capacity for enhancement as needed. I should also note that it is my impression that many prison staff had received little computer training and that the hardware available to most staff was antiquated and slow although I have been told that there was a considerable training component in the recent introduction of the TOMS system.
- 6.152 In summary, it is of concern that the capabilities of the Ministry's information systems were allowed over a period of time to deteriorate to the point where lack of accessible data may well have frustrated forward planning of future accommodation and staffing needs leading to overcrowding and increased pressure on staff. In the context of this Chapter, it also seems to me that the lack of statistical data precludes ongoing review of the health services as recommended by the RCIADIC (Recommendation 153) – or at least makes that task more difficult.

RECOMMENDATION 6.7

That the Ministry monitor the capacity of its new information technology system to ensure that it is adequate to enable it to ascertain the effectiveness of its initiatives, programs and strategies and determine priorities for service modification and development.

OTHER FACTORS

Lack of entitlement to Medicare

- 6.153 Given that health services are short of funds, the lack of Medicare coverage for prisoners is of concern in that it not only places the responsibility entirely on the shoulders of those charged with providing correctional services, it may also send the message to those providers that prisoners are not part of the 'whole' community in relation to their health, thus reinforcing the view that health is secondary to security. Professor Richard Harding noted in his 1995 "Review of the Statewide Forensic Psychiatric Services of Western Australia" that consideration of the Medicare issue was beyond the scope of that review but that:-

"In the case of those who have paid a Medicare levy before commencing their term of imprisonment, this is particularly objectionable. But even in the case of those who have been in prison beyond the term of the last levy which they paid, it is unjust, certainly disadvantaging them in relation to tens of thousands of people in the outside community who for one reason or another do not in fact pay such a levy. This deprivation is almost certainly in breach of the International Covenant on Civil and Political Rights and the United Nations Standard Minimum Rules for the Treatment of Prisoners. "

- 6.154 The JJ/HIDC considered prisoners' eligibility for Medicare at the meeting of 22 September 1995. The Minutes indicate that the Commissioner of Health expressed the view that "exclusion is a policy decision of the Federal Government taken with the introduction of Medicare and enabled rather than enforced by legislation" and that "change in this policy would be difficult, take a long time and would need to be pursued in collaboration with other States and sectors (particularly Family and Children's Services)."

- 6.155 A recommendation that prisoners should “*retain their entitlement to the Medicare system*” is included in the AMA’s *Position Statement* and was repeated in a number of submissions to my inquiry. From contact with the Commonwealth Grants Commission and the Commonwealth Department of Health and Aged Care, it is clear that this issue has not been considered for some considerable time and that it raises questions to which insufficient consideration has been given.
- 6.156 In my view, the lack of Medicare entitlement is a major impediment to the provision of a health service to prisoners which equates to that available to the general community and it is an issue which merits further consideration by an appropriate body. Unfortunately, I believe that such further inquiry is also beyond the scope of this inquiry.

RECOMMENDATION 6.8

That the Ministry raise the issue of the exclusion of prisoners from Medicare coverage with the JJ/HIDC with a view to it being referred to the appropriate State and Federal authorities for comprehensive review and investigation.

Ineffectiveness of the Joint Justice/Health Interdepartmental Council (JJ/HIDC)

- 6.157 In his 1995 review of forensic psychiatry, Professor Harding stated that “*the Review Committee was impressed by the model of a Joint Council*”. I agree that it appears to provide an ideal forum for the full consideration of prison health services using the special knowledge of both health and custodial providers. However, I have been told in submissions and in the course of interviews that the JJ/HIDC has never really achieved its full potential and that the aim of giving the Ministry access to the “*superior resources*” of HDWA and its expertise has – at least in the past - not been realised. Members of the Council from both Departments have indicated disappointment in the JJ/HIDC’s operation and achievements in the past.
- 6.158 In response to my draft report, HDWA stated:-

“While initially progress was slow, the JJ/HIDC is now making significant advancements towards achieving the outcomes outlined within the Terms of Reference established for this Council. Important initiatives include:-

- The establishment of the Forensic Psychiatry Policy Advisory Committee in 1998 to develop a Framework for Forensic Mental Health Services: A Model of Care for WA.*
- The appointment of the Chair of Forensic Psychiatry, who is also the Director of State Forensic Psychiatric Services, by the Ministry of Justice and the Health Department of Western Australia.....*

In addition to these key initiatives the JJ/HIDC is the only high level forum where issues can be discussed that impact on both Justice and Health. Section 4.39 of your report identifies many of the issue that have been considered by the Council. This in turn has resulted in more informed and better coordinated action in these areas. The importance of this type of outcome needs to be recognised.

With the appointment of the Director of Forensic Psychiatric Services and planning well under way for the expansion of these services, it is agreed it would be timely to review the objectives and operation of the Joint Justice/Health Interdepartmental Council as recommended in your draft report.”

- 6.159 The Ministry also advised me in October 2000 that the Council agreed at a meeting in July 2000 to establish an external Clinical Advisory Committee which will oversee clinical standards for Prison Health Services and that the Ministry is to seek accreditation of its health services through an external process such as the Australian Council on Healthcare Standards.

- 6.160 In spite of the recent progress in improving the delivery of psychiatric services – discussion of which was, incidentally, on the Agenda of the Council’s inaugural meeting in October 1994 - in my opinion, the JJ/HIDC seems to have achieved very little in its six years of operation. It could not be said with any confidence that it has had a significant impact on the policy for health care delivery; the availability of resources; the resolution of significant problems in relation to prison health services or in determining priorities and strategies for health issues – the Council’s aims as stated in its Terms of Reference. I have been unable to identify any real achievement by the Council in terms of service provision, and as far as I can see, its terms of reference bear little resemblance to what it actually does.
- 6.161 Although I am sure that the JJ/HIDC provides a valuable forum for discussion, an analysis of its past performance suggests a record of producing few *tangible* benefits for prison health services to date other than providing another forum in which to discuss problems rather than to make and implement decisions. It is, in my view, a body which is in dire need of the review which was supposed to take place 18 months after its establishment but which did not occur. It is of concern, therefore, that in its Summary Response to RCIADIC **Recommendation 153** in the 1995 Implementation Report the Ministry appeared to rely on its existence as a means of providing ongoing review of prison health services:-

“The Justice Health Council which is made up of representatives of the Ministry and Health Department is responsible for general oversight of health services delivered to offenders and is a step forward in ensuring the ongoing review, and a forum to address the other issues mentioned in the Recommendation [153].....The Justice Health Council will continue to monitor the adequacy and relevance of health services provided by the Ministry.”

RECOMMENDATION 6.9

That the objectives and operation of the JJ/HIDC be reviewed as a matter of urgency in order to utilise the full potential of the joint expertise of such a body.

Outsourcing of health services

- 6.162 During 1999/2000 the Ministry sought and considered expressions of interest from private providers to service (under a contract with the Ministry) the health needs of prisoners (other than psychiatric services in the metropolitan area which will continue to be provided by Ministry and HDWA personnel). As this Report was being finalised for printing I was informed by the Ministry that the proposal would not proceed because it had not been possible to negotiate provision of the required services at an acceptable price. I will not, therefore, consider the proposal in detail in this Report. However, I note that, in my view, it would have been a step in the right direction for a number of reasons.
- It seems to me that an external organisation is less likely to become ‘captured’ by the more undesirable aspects of prison ‘culture’.
 - Delivery of health services by professionals who may also work in the community should have the effect of ‘normalising’ prison health services.
 - Very importantly, for the Ministry to engage external providers it will have been forced to articulate precisely the types of health services needed, the standards of service expected (including the various types of health personnel required) and the reasonable costs of delivering such a service.
- 6.163 The failure of the Ministry to conduct this latter form of analysis in the past is, in my opinion, a significant factor in the deficiencies that have been identified in this Report.

6.164 However, based on the comments from prisoners, health staff, a wide range of community interest groups and my own enquiries, I question whether the contracting out of the provision of prison health services goes far enough. For example, it has been suggested to me that nothing short of the total removal from the Ministry of responsibility for health services, planning, funding and delivery would guarantee an appropriate service. Further, only if this occurred would there be a genuine assessment of what services are needed, how best to deliver them and how to generate a proper relationship between health professionals and the prisoner/patient.

6.165 Those who argue in this way believe that the most effective means of achieving this goal is the establishment of a body which is quite separate from the Ministry - funded independently - with the responsibility for both the specification and delivery of prison health services. Obviously such a body would be required to work closely with the Ministry to ensure a balanced relationship between health services and prison operations. It would, however, be able to approach its task from a standpoint that was completely independent and based only on considerations of what the health needs of the prison system are.

6.166 In response to my draft report, the Ministry advised me:-

“The Ministry of Justice does not support the view that the control of Prison Health Services should lie in the hands of an external entity. The Ministry agrees that Prison Health Services should be accountable and supported by a body outside the Ministry. However, the removal of health personnel from the ministerial structure is not considered to be helpful to interactions between prisoners, prison officers and health services personnel.

In other jurisdictions where health services provision is undertaken by a separate entity to the prison management structure, then health is generally seen as an outsider, which has the effect of reducing the level of cooperation between health and operations, which is necessary for the smooth running of the system.”

6.167 The Ministry also commented that *“The issue with prison health is not the separation of health, rather the more difficult, but in the end infinitely rewarding, goal of integrating prison health with operations. This is not a matter of dropping medical standards, it is a matter of delivering standards in the most appropriate way.”*

6.168 I do not disagree, and it is clear to me that the ill-defined - and at times strained – working relationship between health services staff and prison operations has been a major contributory factor in the many deficiencies in the range and extent of prison health services delivered by the Ministry identified in this Report.

6.169 Again, as this Report was being finalised for printing, the Ministry informed me that, having decided not to proceed with the proposal to contract out health service delivery to a private provider, the Ministry would take the following *“positive action to improve its health services”*:

- *“The introduction of a joint management body comprising senior executives from both the Ministry and the Health Department of WA. The joint management body will ensure changes are implemented quickly and effectively, and will be responsible for overseeing a general improvement in prison health service delivery.*
- *The joint management body will be supported by the appointment of a Clinical Advisory Committee headed by Professor Bryant Stokes, which will commence operations shortly. The CAC comprises highly qualified clinicians and senior representatives of groups committed to achieving quality health care for offenders in custody. The CAC is required to provide input to the management of Prison Health Services at a strategic level, on clinical direction.*
- *An upgrade program will begin shortly to bring all prison health services up to the standards required in the Request for Proposal (RFP) document.*

- *The Ministry will be seeking accreditation from a reputable health accreditation body.”*

- 6.170 It has not been possible to establish the detail of these initiatives for inclusion in this Report. However, I would make the observation that the “*joint management body comprising senior executives from both the Ministry and the Health Department of WA*” looks similar to the existing Joint Justice/Health Interdepartmental Council (“JJ/HIDC”). The objectives and achievements of that body have been commented on in paragraphs 4.37-4.41 and 6.157-6.161 of this Report. No doubt the new body will operate somewhat differently from the JJ/HIDC – and will need to if it is to be more effective than that entity.
- 6.171 On balance, my final opinion is that unless health services are controlled and provided by a body completely independent of the Ministry they will remain a second priority. Moreover, prisoners will continue to see health staff as part of ‘the Ministry’ and therefore unable to provide them with an independent service as ‘patients’ rather than ‘prisoners’. In my opinion, the creation of the new body with the HDWA will not be sufficient. A change in control of health services should occur and I have recommended accordingly. In making this recommendation, however, I do not wish to imply that in the process of any changes the extensive knowledge and experience of the particular problems of delivering health care in a custodial setting among the Ministry’s existing health staff should be lost. It would be for the new, independent body to determine how the health services would be delivered. It might choose to enter into contractual arrangements with external providers (as the Ministry has considered) or it may choose to employ its own staff – or some other option.
- 6.172 I recognise that such a fundamental change in approach is unlikely to happen in the short term. The recommendations I have made throughout this Report to improve the provision of the existing health service should, therefore, be actioned in the intervening period.

RECOMMENDATION 6.10

That the planning and delivery of prison health services should be the responsibility of a body entirely external to the Ministry - with independent funding - to ensure the treatment of prisoners as patients and that prison health services are equivalent to those available in the community. Until this change can be brought about the other recommendations in this Report concerning health services should be implemented.

Compliance with standards

- 6.173 In terms of international standards such as the United Nations *Standard Minimum Rules for the Treatment of Prisoners*, and the *Standard Guidelines for Corrections in Australia* in relation to health care, it seems to me that the Ministry complies in theory with most of the principles contained in those rules. I have formed the same view about the extent of the Ministry’s implementation of RCIADIC Recommendations. However, there are areas where, in my opinion, there is non-compliance with either the spirit of the standards or recommendations or there are simply insufficient resources for proper implementation.
- 6.174 In my view, compliance with the following United Nations *Standard Minimum Rules for the Treatment of Prisoners* is questionable:-
- UNR 22(1)** *Medical services should be organised in close relationship to the general health administration of the community or nation.*
- In Western Australia prison health services are exclusively the responsibility of the Ministry - there is no “close” relationship with HDWA, which has very little involvement in prison health services.

UNR 23(1) *In women's institutions there shall be special accommodation for all necessary pre-natal and post-natal care and treatment.*

- As stated at paragraph 6.65 ante-natal care is provided at the prison by prison health staff although prisoners are routinely reviewed by King Edward Memorial Hospital staff prior to delivery at that hospital. Post-natal care is also provided within the prison by prison nursing and medical staff and Bandyup has a nursery for mothers and children up to the age of 12 months. At regional prisons which house female prisoners there are no health services, facilities or programs with a female focus. Presumably arrangements would be made at regional prisons housing female prisoners to transfer pregnant prisoners to Bandyup.

UNR 25(1) *the medical officer shall.....daily see all sick prisoners, all who complain of illness, and any prisoner to whom his attention is specially directed.*

- No prison in Western Australia has routine daily coverage by a medical practitioner. Frequency of 'clinics' varies from once per week at Eastern Goldfields, Pardelup, Riverbank, Roebourne and Nyandi to five days per week at Casuarina and Hakea where a Saturday morning clinic is also held. The Ministry has told me that it "does not attempt to ensure that all sick prisoners are seen by a doctor daily, rather that prisoners who require such attention should be seen daily by a health professional" and that the usual waiting time to see a "health professional" is 1-3 days. This does not seem to me to equate with the standard set out in UNR 25(1) and delays in seeing a medical practitioner continue to be a source of complaint to my Office.³⁵

UNR 32(1) *punishment by close confinement.....shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it.*

- This procedure is not followed in Western Australian prisons.

UNR 32 (3) *the medical officer shall visit daily prisoners undergoing such punishments and shall advise the director if he considers the termination or alteration of the punishment necessary on grounds of physical and mental health.*

- This does not occur on a daily basis in Western Australian prisons. Section 39(f) of the *Prisons Act 1981* provides that a medical officer shall "on the request of the chief executive officer give close medical supervision to a prisoner in separate confinement". DGR 3U provides for a prisoner in separate confinement to be reviewed by medical staff "as soon as practicable after placement" and for "weekly review by medical staff....At discretion of Superintendent access may be in sight of but out of hearing of prison officer(s)".

6.175 To the extent that the *Standard Guidelines for Corrections in Australia* reflect United Nations *Standard Minimum Rules*, I suggest that the Ministry does not comply with *Guideline 5.66* (UNR 22 (1)); *Guideline 5.71* (UNR 25 (1)) and *Guideline 5.34* (UNR 32(3)).

6.176 I am unable to state that the spirit and intent of the following recommendations of the RCIADIC relating to health are currently being complied with:-

Recommendation 150 – prison health care "should be of an equivalent standard to that available to the general public.....adequately resourced.....accessible and appropriate to Aboriginal prisoners.....24-hour a day access.....either available on the premises or on call."

- In my view the service available to prisoners does not meet the requirements of this recommendation because:-
 - Prison health services are not adequately resourced
 - there are minimal health education and preventative programs;
 - there are insufficient nursing staff and medical practitioners to be able to provide adequate services 24 hours a day, seven days a week at all institutions
 - there are inadequate facilities for certain special needs groups who form a large proportion of the prison population
 - the accepted difficulty in employing Aboriginal health staff has not been addressed by the provision of comprehensive and regular training for all health staff in Aboriginal health and cultural issues
 - interference by prison operational considerations when the primary concern should be the health of the individual

Recommendation 152 – *review of health services to Aboriginal prisoners and report upon a number of matters*

- The Ministry does not appear to have conducted a review of health services to Aboriginal prisoners. In terms of the matters it was recommended should be covered in the review:-
 - (152b) There are very limited “*drug and alcohol treatment, rehabilitative and preventative education and counselling programs*” tailored to suit the needs of Aboriginal prisoners. The programs which are available for all prisoners do not occur until pre-release due to lack of resources.
 - (152c) Aboriginal medical services provide services to Broome and Greenough Regional Prisons but are rarely involved in health services of any kind at other prisons.
 - (152g) There are some protocols which outline specific action to be taken by officers for the care and management of prisoners who are: at risk of self harm; intoxicated, drug-affected, angry, aggressive, behaviourally or mentally disturbed. However, there are very limited management options for actually dealing with such prisoners.

Recommendation 153 – *ongoing review of health services; medical staff responsible to professional medical officers rather than prison administration*

- Health services are frequently reviewed when there has been a crisis or a serious problem has arisen. However, there is no guarantee that recommendations made following such a review will be implemented. There appears to be no ongoing review or evaluation of services provided in accordance with the principles of continuous improvement.
- Although health services staff are directly responsible to the Director, Health Services, day to day service provision within prisons is subject to the pressures and constraints of prison administrative considerations.

Recommendation 154 – *training in Aboriginal health, history, culture and life-style in consultation with Aboriginal medical services; the employment of Aboriginal health service providers in prisons*

Recommendation 155 – *prison officer training should include information on the general health status of Aboriginal prisoners to enable them to be aware of the risks.*

- Cross-cultural training is provided but is irregular and is considered by staff to be insufficient. The Ministry claims that it has found it very difficult to recruit sufficient Aboriginal health workers. There appears to be little consultation with Aboriginal health workers in the metropolitan area.

Recommendation 328 – *sufficient resources should be made available to translate the principles of Standard Guidelines for Corrections adopted by the Commonwealth Government and all States and Territories into practice.*

- On the basis of my inquiry I have found that prison health services are inadequately resourced to provide a health service equal to community standards.

SUMMARY OF CONCLUSIONS ON PRISON HEALTH SERVICES

6.177 At the outset I would like to re-emphasise that I have received no evidence which leads me to the view that any deficiencies in the system as a whole can be attributed to the negligence, incompetence or indifference of prison health services staff. In general terms I have been impressed by their professionalism, their dedication and their resilience in spite of frustrations caused by lack of funding and resources; interference in the performance of their function as health service providers and a heavy workload.

6.178 My examination of prison health services has been measured against -

- the basic principle that access to health care of community standard is a fundamental prisoner right;
- the requirements of universally accepted minimum standards and conventions;
- community health care standards;
- ethical principles;
- the Ministry's duty of care; and
- the views and concerns of prisoners and staff.

6.179 In essence, I have formed the opinion that prison health services have been unable to provide the level of service to prisoners necessary to fulfil the Ministry's duty of care and comply with the framework of standards and guiding principles which apply to prisoner health care. In my view, this is because:-

- The independence of prisoner health services is frequently compromised to the detriment of the health of prisoners and the safety of the system as a whole.
- Prison health services are provided with insufficient funding and resources to properly meet the *needs* – not the demands – of prisoners, primarily because prisoner health is considered a lower priority than the demands of prison and custodial operations.
- The Ministry is unable to produce adequate statistical information to enable it to monitor and evaluate current levels of service need in order to anticipate problems and identify areas requiring additional resources and facilities.

6.180 I have made a number of recommendations throughout this chapter which could, in my view, address the deficiencies outlined in this section on prison health services. I realise that there are significant cost implications in my recommendations. However, I make no apology for that for three reasons:-

- (i) In my view there has been significant under-resourcing of health services for some years caused by the Ministry's failure to properly evaluate the effectiveness of its current services in order to ascertain whether they meet the needs of prisoners now and in the future.
- (ii) There are significant long term benefits for prisoners, prison staff and the community if prison health services were to be enhanced as part of a holistic approach to the rehabilitation of prisoners prior to release.
- (iii) Improvement of prisoner health services could also reap significant cost-benefits for the prison system and the community.

SUMMARY OF RECOMMENDATIONS TO IMPROVE PRISON HEALTH SERVICES

6.1 That the Ministry:-

- (a) monitor the level of accommodation and service required by special needs groups of prisoners particularly those suffering the effects of substance abuse; those with a psychiatric disorder; and female prisoners (particularly those in regional prisons) and ensure that its future accommodation plans include adequate facilities for their placement and care;
- (b) enhance its current health services for Aboriginal prisoners by:-
 - initiating formal discussions with community health groups such as Derbarl Yerrigan Health Services and the Albany Health Promotion Unit with a view to encouraging and establishing their greater involvement in the provision of health services to Aboriginal prisoners; and
 - providing adequate funding to enable the Ministry to take advantage of and co-ordinate any specialist services, advice and training that Derbarl Yerrigan and other Aboriginal health groups may be able to provide to prison staff.
- (c) provide routine health reviews for long term prisoners as part of a structured and certain sentence plan which includes education, employment and rehabilitation programs.

6.2 That the Ministry consider the following strategies to address the shortage of nursing staff:-

- (a) promotion of prison nursing as a specialised field of expertise which should be accredited and taught as a unit in the tertiary nursing qualification;
- (b) the greater involvement of trainee nurses in prison nursing to increase awareness of the range of skills required in this field of expertise and similar encouragement of medical students from teaching hospitals to increase community involvement and awareness;
- (c) introduction of a structured career development program for staff by including training and the acquisition of additional qualifications in a continuing education model similar to that available in other professions; and
- (d) given that the nursing community is small and shares experiences, commitment to improvement of its profile as a 'good employer' by addressing the concerns of its staff that they are under-valued, not appreciated and are more likely to be blamed than receive support.

- 6.3 That, as a matter of priority, the Ministry develop a strategy for the employment of all nursing staff under the ANF award as part of a strategy to encourage a cultural change and to enhance the independence of health services from operational staff.
- 6.4 While acknowledging that the Ministry has taken steps to significantly increase the level of training for health staff, that it review its current training programs for health staff in consultation with staff and HDWA in order to evaluate their relevance and adequacy; to identify any deficiencies and to formulate appropriate strategies to rectify those deficiencies.
- 6.5 That, for consistency with community initiatives and in the interests of improving the general health of prisoners and the occupational safety of prison staff, the Ministry develop, fund and implement a comprehensive range of health education and preventative programs utilising the expertise of appropriate community organisations and selected prison staff and prisoners; and
- 6.6 That the Ministry:-
- (a) ensure that the health of prisoners receives, and is seen to receive, the same level of commitment as prison operations; and,
 - (b) take steps to improve the working conditions of health services staff and enhance their status within the system with the aim of emphasising their independence and raising the standard of health services generally.
- 6.7 That the Ministry monitor the capacity of its new information technology system to ensure that it is adequate to enable it to ascertain the effectiveness of its initiatives, programs and strategies and determine priorities for service modification and development.
- 6.8 That the Ministry raise the issue of the exclusion of prisoners from Medicare coverage with the JJ/HIDC with a view to it being referred to the appropriate State and Federal authorities for comprehensive review and investigation.
- 6.9 That the objectives and operation of the JJ/HIDC be reviewed in order to utilise the full potential of the joint expertise of such a body.
- 6.10 That the planning and delivery of prison health services should be the responsibility of a body entirely external to the Ministry - with independent funding - to ensure the treatment of prisoners as patients and that prison health services are equivalent to those available in the community. Until this change can be brought about the other recommendations in this Report concerning health services should be implemented.

- ¹ See Chapter 3, paragraph 3.10
- ² See Chapter 3 paragraphs 3.9 and 3.36
- ³ *Patient or Prisoner?* Chapter 2, pages 1 and 2
- ⁴ The Ministry's suicide prevention strategies and its education, employment, training and rehabilitation programmes are considered in Chapters 9, 11 and 13
- ⁵ I have not included an analysis of the 10 prisoners who have died in 2000 as their deaths are still subject to investigation
- ⁶ Trends and Issues in Criminal Justice No 115 *Elderly Inmates: Issues for Australia*
- ⁷ McCarthy M in *Corrections Today* vol 45, no.1: *The health status of elderly inmates*
- ⁸ See also Chapter 5 paragraphs 5.117-5.123
- ⁹ National Institute of Corrections; Special issues in Corrections, September 1997; *Prison Medical Care: Special Needs Populations and Cost Control*
- ¹⁰ 'Median' is defined as the age below which the ages of 50% of prisoners fall
- ¹¹ I am aware that a life sentence in New South Wales could mean a natural life sentence. However recent lengthy life sentences handed down to offenders and the option to sentence a prisoner to an indeterminate sentence make the problem of dealing with ageing prisoners relevant in Western Australia
- ¹² Released 17 April 2000
- ¹³ Winifred Michael died from complications resulting from a perforated appendix. The two deaths in 2000 have not yet been the subject of inquest
- ¹⁴ Annual Report 1997/1998
- ¹⁵ South West local Aboriginal community newspaper *Noongar Warda*
- ¹⁶ The Ministry estimates that the figure for Western Australia is lower at around 20%
- ¹⁷ See Chapter 5, paragraphs 5.47-5.54
- ¹⁸ See Chapter 12 paragraphs 12.144-12.148
- ¹⁹ Census taken on the night of 30 June for each year
- ²⁰ *Prisoners in Australia 1998*, National Corrective Services Statistics Unit, Australian Bureau of Statistics, June 1999
- ²¹ The figure includes 168 prisoners serving indeterminate sentences
- ²² Ministry of Justice statistics
- ²³ The figure includes 184 prisoners with indeterminate sentences
- ²⁴ *Prisoners in Australia 1999*, National Corrective Services Statistics Unit, Australian Bureau of Statistics, June 2000
- ²⁵ Ministry of Justice statistics
- ²⁶ *Report of an investigation into the administrative action relating to the health care provided to Ms W and Ms E at Bandyup Women's Prison and related administrative matters*, paragraphs 499-500
- ²⁷ See Chapter 11 paragraphs 11.54-11.55
- ²⁸ The Ministry has advised me that medical students have been involved in prison health care since February 2000
- ²⁹ The criticisms which have been drawn to my attention in the course of this inquiry have been levelled for the most part at staff at Casuarina, not at Hakea.
- ³⁰ Recommendation No. R (98) 7
- ³¹ Cited in section 36(1) of the *Prisons Act 1981* as one of the responsibilities of the superintendent
- ³² The *Oath of Athens* signed by health professionals working in prisons on 10/9/79
- ³³ Chapter 1 *Introduction* at page 1
- ³⁴ Defined in the Macquarie Dictionary as "the sorting at the battle front of casualties according to the urgency of treatment required" and as "a similar procedure in hospital". The Ministry's *Health Standards* define triage as "the organisation and delivery of nursing services based upon nursing assessment to determine priority of health need and appropriate intervention"
- ³⁵ See also paragraph 6.136
- ³⁶ RCIADIC Recommendation 177 refers to the need for cross - cultural training for prison officers

CHAPTER 7 MEDICATION ISSUES

BACKGROUND

MEDICATION ISSUES ARISING FROM DEATHS OF PRISONERS

CURRENT OPERATION OF THE PRISON PHARMACY SERVICES

ISSUE OF MEDICATION BY PRISON OFFICERS

REASONS FOR THE DEMAND AND PRESCRIPTION OF MEDICATION

CONCLUSIONS ON MEDICATION ISSUES

SUMMARY OF RECOMMENDATIONS

BACKGROUND

- 7.1 The Prison Pharmacy Service (the Pharmacy) was established and located at Fremantle Prison in the 1960s with one pharmacist to service the needs of the prisoners at that prison. The increasing workload resulted in the appointment of a second pharmacist in the late 1970s to enable the professional functions of the pharmacy – drug information, education and monitoring of drug usage by prisoners - to be performed. In 1980 the Pharmacy was relocated to its current site on the Canning Vale Prison Complex and also assumed responsibility for medication at the new Canning Vale Prison when it opened that year.
- 7.2 In 1988 it was decided to close the Pharmacy and obtain medication through external supply. It appears that after only three months of the operation of the external supply system the cost of supply of pharmaceuticals to prisoners had exceeded the expenditure for the whole of the previous year. In 1989 the Pharmacy was reopened to reduce costs and to apply appropriate standards of control over medication and the current Chief Pharmacist was appointed. Supply to Fremantle was resumed immediately, closely followed by the Remand Centre and Canning Vale Prison. Further expansion of service included Bandyup, Barton’s Mill (now closed), Karnet, Bunbury and Albany with partial supply to Broome, Roebourne and Greenough. Eastern Goldfields received its pharmaceuticals from Kalgoorlie Regional Hospital (and continues to do so). According to the census of prisoners conducted on 30 June 1989 there were 1586 prisoners in the system.
- 7.3 In 1991 Casuarina replaced Fremantle and was added to the list of prisons serviced by the Pharmacy. Riverbank and Nyandi were included in 1999.¹ The current staff establishment is 2 FTEs – a Chief Pharmacist and a Senior Pharmacist, assisted by a Pharmacy Technician appointed in May 1999 on a 12 month contract². The muster on the night of 29 June 2000 was 3118.

Role and functions of the Pharmacy

- 7.4 The ‘departmental’ role of the Pharmacy is to ensure “*patient safety through proper storage, distribution and monitoring the adherence to appropriate administration procedures for pharmaceuticals.*”³ In addition, the Pharmacy is responsible for:
- “*the development and implementation of all policies concerning pharmaceuticals*”;
 - monitoring “*patient drug usage and gives advice to medical and nursing personnel on the correct use, adverse effects and relevant information relating to individual patient drug therapy*”;
 - providing “*a source of drug information within the Department*”; and
 - providing “*continuing education to nursing and other allied health staff.*”
- 7.5 The ‘regional’ role of the Pharmacy is to “*control and supply pharmaceuticals within the region*” and to “*visit all medical centres within the region to give advice on pharmaceuticals with regard to usage and storage.*”⁴
- 7.6 The current job description of the Chief Pharmacist allocates 50% of his time to his “*professional responsibilities*”; 45% to managing the Regional Pharmaceutical Service and 5% to “*policy formulation*”. A similar allocation of duties applies to the Senior Pharmacist.

Medication Policies And Protocols

7.7 To supplement the standard professional responsibilities of Pharmacy and other health staff, the Ministry has developed a number of policies and protocols which, *inter alia*, outline the philosophy of its general prescribing policy and establish guidelines for the prescription and use of, for example, Narcan, Benzodiazepines, Methadone and Naltrexone as well as guidelines for alcohol and drug withdrawal.

MEDICATION ISSUES ARISING FROM THE DEATHS OF PRISONERS

7.8 Although concerns about the actual medication prescribed to a prisoner have not been raised following investigation of prison deaths, a number of administrative issues involving medication arose in relation to the deaths of the following prisoners:-

NAME	DATE OF DEATH	PRISON
Paul Vincent	8 June 1992	CWC Remand
Kenneth Summers	19 April 1993	Casuarina
Darren Boyle	5 September 1994	CWC Remand
Keith Reynolds	29 October 1995	Broome
Carl Jackson	11/12 January 1996	Casuarina
Anthony Wood	11 January 1997	CWC Remand
Noel Clarke	6 April 1997	Casuarina
Colin Shaw	1 October 1997	Hospital ex Casuarina
Geoffrey Lindsay	14 November 1997	Greenough
Tammy Green	13 March 1998	Bandyup

7.9 The issues raised were:-

- procedures when prisoners refuse prescribed medication (Kenneth Summers, Anthony Wood, Colin Shaw, Geoffrey Lindsay)
- flaws in medication procedures (Paul Vincent, Darren Boyle, Keith Reynolds, Tammy Green)
- medication issued at times to suit the administrative convenience of the prison (Kenneth Summers, Darren Boyle, Ronald Hill)
- prescription of Schedule 4 drugs by telephone (Carl Jackson)
- supply of medication to prisons by the Pharmacy at Canning Vale (Tammy Green)

Procedures when prisoners refuse prescribed medication

- 7.10 The investigations of the deaths of Kenneth **Summers**, Anthony **Wood**, Colin **Shaw**, and Geoffrey **Lindsay** all revealed that they had made a positive decision not to take medication that was prescribed to them.
- 7.11 In Mr Summers' case, the Coroner noted this issue in his findings and expressed the view that prisoners cannot be compelled to take medication. It appears to have been known by health staff that Messrs Wood, Shaw and Lindsay had refused their prescribed medication. (Messrs Shaw and Lindsay – both Aboriginal - also refused to attend hospital appointments and Mr Shaw also refused to modify his diet. Mr Lindsay took this course of action in spite of being treated by Geraldton Aboriginal Medical Services.)
- 7.12 It is quite clear that it would be unethical for prisoners to be compelled to take prescribed medication. Nevertheless, where health services staff become aware that a prisoner has *chosen* not to take prescribed medication, the Ministry should, in my view, take appropriate action, particularly if a prisoner's non-compliance is part of a stated intention to die.
- 7.13 In August 1995 the Director, Health Services introduced a formal policy outlining action to be taken by medical/nursing staff in such situations. The instructions provide basic common sense directions requiring nursing and medical staff to discuss with the prisoner the likely effects and repercussions of his/her refusal and to suggest acceptable alternatives where appropriate. They also provide that where there is ongoing refusal to take essential medication the Superintendent should be notified and the matter referred to the Director, Health Services for future management. I understand that a management plan which identified strategies to assist staff interact with Mr Shaw with respect to his non-compliance was developed following consultation with both prison and health staff and that assistance from various sources was sought to encourage him to comply with the health regimen developed for him. This included contact with members of his Aboriginal community and an attempt – albeit unsuccessful – to arrange for a Mabarn man (an Aboriginal healer) to visit Mr Shaw while he was in Eastern Goldfields Regional Prison.
- 7.14 Although I realise that refusal to take prescribed medication does not apply exclusively to Aboriginal prisoners, it is perhaps significant that, with the exception of Mr Summers, all of the above-mentioned prisoners were Aboriginal. Prison health staff at Roebourne Prison informed my inquiry that they also occasionally seek the assistance of traditional Aboriginal healers from the community when treating some Aboriginal prisoners. However, in general this approach does not seem to be widely encouraged by the Ministry. Given that prison nursing staff are predominantly white and female and that there are few Aboriginal nursing staff or health care workers in the prison system, a more flexible approach to traditional healing and 'bush' medicine may merit further consideration.⁵

RECOMMENDATION 7.1

Where there are difficulties in ensuring compliance by some Aboriginal prisoners with Western medication regimes, prison health staff should be willing and able to involve appropriate community members with knowledge of traditional healing methods and /or who may be able to persuade prisoners to accept medication regimes.

Flaws in medication procedures

(a) Prescribing doctor not advised of a prisoner's failure to take prescribed medication

7.15 Allied to the above issue is the situation where the post-death investigation reveals that a prisoner's failure to take prescribed medication was not drawn to the attention of the prescribing medical practitioner by health staff. This situation came to light following the investigation of the death of Darren **Boyle**, who was prescribed medication for the morning and the evening but only collected his morning medication on two occasions. This omission is of greater concern if, as discovered in Mr Boyle's case, a medical review ordered by the doctor did not take place.

7.16 Although the Coroner did not believe the omission in Mr Boyle's case was a causative factor in his death, following his investigation of Mr Boyle's medical management, the then Manager, Health Services recommended:

"That the Director, Health Services issue a protocol dealing with procedures for the administration of essential medication (such protocol to provide for follow up action by nursing staff where non-compliance by prisoner patients is in evidence)."

7.17 As a result, *Health Services Policy 5.14 Refusal of Treatment* was issued in August 1995 and provides that if a prisoner refuses treatment, examination or medication, the prisoner must be called up to the next Nurse's Parade so that the reasons for the treatment can be explained and acceptable alternatives discussed. If the prisoner continues to refuse, the medical practitioner, and the Superintendent where considered appropriate, are to be notified. The Ministry has advised me that this Policy is currently under review. In addition, *Policy 6.7 Depot Medication Charts* (which relates to procedures for the administering of medication for schizophrenia), issued in October 2000, provides that "Nursing staff should document injections given or refused in the medical record. Prisoners refusing medication must be referred to the MHNS⁶ or medical officer as soon as possible." I also note that DGR (B24) governing procedures for the issue of medication by prison officers (which was introduced only in 1999) includes the requirement that a form must be completed by the issuing officer noting the reason for non-issue of a prescribed medication.

(b) Prisoners who receive but do not consume their medication

7.18 Following investigation of the death of Kenneth **Summers**, it came to light that he did not consume his medication in the presence of the officer issuing it and had most probably not taken it for a number of days prior to his death.

7.19 Although I appreciate that there are many ways in which a determined prisoner might fake consumption of his or her medication, the Ministry's medication policy clearly requires staff to witness a prisoner taking medication. This policy is important because it prevents a prisoner from hoarding the medication for later use - with the inherent risk of an overdose - and reduces the opportunity for prisoners to be bullied into giving their prescribed medication to other prisoners for whom it may not be suitable. I would have thought it is essential for staff to ensure that medication is consumed at that time; to alert Unit staff if they have any doubts and to annotate the medication chart accordingly. Failure to take prescribed medication could have serious repercussions for the health and well-being of the prisoner. An omission of this nature is, in my view, a piece of information which is integral to the future management of the prisoner. I note that the Ministry uses medication in liquid form wherever possible to minimise this problem.

(c) Deficiencies in the medical record

- 7.20 Deficiencies in the recording of medication details were uncovered during the investigations of the deaths of Paul **Vincent**, Keith **Reynolds** and Tammy **Green**.
- 7.21 Mr **Vincent** was issued with medication for four days after the ‘stop’ date ordered by the doctor because the usual practice of marking the ‘stop’ date on a prisoner’s medication chart did not occur.
- 7.22 Mr **Reynolds** did not attend the medication parade to receive his prescribed medication on the night of his death. However, the on-duty nurse and a prison officer initialled the medication chart after Mr Reynolds’ death, thereby giving the impression that Mr Reynolds had received his medication on the evening of his death when it was known – and was not concealed - that he had not. Presumably the aim was to conceal the fact that the officer responsible for distributing medication had not noted the chart to that effect at the time. Although a cardiologist called as an expert witness gave evidence this was not a “causative factor” in his death, the Coroner was critical of the action of the nurse and the prison officer and stated:-

“C..... and R..... were extremely unwise, naïve in fact, to have attempted to rectify deficient paperwork after the death of Reynolds. All relevant paperworkshould have been handed forthwith to [the] Superintendent without updating or amendment and then to the investigating police officer. In future it is hoped that the Ministry introduce protocols or standing orders along these lines to avoid the problem that occurred in the present case.”

- 7.23 A number of issues were raised about the provision of medication to Ms **Green** during the inquest. Of relevance in the context of ‘record-keeping’ was the discovery that two members of the nursing staff signed her medication chart to indicate that she had received particular medication even though there was none in stock at the prison. Of significant concern, in my view, is the first nurse’s admission that she “*had a practice of filling out the form prior to provision of the drug to a patient.*”⁷
- 7.24 The second nurse who signed the medication chart said that when she realised that she had made a mistake, she crossed out her signature and wrote “*err*” to indicate that the entry had been made in error. Unfortunately the crossing out was not clear and not only the doctor who reviewed the medication chart after Ms Green’s death but also the IIU investigator believed that the medication had been provided. The Coroner commented:-

“As a result of being misled by this chart [the IIU investigator’s] whole investigation into the circumstances of alleged complaints by the deceased to prisoners that she was not receiving medication was compromised.....It was only a short period before the inquest hearing when the internal investigator attached to the Ministry of Justice was first advised that throughout her period in custody the deceased had never received [the medication].”

- 7.25 Although the Coroner was satisfied that the failure to obtain the medication in question for Ms Green “*does not appear to have directly contributed to her death*”, he also observed that “*it is clear that this caused her considerable distress.*”
- 7.26 The Ministry’s *Health Services Policy 3.1* states:

“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.”

- 7.27 This policy also emphasises the importance of “*accurate and contemporaneous*” documentation. I am aware, however, from discussions with health staff and from my own examination of prisoner records in the course of investigations of complaints that medication charts are not always completed by nursing staff with the reason for the non-issue of medication.
- 7.28 A review of weekend nursing staff levels at Casuarina commissioned by the Ministry in August 1998 noted a consistent failure by nursing staff at that prison to properly complete medication charts. The report stated:-

“All staff would agree that mistakes occur, however the only quality assurance available is the ability of the prisoners to notice any mistakes and bring them to the attention of those issuing their medication.”

“.....When conducting a medication parade there is insufficient time to devote to documenting [listed] medications.....every effort is made to document discretionary hypnotics and tranquillisers, but this does not always happen. The implication is that it is standard practice for nurses not to document medications and as a subsequence [sic] this has become acceptable custom and practice.

Problems relating to documentation that I have observed include, no documentation at all, documentation on different forms..... This ad hoc method makes tracking a particular prisoner’s medication difficult and of course impossible if no documentation has taken place at all. With regard to existing medication charts, again no documenting makes it very difficult for nurses to ensure that prisoners are not being overmedicated.”⁸

- 7.29 I believe that a review of procedures was conducted after receiving the results of this review. However, the Director, Health Services has told me that he still has concerns about the standard of record-keeping and I understand that he has organised for nursing staff at Casuarina and Hakea to undertake a Documentation and Skills Update course for nurses through Curtin University.
- 7.30 Medication charts which have been wrongly completed, either in an attempt to conceal some omission or as a short cut to save time, are a serious flaw in the Ministry’s accountability to prisoners and, I suspect, would constitute a breach of the professional registration requirements of health staff.
- 7.31 I realise that, in the context of the hundreds of records and notes made by health services staff each week, a small number of omissions may be inevitable. Moreover, they may or may not be significant in any particular circumstance. It might be argued, however, that the deficiencies illustrated by the above examples, can be attributed in part to the heavy workload of the majority of prison health professionals and the shortage of staff in all areas of health services. Errors or omissions may also occur because of a shortage of resources which results in inadequate supervision and auditing of medication charts⁹. Concerns about the current standard of record-keeping and the potential for errors with serious consequences have been drawn to my attention by senior Health Services personnel. This issue is considered further in the context of the Ministry’s decision that prison officers at regional prisons should give out medication outside nursing hours.¹⁰

RECOMMENDATION 7.2

That a DGR be introduced to ensure that non-issue of prescribed medication to, or non-consumption of prescribed medication by, a prisoner for any reason is recorded and drawn immediately to the attention of the senior nurse on duty at the time and of the prescribing medical practitioner.¹¹

Medication issued at times to suit the administrative convenience of the prison

7.32 In his findings following the inquest into the death of Kenneth **Summers** the Coroner stated:-

“...the present system meant that medications were given out early in the evening and that some prisoners were reluctant to take medication at that time, particularly if the medication had a strong sedative effect, because the medication might take effect soon after ingestion resulting in the inmate not being able to remain attentive to his surroundings from an early hour in the evening.”

7.33 This was of particular relevance to Mr Summers who was afraid that other prisoners and prison officers were conspiring to harm him and felt vulnerable prior to lock up. The importance of his medication was emphasised by the IJU who concluded that *“It was through the use of medication that this paranoia was suppressed.”*

7.34 The Coroner commented that the expectation that Hospital Officers would advise the prescribing doctor if a prisoner did not take his medication for several days was *“too general an approach to potential problems and does not appear to cater for the individual medical and mental problems of individual inmates.”*

7.35 The Manager of the SNT at the time also expressed concern about the provision of medication and stated:

“I believe there is merit in Unit managers being provided with a list of prisoners within their Unit who are on psychotropic medication or other medication which when withdrawn may be evidenced by behavioural changes. At very least this provides staff with further information which is important.”

7.36 Concerns about the provision of medication, particularly sleeping medication, too early in the evening were raised again by the Coroner and the Manager of the SNT following the deaths of Darren **Boyle** and Ronald **Hill**. The Coroner stated:

“...the difficulties of providing prescribed medication to all inmates of the prison system should not be allowed to override the medical necessity of providing medication of [sic] at appropriate time of day. The prison authorities have a duty of providing the necessities of life, including medical treatment. If medication is required to be provided late in the evening, say at 10.00pm, then this should be put into effect. Such a regime should be instituted for persons on remand as a matter of urgency, as there is clear evidence that persons who have been incarcerated are most vulnerable at this early period.”

7.37 The Manager of the SNT noted:

“The problem of evening medication being given out too early is an issue which prisoners have commented on. If the medication is for sleeping the person falls asleep too early and then may wake up in the early hours of the morning with little else to do but worry about their situation. Often the vulnerable, at risk prisoners have very few coping skills as highlighted by Alison Liebling’s research. A person with coping strategies who awakes in the middle of the night and cannot sleep may read or write letters or even watch television, it is the lack of coping skills which seems to highlight those most at risk.”

7.38 I believe that the reason for all evening medication, regardless of purpose, being given out early in the evening is to fit in with evening lockup procedures. Moreover, the fact that most living units are not staffed at night necessitates use of the Recovery Team to unlock a cell after lockup to administer medication.

- 7.39 If the medical reason for prescribing sleeping tablets to a prisoner is sound, it is clearly absurd and a significant waste of already scarce health funds for prisoners to be given what amounts to pointless medication because it is issued too early. Using Mr Summers' case as an example, the provision of medication at an inappropriate time could also significantly increase a prisoner's risk of self harm. It is encouraging to note, therefore, that Recommendation 2 of the Ministry's draft *Drug Management Strategy Project* (April 1998) proposes:

“Medication designed to promote sleeping and/or the management of depressed states of mind should be issued at the optimum time for the medications to take effect. This is generally accepted as being in the mid-evening (9.00pm). Issuing of such medications should occur within the prisoner's personal cell environment and be actioned by either custodial or nursing staff. Consideration should be given to modification of prison cell doors to include hatches for the provision of medication.”

- 7.40 I am aware that resolution of this particular problem has significant cost implications in that it either involves an increase in staffing levels or structural modification of cell doors. The last sentence in the quotation in the previous paragraph is an obvious reference to the problem of opening cell doors after lock-up in a unit that is not normally staffed at night. The decision not to staff a unit at night is clearly motivated by cost savings and is perhaps a good example of the 'tail' (administrative convenience) wagging the 'dog' (prisoner needs and welfare). I understand that an appropriate means of addressing this problem is still under consideration. In my view this is an important aspect of the provision of adequate prisoner health care issue which the Ministry cannot ignore, even if there are cost implications.

RECOMMENDATION 7.3

That the Ministry as a matter of priority devise a means of providing prescribed medication to prisoners at the time which optimises the therapeutic effect of the medication and not at a time that best suits administrative convenience.

Procedure for the prescription of Schedule 4 drugs by telephone

- 7.41 Counsel representing the family of Carl Jackson at the inquest into his death questioned the legality of the prescribing of Schedule 4 drugs by telephone in an emergency in the context of the *Poisons Regulations* and whether the definition of 'emergency' required the doctor to examine personally the prisoner for whom the medication was prescribed.
- 7.42 After the inquest, Senior Assistant Crown Counsel provided the Ministry with a legal opinion (dated 15 August 1996) which seemed to confirm that it is at least doubtful whether the 'telephone' prescription and subsequent administration of Schedule 4 medication to Mr Jackson were in strict compliance with the *Poisons Regulations* for two reasons:-
- (a) that it was questionable whether it was in accordance with *Regulation 38AA(1)* for a Hospital Officer to administer a Schedule 4 drug to Mr Jackson on the basis of notes of the doctor's instructions made by another Hospital Officer; and
 - (b) that the administration of the Schedule 4 drug to Mr Jackson in his *cell* did not comply with *Regulation 38AA* which authorises the administration of drugs by a person other than a medical practitioner in a *hospital*.

- 7.43 The Ministry's response at that time was that it was "*totally impractical*" for the prison medical officer who was 'on-call' for all metropolitan prisons after hours to personally attend at a prison for the sole purpose of writing out a prescription. Such a practice would lead to an "*immense increase in cost*".
- 7.44 Despite the legal advice available to the Ministry in 1996 questioning the legality of this practice, it took no action at that time. It has subsequently recently advised me, however, that it did seek further "*urgent*" legal advice in April 1999 "*to establish the potential for having this legislation amended to take account of the needs of prisoners and the organisation's capacity to meet those needs.*" In essence, the Crown Solicitor's Office has advised the Ministry that although it is of the view that "*on balance...the prison system is not bound by Regulation 38AA, [the Ministry] should have regard for the intent of the legislation. That is to minimise the risk of incorrect administration of a Schedule 4 drug, and in the event of a mistake, to minimise the time during which the incorrect administration should continue.*" I have also been advised that the Director, Health Services has formulated a revised policy for this issue which he has sent to HDWA for comment.
- 7.45 I accept that it may well be inconvenient, and perhaps even impractical, for a doctor to attend at a prison purely to write a prescription. I also understand from the AMA that it is common for doctors in remote areas to give telephone instructions to nurse practitioners not only in emergencies. However, the important point in the current context is that, in spite of the doubts expressed in the 1996 legal opinion about the legality of this practice in a custodial setting, the Ministry took no further action to clarify or address the issue until April 1999 – after a request from my Office. I would have thought that, *if* there was a significant chance that the Ministry's practices may have been in breach of the *Poisons Act* or *Regulations* (or any other legislation), it should have urgently sought clarification and rectified any problems. In my view, it would be difficult to justify non-compliance with legislation such as the *Poisons Act* purely on the grounds of cost.

RECOMMENDATION 7.4

That the Ministry finalise its legal position in relation to the prescribing of Schedule 4 medication by telephone in a custodial setting and publish a policy to that effect.

Supply of medication to prisons by the Prison Pharmacy Service

- 7.46 As noted at paragraphs 7.23-24 Tammy **Green** did not receive medication prescribed to her by the prison doctor because the prison did not have it in stock and the order did not arrive at Bandyup from the Pharmacy until after her death.
- 7.47 Although not considered essential medication, evidence was given to the Coroner by several prisoners that Ms Green became distressed when she was unable to obtain it. The Coroner noted Ms Green's concerns and stated:-

"In my view...the delay in providing the medication was excessive.

The failure to provide prisoners with prescribed medications from a Monday until the following Friday except in emergency situations is not a satisfactory arrangement.

This case has highlighted the fact that prisoners especially those who come into prison for the first time with a history of emotional problems, can become extremely distressed if prescribed medications are not available within a reasonably short period of time. Even if there was to be an additional medication run to Bandyup Women's Prison so that medications could be provided on Mondays, Wednesdays and Fridays this would improve the situation. I would recommend to the Ministry of Justice that the situation in relation to provision of medications to prisons in a similar position to Bandyup Women's Prison be examined."

- 7.48 As a result of the Coroner's recommendation, health centres at prisons in similar circumstances to Bandyup were canvassed. The Ministry has advised me that the health centres indicated that *"the current delivery arrangements for pharmaceutical supplies from the Prison Pharmacy Service are in accordance with clinical requirements. Alternative emergency supply arrangements have always been, and continue to be, in place."* Presumably those alternative arrangements were not utilised in Ms Green's case because her situation was not considered to justify them. The Ministry has also advised me that in the course of a systems review of the delivery of pharmaceuticals the Drug and Therapeutic Committee has identified a number of other issues which need to be addressed.

RECOMMENDATION 7.5

That, with the objective of achieving equivalence with community standards, the Ministry monitor the efficacy and adequacy of its current pharmacy supply service to all prisons.

THE CURRENT OPERATION OF THE PRISON PHARMACY SERVICE

- 7.49 Concerns about the operation of the Prison Pharmacy Service were raised in submissions to my inquiry and interviews with various prison health professionals. The following issues were particularly identified:-
- there should be wider use of liquid medication to prevent the opportunity for hoarding/bullying;
 - security of storage at some prisons is of concern e.g. medication in a unit at Bunbury Regional Prison is kept in a locked tool box because there was insufficient funding for a second medication trolley;¹²
 - workload and lack of resources in the Pharmacy prevents adequate monitoring of drug usage;
 - findings and recommendations of studies done have been ignored;
 - recommendations for improvements to the design of medication trolleys, methods of bulk storage, service delivery and required staffing levels have been ignored;
 - inadequate funding for training, professional development, required reference books, attendance at professional conferences;
 - compliance with Ministry procedures and directives and staff shortages frequently place Pharmacy staff in a position where they are acting outside the requirements of their professional registration.

Resources

- 7.50 The Chief Pharmacist has occupied the position since 1988. The census conducted on the night of 30 June 1989 reported a prison population of 1586. A Senior Pharmacist was appointed in 1993 when the census on 30 June 1993 showed a muster of 2038¹³. The **same** staff establishment of 2 pharmacists together with a Pharmacy Technician now services a prison population of approximately 3125¹⁴ - which includes increasing numbers of prisoners with behavioural and psychiatric disorders or substance abuse problems and a consequential rise in medications. Continuation of the technician position is dependent on cost-savings made in other areas.
- 7.51 By way of comparison, Graylands Hospital Pharmacy has 8 FTE pharmacy positions, 3-4 pharmacy technicians, 2 stores staff and clerical support to deal with a capacity of 298 patients (including 48 psycho-geriatric beds). I appreciate that the medication needs of patients at Graylands - many of whom may be heavily medicated - and the associated pharmacy service required do not offer a direct comparison with the service required in a prison environment. However, in August 2000, 1465 prisoners out of a total muster of 3108 (838 of whom were in Bandyup, Hakea, and Casuarina) were issued with medication of some form - suggesting a significant imbalance in pharmacy resources between the prison system and that of Graylands Hospital.

Professional responsibilities

- 7.52 Apart from providing pharmacy supplies to all State institutions except Eastern Goldfields and Wooroloo - the “*stores*” function - the pharmacists are responsible for monitoring the drug regimes of individual prisoners to identify inappropriate prescribing practices and general prescribing patterns; alerting the Ministry to problem areas; checking medication charts for procedural deficiencies and prescription errors; educating and informing staff about therapeutic outcomes and new developments in medications - the “*professional*” responsibilities. They must also maintain their own professionalism through professional development, training and attendance at conferences.
- 7.53 The pharmacists have advised me that they are unable to perform their ‘*professional*’ responsibilities adequately because of the amount of time taken up by the ‘*stores*’ function. They are particularly concerned about their inability to conduct drug ‘audits’ to monitor prescribing patterns at sufficiently frequent intervals and to properly monitor medication charts. Casuarina receives the most regular checks with one pharmacist spending one day per week at the prison. This is, however, only 40% of what the pharmacists believe to be the optimum amount of time given the level of medication at Casuarina and the number of errors identified in recent times.
- 7.54 Hakea Prison (formerly Canning Vale and the CW Campbell Remand Centre) is visited as often as possible with the goal of once per week. The fact that the Pharmacy is situated on the Hakea Prison complex facilitates access to those prisons. However, the pharmacists are concerned that they are able to visit Bandyup, where there is also a high level of medication, and Karnet, at infrequent intervals and that Wooroloo is never reviewed. Greenough and Albany/Pardelup are reviewed by the HDWA Regional Pharmacist who reports problems to the prison Chief Pharmacist but no audits are currently conducted at Bunbury, Eastern Goldfields, Roebourne or Broome.
- 7.55 For the same reasons, the pharmacy staff are unable to provide other than “*as required*” advice by telephone or during weekly visits to nursing staff at any of the prisons, particularly regional prisons. The concept of a ‘Pharmacy Newsletter’ which could at least provide information is not feasible because of the time needed to produce it. The Chief Pharmacist has, however, organised a series of monthly seminars at the Pharmacy given by drug company representatives on new developments in pharmaceuticals to interested prison health staff after working hours. I am told that these seminars have proved popular and useful.

Data collection and information systems

- 7.56 Although some monitoring of prescribing trends was possible in the past, the pharmacists have found it increasingly difficult because of workload to provide the Ministry with regular comprehensive statistics showing medication usage by offenders and by prisons to enable it to identify and monitor problems. A major impediment to regular production of data was the inability of the Ministry’s computer software (“AMFAC”) to produce the degree of detail necessary to create a valid management tool because it was designed for a community pharmacy. Although manual extraction of a limited range of statistics was an option, the task was too labour intensive to be efficient or to be considered a high priority.
- 7.57 In this regard, I note that the Ministry’s *Drug Management Strategy Project Report* states:-

“There is little verifiable information on prescribing trends in Western Australian Prisons. At present medical practitioners operate in prisons seemingly devoid of prescribing protocols and directives, regarding specific substances that may be abused. During this project attempts to obtain accurate indications of prescribing trends and prisoner presentations for medical assessment have not been successful. Whilst these details are not readily accessible it is difficult to determine trends and thus the need for changes in present medical responses. The collation of such data by Prison Health Services is considered imperative.

RECOMMENDATION 29 Prison health Services should routinely collect information on prescribing trends in prisons.”

- 7.58 The Ministry has advised me that the new Pharmacy ASCRIBE program has been installed and that it has conducted three-monthly audits of medication usage which has shown a decrease in the use of psychoactive drugs over the last nine months. It is likely, however, that data will continue to be collected by both manual and electronic means.
- 7.59 Prior to the installation of the new computer program, Pharmacy staff told me that they were concerned that, even when it was available, they would not be able to produce and analyse the data without provision of additional resources. Their inability to effectively monitor medication usage is an issue of continuous concern to Pharmacy staff who are frustrated and embarrassed by their inability to perform this essential function. In their view, however, this forced ‘dereliction’ of their professional responsibility is inevitable with their current workload. I can only agree with their concerns.

Professional development and training

- 7.60 Similarly, due to lack of resources and available funding, there is little opportunity for Pharmacy staff to participate in professional development and training programmes. The Senior Pharmacist attended a conference in Tasmania on *Clinical Controversies: Issues in Therapeutics* in December 1998. This was the first conference attended by Pharmacy staff in the past ten years. In addition there are no formal meetings between Pharmacy staff and senior Health Services staff such as the Director, Director of Nursing and the Manager of the FCMT.
- 7.61 I also understand that funding for required texts and reference materials is sufficient to cover only the minimum required subscriptions and that the Pharmacy ‘Reference Library’ does not meet professional standards. For example, as a minimum, a pharmacist is required to have an up to date copy of *Martindale* for reference (to pharmacists what *Gray’s Anatomy* is to medical practitioners). I was told in 1998 that the copy available to prison pharmacists was five years old.
- 7.62 The Ministry has advised me that as from 4 September 2000 Pharmacy staff have access to online pharmaceutical information through the HDWA. I understand that this is currently on a trial basis. Internet access is also available and subscriptions to specific relevant sites are to be finalised. Approval for subscriptions to required journals and an up to date edition of *Martindale* was given on 20 October 2000.

Compliance with legislation

- 7.63 The question of whether the Ministry complies with the legal requirements of the *Poisons Act* arises not only in its practice of permitting on call doctors to prescribe Schedule 4 medications by telephone¹⁵ but also in the appointment of an appropriate licence holder to supervise the supply, distribution and dispensing of pharmaceuticals. The licence holder is the Chief Pharmacist except in relation to a regional prison which receives its supplies from the HDWA Regional Pharmacist, - the situation at Eastern Goldfields.
- 7.64 The Ministry appears to have been aware for some time that it needs to obtain a poisons permit to legalise supply of drugs to Eastern Goldfields. The issue was discussed by the JJ/HIDC on 22 March 1996 and the Minutes of this meeting note:-

“The Ministry requires immediate commitment from the HDWA about its readiness, willingness and ability to provide and/or support its pharmaceutical services in the short term. The Joint Council should request [the Coordinator of Pharmaceutical Services with the HDWA] to ensure that there are proper arrangements for pharmaceutical services to regional facilities of the Ministry which are economical, efficient and effective in nature and make best use of infrastructure of the HDWA and the Ministry.”

- 7.65 The Ministry received legal advice in 1998, following a review of pharmacy services in January 1998¹⁶, that an amendment to the conditions of poison permits to allow re-sale of pharmaceuticals from a government hospital to an authorised person at the prison would solve the problem. The matter was discussed with HDWA in October 1998 and some progress has been made, but as at 8 November 2000 the problem remains unresolved.

RECOMMENDATION 7.6

That the Ministry take steps to legalise the current supply of Schedule 4 drugs to Eastern Goldfields Regional Prison.

Review of Pharmacy Services

- 7.66 In January 1998, a review of prison pharmacy services by a consultant to the HDWA was commissioned to establish whether it would be feasible and more efficient for those services to be provided by private contractor.
- 7.67 The review concluded that *“Pharmacy Services have met supply needs adequately but other professional pharmacy services are less well-developed.”* It noted that maintenance of pharmacy stores absorbed a disproportionate amount of time at the expense of the performance of other professional functions. Specifically, the reviewers found:-
- Pharmacy expenditure had increased recently due to :-
 - recent increases in the cost of psychoactive drugs;
 - cost of treatment of Hepatitis C;
 - gradual ageing of the prison population;
 - the lack of drug audits to monitor prescription trends and patterns;
 - inconsistency in medication procedures and records across the prison system;
 - the absence of a poisons permit for the supply of Schedule 4 drugs at Eastern Goldfields Regional Prison;
 - a lack of training and professional development opportunities for pharmacy staff;
 - the absence of quality improvement programs.

7.68 The reviewers made a number of recommendations, including the following, set out below together with comments about actions taken by the Ministry in response:-

- ***That the Ministry take urgent steps to legalise the current supply of Schedule 4 drugs to Eastern Goldfields Regional Prison by the regional pharmacist.***

7.69 As stated above, the Ministry has been aware of this problem for some time. It was discussed by the JJ/HIDC in March 1996 and a decision on the required course of action made. However, no action was taken by the Ministry. Following re-identification of this problem in the 1998 review, the Ministry decided to seek *further* advice from the HDWA on the appropriate steps to address this legal deficiency. The advice was to be referred to the JJ/HIDC and some progress has been made but at the time of writing the issue remains unresolved.

- ***That as a matter of urgency, the Drugs and Therapeutic Committee develop policies and procedures which provide a comprehensive framework and standards for drug prescribing, supply and administration across the prison system.***

7.70 The Ministry's *Drugs and Therapeutic Committee* has developed a number of policies and protocols relating to, for example, the prescription of Narcan and Benzodiazepines; the nursing management of Benzodiazepines; and drug and alcohol withdrawal; and reassesses policies as they come up for review. The Committee has also actioned guidelines drawn from other reputable sources for, *inter alia*, antibiotics, analgesics and cardiovascular medication.

7.71 Standardisation of procedures for administration of medication and maintenance of records is not yet complete, although I understand that DGR B24 covering the administration of medication by prison officers has been finalised.

- ***That targets be developed for more frequent review of medication charts because of the amount of medication being prescribed and the prevalence of illness among the prison population and that resources be found to permit those targets to be met.***

7.72 The review recommended the following frequency:-

- *Casuarina and the Remand Centre - twice weekly because of the level of medication used at those prisons*
- *Canning Vale and Bandyup - once per week*
- *Karnet - twice per month*
- *Regional prisons not serviced by the regional pharmacist - twice per year*
- *All prisons should be visited once per year*

7.73 The Ministry advised me in November 1998 that it had decided upon the following frequency targets:-

- Casuarina and Hakea - weekly
- Remand Centre - twice weekly
- Bandyup and Karnet - fortnightly
- All regional prisons – monthly

7.74 It conceded that these targets:-

“do not correspond to optimum levels of review frequency. However it should be noted that while the review targets identified are less than optimal, Health Services currently lacks the resources required to achieve this identified level of service.....adequate resourcing of this task will continue to be an issue despite the allocation of a Pharmacy Technician position...”

7.75 It is clear that the Ministry is conscious of the importance of its monitoring function and advised me of its intention to discuss a means of addressing this deficiency at the JJ/HIDC. However, to my knowledge, although a pharmacy technician was appointed in May 1999, no further action to enable more extensive monitoring has been taken. The concerns of the Pharmacy staff about their inability to perform this function, therefore, remain.

• ***that the Ministry establish Quality Improvement Programmes to include:-***

- ***orientation for visiting medical practitioners***
- ***good practice standards for the prescription and administration of medication***
- ***the development of a “Formulary”*** (a set of prescribing protocols and policies to improve overall therapeutic outcomes and to control costs)
- ***drug audits focussing on inappropriate and general prescribing patterns***

7.76 The Ministry acknowledges the potential benefits of a comprehensive orientation package for visiting practitioners but concedes that *“current demands on the Pharmacist’s time would limit his ability to initiate development of the orientation kit in the near future.”*

7.77 The development of a ‘Formulary’ has been discussed by the *Drugs and Therapeutic Committee* but it is acknowledged that there are problems in devising a product suitable for use in a prison system serviced by visiting medical practitioners who may have their own techniques and views on appropriate medication. The Chief Pharmacist advised me that a ‘Formulary’ was more likely to be effective in major government hospitals (all of which in Western Australia operate under a ‘formulary’) and produce tangible benefits for the system because each clinical speciality is headed by an expert in the field who is able to more easily control prescribing policy. Nevertheless, the *Drugs and Therapeutic Committee* is currently in the process of drawing up a ‘Formulary’ suitable for the prison system in consultation with an independent expert.

7.78 I was told that the *Drugs and Therapeutic Committee* was hampered by the time constraints and workload of its members, which included the Forensic Psychiatrist, the Chief Pharmacist, visiting medical practitioners, the Manager Health Services and two Senior Hospital Officers and that it did not meet for some time because *“committee meetings and the tasks delegated in this forum compete for their [the members’] time and availability to perform the functions of their substantive positions?”*. I understand that the Committee – which is now chaired by the Director, Health Services and meets regularly on an approximately monthly basis - is now functioning much more effectively.

7.79 The Ministry also agrees that regular and comprehensive drug audits and the production of statistics would require the employment of additional resources. It recognised that the Pharmacy’s previous software was inadequate for its needs and purchased the ASCRIBE program referred to at paragraph 7.58. Training has been provided to the Chief Pharmacist and ongoing training is available. Although the TOMS project and ASCRIBE will assist in the better capture and storage of data, the question of the provision of additional resources to the Pharmacy to enable it to produce and monitor statistics in accordance with *“professional”* responsibilities is yet to be addressed.

- *That either an additional pharmacy assistant be appointed or the Ministry consider the contracting out of the pharmacy service with a view to enhancing the level of service.*

- 7.80 A Pharmacy Technician was appointed in May 1998. However, the Ministry informed me in November 1998 that, although this appointment was a “*significant improvement*” in resources, muster levels are “*currently peaking at levels significantly higher than that previously experienced by the Ministry, with an identifiable increase in the rate of medication per head of prisoner population.*” In this regard “*the provision of adequate levels of staffing and resources must continue in order to meet the ever-increasing demands for the services of the Pharmacy*”.
- 7.81 I understand that a recent (1999) study of the Pharmacy¹⁷ for the purpose of examining the implications of privatisation had to base its assessment on a staff establishment of four staff and two technicians – *twice* the number of staff currently employed – in order to make a valid evaluation of the merits and costings of the in-house service. The Ministry advised me that the enhancement strategy for the Pharmacy identified a need for an additional pharmacist plus relief together with a further pharmacist (plus relief) if it was decided to introduce the Blister Pack System. The Blister Pack System would, however, result in an offset of nursing hours because blister packs take less time to distribute. In addition, funding would be required to facilitate contracts with Country Health Boards to assist in monitoring professional standards and for travel.
- 7.82 I observe that, in my opinion, it is unacceptable in the extreme that the under-resourcing of the Pharmacy was ignored until it became necessary to consider its outsourcing. If - as seems likely - the pharmacy services are to be contracted out to a service provider, any recommendation made by me regarding staffing levels will be largely irrelevant. However, as it is possible that outsourcing may not occur – or may not occur in the near future – I have decided to make the following recommendation.

RECOMMENDATION 7.7

That, using the staff establishment estimated by the 1999 outsourcing study, the Ministry determine the appropriate staffing levels for the Pharmacy to enable the recommendations of the 1998 Review to be implemented and engage the necessary personnel for that purpose.

ISSUE OF MEDICATION BY PRISON OFFICERS

- 7.83 One of the medication issues raised in the course of my inquiry which generated universal concern among nursing staff was the Ministry’s policy that prison officers should give out medication in dosett boxes to prisoners when nursing staff are not on duty. This does not apply to prisons where there is 24-hour nursing coverage. Although the *means* by which a prisoner received medication has not been questioned in the investigations of the circumstances of the deaths of prisoners, it is the nurses’ primary concern that the Ministry’s policy increases the risk of errors and the potential for the death of a prisoner for which blame would be attributed to any nursing staff involved. It was their unanimous view that the policy could lead to a general fall in the standard of health care for prisoners and that it is inappropriate for prison officers to give out medication.
- 7.84 The nurses believe that, by condoning this practice, they may be in breach of section 50 of the *Nurses Act 1992* which prohibits a registered nurse from permitting “*...a person who is not registered to carry out any nursing for or on behalf of the first-mentioned person.*” This view is also held by the Australian Nursing Federation and the Chief Pharmacist.

7.85 I have been provided with a copy of a legal opinion from the Crown Solicitor's Office obtained by the Ministry which states that in *giving* medication in a dosett box which had been prepared by a nurse, a prison officer was –

“merely the means by which the nurse who fills the dosett box administers or supplies the material medication to the intended prisoner. The filling of a dosett box in accordance with a prescription plainly is.....nursing. However, the physical act of handing over medication from a dosett box to a prisoner in circumstances where no medical judgement or skill is required cannot..... be properly characterised as “carrying out nursing”, at least within the meaning of section 50 of the Nurses Act.”

7.86 The opinion went on to state that the nurse was not “*authorising or permitting*” the distribution “*for or on behalf of*” the nurse because it was the Ministry, not the nurse which determined “*the actual means by which the medication comes into the prisoner's hands*” and that “*medication once received by the prisoner, will have been relevantly “dispensed” or “supplied” by the nurse, notwithstanding that that nurse has not physically handed the medication to the prisoner personally.*”

7.87 In relation to liability for issue of the wrong medication, a further legal opinion from the same source was that –

“Provided the prison officers act within the course of their employment, the State as employer would be liable for the consequences of an unauthorised pill being delivered to the wrong prisoner (assuming, of course, that negligence could be established).”

7.88 Prison officers were equally concerned about the extent of their liability and officers from Bunbury Regional Prison, claiming that the Ministry had a responsibility to employ sufficient qualified staff to administer medication to prisoners, took the issue to the Industrial Commission in May 1998.

7.89 In the course of its investigation, the Commission discovered “*a series of problems which need to be addressed*” and “*potentially serious duty of care issues*” and made the following observations:-

- lack of training of officers in the use of dosett boxes;
- no prison officer had any idea of the contra-indications of drugs which “*seems to fly in the face of the prison officers' responsibility to ensure that a prisoner has consumed the medication, particularly if the medication is essential*”;
- prison officers are unable to answer questions from a prisoner about the medication being issued particularly if the medication had been changed;
- problems in positively identifying prisoners; and
- there was no consistent policy for the issue of medication or for required documentation.

7.90 After considering the prison officers' concerns, the Commission made a number of recommendations:-

- dosett issue recording forms should be standard for the whole prison system;
- dosett boxes should have two labels identifying the prisoner;
- the protocol for the issue of medication should be formalised in a Director General's Rule, compliance with which is a pre-requisite for an officer to fulfil his/her duty of care;
- prison officers must receive formal training in the issue of medication; and,
- where a prisoner does not take medication the prison officer must immediately report to “*an appropriate medical authority*” to seek directions.

- 7.91 The Ministry has advised me that it is incumbent on prison officers to ensure that medication is given to the prisoner for whom it is prescribed by identifying the prisoner. However, it considers the issue of medication in a dosett box by prison officers to be a purely supervisory function and that there is no necessity for officers to be aware of the contraindication of drugs or for the prison officer to answer questions from the prisoner about the medication being used.
- 7.92 Having satisfied themselves that there was no legal impediment to the continuation of the practice, both WAPOU and the Ministry accepted the Industrial Commission's recommendations. The nurses remain unconvinced but have accepted the Ministry's assurances that they will not be held accountable for errors made by prison officers.
- 7.93 The extent to which prison officers are involved with the administration of medication depends on the extent of nursing hours at individual prisons. For example, at Bunbury, prison officers are now required to issue only the final medications at the weekend when nursing hours finish at 4.15pm. Extension of nursing coverage to 7.30pm during the week means that nursing staff are able to complete the final medication round. On the basis of the schedule of nursing hours provided to me by the Ministry¹⁸ it appears that officers are involved with the issue of medication as follows:-
- Broome after 12.30pm at the weekend
 - Eastern Goldfields after 4pm each day
 - Greenough after 4pm at the weekend
 - Karnet before 8.30am and after 4.30pm at the weekend
 - Pardelup after 3pm Mon-Thurs; after 1pm Fri and all weekend medication
 - Riverbank before 8.30am and after 2.30pm Mon - Fri and after 11am at the weekend
 - Roebourne after 4pm at the weekend
- 7.94 This issue is obviously relevant to my inquiry because it raises questions about the Ministry's compliance with general health care standards and whether it can justifiably claim that health care provided to prisoners meets generally accepted community standards of medical practice.
- 7.95 The Ministry's argument for utilising prison officers is that in a community setting a person receiving medication is responsible for taking that medication in accordance with the prescribing doctor's instructions. Although I have some sympathy for the view that a prisoner should be responsible for his/her own health, imprisonment creates circumstances which may require a different approach. A high demand for drugs of any kind by certain sections of the prison population engenders the opportunity for violence and bullying and the potential for some of the prescribed medications to be hoarded, with the accompanying risk of overdose leading to death or, at very least, unpredictable behaviour.¹⁹
- 7.96 By way of comparison with community practices, I have considered the guidelines in the *Integrated best practice model for medication management in residential aged care facilities* produced by the Australian Pharmaceutical Advisory Council in February 1997 which takes a different approach to the administration of medication by persons other than registered nurses to residents of nursing homes.
- 7.97 An appendix to that document entitled "Nursing Guidelines for Medication Management in Nursing Homes and Hostels" includes the following:-
- "2.1 Every resident of a nursing home or hostel is entitled to a quality medication service which includes:....."*
- (b) care by a person who is able to exercise clinical judgement with regard to medications, integrating physical, mental and behavioural assessment with relevant contextual variables*

7.3.3 The role of the registered nurse includes:.....

(c) the administration of medications

9.3 Medication administration aids may be utilised to assist with resident self medication. Where the resident is not self administering, a registered nurse should administer medications.

9.5 A registered nurse must not dispense a resident's own medications into a compartmentalised box for another health worker to administer.”

7.98 Among the diverse views on the propriety and/or legality of medication being given out by prison officers, there is consensus that if such a system is to work at all, as an absolute minimum officers *must* be adequately trained. In this regard, the *Integrated Best Practice Model* referred to above states:-

*“For residents who are not self-administering, medication administration should be undertaken by a registered nurse. If a registered nurse is not available, it is recommended that the facility provide medications in dose administration aids. In all cases, medication should only be administered by **adequately trained** or qualified staff.”* (my emphasis)

There is, however, no definition of what constitutes “*adequately trained*”.

7.99 Trainee prison officers in Western Australia receive instruction on the giving out of medication in dosett boxes as part of their initial training. The same training module was presented to all serving prison officers at prisons which use the dosett system (i.e all prisons which do not have 24-hour nursing coverage), for the most part by members of the nursing staff.

7.100 In relation to weekend medications, officers at Bunbury expressed concern at being required to give new or changed medication or medication for sporting injuries after nursing staff had left the prison. As a result the Ministry instructed nursing staff not to give new or changed medication at the weekends (a further example of administrative convenience taking precedence over health considerations); to treat any sporting injuries after hours if necessary and agreed to provide special training for officers giving out medication at the weekend.

7.101 DGR B24 was introduced in line with the Industrial Commission's recommendations and Health Services has formalised a policy for its own staff. However, I believe that the standardisation of documentation across the prison system is not yet complete.

7.102 It seems to me that the use of prison officers to administer medication is a ‘quick fix’ solution to a problem which stems largely from a lack of health resources, the desire to save money and the inflexibility of prison regimes. Although the Ministry has instituted a number of safeguards, I am concerned about the adequacy of the training which is provided to prison officers.

7.103 In the course of my inquiry I visited several State prisons in Victoria where I understand the level of first aid and other ‘health care’ training provided to prison officers is far superior to that in Western Australia and has resulted in the creation of a specially selected and highly trained group of ‘health care’ prison officers to perform this type of function. It seems to me that the Victorian model merits further consideration by the Ministry *provided* this group is seen as a ‘paramedical’ supplement to a properly resourced and staffed prison health service.

RECOMMENDATION 7.8

- (a) That the Ministry should create a field of “specialisation” for prison officers accompanied by appropriate training to produce well-qualified prison officers with particular knowledge and skills in first aid and general health care to supplement prison health services.
- (b) That the Chief Pharmacist regularly review and evaluate the issue of medication by prison officers to establish whether the practice should continue.

REASONS FOR THE DEMAND AND PRESCRIPTION OF MEDICATION

7.104 Health staff and senior prison staff have told me on many occasions that prisoners as a group have the worst health in the community. They are frequently admitted to prison with multiple problems, some of which are chronic or life threatening, possibly as a result of life style, poor living conditions, physical or sexual abuse or a history of substance abuse. In addition, the prison population in Western Australia includes a number of prisoners with high medication needs including:-

- a high proportion of Aboriginal prisoners - 34.6% as at 30 June 1999 with the same generally poor health as their counterparts in the community;
- increasing numbers of young substance abusers with chronic diseases such as Hepatitis B and C;
- a growing number of elderly prisoners with a range of ailments and chronic conditions associated with ageing; and
- a large number of psychiatrically disturbed offenders.

7.105 The following issues were drawn to my attention in submissions and in the course of interviews:-

- 65-70% of prisoners are on some form of medication;
- there is an increasing demand for medication, particularly codeine-based and sedatives;
- prisoners are becoming more aggressive in their demands for medication;
- ‘drug-seeking’ behaviour is often a substitute for someone to talk to because there are no alternatives in the form of appropriate exercise, employment, recreation, cognitive therapy, cultural activities, conflict resolution techniques;
- herbal medications are used at the Sir David Longland Centre in Queensland and should be used in Western Australia;
- medications are over-prescribed to prevent deaths/self harm; and
- an increase in the incidence of self-harm leads to an increase in prescription medications.

7.106 The Smith Report expressed the view that the demand for prescription medication by prisoners –

“.....needs to be seen in the context of changes in the society from which prisoners come..... In the wider community, many young offenders are putting pressure on medical practitioners for benzodiazepines,²⁰ or minor tranquillisers, either directly or indirectly for their psychoactive qualities or as a way of managing their dependence on opiates.” (paragraph 5.2.7.2)

7.107 It also noted *“.....the increasing drug use in the community generally and the use of psychoactive drugs as either a substitute or a self-management strategy. Taking psychoactive drugs often fulfils the same purpose as the consumption of illicit drugs.”* (paragraph 5.2.7.9).

- 7.108 A study of general practice activity in Australia known as BEACH (“*Bettering the Evaluation and Care of Health*”) based on general practice data combined with patient risk factors and health status produced by the Family Medicine Research Centre at the University of Sydney commented on trends in prescribing rates by general practitioners in the community.²¹ Data were taken from a random sample of 984 GPs who each agreed to record details of 100 consecutive patient encounters between April 1998 and March 1999. Results were reported in terms of patient reasons for encounter, problems managed, medications and other treatments provided, referrals and tests ordered.
- 7.109 Analysis of the age distribution of patient encounters found that one in four encounters were with each of the following age groups – 25-44 (26%), 45-64 (24.4%); and 65 or older (24%)²². The study found that the second most frequent reason for visiting the doctor was to request a prescription (8.2 per 100 encounters)²³. The most common problem was hypertension (8.3 per 100 encounters), followed by upper respiratory tract infection (6.8); immunisation/vaccination (5.2), and depression²⁴ (3.5). The most common management activity by doctors was medication prescribed, advised or supplied, at a rate of 109.7 scripts per 100 visits or 75.5 per 100 problems²⁵.
- 7.110 At least one script was recorded at 60% of encounters and for 51.3% of problems²⁶. Medications (both prescribed and advised for over the counter purchase) most frequently prescribed were for painkillers, antibiotics, asthma medication, psychological medications (particularly benzodiazepines and anti-depressants), flu vaccines and oral contraceptives. Antibiotics accounted for one third of all prescriptions. The ten most frequently managed problems, accounting for one third of all problems, were high blood pressure, upper respiratory tract infections, immunisation, acute bronchitis, depression, asthma, back complaints, diabetes, high cholesterol and osteoarthritis.²⁷
- 7.111 However, in a comparison with the findings of a study conducted in 1990-91 by the Australian Morbidity and Treatment Survey, the BEACH study found that the rate of prescriptions recorded had actually *fallen* in the eight year period - from 66.7 per 100 encounters in 1991 to 64.4 in 1998. Although there was no overall statistically significant difference in the rate of problems managed in the two surveys, there was a significant increase in the management rate of depression – from 2.1 per 100 encounters in 1991 (the tenth most frequently managed) to 3.5 per 100 in 1998 (fourth most frequently managed). There was also an increase in the rate of new depression encounters from 0.5 to 0.7. This is of relevance when considering the problems presented by prisoners.
- 7.112 Although the rate of demand for prescriptions may not have increased since 1991, I note that the Health Insurance Commission (HIC) recently reported that 32.8 million Pharmaceutical Benefits Scheme (PBS) services were processed during the first quarter of 2000 compared with 30.7 million for the same quarter in 1999.²⁸ The HIC also reported that the average number of scripts per person in Western Australia under the Pharmaceuticals Benefits Scheme for the financial year 1998/99 was 5.76 compared to 5.66 per person for the previous financial year²⁹. Anecdotally, I have also been told by a prison medical practitioner (who also practises in the community) that he noticed ‘dissatisfaction’ on the part of patients in the community, and a perception that they are not being treated ‘seriously’ if they are not given medication.
- 7.113 Although it is impossible for the Chief Pharmacist to provide a *per capita* figure for each prisoner because of the inadequacy of the current data capture system, given the trend to more medication in the community and the poor state of health of most prisoners, it is perhaps not surprising that the level of prescription medication in the prison system is high. In this regard, the Ministry’s *Drug Management Strategy Project* stated at page 43:-

“The health and medical services currently available are heavily utilised as the prison population has significant medical needs. Many prisoners have had limited access in the community to such services or by virtue of lifestyle, have not managed their personal health effectively. This places considerable pressure on the process of illness screening and the subsequent management of any identified problems.”

- 7.114 The Ministry has attempted to reduce the amount of prescribed medications as evidenced by its *General Medication Policy* (6.1) drawn up in 1995, which identifies respectively as its ‘principle’ and its ‘objective’:-

“It is the considered belief of the Health Services that the termination and removal from chemical dependency, together with attention to the associated physical and social issues, enable prisoners to be discharged in better physical and mental well-being into the wider community.....”

Consequently the policy of the Health Services is to wean prisoners off drugs following reception as quickly and as fully as practicable. Appropriate use of medication is essential in this rehabilitation process, being careful not to develop alternative dependencies.

In many instances where prisoners present to medical personnel requesting medication there is no evidence of psychiatric disturbance. Medical Case Conference frequently notes that such individuals suffer from behavioural disturbances for which the prisoner needs to accept responsibility, if there is to be any modicum of change in the future.....”

- 7.115 In 1998 the Ministry introduced *Benzodiazepine Prescribing Guidelines* (6.2) and *Nursing Management of Benzodiazepines* (6.2.1), both of which emphasise that this category of drugs should be “prescribed for a maximum period of up to three days for acute crisis situations only (excluding drug and alcohol withdrawal)”. Policy 6.2 lists a number of “very good reasons for not prescribing benzodiazepines”, including

- *“a serious degree of addiction/habitation potential;*
- *severe withdrawal effects after prolonged and continuous use;*
- *development of tolerance requiring increasing doses;*
- *disinhibition;*
- *rebound aggression.*

Benzodiazepines create both a psychological and physical dependence making them relatively contraindicated in a prison setting.”

- 7.116 Policy 6.2.1 states “Benzodiazepines can only be issued by nursing staff, according to standing orders, after a comprehensive nursing assessment to establish their need and discussion of alternative therapies.” A situation where prescription of such medication might be appropriate is described in Policy 6.2.1 as one where a prisoner has been assessed as “*stressing out*” where the criteria for “*stressing out*” are defined as “*events usually not foreseen that adversely affect a prisoner’s ability to cope.*” Such events are the death of a family member or close friend; the break up of a relationship; a serious accident involving a family member and a “*bad telephone call*”.

- 7.117 The policy for the prescription of *Potent Analgesics* (1999) states that “*The use of codeine based analgesics and benzodiazepines is discouraged*” and recommends restraint in prescription “*as extended use has the potential to lead to dependency and trafficking.*”

- 7.118 The 1995 policy for *Psychotropic Drugs* (6.5) - such as benzodiazepines - states:-

“There appears to be an increasingly large number of prisoners presenting with no medical or psychiatric indications for prescribing psychotropic medication. Indeed there are very good medical reasons for not prescribing any medication at all, because of the long term harm it will do to their development and their capacity to learn.

Psychotropic medications have a capacity to compound the problems of impulse control and for such individuals the issue of the locus of control is external. Benzodiazepines in particular reduce the ability of users to learn from experience.

Conflict with prison medical staff is becoming a problem with such prisoners when their inappropriate demands for medication are rejected.....

Alternate Strategies

.....Basic guidelines for self coping for prisoners in dealing with their life problems need to be established.....

The policy of prescribing medication only for appropriate reasons should be persisted with as this is for prisoners' long term best interests. All practitioners are reminded of this policy and are asked to try to follow it."

- 7.119 The Ministry appears to have a comprehensive set of prescribing protocols and guidelines which clearly indicate the problems which can arise from prolonged use of psychoactive medication and the preference for alternative strategies. Nevertheless it conceded in its response to the Smith Inquiry that there had been an increase in the prescription rate of these medications in the past two years and suggested that this was due to intimidation by prisoners through threats of self-harm and “*inflammatory accusations by pressure groups*” in response to an increasing number of deaths.
- 7.120 One of the prison medical practitioners is on record³⁰ as saying that “*Outside prison you may well chat about your depression or what has led to it.....In here, prisoners are utterly of the belief that medication is the only thing that is going to help. I don't see any benefit in trying to change that.*” The same doctor also noted, however, that “*the prison system was not resourced for rehabilitation*” and that the “*few cursory programs which did address issues such as violence and substance abuse were designed to boost prisoners' chances of getting parole - not as a genuine attempt to change their behaviour.*”
- 7.121 The Smith Report suggests that seeking prescription medication is seen as a means of escaping the reality of imprisonment by prisoners and that health services staff may adopt this approach quite simply because there may be no other management or therapeutic option available to them.
- 7.122 For the purposes of this inquiry I have not considered statistics to attempt to establish whether there appears to be a trend towards an over-dependence on prescription medications by prison health staff - largely because consideration of whether the level of prescription medication is *excessive* overall, or in a particular case, requires a clinical judgement.
- 7.123 In response to my draft Report, the Ministry has advised me that, on the basis of three-monthly audits conducted since January 2000 there appears to have been a decrease in the prescription of psychoactive drugs over that nine month period. The reasons why that apparent decrease has come about are unclear, although the Ministry has told me that there is a trend for some prisoners to attempt to ‘swap’ from the use of illegal to legal substances.
- 7.124 I have not considered whether the frequency of reviews of medication charts now conducted is considered sufficient to monitor compliance with procedures and safe practices and to check for adverse reactions or inappropriate drug regimes. However, I am hopeful that the introduction of regular audits is a reflection of a more proactive approach to deficiencies in its systems, an acceptance of the model of continuous improvement and a rejection of the style of “*reactive crisis management*” identified in the Smith Report (paragraph 5.2.7.12).

- 7.125 Leaving aside the issue of whether prisoners receive *excessive* amounts of medication, I have considered the use of psychoactive medication by prisoners and staff from the perspectives set out below, based on views expressed in submissions to my inquiry and interviews; the findings of other investigations and in the Ministry's response to the Smith Inquiry; and in light of my examination of the files of deceased prisoners - many of whom seem to have received a range of medications:-
- medication by intimidation - "*avoiding a death*";
 - "*escaping the reality of prison*";
 - over-crowding;
 - the effect of increasing medication on the workload of nursing staff.

Medication by intimidation - "*avoiding a death*"

- 7.126 I have been told by Health Services staff that there is a growing demand by prisoners for psychoactive medication likely to produce the most 'mind-altering' effect. To satisfy that demand prisoners are becoming increasingly aggressive in their approaches to both nursing staff and prison doctors. As noted earlier this may be merely a reflection of a change in society's demands.
- 7.127 I have no doubt that some prisoners do attempt to intimidate health staff into providing psychoactive medications and are prepared to use threats of self-harm or suicide to get what they want – particularly if they believe that certain medical staff are susceptible to coercion through fear of being blamed for a 'death in custody'. By contrast, numerous prisoners have told me that they frequently feel that they have to "*go off*" or "*act up*" - prisoner terminology for 'threaten to self-harm' - to force prison and health staff to listen to their problems. They may not, of course, always get exactly what they want, because a frequent response to a prisoner who "*goes off*" is to put him or her in a medical observation cell³¹. However, if the staff member involved is sufficiently influenced by the fear of being blamed for any ensuing problem, the prisoner may well also receive some form of medication.
- 7.128 The Smith Report observed³² that "*avoiding a death has become probably the main priority amongst operational staff*" and that staff would do "*whatever it takes*" to achieve that end.
- 7.129 Obviously, it is not unreasonable for prison staff to strive to avoid the possibility of the death of a prisoner - on the grounds that it is an integral part of their duty of care and the death of a prisoner is a traumatic event for all concerned. However, the connotations of the phrase "*avoiding a death*" as used in the Smith Report suggest that occasionally inappropriate action might be taken by staff based on a desire to avoid even the slightest possibility of the death of a prisoner threatening self-harm rather than on the long term interests of the prisoner.
- 7.130 Howells and Hall have stated³³ that a prison officer's duty of care was frequently perceived to mean that:

"...everything will be done to ensure that prisoners do 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."

- 7.131 In this regard, medication to deal with the crisis at hand rather than the underlying causes of the problem may well be, if not inappropriate, at least ineffective in the long term. In my view the fear of being blamed if a death occurs and a belief that they will not be supported by the Ministry which will attempt to shift attention from any deficiencies in the system to the actions or omissions of individuals, are powerful influences on a significant proportion of prison staff. The consistency of this perception among operational staff up to high levels leads me to the conclusion that this fear of blame may well influence staff to take certain actions – including medication or isolation in a medical observation cell - as a “*quick fix*”. Howells and Hall refer to this approach as resulting in the “*safest option being chosen by staff rather than a creative response to the needs of the individual.*”³⁴
- 7.132 Prison staff could, it seems with equal justification, claim that if they must take some action to help the prisoner or to safeguard themselves, then medication is one of the very few management options which is readily available. The acid test in an objective assessment of whether medication is seen as an ‘easy’ option for staff is whether they *continue* to use it as a management tool when alternative therapeutic strategies are available. Unfortunately, the lack of alternative management strategies at most prisons makes this a difficult ‘test’ to apply³⁵.

“Escaping the reality of prison”

- 7.133 It was suggested to me by senior health services staff that one possible reason for ‘drug-seeking’ behaviour was that it frequently provided a substitute for someone to talk to. This has been a familiar theme in submissions from prisoners, who generally feel uncomfortable talking about their problems with prison officers. Unfortunately, however, it seems that the workload of nursing staff and prison medical officers and the need to see as many prisoners as possible during the time available similarly reduce the ability of health staff to talk to prisoners.
- 7.134 There is also anecdotal evidence to show that when there was almost full employment for prisoners at Canning Vale a number of years ago there was a marked reduction in the number of prescriptions issued. However, employment and other therapeutic alternatives such as physical exercise, other forms of recreation, cognitive therapy, cultural activities and training in conflict-resolution techniques are limited and largely insufficient to cater for, or keep pace with, rising muster levels.
- 7.135 The Smith Inquiry commented:-
- “The reasons for the escalation in prescription rates largely centre on the increasing drug use in the community generally and the use of psychoactive drugs as either a substitute or a self-management strategy. In prisons it is almost certainly the former. Taking psychoactive drugs often fulfils the same purpose as the consumption of illicit drugs. It relieves boredom and stress as well as “escaping” the reality of prisons. The demand for drugs may also reflect overcrowding pressures. With an increasing demand for the same number or reduced services, as well as other frustrations for both officers and prisoners, it is easy to understand how the demand for “psychoactive escapes” would increase.”* (paragraph 5.2.7.9)
- 7.136 Perhaps not surprisingly, none of the prisoners who wrote to me or whom I interviewed said that they were given too much medication. Some indicated problems in seeing the doctor or in getting medication for a particular condition and this is a regular source of complaint to my Office. However, a significant number complained of boredom and inactivity, of the lack of alternative therapies, self-help and life skills programmes, relaxation classes or other strategies to help them “*cope*” with prison stresses.

- 7.137 From my observations, the management strategies currently available to assist prison staff deal with those prisoners who are likely to self harm, or are considered to be ‘poor copers’,³⁶ have a history of substance abuse, behavioural problems or have been diagnosed with psychiatric disorders, are limited to all or a combination of the following:-
- management by the Prisoner Risk Assessment Group through the At Risk Management System;
 - management and observation by prison staff;
 - referral to the FCMT;
 - referral to the prison doctor or visiting psychiatrist who can, if appropriate, prescribe medication;
 - placement in a medical observation cell.
- 7.138 Although there is a range of employment, education and rehabilitation programmes and recreational facilities at most prisons, my inquiry has revealed that the opportunities provided are rarely sufficient to ensure that all prisoners are occupied in some form of meaningful activity. In particular, for female prisoners at Bandyup, most of the space originally dedicated to recreational facilities has been utilised to accommodate additional prisoners. When prisoners at Casuarina had little access to programs of any kind during the ‘lockdown’ after the disturbance on Christmas Day 1998, senior health services staff noted an increase in medication. Moreover, there are very limited ‘life-skills’ or self-management programs designed to provide prisoners with the necessary coping skills to ‘help themselves’ until towards the end of the sentence when they are preparing for release. Essentially, the extent of alternative management strategies available to staff dealing with ‘problem’ prisoners is frequently limited by a lack of resources or funding.
- 7.139 It was suggested in a submission to me that the Ministry could provide herbal medications as an alternative to the use of certain Benzodiazepines. I understand that there is a wide range of non-conventional medications of this nature which can be effective as sedatives and tranquillisers (without the harmful side effects) and which are becoming increasingly popular in the community. The Ministry has advised me that herbal medications as an alternative to Benzodiazepines are now prescribed after consultation with, and the approval of, the *Drugs and Therapeutic Committee*. I also understand that the Ministry has developed and now employs a number of alternatives to medication for sleeping problems. For example, Health Services has developed a range of properly resourced therapeutic management strategies which include the LAMBS counselling system to encourage sleep, the development by one of the Health Services doctors of an audio tape designed to induce sleep and the use of herbal medication and counselling where necessary.
- 7.140 This approach is encouraging. Although it may not be easy to convince prisoners that there are alternatives to medication to assist them with their problems, I am sure that there could be considerable long term benefits for prisoners and staff from the introduction of practical therapeutic alternatives, subject, of course, to objective evaluation.

RECOMMENDATION 7.9

That the Ministry continue to explore and develop a comprehensive range of properly resourced therapeutic management strategies using the expertise of organisations outside the prison system in addition to internal experience to provide alternatives to medication in managing prisoners with problems.

Overcrowding

7.141 Allied to the lack of alternative management strategies for ‘problem’ prisoners, the Smith Inquiry also found that:-

“The demand for drugs may also reflect overcrowding pressures. With an increasing demand for the same number or reduced services, as well as other frustrations for both officers and prisoners, it is easy to understand how the demand for “psychoactive escapes” would increase.” (Paragraph 5.2.7.9)

“Some have argued that both the staff and the prisoners are managing overcrowding through an over-reliance on drugs. For prisoners getting psychoactive drugs can be an escape, a way of exerting authority over other prisoners in prison and a reaction to bullying. For staff, prescription medication may provide a “quick fix” way of staving off prisoners’ demands.” (Paragraph 5.2.7.10)

7.142 To the extent that overcrowding increases pressure on resources and prison services and inevitably reduces the range of available management options, it is possible that medication may provide a means of ‘keeping prisoners quiet’.

The effect of increasing medication on the workload of nursing staff

7.143 An inevitable consequence of rising muster levels and large numbers of prisoners entering the system requiring medication is an increase in the workload of nursing staff responsible for administering medication and preparing dosett boxes at prisons where some medication is given out by prison officers.

7.144 A review of medication distribution at Canning Vale prison in 1998³⁷ found that it took one nurse two hours to give out medication to the approximately 35% of prisoners (approximately 120 out of a muster of 320) at that prison receiving regular medication. Distribution of medication would obviously take longer at a prison such as Bunbury which has a larger number of older prisoners and at Casuarina with a muster approximately double that of Canning Vale. Nursing staff at all prisons have told me that medication ‘parades’ are very time-consuming and express concern that, with rising musters, they will be able to spend less time than they consider appropriate in the administration of medication and that the performance of their other duties will suffer unless nursing hours are increased commensurately. Pressure of this nature provides a fertile environment for an increase in medication errors with potentially serious consequences for the welfare of prisoners.

7.145 In my opinion there is substance to the claims of nursing staff that they have insufficient time and resources to properly perform their professional functions. I also believe that the Ministry has adopted “quick fix” solutions - such as the use of prison officers to issue medication at some prisons - rather than other alternatives such as increasing nursing hours.

7.146 I have been advised that the Ministry is conscious of the increasing impact of medication on existing resources and is reviewing its current practices and procedures relating to medication and looking at alternative methods in order to resolve this issue. One option under consideration is the adoption of a different means of dispensing medication which would require a greater involvement by pharmacists but would reduce the time spent by nursing staff.

- 7.147 The Ministry has advised me that it disagrees with my view that it adopts “*quick fix*” solutions to resolve staffing issues. It states that it is “*of the view that nursing (and all other) resources should be used appropriately and other strategies, such as the use of dosett boxes, are appropriate business practice in order to deliver medication where necessary.*”
- 7.148 I cannot disagree with the view that the Ministry should use its resources appropriately and I am aware that the level of resources available to health services has been considerably improved since I commenced this inquiry in February 1998. Nevertheless, I should point out that, to my knowledge, the use of prison officers to issue medication to prisoners was in place *before* the increase in nursing hours and I remain to be convinced that using prison officers to issue medication is necessarily an “*appropriate*” use of resources, particularly when I have observed functions more clearly identified with the role of prison officers not being performed by them – such as staffing prison units at night and becoming more actively involved in prison recreation and sporting activities.
- 7.149 As will be apparent from my conclusions throughout this report, an apparent lack of resources to properly perform functions essential to the safety and well-being of prisoners has been a consistent theme. Although I am not oblivious to the possibility that the work practices of staff could be improved, particularly at some prisons, it is a simple fact of human nature that when people are under pressure, they do not have the time to stand back and objectively view what they are doing. In many respects it is perhaps a credit to the dedication of prison and health staff that they are able to achieve so much with such limited resources.

CONCLUSIONS ON MEDICATION ISSUES

- 7.150 I am satisfied from my enquiries that there is some substance to the suggestion that medication is given to some prisoners because of:-
- the growing aggression of prisoners and the intimidation of staff;
 - staff fears of being blamed for a death in custody if they do not respond to the threats; and
 - the use of medication as a ‘quick fix’ in the absence of non-medical alternatives due to lack of facilities and resources.
- 7.151 In conclusion, however, it seems to me that the trend towards ‘management by medication’ is merely a symptom of other more serious underlying problems, namely:-
- **Lack of resources**
The Pharmacy Department has insufficient resources to enable it to properly perform all of the functions required of it professionally in the dispensing, monitoring and audit of medications to prisoners.
 - **Lack of appropriate information technology**
This has resulted in the absence of vital knowledge about prescribing trends; the changing demographics of current prison populations; and the likely effect on prisoners and staff. As a result the Ministry is poorly equipped to deal with a prison population which is likely to need a greater range of treatment options - substance abusers, behaviourally and psychiatrically disturbed prisoners - and can offer those groups few therapeutic alternatives to medication because of lack of resources and facilities and the absence of tried and tested treatment programs.

- **Lack of alternative therapeutic treatment programs**

If the demand for medication as a substitute for, or in addition to, illicit drugs is because there is a serious lack of non-chemical therapeutic alternatives, the Ministry may need to address the inherent problems caused by drugs and medication by expanding its range of treatment programs and making them available to, and attractive for, *all* prisoners from the date of admission. Currently, drug withdrawal on admission to prison is largely managed chemically without accompanying counselling and rehabilitation programs which are not provided until towards the end of a prisoner's sentence.³⁸

For example, in relation to strategies for the management of prisoners exhibiting serious behavioural problems, I note that Neil Holt, who died in Canning Vale Prison in February 1998, received a wide range of psychoactive medications and was placed on numerous occasions in medical and management observation cells. He was placed in restraints on several occasions but did not receive *any* specialist attention or counselling for his behavioural problems. The Manager of the FCMT has told me that although, in his view, it is a reasonable expectation that FCMT staff should be involved in the management of prisoners with behavioural disorders, they are fully occupied counselling prisoners assessed as 'at risk' and do not have the resources to see prisoners such as Mr Holt and many others like him.

7.152 In summary, it is my opinion that all health service providers in the prison system are under-resourced to provide the level of service required to meet the needs of their client population. I believe that 'corners are cut' and inherently risky strategies - such as the issue of medication by prison officers; the isolation of at risk prisoners in medical observation cells; and the use of medication as a management tool - are utilised to reduce costs at the expense of a comprehensive and effective health service. The emphasis is on crisis management with limited opportunity for education and prevention strategies which could produce long term benefits for prisoners, staff and the system as a whole.

SUMMARY OF RECOMMENDATIONS

- 7.1. Where there are difficulties in ensuring compliance by some Aboriginal prisoners with Western medication regimes, prison health staff should be willing and able to involve appropriate community members with knowledge of traditional healing methods and/or who may be able to persuade prisoners to accept medication regimes.
- 7.2. That a DGR be introduced to ensure that non-issue of prescribed medication to, or non-consumption of prescribed medication by, a prisoner for any reason is recorded and drawn immediately to the attention of the senior nurse on duty at the time and of the prescribing medical practitioner.
- 7.3. That the Ministry as a matter of priority devise a means of providing prescribed medication to prisoners at the time which optimises the therapeutic effect of the medication and not at a time that best suits administrative convenience.
- 7.4. That the Ministry finalise its legal position in relation to the prescribing of Schedule 4 medication by telephone in a custodial setting and publish a policy to that effect.
- 7.5. That, with the objective of achieving equivalence with community standards, the Ministry monitor the efficacy and adequacy of its current pharmacy supply service to all prisons.

- 7.6. That the Ministry take steps to legalise the current supply of Schedule 4 drugs to Eastern Goldfields Regional Prison.
- 7.7. That, using the staff establishment estimated by the 1999 outsourcing study, the Ministry determine the appropriate staffing levels for the Pharmacy to enable the recommendations of the 1998 Review to be implemented and engage the necessary personnel for that purpose.
- 7.8. (a) That the Ministry should create a field of “specialisation” for prison officers accompanied by appropriate training to produce well-qualified prison officers with particular knowledge and skills in first aid and general health care to supplement prison health services.
- (b) That the Chief Pharmacist regularly review and evaluate the issue of medication by prison officers to establish whether the practice should continue.
- 7.9. That the Ministry continue to explore and develop a comprehensive range of properly resourced therapeutic management strategies using the expertise of organisations outside the prison system in addition to internal experience to provide alternatives to medication in managing prisoners with problems.

¹ Wooroloo receives its medications from Wooroloo District Hospital which is supplied by Swan Districts

² The Pharmacy Technician's contract has been extended to end January 2001

³ *Manual of Pharmacy Services* 1 July 1990

⁴ *ibid*

⁵ See also Chapter 5, paragraphs 5.57-5.59 and Chapter 6 paragraphs 6.35-6.50

⁶ Mental Health Nurse Specialist

⁷ Extract from the *Coroner's Record of Investigation into Death* on 21-23 June 1999

⁸ *Review of Nursing Staff Levels at Casuarina Prison on Weekends* at page 3-4

⁹ See also paragraphs 7.53-7.59

¹⁰ See also paragraphs 7.83-7.103

¹¹ The Ministry has advised me that its Operational Instruction CW 16 covers this issue. However, as at November 2000, it was still in draft form

¹² This problem was resolved after the Casuarina riot and medication is now stored in a locked medication trolley

¹³ Figures taken from the 1988/89 and 1992/93 Department of Corrections Annual Reports

¹⁴ As at 6 July 2000

¹⁵ See also paragraphs 7.41-7.45

¹⁶ See also paragraphs 7.66-7.82

¹⁷ By Ms Ruth Mackey

¹⁸ See Chapter 4, paragraph 4.12

¹⁹ See my comments on the findings of the Smith Inquiry below at paragraphs 7.106-107; 121; 124; 128; 135 and 141

²⁰ Benzodiazepines are used in the treatment of drug withdrawal and stress and include a range of products with sedative and tranquillising effects. Psychiatric literature indicates a serious degree of addiction; severe withdrawal effects; development of tolerance requiring increasing doses; disinhibition and 'rebound' aggression.

²¹ *General Practice Activity in Australia 1998-99*, University of Sydney and the Australian Institute of Health and Welfare; October 1999

²² *ibid* page 24

²³ The most common reason was for a check-up (13.7 per encounter)

²⁴ 'Depression' includes 'feeling depressed' – sad, lonely, unhappy, worried, low self-esteem and 'depressive disorder'. The report extrapolated that there were approximately 3.6 million patient encounters involving depression and 709,000 new episodes in Australia per year (page 48). Counselling was "by far the most common form of management, undertaken at a rate of 34.2 per 100 depression encounters and 46.7 per 100 encounters where a new case of depression was identified". However, "drugs were prescribed at a rate of 78 per 100 depression contacts....81.1% were for anti-depressants".

²⁵ *General Practice Activity in Australia 1998-99* at page 52

²⁶ *ibid* page 60

²⁷ The range of illnesses in the list corresponds with those reported by prisoners

²⁸ Health Insurance Commission *Key Results for Quarter 1 2000*

²⁹ Health Insurance Commission Annual reports for 97/98 and 98/99 PBS Statistical Table 14

³⁰ *The West Australian* 17 July 1999

³¹ See Chapter 10 paragraphs 10.178-10.205 and Chapter 11, paragraphs 11.74-11.80 for my views on the use of medical observation cells

³² Paragraph 5.2.7.10

³³ *Review of Ministry of Justice services for treatment and care of adult prisoners at risk of suicide or serious self-harm*; January 1998; page 23

³⁴ *ibid* page 23

³⁵ See paragraphs 7.133-7.140

³⁶ Dr Liebling categorises “*poor copers*” as the highest risk of self-harm (See also Chapter 8 paragraphs 8.23-8.28)

³⁷ Completed during the review of nursing services at Casuarina Prison by *Healthwiz Management* in mid-1998

³⁸ see Chapter 12 paragraphs 12.112-12.134

CHAPTER 8 PRISONER SUICIDE AND SELF HARM

SUICIDE

SELF-HARMING BEHAVIOUR

THE IMPACT OF IMPRISONMENT

SUICIDES BY WESTERN AUSTRALIAN PRISONERS

SUICIDE

- 8.1 The increasing incidence of suicide is not a phenomenon restricted to prisons. National research has found a disturbing increase in the rate of suicide for the community as a whole. A bulletin released by the Australian Institute of Health and Welfare (the AIHW) on 7 July 2000 stated that “*Australian men are more likely to die from suicide than road crashes.*” The bulletin reported that the number of suicides rose by 9% between 1996 and 1997 and that the rate of suicide in men aged between 20 and 39 had increased by 70% in the past twenty years.
- 8.2 According to an earlier report by the AIHW entitled “*The Burden of Disease and Injury in Australia*”, published in November 1999, there were 2515 deaths by suicide in Australia in 1996. In the same year 23 prisoners nationally committed suicide. That report provided a comprehensive assessment of the level of ill health and disability – the “*burden of disease*” – in Australia in 1996 and measured the number of years of life lost due to premature mortality to produce an estimate of the contribution of fatal and non-fatal health outcomes to the burden of disease and injury.
- 8.3 The AIHW report found that cardiovascular diseases, cancer and injuries were responsible for 72% of the total mortality burden for both males and females. Injuries – which include suicide – was the main cause of lost years of life in young adults and children aged 5-14 years. Although there was a decrease in the overall mortality burden between 1981 and 1996, particularly from cardiovascular disease, road traffic accidents, low birth weight and stomach cancers, the incidence of suicide showed a significant increase. In terms of the number of years lost it was the fourth highest cause of death for all persons and the third highest cause for males.
- 8.4 Suicide and road traffic accidents each accounted for 27% of the total number of injuries in spite of a 50% reduction in the mortality burden for road traffic accidents. Depression was found to be the leading cause of the “*non-fatal disease burden*”. For women, the leading cause of mental disorder was depression (87%); for men, substance abuse, particularly alcohol, was found to be the primary cause. The mortality burden was found to be significantly higher among socio-economically disadvantaged people.
- 8.5 The picture painted by the AIHW report is one in which the general physical health of the community and their safety from injury and death from road accidents is improving. However, the incidence of suicide in the community is increasing, particularly for males. Given the steady increase in the incidence of suicide since the 1950s, it would appear that suicide has lost the stigma it once had and is now apparently seen as an acceptable response to today’s frustrations and stresses by certain sections of the community, particularly young, unemployed males in the 18-25 age group who are, coincidentally, also over-represented in the prisoner population.
- 8.6 A report published by the Youth Suicide Advisory Committee– *Suicide in Western Australia 1986-1997* (the YSAC Report) in May 2000, which provides an overview of suicide in Western Australia, includes the following key findings:-
- There was no significant increase in the suicide rates amongst young people during the study period.
 - The suicide rate for males is more than four times that for females (20.2 per 100,000 population compared to 4.7).
 - The highest rates were for young males aged 20-24 years (35.4); followed by the 25-29 age group (30.2) and the 30-34 age group (29.5). Although the rate of suicide for older males aged 75-78 was high (33.8), younger age groups account for a substantially larger proportion of suicides.

- The use of ‘active’ methods of suicide such as hanging increased at a rate of 8.9% for males and 9.3% for females per annum during the study period, while use of ‘passive’ methods such as carbon monoxide decreased by 3.2% for males. Overall males tend to complete suicide by active methods at a significantly higher rate than females.
 - Those who attempted suicide were twenty times more likely to die from suicide and four times more likely to die from other causes.
 - 36.5% of males and 56.6% of females who completed suicide had been treated for a psychiatric disorder – which included depressive illnesses, schizophrenia, drug use, personality disorder and immature personality – at some point in their lifetime.
 - 31% of males and 27% of females who completed suicide had a current substance use issue.
 - Aboriginal males committed suicide at twice the rate of all Western Australian males. A current substance abuse was found in 44.9% of the suicide deaths of Aboriginal males with alcohol being the most common (66%). 36% of Aboriginal males had been diagnosed with a psychiatric disorder.
- 8.7 The YSAC report on suicide noted an increase in the overall suicide rate in Western Australia for both males and females between 1996 and 1997. For prisoners, however, suicide has been a consistently high cause of death for some time. There was a significant rise in prison suicides in Western Australia in 1996 with six deaths, compared to one in 1995. In 1997 there were a further six suicides with a sharp rise in 1998 when there were eight suicides; three hangings where the Coroner subsequently made an open finding and one apparent suicide which has not yet been subject to inquest.
- 8.8 In spite of the claimed acceptance and implementation of the 339 recommendations made by the RCIADIC in 1991, figures produced by the Australian Institute of Criminology (AIC) show that the number of prisoner deaths has not declined and that the number of prison suicides has continued to increase. For example, half (184) of the 367 prisoner suicides nationally between 1980 and 1998 occurred in the seven years between 1992 and 1998 after the RCIADIC report. Although the total prisoner population increased by only 94.5% between 1980 and 1998 there was a 240% increase in the *number* of prisoner suicides between 1980 (10) and 1998 (34) and a significant increase in the *rate* of prisoner suicides - from 102.6 per 100,000 prisoners in 1980 to 179.7 per 100,000 in 1998. Compared to the community rates of suicide, it is estimated that the increase in the suicide death rate for prisoners was almost twice that in the community (75% compared to 38.5%) over the entire period.
- 8.9 Suicide in the community – particularly in small (often ‘rural’) communities such as Esperance or remote Aboriginal communities – are invariably marked by shock and disbelief and can have a devastating destabilising effect on members of the community. However, a similar number of suicides in the prison community – which is also a relatively ‘small’ community - seems to attract a range of reactions from those outside the circle of family or friends. An extreme view was recently put by a Western Australian ‘talkback’ radio host who said of prisoners *“If they want to top themselves they will be doing taxpayers, the community and especially their victims the ultimate favour.”*¹
- 8.10 Researchers Lester and Danto² referred to a similar indifference in the USA - *“..many in our society do not consider inmate suicide a problem worthy of concern. They tend to view all inmates as undeserving of sympathy or special help”*. However, they also commented – *“the fact is that prisons are part of society and inmates are part of the population...accepting suicide because someone is a prisoner is a sad mistake.”*

- 8.11 In the introduction to his 1998 review of suicide and self harm in UK prisons, “*Suicide is Everyone’s Concern*”, HM Chief Inspector of Prisons stated:-

“Death and bereavement inevitably touch us all in some way, and, when a prisoner dies in prison, his or her family and friends are bereaved in the same way as anyone else. But there is an added dimension to a death in prison. First family and friends do not just lose a loved one, they lose him or her in very painful circumstances, separated from them and in conditions that they do not fully appreciate. In addition, staff and prisoners, living and working with the person, are also deeply affected, and have to come to terms with their bereavement as well as that of the family.”

- 8.12 It is clear that the loss and distress for families is no less because the person who has died is a prisoner. In fact, there is a view that the loss is more difficult to come to terms with because of a perception in Western Australia that the circumstances leading to a death in prison are neither fully disclosed by prison authorities nor comprehensively investigated to the satisfaction of the families of the deceased prisoner in spite of the coronial process. In this regard I note that in their 1998 report³ to the Ministry, Howells and Hall observed:-

“From the perspective of the external bodies⁴ the Ministry of Justice can appear defensive and not fully cooperative. We believe that both informal and formal communication with these groups would reduce the level of mistrust.”⁵

- 8.13 Awareness of the underlying reasons for the high number of prison suicides is also important for society, largely because the majority of prisoners are only temporarily separated from the community. The AMA referred to the close relationship between prisoners and the community in its *Position Paper – Health Care of Prisoners and Detainees*:-

“Prisoners and detainees have the same right of access, equity and quality of health care as the general population. Because prisoners 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.”

- 8.14 Society, generally speaking, does not deny its responsibilities to its prisoners and most members of the community would probably agree with Nelson Mandela’s comments about the prison experience in his autobiography, “*Long Walk to Freedom*”, that “*A nation should not be judged by how it treats its highest citizens but its lowest ones.....*” In fact, as discussed in Chapter 3 of this Report, there is a view that a reasonable humane society expects a higher duty of care and protection to be afforded to those who have been deprived of their liberty and, to a large extent, responsibility for their own welfare. In this regard, in their 1998 report to the Ministry Howells and Hall noted:-

“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.”⁶

In Western Australia, the concept of duty of care is reinforced by the statutory obligation on the Coroner pursuant to Section 22 of the *Coroners Act 1996* to inquire into the deaths of all persons “*held in care.*”⁷

- 8.15 In relation to the *practical* meaning of “*duty of care*”, however, Howells and Hall also commented at page 23 of their report:-

*“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 prisoner.” (my emphasis)*

- 8.16 In my view, ‘duty of care’ to prisoners comprises far more than an obligation to ‘protect them from themselves’. I agree with the addendum to the UK Prison Service strategy for the prevention of suicide set out in *Circular Instruction 20/1989*:-

*“...suicide prevention cannot be seen primarily as a matter of procedures and precautions. In its widest sense it must be about creating a climate in which suicidal thoughts and feelings are less likely to take root. Inmates will normally be less prone to resort to suicidal behaviour in the establishment where regimes are full, varied and relevant; where staff morale is high and relationships with inmates are positive; where inmates are treated fairly and as individuals; where good basic living conditions are provided; where every effort is made to encourage contacts with family and the community. **In short, the problem of suicide can never be separated from the Service’s over-arching duty to treat prisoners with humanity and prepare them for release.**” (my emphasis)*

- 8.17 The YSAC report on *Suicides in Western Australia* concludes at page 49 that:-

“Almost every adverse event in a person’s life can be linked to an increased risk for suicide. The risk and protective factors for suicide identified in this report appear to be generally consistent with those from Australian and overseas research. These include individual characteristics such as mental illness and previous suicidal behaviour. Other major factors in this area are alcohol or drug use and stressful life events such as relationship breakdown, loss of employment, legal crises, interpersonal conflicts and confinement to institutions such as prisons and mental hospitals. Most people who end their life by suicide will have experienced a combination of several risk factors.”

- 8.18 These conclusions are obviously applicable to prisoners. Nevertheless, little research had been conducted until comparatively recently into the causes of suicide either in the community or by prisoners or into the management and planning implications for prison authorities. Dr Alison Liebling, one of the leading authorities on prison suicides commented on the lack of information about the subject in her 1992 study of prison suicides in the UK⁸:-

“The relative neglect of the prison suicide problem in research, yet its attraction for media and campaigning organisations, left an absence of reliable or helpful information from which policy and practice could be advised. The gap was filled by myth, cliché and fear on the one hand, and innovation on the other. Inside prisons, a wealth of information and experience existed and examples of good practice in averting suicide attempts could be found. Importantly, staff and prisoners could provide many clues as to the possible causes of suicides in prison. They had never been asked for their account of the problem; where they had spoken, their voices had seldom been heard.”

- 8.19 In his 1994 paper “*What can we learn from suicide and self-injury?*” Professor Richard Harding expressed the following view:-

*“Self-harm is a syndrome of distress; thus, the causes of distress must themselves be mitigated even if they cannot be removed; and these causes are frequently some aspect of the prison experience or prison conditions themselves. **From this point of view, self-harm incidents are almost invariably symptomatic of morale within the particular prison or prison system.**”⁹ (my emphasis)*

- 8.20 In the Introduction to his report, *Suicide is Everyone’s Concern*, HM Chief Inspector of Prisons also referred to the ‘health’ of a prison and its likely effect on the incidence of suicide and self harm:-

“All of us in the Inspectorate are struck by the immediately apparent difference between the atmosphere in prisons which have healthy cultures and those in which alternative cultures rule.....Care for and awareness of others are at the heart of what healthy relationships between staff and prisoners are all about. When we looked at reducing suicide and self harm we concluded that exactly the same applied to any successful strategy. I hope therefore that the ‘Healthy Prison’ concept will catch on, because it exactly describes the outcome of successful delivery of the Prison Service’s Statement of Purpose, namely that it will keep prisoners safely in custody, and treat them with humanity, while preparing them to live a law-abiding life in prison and on release.”

- 8.21 I agree with all of the above views. In summary, an understanding of the reasons for the high rate of suicide and self harm in prisons should be of interest and concern not only to the families of deceased prisoners as part of the grieving process but also to the staff of prisons, other prisoners and the general community - because prisoners return to the community and may well bring existing and new problems with them and because, in my view, there is substance to the theory that prisoner distress is frequently an indicator of the ‘health’ of a prison and, by definition, of the prison system.

Reasons for the high rate of prisoner suicide and self harm

- 8.22 The YSAC Report¹⁰ refers to “major life stress events such as divorce, unemployment or physical illness” as “precipitating stresses” which “can significantly affect an individual’s ability to cope with everyday life. Levels of stress can be heightened if people do not have strategies for coping with stress or lack close friends and/or family to help them through difficult times.” This view seems to me to be very close to the conclusions formed by Dr Liebling in her book, “Suicides in Prison”¹¹ which is considered the “seminal” authority on this subject. Although published in 1992 and using studies and academic comment that are considerably older, Dr Liebling’s conclusions are remarkably – and disturbingly - similar to the findings of the Howells and Hall study commissioned by the Ministry in 1997 and to the views expressed in submissions received in the course of my inquiry.
- 8.23 Dr Liebling identified three main groups of acute suicide risk prisoners – “poor copers”, long term prisoners and those who were psychiatrically ill - and found that the following factors were of significance:-
- those considered most at risk of suicide while in prison were young male prisoners in their early twenties on remand or at an early stage of their sentence and long term prisoners;
 - a history of depression or psychiatric treatment was noted in approximately one third of prisoners who commit suicide;
 - the level of drug or alcohol abuse was high and the frequency of drug abuse appeared to be increasing;
 - almost half of all prisoners who completed suicide had made a previous attempt at self harm;
 - hanging was the most common method;
 - a disproportionate number of suicides occurred in special locations such as the prison infirmary, punishment cells and other areas of seclusion;
 - at least half of all suicides occur at night or in the early hours of the morning and are more likely at the weekend;
 - a high incidence of prison-induced stress;
 - the prime motivation for prison suicide appeared to be “fear or loss: fear of other inmates, of the consequences of one’s crime, of imprisonment, and loss of a significant relationship, such as lack of communication and divorce”; and
 - fear leads to and increases stress and tests a person’s ability to cope.¹²

In Liebling's view, however, "...overcrowding alone is rarely a direct precursor to suicide. It is other problems, concealed by overcrowding but exacerbated by it – such as unwanted interaction, noise, feelings of helplessness, lack of clothing, food, medical and other specialist care, changing hierarchies, administrative and other problems that might contribute to the suicide rate."¹³

8.24 In interviews in the course of the 1992 study, Dr Liebling found that prison staff identified eight main causes of prison suicide: depression, lack of communication, bad news, prison pressures, mental illness, anger, boredom, and guilt – and that they saw suicide and self harm attempts as separate issues with different causes and no connection. Hence, in the opinion of the officers she interviewed, a self harm attempt was either a genuine, but unsuccessful, suicide attempt or a petty, non-serious act.

8.25 In a 1985 study¹⁴, stress was defined as "*the field of negatively toned emotions such as fear, anger, depression, despair, hopelessness and guilt*". It included "*any event in which environmental demands, internal demands, or both, **tax** or **exceed** the adaptive resources of an individual.*" (my emphasis) In this context, "*coping refers to efforts to master conditions of harm, threat or challenge when a routine or automatic response is not readily available.....Coping refers to adaptation under relatively difficult conditions.*"

8.26 Dr Liebling identified a range of 'prison stresses' including:-

*".....the loss of freedom, autonomy and personal safety; the removal from a familiar environment; restriction of movement; compliance with (at times incomprehensible) rules and regulations; subjection to an impersonal decision-making process (e.g. parole); loss of control over outside events; and violence and victimisation."*¹⁵

8.27 Contrary to the finding that the majority of those who commit suicide in the community have some form of clearly identifiable mental illness, Liebling found that "*Psychiatric illness factors have been overstated in prison suicide research. This may also be true of studies carried out in the community (Kelleher, 1988)...*"¹⁶ She quoted from a study of suicide and stress in prison¹⁷ which concluded that the difference between prison suicides and others suggested that "*different vulnerability factors may operate in a prison setting*" and that it may therefore, be "*more appropriate to examine possible precipitants to suicide and in this context most attention has been paid to the stress associated with imprisonment.*"¹⁸

8.28 Ultimately Liebling found that the inability to cope with the stresses of their situation in prison was the almost universal characteristic of prisoners who suicide in prison and quoted from a 1978 study¹⁹ about the effects of imprisonment:-

"The point is that segregation hurts, not so much because of its objective deprivations, though these are admittedly unpleasant, but because it exposes men to special environmental challenges, and calls for special psychological resources. Those unable to marshal appropriate resources are abandoned to defeat and left to ponder, alone and unaided, the nature and import of their failure."

8.29 She also quoted from a study by Johnson and Toch²⁰ which described the potentially destructive effect of unalleviated stress:-

"If a prisoner is placed in an unbearably stressful situation with no means at his disposal to cope with this overwhelming experience, he may divert his feelings of hopelessness towards himself. This 'self-destructive breakdown' has been identified as unique to the prison setting, and it is seen as an index of the personal difficulties that face prisoners."

and commented that:-

“In hopeless young people, with the least available skills and resources for coping with adversity and stress, confinement, isolation and boredom – particularly if combined with conflict and pressure from other inmates – can be the last straw. This is one unintended consequence of imprisonment no society should knowingly or willingly inflict on its law-breakers. Looking after with humanity’ should exclude boring people to death.”²¹

8.30 A study by Associate Professor Kevin Howells and Dr Andrew Day of the University of South Australia and Guy Hall of Murdoch University²² identified four main groups of risk factors as the causes of suicide and self-harming behaviour among prisoners – personal, contextual, clinical and historical²³. Using this framework, a prisoner with some or all of the following characteristics is likely to be at risk of suicide:-

Personal Risk Factors – characteristics of the individual

- More distressed, disordered and vulnerable
- Poorer relationships with other prisoners and staff and reported more threats and intimidation
- Fewer sources of social support
- 75% were likely to have a history of self harm
- The main purpose of self harm was relief from tension; attention-seeking was rare
- Recent experience of stressful life events – threats to personal relationships, domestic problems, loss and a variety of prison stressors including bullying and intimidation, isolation and disturbing psychological symptoms
- Social isolation and segregation
- Boredom, low levels of activity and general frustration
- Higher levels of disciplinary charges
- Impulsivity and hostility
- Shame and remorse
- Failure to cope with either internal or external stresses
- Lack of personal coping and problem-solving strategies **but**
- Neither ethnicity nor age factors were conclusively indicative of a risk of suicide or self harm

Contextual Risk factors

- Remand
- First week of imprisonment
- Recurrence of psychiatric symptoms
- Withdrawal symptoms

Historical Risk factors

- History of self harm
- Drug dependency prior to imprisonment
- Disruptive early family life – physical and sexual abuse

Clinical Risk factors

- Current and past psychiatric history...particularly schizophrenia
- Psychological distress – both general and related to drug dependency
- High anxiety and neuroticism
- Clinical depression

- 8.31 It became clear at an early stage in my inquiry that it is unlikely that a single issue or trigger will cause a prisoner to commit suicide. More often than not a prisoner will have experienced a series of problems, frustrations and anxieties – as a result of internal (prison) and external (family or other) pressures – possibly exacerbated by the effects of long term substance abuse, and culminating in an overall increase in stress and ‘a last straw’ trigger. Ultimately, simple problems of ‘normal’ life take on insurmountable dimensions and lead to a sense of utter helplessness and hopelessness in which suicide may seem for some prisoners the only alternative, particularly in the early stages of imprisonment. Prisoners serving long sentences may also experience similar despair throughout their imprisonment.
- 8.32 The UK Samaritans described suicide in the following terms “*Events, feelings and experiences add strands to a net that can drag you under. The final straw can be the weight of gossamer but the combined effect can be devastating.*”²⁴ A prisoner summed it up as a decision that “*...one will not, cannot go through the next half hour, the next five minutes. Suddenly one comes to a dead end, the point of death. The limit has been reached.*”²⁵
- 8.33 There are also those who take their own lives as an impulsive reaction motivated by frustration or by an inability to cope with the stress of prison life. Of those, there is a strong suspicion that a few may well not have intended to succeed in their self harm attempt; it was simply a cry for help which resulted in unwanted and unexpected consequences.
- 8.34 By contrast, I cannot disregard the view put to me by more than one prisoner that, for some prisoners, suicide is not only a considered and rational decision, it is the only decision in the prison environment that they are able to make for themselves. In other words, for some, suicide may be a rational, conscious response to the situation. The prisoners who put forward this view believed that prisoners should be allowed to take this course of action if that is what they have decided to do.

Profile of a prisoner at risk of suicide

- 8.35 In summary, the profile of a prisoner who should be considered a possible risk of committing suicide while in prison is one who is young (under 25), male, a remandee or has only been in prison a short time, with limited ability to adjust to, and cope with, the stresses of life in prison and who may have attempted self harm on previous occasions. In addition, older sentenced prisoners serving long sentences and who may have been in prison for some time appear to present a similar level of risk. There is also evidence that a substance use issue is an indicator of a higher level of risk – one third (16) of the prisoners found to have committed suicide or apparent suicide between 1991 and 2000 had a history of substance abuse and a further four had alcohol problems. In addition, almost one third (15) had a history of a psychiatric disorder, depression or had been assessed at Graylands. From the available research, in addition to personal risk characteristics, there appear to be two factors which are considered strong indicators of suicide or self harm for a prisoner – previous self-harming behaviour and an inability to cope with the impact of imprisonment.

SELF-HARMING BEHAVIOUR

- 8.36 In her 1994 study of UK prisoners, Dr Liebling described self harm “*as a continuum along which one step may prove to be the first stage of a pathway of despair*” leading to eventual suicide. In psychological terminology – the best predictor of future behaviour is previous behaviour of a similar sort.
- 8.37 Using this basic premise, a clear understanding of the causes of self-harming behaviour - which is far more prevalent in prisons in Western Australia than suicide - should increase the effectiveness of any suicide prevention strategy. However, there have been few academic studies of the causes of self harm by prisoners in Australian institutions. Two have been drawn to my attention and both of those happen to have examined self harm attempts in prisons in Western Australia. The first, conducted by a Hospital Officer from Casuarina Prison, looked at self harm by prisoners in the C W Campbell Remand Centre between 1990 and 1994 (“the Remand Centre study”). The second, a research project by Greg Dear, a clinical psychologist at Edith Cowan University, Professor Don Thomson of Charles Sturt University in New South Wales, Guy Hall from Murdoch University and Associate Professor Kevin Howells of the University of Adelaide, published in July 1998 examined incidents of self harm by all prisoners in Western Australian prisons between 1 July 1996 and 31 March 1997 (“the Dear et al study”) based on information from Ministry intelligence reports or “*Situation Reports*” (Sitreps).

The Remand Centre Study

- 8.38 The purpose of this study was stated as “*to identify and describe the factors that are associated with the incidence of suicide, self harm and behavioural disorders by prisoners at the C W Campbell Remand Centre. If prison nurses understand when and why the at-risk behaviour is likely to occur, then more confidence will be shown in planning and implementing appropriate interventions.*”
- 8.39 The author of the study stated that:-
- “the value of studying self-destructive behaviour and attempted suicides is that a high number of self-inflicted deaths in custody have a history of these behaviours. They may be considered manipulative gestures but a “manipulative” inmate can die from self-inflicted wounds just as easily as a “serious” suicidal inmate”.*
- 8.40 He quoted from a 1994 study²⁶ that “*there should be no such assessment word as “manipulation” as all attempts should be treated seriously and in this way any negative attitudes will not interfere with an ability to professionally diagnose.*” The author suggested that behavioural problems which can include aggression towards officers and other prisoners, destruction of property and self harm are “*reactions to problems the prisoners are unable to deal with in a constructive way.*” He concluded that if the number of self-inflicted injuries is excessively high it should be seen as an indicator that the “*sense of purpose in a prison may have deteriorated to an unacceptable point*” citing prison conditions, overcrowding and withdrawal from drugs as significant aspects of prisoner stress.
- 8.41 The data for the Remand Centre study were collected from a retrospective study of the medical records of prisoners who had self-harmed or had been involved in “*behavioural disturbances*” between January 1990 to December 1994 - 256 incidents of self harm involving 216 prisoners were identified. Analysis of the incidents produced the following profile of a self-harming prisoner:-

- aged 18-29, with prisoners aged around 20 more likely to have ‘slashed up’;
- in prison for less than 14 days;
- most likely charged with an offence involving violence and likely to result in a comparatively long sentence;
- previous history of self harm;
- identified as not coping and prone to impulsive behaviour;
- unlikely to be on prescribed medication; and
- have been in receipt of medical attention or psychiatric assessment.

- 8.42 The study reported a noticeable drop in the number of self-harming incidents between July and December 1993 when the then superintendent commenced an initiative known as “*Making the Remand Centre a Safer Place*”. Under this initiative, recreational time for prisoners was extended; the number of activities and educational opportunities available was increased; management strategies for prisoners were instituted and prisoners were invited to actively participate in the renovation and maintenance of buildings, gardens and facilities. There was, apparently, an obvious ‘team’ approach and the concept was enthusiastically supported by prison staff.
- 8.43 The superintendent told me that identifying the “*safety*” of prisoners and staff as the guiding principle against which all local management decisions had to be made was paramount to the success of the initiative on the basis that:-
- it conditioned staff to ask themselves “*is it safe?*” in all their actions and decisions;
 - it provided a focus for staff and enhanced team spirit; and
 - it helped to identify any gaps in prisoner management and provided a means of measuring the success and effectiveness of strategies.
- 8.44 He believed that this concept ‘broke the pattern’ of suicides at the Remand Centre – in 1992 there were two; in 1993 there were none. As stated above, it was also found that the number of self harm incidents fell while the “*safety*” strategy was functioning well. However, this management approach fell into disuse and finally disappeared after he was transferred from the prison towards the end of 1993. In his view, there were two main reasons for the demise of the ‘safety’ strategy. First, rapid changes in administrative staff in a short period of time after his departure resulted in a lack of stability which was an essential element to the success of such a holistic approach. Second, the introduction of the prison officers’ new salary package which restructured prison officer terms and conditions of employment, caused upheaval in the prison system and a period of readjustment for officers because it affected their Industrial Award and their salary package. The disruption it caused changed the focus of the prison administration from the ‘safety’ of prisoners to the management of staff. The ‘teamwork’ which had been instrumental in the success of the initiative was replaced by a return to an individual and uncohesive approach to prisoner management.
- 8.45 The Remand Centre study supported this view and noted an increase in the number of both self harm and suicides between April and September 1994 during the implementation of the Prison Reform Package – there were three suicides at the Remand Centre between 5 and 15 September 1994. This is in line with the findings of Dr Liebling in her 1994 study that changes in staff working practices tended to create situations where the level of support and communication with prisoners was compromised because staff were distracted by events which impacted on their own lives.

8.46 The Remand Centre study made the following recommendations:-

- completion of formal psychiatric nursing assessments as soon as a prisoner presents with a previous psychiatric or self-harming history;
- development of an assessment form that incorporates identification of risk factors;
- employment of permanent nursing staff at the Remand Centre with formal mental health qualifications;
- employment of an experienced mental health nurse specialist located at the Remand Centre;
- the conduct of research into self harm incidents and prison changes; the impact of formal nursing assessments on the number of self harm incidents and the difference between at risk prisoners who self harm and those who do not; and
- provision of inservice education for all nursing staff and prison officers on risk assessment and management of at risk prisoners.

8.47 The report was never published and received no official response from the Ministry. However, an “*at risk*” assessment form was introduced in late 1997 and prison officers now receive training in strategies for the identification and management of at risk prisoners.²⁷

The Dear et al Study

8.48 The purpose of this study was stated as:-

“The essential purpose in studying self-harm in prison is to inform, and thereby improve, efforts to prevent it. Self-harm incidents are distressing events not only for those who harm themselves but also for their fellow prisoners and for the prison officers who must respond to these incidents.....” (page 5)

8.49 The aims of the study were defined as follows:-

- 1. To obtain reliable descriptive data on the extent and nature of self-harming behaviour in Western Australian prisons;*
- 2. to identify the key situational factors that trigger incidents of deliberate self-harm*
- 3. to identify the key personal factors that differentiate prisoners who have self-harmed from those who have not;*
- 4. to investigate the interaction between the person and situation factors;*
- 5. to determine which of the personal factors identified would be best to include in a screening instrument designed for predicting self-harm among prisoners.”* (page 11)

8.50 Using the Ministry’s intelligence reports or ‘Sitreps’, the study identified 108 non-fatal self harm incidents by 91 prisoners between 1 July 1996 and 31 March 1997 and interviewed 82 of those 91. Analysis of the findings produced the following profile of a prisoner who was at greater risk of self harm:-

- under 26 years;
- on remand;
- a new arrival;
- in a special placement;
- female;
- had a more troubled life pre-prison;
- was more likely to have self-harmed previously;
- had a higher level of “*current distress*”;
- had more difficulty in coping; and
- 50% of the self harm group reported receiving psychiatric /psychological treatment as an adult.

However, the study also found that 40% of self harm attempts were by sentenced mainstream prisoners who had been in prison for more than 3 months.

- 8.51 The main precipitating factor of the self harm attempt (43%) was identified by the study as an internal prison event - such as conflict with, or bullying by, other prisoners; conflict with officers; placement; disciplinary regime; or an aspect of prison routine. Combined with a consequence of imprisonment (15%), the impact of imprisonment in some way was cited as the main reason for self harm by 58% of the prisoners interviewed.
- 8.52 Seventy per cent of prisoners reported that their motive for self harm was in response to distress and to relieve the symptoms; to escape from the source; to change the circumstances and to obtain support, comfort or sympathy; only 22% self-harmed for purely “attention-seeking” reasons.
- 8.53 In comparison with a group of prisoners matched by age, race, sex and custodial status and placement who had not self-harmed in prison, Dear et al found that the “*self harm group displayed a greater level of distress, disorder and vulnerability to distress on almost every measure*”. This group also reported a greater number of traumatic, disruptive life events; exhibited a greater degree of hopelessness and inability to cope; poorer relationships with other prisoners; fewer sources of, or inadequate, social support; and were more likely to have been assessed as vulnerable while in prison.
- 8.54 Fifty percent of the self harm group compared to 30% of the comparison group reported receiving psychiatric or psychological treatment as an adult. They were also more likely to have experienced a stressful situation in the week prior to their self harm attempt and to have had no strategy for dealing with it. Seventy five per cent of this group had previously self-harmed outside prison compared with 29% of the comparison group. The most striking difference between the two groups was found in the significantly higher level of “*current distress*” in the self harm group.
- 8.55 Dear et al concluded that:-
- “Given that prison based, or imprisonment related, events were the most common precipitating factors, it is possible that many of these circumstances could have been prevented. Attempts need to be made to prevent distressing circumstances from arising where this is feasible and to reduce the stressfulness of those circumstances that can’t be prevented. Furthermore, prisoners who are facing stressful circumstances should be provided with practical assistance in coping with their situation... (page 13)*
- ...prison staff will be more successful at identifying self-harmers by monitoring prisoners for signs of current distress rather than screening them for personal background factors.....Monitoring distress levels will also result in a high false positive rate but one can argue that any distressed prisoner warrants some form of assistance even though most will not self-harm.” (page 14)*
- 8.56 They identified “*symptoms of depression, suicidal ideation and the level of subjective distress associated with current stressful circumstances...together with a history of self harm outside prison...*” as the most useful components in a screening instrument. As an alternative to regular screening of prisoners for evidence of distress, they recommended that “*prisoner self-disclosure of depressive symptoms, feelings of distress and suicidal ideation*” should be facilitated and observed that:-

“There should be no disincentives for making such disclosures (eg, automatic placement in an observation cell) and a reasonable likelihood of appropriate and timely assistance. It should be possible to combine skilful monitoring by staff with conditions that encourage and reward open disclosure by prisoners.....The successful detection of prisoner distress relies on the extent to which prison officers are adequately trained in detecting signs of depression and distress and the degree to which they are able to maintain regular monitoring of prisoners’ behaviour. The degree to which prisoners feel comfortable in disclosing their distress to unit staff is also critical.

.....priorities for prevention can be based on considerations of feasibility and prevalence (ie, which types of situation are most easily prevented and which are the most commonly experienced).” (page 15)

8.57 The report recommended, *inter alia*, that:-

- 1. Attention should be focussed on prisons, locations within prisons and categories of prisoner that are most associated with self-harm.....*
- 2. Attempts should be made to minimise the occurrence of preventable stressors.....*
- 3. Prison officers’ training and professional development should include guidelines for detecting and responding to signs of distress among the prisoners they manage.*
- 4. Procedures should be implemented to facilitate prisoners informing staff of their distress before they reach a point of crisis. It is imperative that the response to such disclosures be free of disincentives to further disclosure.....*
- 5. Alternatives to placing persons who have self-harmed in observation cells should be explored. These alternatives should include the provision of emotional support by appropriately trained persons and interventions aimed at identifying and resolving the underlying psychological and/ or social problems.*
- 6. Strategies should be implemented to minimise psychological vulnerability among prisoners. For example, programmes on life coping skills and prison survival skills....*

8.58 The recommendations relating to officer training have been implemented. However, although the philosophical concepts of harm minimisation suggested by Dear et al have been accepted, in my opinion, the remaining five recommendations do not appear to have been put in place in any practical sense.

Form CPS 69 - “Attempted Suicides/Self-Injury”

8.59 As part of my inquiry I decided to look at incidents of self harm which were reported on Ministry *Form CPS69*, a form that is supposed to be completed by prison officers after a self harm attempt by a prisoner. Although, I examined only incidents reported on *Form CPS69* for the three years 1996-98 (the years which showed the greatest increase in suicide), from a basic analysis of the data a profile of a self-harming prisoner similar to that found in the two earlier studies emerged.

8.60 Significantly however, when I examined the information contained in *Form CPS69* for the same period of data collection as that used in the Dear et al study, I found records of 66 self harm attempts and three threats of self harm compared with 108 incidents reported in the ‘Sitrep’ documents used by Dear. More significantly, only **18** of those 69 incidents were also recorded in the Sitreps. At very least, this discrepancy in the two forms of recording self harm attempts indicates that neither form contains a complete record of self harm attempts and that the Ministry does not know the true extent of self-harming activity in its prisons.

RECOMMENDATION 8.1

That the Ministry formulate a single means of reporting incidents of self harm, attempted self harm and threats of self harm to facilitate the reliable collection of data and to enable comprehensive and regular research into the characteristics of the prisoners involved and the circumstances in which incidents occur.

- 8.61 There are clear similarities between the profile of the self-harming prisoner which emerged from the Remand Centre study and the Dear et al study conducted three years later. Both studies point to the importance of being able to identify those prisoners who are more likely to self harm because of the link between self-harming behaviour and suicide at *some* time in the self-harmer's life. The Dear study endorsed the conclusion made from earlier studies in the UK²⁸, namely that self harm attempts are 100 times more likely to result in suicide at a later stage. This places previous self harm as one of the most significant at risk indicators.
- 8.62 In this regard, I note with concern the recent finding by the Auditor General²⁹ that although the number of suicide attempts at the Remand Centre fell from 18 between 1 January 1994 and 31 March 1997 to five in 1997-98 and two in 1998-9 "...far less success has been achieved in reducing incidents of self-harm, with the number of incidents more than doubled in 1998-99 compared to the previous year". These figures could suggest that the Ministry's At Risk Management System (*ARMS*), which was introduced in late 1998, may succeed in preventing only the *immediate* risk of suicide and that greater attention needs to be given to addressing the underlying causes of self-harming behaviour among prisoners. *ARMS* is considered in some detail in Chapter 9.
- 8.63 If the apparent strong connection between self harm attempts and subsequent suicide by prisoners is accepted, the tendency by many prison officers to see incidents of self harm as attention-seeking rather than as a good indicator of a future suicide is of concern given the finding by Dear et al that only 22% of prisoners interviewed after a self harm attempt said that their self-injury was 'attention-seeking'.
- 8.64 Many of the prison officers and other prison staff who spoke to my inquiry were of the view that prisoners self harm primarily to get attention or to manipulate the system in some way. Most did not describe self harm attempts as indicative of underlying problems or distress. Self harm was seen primarily as manipulative and a means of obtaining some benefit – medication, a different placement - or to avoid some consequence – transfer to a different unit or prison. Repeat acts of self harm were frequently seen as signs of difficult or troublesome prisoners. The fact that female prisoners have a very high rate of self-harming behaviour but rarely commit suicide is seen by some as evidence of the attention-seeking nature of self injury.
- 8.65 The perception by prison officers that self harm is a form of manipulation by prisoners is consistent with Liebling's finding that UK prison staff tended to see self harm attempts as entirely separate from suicide and arising from different motivations.³⁰ Liebling rejected this view of self harm and commented that:-

"Inmates may make these 'gestures' as a last ditch effort to provoke a solution, or to draw attention to their plight. Despite worn statements by staff that this was 'a cry for help', help is rarely forthcoming. The 'gesture' is a declaration of resourcelessness: the bravest plea the inmate can muster. Without rescue or support, their determination to escape from misery is likely to take a different and more dangerous course.

Alternatively, the inmate may omit any 'cry for help' and proceed directly down a pathway to suicide. Not even daring to manipulate their own rescue, these inmates simply give up."³¹

- 8.66 A study of self harm by prisoners at a UK women's prison conducted in 1997³² reported that the majority of staff saw acts of self injury as “*an inability to express oneself in alternative ways*” and as “*an effective means of achieving desired ends*”. A recent University of South Australia study³³ of 76 correctional officers in two South Australian prisons found that prison officers believed the two main causes of self harm attempts were “*a cry for help*” or to “*gain attention*” in almost equal proportions. Clearly, because prison officers have the closest and most frequent contact with prisoners, and positive interaction and communication between officers and prisoners is seen as the cornerstone of an effective suicide prevention strategy, this attitude towards self harm could well have unwanted consequences.
- 8.67 First, if officers consistently view self harm as ‘attention-seeking’ or manipulative, they may well over time become de-sensitised to signs of current distress. Furthermore, there has been a growing tendency in Western Australian prisons for officers to see prisoners who have been identified as ‘at risk’ as a medical/health problem to be dealt with by health staff. Passing on the responsibility for the problem to others will tend to diminish officers’ skills in dealing with the problems themselves.
- 8.68 In his 1998 report on suicide in UK prisons HM Chief Inspector of Prisons wrote³⁴:-
- “We do not underestimate the difficulty for staff in managing persistent self-mutilating behaviour of some prisoners particularly children, young adults and female prisoners. However, what is always important is to take their behaviour seriously.....Not all unhappy people are able to admit or express their feelings in a constructive way. This may be particularly so for young people and those on remand. To some extent their actions are “attention-seeking” but labelling the behaviour in a dismissive way is likely to increase the distress.”*
- 8.69 Second, prisoners have told me that they feel they have to “*go off*” or “*act out*” to get any attention from prison staff. For some, “*going off*” will include self harm. Although I do not doubt that some prisoners will go to extraordinary lengths to ‘get what they want’ from the system, the requirements of the Ministry’s duty of care mean that some middle ground needs to be found. The Ministry also came to that view in early 1998 after an unacceptably high number of prisoner suicides in 1996, 1997 and the first quarter of 1998, and a growing realisation that prison officers were becoming less involved at the ‘front line’ with disturbed and vulnerable prisoners. As a result, it commissioned the study by Howells and Hall (referred to throughout this report), which led to the formulation and introduction of *ARMS*³⁵.
- 8.70 Although the validity of previous self-harming behaviour is now generally accepted as an indicator of future behaviour,³⁶ research to date does not assist in predicting the likely *timing* of a future ‘successful’ self harm attempt with the result that the subsequent management of at risk prisoners becomes complicated. For example, if a self-harming prisoner were to be considered as ‘at risk’ of suicide for the duration of his/her imprisonment, such an approach would have significant resource implications for prison authorities and one which they may find hard to justify - given that only three of the 23 prisoners who subsequently committed suicide between 1996 and 1998 were reported in the Form CPS 69 as having made a previous self harm attempt.
- 8.71 In my view, the most significant value of the two studies of self harm in Western Australian prisons lies in the comprehensive recommendations each made to improve the system for identification and management of at risk prisoners. I have considered the extent to which these recommendations have been accepted by the Ministry and incorporated in current suicide prevention strategies in Chapter 11.

THE IMPACT OF IMPRISONMENT

8.72 The impact of imprisonment on people with already limited ability to cope with problems is acknowledged as being one of the major “*last straws*” for prisoners. As stated earlier in paragraph 8.25, Liebling identified a number of specific ‘stressors’ associated with imprisonment. Professor J Gunn wrote in 1994 in his unpublished report on suicide in Scottish prisons³⁷:-

“Prisons collect individuals who find it difficult to cope, they collect excessive numbers of people with mental disorder, they collect individuals who have weak social supports, they collect individuals who, by any objective test, do not have rosy prospects. This collection of individuals is humiliated and stigmatised by the process of arrest, police inquiry and court appearance. Prisoners suffer the ultimate ignominy of banishment to an uncongenial institution, which is often overcrowded, where friends cannot be chosen, and physical conditions are spartan. Above all they are separated from everything familiar, including all their social supports and loved ones, however unsatisfactory. This is what is supposed to happen, this is what the punishment of imprisonment is all about. This collection of life events is sufficient in any individual to make him or her depressed.....Sometimes this will inevitably lead to suicidal activity and some deaths.”(my emphasis)

8.73 Whether society considers the prime purpose of imprisonment to be punishment, the protection of the community or the rehabilitation of offenders (or a combination of the three), there is little doubt that for many offenders imprisonment is a difficult and traumatic experience. I asked prisoners and prison staff for their views on the causes of prison suicides. One prisoner told me:-

“The general feeling in prisons across the board by inmates about dealing with issues via the authorities is fear. Fear that something will be used against them, that it might affect their release, that it’ll end up on their file or worse still... be ignored.”

8.74 Another described the prison experience as “*tension, inequality and anxiety*”. Others have pointed to boredom, uncertainty about daily prison life and the future, no-one to talk to; “*day-dreaming about people on the ‘outside’*”. Prison chaplains who wrote to my inquiry referred to despair, lack of fulfilment, lack of support and that imprisonment created the desire for revenge.

8.75 In other submissions and during interviews prisoners identified the following causes of stress and anxiety:-

- the “*shock of imprisonment*”;
- lack of positive contact with, and distrust of, prison staff, particularly uniformed officers;
- isolation/segregation;
- inexperienced and unskilled officers;
- loss of self-esteem;
- boredom and inactivity;
- perception that prison rules are unfair;
- hopelessness;
- low staff morale;
- under-resourced services for prisoners and over-worked staff;
- lack of interaction with officers;
- officer insensitivity to prisoners’ loss or tragedy ‘on the outside’; and
- violence.

- 8.76 Consequently, for offenders who may lack the skills or internal resources to cope with their own problems, the additional impact of imprisonment and its accompanying stresses may well lead to self-harming and suicidal behaviour. For example, boredom and inactivity resulting from a lack of structured work, education or other productive occupation can lead to an increased focus on personal problems and fears which, after 'lockup', become magnified and overwhelming. From my observations, the rigidity and inflexibility of prison life and the emphasis on security and control rather than interaction and rehabilitation also diminish to a large extent the ability of prison staff to reduce the effect of known stressors on prisoners' lives.
- 8.77 Because the impact of imprisonment has been found to be a significant factor in suicidal and self-harming behaviour, it is necessary to examine in some detail all aspects of the prison environment which contribute to that result. Subsequent chapters in this report give my conclusions on the degree to which the Western Australian prison system attempts to reduce the impact of prison stresses and also considers the effectiveness of the Ministry's strategies for identifying and managing its vulnerable prisoners.

SUICIDES BY WESTERN AUSTRALIAN PRISONERS

- 8.78 My inquiry has focussed on the period since the report of the RCIADIC was published in 1991 until 30 June 2000. In that time 74 prisoners died in Western Australian prisons. Forty seven³⁸ of those deaths were by suicide (30) or apparent suicide (6)³⁹ with 11 possible suicides not yet subject to inquest. For the purposes of this Report I have included the deaths which were the result of apparent or possible suicide. Twenty one - almost half - of the 47 deaths occurred between January 1996 and 1 June 1998. A brief analysis is set out in **Table 8.1**

TABLE 8.1 SUICIDES AND APPARENT SUICIDES 1991- 2000

Year	No. of suicides and apparent suicides	Suicide by remand prisoners	Suicide by long term prisoners	% of total deaths
1991	4 (8)	4		50%
1992	3 (4)	2		75%
1993	2 (3)	1		66%
1994	3 (6)	3		50%
1995	1 (5)	1		20%
1996	6 (6)	2	1	100%
1997	6 (12)	5	1	50%
1998	12 (14)	7	4	78%
1999	4*(8)	1	1	50%
2000**	7*(10)	5	2	70%

Notes

The figures in brackets are the total number of deaths for the year

"Long term" is defined as a sentence of 5 years or more or indeterminate

**Number of deaths to 30 June 2000

*Apparent suicides. Deaths not yet subject to inquest

- 8.79 Consistent with other jurisdictions, the primary cause of death was hanging – 40 deaths occurred by this means. In addition, five prisoners died from asphyxiation using a plastic bag; there was one death as a result of electrocution and one from poisoning. Five of the prisoners were Aboriginal. All the deaths have been the subject of internal Ministry investigations and all but the deaths in 1999 and 2000 have been the subject of coronial inquest. The results of my examination of those deaths and the issues they have raised are explored in detail in this and subsequent chapters.
- 8.80 In his report on suicide and self harm⁴⁰, HM Chief Inspector of Prisons concluded:-
- suicide is a means of escape from unbearable emotional pain when there seems to be no other option;
 - unimaginable circumstances might be bearable to one person but may bring overwhelming feelings upon another;
 - most people give some signs of their intentions;
 - background history may make someone vulnerable to suicide;
 - a range of events may trigger suicidal feelings;
 - there is no foolproof means of predicting who will commit suicide or when; and
 - listening and encouraging suicidal feelings with a sympathetic person in a safe environment reduces distress.
- 8.81 The background to a Western Australian prisoner's decision to commit suicide appears not dissimilar to the Chief Inspector's findings and those in other internationally accepted research. In that regard, there are essentially no surprises in the opinions expressed in this Report. Prisoners in Western Australia appear to face the same anxieties, fears and uncertainties as prisoners throughout the world - although it was noted at the 15th Asian and Pacific Conference of Correctional Administrators⁴¹ that "*generally, completed suicide rates within the region were extremely low, with New Zealand and Australia being somewhat exceptional in this regard.*"
- 8.82 I am not convinced that the high rate of suicide and self harm by prisoners in this State is explicable purely on the ground that prisoners are a 'high risk' group. It is of concern that the numbers continue to rise – there have been to date in 2000 seven apparent suicides in Western Australia, five of which occurred between 7 May and 25 June - in spite of the introduction of a number of suicide prevention initiatives during the past eighteen months.
- 8.83 I have, therefore, focussed on the adequacy, standard and resourcing of the Ministry's strategies for the identification, assessment, management and care of at risk prisoners and whether those strategies fulfil the Ministry's duty of care; the objective standards of reasonableness and humanity expected by the community and the recommendations of the RCIADIC. I have also examined the existence of prison stresses (*'stressors'*), and the steps, if any, taken by the Ministry to identify and address their causes. As stated above, I am quite aware that the ultimate decision by a prisoner to take his⁴² own life may have been the result of a number of precipitating factors. I have not, therefore, formed any view on the specific *personal* reasons why a particular prisoner may have chosen that course of action.

- ¹ Reported in the *Wanneroo Times* 12 October 1999
- ² *Suicides behind bars*; Philadelphia; 1993
- ³ *Review of Ministry of Justice Services for the Treatment and Care of Adult Prisoners at Risk of Suicide or Serious Self Harm*; January 1998, at page 39
- ⁴ The Royal Commission into Aboriginal Deaths in Custody, the Ombudsman, the Coroner and the Deaths in Custody Watch Committee
- ⁵ at page 39
- ⁶ at page 23
- ⁷ Section 3 of that Act defines a "person held in care" as "a person under, or escaping from, the control, care or custody of ... (i) the department of the Public Service principally assisting the Minister administering the Child Welfare Act 1947 in its administration, (ii) the Chief Executive Officer of the department of the Public Service principally assisting the Minister administering the Prisons Act 1981; (iii) a member of the Police Force;..." The definition also includes a person "admitted to a centre under the Alcohol and Drug Authority Act 1974"; a person "admitted, or received, into an approved hospital under the Mental Health Act 1996" and a person "detained under the Young Offenders Act 1994"
- ⁸ *Suicides in Prison*: Routledge; 1992 at page 1
- ⁹ "What can we learn from suicide and self-injury?" 1994
- ¹⁰ At page 21
- ¹¹ Routledge; 1992
- ¹² Chapter 2 *The prison suicide profile*
- ¹³ *ibid* at page 52
- ¹⁴ Monat and Lazarus "Stress and Coping: An Anthology" (1985) Columbia University Press: New York
- ¹⁵ *Suicides in Prison* at page 54
- ¹⁶ *ibid*, page 232
- ¹⁷ Backett, *Imprisonment Today* (1988) at page 76
- ¹⁸ *Suicides in prison*, page 55
- ¹⁹ Johnson: *Youth in Crisis: Dimensions of Self-destructive Conduct Among Adolescent Prisoners*
- ²⁰ (1982) *The Pains of Imprisonment*. Sage: California
- ²¹ *Suicides in Prison* at page 165
- ²² "The Management of Suicide and Self-harm in Prisons" published in the *Australian Psychologist*, November 1999
- ²³ These factors were originally devised in 1994 (Monahan and Steadman: *Violence and Mental Disorder*) in assessing risk of violent behaviour but were found to be equally relevant indicators of suicide and self harm.
- ²⁴ Foreword to *Waking Up Alive* by Dr Richard Heckler, 1994
- ²⁵ Klaus Mann *Turning Point* quoted by Diekstra and Hawton 1987 *Suicide in Adolescence*
- ²⁶ J R Rowan *Prevention of suicides in custody*
- ²⁷ See also Chapter 9
- ²⁸ Dr Alison Liebling 1992
- ²⁹ *Public Sector Performance Report 1999* tabled November 1999
- ³⁰ See paragraph 8.24
- ³¹ *Suicides in prison* at page 233
- ³² Louisa Snow, Suicide Awareness Support Unit, UK Prison Service; *A pilot study of self-injury amongst women prisoners; Issues in Criminological and Legal Psychology*; 1997
- ³³ *Correctional Officers' beliefs regarding self harm in prisoners: An empirical investigation*; Pannell, Howells and Day; School of Psychology; 1999
- ³⁴ *Suicide is Everyone's Concern: Background and Context* at page 21
- ³⁵ See Chapter 9
- ³⁶ I note that the ARMS Manual emphasises that all attempts at self harm should be considered 'cries for help'.
- ³⁷ *Suicide in Scottish Prisons*; Professor J Gunn (Department of Forensic Psychology, Institute of Psychiatry, the Maudsley Hospital, UK) 1994 (Unpublished but cited in the Chief Inspector's Thematic Review *Suicide is Everyone's Concern*)
- ³⁸ Excluding the late Wendy Eadie who was found hanging in Graylands Hospital on 1 November 1998.
- ³⁹ 'Suicides' are those deaths where the Coroner has found the cause of death to be suicide. 'Apparent suicides' are those deaths where the coroner has made an open finding because the evidence did not unequivocally suggest that the prisoner intended to take his own life. 'Possible suicides' refer to those deaths where the coronial inquest has not yet taken place.
- ⁴⁰ At page 16 *Understanding Suicide*
- ⁴¹ Held in Tokyo in September 1995
- ⁴² No female prisoners committed suicide (while in prison) between 1991 and 30 June 2000

CHAPTER 9 DEVELOPMENT OF STRATEGIES FOR THE IDENTIFICATION, ASSESSMENT AND MANAGEMENT OF AT RISK PRISONERS

IDENTIFICATION AND ASSESSMENT

MANAGEMENT

INITIATIVES TAKEN BY THE MINISTRY IN 1998

IDENTIFICATION AND ASSESSMENT

- 9.1 The *Prisons Act 1981* requires a medical officer “on the request of the chief executive officer” to “examine every 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.”¹ Usually a member of the nursing staff performs the initial medical assessment as part of the reception process with a subsequent examination by a medical practitioner the following day or within 72 hours of admission (as recommended by the RCIADIC in **Recommendation 156**).
- 9.2 The initial assessment is also governed by Director General’s Rule 3B (DGR 3B)² - entitled “*Identification and management of prisoners with self harm risk*” - which provides that prisoners are to be “screened by the receiving prison officer and nursing staff involved in the reception of new arrivals for signs that the prisoner is, or may be, at risk.” A prisoner “with self harm risk” is defined in DGR 3B as one who is:-
- under the influence of, or suffering withdrawal from, alcohol or drugs;
 - suffering from serious physical health problems;
 - emotionally or psychiatrically disturbed;
 - suicidal or suspected of being suicidal; or
 - in a state of personal crisis.
- 9.3 Procedures for the management of such a prisoner are based on the “principle” that:-
- “All officers have a duty 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.”*
- 9.4 DGR 3B also makes it clear that “A prisoner may also be identified as being at risk or potentially at risk at any time during imprisonment by any officer who knows or suspects that a prisoner’s health is at risk” and includes the following provisions:-
- To assess whether a prisoner is at risk information³ may be sought from a range of people who may have been involved with the prisoner: including the Superintendent, a senior prison officer, health staff, the prisoner him/herself, other prisoners, the police, the sending institution or escorting officers, family members, previous imprisonment and medical history, family doctor, Aboriginal Medical Service, or any other relevant agency.
 - A written record of the risk must be made by the person identifying the risk.
 - An interim management plan should be determined and include consideration of, *inter alia*, appropriate placement for a prisoner – with another prisoner; with another Aboriginal prisoner; in a cell under close supervision (medical observation cell).
 - Written records of the prisoner’s condition and all actions should be placed on either the prison or medical file and the officer managing the prisoner informed.
 - On the transfer of an at risk prisoner between prisons, the escorting officers and the receiving prison are to be fully briefed on why he/she is considered to be at risk.
 - For safety a prisoner’s cell and person must be searched for any items which might be used to self harm.
- 9.5 In February 1992 (in response to RCIADIC Recommendations 136 and 137) procedures for dealing with a “non-responsive prisoner” (ie. an unconscious prisoner) were added to DGR 3B including the direction that an officer must summon immediate assistance from a person trained in resuscitation technique; open the cell; attempt to rouse the prisoner and, if necessary, summon medical assistance.

- 9.6 DGR 3B was further amended in July 1997 to include reference to:-
- the Assessment Check List completed by the nursing officer (introduced in early 1997);
 - the Risk Management Plan drawn up by a member of the Forensic Case Management Team;
 - the attending psychiatrist as a source of information about a prisoner's at risk status; and
 - the requirement for a written report where a prisoner is considered to be at risk at any time after admission and for the risk status to be highlighted.
- 9.7 New at risk assessment forms for completion by both the reception officer and nursing staff on admission of a prisoner were introduced in August 1996. The forms included a more comprehensive range of questions aimed at establishing whether a prisoner was at risk and the nature of the risk. The initial nursing assessment (which is in addition to the medical assessment by the prison doctor) includes:-
- assessment of physical aspects - such as appearance, nutritional status, old scars indicating previous self harm, injuries, bruising or evidence of intravenous drug use;
 - routine observations (such as temperature, pulse, blood pressure) which may indicate withdrawal symptoms;
 - mental state assessment including mood, facial expression, feelings, access to family support;
 - information from police reports of behaviour while in police custody;
 - observations made by the reception officer; and
 - previous medical, psychiatric drug use history.
- 9.8 The new form was introduced without any notice or prior consultation and I was told that neither nursing staff nor reception officers were provided with training in the completion of the complicated form until there was almost universal protest by members of the nursing staff. In light of the nurses' concerns, basic training in completing the forms was provided and the format of the form was modified in late 1997.
- 9.9 Nevertheless, widespread discontent continued because of the directive that the nurse completing the form *must* classify a prisoner's level of risk (of suicide or self harm) as high, medium or low - although no criteria on which to base the classification were provided and the majority of prison nursing staff had no previous psychiatric nursing experience. Nursing staff expressed concern to me that they would be held accountable for their assessment in spite of their lack of expertise.

MANAGEMENT

Support Services

- 9.10 Prior to 1989/90, non-uniformed welfare officers and uniformed prison officers had the prime responsibility for prisoner 'welfare'. Health care in its broadest sense – which might well include the general welfare and well-being of a prisoner - was shared by nursing and medical staff, a visiting psychiatrist and a team of social workers and psychologists (including 17 clinical psychologists) known as the Special Needs Team (the SNT). The SNT was organisationally part of prison operations and team members reported to the prison superintendent of each prison.
- 9.11 When the principle of 'unit management' was introduced in 1988/89⁴, it was decided to abolish the welfare officer positions and transfer the 'welfare' function to prison officers in return for additional remuneration. The basis for that decision was that unit management "*maximizes officer/prisoner interaction, provides opportunities for a level of self-determination and minimizes the necessity for traditional barrier supervision.*"

- 9.12 Under unit management, day to day welfare, support and counselling became, in theory, the prime responsibility of uniformed prison officers, although nursing staff and the SNT were available for counselling and treatment. In addition, other groups such as the Aboriginal Visitor Scheme (which commenced as a pilot program at Eastern Goldfields in July 1988), the prison chaplaincy, Outcare and prisoner advocacy groups, could also become involved if requested by a prisoner or on referral. In terms of specialist care, there was at that time limited access to the services of a visiting psychiatrist for prisoners diagnosed with a defined psychiatric disorder and in need of treatment (as distinct from support, counselling or therapy). Transfer to the Frankland Centre at Graylands Hospital for this purpose was problematical and a rare occurrence at that time.
- 9.13 The transfer of the welfare function to prison officers in 1989 was not without its detractors. According to information provided to me by both long term prisoners and long-serving officers - who appear to look back fondly on the 'old Fremantle days' - the concerns remain. Long term prisoners who had experienced welfare officers in the system told me that, generally, prisoners were much more willing to reveal their problems to welfare officers, whose lack of uniform made them seem less 'part of the system' and who appeared able to recognise the value of a 'welfare' telephone call as a short term solution for a prisoner's anxieties. (It should be remembered that, at that time, prisoners did not have the relatively unrestricted access to telephones that they do now.) By contrast, it was claimed that prison officers tended to be more rigid in granting a 'welfare' call because they still saw access to the telephone as a privilege which could be removed as a punishment.
- 9.14 This unfavourable comparison was echoed in a submission to my inquiry from a former Ministry health professional who said that when prison officers were given the 'welfare' role they received inadequate training in problem-solving techniques. As a result, many felt uncertain of the extent to which they should go to help a prisoner before calling in a psychologist or member of the SNT. He also confirmed that some officers used the welfare role to punish a prisoner by, for example, refusing a 'welfare' telephone call because of some prior problem.
- 9.15 It was also claimed that at that time there was a shift in prison officer culture which saw officers discouraged from becoming too close or friendly with prisoners. I was told that, ultimately, the 'them and us' situation got in the way of the proper performance of the 'welfare' function. As the work of the health staff and the SNT was 60% crisis care with little time for the important function of simply talking to prisoners to defuse potential crises, a gap in the care of vulnerable prisoners began to develop.
- 9.16 The same submission argued that, coincidental to the transfer of the welfare role to prison officers, there was a shift from the holistic approach to the management of at risk prisoners which saw one-to-one counselling replaced with group therapy for behavioural problems. It was claimed that this led to an increase in the bullying of prisoners who had been forced to publicly acknowledge their problems until, eventually, prisoners became less willing to reveal their problems - which remained unidentified and untreated and brought them back into the prison system at a later stage. It was also claimed that little attention was paid by prison authorities to the developmental, as distinct from legal, age of prisoners in the 18-25 age group who were then (and still are) the group most at risk of self harm. The question of whether prison officers are equipped to perform this 'welfare' role was a continuing theme in submissions to my inquiry and is considered elsewhere.
- 9.17 The submission also raised concerns about the independence of health staff who were required to report to the Superintendent and to balance the emotional needs of the prisoners with – at least from the health perspective – less important operational restrictions. It was claimed that when the clinical psychologists' concerns were largely ignored, several resigned.

- 9.18 In relation to the management of at risk prisoners, Dr Liebling noted that the growing tendency by prison officers to see suicide prevention as a medical problem was a contributory factor in the increasing number of suicides in UK prisons in the 1990s.

“One of the major themes to emerge from the staff interviews was that prison officers did not easily see suicide prevention as being part of their primary role, only identification: they saw suicide as a medical problem with suicide risk as a problem that medical staff were more properly qualified to assess.”²⁵

- 9.19 She attributed this ‘medicalisation’ to the emphasis on security and control in the role of the prison officer and that it was in these areas that:-

“.....skills and pride are most obvious, that training is concentrated, and that status and respect are conferred. Welfare work, rehabilitation, and counselling are less readily ‘owned’ without reservation or limitation – not because they are unpopular or unwanted, but because they are tasks which have never been ‘given’ to or uncritically accepted by prison officers. They are tasks which are difficult to define, operationalise and, perhaps, achieve; ‘welfare’ is increasingly seen as the vocation of specialists, such as probation officers, psychologists and psychiatrists.”²⁶

and concluded that uncertainty about *their* role is the most likely reason why prison officers do not become more involved in the welfare of prisoners.

- 9.20 Between 1991 and 1996 there was a steady rise in prison musters which was not matched by a corresponding increase in the number of nursing and medical staff or of members of the SNT. In fact the number of SNT staff fell from 17 in 1989/90 (for 842 prisoners as at 30 June 1990 in the four metropolitan prisons - Casuarina, Canning Vale, the Remand Centre and Bandyup) to 10 approved FTEs - with only 5.8 FTEs of actual staff - in 1994 to serve 1022 prisoners in the metropolitan prisons and other prisons throughout the State. The total daily average muster in 1994 was 2099. It should be noted that the 5.8 staff included the manager, a full time SNT member based at Greenough and one at Albany.

- 9.21 During the course of 1996, growing concern about the number of prison suicides (six in 1996 compared to one the previous year) led to the decision to transfer the SNT from the sphere of prison operations to the newly formed Health Services Directorate where it would report to the Director General through the Director Health Services. It was renamed the Forensic Case Management Team (the FCMT) and had an approved staffing level of 11 FTEs, - eight of which were filled – to provide support and counselling services to 1054 prisoners in the metropolitan prisons and to other prisons (the total muster on 30 June 1996 was 2254). As was the situation in 1994, the FCMT establishment included the manager and fulltime members at Albany, Greenough and, by 1996, Bunbury.

- 9.22 I have received opposing views about the advantages of placing the FCMT under the auspices of the Health Services Directorate rather than being part of prison operations. Some submissions suggested that removal from the sphere of prison operations gave the FCMT greater independence. Others argued that FCMT staff members had become more isolated and that their reporting to the Director, Health Services rather than the Superintendent of each prison provided the prison administration and prison officers with the opportunity to ignore the advice of the FCMT and health services staff generally. I was also told that a number of psychologists resigned after the transfer of their management to Health Services.

- 9.23 Some submissions criticised the social work emphasis of the FCMT and the absence of clinical psychologists in the system. Conversely, others believed that the focus was too ‘forensic’ with insufficient recognition of the fact that prison stress is frequently heightened by social issues such as family or relationship problems or lack of coping skills. Ultimately, given that they are the group of health professionals who are most involved in the management of at risk prisoners, it seems to me that the FCMT should be a well-trained multidisciplinary team of professionals, including both clinical psychologists and social workers and that it should be provided with sufficient resources to enable it to properly perform its function. I do not believe that that was the case in 1996.
- 9.24 Also in 1996, ten Prisoner Support Officer positions located at prisons throughout the State were created to assist in the establishment and maintenance of peer support programmes. The positions were initially created to provide a culturally appropriate form of support service for Aboriginal prisoners in response to RCIADIC **Recommendation 183**, based on the principle that many prisoners are reluctant to reveal their problems to a uniformed prison officer or to a person closely associated with the prison administration or the “Ministry”. Prisoner Support Officers are only available during core hours from Monday to Friday and are not on duty after hours or at the weekends.

Management strategies

- 9.25 In 1991, following identification of a prisoner as being at risk of self harm, there were few therapeutic intervention strategies at the early and accepted high risk stage of a sentence. There was no comprehensive orientation process to assist prisoners in adjusting to imprisonment; no treatment program for those whose level of risk was attributed to behavioural disorders or the effects of substance abuse and no special therapeutic placement facilities which enabled a prisoner to be properly observed and supported.
- 9.26 Apart from monitoring by prison officers, at risk prisoners could be referred to the SNT when a crisis occurred and were discussed by the Superintendent, prison and health staff at weekly meetings. ‘Medical’ management with such medications as benzodiazepines and tranquillisers was common.
- 9.27 The initiative referred to in Chapter 8⁷, which was instituted at the Remand Centre in 1992 by the then Superintendent with the aim of making the prison a “*safer place*”, included an increase in educational opportunities and recreational time and activities for prisoners who were also involved in the design and implementation of the new strategies. Changes were made in the management of prisoners by the introduction of a more consultative approach and improved communications between prison and health staff and with support services such as the Aboriginal Visitors Scheme.⁸ The programme was short-lived, however, and not repeated at other prisons in spite of the reduction in self harm attempts and suicide while in operation.⁹
- 9.28 The Ministry instituted what might be termed general ‘harm minimisation’ strategies in response to RCIADIC **Recommendation 165** (removal of obvious hanging points). It stated in the 1995 Government Implementation Report that it had implemented Recommendation 165 in terms of the safe placement and scrutiny of equipment likely to cause harm but there was no reference to the removal of obvious hanging points. It seems to me that, although steps are taken to remove some of the obvious hanging points in prisons where deaths have occurred, the Ministry has no ongoing strategies for the removal of hanging points.¹⁰
- 9.29 RCIADIC **Recommendation 140** refers to the establishment in all cells of an emergency cell call system which enables prisoners to communicate directly with “*custodians*”¹¹. Although the recommendation appears to refer primarily to cells in police lockups, the Ministry has advised me that cells in all but minimum security prisons are equipped with an emergency cell call or intercom system.

Placement options

- 9.30 Ideally, the nature of the risk identified should influence the management and placement of an at risk prisoner. However, steadily rising muster levels after 1991 meant that all prison facilities were coming under increasing pressure. This had a number of consequences for certain groups of at risk prisoners who were frequently not able to be accommodated in appropriate facilities.
- 9.31 Remand prisoners are universally acknowledged to be a group with one of the most acute risks of self harm or suicide and it is widely accepted - and stated in *United Nations Standard Minimum Rule 8(b)*¹² – that remand prisoners (particularly first time remand prisoners) should be placed in a *dedicated* remand prison where facilities (and staff) can be tailored to their needs.
- 9.32 The C W Campbell Remand Centre, which was opened in 1980 to cater for 98 remand prisoners, was expanded in 1987 to 155 beds. In 1991, ‘double-bunking’ increased its capacity to 170. However, of the 15 remand prisoners who committed suicide between 1991 and the end of 1996, 5 were held in prisons other than the Remand Centre (1 in Fremantle; 1 in Greenough and 3 in Casuarina). Of those, two were first time remandees. Although the Ministry was aware of its obligations to house remand prisoners separate from sentenced prisoners, there was no expansion of remand facilities to cater for the growing prisoner population, and remand prisoners in the metropolitan area continued to be – and still are - placed in Casuarina and Hakea. Remand prisoners from outside the metropolitan area are routinely held in the regional prisons and it should be noted that Western Australia has *never* had a separate remand institution for female prisoners.
- 9.33 Within a prison, placement options for at risk prisoners were limited to ‘doubling-up’ (placement with a ‘buddy’ in a shared cell) or isolation in a medical observation cell¹³ if a prisoner was considered an immediate risk of self harm.
- 9.34 Prisoners who are behaviourally disturbed or suffering the physical effects of withdrawal from drugs should ideally be housed where they can be monitored by health staff. There were – and continue to be - no special facilities for such prisoners who are generally placed in a normal cell in a mainstream unit, unless there is some exceptional reason for their placement in the Infirmary (or the Crisis Care Unit after April 1999) at Casuarina. The 20-bed infirmary at Casuarina and the 2-bed facility at Bandyup are generally reserved for medically sick prisoners. At least one first time remandee in withdrawal – Carl Jackson - committed suicide in his cell in a mainstream unit within 24 hours of admission to Casuarina.
- 9.35 Unfortunately, although I think it would be fair to say that efforts are generally made to place prisoners appropriately, the growing pressure of prisoner numbers means that the ultimate choice of placement is primarily governed by available space. In the absence of any other therapeutic facility, prison authorities are left with the choice of placing the prisoner either in mainstream and relying on the vigilance of officers and perhaps other prisoners, or in a medical observation cell. The choice becomes more difficult if the assessed risk is considered likely to continue for a period of time.
- 9.36 The concept of ‘specialling’ – 24-hour one-to-one observation which is used in institutions in the community for acute risk patients (such as the Frankland Unit at Graylands Hospital) is not considered a viable or practical option in the custodial setting. In reality, therefore, the most commonly used placement for an acute high risk prisoner is in a ‘medical’ observation cell which - with the exception of Casuarina where such cells are located in the Infirmary – is located in the same area as the multi-purpose and punishment cells.

- 9.37 It also became clear to me in the course of my inquiry that a medical observation cell is frequently seen by some prison officers as an ‘easy’ option which would protect them from blame if the prisoner subsequently attempts or commits suicide. In reality, of course, it is unlikely that isolation in a medical observation cell will reduce a prisoner’s long term risk of suicide or self harm, particularly if he or she is returned to mainstream with no further management strategy and with the underlying cause of the problem not addressed.
- 9.38 Almost all prisoners hate being “sent to obs” where there is generally nothing to do and they are required to wear special, somewhat degrading, clothing known by them as a ‘monkey suit’. Other than monitoring by the SNT/FCMT there were – and are still - no therapeutic regimes (other than television in some prisons) for disturbed prisoners held in observation cells. The austere conditions in such cells are essentially designed to protect a prisoner from him/herself by removing the opportunity and the facility to self harm. The period of isolation should be for as short a period of time as necessary to diffuse any self-destructive impulse. That should be the sole purpose of placing a prisoner in such sensory-deprived surroundings.
- 9.39 The overuse, inappropriateness of, and conditions in, medical observation cells for at risk prisoners and the questionable value of such isolation in providing *any* kind of therapeutic assistance has attracted almost universal criticism in submissions to my inquiry and I have explored this issue in some depth in Chapters 10 and 11.
- 9.40 Essentially, the Ministry took no action to address the obvious, and increasing, gaps in its placement options for disturbed and vulnerable prisoners until planning commenced in 1998 for the Crisis Care Unit, which opened at Casuarina in April 1999, and with progression of its plans to convert the Canning Vale Prison Complex to a dedicated Assessment and Receiving Prison (Hakea). In fact, as stated above, options became more restricted as muster levels continued to rise. In my view, prisons in Western Australia were for the most part environmentally ill-equipped to deal with disturbed and vulnerable prisoners. The Ministry has advised me that it does not agree with that assessment.
- 9.41 Although there are now Crisis Care Units at Casuarina and Hakea and such facilities are planned for Bandyup and Acacia, it seems to me that those units will be required to cater for not only disturbed and vulnerable prisoners and prisoners in withdrawal, but also for those with behavioural problems and those with psychiatric disorders because there are no specific facilities for groups of prisoners with those special needs. In addition, there are no crisis care facilities for prisoners at the regional prisons which face a wider range of problems because at least some of them house both male and female prisoners. Although I recognise that budgetary constraints mean that facilities need to be multi-purpose, I am not satisfied that the current facilities will be capable of dealing with the number of prisoners requiring some form of specialised accommodation. Of particular concern to me is the continuing use of medical observation cells at all prisons.¹⁴
- 9.42 Management of at risk prisoners will continue to be based on ‘crisis’ care with few formal self harm/suicide prevention strategies or what might be considered ‘therapeutic’ options available at most prisons. In conjunction with a prevailing attitude that at risk prisoner care is primarily a health services problem, it is perhaps not surprising that a number of at risk prisoners simply ‘fall through the cracks’ which were, in my view, becoming increasingly visible as early as 1996.

INITIATIVES TAKEN BY THE MINISTRY IN 1998

9.43 As the number of suicides continued to rise - with 14 between 1 January 1997 and 1 June 1998 - the Ministry, clearly also concerned and accepting that there may be deficiencies in its management of at risk prisoners, commissioned a review of its existing suicide prevention strategies (the Howells and Hall *Review of Ministry of Justice Services for treatment and care of adult prisoners at risk of suicide or serious self harm*). In light of the findings of the review it introduced a new *At Risk Management System* (ARMS) in late 1998.

The Howells and Hall Report

9.44 The Howells and Hall Report¹⁵ (completed in January 1998) commented on the Ministry's risk management strategy at that time and also included observations about the prison system as a whole and its underlying culture and made a number of recommendations.

9.45 Essentially, the report commented favourably on the success of the system for the *initial* identification of at risk prisoners but expressed the view that “*much needs to be done in terms of identifying ongoing stressors*” and that this “*inevitably, will be a task for prison officers who are the only staff in day to day contact with prisoners.*” In particular, the report was critical of the lack of short term management options for acute high risk prisoners, describing the use of placement in a medical observation cell as “*isolating*”, and more likely to “*exacerbate stress*”. The report found that prisoners saw placement in medical observation as a punishment rather than therapy with the result that they were more inclined to conceal their – and others’ - anxieties to avoid being sent there. It also concluded that there were no therapeutic interventions for the management of long term at risk prisoners.

9.46 In conclusion, the review pointed to:-

- a lack of a formal policy on which to base suicide prevention strategies;
- an increasing number of new prisoners entering the system for whom self harm and suicide was an acceptable response;
- a lack of placement options;
- a disturbing increase in the number of remand prisoners in Casuarina because of rising musters at the Remand Centre;
- a “*widening gulf between service need and actual resource*”;
- a deterioration in the relationship between prisoners and prison officers exacerbated by the 12 hour shift;
- a lack of ongoing training for officers – levels of training in Western Australia “*fall far short of what is needed*”;
- fear as a result of a growing culture of attributing blame when a prisoner died;
- the inadequacy of the Ministry's data collection ability which was a significant impediment to its forward planning of future prison accommodation and staffing needs;
- conflict between health services and prison operations;
- lack of training for nursing staff;
- insufficient psychiatrists;
- FCMT staff were “*burnt out*” and too busy to monitor or provide ongoing review of prisoners;
- a major shortfall in psychological services which fell behind other jurisdictions;
- decline in the social work services;

- lack of adequate case management;
- changes in the numbers, demography and characteristics of prisoners leading to severe stress on services;
- lack of a screening tool to assess psychiatric disorders;
- the need to monitor the “*institutional atmosphere*” to measure the quality of prisoner/prison officer relations;
- the Ministry’s “*reactive*” management of at risk prisoners.

9.47 Many of those concerns had already been expressed in the course of investigations of prisoner deaths and were drawn to my attention through submissions to my inquiry. As a result of the Howells and Hall study, the Ministry set up a Strategic Working Group which produced the *Report on Suicide Prevention Strategies for Prisons in Western Australia*. This report formed the basis for a new suicide prevention strategy known as the ***At Risk Management System (ARMS)*** which was introduced in late 1998.

At Risk Management System (ARMS)

9.48 The principles and procedures for *ARMS* are contained in the *ARMS* Implementation Manual (the *ARMS* Manual) which also identifies in the *Introduction* the following research findings:-

“Research has shown that there is no single profile for the suicidal prisoner which can be used to predict suicide attempts with any certainty, and no single preventive solution.

.....All prisoners may be vulnerable at certain times, though there are three particularly vulnerable groups: the mentally ill, serious adult male offenders and younger “poor copers”.

Mental illness is present in no more than a third of prison suicides. In most cases, coping problems and situational triggers are more significant than psychiatric explanations.....

The research noted a “tendency to dismiss acts of self-harm as manipulative, rather than as genuine cries for help and a sign of potential suicide risk. Most self-harmers were distressed and had some thoughts of suicide. A judgmental response increased their distress.

The risk of self-harm and suicide could be reduced by a range of “protecting agents” including supportive and helpful staff, constructive activities, family contact, action against bullying and involvement by outside agencies. Above all the vulnerable prisoner needed listening and understanding.”

9.49 Information sessions about the new system had been presented to approximately 50% of prison staff at all prisons by December 1998 and a *Prisoner Risk Assessment Group (PRAG)* established at each prison. The *PRAG* is responsible for monitoring the operation of the *ARMS* system; identifying and remedying procedural weaknesses; developing the quality of work done by staff and continuing the awareness process among staff.

9.50 Membership of the *PRAG* is not fixed and may depend on the nature and structure of each prison. It must, however, include one health professional and follow the principle that its aim is to provide as wide a range of knowledge and expertise as possible. To this end all departments within the prison should be represented or at least receive minutes of *PRAG* meetings; prisoners should be regularly consulted; and outside groups such as the Aboriginal Visitors Scheme, community health care services and Prison Visitor Groups should be involved.

9.51 The PRAG is required to formulate a risk management plan for each prisoner identified as posing a risk of self harm, including:-

- the placement of the prisoner to ensure his/her safety;
- the perceived level of risk;
- the frequency of observations considered necessary;
- the prisoner's access to support systems, programmes or special requirements including cultural, spiritual, social, mental health or other special needs;
- scheduled reviews of the at risk status;
- the names and roles of key people involved in the plan;
- any ongoing assessment, management or monitoring considered necessary, including procedures for a prisoner released from a medical observation cell.

9.52 The ARMS Manual states that there are seven principles involved in the care of the suicidal:-

“Suicide is not inevitable

Most people are indecisive about suicide and want to be helped right to the very end. We should attempt wherever possible to restore hope rather than confirm despair.

Change is always possible

.....There is no room for value judgements or whether another person's life is no longer worthwhile.

Awareness of suicide can significantly reduce the risk

.....The greater the awareness and sensitivity of all those in contact with those at risk, the more chance of averting a crisis.

The suicidal person must consent to the help which is offered

We should not aim to coerce or simply mount surveillance, but set up a supportive relationship which allows the suicidal person to cope.....If deprived of control there is a risk they may not disclose their suicidal feelings and they will see this as the only way of gaining control.

Positive listening alleviates despair

Talking about suicidal feelings has enormous therapeutic value. Positive listening which reaches out empathetically and accepts the suicidal person without judgement is the most effective way of reducing despair.

Some suicides will still occur despite excellent care

Suicide is ultimately a matter of choice. We can usually influence that choice and should always seek to intervene. However, there will always be some who do not seek or respond to help. Not all suicides are preventable.

The need to support staff

Where suicides do occur, staff who have acted with due care and done their best to help should be fully supported. The causes of suicides are complex and cannot be attributed simply to the actions or omissions of any particular individual.”

9.53 The most fundamental change in approach in the management of at risk prisoners is reflected in the first principle of primary care in ARMS, namely that “All staff will be alert to the potential risk of suicide or self harm?”. This approach is based on the premise that suicide prevention requires an integrated approach by, and is the responsibility of, “the whole prison community”, not only health staff and requires that:-

“the unit manager will co-ordinate action to address the prisoner's individual needs (as determined by the PRAG management plan) including the provision of any necessary support and supervision, consulting and involving other staff disciplines, outside agencies, the prisoner and his/ her family.”

9.54 The aim of the *ARMS* procedures is to:-

- encourage a team approach to the management and support of those at risk;
- draw on the resources, skills and knowledge of all staff disciplines, the outside community and prisoners;
- facilitate good communication between all those involved, including the prisoner him/herself;
- provide both for emergency action at times of acute crisis and follow-up action to sustain recovery, address underlying needs and improve the prisoner's ability to cope;
- ensure a high level of staff awareness while the prisoner requires special monitoring and support;
- encourage the prisoner him/herself to be involved in identifying action to improve coping; and
- review its own procedures at regular intervals.

9.55 The *ARMS* Manual provides not only detailed procedures for the identification, care and management of at risk prisoners but also operational instructions, guidelines, checklists and copies of forms. It includes statements of principles, interview techniques for the assessment process, lists of possible stress factors, "*Cues and clues*," on how to be "*a listening ear*", and descriptions of the three main types of prison suicide etc. In other words it is a comprehensive instruction manual for all prison staff in dealing with at risk prisoners. Excerpts include the following statements:-

- "*The policy of caring for the suicidal prisoner has developed primarily from a medical model of suicide prevention towards an integrated approach based on the responsibility of the whole prison community for the care of those in distress.*" (Introduction page 1)
- "*The use of unfurnished or protected accommodation is inappropriate for suicidal prisoners. It takes away the prisoner's dignity and control, and is often felt to be punitive. The trust of prisoners in staff will be undermined. They will be less likely to admit to distress in the future, and may even see suicide as a way of reasserting control of their destiny.*"
- *Supportive supervision and befriending is a more humane and effective way of containing a crisis and enabling the prisoner to choose the path to recovery.*" (Introduction page 7)
- The attributes of a 'case manager' of an at risk prisoner are listed as:-
"*....someone who knows the prisoner and who possesses the skills of communicating, listening, establishing rapport and expressing empathy. They should also be able to give time to the prisoner.....It is clearly an advantage if the case manager has had some special training in identifying and supporting suicidal prisoners.*"(Supporting Prisoners at Risk page 1)
- Reward is more effective than punishment:-
"*Basic behavioural principles can be followed by all staff in their dealings with prisoners. The most important thing to remember is that reward for desirable behaviour is far more effective than punishment for undesirable behaviour.*" (Supporting Prisoners at Risk page 11)
- Prison officers should aim to listen sympathetically:-
"*..... time should be given to listening sympathetically to the prisoner's concerns and needs – in other words, to facilitate the need to communicate. Appropriate help and support should be given as with any prisoner who feels distressed. This should alleviate the prisoner's immediate and overwhelming sense of frustration and helplessness. Research and clinical practice has proved that simply listening in these situations can produce amazing results.*" (Supporting Prisoners at Risk page 13)

9.56 Of particular relevance to the management of prisoners released from a medical observation cell is the inclusion in the ARMS system of a 'checklist' for the continuing observation of such prisoners by means of a "*post-discharge management plan*" drawn up by the PRAG in consultation with the prisoner. The check list includes the briefing of all unit staff, the making of a follow-up appointment with a health professional, procedures to ensure the continuity of care and support, the organisation of activities for the prisoner and a suitable cellmate if appropriate, and the level of supportive supervision required by the prisoner.

Summary of the Ministry's suicide prevention strategies as at 31 December 1998

9.57 The Ministry's system for the identification, assessment and management of at risk prisoners by the end of 1998 was based on the following:-

- a detailed assessment on initial reception by prison and nursing staff resulting in allocation of a high, medium or low risk classification with assessment by a medical practitioner as soon as practicable;
- management according to the principles of ARMS;
- placement in a normal unit, shared cell or medical observation cell;
- referral to the FCMT and/or psychiatrist;
- involvement of the Prisoner Support Officer and Peer Support Group;
- ongoing management by the Prisoner Risk Assessment Group (PRAG).

9.58 The extent to which the introduction of the new system and the application of the principles of ARMS rectified the deficiencies highlighted by the deaths of prisoners prior to its introduction and whether it would be effective in preventing future deaths and serious self harm is considered in the following chapters.

¹ Prior to December 1999 when it was amended by the *Prisons Amendment Act 1999*, there was no reference to the "*request of the chief executive officer*" in section 39(b)

² In place since 1982

³ The RCIADIC made a number of recommendations concerning its views on the importance of information - Recommendations 126, 157 and 166. See Appendix 1

⁴ See also Chapter 15

⁵ *Suicides in Prison* at page 219

⁶ *ibid* at page 220

⁷ At paragraph 8.42

⁸ *A descriptive study of all self-harming episodes in a maximum security remand prison between 1990 and 1994*, Steve Whittred, Hospital Officer, Casuarina Prison 1995

⁹ *Ibid*

¹⁰ Recommendations 165 and 140. See Appendix 1

¹¹ See Chapter 5 paragraphs 5.131-5.140

¹² "*Untried prisoners shall be kept separate from convicted prisoners*"

¹³ See also Chapter 10 paragraphs 10.166-10.205

¹⁴ See also Chapter 10

¹⁵ *Review of Ministry of Justice Services for the Treatment and Care of Adult Prisoners at Risk of Suicide or Serious Self Harm*



CHAPTER 10 ISSUES ARISING FROM PRISON SUICIDES 1991-1999

INTRODUCTION

CARE OF AT RISK PRISONERS

RESOURCES

PLACEMENT OPTIONS

SUMMARY OF RECOMMENDATIONS

INTRODUCTION

10.1 As previously recorded, 47¹ prisoners died as a result of suicide or apparent suicide between 1991 and 30 June 2000. The ten deaths which occurred between 1 October 1997 and 16 February 1998 – four suicides, two apparent suicides and four from natural causes - aroused intense media interest and outcry from prisoner advocacy groups. In light of the public – and my own – concern at the high number of prisoner deaths and their traumatising effect on prison staff and prisoners and the stability of the system as a whole, I decided to commence this inquiry. At the same time, the Ministry commissioned the Howells and Hall review of its suicide prevention strategies, referred to throughout this chapter. Tables 10.1 to 10.3 below provide brief details of the 47 prisoners.

TABLE 10.1

Suicides 1991-1998

Name	Date of death	Method	Prison	Remand=R 5 Years+=L
1991				
James Reynolds	27 June	Plastic bag	CWCRC	R
1992				
Paul Vincent	8 June	Hanging	CWCRC	R
Russell Gibson	26 October	Hanging	CWCRC	R
Shane Bourbon	5 November	Plastic bag	Albany	
1993				
Kenneth Summers	20 April	Hanging	Casuarina	L
Shane Hitchcock	15 June	Hanging	CanningVale	
1994				
Darren Boyle	5 September	Hanging	CWCRC	R
Ronald Hill	14 September	Hanging	CWCRC	R
Ryan Kennedy	15 September	Hanging	CWCRC	R
1995				
Martin Hayes	13 June	Hanging	Casuarina	R
1996				
Carl Jackson	12 January	Hanging	Casuarina	R
Malcolm Inman (A)	24 April	Hanging	CWCRC	R
Alan Bangmorra (A)	30 July	Hanging	Broome	
Victorino Vivas	29 October	Hanging	Wooroloo	
Shaun Rawlings	20 October	Hanging	Casuarina	
1997				
Anthony Wood	11 January	Electrocution	CWCRC	
Wesley Doorey	24 January	Hanging	Casuarina	R
Noel Clarke	6 April	Hanging	Casuarina	R
Darren Osborne	6 August	Hanging	Casuarina	L
Sean Hayes	21 August	Plastic bag	CWCRC	R
Christopher DeGois	25 November	Hanging	Casuarina	R

Table 10.1 continued		Suicides 1991 - 1998		
Name	Date of death	Method	Prison	Remand=R 5 Years+=L
	1998			
John Jackamarra (A)	3 February	Hanging	Greenough	L
Huy Van Le	15 February	Hanging	CWCRC	R
Steven Dawson	16 February	Poison	CWCRC	R
Alessandro Leone	8 April	Hanging	Casuarina	L
Kenneth Groth	9 April	Hanging	Casuarina	L
David Ryan	17 May	Hanging	Casuarina	L
Dean Lauder	1 June	Hanging	CanningVale	
Gregory McIntosh	15 July	Hanging	Albany	
Phillip Halligan	8 October	Hanging	Casuarina	R

10.2 Table 10.2 summarises apparent suicides where the Coroner has made an open finding:-

TABLE 10.2		Apparent suicides – open finding by the Coroner		
Name	Date of death	Method	Prison	Remand=R 5 Years+=L
Justin Walsh	1 Jan 1991	Hanging	Fremantle	R
Darryl Cameron(A)	17 Dec 1991	Hanging	Casuarina	R
David Metcalf	27 Dec 1991	Hanging	Greenough	R
Michael McMahon	7 April 1996	Hanging	Casuarina	R
Bevan Cameron(A)	7 Jan 1998	Hanging	Greenough	R
Neil Holt	25 Jan 1998	Hanging	CanningVale	R

10.3 Table 10.3 summarises possible suicides² where the inquest has not yet taken place:-

TABLE 10.3 Apparent suicide where the inquest has not yet taken place				
Name	Date of death 1999	Method	Prison	Remand=R 5 Years+=L
James Malone	12 March	Hanging	Canning Vale	L
Kenneth Layfield	19 July	Plastic bag	Casuarina	R
Wayne Coyne (A)	19 Aug	Hanging	Casuarina	
Bradley Rapley	2 Sept	Plastic bag	Casuarina	R
2000				
Adam Garner	6 Jan	Hanging	Hakea	R
Phillip Joseph (A)	6 Jan	Hanging	Roebourne	R
Leslie Wesley (A)	7 May	Hanging	Casuarina	R
Bradley Savory	23 May	Hanging	Albany	L
Scott Davidson	5 June	Hanging	Casuarina	L
Simon Otero	15 June	Hanging	Hakea	R
Gerhardus Theron	25 June	Hanging	Hakea	R

10.4 Concerns and recommendations about the management of two thirds of those prisoners raised by the Coroner, the Internal Investigations Unit of the Ministry and by Ministry health staff are considered in this chapter.

CARE OF AT RISK PRISONERS

10.5 Whether they accept or really want an involvement in suicide prevention strategies, there can be little doubt that prison officers who are in daily contact with a prisoner are in the best position to at very least observe and be intuitive to the stresses affecting that prisoner and how that prisoner is coping. However, the extent to which this knowledge and observation is put to optimum use in terms of the care and welfare of a prisoner will largely depend on the officer's communication skills - which will in turn reflect the adequacy of the training provided to the officer and whether prison authorities rigorously reinforce the underlying philosophy that suicide prevention and harm minimisation are the responsibility of **all** prison staff.

10.6 As discussed in Chapter 9, prior to 1998 and the introduction of the At Risk Management System (*ARMS*), the prison system in Western Australia appeared to have moved away from that focus and the circumstances of the deaths of a number of prisoners provide examples of a lack of awareness of the needs of disturbed and vulnerable prisoners and a failure to respond to those needs.

(i) **Lack of supervision and management of prisoners released from medical observation**

10.7 A prisoner considered to be an acute risk of self harm is likely to be placed in a medical observation cell until it is believed that the immediate risk has passed. However, the lack of management strategies for prisoners *released* from medical observation was raised by the IIU in its investigation of the death of David **Metcalf** in 1991 who was found hanging in his cell shortly after his release from an observation cell. The decision to return him to his unit had been based on the judgement that it would be better for him to socialise with prisoners he knew than to be isolated in an observation cell. However, the IIU investigator commented:-

*“I am not entirely satisfied with procedures that allow for a person to be released from observation after having threatened to kill himself without any checks whatsoever being carried out upon his return to his Unit, as happened in this instance. I am, however, advised that this is **current procedure in all instances.** (my emphasis)*

“Although staff acted correctly at all times and my investigations indicate that neither staff nor prisoners had any idea that METCALF intended committing suicide, I recommend that the management procedures for the supervision of vulnerable and disturbed prisoners, particularly any prisoner released from an observation cell regime, should be reviewed.”

10.8 The files provided to me by the Ministry in relation to Mr Metcalf’s death contain no information on the response to this recommendation other than a request dated 8 January 1992 to the Superintendent of Casuarina to discuss the matter with the SNT. It is unclear whether or not any discussion took place as the Ministry has been unable to provide me with further information on the status of this recommendation.

10.9 On the face of it, the decision to allow Mr Metcalf to return to his unit and to socialise with other prisoners does not appear unreasonable. Solitary confinement is generally not considered to have any therapeutic benefit for a prisoner who is not a danger to others. However, without suggesting that his death could have been foreseen, I consider it surprising that not only did the unit officers not check on him or ‘observe’ him once he had returned to his unit, but that this lack of observation was “*current procedure in all instances*”.

10.10 Apart from comments by a medical practitioner in July 1991 that Mr Metcalf “*needs as much scrutiny as possible*” when he was released from a previous placement in a medical observation cell and that he would need “*continuing close observation*”, I find it surprising that ‘observation’ – “*the act of regarding attentively or watching*”³ - of prisoners within their care was **not** considered to be an integral and focal part of **every** prison officer’s role, especially a prisoner who was known to be vulnerable and unstable and to have made previous attempts to self harm.

10.11 The failure by prison officers to automatically and intuitively monitor a prisoner in Mr Metcalf’s situation may be a result of poor job definition, poor training or poor selection in the recruitment process or it may reflect an increasing tendency at that time for the management of vulnerable prisoners to be considered a medical problem - possibly reinforced by the wording of DGR 3B which refers to the duty of prison officers to “*facilitate access to necessary **medical care***” – rather than one of the duties of a prison officer. As discussed in Chapter 8 this ‘medicalisation’ of the management of at risk prisoners was identified by research in the early 1990s⁴ as a contributory factor to an increase in the number of suicides in UK prisons.

10.12 Management strategies for prisoners released from medical observation are now, however, included in *ARMS* introduced in late 1998.⁵ There should be, therefore, no doubt about the role of prison officers (who agreed to take on the welfare role in return for additional remuneration in 1989/90) and all others involved in prisoner management. Nevertheless, from my observations, I am inclined to agree that many prison officers are more ‘security’ focussed and prefer to refer the problems of disturbed and vulnerable prisoners to health staff rather than being prepared to become involved themselves.

(ii) Prison officers' lack of awareness of the needs of 'at risk' prisoners

- 10.13 Concern about an apparent lack of awareness by prison officers of the needs of at risk prisoners was expressed following the investigation of the deaths of 3 young remand prisoners - Darren **Boyle** (aged 19), Ronald **Hill** (aged 21), and Ryan **Kennedy** (aged 18) – who committed suicide at the Remand Centre between 5 and 15 September 1994. The three knew each other and each one fell within the definition of an 'at risk' prisoner in DGR 3B as they were suffering from the effects of substance abuse.
- 10.14 Darren **Boyle** had been classified as 'at risk' but had opted to share a cell rather than be placed in medical observation. His request to continue to 'double-up' was, however, refused by an officer apparently because only one night had been authorised. It also appears that he was upset because of a cancelled visit by his mother whose explanation was not conveyed to him by the officers, and by an officer's subsequent refusal of his request to telephone her. He was found hanging in his cell a few hours later.
- 10.15 Ronald **Hill** committed suicide two days after being remanded in custody. Although it had been noted that he was depressed because of his heroin addiction, he was not considered a "serious" risk of self harm at that time. It appears, however, that he had been assaulted on the day of his admission to the Remand Centre and told two other prisoners that he felt like 'killing himself'.
- 10.16 Ryan **Kennedy** who committed suicide on 15 September 1994 was known to be an associate/friend of both Messrs Boyle and Hill and was apparently particularly distressed by Mr Hill's death.
- 10.17 The Coroner commented that "*There is clear evidence that persons detained on remand in prison custody may be distressed and upset by their circumstances and are particularly vulnerable in the first hours and days of such custody.*" He went on to express concern that, on the basis of the treatment of Darren Boyle and Ronald Hill, there appeared to have been "*little to distinguish the form of custody of a sentenced prisoner and that of a person who was unconvicted of the offence with which he was charged and who was, as a matter of law, innocent.*"
- 10.18 The then Manager, Health Services was also critical of Mr Boyle's management and concluded that the provisions of DGR 3B had not been complied with. In a memorandum dated 9 September 1994 he stated:-

"It has been reported that the deceased's case had been formerly [sic] discussed at the prison's case management meeting and that he was sufficiently settled to return to standard sleeping accommodation and to be returned to mainstream activities. There is no documentary evidence of these discussions. Direct involvement by the medical officer in these deliberations neither occurred nor are they recorded in any other documentation. The actions outlined here or lack thereof depart from the requirements of DG's Rule 3B."

As a result he recommended the establishment of formal procedures "*on a Statewide basis for the management of "at risk" prisoners consistent with recent trials conducted at the Remand Centre and Greenough Prison.*"

- 10.19 In relation to Mr Boyle's death, the IIU recommended that "*an assessment of staff training be made to establish whether or not staff can be trained to be more aware and intuitive towards "at risk" prisoners.*" The IIU also made the same recommendation following the death in January 1996 of Carl **Jackson** - a first time remand prisoner in withdrawal who committed suicide in Casuarina on the night of his admission. Mr Jackson was clearly an at risk prisoner within the terms of DGR 3B but was placed in a single cell in a normal unit which was unmanned at night.⁶

- 10.20 The Ministry was unable to provide me with any further information about its response to the 1994 recommendation that formal at risk management procedures be established across the prison system. As there was little change to the assessment and management system for at risk prisoners until late 1996 with the introduction of the new assessment forms, and late 1998 with the implementation of *ARMS*, I can only presume that the trials conducted at the Remand Centre and at Greenough did not produce any significant outcome. Ultimately the Ministry does not appear to have initiated any comprehensive changes to address the concerns raised by these deaths prior to 1998.
- 10.21 DGR 3B has since 1982 provided officers with guidelines on what to look for when assessing whether a prisoner is at risk and on how to manage such prisoners. However, although it effectively reinforces the principle that it is part of their role to become involved in the management of at risk prisoners, I suspect that – unlike other DGRs (which for the most part) regulate or control aspects of prison life such as visits, property, punishment regimes, searches, use of restraints etc – DGR 3B is rarely referred to by officers even though it is specifically covered in the training in at risk identification and management techniques provided to prison officers.
- 10.22 All prison officers are expected to familiarise themselves with the contents of DGRs and their corresponding obligations and responsibilities. The normal procedure for the distribution of new or amended DGRs is for the Rule to be forwarded by the Ministry's Records Section to all relevant and interested parties, of whom prison superintendents are a major group. It is then the responsibility of the Superintendent of each prison to ensure that copies of the new or amended rule are placed in each 'work place' (unit, workshop, education centre, library, medical centre gate house etc). There is no uniform method by which the introduction of new rules is *specifically* drawn to the attention of officers and staff. For example, at Hakea, advice of new or amended DGRs is included in the weekly notices and in daily debriefing meetings. There is, however, no formal process of this nature in place at Casuarina.
- 10.23 In my view, procedures for the identification and management of at risk prisoners – which require discretion and interpretation by officers - do not fit comfortably in DGRs which, for the most part, are prescriptive. In many respects, therefore, I am not surprised that this less definable aspect of a prison officer's function often takes second place to other more security-focussed duties – in spite of the fact that non-compliance with a DGR constitutes a disciplinary offence. Moreover, for those officers who have studied DGR 3B more closely, I believe that it sends a 'mixed' message by referring specifically to the duty of officers to "*facilitate access to necessary medical care*" (my emphasis). This direction could be interpreted by officers as an instruction to refer at risk prisoners to health staff. Based on submissions to my inquiry, I have no doubt that there has been a growing tendency by prison officers over the past few years to see the management of disturbed and vulnerable prisoners as a medical problem to be dealt with by health staff. I am also inclined to agree with the result of the UK research which attributed the rise in prison suicides in UK prisons to this polarisation of care.

(iii) Insensitivity/lack of involvement by prison officers

- 10.24 Immediately prior to his death in Casuarina in January 1997, Wesley **Doorey** was seen by a number of prison officers crying in his cell. Although the officers recorded this 'observation', none of the officers made any attempt to talk to him to find out what was wrong or to call a health services professional to assist. The Ministry accepts that the staff involved in this case did not 'personally intervene' with the prisoner in question. However, the officer who observed Mr Doorey at lockup alerted the Unit Manager who instructed another officer to keep an eye on him. Unfortunately this officer was not aware that Mr Doorey had a history of self harm because it was the officer's first night in the unit. Nevertheless, additional cell checks were carried out. I understand that the officers in question were subsequently 'counselled' for their lack of response.

10.25 It is difficult to imagine why prison officers would not try to deal with the obvious distress of a young man with a background of self harm attempts. Even if they had not been made aware of his problems by the FCMT, I would expect that prison officers (who had received additional remuneration to perform a 'welfare' role in 1990) would at very least try to find out what was wrong, even if they then decided to pass on the problem to the FCMT or other health staff. Whether this lack of action was a result of indifference, insensitivity or a feeling that it was 'not their job'; or that they simply did not know what to do, their failure to respond to Mr Doorey provides, in my view, a clear example of prison officers not becoming involved with vulnerable prisoners to an appropriate degree.

10.26 Professor Richard Harding said in his 1994 study of self harm in Victorian prisons:-

“Self-harm is a syndrome of distress; thus the causes of distress must themselves be mitigated even if they cannot be removed; and these causes are frequently some aspect of the prison experience or prison conditions themselves. From this point of view, self-harm incidents are almost invariably symptomatic of morale within the particular prison or prison system.”

10.27 Howells and Hall said:-

“The organisational culture or environment is critical to the prevention of self harm and suicide. Prisoners will not reveal their feelings and intentions unless a good relationship exists. Hence a major concern in long-term planning must be how to enhance staff prisoner interaction.....The selection of officers who are people oriented, modelling of expected behaviour by senior staff, and effective case management have an important part to play in developing an appropriate atmosphere and culture.”(page 38)

10.28 Howells and Hall also reported noticeable differences in the atmosphere between institutions. For example, they found that Albany Regional Prison *“appeared to promote and encourage positive rapport between prisoners and officers, and senior staff explicitly address the “us versus them” mentality”*. Based on my experience, this is an accurate portrayal of the atmosphere which I felt when visiting Albany and which was reinforced by the many positive comments from prisoners about the way they were treated there by the staff, compared to their experience at other prisons. One prisoner from Albany wrote in a submission:-

*“On the whole, both prisoners and staff live and work in a positive environment.....Unlike Casuarina if a prisoner has a genuine personal crisis here, the staff act on it promptly and are not indecisive when it comes to decision making. In this manner, possible major crisis's [sic] for prisoners are alleviated as soon as is humanly possible, thus avoiding undue stress on the person involved. It is simply a case of staff doing the job they are employed to do and they are good at it. This prison is administered and run exceptionally well and I feel should be used as a role model for prison administration throughout the state. If this man management style was adopted in prisons throughout WA I am sure the suicide rate in the prison will drop dramatically.”*⁷

10.29 This view is very much in keeping with the concept of a 'healthy prison' promoted by HM Chief Inspector of Prisons in his 1998 report *“Suicide is Everyone's Concern”*. In Chapter 7 of that report he stated that *“the total experience of imprisonment affects suicidal behaviour”* and quoted a statement made by the UK Prison Reform Trust in 1996:-

“In its widest sense it (suicide prevention policy) must be about creating a climate in which suicidal thoughts and feelings are less likely to take root. Inmates will normally be less prone to suicidal behaviour in the establishment where regimes are full, varied and relevant; where staff morale is high and relationships with inmates positive; where good basic living conditions are provided; where every effort is made to encourage contacts with family and the community.....”

“.....overwhelming conclusion from ...research is that suicidal behaviour is influenced by the quality of prison regimes and the response of staff. Evidence heard at inquests far too often seeks to explain the deaths in terms of the individual’s inability to cope or their supposed personality problems, rather than looking at the psychological distress caused by regimes, conditions, isolation and lack of access to education, training and support.” (paragraph 7.2)

- 10.30 He suggested that one of the tests of a healthy prison is that *“prisoners are treated with respect as individuals”* and that:-

“Prisoners will not learn to respect others unless this is demonstrated to them: one of the key responsibilities of prison staff therefore is to present a model of how people should relate to each other. When officers have treated prisoners with kindness we have been told how much this has meant to them and how effective it has been in taking matters forward. Compassion should not be mistaken for condoning the prisoner’s offence nor excusing behaviour but as a means of showing understanding which needs to be sustained even in the face of rejection and hostility.” (my emphasis) (paragraph 7.18)

- 10.31 *ARMS* - which was based on the findings of Howells and Hall - acknowledges that prison officers have the most contact with prisoners and can, therefore, strongly influence the prison environment. In my view, as expressed elsewhere in this report, the growing tendency for officers to see the management of at risk prisoners as a medical problem had the effect of de-sensitising some officers to the signs that a prisoner may be distressed or vulnerable.
- 10.32 The Ministry has advised me that, as part of their initial employment training, all recruited prison officers receive ‘special needs awareness’ training, including an understanding of the special needs of offenders and suicide and self harm prevention strategies. Nevertheless, I note from comments in submissions and in interviews that ongoing training in at risk awareness for officers is considered by many prison staff to be inadequate. In spite of the comprehensive directions and guidelines in the *ARMS* Implementation Manual, I remain concerned that it may not be as successful as it could be without a determined effort to provide regular and ongoing training for staff of all levels of seniority.
- 10.33 On the basis of available research and my own observations, it is clear that poor or hostile interaction between prison officers and prisoners can lead to an increase in internal prison stresses for all prisoners, and particularly vulnerable prisoners. Conversely the establishment of positive relationships between prisoners and prison officers can – and should be accepted as such - become the cornerstone of any effective suicide prevention strategy. Although not suggesting that all – or even most - prison officers would or do treat prisoners with the apparent lack of sensitivity which in my view was evident in the management of Wesley Doorey, I cannot ignore the comments from prisoners about their treatment by some officers. The relocation of officers who clearly do not have the aptitude to deal with prisoners with appropriate sensitivity when necessary, should be seen as an integral part of an effective harm minimisation strategy.

RECOMMENDATION 10.1

When recruiting prison officers sufficient weight must be given to their interpersonal and communication skills and their overall attitude towards prisoners and the prison environment in general.

(iv) **Lack of individual care plan and inadequate multidisciplinary coordination of at risk management**

10.34 Malcolm **Inman**, a young Aboriginal remand prisoner who had been assessed as a high risk of self harm, committed suicide in the Remand Centre in April 1996. Mr Inman's files show that he was seen by various members of the SNT, an Aboriginal psychologist and an Aboriginal elder during his imprisonment. All staff saw him as a high risk of self harm but responsive to counselling. Nevertheless, both the Acting Director and the Manager, Health Services were critical of Mr Inman's overall care, in particular the absence of all relevant assessment notes on his file; the lack of an individual care plan for him and the absence of therapeutically orientated programmes and facilities. They concluded that "*the management of disturbed and vulnerable prisoners necessitated multidisciplinary co-ordination between clinical staff and prison management which should be improved.*" Although the Coroner found that Mr Inman had received adequate care and support, he commented on the need to identify appropriate tribal elders who could offer support; to establish peer support prisoner groups; and to create the position of Prisoner Support Officer.

10.35 In its management review (dated 20 November 1998) of the circumstances of the death of Sean **Hayes** who, after a history of self harm and suicide attempts, committed suicide in the Remand Centre on 21 August 1997, the Ministry stated:-

".....although managed in a systematic way by the FCMT staff, [his "at risk" status] was not comprehensive as it did not involve the uniformed staff in the development and implementation of an ongoing management plan.....there was clearly a lack of an overall comprehensive management strategy involving all relevant staff, which identified risks, stages, and approaches to Mr Hayes's cognition's [sic] and behaviours." (my emphasis)

10.36 A similar breakdown in communication was noted following investigation of the death of Phillip **Halligan** (8 October 1998, Casuarina) when it was found that information about a serious suicide attempt by Mr Halligan while in Carnarvon police lockup on 24 August 1998 was contained *only* in his medical file. It was not conveyed to the prison officer in charge of the unit where Mr Halligan was placed in Casuarina and where he subsequently took his life.

10.37 At the Inquest into Mr Halligan's death, the Coroner stated:-

"I am satisfied that had either [Prison] Officer ... or [SNT Member] Ms ... been aware on 7 October of the earlier suicide attempt on 24 August 1998 they would have appreciated that the deceased's concerns were a matter of real urgency and would have taken direct action to ensure that he was appropriately counselled and possibly also transferred within the Prison.

The failure to adequately record information in relation to the deceased's previous suicide attempt on the Unit File, which was the file available to prison officers in charges of the Unit where the deceased was housed, seriously compromised the ability of Officers in the Unit to assess his at risk status."

10.38 The Coroner concluded that Mr Halligan "*could have been better supervised and managed while in custody if prison officers responsible for his supervision had been better informed. The Court has, however, been informed that the new ARMS system has improved communication of information about risk of self harm within Western Australian prisons and so such a situation is unlikely to occur in the future.*"

10.39 The failure of health staff to involve prison officers in Mr Halligan's management highlights the lack of 'ownership' of the suicide/self harm problem by those responsible for the care of prisoners and a clear lack of coordination between health and prison staff.

10.40 As stated earlier, although the Ministry was alerted to deficiencies in its strategies for the management of at risk prisoners in 1994, 1996 and 1997 following the deaths of Messrs Boyle, Jackson and Hayes, respectively, it took no action to review the system until late 1997 when the Howells and Hall study was commissioned. The Howells and Hall Report ultimately led to the formulation of a new suicide prevention strategy and the introduction in late 1998 of *ARMS* which attempted to emphasise that management of a suicidal prisoner was the responsibility of the whole prison community and must be seen as such by all staff.

(v) **Access to information**

Expressions of concern by relatives

10.41 Specified as a source of information by DGR 3B - and one would have thought as a matter of common sense - expressions of concern from family members about a prisoner should be considered when determining a prisoner's level of risk and subsequent management. Failure to adequately consider such concerns by relatives was identified as an issue in the deaths of Darren **Boyle** and Ronald **Hill** in 1994 and Wesley **Doorey** in 1997.

10.42 In relation to Messrs Boyle and Hill, the Coroner stated:-

“The difficulty, and perhaps impossibility, of predicting suicide except in the most patent of presentations is acknowledged but it may be worthwhile reviewing the weight placed on expressions of concern by relatives when assessing persons, particularly those in remand.”

10.43 The Manager of the SNT also wrote in a report:-

“It would seem appropriate to place considerable weight on any expressions of concern from family members [as] obviously they know the person better. Monitoring and reviewing could go on for longer rather than shorter periods to provide extra caution and perhaps get to know the person better. Both prisoners were vulnerable and should have been viewed as such whether or not they actually admitted to feeling suicidal.”

10.44 Although Wesley Doorey's mother gave evidence at the inquest that she had telephoned the prison two weeks before Mr Doorey's death to advise of his suicide threats, there was no record of this information on his file and members of the FCMT said that they were not aware of any such contact by Mr Doorey's family. Prison staff disputed that the prisoner's family had advised the prison of concerns for his wellbeing and the Coroner did not comment on this issue.

10.45 In my view, what is of particular concern is that in all of these cases prison staff disputed that the prisoner's family had contacted the prison to voice concerns about the prisoner's wellbeing. Unfortunately, the fact that there is no routine documentation of calls from prisoners' families in a record which is available to officers on subsequent shifts or which can be passed on to the appropriate health staff does not enable this issue to be fully explored in the cases where the question has arisen.

10.46 From my observations and from comments provided to me, it seems to me that calls from prisoners' families are frequently seen by prison staff as an inconvenience which interferes with the daily work of the prison. I know from personal experience that anyone who has tried to contact a staff member or a prisoner at Hakea Prison through the switchboard needs an extraordinary amount of patience and resilience to remain on the line through the innumerable repeats of the recorded message before - and sometimes, if - an embodied voice appears. It is difficult to understand why a prison would want to adopt this form of telephone system. Whether or not it is a deliberate policy (and the Ministry has told

me that it is not) to discourage constant calls from prisoners' families - which may well be considered to interfere with the running of the prison - it certainly has that effect. More importantly, it also militates against the receipt of genuine expressions of concern about a prisoner - especially if, as it would appear, there is no formal recording of relevant messages to ensure that the message is passed on to the appropriate staff member or prisoner.

- 10.47 No specific action appears to have been taken by the Ministry to improve the procedures for recording telephone calls from prisoners' families. To ensure compliance with the provisions of DGR 3B relating to the use of information from families in judging a prisoner's level of risk and in order for the *ARMS* procedures to be properly applied, prison staff may need to be reminded to not only actively involve the prisoner's family but also to record and use any information provided by them. In this regard, I suggest that the establishment of an efficient message recording system at all prisons deserves a measure of priority. Recording details of telephone contacts with members of the public is not an unusual practice - to my knowledge, this is done by the Ministry's Community-Based Services staff. In the circumstances, I would have thought that, in the long run, not documenting telephone calls from prisoners' families is a risk not worth taking.

RECOMMENDATION 10.2

That a system be devised that:-

- (a) encourages family members to telephone a prison to express concerns about the welfare of a prisoner; and**
- (b) ensures such information is recorded – either by an individual taking the call and recording the information or by having the calls tape recorded and monitored regularly.**

Police Form P10b

- 10.48 Concerns about the accuracy of the information in Police *Form P10b* and its availability to prison staff arose in the cases of Alan **Bangmorra** (July 1996; Broome); Christopher **DeGois** (November 1997; Casuarina) and Bevan **Cameron** (January 1998; Greenough). The form is prepared by police officers to convey observations about a prisoner while in police custody for the benefit of prison personnel who subsequently receive the prisoner. It usually contains information about the prisoner's medical condition, any talk of self harm and any other behaviour considered significant.
- 10.49 During the inquest into Mr **Bangmorra's** death, the Coroner noted that a copy of *Form P10b* was not on his main prison file although a copy was later found on the IIU investigation file. It was suggested in evidence that although the form was useful for prisoners who were not previously known to the prison administration, in Mr Bangmorra's case the forms would have provided relatively little assistance because they related to long past incidents and Mr Bangmorra had been assessed more recently in prison. The Coroner agreed but observed that the forms should be appropriately filed and used. The Ministry's review (in February 1998) of the Coroner's findings stated that the form was not being routinely provided by police and recommended that "*Any review of initial 'At Risk' procedures should consider the utility of Police form P10b 'Medical and Behavioural History of Detained Person'.*"

- 10.50 On the day of his death, Mr **DeGois** had been in the custody of police officers during an appearance in the Armadale Court. He had been upset by the Court proceedings and had audibly stated in Court and to police officers in the holding cells that he intended to kill himself on his return to prison. According to the IJU report the police officers claimed to have told the escorting prison officers of Mr DeGois's remarks. Whether or not this was so, there is no record of this information being passed to reception officers at Casuarina Prison on the day in question. The copy of the *P10b* subsequently obtained by the Ministry from police records Mr DeGois' threat of self harm.
- 10.51 The IJU report commented:-
- “In instances where escorting officers are advised by police of a prisoner's threat to suicide, then that information is passed verbally to reception officers...Such threats are recorded in paperwork relative to the escort of a prisoner in an accompanying Form P10B, usually handed to the escorting officers. Should Reception officers receive such notification, then depending upon the time of day, FCMT or hospital officers are advised and an 'At Risk Assessment' is conducted upon the prisoner. In this instance no such action was taken. Form P10B's are not retained on file by the Reception Office and it cannot be established if in fact a P10B was issued by Police, received by escorting officers or Reception officers at Casuarina Prison.”*
- 10.52 The Ministry has advised me that if a *Form P10b* is received by a prison Reception Officer it should be attached to the Initial Assessment form completed by prison reception staff. The assessment form and any attachments are then forwarded to nursing staff to conduct their part of the risk assessment. In this way, a *Form P10b* should eventually be placed on the medical file. The Coroner accepted that the police had not provided a *Form P10b* to prison officers who subsequently dealt with Mr DeGois. Nevertheless, it appears from the Coroner's report that officers in Mr DeGois' unit were aware that he was not pleased with the outcome of his court appearance and talked to him about it. The senior officer took the opportunity to assess Mr DeGois' at risk status. It is reported that Mr DeGois assured the officer that he was all right and that he would not self-harm.
- 10.53 The IJU report implies, in my view, that the utility of the information in *Form P10b* might well have been limited by Mr DeGois's later behaviour after being returned to prison custody. Nevertheless, it is of concern that there is no police record that police had issued a *Form P10b* in relation to Mr DeGois and further, that these forms are not filed and retained in prison reception. Although the action taken by the prison officers following Mr DeGois' return from court overtook to a large extent the previous events at court, if the prison had been advised of his threat of self harm his risk status may well have been perceived differently and he may have been referred to the FCMT for assessment.
- 10.54 A *Form P10b* was completed by police in relation to Bevan **Cameron** and given to the prison reception officer. However, it did not include the information that he had been remanded in custody for alleged offences against members of his family, information which the Coroner described as *“...a matter which was likely to have a bearing on his future management in custody...”* Although Mr Cameron was seen the following day by a medical practitioner, a psychologist, and a psychiatrist, there is no guarantee that he would have revealed the nature of his offences.
- 10.55 The Coroner noted the evidence given by the then Director, Health Services that the forms are *“...rarely helpful...rarely completed adequately by police officers and...the relevant section of the form is very rarely filled in”* but went on to recommend that the form be redrafted by police in consultation with the Director, Health Services to allow for the inclusion of all relevant information which might be of value in the management of a prisoner.

- 10.56 In its review of the coronial findings into Mr Cameron's death provided to the Attorney General in July 1999, the Ministry advised that preliminary discussions with police had taken place "*to progress the issue of redrafting the Form P10b to include information required by prisons and to ensure handover of the form.....The Health Services Directorate will be a contact point to articulate the 'at risk' information required in the redrafted form.*"
- 10.57 In the review of the coronial findings into Mr DeGois' death dated February 2000, the Ministry advised that a revised procedure had been agreed with Police. As a result, Police *Form P10A* was to be used in place of *P10b* and appropriate instructions were to be issued to both Ministry staff and police officers.
- 10.58 It seems to me that prison staff should have access to any information which might assist them in identifying and managing a prisoner at risk of suicide or self harm. whether previously assessed as at risk or not - particularly as the first stages of imprisonment are universally acknowledged as the most critical to a prisoner's safety. As prisoners may not always reveal their fears and anxieties at this crucial stage when the reality of a sentence of imprisonment is likely to have an initial impact, it is important that any knowledge gained by police – or passed on by a prisoner's family - is recorded and conveyed as accurately as possible to appropriate prison staff. If there are deficiencies in the transfer of information between the police and the receiving prison then the Ministry should have attempted to address the problem. I support the Coroner's recommendation that *Form P10b* be reviewed. In my view this should be done in conjunction with a joint review by police and the Ministry of the general procedures for information-sharing as recommended by the RCIADIC in **Recommendations 130 and 166**. I understand that *Form P10A* was introduced and that a new form was initiated after the transfer of prisoner transport to CCA in July 2000.

RECOMMENDATION 10.3

That the Ministry:-

- (a) monitor the adequacy of the information in the new form used by CCA and the new handover procedure; and**
- (b) conduct an overall review of information-sharing procedures as recommended in RCIADIC Recommendation 166.**

(vi) Lack of culturally appropriate assessment of, and support for, Aboriginal prisoners

- 10.59 In relation to the death of Alan **Bangmorra** (Broome; 30 July 1996) the Coroner found that Mr Bangmorra was "*a reserved person who did not readily discuss his concerns with other prisoners or with members of the Aboriginal Visitors Scheme*". However, prison staff at Broome expressed concern to my investigating officers about the appropriateness of the official risk assessment procedures for traditional Aboriginal prisoners. They believed that procedures which concentrated on behavioural observations rather than a long list of questions were frequently more relevant for Aboriginal prisoners who may provide the answer they believed the questioner wanted to hear rather than what they were actually feeling. It was also suggested that some of the questions asked in the initial assessment process could be embarrassing for traditional Aborigines or exacerbate their distress and anxiety. In addition, the lack of privacy in the reception area of many prisons - particularly at a prison like Broome - is a significant obstacle to eliciting information about stressful life events and personal matters.

- 10.60 The Coroner commented on the adequacy of the assessment and support available to Aboriginal prisoners in his findings on the death of Malcolm **Inman** (Remand Centre; 24 April 1996). He said:-

“Counsel for the family suggested that it would be helpful if on reception at a prison an aboriginal prisoner’s tribal group could be identified. This information could be important at times of crisis and would assist prison officers, the Special Needs Team etc to identify appropriate persons to contact about such issues. It was further suggested that there should be available contact numbers and addresses of persons who could provide cultural assistance.

In my view these were very helpful suggestions. Aboriginal prisoners may well be distressed by the prison environment and it would be of assistance to have available points of contact so that important cultural issues could be quickly addressed.”

- 10.61 Although Mr Inman had been seen by an Aboriginal psychologist and by an Aboriginal elder, the Coroner added the rider to his findings that, on admission to prison, an Aboriginal prisoner’s tribal group and language should be identified and recorded for future reference and that a resource system of the names and contact details of tribal elders who could provide assistance with cultural issues causing concern for Aboriginal prisoners. The IIU investigation into Mr Inman’s death recommended that more Aboriginal staff be employed in the SNT; that Aboriginal staff currently employed by the Ministry be more effectively utilised to provide the welfare/support role within prisons (RCIADIC **Recommendation 174**); and that a prisoner/peer support group be established in line with RCIADIC **Recommendation 183**.
- 10.62 In relation to the employment of more Aboriginal staff to provide welfare/support for Aboriginal prisoners, the Ministry has told me – and I have no reason to doubt that it is the case - that it has great difficulty in recruiting Aboriginal staff in all areas, particularly health services. However, it seems to me from my discussions with the Director of Derbarl Yerrigan Health Services (the Aboriginal Medical Service in Perth) that there is a considerable amount of enthusiasm among Aboriginal health professionals to become more involved in providing a broad range of health services and support to Aboriginal prisoners. They would, however, need adequate funding to do so.
- 10.63 The Prisoner Support Officer concept had been trialled at Greenough in 1993 with funding from a grant from the Commonwealth Youth Bureau. A key aspect of the program was to implement changes to prisoner management procedures to reflect understanding of Aboriginal culture and a working knowledge of indigenous issues. In spite of the acknowledged success of the program – and the continued provision of Commonwealth funding – the program was not extended to other prisons until October 1996 (after Mr Inman’s death) when the Ministry approved the establishment of ten Prisoner Support Officer positions. Although accessible to all prisoners, the Prisoner Support Officer is designated for Aboriginal persons under section 50d of the *Equal Opportunity Act*. There are now Prisoner Support Officers at all State prisons except Bunbury, Karnet and Wooroloo where the positions are currently vacant.⁸
- 10.64 In its review dated 13 May 1999 of the Coroner’s findings, the Ministry supported the need to establish an Aboriginal prisoner’s language group but only partially supported the development of a list of persons of standing in the community who could be called on to assist with cultural matters on the ground that “*an elder to one group may not be accepted as an elder to another group.*” It stated that the Aboriginal Policy and Services Directorate was active in raising staff awareness of the special services available to assist in the management of Aboriginal prisoners and referred to the establishment of the *Aboriginal Spiritual Support Review Committee* which included representatives from the Ministry, from the Association of Heads of Churches and high profile members of the Aboriginal community. In spite of extensive enquiries by my Aboriginal Liaison Officer within the Ministry of Justice and in the community, there

appeared to be little knowledge of this committee or its activities. The Ministry has subsequently advised me, however, that the Spiritual Support Review Committee was set up by the then Director of Aboriginal Policy and Services and met twice. It has not met recently following the withdrawal of a number of committee members but the Ministry intends to seek nominees for Committee membership from the Aboriginal Justice Council.

10.65 Although I am aware of the difficulty of the task of establishing a register of community elders who would be prepared to assist with distressed Aboriginal prisoners, I am surprised that the Ministry's response to the Coroner's findings was framed in such negative terms. It has subsequently been explained to me, however, that knowledge of whether an Aboriginal prisoner spoke a traditional language and which one, was important in identifying an appropriate member of the community with whom the prisoner would feel comfortable. From my discussions with prison staff during my visits to prisons throughout the State, I am confident that staff - at least at regional prisons - would have sufficient local knowledge (particularly if they consulted with Aborigines at the prison) to set up a network. I note that contact with, and the involvement of, tribal elders has been found to be a significant component in the suicide prevention strategies for Maori prisoners in New Zealand.

10.66 The Maori Suicide Review Group stated in its report in 1996:-

"It is important that the Department of Corrections involve the whanau (extended family) of at risk Maori inmates in the management of the inmate. The inmate's whanau has knowledge of the inmate that is essential to addressing the issues that the inmate is facing. The whanau is also better able to provide the emotional support required to keep the inmate alive. Where no-one from the inmate's whanau can help, an advocate needs to be identified who can have input into the management of the inmate.

*Some prisons are known to take a well developed team approach to management of at-risk inmates. The team advising on management will include custodial, health and other professional support staff working in the prison, as well as psychiatrists, psychologists and for particular cases kaumatua (respected elder) from local iwi (tribe)....."*⁹

10.67 The importance of 'culture' and the involvement of Maori healers and family members is freely acknowledged in New Zealand prisons to the extent that a new prison in Auckland has recently incorporated a traditional meeting house in its facilities and a cultural assessment by a Maori elder is an integral part of the reception and initial assessment process.¹⁰

10.68 It has been said that because psychology and psychiatry are areas developed by affluent western societies, they are "culture bound and culture blind."¹¹ In this regard prison staff may be faced with a growing number of prisoners from diverse ethnic backgrounds requiring different techniques and awareness and may well need broader cultural awareness training.

10.69 I am aware that the more experienced reception officers will automatically attempt to ask questions in a tactful way, particularly at prisons such as Broome, Albany and Greenough where there is a 'specialist' reception officer and possibly a higher proportion of prisoners who are Aborigines or from other ethnic groups. However, at prisons where the role of reception officer is performed on a roster basis the usefulness and accuracy of the information elicited from Aboriginal prisoners and those from other ethnic backgrounds on admission will depend on the personal communication skills of the officer. To my knowledge, although I understand that all officers receive cultural awareness instruction, little effort has been put into the training of officers in the correct way to ask questions during the admission process.

RECOMMENDATION 10.4

That the Ministry:-

- (a) endeavour to establish a network of elders from Aboriginal communities surrounding each prison to provide support and counselling; and
- (b) enlist the help of established Aboriginal health service providers to enhance its provision of appropriate services to Aboriginal prisoners.

(vii) **Methods of suicide**

Hanging points

10.70 Hanging is universally the most commonly used means of suicide by prisoners. It is not surprising therefore that 33 of the 40 prisoners who committed suicide or apparent suicide between 1991 and 1999 chose hanging as a method using the following anchor points:-

Window bars	9	(Walsh, Metcalf, Cameron D, Vincent, Gibson, Hitchcock, Cameron B, Jackamarra, Malone)
Light fitting	5	(Hill, Inman, Holt, Le ,Lauder)
Cell door	3	(Boyle, Bangmorra, Groth)
Wardrobe door	3	(Leone, Groth, DeGois)
Top bunk rail	3	(Kennedy, Jackson, Halligan)
Shelf brackets	2	(Summers, McIntosh)
Doorstop	2	(Hayes M, Rawlings)
Grille in yard	2	(McMahon, Coyne)
Shower	2	(Clarke, Ryan)
Tree	1	(Vivas)
Door hatch	1	(Osborne)

10.71 Paul **Vincent** and Russell **Gibson** used the window bars as an anchor point at the Remand Centre in June and October 1992, respectively. At the inquest in January 1993 into Mr Vincent's death, the Coroner recommended that the top parallel window bar be removed from all cells at the Remand Centre. The Ministry apparently considered the Coroner's recommendation to be impractical and proposed as an alternative the installation of stainless steel mesh over the window bars. At the inquest into Mr Gibson's death in March 1993 the Coroner observed that approval had been given to install the wire mesh and stated "*I recommend that this work be undertaken expeditiously.*" I understand that the work at the Remand Centre was completed shortly after the Coroner's comments in Mr Gibson's case and there have been no further deaths using this means at the Remand Centre.

10.72 However, similar remedial action was not taken at other prisons. Since 1993 five other prisoners have hung themselves from the window bars - Bevan Cameron and John Jackamarra in 1998 at Greenough, James Malone at Canning Vale, Wayne Coyne at Casuarina in 1999 and Phillip Joseph at Roebourne in 2000. Moreover, three prisoners had used the window bars as hanging points in 1991 *prior* to the deaths of Messrs Vincent and Gibson – Justin Walsh in Fremantle; David Metcalf in Casuarina and Darryl Cameron in Greenough.

- 10.73 Martin Hayes used the doorstep mechanism at the top of the door of his cell in the prison infirmary when he hanged himself at Casuarina in June 1995. Although, following his death, the devices were relocated to a much lower part of the doors in the Infirmary, the cell doors in the rest of the prison were not similarly modified and the doorstep on an internal cell door adjoining a 'buddy cell' in Casuarina was used as a hanging point by Shaun Rawlings in October 1996. I understand from the Ministry that doorstep mechanisms were removed from 'buddy cells' after Mr Rawlings' death and that similar 'anti-slam' devices have been progressively removed from cell doors throughout that prison.
- 10.74 Darren Osborne hanged himself from the upper portion of the hatch in the cell door in Casuarina in August 1997. At the inquest into his death in February 1999 the Coroner noted that "...steps have been taken since the death to weld the top of the bars over hatches in similar cells [at Casuarina] so that the bars cannot be used as hanging points."
- 10.75 The RCIADIC recommended (**Recommendation 165**) that steps should be taken to remove obvious hanging points. Although I accept the view of both prisoners and prison staff that it is not possible to prevent a prisoner who is determined to commit suicide from finding a means of doing so, given the frequency of hanging as a means of suicide over the past eight years in Western Australian prisons I have considered the adequacy of the measures already taken the Ministry to remove *obvious* hanging points from all cells – not just those at the prison where the problem was highlighted.
- 10.76 In this regard, installation of the stainless steel window mesh at the Remand Centre appears to have been successful in preventing deaths using the window bars as a hanging point. However, this remedial action was not taken at other prisons and there have been, in total, eight other deaths in which window bars have been used as hanging points – two at Casuarina (one in 1991); three at Greenough (one in 1991); two at Hakea and one at Roebourne.
- 10.77 On the other hand, at prisons where remedial measures *have* been taken, such as at the Remand Centre (the window mesh) and at Casuarina (removal of 'anti-slam' devices and welding of bars in the door grille) prisoners have found an alternative means of hanging themselves. For example, the light fitting was used by Messrs Hill (1994), Inman (1996) and Le (1998) at the Remand Centre and Messrs Holt (1998) and Lauder (1998) at Canning Vale). Mr Kennedy (1994) at the Remand Centre and Messrs Jackson (1996) and Halligan (1998) at Casuarina used the top bunk rail¹². Shelf brackets were used by Mr Summers (1993) at Casuarina; and the shower recess by Messrs Clarke and Ryan at Casuarina¹³. Moreover, three prisoners have used a prison-issue belt as a means of suspension.
- 10.78 In his comments on the quality of care provided to Mr Le, the Coroner said "*The hanging point used in the cell, a light fitting attached to the ceiling, was not an obvious hanging point and it is somewhat surprising that the fitting was able to take the weight of the deceased without damage.*" The Ministry did not comment on the Coroner's observation in its report to the Attorney General on the Coroner's comments. Although it may not be an 'obvious' hanging point, five prisoners –**all** at either the Remand Centre or at Canning Vale - have used the light fitting as an anchor point. This frequency of the use of the light fitting suggests to me that it should be considered an *obvious* hanging point at those prisons. By way of illustration, of the five prisoners who used hanging as a method after the window bars were covered in mesh at the Remand Centre, three used the light fitting. Similarly, two of the four prisoners who used hanging as a means of suicide at Canning Vale used the light fitting.
- 10.79 I have established from the Ministry's maintenance and works section that the light fittings at Hakea are only "*vandal resistant*" - with the exception of those in medical observation cells which are "*smash resistant*" with tamper proof screws and are the type used in police 'safe cells'. Light fittings at Casuarina – which is a newer prison – are the 'safe cell type'.

- 10.80 I understand that the Ministry has been advised by its works and maintenance staff that the light fittings in Hakea should be replaced by the ‘safe cell’ model but that funding was not approved on the ground that it was not necessary because of greater interaction between staff and prisoners at those prisons. I believe that where it becomes necessary to replace light fittings – say in the course of refurbishment – or in the construction of new cells or facilities, ‘safe cell’ light fittings should be used.
- 10.81 The Ministry has advised me that “*Reviews of cell furniture and fittings take place on a regular basis where consideration is always given to the number of suspension points contained in cells.....*” and that:-
- “Where practical, measures have been effected in all prisons to reduce the number of suspension points in cells. It should be noted that in the proposed construction of the new Wooroloo Prison South there has been included as part of the specifications a requirement to minimise the number of ligature points in cells. In existing prisons where it has been found practical to do so those items in cells serving little or no purpose but have the potential to be used as suspension points have been removed. The Ministry of Justice is cognisant of the need to reduce suspension points in cells including refurbishment of existing cells, construction of new cells and construction of new facilities.”*
- 10.82 I am not convinced that the exclusive focus of scarce corrections dollars on the *physical* minimisation of opportunity will *per se* reduce the incidence of suicide. There is a fine line between removing *obvious* hanging points which have been highlighted by earlier deaths or modifying a particular design of fixture or fitting in a new facility because it offers a potential hanging point to a stressed and impulsive prisoner, and an *exclusive focus* on the physical prevention of opportunity for suicide at the expense of human interaction and communication.
- 10.83 The point is illustrated by the comments of the Tasmanian Coroner on the death of a prisoner who committed suicide by hanging from the window bars in his cell in the hospital at Risdon Prison, in July 1999. The Coroner questioned why the prisoner – a diagnosed schizophrenic - was in a cell which “*contained in excess of 30 suspension points which any person, whether or not they had shown a previous disposition to self-harm, could have accessed to hang themselves*”. The Coroner was critical of the government’s failure to remove suspension points, despite this being recommended by at least three coronial inquests into prison suicides.¹⁴
- 10.84 Similarly, in his evidence to the coronial inquiry into deaths at Port Phillip Prison in Victoria in April 2000 on the issue of hanging points, psychiatrist, Professor Mullen, stated:-
- “...by all means make cells decent places to live in and also safe places to live in, but don’t think that the solution to suicide is to take away the mechanical capacity to kill yourself. Apart from anything else it shows an extraordinarily demeaning attitude to the human beings who kill themselves. We all live surrounded by hanging points. Now, we don’t hang ourselves on them because that happens to be a convenient hanging point; we hang ourselves ...because we’ve reached the end of our capacities to go on coping with the situation as we see it, and so, yes, it’s important to have safe cells, but this extraordinary focus you sometimes see on the mechanisms of suicide seems to me misplaced.”(page 48)*
- 10.85 I am sure that prison cells in many jurisdictions provide ample opportunity for suicide to the determined prisoner. Possibly the only cells which might be considered “suicide-proof” are the medical observation cells. Even so, prisoners in such cells have attempted suicide using strips of “untearable” gowns and bedding and by using the toilet bowl. However, the sterility of these cells and its accompanying dehumanisation and sensory-deprivation are universally considered far more likely to exacerbate the distress of an at risk prisoner and may only prevent a self harm attempt at that particular time¹⁵. Ultimately, in terms of harm minimisation, there is no substitute for human interaction.

- 10.86 My preference would be for, as suggested in the Howells, Hall and Day study, “*the humanisation of cells as an alternative to suicide-proofing*” by design and by the encouragement of a higher level of communication and interaction between prisoners and prison officers. To this end it seems to me that a combined approach by the Ministry is necessary. This should include - as so frequently said in this report – recruitment of prison officers with a high level of communication and interpersonal skills; provision of comprehensive staff training in this area; modification of cell designs which contain *obvious* hanging points; and removal of hanging points which have been used by several prisoners, particularly at the same prison.

RECOMMENDATION 10.5

That the Ministry:-

- (a) take immediate steps to replace the light fittings in Hakea Prison with ‘safe cell’ fittings;
- (b) progressively replace similar light fittings at other prisons;
- (c) progressively remove frequently used hanging points in all prisons, not just the prison where its use as an anchor point has identified its potential as a hanging point; and
- (d) constantly emphasise the importance of, and encourage, positive interaction between officers and prisoners

Plastic bags

- 10.87 Between 1991 and 1997¹⁶ three prisoners - James **Reynolds** (CWCRC; June 1991); Shane **Bourbon** (Albany; November 1992); and Sean **Hayes** (CWCRC; August 1997) - committed suicide by asphyxiating themselves with a plastic bag. Two further deaths by this means occurred at Casuarina Prison in 1999.¹⁷ Neither of the latter deaths has yet been subject to inquest.

- 10.88 During his inquest into the death of Mr **Reynolds** the Coroner made the assumption that he had obtained a plastic bag from prison supplies and stated “*I was informed at the enquiry that following this incident only paper bags are now used.*” However, following the suicide of Mr **Bourbon** in November 1992 - after the inquest into Mr Reynolds’ death - the IIU investigator stated:-

“Plastic bags such as the one used [by Mr Bourbon]...are freely available within the prison. These plastic bags are used in prisoners’ rubbish bins in their cells, used to line rubbish bins around the prison and are used by prisoners to carry possessions in. A previous practice of having holes in the plastic bags or using paper bags proved impractical as foodstuffs and liquid would drip out, consequently prisons reverted to complete plastic bags.

With the packaging of various items that are delivered to the prison being in plastic liners the banning of plastic rubbish bags would not prevent a prisoner obtaining a plastic bag should he so desire.”

- 10.89 The then Acting Director of Prison Operations and the then Executive Director concurred with this assessment and advised the then Minister in November 1992 that “*...Should a prisoner be so focused to suicide then a plastic bag is only one item of many that could be used to achieve this purpose.*” The Coroner did not comment on the use of plastic bags in his findings on Mr Bourbon’s death.

- 10.90 Mr **Hayes**, an acute high risk prisoner, committed suicide using a plastic laundry bag in August 1997. Neither the Coroner nor the Ministry (in its management review of the death) commented on the method of suicide or on the continued use of plastic bags in the prison system.
- 10.91 The Ministry has subsequently advised me that large plastic bags are used for general refuse in most prisons. However, it does not have a standard policy on use of plastic bags and the practice varies between prisons. For example, at Bandyup plastic bags are not issued to prisoners who are considered to be at risk of self harm. Prisoners at Bunbury are not issued with plastic bags for personal use and large plastic bags for refuse are not used in the maximum security section. At Hakea and Casuarina the plastic bags issued for individual use in cells are perforated, as are the bags issued for canteen spends at Riverbank. Paper bags are used for canteen spends at Eastern Goldfields. At Greenough, Karnet and Wooroloo there is no formal policy or practice.
- 10.92 Although I accept that it is probably impractical to remove all forms of plastic bags from prisons – and I note that the recent deaths occurred at Casuarina where prisoners are issued with perforated plastic bags for use in their cells - it is undeniable that plastic bags provide a relatively simple means of suicide and have been used on five occasions since 1991. In my opinion such a means of suicide deserves much greater consideration and a strategy which balances the benefits of the use of plastic bags against the obvious risks. The Ministry should have a considered and uniform policy on the issue.

RECOMMENDATION 10.6

That the Ministry review the availability and use of plastic bags across the prison system, particularly to those prisoners identified as at risk of self harm, and introduce a uniform approach on the issue.

RESOURCES

(i) Inadequate resources for the SNT/FCMT

- 10.93 Following investigation of the deaths of Messrs Hitchcock, Boyle, Hill, Inman and Rawlings concerns were expressed about the adequacy of the resources available to the SNT and the increasing demands that were being placed on members of its staff.

- 10.94 In relation to Messrs **Boyle** and **Hill**, the Coroner said:-

“I note that the function of the Special Needs Team is both to provide consultation and advice to prison administrators on the management of prisoners and also to provide assessment, crisis intervention and support to inmates of the system.”

- 10.95 In her response dated 26 June 1995 to the Coroner’s findings, the Manager of the SNT at the time stated:-

“I am advising you of this [the Coroner’s comments as above] as for sometime the issue of the lack of adequate numbers of SNT staff to appropriately cover the Metropolitan Prisons has been raised. When leave is taken the numbers are reduced in other prisons to cover for the staff member taking leave or the prison will have emergency cover only. As I have advised before staff feel real pressure that they are verging on, if not already in, a dangerous situation with regards to providing advice virtually on the run.

The situation at present is 5.8 Metropolitan staff one of whom is acting Manager SNT, with a catchment prison muster (4 prisons) of 1022 prisoners.”

- 10.96 In his comments during the inquest into the death of Wesley **Doorey** in September 1997 the Coroner stated:-

“This case has again highlighted the important task performed by the FCMT which is tasked with dealing with the very many at risk prisoners within the WA prison system. Proper assessment of risks takes time which is a scarce commodity for members of the team who must deal on a daily basis with large numbers of acutely at risk prisoners. I would urge the Ministry to provide more support to this very important team, both in respect of manpower and training.”

- 10.97 In its review of the Coroner’s findings (dated 24 May 1998), the Ministry acknowledged the importance of the role of the FCMT and advised that the budget of the FCMT had doubled since 1996. I understand from information provided to me that, as at 25 June 1998, the FCMT had an establishment of 15.2 FTE for a muster of 1044 at the four metropolitan prisons. This was further increased to 36.2 FTE (as at 18 October 2000).

- 10.98 In submissions to my inquiry, the almost universal opinion about the SNT/FCMT was that they were grossly understaffed and overworked; that it was difficult for them to see all the prisoners who wanted and needed to see them and that their involvement in therapeutic care and monitoring in addition to ‘crisis’ care was impossible. Further comment on this issue appears at paragraphs 10.153-157.

- 10.99 Howells and Hall in 1998 described the FCMT as *“the heroes in the system.”*¹⁸ From my experience there are very few people who would disagree with that comment. However, Howells and Hall went on to say that they found that:-

“...morale was very low amongst FCMT staff. There is a general perception within the prisons we visited that FCMT staff are markedly overworked and subject to considerable strain as a result of unrelenting and increasing demands posed by trying to meet the needs of at-risk prisoners. This perception appears to be shared by many FCMT staff themselves, but also by other professions who are able to observe, with concern, the effects of these high demands. The phrase “burned-out” was used frequently. The numbers of FCMT staff actually in post is often markedly lower than official FTE’s suggest, because of high staff turnover and sickness.

FCMT staff have little time for mutual support, professional development, supervision or training. In addition, FCMT staff report insufficient time to immediately enter reports into the computer.

.....Part of the excessive workloads of FCMT staff may be attributable to inappropriate referrals. Certainly, many FCMT staff report frequent referrals of a “welfare” nature from the units which would be more appropriately dealt with by prison officers.

There appears to be widespread agreement amongst FCMT staff that they have little opportunity to “follow through” on prisoners deemed to be at-risk. By this they mean that they are able to assess risk and make immediate recommendations, but they do not have the time resources to follow-up prisoners later, to see how they are progressing or to treat them. This leaves a major gap in the service for at risk prisoners, which is not filled by any other professional group.

.....A substantial further increase in resources will be required, however, to accomplish some important tasks, including the following:

- 1) *Instituting a system of clinical supervision, whereby less experienced staff members receive regular supervision and advice from more experienced and qualified staff.*
- 2) *Instituting a formal induction training program to be completed by all new FCMT staff, and regular update training events.....*
- 3) *Introducing a system of rotation of duties so that staff receive some break from coal-face work with at risk prisoners."*

10.100 Howells and Hall were also critical in general terms of the level of provision of psychological services in Western Australia which they said "*seems to fall behind that of other jurisdictions. The New South Wales Department of Corrections, for example has a psychological service with more than 90 staff.*" I agree with the conclusions in the Howells and Hall Report. In my view a number of consequences flow from the inadequacy of the resourcing of the FCMT.

(ii) Lack of regular monitoring and routine reviews of at risk prisoners

10.101 The lack of regular ongoing monitoring by the SNT/FCMT (or the psychiatrist where appropriate) was highlighted in the investigations of the deaths of Messrs McMahon, Doorey; Osborne; Holt; Leone; Groth; and Ryan.

10.102 Mr **McMahon** (April 1996, Casuarina) had been placed in a medical observation cell on numerous occasions and was considered a high risk of self harm after an attempt at the Remand Centre. In its report on his death, the IJU recommended that prisoners listed on medic alert as a self harm risk or with psychiatric problems be regularly monitored on a monthly basis by the SNT.

10.103 DGR 3J provides for "*Regular preferably daily review by medical staff*" for prisoners in medical observation. However, at that time there was no formal review or monitoring by the SNT of at risk prisoners who were *not* in a medical observation cell and had *not* themselves requested to see a member of the SNT or another health professional. In addition, it was also likely that, for the most part, prison officers themselves viewed at risk prisoners as a *health* issue rather than a *welfare* issue and did not become involved in the monitoring of prisoners who had been assessed as 'at risk' at some time but were not under any special monitoring regime. I note that the Coroner referred obliquely to this issue in his comments on Mr McMahon's death that there appeared to be very little information available to the Superintendent about Mr McMahon's previous mental health or self harm history.

10.104 Wesley **Doorey** (January 1997, Casuarina) was known to have a history of self-harming. However, he was not considered a high risk at an interview 13 days before his death and was not scheduled for follow-up.

10.105 Messrs Osborne, Leone, Groth and Ryan in Casuarina and Jackamarra in Greenough were all long term prisoners who were known to have some coping difficulties but were not routinely monitored by the FCMT. Neil Holt, a young remand prisoner who was described as "*a serious management problem*" was seen by the FCMT on several occasions because of his placement in a medical observation cell and was assessed by a member of the FCMT prior to his release into close supervision. He was subsequently seen "*informally*" by the FCMT and was "*monitored*" by uniformed staff.

10.106 At the outset, it is important to emphasise that my comments are not intended as, and should **not** be construed as criticism of individual FCMT members or of the work of the FCMT as a whole. Virtually **no** prisoners are routinely monitored by the FCMT, which is primarily occupied with crisis care. Although a policy for the monitoring of "*chronic at risk prisoners*" was drafted in October 1997, it was overtaken by the Howells and Hall inquiry and has never been implemented.

- 10.107 It could be argued that the cases cited above merely illustrate that a prisoner who is determined to self harm will find some opportunity to do so and that nothing short of 24-hour surveillance or isolation in an observation cell can ensure that this does not occur. Another view sometimes put forward by prison staff is that prisoners who need assistance or support at times of great stress are able to seek that help *themselves* by approaching the FCMT, nursing and medical staff, the Prisoner Support Officer or the Peer Support Group or the chaplain.
- 10.108 Twenty-four hour surveillance (known in Graylands Hospital as ‘specialling’) is an expensive option which is unrealistic under current staffing and funding levels in prisons. Isolation in an observation cell with its inherent sensory deprivation is widely accepted as being therapeutically inappropriate.¹⁹ Transferring the responsibility for seeking help from health professionals back to a disturbed and vulnerable prisoner with limited coping skills (and from whom the prison system has removed much of his/her decision-making ability) seems to me to be neither rational nor reasonable.
- 10.109 The Ministry’s combined approach of crisis management and *laissez faire* (self-help) seems to me to have been caused and perpetuated by two things - an increasing tendency by non-health staff to see at risk management as a health problem and an ongoing failure by the Ministry to review and resource health services such as the FCMT in line with increasing musters to enable them to offer a therapeutic service to prisoners *as well as* crisis care. The inability of the FCMT to provide regular and ongoing assessment and counselling for at risk prisoners in addition to crisis management, is a serious flaw in the Ministry’s suicide prevention and harm minimisation strategies. This is an even more serious problem for long term prisoners who may present an ongoing risk over a period of time or for those such as Neil Holt who may have been considered ‘difficult’ rather than ‘vulnerable’.

Long term Prisoners

- 10.110 The vulnerability of long-term prisoners is acknowledged in the Ministry’s *Analysis of Self-Inflicted Deaths in WA Prisons* which states:-

“A disproportionate number of suicides were among long-term prisoners (60%) compared with the proportion of long-term prisoners among the general population of sentenced prisoners (36%).

Although the numbers are small (14 sentenced prisoners altogether – the balance being remandees), an indicative trend is that suicides tended to occur among prisoners who had:

one month left to serve.....

2 to 5 years to serve.....

more than five years to serve ”

- 10.111 In this regard I note that the McGivern report on the Fremantle riot in 1988 recommended that:-

“Policies and facilities for long term prisoners.....must be implemented as soon as practicable and without waiting for the opening of the new Maximum Security Prison. Such improvements could do much to reduce the level of hopelessness and frustration felt by many of the prisoners.” (paragraph 6.5.1)

- 10.112 As stated above, Messrs Osborne, Jackamarra, Leone, Groth and Ryan, all long term prisoners with known coping difficulties, were not routinely seen by the FCMT.

- Darren Osborne wrote in his suicide note *“I have been asking for help but no won [sic] would listen..... I have been telling you c---s for weeks now that I was paranoid and depressed.”* His last meeting with the FCMT was on 17 April 1997. He died on 6 August 1997.
 - John Jackamarra was not routinely reviewed but was assessed by a psychologist in November 1996; by psychiatrists in January 1997 and by the FCMT on 28 January 1998. There is no evidence in his medical records that this was part of a scheduled review.
 - There appears to have been no strategy to monitor Alessandro Leone after he was informed that his parole had been deferred. Although he told other prisoners he was angry about the deferral he did not appear at the time to be distressed. His suicide note indicates differently. Mr Leone’s records indicate that he had *“a psychiatric history going back many years”* and he had been seen by a forensic psychiatrist on a number of occasions, he was last seen by the psychiatrist on 30 January 1998 and he does not appear to have been seen by the FCMT in the four months prior to his death.
 - Although described as a *“very disturbed individual”*, Ken Groth was assessed as a low risk of self harm and was not routinely monitored by the FCMT or by prison officers.
 - The initial psychological assessment of David Ryan indicated that *“he is ...most likely to suicide in custody at some time”*. An assessment five days prior to his death described him as *“a chronic risk of suicide for 2 years+”*. Although Mr Ryan was seen by health staff on a regular basis, these were instigated by him. He was not called up as part of a schedule of regular reviews. Other prisoners said that he *“was screaming for help.”*
- 10.113 I also note that Messrs Osborne, Jackamarra and Leone had not been assessed using the new risk assessment form. I suspect that there are a number of other long term prisoners received into the system before the introduction of the form in 1996 who have never been assessed against the more comprehensive criteria in the new form.
- 10.114 No action was taken to implement the recommendation in the McGivern Report following the Fremantle Prison riot in 1988. Long term prisoners and concerned prison officers told me that under the current system there is still also virtually no sentence management or forward planning for long term prisoners. I am pleased to note that this situation has been reviewed by the Ministry, and that the aim of the new management system is for long term prisoners to be provided with individual management plans and to be reviewed every 12 months. With the increasing number of long sentences being handed down by the courts, the general welfare of prisoners who will be in the system for lengthy periods of time - and those who already are - will require specific and urgent attention.
- 10.115 The management difficulties caused by the growing number of long term prisoners was recognised by HM Inspectors of Prisons and Probation in their review of *“Lifers”* in 1998. In spite of the establishment of a ‘Lifer Management Unit’ within the UK Prisons Department – the equivalent of which does not exist within the Ministry – HM Inspectors found that the system was not working well because:-
- “.....there is no one postholder with overall accountability for the outcomes of lifer management. Marked variations exist in the quality of regimes for those serving life sentences, which stem from the absence of guidance from prison service headquarters as to what should be provided. Within the Lifer Management Unit itself there are no offending behaviour specialists. Management is largely a bureaucratic process and.....procedures remain bureaucratic and unwieldy causing delays which have serious natural justice implications. Current arrangements do not ensure the timely transfer of lifers through the prison system so that they are able to achieve release within the timescale of their tariffs, having challenged their offending behaviour and satisfied the Parole Board of their suitability for release.....”*

.....*We conclude that this has not happened because no single unit/department is responsible for ensuring that sentence management for lifers is centrally directed, and that the prison system is not structured and resourced to cope with their needs.*" (page 2)

- 10.116 In my view, HM Inspectors' conclusions accurately summarise the situation in the Western Australian prison system regarding the management of long term prisoners. Improvements in the risk management of long term prisoners are urgently required. I would encourage the Ministry to expedite the introduction of its new integrated management system for long term prisoners. This issue is considered further in Chapter 13.
- 10.117 In this regard I also note concerns expressed by long term prisoners and prison officers that not only the lack of planned sentence management but also the lack of any certainty in their sentence progression is a source of significant distress to some long term prisoners. This is in contrast to the system in Victoria, for example, where I am told that there is a high degree of certainty that the various components in a sentence plan will occur as scheduled.

'Difficult' prisoners

- 10.118 Neil **Holt** was, in the weeks prior to his death, considered to be a "*serious management problem*" who was, for the most part, 'managed' by disciplinary measures – close supervision regimes, restraints etc. He was found hanging in his cell in January 1998²⁰. Although he was never assessed as at risk of self harm, it seems clear to me that he had obvious coping difficulties of the type described by Howells, Hall and Day as "*personal risk factors*".²¹ He was seen by the FCMT while in medical observation and prior to being released into close supervision but, I understand, in relation to his ability to cope with those regimes. The Ministry has told me that Mr Holt "*..was also seen informally by FCMT, and his behaviour was monitored by uniformed staff and reported on accordingly to FCMT.*" I am not convinced that this type of 'second-hand' monitoring is a substitute for one-to-one counselling and there appears to have been no attempt to manage Mr Holt's problems other than by disciplinary measures.
- 10.119 In my view, prisoners who might be classified as 'difficult' or as 'management problems' – such as Mr Holt - because of their difficulty in conforming to prison life, may frequently present a serious risk of self harm. However, because they often do not present with obvious indications that they intend to self harm, they are unlikely to be assessed as at risk or be referred to the FCMT - although their behaviour nevertheless demonstrates an inability to cope in one way or another.
- 10.120 The vulnerability of 'difficult' prisoners and their characteristics are acknowledged in the *ARMS Implementation Manual* which also suggests an entirely different management approach for prisoners such as Mr Holt:-

"Angry, uncooperative prisoners may be just as much at risk of suicide as those who are depressed. Many such prisoners will have acquired the label of personality disorder because of behavioural difficulties extending back over many years. This should not be taken to mean that they never get into difficulties in which suicide risk might be severe, requiring short-term crisis intervention.

Professor Gethin Morgan has termed the syndrome of poor behaviour combined with lack of positive relationships as "malignant alienation". The individual fails to respond to intensive help, perhaps relapsing repeatedly or behaving in a challenging and uncooperative way. Attitudes of others become critical and judgemental. The individual is perceived as difficult, manipulative or over-dependent, loses the sympathy and support of others and becomes socially isolated.

*Of course prisoners may sometimes earn criticism of this kind, but it is essential to review their behaviour as objectively as possible. **Difficult behaviour may in some cases reflect severe despair** and total failure through illness to cope with problems, rather than deliberate misbehaviour, which might have been avoided by self-control. There may be a real risk of suicide in such cases.”²² (my emphasis)*

...Basic behavioural principles can be followed by all staff in their dealings with prisoners. The most important thing to remember is that reward for desirable behaviour is far more effective than punishment for undesirable behaviour.”²³

- 10.121 I understand from discussions with the Manager of the FCMT that their lack of involvement in the management of ‘difficult’ prisoners is not a deliberate policy. He told me that, in a “reasonable world”, prisoners such as Mr Holt would be actively monitored by the FCMT. However, under current staffing levels, this type of suicide prevention and general management strategy was simply not possible.
- 10.122 I am sure that prison officers would be able to name a number of prisoners in the system who fit this profile and who present management difficulties and absorb management attention quite disproportionate to their numbers. In my view, there is a real need for officers to seek the expertise of the FCMT in managing this category of prisoner at an early stage, even if they do not appear to fit what prison officers might consider a typical “vulnerable” prisoner. Although it would be necessary to provide the FCMT with additional resources to maintain a continuing involvement in the management of prisoners with behavioural problems, there could also be long term cost benefits because the ‘disciplinary’ management of ‘difficult’ prisoners is already extremely resource-intensive.

RECOMMENDATION 10.7

That the Ministry:

- (a) provide sufficient resources to enable the FCMT to provide both crisis care and to become involved in:-
- suicide prevention and harm minimisation strategies and educational and self-help programmes;
 - therapeutic counselling and support to prisoners with behavioural disorders; and
- (b) In recognition of the acute self harm risk of long term prisoners, expedite the introduction of a specific management system for such prisoners to include regular reviews of their health and at risk status and a formalised progressive programme of work, education and rehabilitation.
- (iii) **Absence of relevant risk assessment notes on a prisoner’s medical file**
- 10.123 Darren **Boyle** was discussed at a ‘case management’ meeting a few days before his death because of concerns that he was depressed and may be at risk of self harm but no record of the discussion about his possible future management was made. Obviously, in such circumstances, it is impossible to judge whether his management – or lack of it – was appropriate.

- 10.124 In his review of the circumstances of Malcolm **Inman's** death, the Acting Director Health Services was very critical of the standard of record-keeping, particularly in relation to the lack of SNT notes on Mr Inman's medical file, including significant assessment and management notes and case-notes of weekly "*disturbed & vulnerable*" meetings. As a result, the file contained "*contradictory and uncorroborated information*". In its report on Mr Inman's death, the IIU recommended that medical files of all prisoners identified as at risk should include copies of SNT assessments and the relevant case management meeting decisions relating to disturbed and vulnerable and psychiatric prisoners.
- 10.125 The Coroner stated that:-
- ".....at the time of Mr Inman's death there were deficiencies in the system and I note that the Acting Director of Health Services..... in a report dated 25 April 1996 stated – "Once again the medical records do not contain clear, complete and accurate information regarding assessment and management. This has been the subject of ongoing efforts at remedy. I shall be taking this issue up again collectively and individually with health care staff and SNT.""*
- 10.126 The unavailability of FCMT interview notes to other health staff arose again a year later in the management of Noel **Clarke** and Darren **Osborne** at Casuarina in 1997.
- 10.127 The FCMT member involved with Mr Clarke stated in her report to the then Director, Health Services that she had provided Hospital Officers with a verbal assessment of Mr Clarke. However, she also expressed concern that, as a new employee, she had received inadequate induction and training in accessing prisoner medical records²³. The investigation into Darren Osborne's death revealed that FCMT reports appeared on neither his personal nor medical files.
- 10.128 In his review of the health care provided to Mr Clarke, the Director, Health Services noted his concern that the notes of interview were not placed on the medical file but also pointed out that there had been a reported problem with computer access by members of the FCMT for *three weeks* which the Ministry had failed to address. He indicated his intention to ensure that copies of all records pertaining to a prisoner were placed on the medical file.
- 10.129 Discrepancies in the medical records of deceased prisoners have also been considered in Chapter 5²⁴. As I have commented in some detail in that chapter, *Health Services Policy 3.1* makes the importance of accurate written records unequivocally clear in the statement that "*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***" (my emphasis). It also requires that a prisoner's progress notes should be "*integrated*" (that is, medical, nursing and 'allied' health professionals should all be using the same record).
- 10.130 Regardless of health services 'rules' I would have thought that the making of an accurate record of a consultation is a fundamental part of a health professional's role and that integration of FCMT notes (and notes by other health professionals) on the medical record should *always* occur. I am pleased to note, therefore, that the Ministry has introduced an additional safeguard under the new *ARMS* procedures which provide for the creation and maintenance of a separate 'at risk file' containing all notes, observations and interviews (other than confidential medical notes) which is kept in the prisoner's unit. The file is updated and retained until the *Prisoner Risk Assessment Group* (PRAG) decides that the prisoner is no longer a risk.
- 10.131 As a peripheral comment, having examined the medical files of a number of prisoners, it would not be surprising, in my view, if health staff simply found it too hard to peruse previous clinical notes and information because the hand written notes are frequently almost illegible or indecipherable. Some particularly poor examples were observed.

RECOMMENDATION 10.8

That the Director, Health Services reinforce the importance of an integrated medical record to all Health Services staff through periodic file audits to monitor the standard of record-keeping. Disciplinary action should be considered for repeated failure to maintain comprehensive records and to integrate them with other relevant records.

(iv) Lack of training/orientation for new FCMT staff

- 10.132 It was claimed that one of the reasons for the absence of FCMT notes on Noel **Clarke's** file was the fact that the new FCMT member involved had received minimal orientation and no specific training prior to joining the team.
- 10.133 I am told - and have no reason to doubt - that working in the prison environment presents unique problems which a person new to the system would not have encountered before. I would venture to say that the Ministry's antiquated computer system (the failure of which I note was a factor in Mr Clarke's case) and its "*frequent crashes*" which appear to be "*the cause of much frustration for FCMT staff*"²⁵ would in itself present an unexpected obstacle to psychologists or social workers used to working in the community.
- 10.134 The lack of training available to FCMT members was highlighted by Howells and Hall²⁶ who observed that "*FCMT staff have little time for mutual support, professional development, supervision or training. In addition, FCMT staff report insufficient time to immediately enter reports into the computer.*" Howells and Hall also recommended that a formal induction training programme for all new staff and regular update training events be established and that it may be desirable "*to link training to a local centre for tertiary education. This would enhance the status of the FCMT and ensure the quality and consistency of training inputs.*"
- 10.135 In its review of Mr Clarke's case the Ministry acknowledged that:-
- "Training of (new) FCMT staff has been identified as an issue to be followed up to ensure that new staff are inducted into the system in a systematic planned manner. This is not occurring now and staff are being placed in situations which they have not been adequately trained for."*
- 10.136 I have been advised that FCMT staff are now provided with comprehensive training in a wide range of issues relevant to the management of prisoners. Seminars are provided on a regular basis at Fremantle Hospital and staff are flown to Perth from regional prisons to attend the training sessions.
- 10.137 I fully support the conclusions and recommendation made by Howells and Hall. I also agree with their suggestion of a rotation of duties system so that staff receive some break from "*coal-face work with at risk prisoners*". If this approach enabled the Ministry to retain experienced staff for longer it seems to me that the long term benefits for at risk prisoners and the system as a whole would justify additional expenditure on training and induction programs.

(v) Failure to carry out scheduled reviews and referrals

- 10.138 In a number of deaths, evidence was heard that scheduled reviews of prisoners ordered by prison health professionals (including medical officers, psychiatrists and psychologists) did not take place. This issue arose in the deaths of Messrs Vincent, Hitchcock, Boyle, McMahon, Osborne, and Jackamarra.

- 10.139 In Paul **Vincent's** case, the doctor who saw him on 19 May 1992 recommended that he be reviewed on 27 May but this was not done. The Ministry's investigation file noted that scheduled medical reviews of prisoners were organised at that time by means of a *desk calendar* and included a memo from the Remand Centre health administrator to then Director, Health Services dated 16 June 1992 which referred to the shortage of nursing staff and rising muster levels at the Remand Centre. The administrator went on to say that:-

“Increased workload has put considerable strain on the nursing staff and has jeopardised the standard of nursing care and safe practice to the point that a very serious incident occurred resulting in the death of Prisoner Vincent.....

There have been numerous reports from Prison Health requesting extra assistance with the increasing workload

There is a desperate need for a Clerical Assistant/Prisoner movements Co-ordinator for the duration of the medical parades at the Remand Centre..... A system needs to be put in place to ensure that follow up appointments for prisoners are noted and acted upon..... This position is vital to ensuring that a similar incident will not occur.....

A nurse trying to perform nursing treatments, do clerical work, and look after the medical parade cannot perform any of them safely. The Remand Centre by its very function has an unstable prison environment with a particularly vulnerable prisoner population, and a lot of prisoner movement. The appointment of a clerical officer there, or a Prison Officer undertaking clerical duties (providing it is a dedicated person ensuring continuity) is essential if we are to at least try and ensure a safe level of service.”

- 10.140 A visiting psychiatrist noted on 10 September 1992 that Shane **Hitchcock** was a possible suicide risk and recommended that he have “*frequent follow ups*” and be referred to the SNT. Approximately 4 weeks later, the same psychiatrist expressed his concern that Mr Hitchcock had not been seen by the SNT and said that he would see him again a month later. Although Mr Hitchcock had in fact been seen by a member of the SNT on 7 October, this was because he had been placed in a medical observation cell rather than as a result of the referral. Mr Hitchcock's records indicate that he was not seen again by a psychiatrist until 3 June 1993 after his escape from Wooroloo and his re-arrest. He committed suicide by hanging on 15 June 1993.
- 10.141 In September 1994 a review of Darren **Boyle** ordered by the doctor for four days later did not occur. In this case, the doctor also prescribed medication for anxiety, depression and insomnia but it appears Mr Boyle did not take any of the prescribed medication.²⁷
- 10.142 In September 1995 a member of the SNT recommended that Michael **McMahon** be reviewed a week later. Although he was seen by a visiting psychiatrist later that month, the review ordered by the member of the SNT did not take place and his records show that the SNT did not see him again until 5 April 1996 (two days before his death) following his placement in a multi-purpose cell.
- 10.143 A note on the medical file dated 1 July 1997 by the prison doctor to refer Darren **Osborne** to the psychiatrist “*for further advice*” was not acted upon nor was a note by the Forensic Liaison Community Nurse from Graylands to see him the following week. He was not seen by the FCMT in the four months prior to his death. John **Jackamarra** was recommended for further counselling by the FCMT but this does not appear to have been acted upon.

- 10.144 Although it is not suggested in the IIU investigation reports or inquests of any of the above cases that the absence of a scheduled review contributed to, or might have prevented, the deaths of the prisoners, the failure to initiate and carry out such a simple administrative instruction – which may have resulted in a prisoner being managed differently or in specific action which may have reduced the risk of suicide – clearly casts some doubt on the standard of care in each case. Such an omission would not be acceptable in the community and should not be condoned in the prison environment.
- 10.145 Having said that, I suspect that the administrative omissions can be attributed at least in part to the heavy workload of the majority of prison health professionals and I am inclined to agree with the views of the Health Administrator in his memo of 16 June 1992 regarding the death of Paul Vincent that the appointment of a health centre clerical assistant would be a cost-efficient and effective means of reducing this problem. It was, however, not until comparatively recently that steps were taken to employ additional staff for this purpose. Currently, there are clerical assistant/medical records officers at all prisons except Nyandi, Pardelup, Riverbank and Wooroloo.

(vi) Lack of psychiatric services for prisoners

- 10.146 In his comments at the inquest into the death of Russell **Gibson** who committed suicide at the Remand Centre in October 1992, the Coroner recommended that:-

“.....interim arrangements be introduced so that a psychiatrist in private practice is made available...to assess and treat all prisoners recognised as being “at risk” of self harm. Whilst such an arrangement may be expensive and will not prevent suicides in custody it should reduce the risk of such incidents and more properly satisfy the common law duty of care owed by the State to prisoners, particularly remand prisoners who have not been convicted of charges.”

- 10.147 The rationale for the Coroner’s recommendation about the need for psychiatric services appears to be his concerns about the expertise of the psychologist who assessed Mr Gibson. However, I have been told by the Ministry’s senior psychiatrist that, clinically, the majority of prisoners who commit suicide could not be classified as having a psychiatric disorder.
- 10.148 In her study of suicides in UK prisons, Dr Liebling found *“Importantly, there is little evidence to link prison suicides with depressive illness.”*²⁸ She also found that:-

*“Prison suicides may be slightly more likely than the general prison population to have received in-patient psychiatric treatment. They are far less likely than the general population of suicides to have a history of depressive illness and/or psychiatric treatment, however. Virtually all suicides in the community are found to have a history of depression and psychiatric treatment. This is true of only a third of all prison suicides. Other factors than those normally associated with suicides in the community may therefore play a part.”*²⁹

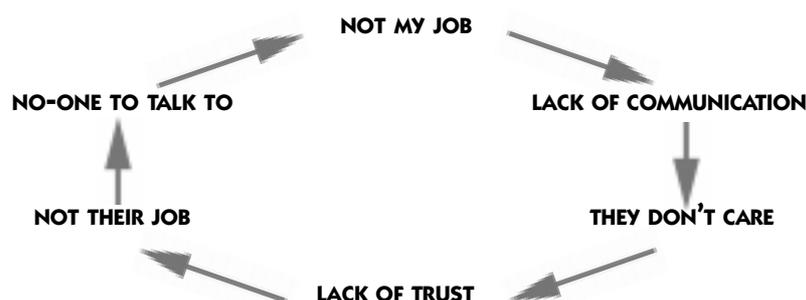
- 10.149 Nevertheless, there is clearly a need to provide formal and regular psychiatric services to those prisoners who have been diagnosed as having a condition which, in the community, would result in their receiving psychiatric assessment, treatment and, if necessary, placement in a psychiatric facility such as Graylands Hospital. This issue was discussed at length at the inaugural meeting of the JJ/HIDC on 1 August 1994. The Agenda for this meeting states:-

“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 disorder are being managed within the prison system, major difficulties are being experienced with the preparation of pre-sentence reports including lengthy delays when these are being completed.”

- 10.150 Supporting information for this agenda item states that there were at that time three sessions per week in the metropolitan area (although the Ministry had assessed its need as seven sessions per week) for purposes of assessment and treatment and that there was no service at Greenough. Concern was also expressed at the scheduling of the three sessions late in the day because the timing had “*serious adverse operational consequences*” exacerbated by the 12-hour shift arrangement.
- 10.151 On 30 October 1995 the Ministry obtained from HDWA the services of a senior consultant psychiatrist. Although still employed by the HDWA, the Ministry paid for the 80% of his time spent in providing psychiatric consultations to prisoners. However, the agenda of the meeting of JJHIDC on 22 March 1996 still drew attention to the inadequacy of prison psychiatric services with the statement that:-
- “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.”*
- 10.152 At that time general psychiatric care in the metropolitan area was provided exclusively by this psychiatrist, with private specialists based in Albany and Bunbury providing one session per fortnight at those prisons. A psychiatric service is now available at all the metropolitan prisons and at most of the regional prisons.³⁰

Summary of conclusions on the operations and resourcing of the FCMT

- 10.153 It is quite clear from my observations and comments received during the course of my inquiry that the pressure on FCMT members to deal with crisis situations is intense and unrelenting - with the result that they have little or no opportunity to become actively involved in suicide prevention strategies and harm minimisation programs. It is also quite clear that similar concerns were raised some years ago following the investigation of the suicides of a number of prisoners between 1991 and 1996.
- 10.154 It seems to me that the disparity between staffing levels of the FCMT and its workload has come about for two reasons. First, some prison officers saw – and I believe still see to some degree - at risk crisis management as principally the function of health staff and tend to involve the FCMT before or instead of becoming involved themselves. Second, the more this approach is used, inevitably, some prison officers will become genuinely de-sensitised to the outward signs that a prisoner is under stress or not coping, again increasing the workload of the FCMT.
- 10.155 I accept that on occasions, prison officers may be left out of the picture by health staff⁵¹ and that many prisoners do not feel comfortable confiding in uniformed prison officers with whom their contact is primarily related to security, control or discipline. Nevertheless, in my view, unless all prison officers accept that it is a clear part of their function to communicate with prisoners a ‘vicious’ circle could arise - which may be depicted on the following lines –



The result is a gap in the system through which distressed prisoners can and do fall, particularly if the FCMT is exclusively used to deal with daily crises.

- 10.156 The re-emphasis (through *ARMS*) of the global responsibility and ownership of the assessment and management of at risk prisoners by the *whole* prison community and its introduction of the new PRAG system are encouraging measures aimed at modifying the ‘medical model’ which should, if operated as intended, be of benefit to both prisoners and prison officers. In this regard, the Ministry stated in its review of Sean Hayes’ death:-

“The recently introduced (November 1998) Prisoner Risk Assessment Group (PRAG) system will address the concerns regarding the lack of a planned, systematic intervention process for those at risk of self harm. The PRAG system will assist in reducing the likelihood of deaths in custody by involving relevant staff in the decision making relating to a comprehensive individual management plan that will define strategies, stages for managing at risk behaviours and opening and closure of at risk files.

PRAG will enable the FCMT staff to concentrate their interventions on those with severe personality and depressive problems, organic brain disorders and other associated high risk diagnoses with prison officers providing the basic support role.”

- 10.157 In order to be effective, however, the new system must be accompanied by a global acceptance of the view that prevention of the stressors that can lead to suicide and self harm is as important as appropriate management of the crisis when it occurs and a significant increase in the resources of the FCMT to enable it to become much more involved in performing this function. This should include the maintenance of rostered FCMT members (and Prisoner Support Officers) on site at the weekends in preference to the current situation where they are on-call. In my view the lack of on duty FCMT staff at the weekend (when prisoners are not involved in work or education) is a missed opportunity for the Ministry to establish harm minimisation and self-help programmes for disturbed and vulnerable prisoners, with long term benefits for both prisoners and the prison system.

RECOMMENDATION 10.9³²

That the Ministry provide funding and resources to facilitate routine weekend coverage at the metropolitan prisons (ie Casuarina, the Hakea complex and Bandyup) by the FCMT and Prisoner Support Officers.

PLACEMENT OPTIONS

(i) Inappropriate placement of first time remand prisoners

- 10.158 It is a widely accepted principle that remand prisoners, who represent the highest risk group, should not be placed in an institution with sentenced prisoners unless they request it (for example, to be with a friend or relative for support or protection). The placement of remand prisoners in a separate institution is confirmed by Rule 8(b) of United Nations *Standard Minimum Rules for the Treatment of Prisoners*³³. Guideline 5.17 of *Standard Guidelines for Corrections in Australia* provides that “*Where practicable remand prisoners must not be put in contact with convicted prisoners against their will.*”
- 10.159 In the case of Carl **Jackson**, a first time remand prisoner in Casuarina, in 1996 the IIU report recommended that “*All prisoners being received into prison for the first time to be placed at one prison i.e. C W Campbell Remand Centre where specially qualified uniform and support staff will identify and assess their specific needs.*”

- 10.160 Although the proposal was approved in principle, reservations were voiced on the grounds that remandees are also received at the regional prisons and that the Remand Centre was already at peak muster levels. Doubt was also cast on a proposal to make Canning Vale the remand prison because, with a capacity of 317, there was not the demand for that number of remand places. I note that on 30 June 1996 there were 189 male and 15 female prisoners on remand in metropolitan prisons (158 at Canning Vale).
- 10.161 Despite ‘in principle’ approval in 1996 to this recommendation (and the knowledge that failure to separate sentenced and remand prisoners breached United Nations codes), no further action was taken until mid-1998 with the proposal for the building of a dedicated Receiving and Assessment Prison on the Canning Vale site. The Ministry advised me in March 1999 that the practice of keeping all first-time remandees in one prison is not yet taking place but will be addressed with the commissioning of the planned Receiving and Assessment Prison at Canning Vale in late 2000.
- 10.162 Two of the prisoners who have died since January 1996 were first time remandees not held in the Remand Centre - Wesley **Doorey** at Casuarina in 1997 and Neil **Holt** at Canning Vale in 1998. Martin **Hayes**, also a first time remandee, died in Casuarina on 13 June 1995. The point which was also emphasised by the IIU in its report of the investigation of Mr Jackson’s death was that there were “*specialty qualified uniform and support staff*” at the Remand Centre who were available to assist at risk remand prisoners. In this regard, I am also aware that units at the Remand Centre are manned 24 hours a day whereas most units at Casuarina Prison are not staffed at night because of staffing levels at the prison.
- 10.163 According to figures provided to me in September 1998, there were at that time 24 first time remandees at Casuarina Prison and nine at Canning Vale. The total number of male remand prisoners in the metropolitan prisons on 20 August 1998 was 224 – of which 72 were held at Casuarina - plus 34 female prisoners at Bandyup. The Smith Report criticised the Ministry’s continuation of the placement of remand prisoners with sentenced prisoners and noted that on the day of the riot 67 of the 529 prisoners held in Casuarina were remandees.
- 10.164 By 30 June 1999 there were 288 male remand prisoners (29 at Casuarina) and 36 females in the metropolitan prisons. As at 29 June 2000 there were 355 males (290 at the Remand Centre; 41 at Hakea and 14 at Casuarina) and 34 female remands. In the four years since the recommendation made following Mr Jackson’s death the number of both male and female remandees has almost doubled and the number held at Hakea and the Remand Centre on 29 June 2000 was 331. From the current numbers of remand prisoners, it seems to me that the projected number of remand prisoners on which the new remand prison proposed in 1996 was based was remarkably accurate. In my view it is unfortunate that the Ministry did not take action sooner.
- 10.165 Although most remand prisoners are now housed separately, their continued placement in an institution with sentenced prisoners is of concern for two reasons. First, the Ministry’s practice of holding remand and sentenced prisoners in the same facility was in breach of international and national standards in 1996. Second it continues to be so for female prisoners - there are now 40 female remandees in Bandyup - because no action was taken to remedy the situation in spite of in principle acceptance of the 1996 recommendation (following Carl Jackson’s death).

RECOMMENDATION 10.10

That the Ministry as a matter of priority provide separate facilities for female remand prisoners.

(ii) 'Doubling-up'

10.166 The issue of 'doubling-up' – sharing a cell with another chosen prisoner who could provide support after lockup - arose in the cases of Darren **Boyle** and Ryan **Kennedy**, both of whom committed suicide within a few days in September 1994 at the Remand Centre.

10.167 In the week prior to his death, Mr Boyle had been doubled up with another prisoner for four days at the direction of a member of the SNT. His request to be doubled up for a further night was refused (without reference to the SNT) by a prison officer, apparently on the ground that written authorisation to be doubled-up was only for one night, even though it was clear that Mr Boyle had already been doubled up for four nights by that time.

10.168 In commenting on issues arising from Mr Boyle's death, the then Manager of the SNT advised the Director of Prison Operations in November 1995:-

“At times, doubling up is viewed by some prison officers with great suspicion and the view seems to be unless there are very good reasons for prisoners requesting this then it should not happen. It should in fact be viewed as unless there are very good reasons not to double prisoners who request this, then it ought to be supported as it provides a source of support for prisoners.”

10.169 Mr Kennedy was doubled-up with another prisoner, W, on the night of his death. It was believed at the time that W was asleep as a result of taking medication for drug withdrawal and was not aware of Mr Kennedy's suicide. The IJU report recommended that *“The procedure in place for the 'doubling up' of prisoners be reviewed to ensure that the 'doubling up' will provide support for the 'at risk' prisoner.”* W was, however, subsequently convicted of assisting Mr Kennedy to commit suicide in spite of the argument in his defence that W was himself undergoing an emotional crisis and was not equipped to support another prisoner. That argument is not altogether inconsistent with the IJU recommendation regarding the suitability of 'cell-mates'.

10.170 I am not aware of any modification to procedures in response to the IJU's recommendations in Mr Kennedy's case and a similar issue regarding the suitability of the chosen 'cell-mate' arose in the course of the investigation into the death of Sean **Hayes** at the Remand Centre in 1997.

10.171 Mr Hayes had requested to be doubled-up with a younger man, B, a first time prisoner who had been admitted only two weeks previously. Mr Hayes had been assessed as at risk on admission and had apparently threatened to harm himself because of problems with his girlfriend. It is reported that B had *“told him not to do it, changed the subject and tried to calm him down”* and had refused to assist in any way, saying *“he wanted nothing like that on his conscience”*. B did not, however, tell prison officers of his conversations with Mr Hayes. The Coroner recommended that *“prisoners asked to share a 'double-up' cell with an 'at risk' prisoner be given advice (preferably written) as to what action to take in the event of the 'at risk' prisoner talking of suicide or self harm.”*

10.172 In the Ministry's management review of Mr Hayes' case (in November 1998) concern was expressed that B did not seek assistance for Mr Hayes. The management review also noted however:-

“Mr B was placed in a difficult complex situation, which required him to consider the psychological needs of his cellmate as well as his own needs.....”

Mr B would most probably at his receipt into the prison not have received any information regarding what to do in times of crisis of self or fellow prisoners, his orientation would have concentrated upon the more pragmatic issues. When considering cellmates for at risk purposes at this time there was also no formal system of assessing a proposed cell mate's capacity to support another person psychologically and emotionally."

In addition, it stated that there was no standardised, comprehensive orientation programme available within the prison system.

- 10.173 The management review included comments on several 'crisis management' strategies including *ARMS*; improving visits and access to telephone calls; the new Receipt and Admissions Prison at Canning Vale; generic standards of induction and orientation; advice to prisoners on what to do if other prisoners threaten self-harm; revision of procedures for checking prisoners after lockup; review of emergency procedures and improvement of management storage of telephone call records.
- 10.174 The Ministry has advised me in the course of this inquiry that, because of current high musters, doubling-up is a routine necessity rather than a management strategy for at risk prisoners. Although I believe that, as far as possible, prisoners are doubled-up with a peer support prisoner, a family member or known acquaintance after seeking the advice of the Prisoner Risk Assessment Group (PRAG) - which includes FCMT staff - pressure on bed space will inevitably reduce the effectiveness of appropriate doubling-up as a strategy in the management and care of at risk and vulnerable prisoners.
- 10.175 In addition, it is essential that peer support prisoners are provided with the necessary training to enable them to properly assist a vulnerable prisoner. In my view all peer support prisoners should receive appropriate and ongoing training but it is particularly important if the Ministry is, in effect, delegating aspects of its duty of care after lockup to a prisoner. I also believe that peer support prisoners should receive a gratuity in recognition of their work with other prisoners.³⁴
- 10.176 I appreciate that prisoners are usually asked first if there is a family member or friend with whom they would like to be doubled-up. However, for those prisoners without family or friends in the prison, it may be necessary for the Ministry to consider establishing a group of prisoners – such as the peer support group - who are considered to be suitable to provide some support to a distressed or vulnerable prisoner. This is an important role and, in my opinion, no prisoner should be asked to "double-up" with another prisoner who is regarded as 'at risk' of self harm or suicide unless he/she has:-
- been informed that the prisoner has been assessed as being at risk of self harm and expressly consents to be 'doubled-up'; and
 - has been expressly assessed by the Ministry as suitable to undertake the task.
- 10.177 The Ministry has advised me that it is currently undertaking modifications to *ARMS* to incorporate issues relating to selection of, and advice to, potential 'buddies' for at risk prisoners. It has argued that confidentiality issues are raised in connection with what a prisoner can be told about another prisoner's at risk assessment. Consequently, a prisoner who is doubled up with a prisoner assessed as being at risk will be told only that the other prisoner is "*experiencing some difficulties*". If this means that one prisoner can be asked to provide support for another prisoner without knowing the nature and extent of the risk, then, in my opinion, that is quite unsatisfactory.

RECOMMENDATION 10.11

That the Ministry:-

- (a) evaluate doubling-up procedures to ensure the placement of at risk prisoners only with prisoners considered suitable and sufficiently skilled to be able to offer support; and
- (b) ensure that the support prisoner is made aware of the nature and extent of the assessed risk presented by the prisoner he or she is meant to be assisting and consents to the doubling-up.

(iii) Lack of therapeutically suitable facilities for acute or chronic ‘at risk’³⁵ prisoners

10.178 Although there has been no specific criticism of the placement of a prisoner in a medical observation cell in investigations of any death by the IIU or the Coroner, the “*absence of a therapeutically orientated clinical psychology service and a suitable facility for placement of disturbed and vulnerable prisoners which avoids isolation and offers ongoing socialisation and support*” was raised by both the Acting Director and the then Manager, Health Services in their comments on the care of Malcolm Inman following his death. Implicitly it was an issue in the deaths of Messrs Rawlings, Hayes and Doorey, all of whom were considered chronically at risk, ie at risk over an extended period of time.

10.179 Comments in the files of Mr **Rawlings** show that he was considered to present an “*extreme degree of suicide risk*”. He had frequent contact with the SNT, was seen several times by a psychiatrist and had numerous placements in medical observation. It appears that placement in Graylands was not an option and a member of the SNT advised the Assistant Superintendent Prisoner Management in January 1996 that:-

“While placement in observation cell may not be assisting his mental state, the extreme degree of suicide risk dictates against any other placement unless prison staff can guarantee close “line of sight” supervision. Given that this is unrealistic he should remain in the observation cell pending further review.....”

10.180 The Ministry has told me that:-

“Prisoners who are deemed to be acutely suicidal [those exhibiting the sudden onset of suicidal ‘ideation’] may be placed in a medical observation cell, a buddy cell, and two-out accommodation or indeed transferred to Frankland Unit at Graylands. Wherever, they will initially be seen by a member of the Forensic Case Management Team and a suitable management plan devised.

Those who are deemed chronically at risk [longer term risk of self harm extending over a period of time].....whilst not being placed in medical observation are afforded the same management options as above. While a prisoner continues to be assessed as suicidal they are managed in a therapeutic manner.

The Ministry has made significant moves to increase the availability of therapeutically suitable facilities for acute at risk prisoners. There is a Crisis Care at Casuarina and a similar unit at Hakea is due to come on stream in November 2000. A similar unit has also been included in the upgrade redevelopment at Bandyup.”

- 10.181 Although there are crisis care facilities at Casuarina and Hakea - and such accommodation will be available at Acacia and Bandyup - from the Ministry's response to my draft Report, it is quite clear that those facilities are also intended to provide accommodation for prisoners suffering the effects of withdrawal from drugs and possibly also for psychiatrically disturbed prisoners. Moreover, there are no such facilities at any of the regional prisons. Placement options for acute or chronic at risk prisoners at those prisons remain the same as previously – a shared cell in a mainstream unit or a medical observation cell. Since growing musters have effectively removed the 'buddy cell' option³⁶ placement in a medical observation cell is a much more likely occurrence for acute at risk prisoners – at most prisons.
- 10.182 If the options for “*extreme*” at risk prisoners are placement in a medical observation cell or constant “*line of sight*” supervision by prison officers - as suggested in Mr Rawlings' case - it is perhaps not surprising that officers opt for placement in a medical observation cell which may well prevent the prisoner from self-harming on *that* occasion. It does not, however, ensure that the vulnerable and disturbed prisoner will not commit suicide on another occasion if the **cause** of his/her suicidal tendencies is not addressed. The regimes under which prisoners were - and are - held in medical observation are so disliked by prisoners that, by the time of my inquiry, I was told openly by prisoners, prison officers, health staff and others that prisoners preferred not to reveal their anxieties rather than risk being “*sent to medical obs*”.

Medical Observation Cells

- 10.183 All submissions to my inquiry and comments in interviews from prisoners, health staff, some prison officers and prisoner rights groups have condemned the use of isolation in a medical observation cell - also known as 'strip cells' because every possible means of self harm has been removed – for vulnerable and disturbed prisoners.
- 10.184 The RCIADIC recommended at **Recommendation 181** “*That Corrective Services should recognise that it is undesirable in the highest degree that an Aboriginal prisoner should be placed in segregation or isolated detention.....*”
- 10.185 Submissions to my inquiry criticised the use of mechanical restraints on prisoners in a medical observation cell and the lack of special training of officers on duty in that area. Prison and health services staff and prisoner rights groups told me that medical observation cells:-
- are inappropriate for suicidal prisoners;
 - are degrading, boring and intimidating;
 - cause sensory deprivation;
 - are seen as punishment;
 - engender feelings of anger and rage;
 - have no therapeutic benefit if observation by officers is merely 'watching' without interaction;
 - prevent suicide in the short term but do not address the underlying causes;
 - are over-used;
 - increase distress; and
 - discourage prisoners from revealing fears and anxieties.
- 10.186 Prisoners have described the experience of being placed in a medical observation cell as 'torture', boring, punishment and sometimes a reminder of past traumas. They are generally ignored and have no-one to talk to. Specific complaints from prisoners who have been confined in an observation cell include:-

- removal to an observation cell without explanation ‘in the middle of the night’;
- verbal abuse by officers during removal to, and confinement in, an observation cell;
- being stripped of clothing and manacled to a ‘restraint bed’ with hands secured above the head;
- being left manacled in this way for two days without water and without use of toilet facilities;
- placement in a body belt while in observation;
- clothing being cut away while being restrained in observation;
- restrained in the ‘foetal’ position;
- forced administration of sedative injections;
- physical restraint by officers as a result of an adverse reaction to forcible removal to an observation cell;
- charges while in observation for using abusive and insulting language; and
- placement in observation for two days over the weekend.

10.187 The Ministry has confirmed the use of the range of restraints alleged in the above complaints; that at least one prisoner has been left without clothing while restrained on the restraint bed; and that placement in medical observation because of an identified acute and immediate risk of self harm does not mean that a prisoner’s behaviour will not be subject to the same disciplinary sanctions as are applied to a ‘normal’ prisoner in a normal unit. From my own enquiries, I am satisfied that prisoners are frequently merely ‘observed’ with little positive interaction with officers.

The detrimental effect of isolation/solitude – the literature

10.188 The detrimental effect of long term placement in the sensory deprived environment of a medical observation cell is almost universally acknowledged. In this regard, it should be noted that the definition of ‘long term’ placement in the community setting is measured in minutes rather than hours and certainly not ‘days’. In the prison setting it is not unusual for a prisoner to be kept in observation for several days, particularly if there is shortage of beds in mainstream.

10.189 I have tried for the sake of balance to find an opinion which supports the use and configuration of medical observation cells - but have been unsuccessful. The consensus of international opinion is that isolation of at risk prisoners may remove the immediate means of suicide but will not assist to remove the underlying distress and may well cause a significant deterioration in a prisoner’s wellbeing and ‘safety’. Examples of the universal condemnation of medical observation cells and their inability to provide anything other than a temporary removal of the opportunity to self harm include:-

- *A woman was locked up alone...they told me she was bent on committing suicide. If anything could strengthen her in her resolution it would certainly have been the unsupportable monotony of such an existence.*
(*American Notes* 1842, Charles Dickens)
- *Solitude, let me repeat, does not reform men,...experience has proved this; it makes him insane or furious or brutal or else it pushes him to suicide via despair.*
(The French Inspector of Prisons in 1853 ³⁷)
- *Nothing is more dehumanising than isolation from human companionship.*
(Nelson Mandela, *Long Walk to Freedom*)
- *For the suicidal inmate, observation was useless, not even an effective situational deterrent. What they needed was treatment, counselling, support and the resolution of particular problems. Staff felt they did not have the time, nor the training to provide such support.*
(Dr Alison Liebling *Suicides in Prison* at page 241)

- *Strip cells are inhumane and an ineffective method of suicide prevention which future generations of psychiatrists will look back on with shame.* (Seclusion in Strip Cells, BMJ 1993 307; Liebling and Hall)
- the treatment of “mentally disturbed or violent patients [prisoners]” should be through:-
 - “close supervision and nursing support, combined, if considered appropriate, with sedatives. Resort to instruments of physical restraint shall only very rarely be justified and always be either expressly ordered by a medical doctor or immediately brought to the attention of such a doctor with a view to seeking his approval. Instruments of physical restraint should be removed at the earliest possible opportunity.” (The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 3rd General Report 1/1/91-31/12/92)
-solitary confinement of a mentally ill prisoner and the recourse to means of restraint can be considered as acceptable only if the treatment of such a prisoner is under the entire and sole responsibility of medical personnel. (The European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 1990 report to the Danish Government)
- *the tendency to equate reduction of risk with the elimination of opportunities” is a “fatal design error.....Preventive Design must relieve distress as well as reduce opportunity.* (Research paper by Dr Joseph Reser “Design of Safe and Humane Cells” referred to by the RCIADIC)
- *The principle of nursing suicidal prisoners and detainees is supportive human contact. A prisoner or detainee should not be put into seclusion solely on account of their suicidal ideation.*
 -solitary confinement is medically harmful as it may lead to a number of physical and/or mental disorders. (The AMA Position Paper on Health Care for Prisoners and Detainees 1998)
-new authoritative research suggests that stripping cells of all amenities contributes to a suicidal person’s thoughts of loneliness, isolation, marginalisation and hopelessness. In audit opinion, it is difficult to imagine why any prisoner would voluntarily alert staff to their intention to attempt suicide or inflict self harm if the final outcome was for the prisoner to be placed in an observation cell. (Victorian Auditor General Victoria’s Prisons: Community Protection and Prisoner Welfare; May 1999; Part 8: Servicing Delivery Outcomes; page 38)
- *One can only conclude that the desire to prevent the prisoner from killing himself or herself at all costs and so to keep the statistics down overrides any desire to work out what is precipitating this need to or wish to die, or to deal with that actual problem....* (Uniting Church in Australia to the Taskforce set up to look at deaths in Victorian prisons)
- ...the Taskforce is convinced that isolation of suicidal prisoners is an unacceptable practice.
 -There is no doubt that there is pressure on staff to act in an overly defensive way in order to take all reasonable measures to prevent suicide. This has the unfortunate consequence of lowering the threshold for the use of isolation cells.”
 -a culture of blame appears to be an obstruction in the search for more effective, therapeutic treatment. (The Kirby Report of that inquiry at page 117)
- ...all observation cells in the major metropolitan prisons are isolated and isolating and are thus likely to have deleterious effects on the mental health of anyone placed in them. We identify the following major concerns regarding the use of medical observation:-

Prisoners are confused and unclear as to whether they are being treated or punished when they are placed in an observation cell.

The environment itself is hostile, often housing prisoners who are acting out, with officers consequently being required to exert physical control.

The presence of prisoners undergoing punishment results in an atmosphere which is punitive and coercive rather than therapeutic.³⁸

The cells in these prison are located at some distance from the medical and FCMT staff who should be providing regular input.

Medical observation is an extremely isolating experience which can only exacerbate the level of distress and suicidal rumination.” (The Howells and Hall Report at page 33)

- *The use of unfurnished or protected accommodation is inappropriate for suicidal prisoners. It takes away the prisoner's dignity and control, and is often felt to be punitive. The trust of prisoners in staff will be undermined. They will be less likely to admit to distress in future, and may even see suicide as a way of reasserting control of their destiny.* (Ministry of Justice ARMS Implementation Manual Introduction, page 7)

- 10.190 The European Committee recommended that where an ‘ill’ prisoner was held in solitary confinement, a medical doctor should immediately carry out a medical examination and report on the prisoner’s physical and mental condition and the likely effects of prolonged isolation.
- 10.191 *Australian Standard Guidelines for Corrections* (1996) contain little which could be said to apply to suicide prevention strategies other than 5.70 in the section on *Health Services* which provides that “*Prisoners isolated for health reasons should be afforded all rights and privileges which are accorded to other prisoners so long as such rights and privileges do not jeopardise the health of others.*”
- 10.192 If this refers to prisoners in medical observation cells, then I would suggest that current regimes in some prisons which deprive a prisoner of normal clothing, the opportunity to socialise and almost every means of ‘entertainment’ (TV, radio, books, writing materials) would be in breach of this guideline.³⁹ I also note that *Guideline 5.33* in the section on *Discipline and Punishment* provides that “*sensory deprivation... must not be used*” as a form of discipline or punishment.
- 10.193 As part of my inquiry, I inspected rooms used for observation at the Frankland Centre at Graylands Hospital and discussed with staff of the Centre their methods of dealing with prisoners/patients for whom a period of confinement under medical observation is considered necessary – which might include a risk of suicide. Importantly, at the Frankland Centre, placement in an observation room is used as a last resort for a disturbed patient or prisoner. The length of time a person may be confined in such a room is usually a matter of minutes but if it is considered necessary to continue the confinement for more than two hours, then authority to do so must be given by a medical practitioner. Mechanical restraints are never used and the administration of any medication (such as a sedative) must also be authorised by a medical practitioner.

- 10.194 The Ministry has pointed out that patients in observation rooms in the Frankland Centre are frequently heavily sedated and that there is a medical practitioner on duty at all times and that “...prisoners can be transferred to the Frankland Centre from prison, and there is no need to duplicate the facility. However while applying and arranging for an acute disturbed prisoner to be transferred to Graylands, it is often necessary to place that prisoner in a medical observation cell.” These are valid comments but the point of the comparison I made is to emphasise that the observation rooms are considered a last resort; and that they are used for very short periods of time. An additional comparison which I could use – also from personal observation – is with the operation of observation cells at the juvenile facilities at both Banksia Hill and Rangeview where detainees placed in those areas are not only able to converse with, but are constantly ‘observed’ by, a staff member. At both the Frankland Centre and in the juvenile facilities, ‘observation’ involves a large measure of interaction with other persons.
- 10.195 It seems to me that if the use of observation cells is *wholly* based on a perceived risk of self harm and the wellbeing of the prisoner, rather than confinement for any other reason, then the model adopted by the staff of the Frankland Centre or at juvenile detention centres would be more appropriate.

Isolation=punishment

- 10.196 On the basis of what appears to be the hierarchy of legislative provisions governing the confinement in, and removal of prisoners from, observation cells and the operational procedures for the management of prisoners while so confined, it seems to me that there may be some confusion and blurring of the purpose of confinement in observation cells and the way in which prisoners subjected to this regime should be treated.
- 10.197 DGR 3B - “*Identification and Management of Prisoners with self harm risk*” - is cross-referenced to sections 27,43 and 41 of the *Prisons Act*, which relate to removal for medical treatment, separate confinement and search of prisoners; and to Regulations 26 and 29 which provide for the procedure when a prisoner is suspected of being under the influence of or in possession of alcohol or drugs and the admissibility of breath tests.
- 10.198 The use of mechanical restraints and the removal of a prisoner’s usual access to amenities and entertainment reinforces the perception of punishment with the inevitable consequence that prisoners, at very least, *believe* that they are being punished. The allegations by prisoners outlined above also seem to illustrate that prison officers may have similar views of, or be confused about, the purpose of placement in observation cells. Such a view would not be discouraged by the location of observation cells adjacent to punishment cells in most prisons. I have no doubt that many prisoners prefer to ‘suffer in silence’ than to reveal fears and anxieties which may cause them to be ‘sent to medical obs’.
- 10.199 The following two case studies of complaints received by my Office in the last two years illustrate how placement in a medical observation cell should not, in my view, be used.

Case Study 1

*A prisoner in Casuarina serving a life sentence is from a non-English speaking background and has no outside support in Western Australia. He made a serious and almost successful suicide attempt shortly after being sentenced and was assessed as an acute risk of self harm at times of increased stress - such as when he lodged an appeal against his sentence. For this reason the FCMT recommended that he be placed in a medical observation cell **after** his return from court although his file notes that placement in a medical observation cell could be detrimental to his welfare.*

*Prison administrative staff decided that he should be placed in observation **before** his court appearance and removed him from his cell at night after lock up without warning. He was given no explanation for his removal to medical observation either at the time or subsequently. The morning after his placement in medical observation he did not receive his usual medication, again without proper explanation. When he became agitated and upset and verbally abused the officer in charge he was charged with the prison offence of using abusive and threatening language. He was seen later that morning by the Director Health Services who recommended that he be released from observation during the day to socialise with other prisoners. However, this recommendation was not acted upon until several hours later and only after he had also been seen by the Manager of the FCMT.*

The Superintendent decided that the charge should be heard by the visiting justice although it was a minor prison offence. The prisoner was subsequently sentenced to 7 days' solitary confinement.

Case Study 2

An Aboriginal remand prisoner in Casuarina, received news of his mother's death – only five weeks after the death of his father. Later that morning he was refused access to the telephone and became involved in an altercation with a prison officer who, he alleged, racially abused him. He reacted aggressively and was subsequently removed to a punishment cell by a group of officers, having been restrained with handcuffs and rope hobbles. Medical records and photographs show that he sustained severe injuries to his ankles from the hobbles. While confined he attempted to hang himself using a strip from his prison uniform.

As a result he was removed to a medical observation cell where he made a further attempt on his life using a strip of the 'untearable' mattress cover. As a result of this attempt he was placed in a body belt but made a further suicide attempt when the restraints were removed. His clothing was then removed and he was placed on a restraint bed secured at the ankles and with his hands tied above his head. He was sedated and left without clothing, food, fluids or access to toilet facilities overnight.

He was seen the next morning by the Manager of the FCMT who 'negotiated' with prison officers to remove one arm at a time to restore circulation and movement to his arms. Prison records show that, because of his continuing aggression and agitation, he remained in some form of restraint for 34 of the 45 hours he was confined in an observation cell. He was seen by medical staff and by members of the FCMT who recommended that his management should be directed "primarily at counselling and careful improvement of his restrictions while clarifying his chance of getting to his mother's funeral".

- 10.200 It seems to me that the management techniques in both these cases produced no therapeutic results – either short or long term - for the prisoners. In fact, viewed objectively, their level of "current distress" could only be seen as worse given that one was charged with a prison offence while supposedly being therapeutically observed and was sentenced to a period of solitary confinement; and the other was held in restraints for 35 hours (having sustained physical injuries during his removal to a punishment cell) but received no grief counselling for the death of his mother. In this regard it seems to me that the spirit of **RCIADIC Recommendation 163** has not been fully implemented.
- 10.201 It is of some concern that in spite of the universal condemnation of the use of medical observation cells and the unanimous opinion that they do not alleviate the symptoms of distress felt by a suicidal prisoner but merely ensure that he or she does not self harm – *this time* - the Ministry not only continues to use observation cells for suicidal prisoners but had not seriously considered or developed more therapeutically orientated management options (such as the Casuarina Crisis Care Unit) until comparatively recently.⁴⁰
- 10.202 Because of my concerns about the wholly inappropriate use of observation cells, in September 1998 I recommended that the Ministry "give immediate consideration to the discontinuation of confinement of at risk prisoners in observation cells at Casuarina specifically but also at other prisons". The Ministry advised me in May 1999 that "this is not a practicable proposition" but that "the management of at risk prisoners is aimed at ensuring that when observation cells are used it will be for the shortest period possible and as a measure of last resort." However, I note that an inspection of Bunbury Regional Prison conducted by the Ministry's Custodial Services Inspections Project between 25 and 30 July 1999 stated:-

*“The two observation cells were bare, unfurnished and bereft of any atmosphere conducive to care. They contained no bed, prisoners slept on a thin tear proof mattress which lay on a concrete platform. Prisoners held in the observation cells wore special tear proof clothing.....Monitoring was by way of closed-circuit television (CCTV), which enabled the prisoner to be observed by staff in the maximum-security staff office. The signal was also relayed to the front gate area, which allowed for surveillance at night. If prisoners need constant observation then this should be provided in person. We did not feel that the current arrangements were sufficient. We were also concerned that vulnerable prisoners, sometimes needing protection, were placed in the same unit as prisoners undergoing punishment and restricted supervision regimes. We were aware of the planned building of a new health care centre within the prison, we support these plans. Such a centre should contain appropriate accommodation to deal with prisoners felt to be at risk of suicide. **The practice of placing such prisoners in bare observation cells should cease and alternative ways of dealing with those at risk of suicide developed.**” (my emphasis) (paragraph 2.21)*

- 10.203 The Report of the inspection of Wooroloo conducted in August 1999 focussed on the “.....*blurred policy and the lack of different regimes between “Observation” and “Punishment” cells...*”. In particular, the inspection team was concerned about the emphasis of the local orders which “*prescribed the use of these cells for observation and/ or punishment and security purposes but the regimen referred only to punishment.*” The team found that prisoners who had been segregated as punishment for a prison offence and those who had been isolated because they had been assessed as an immediate risk of suicide or self harm –

“...were left alone without supervision in a bleak cell with only a mattress, pillow and blankets and a small bottle of water. The occurrence book revealed two hourly checks were made. No furniture was provided.

No visual surveillance was maintained by either camera or a permanent officer present. No attempt was made to provide some amelioration of the distress both prisoners were experiencing by providing magazines, newspapers or access to a television. Unless these cells are extensively refurbished and adequate supervision introduced they should not be used to hold prisoners felt to be at risk of self harm. Prisoners felt to be at risk must not be treated as if they are undergoing a punishment regime.” (paragraphs 2.2.37-2.2.38)

- 10.204 By the second phase of the inspection in November 1999, the team were able to report a “*number of indications that suggested prisoners in these cells were beginning to be treated more appropriately*”. I understand that recommendations made by the Custodial Services Inspections Team following inspections of Bunbury, Albany and Wooroloo are under consideration by the Ministry.
- 10.205 In my view, medical observation cells are used in Western Australian prisons (to a greater or lesser extent, depending on the prison) because there are no other options and because prison staff believe removing the opportunity for self harm will absolve them from blame. This lack of choice does not, however, absolve staff of responsibility when they decide to place a prisoner in an observation cell or from managing prisoners so confined in an inappropriate manner.

RECOMMENDATION 10.12

That the Ministry immediately discontinue use of medical observation cells as they are currently operated and establish alternative placement facilities for the separate placement of at risk prisoners at all prisons.

RECOMMENDATION 10.13

As far as possible, prisoners who are considered to present such a high level of risk of suicide that they require constant observation should be housed in cells which are as “normal” as possible but which permit observation by, and positive interaction with, selected officers.

SUMMARY OF RECOMMENDATIONS

- 10.1 When recruiting prison officers sufficient weight must be given to their interpersonal and communication skills and their overall attitude towards prisoners and the prison environment in general.
- 10.2 That a system be devised that:-
- (a) encourages family members to telephone a prison to express concerns about the welfare of a prisoner; and
 - (b) ensures such information is recorded – either by an individual taking the call and recording the information or by having the calls tape recorded and monitored regularly.
- 10.3 That the Ministry:-
- (a) monitor the adequacy of the information in the new form used by CCA and the new handover procedure; and
 - (b) conduct an overall review of information-sharing procedures as recommended in RCIADIC Recommendation 166.
- 10.4 That the Ministry:-
- (a) endeavour to establish a network of elders from Aboriginal communities surrounding each prison to provide support and counselling; and
 - (b) enlist the help of established Aboriginal health service providers to enhance its provision of appropriate services to Aboriginal prisoners.
- 10.5 That the Ministry:-
- (a) take immediate steps to replace the light fittings in Hakea Prison with ‘safe cell’ fittings;
 - (b) progressively replace similar light fittings at other prisons;
 - (c) progressively remove frequently used hanging points in all prisons, not just the prison where its use as an anchor point has identified its potential as a hanging point; and
 - (d) constantly emphasise the importance of, and encourage, positive interaction between officers and prisoners
- 10.6 That the Ministry review the availability and use of plastic bags across the prison system, particularly to those prisoners identified as at risk of self harm, and introduce a uniform approach on the issue.

- 10.7** That the Ministry:-
- (a) provide sufficient resources to enable the FCMT to provide both crisis care and to become involved in:-
- suicide prevention and harm minimisation strategies and educational and self-help programs;
 - therapeutic counselling and support to prisoners with behavioural disorders; and
- (b) In recognition of the acute self harm risk of long term prisoners, expedite the introduction of a specific management system for such prisoners to include regular reviews of their health and at risk status and a formalised progressive program of work, education and rehabilitation.
- 10.8** That the Director, Health Services reinforce the importance of an integrated medical record to all Health Services staff through periodic file audits to monitor the standard of record-keeping. Disciplinary action should be considered for repeated failure to maintain comprehensive records and to integrate them with other relevant records.
- 10.9** That the Ministry provide funding and resources to facilitate routine weekend coverage at the metropolitan prisons (ie Casuarina, the Hakea complex and Bandyup) by the FCMT and Prisoner Support Officers.
- 10.10** That the Ministry as a matter of priority provide separate facilities for female remand prisoners.
- 10.11** That the Ministry:-
- (a) evaluate doubling-up procedures to ensure the placement of at risk prisoners only with prisoners considered suitable and sufficiently skilled to be able to offer support; and
- (b) ensure that the support prisoner is made aware of the nature and extent of the assessed risk presented by the prisoner he or she is meant to be assisting and consents to the doubling-up.
- 10.12** That the Ministry immediately discontinue use of medical observation cells as they are currently operated and establish alternative placement facilities for the separate placement of at risk prisoners at all prisons.
- 10.13** As far as possible, prisoners who are considered to present such a high level of risk of suicide that they require constant observation should be housed in cells which are as “normal” as possible but which permit observation by, and positive interaction with, selected officers.

- ¹ Excluding Wendy Eadie who died in Graylands Hospital on 1 November 1998 having never been admitted to a prison.
- ² See Chapter 8, endnote 39
- ³ Definition taken from the Macquarie Dictionary
- ⁴ *Suicides in Prison* Dr Alison Liebling 1992 (Routledge)
- ⁵ See also Paragraphs 9.48-9.56
- ⁶ See also paragraphs 10.158-10.165
- ⁷ See also Chapter 11 paragraphs 11.40-42
- ⁸ See also Chapter 11 paragraphs 11.59-11.62
- ⁹ Paragraph 151; page 43
- ¹⁰ Dr Haami Piripi; NZ Department of Corrections; at *Best Practice Interventions for Aboriginal People*, Adelaide October 1999
- ¹¹ *Psychology and Culture* Lonner and Malpass, 1994
- ¹² The top bunk rail has been used by 2 prisoners who died from hanging in 2000, the first at the Remand Centre in January and the second at Casuarina in June.
- ¹³ Gregory McIntosh used the shower recess as a hanging point at Albany Prison
- ¹⁴ Extract from *The Drum* (12/7/99) - a weekly news service for Australian/New Zealand/Asia Corrective Operations
- ¹⁵ See also paragraphs 10.183-10.205
- ¹⁶ A prisoner at Fremantle Prison committed suicide by this means in January 1990
- ¹⁷ Kenneth Layfield, an elderly remand prisoner in August and Bradley Rapley, a young sentenced prisoner in September.
- ¹⁸ *Review of Ministry of Justice Services for the Treatment and Care of Adult Prisoners at Risk of Suicide or Serious Self Harm*; January 1998 at page 28
- ¹⁹ See paragraph 10.189
- ²⁰ The Coroner made an 'open' finding at the inquest in February 2000
- ²¹ See Chapter 8 paragraph 8.30
- ²² *Identifying Prisoners at Risk*, at page 4
- ²³ *Supporting Prisoners at Risk* at page 11
- ²⁴ See also Chapter 11 paragraphs 11.3-7
- ²⁵ At paragraphs 5.27-5.54
- ²⁶ *Review of Ministry of Justice Services for the Treatment and Care of Adult Prisoners at Risk of Suicide or Serious Self Harm*; at page 29
- ²⁷ *ibid*
- ²⁸ See also Chapter 7 paragraphs 7.15-17
- ²⁹ Liebling *Suicides in Prison* at page 58
- ³⁰ *ibid* at page 59
- ³¹ See Chapter 4 paragraphs 4.14-4.19
- ³² See also paragraphs 10.34-40
- ³³ The Ministry has advised me that a Saturday roster for the FCMT will commence at Bandyup, Hakea and Casuarina as from 24 November 2000. The need for coverage on a Sunday will be monitored.
- ³⁴ "Untried prisoners shall be kept separate from convicted prisoners."
- ³⁵ See also Chapter 11 paragraphs 11.59-11.62
- ³⁶ From a psychological perspective 'acute' is used to refer to the sudden onset of suicidal ideation and is usually short-lived. 'Chronic' refers to a longer term, drawn out condition extending over a period of time
- ³⁷ Because most cells are automatically shared.
- ³⁸ Liebling *Suicides in Prison* at page 165
- ³⁹ Not in Casuarina where the observation cells are located within the Infirmary. However, there is evidence that prisoners in medical observation cells in Casuarina are physically restrained.
- ⁴⁰ Access to a television is available in some prisons
- ⁴¹ A 15-bed facility is to be included in the Hakea complex redevelopment and a 10-bed facility is planned for the Bandyup refurbishment

