



OMBUDSMAN

Western Australia

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

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

Mr President, Mr Speaker

Report on an investigation into deaths in prisons

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

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

A handwritten signature in black ink, appearing to read 'Murray Allen'.

Murray Allen
Parliamentary Commissioner for
Administrative Investigations

15 December 2000

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GLOSSARY OF ABBREVIATIONS

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

OMBUDSMAN'S FOREWORD

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

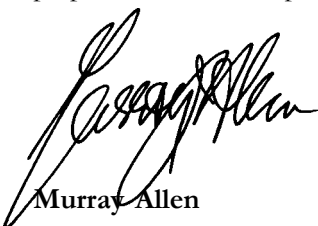
that it can achieve the outcomes that its new initiatives are designed to deliver. Prisons are hostile places and the past has shown us that achieving change within them is no easy task. It seems to me that security considerations have always prevailed over all others in this State's prisons, and reasons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

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

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

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

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



Murray Allen

December 2000



CHAPTER 1 INTRODUCTION

COMMENCEMENT OF INVESTIGATION

DEATHS IN PRISONS - THE NUMBERS

COMMENCEMENT OF INVESTIGATION

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

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

DEATHS IN PRISONS - THE NUMBERS

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

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

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

Source: Australian Bureau of Statistics

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

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

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

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

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

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

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

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

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

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

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

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

Source: Australian Bureau of Statistics

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

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

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

CHAPTER 2 THE PRISON SYSTEM

THE MINISTRY OF JUSTICE

OVERCROWDING

THE PRISONERS

THE ABILITY OF THE MINISTRY TO LEARN FROM DEATHS

THE MINISTRY OF JUSTICE

Formation

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

Offender Management Division

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

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

2.6 During 1998/99 the OMD was

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

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

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

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

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

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

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

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

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

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

^The same person argued that

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

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

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

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

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

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

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

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

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

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

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

OVERCROWDING

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

Table 2.1 Prisoner numbers compared to available accommodation 1990 -1998

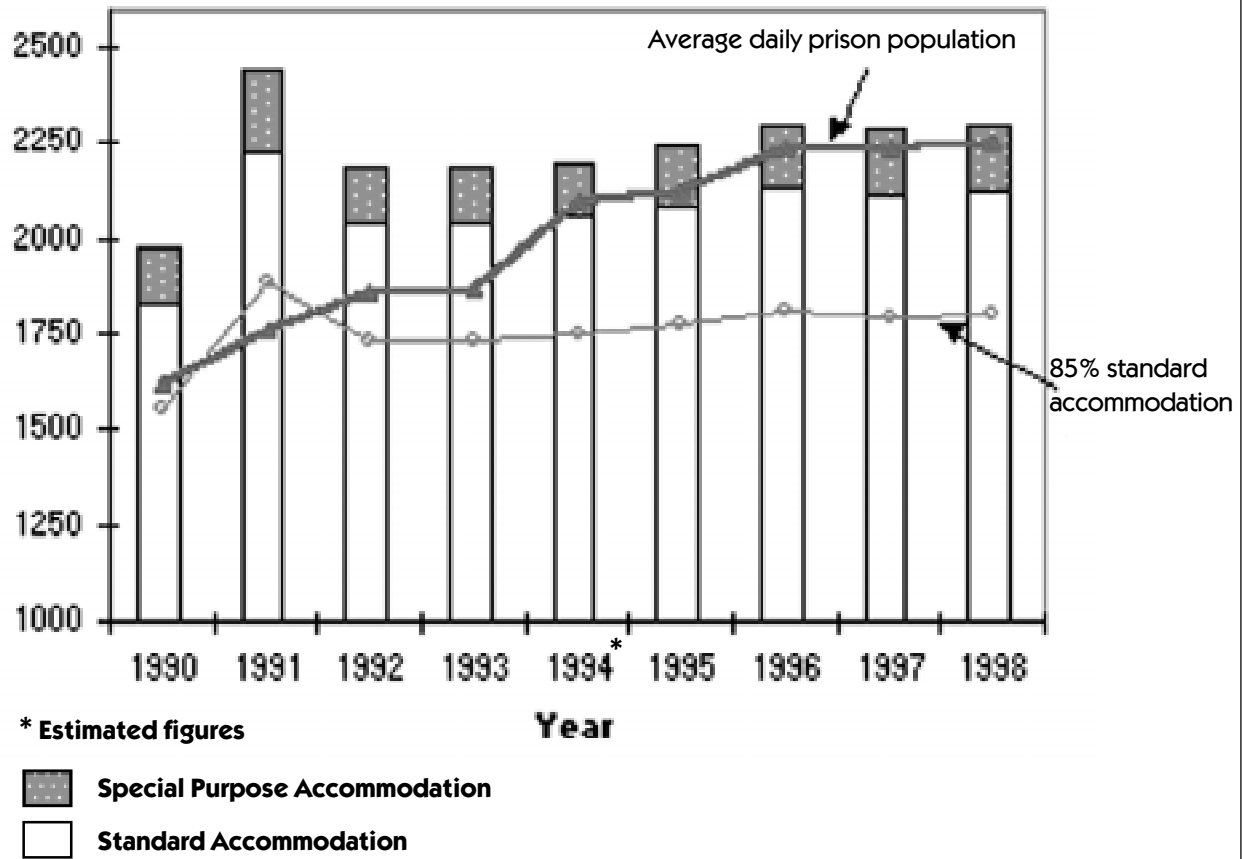


Table 2.2 Prison utilisation rates, Western Australia, 1994/95 to 1998/99

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

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

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

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

THE PRISONERS

Prisoner numbers 1982 – 1999

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

Table 2.3

Prison Populations 1982-1999

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

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

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

Table 2.4 Rates of imprisonment 1982-1999

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

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

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

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

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

Who are the prisoners ?

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

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

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

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

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

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

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

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

Table 2.6 Characteristics of Prisoners 1990–1999, Western Australia

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

Table 2.7 Average age of prisoners as at 30 June 1999

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

Source: ABS, Prisoners in Australia 1999

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

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

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

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

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

2.49 A former senior prison administrator put it this way:

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

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

THE ABILITY OF THE MINISTRY TO LEARN FROM DEATHS

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

Failure to investigate concerns raised by its own staff

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

Failure to comply with DGR 2M(10)

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

1 Ministry Handbook, 1998, p. 61

2 Ministry Handbook, 2000, p.69

3 paragraph 5.2.8.1

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

5 2000 Report, at page 757

6 at paragraph 5.2.7.12

CHAPTER 3 HEALTH SERVICES - INTRODUCTORY ISSUES

INTRODUCTION

STANDARDS OF HEALTH CARE

ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY

DUTY OF CARE

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

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

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

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

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

STANDARDS OF HEALTH CARE

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

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

Prisons Act 1981

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

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

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

Standard Guidelines for Corrections in Australia

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

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

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

Standards for Health Services of the Correctional Service of Canada

- 3.25 The *Objective* of the *Standards for Health Services of the Correctional Service of Canada*, which the Ministry has advised me are reflected in its health service standards, is stated as:-

"The inmate has the primary responsibility for his/her own health decisions, habits and behaviours. The CSC [Correctional Service of Canada] is responsible for ensuring appropriate, equitable and adequate access to professional physical and mental health services. These services sustain and enhance health status, contribute to the inmate's adjustment within the institution and assist them to become law-abiding citizens."

- 3.26 The *Principles governing the management and delivery of health services* as described in the Canadian Standards include:-

1. *The Correctional Service of Canada will deliver essential health services comparable to provincial and community standards, notwithstanding the constraints inherent in the correctional environment.*
2. *Inmates will bear the primary responsibility for maintaining and improving their individual and collective health.*
3. *Health promotion/illness prevention will be the primary activity for health service staff...*

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

Australian Council on Healthcare Standards *EQuIP* Guide

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

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

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

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

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

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

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

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

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

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

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

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

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

ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DUTY OF CARE

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



CHAPTER 4 PROVISION OF HEALTH SERVICES TO PRISONERS

INTRODUCTION

DEVELOPMENT OF HEALTH SERVICES IN WESTERN AUSTRALIA

INTRODUCTION

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

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

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

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

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

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

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

DEVELOPMENT OF HEALTH SERVICES IN WESTERN AUSTRALIAN PRISONS

Nursing and medical services

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

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

TABLE 4.1 NURSING AND MEDICAL SERVICES

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

*Medical practitioners are provided by the local Aboriginal Medical Service

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

Psychiatric Services

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

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

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

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

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

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

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

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

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

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

Psychological Services

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

Prison Health Facilities

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

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

Funding

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

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

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

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

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

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

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

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

RECOMMENDATION 4.1

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

Joint Justice/Health Interdepartmental Council (JJ/HIDC)

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

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

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

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

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

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

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

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

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

1 See also Chapter 6 paragraphs 6.162-6.172

2 See also paragraphs 4.37-4.41

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

4 See also Chapter 6 paragraphs 6.87-6.95

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

6 See Chapter 7 for discussion of the prison Pharmacy Department

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

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

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

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

INTRODUCTION

DEATHS OF ABORIGINAL PRISONERS FROM NATURAL CAUSES

EXAMINATION OF ISSUES RAISED BY DEATHS FROM NATURAL CAUSES

SUMMARY OF RECOMMENDATIONS

INTRODUCTION

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

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

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

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

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

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

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

DEATHS OF ABORIGINAL PRISONERS FROM NATURAL CAUSES

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

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

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

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

EXAMINATION OF ISSUES RAISED BY DEATHS FROM NATURAL CAUSES

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

Issue 1: Availability of Information and Record Keeping

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

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

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

(a) Availability of information

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

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

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

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

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

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

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

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

Failure to obtain a prisoner’s previous medical records

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

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

Prisoner's change of name not recorded

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

Conclusions on Issue 1(a)

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

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

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

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

RECOMMENDATION 5.1

That the Ministry:-

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

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

(b) Inadequate record-keeping by prison health staff

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Conclusions on issue 1(b)

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

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

RECOMMENDATION 5.2

That the Ministry:-

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

Issue 2: Quality of Prison Health Services

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

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

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

RECOMMENDATION 5.3

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

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

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

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

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

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

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

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

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

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

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

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

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

- 5.69 The Ministry's files indicate that Mr Cameron had had significant contact with prison health services dating back to 1992, resulting in various tests and his referral to external medical practitioners. However, contact with health staff had been primarily initiated by him rather than as part of a general review of his health as a long term prisoner.
- 5.70 In its review of the Coroner's findings (dated 6 August 1998), the Ministry did not support this recommendation on the ground that it would be "*extremely expensive and not consistent with normal community standards*". The review went on to say that:-

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

- 5.71 In the course of my consideration of this issue I looked at prison statistics for the year ended 30 June 1999 and found that as at 30 June 1999 there was a relatively small number of prisoners with an expected time to serve of more than five years (including those serving indeterminate sentences) - 538 out of a total of 2660 (20%) of whom 140 (26%) were Aboriginal.¹² Significantly, eight (35%) of the 23 prisoners who died from natural (or apparent natural) causes between 1991 and 30 June 2000 (four Aboriginal prisoners and four non-Aboriginal prisoners) were serving long (or indeterminate) terms of imprisonment. It seems to me, therefore, that the introduction of periodic health reviews could have long term benefits in reducing the number of deaths from natural causes.
- 5.72 I am pleased to note, therefore, from its response to my draft Report that "*The Health Services Directorate supports regular medical reviews and is in the process of addressing this matter*" that the Ministry now also appears to hold this view. I understand that it has recently introduced a program for monitoring and conducting outstanding annual health reviews.¹³

RECOMMENDATION 5.4

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

(e) Initial medical assessment of prisoners

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

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

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

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

5.82 The Coroner stated:-

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

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

“The following Health Services Standards apply:

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

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

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

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

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

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

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

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

RECOMMENDATION 5.5

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

(f) Treatment of terminally ill prisoners

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 5.98 I also note that RCIADIC **Recommendation 163** recommended that prison officers (and police officers) be provided “...with training which positively discourages the use of physical restraint methods except in circumstances where the use of force is unavoidable. Restraint aids should only be used as a last resort.”
- 5.99 In my view, the reluctance by officers to remove Mr Shaw’s restraints indicates a tendency to adhere strictly to ‘procedure’ and may well reflect a lack of knowledge by prison officers of the extent of their discretion. Although I accept that the potential risk to safety of hospital staff and other patients is of paramount importance when considering appropriate security measures for certain prisoners, it is hard to visualise the actual threat posed by a prisoner who had been admitted to intensive care for emergency treatment and whose condition had necessitated resuscitation. Although not diminishing the importance of security in a public hospital, this case seems to me to be a further example of security considerations being inflexibly applied to a medical situation - a subject considered later in this Report.

RECOMMENDATION 5.6

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION 5.7

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

Issue 3: Prison Diet

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

RECOMMENDATION 5.8

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

Issue 4: Health Facilities and Equipment

(a) The placement of elderly prisoners

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

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

RECOMMENDATION 5.9

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

(b) Equipment

Resuscitation equipment

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

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

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

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

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

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

RECOMMENDATION 5.10

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

Emergency Cell Alarms

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY OF RECOMMENDATIONS

That the Ministry:-

5.1.

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

5.2.

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

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

1 See also Chapter 10

2 An Aboriginal prisoner died of an overdose in 1994

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

4 See my 1999 Annual Report at page 47

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

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

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

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

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

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

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

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

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/habituation 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 Reception 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.”*⁷⁷

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.”

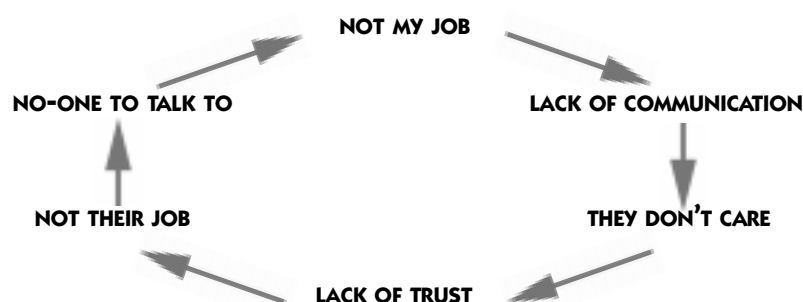
- 10.150 Supporting information for this agenda item states that there were at that time three sessions per week in the metropolitan area (although the Ministry had assessed its need as seven sessions per week) for purposes of assessment and treatment and that there was no service at Greenough. Concern 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



CHAPTER 11 EVALUATION OF THE MINISTRY'S CURRENT SUICIDE PREVENTION STRATEGIES

IDENTIFICATION AND ASSESSMENT PROCEDURES

MANAGEMENT STRATEGIES

SUPPORT SERVICES FOR AT RISK PRISONERS

USE OF EXTERNAL SUPPORT GROUPS AND PRISONERS' FAMILIES

PLACEMENT OPTIONS

'BEST PRACTICE' PRINCIPLES FOR SUICIDE PREVENTION

**EVALUATION OF THE MINISTRY'S SUICIDE PREVENTION STRATEGIES
AGAINST 'BEST PRACTICE' PRINCIPLES**

**SUMMARY OF CONCLUSIONS ON THE MINISTRY'S SUICIDE PREVENTION
STRATEGIES**

SUMMARY OF RECOMMENDATIONS

- 11.1 At risk prisoners are currently managed largely in accordance with the system in place at the end of 1998 as outlined in Chapter 9¹. Although there appears to have been a significant improvement in the Ministry's suicide prevention strategies system since the introduction of *ARMS* in December 1998, having considered the new initiatives and the concerns raised in submissions to my inquiry, in my view there remain a number of residual problems which have not been addressed by *ARMS*.

IDENTIFICATION AND ASSESSMENT PROCEDURES

- 11.2 As stated in Chapter 9², the new format assessment forms introduced in late 1996 and modified in 1997 attracted almost universal criticism from nursing staff in submissions to my inquiry. The direction that nursing staff *must* classify a prisoner's level of risk as high, medium or low attracted even greater opposition. Broadly speaking the concerns raised by the nursing staff can be categorised as follows:-

- lack of consultation and training;
- time constraints;
- the blame culture.

Lack of consultation and training

- 11.3 The lack of training and orientation programs for health staff has been considered in some detail in Chapter 6.³ Similarly the lack of consultation at all levels was drawn to my attention as an illustration of both the low priority of health when compared with security considerations, and the lack of planning of new health initiatives such as the Crisis Care Unit at Casuarina. The systemic problems caused by lack of training were raised by the Coroner in a number of inquests⁴ and also by health staff.
- 11.4 I am inclined to agree with nursing staff that it was unfair and unreasonable to require them to implement the new assessment forms without notice or prior consultation and without training in interviewing techniques. This concern in conjunction with the time constraints caused by prison operational considerations (see below) has the potential to place prisoners at risk and cause management problems. In this regard I note that the Longford Inquiry into the Esso gas explosion in Victoria found that Esso was at least partially liable for deficiencies in the safety system because it had failed to provide its staff with adequate training.
- 11.5 In general terms, in the past, prison staff in all areas have been provided with minimal opportunity for training and professional development in essential aspects of their job requirements. I am pleased to note that the current Director Health Service has begun to organise regular training sessions for health staff and that the Ministry recently held a Health Services Conference for staff from all prisons around the State.
- 11.6 In relation to the initial assessment of a prisoner's risk of self harm, it should be noted that the majority of prison nurses do not have a background in mental health nursing or behavioural diagnosis. Concerns about the complexity and insensitivity of the questions which must be put to prisoners on admission to prison seem to me to be a reflection of the fact that nursing staff were provided with very little training in how to ask those questions in an indirect way without appearing provocative or intimidating to, or causing distress for, the prisoner being interviewed. Although I am aware that the more experienced members of the nursing staff already adopt a more indirect approach, others, particularly new staff, may not feel sufficiently confident to depart from the strict wording of the form and may provide an incomplete picture of the prisoner in question. It is clear to me that the value of the initial assessment of a prisoner's risk status will depend on the expertise of the nursing staff asking the questions and,

importantly, the preparedness of the prisoner to disclose information. The Ministry should therefore endeavour to employ nursing staff with an appropriate mental health background to perform this initial assessment.

- 11.7 However, in spite of my concerns about aspects of the assessment procedure, I believe that it would be counter-productive to place too much emphasis on the results of the initial assessment. It seems to me that the primary value of the first interview is to establish as far as possible if a prisoner shows any *obvious* suicidal or self-harming tendencies *at that time*. An indication of a prisoner's medium to long term risk status is more likely to be gained from observation over a period of time by a person experienced in this type of psychological assessment than from the responses provided by a distressed and possibly terrified prisoner on arrival at a prison. For this reason a more accurate picture of the prisoner's vulnerability will be obtained if the initial assessment is followed by the opportunity for comprehensive orientation and induction in a specialised facility – such as that proposed at Hakea – when subsequent assessments and monitoring of progress during the 'settling in' period are a part of the routine.

RECOMMENDATION 11.1

That the Ministry provide all health services staff with appropriate and ongoing training in the assessment of prisoners to establish any self harm or suicidal tendencies – both on admission to prison and during the term of imprisonment.

Time constraints

- 11.8 Most new prisoners are received at prisons from the courts at the end of the day. Although the new risk assessment forms take longer to complete than the previous version (particularly without proper training), nursing staff told me that pressure to complete the forms in less time than they felt comfortable with comes from prison officers who, it is alleged, are anxious for the initial medical assessment to be completed so that they can finish their operational duties before the end of their shift. It has been suggested that this is one of the consequences of the 12-hour shift system for prison officers.⁵
- 11.9 As this same issue was raised by the Select Committee into the *Misuse of Drugs Act 1981* and conceded by the Ministry in its *Drug Management Strategy Project* (the *DMSP*)⁶ I have no reason to doubt the claims made by the nursing staff. In my view this apparent conflict between health and operational considerations should be resolved by the Ministry as a matter of urgency given the importance of the initial assessment in the management of newly admitted prisoners - an issue which was emphasised in RCIADIC **Recommendation 156**. The operational attractiveness of having all prisoners processed by a certain hour – to facilitate the evening lockup and the end of the shift – must not come at the expense of insufficient time to complete the risk assessment process.
- 11.10 In relation to the early identification of prisoners suffering the effects of substance abuse on receipt into prison, the *DMSP* recommended that nursing personnel should be afforded “*immediate access to newly arrived prisoners following the completion of essential reception tasks as a priority function of the reception process*” (Recommendation 22). I fully support that recommendation.
- 11.11 Although the opening of the new dedicated receipt prison at Hakea will help resolve the problem for new male prisoners in the metropolitan area, it will not assist staff at female or regional prisons. If, in the interests of the welfare and well-being of prisoners, the Ministry identifies the need to examine the effect of the 12-hour shift system under which prison officers work on the welfare and safety of prisoners, it should, in my view, ‘grasp the nettle’.⁷

RECOMMENDATION 11.2

That the Ministry take all steps necessary to ensure that prison regimes are organised to permit sufficient time for the initial medical and risk assessment process to be completed properly.

'Blame culture'

- 11.12 Nurses told me that they were reluctant to make a final classification on the level of risk presented by a prisoner because they were concerned that they would be criticised and blamed if it was subsequently found to be inaccurate - for example if a prisoner classified as low risk committed suicide. As a consequence, some either did not 'tick the box' at all or always classified a prisoner as high risk. Both approaches are unhelpful – the latter particularly so - because it may produce false positives which appear to exaggerate the problem of self harm. From the prisoner's perspective it may well result in placement in a medical observation cell even though he/she genuinely had no suicidal thoughts.
- 11.13 I have been told by the Ministry's senior psychiatrist that it is a widely accepted clinical principle that a prisoner who subsequently commits suicide or serious self harm might quite properly have been classified as a low risk at the time when he/ she was seen by the FCMT or nursing staff. An assessment of risk can generally only reflect the way a prisoner is feeling at the time of assessment. It is reasonable to recognise that a prisoner's level of stress and associated risk of self harm could be subsequently affected by the intervention of other factors which could be any one or a combination of the prison stressors identified by Dr Liebling.⁸ Some prisoners will feel better by simply talking to a health professional but lose their ability to cope later when they are alone. Others will not reveal their thoughts or intentions at all. If, as I believe to be the case, the view expressed by the senior psychiatrist is accepted by senior Ministry health professionals, it is unfortunate that many of the nurses we spoke to did not appear to be aware of it.
- 11.14 However, the frequency of concerns in submissions and interviews with staff at all levels and from all areas of the prison system about the 'blame culture' and the lack of actual moral support provided at a senior level, lead me to believe that the concerns of nursing staff about their possible 'liability' are not without some foundation.
- 11.15 Howells and Hall made particular reference to the external and internal pressures which give rise to the 'blame' culture⁹:-

“This blame culture appears to have grown over time and in response to both internal and external pressures. The external pressures include the Royal Commission into Aboriginal Deaths in Custody (and the response to it), the Ombudsman, the Coroner and the Death Watch Committee. From the perspective of staff many of these bodies appear antagonistic and intent upon finding a person responsible for a death in custody. Not surprisingly there is an atmosphere of suspicion and defensiveness when these external bodies interact with the system.

.....It is also the perception that when “a failure” occurs the system responds by attempting to identify an individual to blame rather than by detailed scrutiny of policies and procedures.”

- 11.16 Although Howells and Hall found “considerable mutual support” among staff, they also reported a lack of the same level of support from the Ministry, particularly in relation to appearing before the Coroner:-

“One non-custodial staff member noted that the Superintendent and Assistant Superintendent stayed on at the coronial enquiry while he gave his evidence to provide him with support.....

However, there were some criticisms noted. The most prominent was that staff felt abandoned when they faced a coronial court. While the Government or the Ministry is represented it is clear that this representation is not for the benefit of staff. Indeed, one interviewee commented that at one point in an inquest the Crown Solicitor representative "turned on me"?

11.17 In this regard I note that members of WAPOU have been represented by a Union-appointed lawyers at only one inquest since February 1999 – that into the death of Neil Holt. Other members of staff - such as those nurses who are members of the ANF are occasionally represented by an ANF-appointed lawyer. Apart from having the effect of lowering staff morale and confidence, a perception that they will not be supported by the Ministry at an inquest has distinct disadvantages for the quality of care provided to prisoners.

11.18 Some staff referred to the activities and media profile of the Deaths in Custody Watch Committee as contributing to the blame culture but, almost universally, officers and staff at all levels registered greater concern about the reaction and attitude of "Head Office" (meaning the head office of the Ministry of Justice in Westralia Square) following a death in custody. Sadly, most appeared to be of the view that they would be abandoned by 'Head Office' and made a scapegoat if it was possible for some element of blame to be attributed to their actions or omissions. In fact the initial reluctance by many officers to provide me with their views appears to have been their concern that they would be victimised by the Ministry for doing so, rather than suspicion of my procedures. In this regard, I cannot be entirely satisfied that prisons in Western Australia could be considered for the most part 'healthy' for either staff or prisoners.

11.19 Howells and Hall also commented on a further consequence of the 'blame culture' at page 38-39:-

"One of the recurrent themes identified in our interviews is the perceived reactive nature of the Ministry's management of at risk prisoners. There is a wide spread perception by the staff that, in the absence of a long term strategy and philosophy for managing self harm, hasty and ill thought out reactions occur to serious incidents..... The "blame culture" as one respondent called it, has the effect of excessively focussing staff attention on bureaucratic and legalistic aspects of care rather than human and organic aspects. This often results in the safest option being chosen for staff rather than a creative response to the needs of the individual.

In our view, the perceived "blame culture" explains some of the problematic staff reactions to at risk prisoners: a concentration on record keeping rather than information giving; the high use of observation cells; excessive referrals to, and reliance upon FCMT staff; an emphasis on getting information on prisoners rather than interacting with them in a more informal manner; and the lack of support provided to staff during a coronal enquiry....."

11.20 In my view the Ministry should take steps to become more intuitive to prison 'atmosphere'. To this end I suggest that senior prison administrators and staff based at 'Head Office' should also become more proactive in their relationships with prison officers.

MANAGEMENT STRATEGIES

- 11.21 Prisoners are now managed according to the principles of the *At Risk Management System (ARMS)* which has been in operation since December 1998. Although I accept that it is virtually impossible to prevent all prison suicides, it seems that the steps taken by the Ministry during 1999 were largely successful in reducing the number of deaths in spite of the unacceptably high musters - particularly at Casuarina - and the strict regime imposed on prisoners for several months following the riot on Christmas Day 1998. I have been told by the Manager of the FCMT that, on the basis of a recent review of the system at Hakea, Bandyup, Eastern Goldfields and Broome, the *ARMS* concept has been embraced by most staff. I have also been told by the Director, Health Services, however, that he has noted at some prisons a relatively poor standard of record-keeping in the Prisoner Risk Assessment file kept in the units.
- 11.22 It is encouraging to hear that the concept of *ARMS* has been widely accepted. In my view the reduction in the number of suicides in 1999 – four compared to 12 in 1998 – may also suggest that the changes to the Ministry's suicide prevention strategies have been successful. It may also be attributable to the widespread promotion by senior staff of the principle that at risk management is the global responsibility of *all* staff and not just the province of health staff. The seven apparent suicides between 6 January and 25 June 2000 (five since 7 May) are, however, a reminder that the system cannot become complacent. The Ministry appears to share this view and has established a Taskforce to investigate the recent deaths and their causes. The project will include an evaluation of *ARMS* to identify the elements which can be improved and means of heightening awareness of suicide in prison.

Poor prisoner/officer relations

- 11.23 Strained and occasionally obvious hostile relationships between prisoners and prison officers were evident in most of the prisons I and my staff visited in the course of this inquiry. This issue was also a constant theme in submissions and interviews. Although I am certain that a certain amount of '*them and us*' is inevitable in the prison environment, the stress which can be created and engendered by the actions and attitudes of a small number of officers can ultimately pervade the whole system, with the result that prisoners will see all, or most, officers as adversaries. For example, I have strong reservations about the success of *ARMS* at Casuarina – the prison with the most problematical prisoners and the highest rate of self harm and suicide – in the aftermath of the lockdown regime and the new 'barrier' type of control. In my Annual Report for 1998/1999¹⁰ I commented on my observations of "barriers" between officers and prisoners:-

"...I had a number of concerns about the situation at Casuarina in terms of both the current functioning of the prison and what might occur in the future. Underlying these concerns was my long-held concern about the need for a high degree of positive interaction between prisoners and prison staff of all types if the concept of unit management is to have any real meaning. My observations at Casuarina left me with a significant sense of unease about the future culture of the prison. This unease was that once the "yards" were in place and operating, not only would there be physical barriers between prisoners and prison staff but also attitudinal barriers that have been allowed to develop because of the lockdown regime – of such a nature and magnitude that the kind of positive interaction that is desirable will not be possible to the necessary degree."

- 11.24 The Ministry was alerted to a growing deterioration in prisoner/officer communication by Howells and Hall and acknowledged at page 14 of its *Report on Suicide Prevention Strategies for Prisons in Western Australia* (December 1998) that a known 'stressor' for prisoners is:-

"Lack of positive contact with staff

Positive interaction between prison officers and prisoners is a key to the prevention of suicide and the management of vulnerable and distressed prisoners. Prisoners will not reveal their feelings and intentions unless a good relationship exists (Howells and Hall 1998:38)." (my emphasis)

- 11.25 The Dear et al study of self harm also found that the final trigger for most prisoners who had self-harmed was an internal prison event which may have been caused by interaction with officers or with other prisoners. As a prisoner's daily life is for the most part influenced by and under the control of prison officers, daily contact that is negative, indifferent or hostile, is less likely to result in a positive relationship and also increases the potential for that contact to become a trigger for self harm or suicide.
- 11.26 The effect of a "*lack of positive contact*" has been noted in a number of IIU and coronial investigations – the first in relation to the death of David Metcalf in 1991 - following the death of a prisoner, with the repeated recommendation that officers need to be trained to become more intuitive to the needs of at risk prisoners.¹¹ It is, therefore, of concern that it was not until 1998, after a dramatic increase in the number of deaths and consideration of the Howells and Hall study, that the Ministry appears to have accepted that there were serious deficiencies in its existing risk management strategies and to have recognised that this was at least partly attributable to a deterioration in prisoner/prison officer relations. By that time the problem had been left for so long that it became necessary to reinforce by means of the *formal* procedures and *written* instructions in the *ARMS* manual that the care and management of vulnerable prisoners is the responsibility of **all** prison staff - a responsibility which I would have thought was automatically an *integral* and essential component of the obligations of anyone involved in the management of a person held in care.
- 11.27 It is not clear whether the Ministry's failure to respond to recommendations made over a number of years (certainly between 1992 and 1998) was because it disagreed with the principle of the recommendations; because it lacked, and could not obtain, funding or resources to implement the recommendations; or whether its inaction stemmed from indifference, a lack of co-ordination or negligence. To the extent that it has largely been unable to provide me with documentation outlining its responses to various recommendations, I am inclined to the view that the Ministry's inaction was the product of apathy, lack of co-ordination and an unwillingness to deal appropriately with difficult problems, particularly when solutions required expenditure of scarce funding.

Lack of trust/unwillingness to confide in prison officers

- 11.28 Howells and Hall stated:-

"The organisational culture or environment is critical to the prevention of self harm and suicide. Good staff-prisoner interaction is a necessary pre-requisite in this task. Prisoners will not reveal their feelings and intentions unless a good relationship exists. Similarly, prisoners will be unlikely to identify other prisoners at risk. Hence a major concern in long-term planning must be how to enhance staff prisoner interaction."

- 11.29 An inevitable by-product of a deterioration in prisoner/officer relations is that prisoners will become unwilling to confide in or seek help from a prison officer for themselves or for other prisoners and prison staff may only discover after the death of a prisoner that other prisoners were aware that he/she had threatened suicide or was acutely vulnerable through having taken drugs. This lack of communication by other prisoners in whom a fellow prisoner has confided came to light following investigation into a number of prisoner suicides.
- 11.30 For example, it emerged that Sean **Hayes** (Remand Centre, August 1997) had told his cell-mate of problems with his girl friend and his intention to take his own life, but the cell-mate did not advise anyone of the discussions. In the case of Douglas **Yorkshire** (who died from a drug overdose in Canning Vale in January 1994) neither of the two prisoners, who allegedly physically assisted him back to his cell after he had taken drugs and who were unable to rouse him before returning to their cells for lockup, told officers of Mr Yorkshire's condition. Anthony **Wood**, who electrocuted himself at the Remand Centre in January 1997, had apparently discussed his intention at length with two other prisoners. Although it is reported that the two prisoners attempted to keep Mr Wood occupied and to help him when he was feeling distressed, they did not advise prison staff of their concerns.
- 11.31 Christopher **DeGois** who committed suicide in Casuarina in November 1997, was known to be at risk of self harm by prison staff, although he had assured prison officers on the day of his death that he was feeling positive and would not self harm. Later that evening, after a telephone conversation with his brother, he told two prisoners of his suicidal intentions. The prisoners subsequently said that they did not advise prison staff because they did not think he was serious.
- 11.32 Prisoners have told IIU investigators looking into the death of a prisoner – and also members of my staff in the course of this inquiry – that they were also reluctant to tell prison staff of their concerns because the most likely result would be for the prisoner in question to be placed in a medical observation cell, a prospect feared and detested by the majority of prisoners.
- 11.33 In findings following the inquest into the death of Mr Yorkshire, the Coroner stated:-

“It has been a recurring theme in this and other Inquests that prison inmates see the prison system as an adversary and that to perpetuate a deception upon prison officers, who are instruments of the prison system, is to achieve a success in the continuing contest.

There is also a well understood but unwritten rule that inmates would not inform on each other to prison officers and that so far as was able, inmates would protect fellow inmates from detection for infringements of prison discipline or illegal activity.”

- 11.34 The only significant response by the Ministry to this issue appears to have been in June 1998 in its comments on the Coronial findings in the case of Anthony Wood:-

“This matter of prisoners feeling confident about talking to prison officers of concerns that they have for their peers’ well being is a complex one that needs to be addressed on a number of fronts. Prisoners in most instances feel reluctant to either engage, or be seen to be engaged, in earnest conversations with prison officers. This is a cultural issue that can be addressed through carefully planned training and education, for both prisoners and prison officers.

The prison officer induction-training schedule allocates 2 of the 10 weeks training period to the development of communication skills. However verbal communication and interpersonal skills are not assessed in the initial selection process and if a base level of skills is not present it is difficult to enhance what does not exist.”

11.35 The review went on to recommend:-

“That prisoner induction and, peer support programs actively promote the need for prisoners to talk with prison officers about concerns they [have] regarding prisoners (including themselves) who may self-harm.

That future ‘update’ or ‘refresher’ prison officer training programs target the development of ‘active listening’ and verbal communication skills.

That verbal communication and interpersonal skills are highlighted as essential selection criteria for prison officers.”

11.36 I do not disagree with these observations. In my view, the breakdown of communications between prisoners and prison officers has serious implications for the effective management of at risk prisoners and is an indictment of the system of Unit Management in Western Australian prisons, an *essential* feature of which was supposed to be constructive interaction between prisoners and prison officers. I would also observe, however, that the issue must not be seen only as one of encouraging prisoners to talk to prison officers. Equally, or perhaps more, important is the need for prison officers to take the initiative and actively engage prisoners in general conversation to break down the barriers and encourage positive interaction. To do this officers must be both willing and able (through natural ability or through training) to overcome the current obvious obstacles to communication with prisoners.

11.37 The recent Howells, Hall and Day study “*The Management of Suicide and Self-harm in Prisons: Recommendations for Good Practice*”¹² stated at page 162:-

“Good staff-prisoner interaction is a necessary prerequisite for suicide prevention. Prisoners are unlikely to reveal their feelings and intentions to staff unless a good relationship exists. Similarly, prisoners will be unlikely to identify other prisoners as at risk. Identifying barriers to help-seeking is an important task, particularly when working with young people in detention. 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. In view of the importance of this issue, consideration needs to be given to monitoring institutional atmosphere in prisons, to using social environment assessment instruments and to setting management objectives to improve staff rapport. There is considerable agreement in the published literature on suicide in prisons that good staff training (at all levels) is essential for an effective system.”

11.38 The Dear et al study of self harm pointed to the value of self-disclosure of distress and depression as a means of preventing self harm by prisoners but cautioned 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.*” In other words, prisoners can be assured that officers will take them seriously and will do something to help them, rather than leave them in obvious distress as occurred in relation to Wesley Doorey.¹³

11.39 In response to my request for information on the progress of the recommendations of the review of Mr Wood’s death, the Ministry advised:-

“Currently upon being received into any prison, offenders receive information as part of their induction, which includes the encouragement to bring any problems to Prison Officers’ attention as a first response.

An enhanced Peer Support Program was introduced into all prisons with newly created positions of Prisoner Support Officers being responsible for the establishment of and ongoing training in the Peer Support Programs. This enables prisoners to recognise fellow prisoners who are ‘at risk’ and to support them through appropriate attentive listening and communications skills.

The program encourages prisoners to talk to Prison Officers when concerned about self-harm and other problems. There are Prisoner Support Officers in all prisons except the minimum-security prisons at Karnet, Pardelup and Wooroloo.”⁴

- 11.40 The particularly good relations which are evident between officers and prisoners at Albany Regional Prison have been remarked upon in a number of studies. For example, in their 1997/8 review of the Ministry's suicide prevention strategies Howells and Hall observed:-

“In our interviews, we did note some differences between prisons. For example Albany Prison appeared to promote and encourage positive rapport between prisoners and officers, and senior staff explicitly address the “us versus them mentality.....”” (page 38)

- 11.41 The Custodial Services Inspection team which inspected Albany Prison in September 1999 wrote, *inter alia*, in their report:-

“What we were told by Prisoners

There was mutual respect between officers and prisoners (we observed this).

Officers had a good attitude towards prisoners (we agreed).

What we were told by Staff

Officers were prisoner focused (this was true).

Prisoners were able to bring their problems to officers (we agreed and saw this as evidence of a good relationship with prisoners).

It was part of the Albany prison ‘culture’ to mix with prisoners.

Staff and Prisoner Relationships and Unit Management

Unit Management was focused on the solving of prisoner problems.....The case management of all prisoners was a significant achievement that undoubtedly contributed to the generally excellent relationship between prisoners and staff. This achievement was the more notable as it had been accomplished with a prisoner population that included prisoners with records of extreme violence and history of intractable behaviour at other prisons.

Conclusion

.....The management of the prison was focused on meeting the needs of prisoners, the interaction between staff and prisoners was commendable – the widespread practice by officers of calling prisoners by their first name being an example of this.

Prisonersfelt safe and said that the ‘relaxed atmosphere’ of the prison was due to staff treating them with respect and dealing with their complaints promptly.”

- 11.42 These comments mirror my own observations during my visit to Albany and are in sharp contrast to my comments on the situation at Casuarina post-riot in my 1998/99 Annual Report.¹⁵
- 11.43 In my view, until the longstanding barriers and the lack of trust between prison officers and prisoners are effectively dismantled, so that prisoners and prison officers feel comfortable talking to each other, it is unlikely that the full potential of ARMS will be achieved. Ultimately, the success of ARMS will depend on three factors - the selection of suitable prison officers with advanced communication and conflict resolution skills and a willingness to use them; their ability to put into practice the principles of the ARMS system; and the provision of adequate training both initially and on an ongoing basis.

The issue of training has been a continuing theme throughout this report. However, it is also one which I cannot avoid repeating both because of its importance and because of its clear inadequacy in all areas of the Western Australian prison system.

- 11.44 The effectiveness of *ARMS* will also depend on the Ministry's willingness to transfer those officers who may be unsuited to the role envisaged in *ARMS* to areas where they have less contact with prisoners and to encourage those who appear unsuited to the care of persons in custody to leave the prison service altogether. I should say that this is a view that was put to me in more than one submission from serving prison officers.

RECOMMENDATION 11.3

That, recognising the importance of good prisoner/prison staff relations, the Ministry review its selection and recruitment process for all prison-based staff to ensure that sufficient priority is given to high level communication and interpersonal skills as basic requirements for all staff dealing with prisoners.

Conflicts between health and security considerations

- 11.45 As discussed at length in Chapter 6 the tension between health and prison staff over the relative priority of health and custodial issues has been raised with me in submissions and interviews. Examples given to me included:-

- decisions and recommendations of health staff and FCMT regarding the placement - or continued placement - of a prisoner in an observation cell being over-ridden by clinically unqualified prison staff;
- placement of prisoners in the Infirmary and the Crisis Care Unit being controlled by prison operation staff rather than by health professionals;
- recommendations by FCMT staff regarding the use and continued use of restraints on prisoners in observation being ignored; and
- pressure being placed on health staff to complete risk assessments to fit in with operational duties at the end of a shift.

- 11.46 Disagreement between prison disciplinary and health staff in the management of at risk prisoners, particularly those in the observation cell area is of concern because it can only disadvantage the prisoner. Ultimately, it is difficult to comprehend a system which allows the medical and clinical judgement of qualified health personnel to be over-ridden by *unqualified* prison staff. At very least, conflicts of this nature - which would be well known to prisoners - create uncertainty and a lack of confidence in health services, which means that prisoners may not seek help when they need it. This problem was highlighted by Howells and Hall, who commented at (at page 24 of their report):-

“In our interviews we were impressed by the good communication that generally exists between operational and health staff, particularly at the unit level. However, there is a need for greater co-ordination and for joint planning, and to build upon the general level of good will which exists amongst staff working in prisons. In any case, the most effective method of achieving the organisation's goals is to have a highly integrated work force.”

- 11.47 The importance of maintaining the balance between security, control and justice as a test of a 'healthy' prison was referred to in HM Chief Inspector's report on suicide and self harm in UK prisons. The Chief Inspector quoted from the report of Lord Woolf following the Strangeways Prison riot in 1991, which stated:-

“... “Security” refers to the obligation of the Prison Service to prevent prisoners escaping. “Control” deals with the obligation of the Prison Service to prevent prisoners being disruptive. “Justice” refers to the obligation of the Prison Service to treat prisoners with humanity and fairness and to prepare them for their return to the community in a way which makes it less likely that they will reoffend. There are two basic rules if these requirements are to be met. They are: i) sufficient attention has to be paid to each of the requirements; ii) they must be kept in balance.”

- 11.48 The guidelines in the *ARMS* Manual clearly promote a ‘global’ responsibility which, in my view, means that neither security nor health is the dominant consideration but that an at risk prisoner’s management should be a combination of the two. Although I support the Ministry’s change in focus from the solely ‘medical’ management of at risk and vulnerable prisoners and its promotion of the view that the care and management of such prisoners is the responsibility of **all** prison staff, it is essential that prison officers do not see this approach as an indication that they do not need to consult or be advised by appropriately qualified health staff.

RECOMMENDATION 11.4

That the Ministry’s operational rules require that:-

- (a) the Director, Health Services and relevant health staff are consulted and involved in proposals and decisions relating to the health of prisoners and the management and placement of prisoners considered at risk; and that**
- (b) decisions made by qualified health professionals must not be over-ruled by unqualified prison staff.**

SUPPORT SERVICES FOR AT RISK PRISONERS

- 11.49 Prisoners in need of treatment, counselling and/or support are able to seek help from the FCMT, medical and nursing staff, the visiting psychiatrist, the Prisoner Support Officer and Peer Support Group, members of the Aboriginal Visitors Scheme, chaplains and prison officers. From my observations while visiting prisons around the State, I would also like to acknowledge the positive – and largely unsung - role played by many prison Education Officers and Industrial Officers in helping prisoners – whether ‘disturbed and vulnerable’ or not. The Education Officer seems to be seen by prisoners as a non-judgmental ‘someone to talk to’ who, through the provision of practical therapeutic and life-skills programs – sometimes with little or no support from prison management and the Ministry – are able to assist prisoners to cope with their imprisonment and life in the community on their release.¹⁶ The same can be said for Industrial Officers who seem to be able to relate to prisoners at a much more personal and relaxed level than do many prison officers. The extent to which members of a prisoner’s family are involved by prison staff in managing prisoners still has, in my view, a long way to go to reap the maximum benefit in terms of suicide prevention strategies.¹⁷

The Forensic Case Management Team

- 11.50 The Ministry has advised me that it has increased the resources of the FCMT since 1998 and now has a total of 36.2 FTEs (including the Manager (1 FTE), a clinical specialist (0.5 FTE) and 1.25 FTE for occupational therapy). In addition there are 12 FTE for Prisoner Support Officers (one at each prison except Casuarina and Hakea which have two, and 0.5 of an FTE at both Karnet and Wooroloo). **Table 11.1** summarises the coverage by FCMT at each prison:-

TABLE 11.1 Forensic Case Management Team services as at 18/10/2000

Prison	Days/Week	On duty coverage	FTE's
Albany/Pardelup	Mon-Fri	Full time	1
Bandyup/Nyandi	Mon-Fri	3 Full time; 1/3 days Plus 0.5 O/T	4
Broome	Tues	2.5 hours per week	0.25
Bunbury	Mon-Fri	1/23 hours; 1/15 hours	1
Casuarina	Mon-Fri	Full time Full time O/T*	11
Eastern Goldfields	Eastern Goldfields Mental Health Services-	As required	0
Greenough	Mon-Fri	1 Full time; 1/19 hours	1.5
Hakea	Mon-Fri	Full time	12.25
Karnet	1 day per week		0.2
Riverbank	1 session per week plus on-call from Bandyup as needed and 0.5 of the O/T at Bandyup		0.5
Roebourne	Fortnightly	8 hours per fortnight	1
Woorloo	Serviced by FCMT from Bandyup		0

* The Occupational Therapist position will be shared with Hakea when the Assessment Centre is operational

- 11.51 The Ministry has advised me that “[T]here are difficulties in maintaining all of these FTE at the optimal level due to recruitment difficulties in regional locations, difficulties in attracting Occupational Therapists and other budgetary considerations.” Nevertheless, the number of FTE available to the FCMT is now greater than it has ever been – approximately 5 times the 1994 level. I have also been advised that the Ministry has recently agreed to deploy additional FCMT staff if the muster at the main prisons reaches a predetermined level.
- 11.52 In my view the introduction of the concept of an increase in FCMT establishment if prisoner numbers exceed a certain predetermined level – a proposal made by my predecessor in relation to nursing staff in his 1995 report on health care at Bandyup¹⁸ - will lead to a significant enhancement of the support services available to prisoners and will also relieve the unrelenting pressure to which all health staff seem to be subjected.
- 11.53 I am uncertain whether current staffing levels will now enable the FCMT to monitor and regularly review acute at risk groups such as long term prisoners and those assessed as vulnerable based on the principles of ARMS, young prisoners and those suffering the effects of substance abuse who are not classified as ‘at risk’. In my view, the inability of the FCMT to provide support other than as crisis management is a serious, and possibly for some prisoners a fatal, flaw in the Ministry’s management strategies.
- 11.54 In this regard, if members of the FCMT were ‘on duty’ at the weekends - instead of ‘on call’ - it may provide an ideal opportunity for the running of preventative and self-help programs¹⁹ as well as ensuring that prisoners who need to be seen by the FCMT could be. The situation described by one prisoner in his submission to my inquiry might be avoided :-

“Let me first point out to you that I am a minimum rated security prisoner in a maximum facility. Now I am back in obs (last two nights) and will be spending tonight Monday night in there as well. As yet I have seen no mental health care professional (psychiatrist or special needs team) and will not be seeing them until tomorrow. The reason for this is there is nobody in this capacity on weekends and public holidays in this case four (4) days running.....”

- 11.55 I was, therefore, pleased to receive the Ministry's advice on 14 November 2000 that a Saturday roster of FCMT is to commence at Casuarina, Hakea and Bandyup from 25 November 2000. Extension to include a roster on Sundays will be considered if found to be necessary.

RECOMMENDATION 11.5

That the Ministry provide the FCMT with sufficient resources to enable it to:-

- (a) become involved in harm minimisation and self- help educational programmes for prisoners; and**
- (b) monitor and regularly review long term prisoners, those with severe behavioural disorders and/or suffering from the effects of substance abuse.**

Psychiatric Services

- 11.56 The provision of psychiatric services for the assessment and treatment of prisoners with a clinical psychiatric illness who may also be at risk was discussed in Chapters 4 and 10. Essentially, there is a very limited psychiatric service available to prisoners²⁰ at most prisons. At Casuarina there were until recently three psychiatric sessions²¹ per week plus a further session per fortnight. The number of weekly sessions has now been increased by the addition of two sessions by a psychiatric registrar. The number of weekly sessions has been increased from three to four at Hakea. At Bandyup there are now two sessions per week. From interviews with health staff, it seems that the frequency of psychiatric clinics at most prisons is considered to be inadequate to meet the demand for psychiatric counselling, with the result that at prisons where the clinic is fortnightly – such as Karnet - a prisoner may have to wait four weeks to receive specialist help.
- 11.57 Preliminary health statistics currently being prepared by the Director, Health Services to assess prison health service needs, show that approximately 40% of prisoners have some form of psychiatric disorder (including depression) and around 9% of those prisoners have a serious psychiatric illness. Although a prison 'stressor' or environmental factor is considered to be the trigger in the majority of prisoner suicides, the presence of a psychiatric disorder has been found to be relevant in only a minority of cases.²² The Director, Health Services estimates that a psychiatric disorder could be a precipitating factors in approximately 30% of prisoner suicides in Western Australia.
- 11.58 Whether relevant in the context of suicide or not, it is quite clear from the analysis of 'Medalerts'²³ by the Director, Health Services that the incidence of psychiatric disorder among prisoners is increasing – a pattern which he has been advised is common to other jurisdictions in Australia. In the light of a changing prisoner profile, the range of psychiatric services available to prisoners - which is considered by health staff to be already inadequate - will be placed under increasing and, perhaps, untenable pressure.

RECOMMENDATION 11.6

That the Ministry review the adequacy of its psychiatric services to prisoners and provide sufficient resources to cater for identified needs.

Prisoner Support Officers and the Prisoner Peer Support Group

11.59 The Ministry considers that an additional means of support for disturbed and vulnerable prisoners is available through the Prisoner Support Officer and the Prisoner Peer Support Group. Although this system is a valuable initiative, submissions to my inquiry (and my own observations) raised concerns about the practical operation of peer support groups, including:-

- Prisoner Support Officers are not on duty at the weekends;
- there is only one Prisoner Support Officer at each prison regardless of size;
- Prisoner Support Officers should not be exclusively Aboriginal;²⁴
- peer support prisoners are not actively involved in the reception process of new prisoners;²⁵
- Prisoner Support Officers and peer support groups have told me that they frequently encounter hostility and suspicion from prison administrative staff and prison officers, some of whom do not appear to accept that they have a positive contribution to make; and
- the Peer Support Group rarely meets with the prison superintendent and is only infrequently involved in planning of new prisoner initiatives.

11.60 Although the peer support programme is clearly a valuable initiative, there are, in my view, a number of obstacles to its optimum use. First, where the system is allowed to be proactive, the Ministry must resist the temptation to place too much responsibility for prisoner welfare on prisoners at the expense of re-emphasising the role of prison officers and other Ministry support structures. Second, I am not convinced that enhancement of the programme will be sufficient to overcome the innate distrust which appears to exist between prisoners and some prison officers.

11.61 In my view, peer support prisoners can only *assist* prison officers and other personnel in the performance of their duty of care towards prisoners. Greater expectation or reliance than that is to place an unfair burden on prisoners who have no such duty of care other than as one human being to another and (usually) no training for the role. It is also an inappropriate delegation of an integral part of the primary function of a prison officer. The key to establishing (or re-establishing) prisoner confidence in prison officers lies in greater emphasis on the importance of the communication and interpersonal skills of prison officers.

11.62 Although I am pleased to note that there is now an FTE for a Prisoner Support Officer at every prison, and that there are now two at Casuarina and Hakea, in my view the system could be improved by the following initiatives:-

RECOMMENDATION 11.7

That the Ministry:-

- (a) encourage the Peer Support Groups to make suggestions for improvements to the reception and orientation process for new prisoners;
- (b) pay peer support prisoners a gratuity for performing the role;
- (c) ensure that prison superintendents have regular meetings with the Peer Support Group and the Prisoner Support Officer and encourage their involvement in the planning of new initiatives aimed at improving prisoner welfare; and
- (d) ensure that the prison superintendents, administrative staff and prison officers accept the concept of peer support as a serious and integral part of prisoner welfare.

USE OF EXTERNAL SUPPORT GROUPS AND PRISONERS' FAMILIES

The Samaritans

11.63 I agree with the views expressed in a submission to my inquiry from The Samaritans who stated:-

"The particular value of The Samaritans lies in:

- *their specialised experience of befriending people who are thinking of suicide;*
- *their neutrality, meaning that some prisoners may open up to them in a way they would not do with staff;*
- *their non-religious status making them acceptable to people of all (and no) religious persuasions.*

There would seem to be too much distress and sadness in evidence in our prisons for an organisation with the ethical slant of The Samaritans to willingly remain distanced from the situation. It is our attitude that the real issue is not simply to prevent suicide, but to help eliminate the despair which causes the attempt. The shame of this situation is not simply the statistics for deaths in custody, but the despair and human agony that these statistics represent. In this day and age, this often seems to be overlooked."

11.64 In January 1998 The Samaritans made a number of proposals to the Ministry to facilitate its formal involvement in prison suicide prevention strategies, namely:-

- visits on a regular basis to befriend prisoners who are suicidal or in need of the support Samaritans can offer;
- confidential telephone access by prisoners to a Samaritan Centre - either by link up with the cell intercom system to an unmonitored telephone line or by use of call restricted mobile telephone or by a separate direct line using strategically placed handsets;
- selection, training and supporting listener schemes for Prisoner Support Officers and peer support groups;
- talks to prison staff about the Samaritans;
- assisting in staff training;
- supporting staff and prisoners after a suicide; and
- representation on the Suicide Awareness and Post-Incident Care Team.

11.65 The Ministry initially advised The Samaritans of its reservations about these suggestions but in January 1999 it responded more positively by apparently accepting the following proposals:-

- a mobile telephone connected exclusively to the Samaritans' Emergency Line could be made available to prisoners in the Crisis Care Unit at Casuarina;
- the successful peer support training based on the Samaritan model at Casuarina can be developed for all locations where there is a Prisoner Support Officer;
- the involvement of The Samaritans in prison officer training; and
- The Samaritans will be involved in counselling prisoners after the death of a fellow prisoner.

11.66 However, I understand from the current Director of The Samaritans that there has been no further communication from the Ministry in relation to any of these proposals and that The Samaritans are not currently involved in any way in assisting prisoners. The Ministry has confirmed that this is the case - although funding to establish an accredited 'Listeners' program had been sought from the Commonwealth government. The proposal for the availability of a mobile telephone at Casuarina apparently faltered because of reception problems at the Casuarina site. It has not been considered for any other prison.

- 11.67 In my view it is indeed a pity that The Samaritans' proposals have not been progressed. I can only agree with the view of the Samaritans that it is unfortunate that a concept which has been routinely available in most prisons in Great Britain and Northern Ireland for some time has received such a negative reception in Western Australia.

Family contact

- 11.68 Having considered the literature on the subject and comments in submissions and interviews with prisoners, staff and health professionals, it seems to me undeniable that the involvement of family members through visits, telephone contact or special meetings should be an essential component of any suicide prevention or management strategy. Although I am also conscious that 'bad' family contact can be highly damaging to an at risk prisoner, I expect that the extensive censorship of mail, monitoring of telephone calls and supervision of visits would allow observant and conscientious prison staff to be alert to any ensuing problems.
- 11.69 It is of some concern to me, therefore, that to a large extent access to visits and telephone calls is still seen primarily as a privilege which can be administratively taken away as punishment for misconduct - even if the prisoner is not charged or convicted of any prison offence. In fact, it is often the *first* consequence of any alleged misconduct. The Ministry has advised me that its new draft Operational Instruction CW 13 will provide for two telephone calls for every seven day period as a minimum standard. As at 10 November 2000, however, the Instruction remains a 'draft'.
- 11.70 I also have the impression that some prison staff see visits primarily as potential breaches of security - particularly as a means of smuggling drugs into a prison - which should be kept to a minimum. This approach, in my view, ignores the possibility that a difficult or vulnerable prisoner may respond better to a family member than to prison staff. Obviously, if prison staff are made aware that a prisoner's problems actually stem from a family issue then this should be taken into account. However, I am more concerned that there is a 'mind-set' among some prison staff which does not recognise the assistance that the family *may* be able to provide.
- 11.71 In relation to telephone calls, the introduction of the Arunta automated telephone system, which enables a prisoner to have as many ten-minute calls to approved numbers as they can afford, has given prisoners greater access to the telephone - in theory at least. However, calls are charged at public call box rates which are expensive - especially for prisoners at regional prisons and those who are unemployed or receiving the lower levels of gratuity. In addition, prisoners may only use the telephones at certain times of the day - and obviously not after lockup - and there are, in general, too few telephones to cater for the numbers of prisoners wanting to use them. I also suspect that although 'welfare' calls can still be granted, many officers would not consider that as a *first* option to assist a distressed prisoner.
- 11.72 The Custodial Inspection Team which visited Albany in September 1999 commented on the high cost of telephone calls and found that each prisoner spent on average \$40 per month on telephone calls and that more than half this amount was provided to prisoners by their families. The team also noted, however, that for the three months June to August 1999, officers at Albany had initiated \$618 worth of calls. The team went on to recommend to the Director General that prisoners in Albany who were from outside the Albany area should be granted an automatic telephone credit of \$10 per month. I support this recommendation and would extend it to all prisoners who, because of their prison placement, are unable to call their immediate family at local rates.

- 11.73 Although I note that the new *ARMS* procedures emphasise the value of family involvement in the care of at risk prisoners, it remains to be seen whether this concept will be accepted – and put into practice - by a prison culture which sees visits and telephone contact with family as interference with the security and ‘good government’ of the prison, and as privileges which can be easily lost as a punishment rather than as a positive management tool.

RECOMMENDATION 11.8

That the expertise of all relevant community support organisations be utilised and that the assistance of family members be sought wherever possible in the management of at risk prisoners. In particular, the Ministry should re-open discussions with The Samaritans to establish whether and how that organisation could become involved in prisoner welfare.

RECOMMENDATION 11.9

That:-

- (a) the recommendation of the Custodial Inspection Team in relation to the cost of calls from Albany Prison be extended to all prisoners who, because of their prison placement, are unable to call their family at local rates; and**
- (b) that the number of telephones be increased in line with rising muster levels to provide all prisoners with a reasonable opportunity to contact their families.**

PLACEMENT OPTIONS

- 11.74 At the time of writing this report placement options remain largely the same as before at most prisons, but with the addition of a Crisis Care Unit at Casuarina in April 1999 and similar facilities planned for Hakea and Bandyup. However, increasing prisoner numbers and more extensive doubling-up have effectively reduced the little existing flexibility in alternative placement as a management strategy.
- 11.75 Although, increasingly, the behavioural problems of many of the more seriously disturbed and vulnerable prisoners are exacerbated by long term substance abuse, prison facilities are not designed to facilitate effective drug rehabilitation or detoxification. Prison health service resources are inadequate to perform this function or to offer separate or specialised accommodation for those prisoners suffering the physical symptoms of withdrawal - other than at Casuarina where prisoners suffering more acute withdrawal symptoms may be housed in the Crisis Care Unit.
- 11.76 As previously noted, there continue to be no special facilities for psychiatrically disturbed prisoners. It concerns me that a wing of the Infirmary at Casuarina, which was originally intended to provide accommodation for up to 13 psychiatrically disturbed prisoners, has *never* been used for that purpose. Soon after Casuarina opened, this wing was commandeered for the running of the residential Intensive Sex Offenders Treatment Programme (SOTP) in spite of the fact that the cells were specially designed for ‘infirmary’ use and that there are no office facilities in the wing for the course presenters. It seems to me that this usage of part of the Infirmary is a waste of precious health resources which could be used for psychiatrically disturbed prisoners as originally intended or as a detoxification unit.
- 11.77 It will have become obvious from comments earlier in this report that I view the use of medical observation cells for acutely at risk prisoners as inappropriate, potentially detrimental to their well-being and unlikely to offer any assistance in addressing the *causes* of a prisoner’s distress. My conclusions on the current use and operation of medical observation cells are:-

- (a) On the basis of universally accepted psychological research, a prisoner confined to an observation cell as presently configured and managed, will experience marked sensory deprivation which is more likely to aggravate any feelings of self harm than alleviate them.
 - (b) There is justification in the view of prisoners that placement in an observation cell is often punitive rather than therapeutic.
 - (c) Prisoners may not reveal their own or others' anxieties and problems because they do not want to be placed in an observation cell.
 - (d) Medical observation cells are frequently used for non-medical purposes.
 - (e) It is inappropriate that recommendations by a member of the FCMT or by a prison medical officer that a prisoner be removed from observation following examination can be, (and, are, on occasion) over-ridden by forensically unqualified prison staff.
 - (f) The use of a 'restraint' bed and the practice of leaving a prisoner without clothing and necessities such as fluids and access to toilet facilities is most probably in breach of not only the Ministry's duty of care to prisoners but also of its obligations under International Conventions.
 - (g) Some officers 'observing' prisoners in this area are untrained and unskilled in communication. Part of the Ministry's duty of care towards a prisoner is to ensure that *only* prison officers with appropriate skills and adequate training should be rostered in the medical observation area.
 - (h) If some form of distress or agitation - which may manifest itself in various behaviours such as swearing or adverse physical reaction - is the justification for placing a disturbed prisoner in an observation cell, it seems to me to be quite inappropriate for such behaviour (which might be considered a disciplinary matter in a 'normal' setting) to result in the prisoner being charged by officers who are supposed to be 'observing' him and 'caring' for his well-being.
- 11.78 It is of grave concern that, in spite of universal condemnation of the use of 'stripped' observation cells, placement in a medical observation cell is still the *only* alternative at most Western Australian prisons and that the Ministry has taken no steps to develop more therapeutically orientated options at most prisons. It is also quite clear that the Ministry's response in the 1995 and 1997 *Government Implementation Reports* that it had "*implemented*" RCIADIC Recommendation 181²⁶ through DGRs 6A and 6B relates only to the minimum standards for segregation recommended by the RCIADIC. In my opinion, the recommendation 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*" appears to have been completely ignored. *Case Study 2* in Chapter 10²⁷ illustrates my point.
- 11.79 As stated at Chapter 10, paragraph 10.195, I have previously recommended the discontinuation of the use of medical observation cells as currently operated and was advised that there were no alternatives. A similar recommendation was also made after the inspection of Bunbury Regional Prison by the Custodial Inspection Unit. In my view, the Ministry's failure to *provide* alternatives, and the continued usage of a method which is universally condemned on practical, social and clinical grounds, is untenable.
- 11.80 Essentially, based on the evidence available to me and my own observations, I have formed the view that prisons in Western Australia are for the most part quantitatively and environmentally ill-equipped to deal with **all** categories of at risk prisoners.

RECOMMENDATION 11.10

That the Ministry as a matter of priority provide therapeutically appropriate placement options for all categories of at risk prisoner including:-

- (a) rehousing the Intensive Sex Offenders Treatment Programme to facilitate use of the vacated facilities within the Casuarina Infirmary as a detoxification centre for prisoners suffering the effects of substance abuse or to house psychiatrically disturbed prisoners;
- (b) developing and providing alternative therapeutic facilities for at risk prisoners in need of 'observation' at all prisons; and
- (c) discontinuing the confinement of at risk prisoners in medical observation cells as currently configured and operated at all prisons.

'BEST PRACTICE' PRINCIPLES FOR SUICIDE PREVENTION

11.81 Howells, Hall and Day²⁸ identified the following good practice principles for an effective suicide prevention strategy:-

Primary Prevention – early detection through risk screening on initial admission -

1. Have detailed protocols for identifying prisoners at risk, based on the research literature.
2. Have an identification system that incorporates the prisoner's response to ongoing stressors arising in the prison environment ("state" factors) as well as long-term vulnerability ("trait" factors).

Secondary prevention – *“development of a management plan to ensure the safety of the prisoner and address the dynamic risk factors that contribute to risk”* -

1. Have a range of crisis-management options.
2. Minimise the use of seclusion.
3. Provide therapeutic interventions for prisoners with a chronic, longer term risk.
4. Adopt a case-management approach with clearly defined reporting/communication mechanisms.

11.82 In my view, the principles developed by Howells, Hall and Day provide a good model on which to base a strategy for the prevention of suicide and self harm by prisoners. If they are accepted as 'best practice', how do the Ministry's current suicide prevention strategies as encompassed by *ARMS* measure up?

EVALUATION OF THE MINISTRY'S SUICIDE PREVENTION STRATEGIES AGAINST 'BEST PRACTICE' PRINCIPLES

11.83 Having considered the development of the Ministry's suicide prevention strategies and procedures for the identification, assessment, management and placement of at risk prisoners since 1991, it is quite clear that enormous progress has been made over the past 18 months. Essentially, *ARMS* incorporates all of the components listed by Howells, Hall and Day. However, my inquiry has revealed a number of residual problems or weaknesses in the effective implementation of the new approach.

Primary Prevention

“Detailed protocols for identifying prisoners at risk”

- 11.84 The Ministry's “detailed protocols for identifying prisoners at risk” are contained in the initial assessment form completed by nursing staff during the reception procedure. There is also the facility for prison officers or any other member of the prison staff to refer a prisoner, who is believed to be at risk, to the Prisoner Risk Assessment Group (PRAG) at any time after admission.
- 11.85 However, concerns about the nature of the questions in the assessment tool, restrictions on the time available to complete the form properly and the lack of training provided to nursing staff expected to make the preliminary judgement on a prisoner's risk status, are practical problems which the Ministry will need to address to ensure that its initial assessment procedures are effective.

“An identification system which incorporates the prisoner's response to ongoing stressors in the prison environment as well as long-term vulnerability”

- 11.86 Typically prison stressors are considered to include “*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 (eg parole) loss of control over outside events; and violence and victimisation.*”²⁹
- 11.87 The ‘best practice’ strategy contemplated by Howells, Hall and Day seems to envisage an awareness by the correctional authority of, and a proactive response to address, identified problems which are likely to increase the distress of prisoners, including:-
- adjustment to prison life, particularly for first time prisoners;
 - loss of contact with family and friends;
 - inflexible prison regimes;
 - removal of personal decision-making;
 - the frustration of being subjected to ‘faceless’ external bodies;
 - helplessness to solve or be involved in outside family problems; and
 - violence and bullying from other prisoners and, occasionally, prison staff.
- 11.88 On the basis of my inquiry, I consider that although the Ministry may be ‘aware’ of stress-creating factors within the prison system a ‘proactive response’ to address identified problems is less likely. There are numerous examples throughout this Report of a lack of response to problems identified by the Coroner, the IIU, members of the health and prison administrative staff, and in studies commissioned by the Ministry. Some of the initiatives which have been introduced such as the multi-disciplinary FCMT and the PRAG are under-resourced or inadequately trained.
- 11.89 In August 1999 the AIC published an overview of “*Strategies for Managing Suicide & Self-harm in Prisons.*” It appears from the report that the Ministry advised the authors of the study that it had made the “*reduction of prison stressors a priority within its new suicide prevention framework*” through:-
- “*a new emphasis on the role of fellow prisoners and the extension of the peer support programs;*
 - *an increase in recreational activities, including greater access to radio and television for prisoners on remand and those identified as being at risk of self-harm; and*
 - *an upgrading of facilities to relieve overcrowding.*”

- 11.90 In my view, the measures outlined in the AIC's overview have not been fully implemented by the Ministry in *practice*. For example, some prisoners involved in the peer support program have told me that they are not taken seriously; and that they are denied access to prisoners during the reception process. Prisoner Support Officers feel that they are spread 'too thinly' to properly perform their function. Although there are now Prisoner Support Officers at all prisons and two at the larger prisons, I am not convinced that the peer support concept has been universally embraced by prison staff and administrators. To that extent, peer support is still not used to its full potential.
- 11.91 I have not encountered an increase in recreational activities at any prison which I visited - with the exception of the introduction of television sets for all prisoners at the Remand Centre in 1998. This initiative produced a marked decrease in incidents of self harm and there were no suicides between February 1998 and June 2000. Some prisoners in medical observation cells are now also able to watch television.
- 11.92 However, from my observations, prisoners are frequently bored and are not able to be fully occupied at any prison. Recreational facilities at other prisons such as Bandyup are stretched and incapable of meeting demands. Rooms previously used for recreational activities at that prison have been made into cells to accommodate a muster which is almost twice its capacity. Female prisoners held in regional prisons are poorly provided for in terms of both recreation and employment. The Bunbury Custodial Inspections Report completed on 30 July 1999 found that there were inadequate facilities for both passive and active recreational activities. Albany Prison, however, was found to have adequate and well-organised sporting activities in spite of the fact that there was no 'dedicated' Recreation Officer.
- 11.93 I agree that the Ministry has commenced a programme of "*upgrading of facilities to relieve overcrowding,*" and that the additional 'bed space' created and planned for at Hakea and Bandyup will – in the long term - alleviate pressure on accommodation. However, I am not entirely convinced that overcrowding *per se* is a prison stress. In my view, the stress is generated when the rising musters increase pressure on staff, prisoner services, and facilities, and no remedial action is taken.
- 11.94 Dr Liebling included violence or victimisation (by prisoners and prison officers) in her list of prison 'stressors'. I entirely agree.³⁰ However, my experience is that prisoners rarely make official complaints because of fear of recrimination from either prisoners or prison staff, and those that are made are rarely substantiated.
- 11.95 In relation to loss of family contact - to which Dr Liebling also refers - the majority of prisons tolerate but do not generally encourage visits or the involvement of family members in the management of a vulnerable prisoner. For the most part, visits are considered to be a privilege which are frequently lost as a form of punishment.
- 11.96 In my view, therefore, the Ministry's response to identified prison stressors will need to be significantly improved before it can claim that it is sufficiently "*proactive*" to be considered 'best practice' based on the Howells, Hall and Day model. On a positive note, however, the commencement of the new assessment process at Hakea is an important step towards assisting prisoners to adjust to prison life in the early stages of imprisonment - a time recognised as one when prisoners are most vulnerable. Depending on their length of sentence and individual needs, prisoners will undergo a series of assessments that will assist in their management. Importantly, they will also remain at Hakea for a period of up to three weeks' orientation prior to placement in a mainstream unit. This initiative is in line with RCIADIC **Recommendation 175**, based on a submission by WAPOU, that "*there be a short transition period in a custodial setting for prisoners prior to them entering prison routine.*"

Secondary Prevention

"A range of crisis management options"

11.97 As discussed above, the Ministry strategy for crisis management includes:-

- observation and support by officers and other prison staff;
- counselling and support by the FCMT;
- peer support;
- 'doubling-up' with a friend, family member or peer support prisoner;
- medical management through 'calming' medications; and
- isolation in a medical observation cell.

11.98 There were until very recently few specially designed 'self-help' or therapeutic programmes to train prisoners to cope with immediate distress – at least at the beginning of a sentence. The new Cognitive Skills program launched by the Minister for Justice on 12 June 2000 is designed to involve *"prison-based staff working closely with prisoners to help them improve their thinking skills so they become less impulsive and are better able to manage problems such as anger and violence."*³¹

11.99 Howells, Hall and Day refer to a system devised by Lester and Danto in 1993³² which comprises five *"therapeutic tasks that need to be accomplished"*:-

- *"evaluate the security of the crisis situation;*
- *develop a relationship with the person in crisis;*
- *help the person identify specific problems;*
- *assess and mobilise the client's strengths and resources; and finally*
- *develop an action plan."*

11.100 Howells, Hall and Day observe:-

"These tasks clearly require counselling or "active listening" skills. Lester and Danto recommended the use of counsellors with experience in dealing with both prisoners and with suicide. These authors recommended counselling training for prison officer staff, as well as for mental health workers, so that prison officers come to "own" the problem of suicide."

11.101 I am not convinced that the current level of prison officer training provides them with the *"counselling"* skills envisaged by either Lester and Danto or by Howells, Hall and Day. The role of counsellor is performed primarily by the FCMT which, as earlier discussed, is, in my view, insufficiently resourced to counsel all prisoners. It is also widely recognised that it is neither appropriate nor desirable for prison officers to be left out of this task. In my view, for the Ministry to achieve 'best practice' in 'secondary prevention', suitable prison officers need to be specially selected and given comprehensive training in counselling and interpersonal skill. In addition, the FCMT should be provided with sufficient resources to provide an ongoing counselling service to prisoners – not just in times of crisis - and to be on duty at the weekends to provide education programmes and to assist and support prison officers.

“Minimise the use of seclusion”

11.102 Yet again, Howells, Hall and Day draw attention to the contraindications of using observation cells which they also describe as “*suicide-proof by removing all opportunities for self-harm*” and located in “*the same unit or management area as punishment cells*” for crisis management of at risk prisoners:-

*“We suggest that the **routine** use of observation cells of this sort is a cause for concern, for the following reasons:*

- Prisoners may be confused and unclear as to whether they are being treated or punished when they are placed in an observation cell.*
- The environment may be 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 that is punitive and coercive rather than therapeutic.*
- Observation is an isolating experience that is likely to exacerbate the level of distress and suicidal rumination (Howard League for Penal Reform, 1991)”.*

11.103 Howells, Hall and Day conclude “*Whilst these facilities may sometimes be useful in ensuring the safety of a proportion of prisoners identified as being at high risk, **it is important to have a wider range of crisis-management methods.***” (my emphasis)

11.104 At most prisons in Western Australia, observation cells are ‘stripped’ of all obvious opportunities for suicide and, other than at Casuarina where they are part of the Infirmary, are located in the same area as punishment cells. From my observations, all the reasons cited by Howells, Hall and Day for *not* using observation cells for crisis management of at risk prisoners apply to such cells in this State. Furthermore, such cells are *routinely* used at most prisons because there are few alternative placement options. Prisoners hate and fear being sent to an observation cell and, therefore, do not reveal levels of distress that may result in such a placement.

11.105 To date, the Ministry has been unmoving on recommendations from a number of sources that it discontinue using medical observation cells in their current form. My recommendation in September 1998 that the Ministry discontinue the use of medical observation cells at Casuarina was rejected on the ground that it was “*not a practicable proposition*”. I was assured, however, that placement in a medical observation cell is used as a last resort and for the shortest possible period of time. I was also advised that my comments would be passed to the At Risk Management Taskforce. Recommendations by the Coroner following the inquest into the deaths of a number of prisoners for the establishment of other, therapeutically oriented placement options have been ignored. Although there is a crisis care unit at Casuarina, medical observation cells are still used at that prison and at all others to a greater or lesser degree.

11.106 In my opinion, the Ministry has made little effort to either provide alternative management options or to minimise the use of seclusion as a crisis management strategy and cannot be said to have adopted ‘best practice’ principles in this regard.

“Provide therapeutic interventions for prisoners with a chronic, long term risk”

- 11.107 There are currently few therapeutic treatment or support programs for prisoners at any prison. Most ‘treatment’ programs occur at the end of the sentence with the focus on parole eligibility. In submissions to this inquiry, prisoners have suggested the introduction of self-help programs such as yoga, relaxation, meditation, problem-solving, decision-making and conflict resolution to assist in addressing the problems created by their poor coping abilities which frequently underlie suicide and self harm attempts. Few prisons are able to provide such programs although the introduction of the Cognitive Skills program is a significant step in the right direction.
- 11.108 The FCMT is insufficiently resourced to enable it to become involved in ongoing monitoring or routine reviews or in the presentation of the therapeutic programs referred to above. Long term prisoners in particular – a recognised ‘high risk’ group - are currently provided with no progressive or holistic sentence plan and are not given routine reviews by the FCMT.
- 11.109 The introduction of *ARMS* and the establishment of a PRAG at each prison has ensured that prisoners are monitored on a sliding scale of intensity rather than being dealt with as a high risk one day and left to their own devices the next (as happened to David Metcalf.³³) However, I could not say with any confidence that therapeutic interventions for prisoners with a long term risk are provided as a matter of *routine* rather than in response to an immediate crisis.

“Adopt a case-management approach with clearly defined reporting/communication mechanisms”

- 11.110 Howells, Hall and Day recommend that “*a case-management system would comprise at least the following processes: –*
- *Specification of criteria for the classification of prisoners at risk*
 - *Use of a standard risk-assessment procedure*
 - *Assessment of treatment and management needs of prisoners deemed to be at risk*
 - *A formal/ care management plan for each prisoner based on this assessment. This plan would need to be known by all staff having significant interaction with the prisoners*
 - *Specification of who would be the case manager for each prisoners. The case manager would normally, with consultation with other staff groups, have responsibility for coordination of the assessment and management process. The case manager would need to know the prisoner well.*
 - *A system for monitoring and reviewing progress. Part of the review process would involve dropping from the at risk list those prisoners who had improved.*
 - *Discharge planning. The case manager (or a delegated other professional) would take responsibility for liaison with, and “hand-over”, to other agencies.”*
- 11.111 As stated previously, *ARMS* and the PRAG provide for the monitoring of at risk prisoners until such time as the PRAG believes the risk has been reduced to a satisfactory level. The concept that the care of at risk prisoners is the global responsibility of all prison staff emphasised by *ARMS* should also ensure that prisoners are properly observed and elevations in current distress noted and acted upon. Although *ARMS* incorporates aspects of the components suggested by Howells, Hall and Day, and has significantly improved the Ministry’s system for the assessment and management of at risk prisoners, the model suggested by Howells, Hall and Day does seem, however, to envisage a longer term plan which might extend *outside* the prison system. I am not certain that *ARMS* envisages – or can provide - such a transitional extension of support.

11.112 I am also satisfied that the Ministry's previous sentence planning system was not capable of providing the complementary components of sentence management necessary to create certain outcomes for prisoners throughout their sentence and thereby relieve a significant prison stressor. This was a particular concern for long term prisoners who are identified by research as an identifiable high risk group throughout their sentence. The Ministry's new *Integrated Prison Regime* (IPR) appears to recognise the deficiencies of its earlier case management system. The Acting Manager Strategic Projects has advised me that:-

"The steps involved in Case Management include comprehensive assessment, service planning and delivery, regular monitoring and review. Central to effective Case Management is the co-operative relationship established between the prisoner and designated Case Officer. Case Management promotes the delivery of services in an integrated and seamless manner which facilitates the 'throughcare' of services for prisoners.

.....The key impacts that the Ministry is seeking from the Integrated Prison Regime Project in general, and the introduction of Cognitive Skills in particular, is greater involvement and ownership by prison staff in the delivery of rehabilitative interventions with prisoners and an improvement in the quality of the prison environment."

11.113 The principles of the new Case Management system are sound but whether it produces the desired results will depend on the commitment of prison administrators and prison officers to the practical application of those principles.

SUMMARY OF CONCLUSIONS ON THE MINISTRY'S SUICIDE PREVENTION STRATEGIES

11.114 I have concluded that:-

- (a) *ARMS* represents a significant improvement in the Ministry's suicide prevention strategy particularly in its promotion of the concept that suicide prevention and at risk management is the global responsibility of *all* prison staff.
- (b) There are insufficient therapeutically orientated management options to deal appropriately and comprehensively with at risk prisoners, particularly female prisoners, other than medical observation cells, the current use of which should be discontinued.
- (c) All prison staff are provided with inadequate training to enable them to properly perform this function.
- (d) Although there have been significant improvements in the allocation of staff and resources to the FCMT, it remains inadequately resourced to provide long term counselling and therapy to address the underlying causes of prisoner distress and stress which lead to suicide and self harm.
- (e) The peer support program does not operate to its full potential because of lack of prestige and opposition from some prison officers and administrators.
- (f) There should be greater involvement of community-based professional organisations and support groups to assist in suicide prevention strategies.
- (g) Family contact and support is under-utilised and diminished because of a reactive and inflexible approach to visits and use of telephones.

- (h) Suitable prison officers with a recognised ability to manage acute high risk prisoners in the Crisis Care Unit at Casuarina and medical observation cells generally should be selected and extensively trained in the necessary skills.
- (i) The Ministry's failure prior to 1998 to react promptly to problems and deficiencies in its procedures which were drawn to its attention through investigations into the deaths of the 41 prisoners who committed suicide between 1991 and 1999 shows an unacceptable lack of organisation and coordination.
- (j) The Ministry's lack of attention to the issues identified by these deaths represents a wasted opportunity to address those deficiencies; improve conditions for both prisoners and prison staff and possibly prevent future deaths in custody.

SUMMARY OF RECOMMENDATIONS

- 11.1 That the Ministry provide all health services staff with appropriate and ongoing training in the assessment of prisoners to establish any self harm or suicidal tendencies – both on admission to prison and during the term of imprisonment.
- 11.2 That the Ministry take all steps necessary to ensure that prison regimes are organised to permit sufficient time for the initial medical and risk assessment process to be completed properly.
- 11.3 That, recognising the importance of good prisoner/prison staff relations, the Ministry review its selection and recruitment process for all prison-based staff to ensure that sufficient priority is given to high level communication and interpersonal skills as basic requirements for all staff dealing with prisoners.
- 11.4 That the Ministry's operational rules require that:-
 - (a) the Director, Health Services and relevant health staff are consulted and involved in proposals and decisions relating to the health of prisoners and the management and placement of prisoners considered at risk; and that
 - (b) decisions made by qualified health professionals must not be over-ruled by unqualified prison staff.
- 11.5 That the Ministry provide the FCMT with sufficient resources to enable it to:-
 - (a) become involved in harm minimisation and self- help educational programs for prisoners; and
 - (b) monitor and regularly review long term prisoners, those with severe behavioural disorders and/or suffering from the effects of substance abuse.
- 11.6 That the Ministry review the adequacy of its psychiatric services to prisoners and provide sufficient resources to cater for identified needs.

11.7 That the Ministry:-

- (a) encourage the Peer Support Groups to make suggestions for improvements to the reception and orientation process for new prisoners;
- (b) pay peer support prisoners a gratuity for performing the role;
- (c) ensure that prison superintendents have regular meetings with the Peer Support Group and the Prisoner Support Officer and encourage their involvement in the planning of new initiatives aimed at improving prisoner welfare; and
- (d) ensure that the prison superintendents, administrative staff and prison officers accept the concept of peer support as a serious and integral part of prisoner welfare.

11.8 That the expertise of all relevant community support organisations be utilised and that the assistance of family members be sought wherever possible in the management of at risk prisoners. In particular, the Ministry should re-open discussions with The Samaritans to establish whether and how that organisation could become involved in prisoner welfare.

11.9 That:-

- (a) the recommendation of the Custodial Inspection Team in relation to the cost of calls from Albany Prison be extended to all prisoners who, because of their prison placement, are unable to call their family at local rates; and
- (b) that the number of telephones be increased in line with rising muster levels to provide all prisoners with a reasonable opportunity to contact their families.

11.10 That the Ministry as a matter of priority provide therapeutically appropriate placement options for all categories of at risk prisoner including:-

- (a) rehousing the Intensive Sex Offenders Treatment Program to facilitate use of the vacated facilities within the Casuarina Infirmary as a detoxification centre for prisoners suffering the effects of substance abuse or to house psychiatrically disturbed prisoners;
- (b) developing and providing alternative therapeutic facilities for at risk prisoners in need of 'observation' at all prisons; and
- (c) discontinuing the confinement of at risk prisoners in medical observation cells as currently configured and operated at all prisons.

- ¹ At paragraphs 9.48-9.56
- ² At paragraphs 9.7-9.9
- ³ At paragraphs 6.96-6.100
- ⁴ Chapter 10, paragraphs 10.132-10.137
- ⁵ See also Chapter 15, paragraphs 15.6 and 15.35
- ⁶ See Chapter 12 paragraphs 12.64-75
- ⁷ See also Chapter 15
- ⁸ Chapter 8, paragraphs 8.26-8.29
- ⁹ *Review of Ministry of Justice Services for Treatment and Care of Adult Prisoners at Risk of Suicide or Serious Self Harm* at pages 38-41
- ¹⁰ At page 42
- ¹¹ For example, David Metcalf in 1991, Darren Boyle, Ronald Hill and Ryan Kennedy in 1994; Carl Jackson in 1996 and Wesley Doorey in 1997
- ¹² *Australian Psychologist*, November 1999 pp157-165
- ¹³ See Chapter 10, paragraph 10.24-10.25
- ¹⁴ There are now part time Prisoner Support Officers at Pardelup, Karnet and Wooroloo.
- ¹⁵ See paragraph 11.23 above
- ¹⁶ See also Chapter 13 - *Programs*
- ¹⁷ See paragraphs 11.68-11.73 and 15.97-15.101
- ¹⁸ *Report on 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*; tabled in Parliament on 30 November 1995
- ¹⁹ See also Chapter 10, paragraphs 10.101-10.117
- ²⁰ See Chapter 4, paragraph 19 and Table 4.2
- ²¹ A session is approximately 3.5 hours
- ²² See Chapter 8, paragraphs 8.27
- ²³ A notation in the medical file of the presence of certain medical conditions such as asthma, cardiac problems, epilepsy, blood borne communicable disease, psychiatric disorder and self harm
- ²⁴ Although I am not aware of non-Aboriginal prisoners being refused assistance, the Ministry should recognise that this should be seen to be a support service for all prisoners regardless of ethnicity
- ²⁵ Prisoners have told me that requests for more exposure to, and interaction with, new prisoners in the reception process are generally refused
- ²⁶ See Appendix 1
- ²⁷ At paragraph 10.199
- ²⁸ *The Management of Suicide and Self-harm in Prisons: Recommendations for Good Practice*; Australian Psychologist; November 1999
- ²⁹ Dr Alison Liebling, *Suicides in Prison* at page 54
- ³⁰ See Chapter 15, paragraphs 15.17-15.30
- ³¹ See also Chapter 13, paragraphs 13.128-13.133
- ³² *Suicide behind bars*; Philadelphia
- ³³ See Chapter 10, paragraphs 10.7-10.12



CHAPTER 12 DRUGS IN PRISONS

INTRODUCTION

THE EXTENT OF THE PROBLEM

THE CONSEQUENCES OF DRUGS IN PRISONS

THE MINISTRY'S DRUG MANAGEMENT STRATEGIES

SUMMARY OF RECOMMENDATIONS

INTRODUCTION

- 12.1 DGR 3B identifies a prisoner as “*at risk*” if he or she is “*under the influence of, or suffering from withdrawal from, alcohol or drugs.*” History of drug or alcohol abuse is included in the list of “*Medical factors*” to be taken into account in the assessment of a prisoner’s vulnerability to suicide or self harm in the Ministry’s *At Risk Management Implementation Manual*. “*Drug-related offence*” is considered to be one of the *Psychological and Social factors* which should be taken into account, particularly in assessing younger prisoners.
- 12.2 In the context of my inquiry, three prisoners have died of a possible drug overdose since 1991 - Douglas Yorkshire (1994), Stephen Maslin (1997), and Craig Spencer (1997). Twenty two prisoners of the 29 who committed suicide between 1991 and 1999 and five of the six apparent suicides where the Coroner returned an open finding were known to have a history of illicit drug or alcohol abuse at the time of admission to prison. Seven of the 20 prisoners who died from natural causes were also found to have a history of substance abuse.
- 12.3 I have been told by the Ministry and by prison staff and prisoners that the number of prisoners entering prison with a history of illicit substance abuse is high and increasing.

THE EXTENT OF THE PROBLEM

Research and Inquiries

- 12.4 In April 1998 the Ministry completed its Drug Management Strategy Project (the DMSP) - a three-year plan for a “*comprehensive, integrated approach to addressing substance abuse issues within custodial centres and linking these to other sectors of the Offender Management Division*” - in recognition of the fact that there has been “*an escalation in the numbers of substance users within Western Australian prisons*” and in response to a “*growing awareness of substance abuse issues and the associated behaviour of offenders*”.
- 12.5 In October 1998, prior to the release of its *Position Paper on the Health Care of Prisoners and Detainees*, the Federal Vice President and Chair of the AMA’s Ethics and Public Health Committee, Dr Sandra Hacker, reported that national prison population studies showed that:-
- 68-83% have an alcohol or drug problem relating to their incarceration
 - 20-25% of inmates use heroin
 - 64-69% of inmates share needles
 - more than 70% smoke tobacco
 - 33-44% use marijuana
 - 33-66% are Hepatitis C carriers¹
 - 21-39% have attempted suicide.
- 12.6 The prevalence of drugs in the prison system and growing numbers of prisoners with a history of substance abuse appear to be supported by submissions and information received from a wide cross section of prisoners and prison and health staff during the course of my inquiry. However, it is of some concern that, in spite of an apparent awareness of the increasing availability of drugs within the prison community and the acknowledged impact on the security of the prisons and the management and safety of prisoners and prison staff, the most recent *statistical* analysis of the extent of the problem in Western Australian prisons available to the Ministry appears to be a study completed in 1988² which found that:-

- 52.4% of prisoners screened were either “concerned” or attributed the reason for their imprisonment to alcohol;
 - 24% described themselves as regular drug users prior to imprisonment; although only
 - 17% of those accepted that they had drug “problems”.
- 12.7 In June 1997 the Legislative Assembly of the Parliament of Western Australia established a Select Committee into the *Misuse of Drugs Act 1981* (the Select Committee) to:
- “examine mechanisms to prevent and ameliorate illicit drug problems through the application of effective legal sanctions; and
 - to provide educational, health services and community support structures to assist those who are affected by the use or abuse of illicit drugs.”
- 12.8 The Select Committee’s Interim Report – *Taking the Profit out of Drug Trafficking* – (the Interim Report) tabled in November 1997, considered the issue of drug use in prisons and the Ministry’s management strategies at the time. *Inter alia*, the Select Committee registered its surprise and concern that the Ministry did not appear to have current or reliable statistical data on the extent of the problem of substance abuse among prisoners before and during imprisonment and recommended that it:-
- “...in consultation with relevant law enforcement agencies, institute a State wide process for the mandatory and anonymous monitoring of drug use by offenders at the time they first enter the criminal justice system.”(Recommendation 60)
- 12.9 The Select Committee was also critical of the lack of detail recorded in the Ministry’s initial assessment of prisoners on admission³ and recommended that -
- “the assessment, management and treatment of offenders with licit and illicit drug problems be an integral part of all institutional and community based programs, across all stages of each offender’s contact with the Ministry of Justice.” (Recommendation 62)
- 12.10 The Select Committee looked at studies conducted in other jurisdictions and included in its Interim Report results of more recent research which indicated similar – and probably comparable - drug problems in prisons elsewhere. For example, a 1995 study in New South Wales⁴ found that:-
- 67% of prisoners said that they had been under the influence of drugs at the time of their most serious offence;
 - 66% attributed their imprisonment to their drug use: and
 - 74% admitted to having problems because of their drug use.
- 12.11 A report into levels of drug abuse by female offenders⁵ in NSW in 1995 reported particularly high levels of drug abuse among a sample of 130 women, including:-
- 62% reported being intoxicated at the time of offending;
 - 46% had consumed drugs (not alcohol);
 - 66% had consumed heroin;
 - 72% attributed their imprisonment to their drug use;
 - 50% had committed the offence to purchase drugs;
 - 25% worked in the sex industry;
 - 33% had used heroin daily over the previous 6 months.

- 12.12 A sample of 395 offenders screened in 1997 at reception to NSW prisons found⁶:-
- 20-40% were withdrawing from alcohol and/or other drugs;
 - 30-40% were receiving psychoactive medication;
 - 70-80% were intoxicated when they committed the offence for which they had been convicted;
 - 35-70% reported injecting drug use in the past 12 months.
- 12.13 A paper presented at the 1st National Public Health Conference on Health in Prisons in Sydney on 15 February 1999 claimed that 75-80% of prisoners in NSW are imprisoned on drug related charges.⁷ This Conference also noted as one of its resolutions “*the high correlation of alcohol, drugs and crime and the effectiveness of harm minimisation.*”
- 12.14 The Report on Suicide Prevention Strategies for Prisons in Western Australia commissioned by the Ministry in late 1997 noted the presence of a “*high number of prisoners with substance abuse*” and that these prisoners are “*particularly ‘at risk’ in the early days of imprisonment.*”⁸
- 12.15 The Smith Report on the Casuarina ‘riot’ on 25 December 1998 commented on the extent of the problem in Western Australia:-
- “Various indications, despite their inadequacies, point to growing drug use amongst offender groups, particularly in regard to opiates which are now fairly cheap and widely available. Drug use amongst offender groups is now so widespread it is probably more than likely that an offender entering a prison such as Casuarina (and other prisons) has a drug problem. It may be wise in fact to assume as a matter of course that prisoners are drug dependent rather than not.....”* (my emphasis)⁹
- “In prison the demand for drugs is evidenced in a number of ways. First the amount of illicit drugs in the prison, the number of overdoses due to opiates, and more recently the pressure to get psychoactive drugs from medical staff.”*
- 12.16 On the basis of information received during the course of my inquiry, I have reason to believe that the prevalence of drugs at Bandyup Women’s Prison is also significant. Certainly, from my experience, female prisoners made little attempt to deny their drug taking when speaking with me and members of my staff.

Changing prisoner profile

- 12.17 I have been told by a significant number of prison officers, health staff and by prisoners (particularly prisoners who have been in the system for some time) that there has been a change in the type of offender entering the prison system. Interviewees who raised this issue overwhelmingly attributed the changing prisoner profile to the increasing use of illegal substances by younger offenders.
- 12.18 There is apparently no clear indication from research to date whether drug abuse generates crime or whether those with a history of offending are more likely to engage in other criminal activity such as drug abuse. A 1995 study of violent property crime conducted by Dr David Indermaur of the Crime Research Centre at the University of Western Australia concluded:-

*“It is likely that the minority of drug users who do commit crime were already engaged in criminal activities before becoming addicted. It is, therefore, the lifestyle that underlies both crime and drug use which provides the most informative link.”*¹⁰

12.19 An American study conducted in 1995¹¹ concluded that:-

“...extensive research on the relationship between drug abuse and crime provides convincing evidence that a relatively few substance abusers who have a severe drug problem are responsible for an extraordinary proportion of crime.”

12.20 That report also observed that ‘drug abusing offenders’:-

“...are responsible for a relatively large amount of crime. Among them the most predatory – the heroin-using ‘violent predators’ – committed 15 times more robberies, 20 times more burglaries and 10 times more thefts than offenders who do not use drugs. Studies conducted among heroin users in Baltimore and New York demonstrated that active drug use accelerates the users’ crime rate by a factor of four to six.....drug-using felons are also a primary source of failure on parole; that is they constitute a disproportionate share of repeat offenders.....The ‘revolving door’ analogy epitomises the situation with offenders who use hard drugs.”

12.21 The Report by the Victorian Law Reform Committee on *Criminal Liability and Self-Induced Intoxication* stated:-

“During its public hearings and inter-state visits the Committee was presented with overwhelming evidence of a strong link between alcohol and drugs and crimes of violence, with up to 90 per cent of crimes of violence involving some sort of consumption of alcohol and/or drugs.” (Paragraph 5.21)

12.22 The submission to me by the Australian Nursing Federation also suggested that the type of drug-dependent prisoner was also linked to the availability of drugs in the system. For example, the presence of one or more heavy users among the prison population was likely to increase demand, availability, usage and, inevitably, management problems. Where there are primarily ‘social’ users, demand and usage will be less. Although this may sound self-evident, from a management point of view, the more that is known about the type of drug user, the better the Ministry should be able to allocate its resources. As discussed below (at paragraphs 12.76-82) the Ministry currently has no such planning ability.

Increasing recidivism

12.23 Using data from the police arrest database (arrests in Western Australia from 1984 to 1995) the Select Committee estimated the likelihood or probability of re-arrest for drug offenders and found that, overall, the probability of re-arrest for *any* offence was 53% (or one in two) for drug offenders with no prior record of arrest and 76% (or three in four) for those with a previous history of arrest¹². The Select Committee also found that the drug offenders without prior records generally took longer to be re-arrested for any offence than offenders with a previous history. Interestingly, the Committee’s research also showed that only 30% of first drug offenders and 50% of those with a previous history of arrest were likely to be re-arrested for another *drug* offence in their lifetime.¹³

12.24 On the basis of the available evidence – albeit largely anecdotal and not part of a formal study of the issue – it seems reasonable to conclude that at very least the drug problem in Western Australian prisons is greater than it was in 1988 and that it has given rise to a range of problems with consequences for prisoners and prison staff, the prison system as a whole, and ultimately, for the community.

THE CONSEQUENCES OF DRUGS IN PRISONS

- 12.25 The Victorian Law Reform Committee report on *Criminal Liability and Self-Induced Intoxication* noted at paragraph 5.13:-

“The neurobiological changes brought about by the use of intoxicants may include impaired self-control, hallucinations, unpredictable violent behaviour, fear, anxiety, psychotic behaviour and loss of memory. What effect intoxicants will have on a particular individual varies because ‘each psychoactive drug produces its own distinct array of neurobiological changes’...”

In summary, intoxicants have a substantial impact on human behaviour, but the nature of this impact varies between and within individual drug classes.”¹⁴

- 12.26 There is little doubt that offenders admitted to prison with a history of substance abuse; in withdrawal from, or under the influence of, ‘intoxicants’; or with drug-seeking tendencies present prison staff with a range of significant management problems, both short and long term. For example, a submission to my inquiry from a Health Services staff member stated:-

“For long term heroin addicts there are no medical alternatives other than abstinence in gaol. This presents us with serious health management problems in terms of illicit use of drugs in gaol, erratic supply of heroin of different strengths, needle-sharing which spreads blood-borne communicable diseases, prisoners sharing their prescribed medication, and the use of standover tactics by some prisoners to get other prisoners’ medication.”

- 12.27 The same submission highlighted the problems created by drug-dependent prisoners who have “*limited coping skills*” or are “*emotionally disturbed, or psychiatrically ill*” or have been “*assessed as being a suicide risk*”.

- 12.28 In summary, it seems to me that the presence of large numbers of drug-dependent offenders in the prison system causes at least the following management problems:-

- poor and deteriorating physical health and increased health risks to **all** prisoners and staff;
- increased risk and incidence of self harm and suicide;
- unpredictable behaviour; and
- increased potential for bullying, standover and violence.

- 12.29 Strategies to properly address the consequences of drugs in prisons - comprehensive treatment and rehabilitation programs and detection and deterrence mechanisms - are expensive and resource-intensive because, ideally, they require the introduction of additional management strategies and purpose-built facilities and the employment of specially trained staff.

Poor and deteriorating physical health and increased health risks

- 12.30 One of the major consequences of the use of injectable drugs by offenders both prior to admission and within the prison system is the increased risk of the transmission of blood-borne and sexually transmitted diseases such as HIV and Hepatitis A, B and C through the sharing of needles. In response to a parliamentary question on 9 September 1999, the Minister for Justice advised that between 20-40% of all new arrivals in prison tested positive to Hepatitis C; that a survey conducted by Health Services in 1997 found that approximately 13% of prisoners were Hepatitis C positive; and that there was no data on how many prisoners had contracted Hepatitis C while in prison.

- 12.31 During a panel¹⁵ discussion of the treatment of blood borne communicable diseases at a Health Services Conference for Western Australian prison health staff held in June 2000 it was stated that 37-66% of prisoners had a history of intravenous drug use (IDU) and that 10% commenced IDU and 42% reported IDU while in prison. Although the panel were of the view that IDU was less prevalent in prison than in the community, it was also considered that sharing of equipment was more likely.
- 12.32 The incidence of unprotected consensual and non-consensual sexual contact between prisoners increases the possibility of the transmission of blood-borne diseases. The real extent of sexual contact between prisoners is a further area where the Ministry has no statistical data. I also found that, even anecdotally, it was difficult to obtain an accurate view of this sensitive area because of the reluctance of most prisoners and others to talk about the issue.
- 12.33 It seems to me that the increased risk of transmission of blood-borne and sexually transmitted disease is an inevitable outcome in Western Australian prisons where there is no needle exchange program - so that needles and syringes can *only* be obtained as contraband items. The provision of condoms via vending machines has been progressively introduced since March 1998 when the first machine was installed in Canning Vale and has been available at all prisons throughout the State since the end of July 2000. The Ministry has told me that there have been no reported incidents or breaches of security involving condoms since the initiative was introduced and that, on the basis of the limited monitoring possible of this sensitive subject, there is a relatively high turnover of stock.
- 12.34 The AMA's *Position Statement* on prison health services confirms the medical view of the hazards of using injectable drugs in a section entitled *Harm Minimisation*:-

“Many prisoners and detainees have used injectable drugs. Imprisonment can increase drug use and the risks of transmission of blood-borne and sexually transmitted infections. Harm reduction programs are important in the prevention of the spread of HIV and Hepatitis C among injecting drug users. (9.1)

In order to protect staff, prisoners, detainees and the public, appropriate arrangements for access to needle and syringe exchange programs, sterilising equipment for tattooing and skin piercing, methadone maintenance therapy, specific education about HIV, Hepatitis C and other blood-borne and sexually transmitted infections, and access to condoms should be available.” (9.3)

Increased risk of self harm and suicide

- 12.35 By means of references in both DGR 3B and the *ARMS* Implementation Manual the Ministry clearly recognises that a prisoner's vulnerability to self harm and suicide is likely to be enhanced by a history of drug or alcohol abuse or by the fact that he or she was involved in a drug-related offence. The Report of the Ministry's *DMSP* refers to –

“.....an increasing concern over the incidence of substance abuse, and the perceived overdose rates within the community and prisons. This has been exacerbated by the death of several prisoners recently, that are attributed to substance use, whilst in custody”

- 12.36 Following the suicides of several prisoners with a substance abuse history soon after their admission to prison (16 of the 29 prisoners referred to in paragraph 12.2 were remand prisoners) questions were raised by the Coroner and prison health professionals about the adequacy of the Ministry's approach to the management of such prisoners. In particular, concerns were raised about the unavailability of methadone maintenance programs for all but a very small number of exceptions¹⁶ and the lack of appropriate resources and facilities to properly care for, support and accommodate prisoners suffering the effects of substance abuse.¹⁷
- 12.37 The Smith Report said that "*Drug use amongst prisoners is now so widespread.....[it] may be wise in fact to assume as a matter of course that prisoners are drug dependent rather than not.*"¹⁸ If this is true, one of the biggest management issues facing the Ministry is the extent to which it is able to deal with such prisoners and the amount of funding it is prepared to allocate to its strategies. For example, to reduce the risk of self harm by drug-dependent prisoners - particularly at an early stage of their first period of imprisonment or remand - they may well require placement in suitable detoxification facilities under the management and supervision of qualified staff who are able to monitor physical and other symptoms and provide ongoing support and counselling. It appears from my inquiry that the Ministry is currently unable to provide that degree of specialised care at any of its prisons.

Unpredictable behaviour

- 12.38 The Victorian Law Reform Commission Report stated:-

"It is difficult.....to accurately predict the response of an individual to particular intoxicants, not only because of the distinct impact of the intoxicants themselves, but also because of the existence of other factors extraneous to drug type. Some of those factors which have an impact upon an individual's psychological response to intoxicants include:

- (a) Dosage and how the intoxicant is taken.....*
- (b) Previous experience with drugs.....*
- (c) Genetic factors.....*
- (d) Psychological state....."* (Paragraph 5.13)

- 12.39 There is little doubt that, on admission to prison, all offenders, but particularly those who are drug-dependent, bring with them a range of complex behavioural problems. The physiological and psychological effects of some intoxicants may result in behaviour which even the user is unable to control or recall subsequently. Prison officers are not behavioural psychologists - nor should they be - and unpredictable behaviour by definition is one of the most difficult for them to deal with.
- 12.40 Although prisoners may cause management problems by being 'difficult' for a number of reasons - for which disciplinary measures are entirely appropriate - the behavioural problems related to drugs may have different consequences and call for a different approach. For example, the presence of drugs was identified by the Smith Inquiry¹⁹ as having "*a central place in any analysis of the riot*". The effects of drugs were seen as being "*a direct contributor to the unruly and defiant behaviour of the prisoners that culminated in the mob violence that was the riot.*"

- 12.41 Neil **Holt**, an 18 year old remand prisoner who died by hanging in Hakea Prison in January 1998, was described in the IIU investigation of his death as a serious “*management problem*” whose behaviour was both unpredictable and impulsive. His behavioural problems were largely dealt with as disciplinary matters by use of punishment, isolation and restraint, although his file indicates that he was a poly-drug user who was withdrawing from heroin on his admission to prison and had been diagnosed as suffering from ADHD. In spite of the inclusion of a history of substance abuse as an ‘at risk’ indicator in DGR 3B, and the knowledge that Mr Holt was a poly-drug user, he was not assessed as being at risk of self harm. Although he was seen by the FCMT while in a medical observation cell and prior to being released into close supervision, he was subsequently only seen “*informally*” by the FCMT.
- 12.42 In my view, *effective* management of ‘problem’ prisoners with a history of substance abuse, requires the allocation of resources in the form of specially trained staff; appropriate treatment programs and dedicated facilities.

Increased potential for bullying, ‘standover’ and violence

- 12.43 The presence of large quantities of drugs in prisons has implications for the “*good government, good order and security*” of the prison in that it leads to tension between prisoners based on those who have drugs and those who do not. Prison officers have told me that pressure from other prisoners to obtain drugs can be a major stressor for prisoners, particularly new prisoners. Prisoners’ families can be pressured to import drugs either for the use of a prisoner or because he or she is subject to standover tactics. Detection and the subsequent punishment (which may include loss of contact visits) can have a significant effect on the welfare and well-being of an already vulnerable prisoner.
- 12.44 Internal drug trafficking between prisoners tends to engender violence and bullying and causes an undercurrent in the prison system which is difficult to deal with because, like that in the community, the prison drug culture is based on activities which are essentially illegal. Because they are subject to severe sanctions by the system, prisoners will go to great lengths to conceal not only the trafficking and use of drugs but also the effects of any associated violence or retribution. For example, the inquest into the death of Dean **Lauder**, who committed suicide in Canning Vale in May 1998, revealed that he had attempted to arrange for a visitor to bring drugs into the prison because he “*owed*” another prisoner. When the visitor did not arrive at the prison, Mr Lauder was said to have been “*fearful of what might happen to him at the stage when he was released from solitary confinement if the drugs were not smuggled into the prison*” and to have told his sister “*I’m dead, I’m f----g dead.*”
- 12.45 The lack of reporting by victims and unavailability of witnesses mean that violence against prisoners creates an undercurrent which, in my view, is as disruptive to the good order and security of the prison system as open defiance and disobedience. It is also without doubt a significant stressor for prisoners and an accepted factor in suicides and self harm. Although I acknowledge the difficulties which both the Ministry and the police face when dealing with a ‘code of silence’, I am also aware that prisoners have little confidence that their complaints will be properly investigated even if they are prepared to take the risk of making a complaint. The existence of this sub-culture of unaddressed violence has serious repercussions for the ‘good order of the prison’. It also creates a prison stress which may increase the risk of self harm in a vulnerable prisoner.

- 12.46 I am satisfied from submissions and evidence to my inquiry that all of the above problems – deteriorating health, unpredictable behaviour, increased risk of health problems and self harm and suicide and greater potential for violence and bullying – are present in Western Australian prisons to a greater or lesser degree. The extent of the problems and their implication for staff working in the prison system will depend on the Ministry’s ability and willingness to introduce strategies to address the concerns and manage what is clearly an increasing problem. The possible outcome of *not* accepting the extent and consequences of the presence of drugs is reflected in the conclusion in the Smith Report that:-

“The riot on Christmas Day reflects the delay in tackling the growing drugs crisis in prisons and indeed the reactive crisis management that has come to characterise the operations of the Offender Management Division, particularly in terms of prisoner services.”²⁰

THE MINISTRY’S DRUG MANAGEMENT STRATEGIES

- 12.47 The AMA’s *Position Statement* states the following as essential components of a prison health service:-

“Adequate facilities for detoxification and for the management of alcohol and substance abuse must be available to prisoners and detainees.” (8.4)

- 12.48 At page 163 of its Interim Report the Select Committee stated:-

“A more comprehensive approach to responding to drug problems would contain the following elements:

- *supply reduction;*
- *demand reduction; and*
- *problem solving.*

The object of early intervention is to identify, assess and treat those individuals who have histories of serious drug abuse, and if who remain untreated are likely to create considerable management difficulties, sustain the demand for drugs within the correctional environment and add to the pressures for dealing in drugs within prisons.”

- 12.49 The Report of the DMSP conceded that the Ministry’s previous practices and policies “*were often isolated, not evaluated and lacked cohesion internally as well as with other Directorates.*” To address these deficiencies the DMSP report proposed that successful drug management strategies should place an equal emphasis upon a “*tripartite set of goals*”:-

- (i) reducing the supply of substances – through detection and deterrence;
- (ii) reducing the demand for substances – through medical management;
- (iii) reducing the problems of substance abuse – through non-medical management;

and made a number of recommendations designed to achieve those goals.

- 12.50 In April 1999 the Ministry conducted a review of the recommendations made in the DMSP report and of progress or otherwise in their implementation. In early 2000 the Ministry decided to adopt the report of the DMSP as “*a reference document contributing to the development of an Offender Management/Prison Services Drug Management Strategy*”. As part of my inquiry, I have examined the Ministry’s strategies and the extent of their implementation in practice.

(i) Reducing supply - detection and deterrence

Detection

- 12.51 In order to reduce the supply of drugs in prisons, an effective means of detection is essential. This is achieved by means of searches of prisoners, their cells, property and visitors; by urine testing; observation in visiting areas; random checks on prison staff; use of passive dogs, surveillance and intelligence reports. The Ministry appears to be of the view that the primary source of drugs in prisons is prisoners' visitors and aims its major detection initiatives at this point of entry. The *DMSP* report proposed additional measures to control and monitor visitors and visits, including amendment of the *Prisons Act* to allow prescribed bans on visitors who have committed drug offences; allowing contact visits only with approved/nominated visitors and by enhancing the level of supervision of visits using specialised staff trained in behavioural management and basic group management. I understand that none of these proposals has been implemented to date.
- 12.52 On the basis of submissions to my inquiry and interviews with a wide range of interested persons, and the large amount of drugs which is reputed to be freely available within every prison, I question whether the primary focus on visitors is effective.
- 12.53 A submission by the Howard League for Penal Reform to the UK Home Affairs *Select Committee on Drugs In Prison* (1998) contained the results of a survey of visitors to four UK prisons and young offender institutions "*in order to ascertain which drugs were predominantly smuggled into prison and for which drugs both prisoners and visitors were being punished.*" The survey found that "*less than one percent of the visiting population were found with drugs in their possession and in an overwhelming proportion of those cases (between 71 and 94 percent) cannabis was the offending drug.*" To my knowledge, the Ministry has never conducted a similar survey. As a consequence it has no similar empirical data on which to base its current detection focus.
- 12.54 Little proactive attention appears to be given to the possibility of trafficking by prison staff of all levels, or through, for example, deliveries and other means of entering a prison. Officers in the IJU have told me that, on the strength of intelligence information alleging involvement in drug trafficking by persons other than prisoners' visitors, it has recommended a number of avenues of investigation to the Ministry or to individual prison superintendents over the last two years. According to those officers no action was taken. However, I do not believe this assessment is entirely accurate as I am aware that the Ministry has, in conjunction with the police, taken steps to investigate suspected involvement in drug activity by persons other than prisoners' visitors. For example, a prison officer was recently convicted of attempting to import drugs into a prison.
- 12.55 One of the visiting justices who made a submission to my inquiry was of the view that current detection methods were unsuccessful and that there should be a greater focus on possible trafficking by prison staff. In the course of this inquiry I received (non-specific) allegations that some officers provide prisoners with drugs in return for some form of payment from the prisoners' families or in return for information. I also question whether other illegal items, such as mobile phones, which have been found in the possession of prisoners, could be imported by a prisoner's visitor without detection. From my own experience and observations, searching of persons who enter a prison, *other* than visitors to prisoners, is superficial and haphazard. I was pleased to hear that the 1999 review of the *DMSP* has resulted in a move to focus attention on all possible points of entry for drugs including prison staff and deliveries of goods.

Deterrence

- 12.56 Dr Wendell Rosevear, a doctor and visiting medical officer to correctional centres in Brisbane, and one of the members of the working party which formulated the AMA's *Position Statement* on prison health services wrote²¹:-

“Placing a wall around a drug addict doesn't stop them from becoming an addict. When they continue to use drugs authorities feel a failure and respond with increasing power, denying the reality that only one person can stop someone using drugs and that is the person involved. Authorities think that by increasing the punishment consequences, they can effect change, but they deny the fact that drug addicts don't live in a world of consequences, they live in a world of instant relief.”

- 12.57 The focus of the Ministry's drug deterrence strategy has been primarily on “*disincentives to prisoners and significant others to reduce their willingness to participate in the illicit use of drugs and alcohol, and the introduction of such substances and associated paraphernalia into prisons...*”²² Disincentives might include separate confinement, loss of privileges, loss of remission, and – until mid December 1999 when empowering regulations were disallowed by Parliament - restitution of the cost of urinalysis testing. However if, as stated by a visiting justice in a submission to my inquiry, 95% of charges he heard were drug-related, the efficacy of the ‘stick’ philosophy in reducing the demand for drugs is questionable.
- 12.58 It is encouraging to note, therefore, that the *DMSP* report acknowledges that there might be other and more effective means of deterrence, such as “*incentives*”:

“There is growing acceptance, supported by “best practice” literaturethat incentives offered to prisoners act as strong inverse deterrents in managing substance use within prisons. Therefore, this will form an integral part of the proposed strategy, to balance the preponderance of the sanctions based policy framework, that has been operational to date.” (page 28)

*“.....Promotion of incentives is seen as the most effective method to encourage abstinence from substance usage during incarceration. The incentives regime should be complemented by sanctions directed at prisoners who choose to engage in substance use. **In this manner the prison setting utilises a pro-active prisoner management approach to encourage a pro-social environment and effectively “shapes” the behaviour.**”* (page 30)

- 12.59 Incentives might include extra or special visits, work placement, program availability, leave of absence and positive parole recognition. To this end recommendations in the *DMSP* report suggest the establishment of drug-free units with “*defined incentives in the structured day, which include privileges and program availability*” (Recommendation 5); and propose a “*standardised system of incentives for statewide implementation*” with “*increasing opportunities at decreasing security ratings.*” (Recommendation 6)
- 12.60 This is an enhancement of the current policy for placement in a self-care unit which requires that a prisoner must be drug-free but does not formally monitor the prisoner to verify his or her ongoing status. It is proposed that eligibility for placement in a drug-free unit would be subject to participation in intensive treatment programs and that incentives could include additional privileges (eg visits, greater access to electrical items) and provide a wider range of programs and recreational activities. Privileges could be increased in line with a decreasing security rating. It is unclear from the *DMSP* report whether funding has been approved for this initiative.

- 12.61 The apparent change in the Ministry's approach is encouraging. Although the 1999 review states that no further action other than the utilisation of existing self-care facilities on a pilot basis is intended I have been advised by the Ministry that Nyandi is to be established as a drug-free unit. The proposal is for an incentive-driven environment with both methadone and naltrexone programs and a testing regime. Prisoners detected using cannabis will be given one chance but will be required to undertake counselling. Any prisoners found with 'hard' drugs will be transferred back to a normal prison. It appears from the 1999 review that there has been no further positive action on a standardised system of incentives other than the development of draft DGRs.
- 12.62 There is widespread support for the establishment of drug-free units (or prisons) as part of a hierarchy of incentives to prisoners to become and remain drug-free. I fully support the recommendation in the *DMSP* report and urge the Ministry to provide the necessary funding.

RECOMMENDATION 12.1

That the Ministry allocate funds and resources to facilitate implementation of Recommendations 5 and 6 in the Report of the *Drug Management Strategy Project* as a matter of priority.

(ii) Reducing demand – medical management

- 12.63 Appropriate management of a prisoner suffering the effects of substance abuse on admission to prison requires knowledge of the extent of that prisoner's prior drug or alcohol use (the initial assessment) and a strategy for the medical management of that identified problem during the sentence (pharmacotherapies). The Select Committee was critical of the Ministry's efforts in both these areas.

Initial assessment - the welfare of the prisoner

- 12.64 The initial assessment of prisoners on admission is an essential health management tool for the identification of physical problems. It is also an important strategy in recognising a prisoner's likelihood of self harm during what is widely recognised as the time of greatest vulnerability. The importance of the first assessment was recognised by the RCIADIC which recommended in **Recommendation 156** that the initial medical assessment should be performed "*within 24 hours by a medical practitioner or trained nurse and by a medical practitioner within 72 hours if the initial assessment is performed by a nurse.*" The Government's response to Recommendation 156 stated that initial assessments were completed at most prisons within the recommended time frame.²³
- 12.65 Section 39(b) of the *Prisons Act 1981* provides that the prison medical officer shall "*on the request of the chief executive officer, examine a prisoner as soon as practicable after the prisoner's admission to prison and ascertain and record the prisoner's state of health and any other circumstances connected with the prisoner's health, as the medical officer considers necessary.*" *Health Services Policy 1.1* provides that all new prisoners must "*have a nursing assessment completed within 24 hours of receipt or the next time a nurse is available when there is no 7 day nursing cover*" and "*must see a medical practitioner at the next available medical clinic.*"
- 12.66 In its Interim Report the Select Committee stated its belief in the importance of the initial assessment and expressed concern about the adequacy of the Ministry's initial assessment procedure particularly in relation to the questions about a prisoner's previous substance abuse history:-

“.....it is to the mutual benefit of the prisoner, the prison system and the wider community if those prisoners with significant drug problems can be identified at the point of entry into prison. The next step in the process is to engage such individuals into an effective and relevant treatment process, with the initial object of psychologically and medically stabilising the prisoner. The payoff for the prisoner, and the prison community into which he or she is placed, is that with proper management of his or her drug problems the prisoner will not need to use drugs.....”

The routine comprehensive assessment of drug problems in offenders to determine their current drug usage and possible treatment needs does not apparently occur in WA prisons. Prisoners are routinely assessed with respect to their degree of risk for self-harm, with only 2 lines of information as an open ended question in relation to drug and alcohol use or dependency, Substance abuse history, on the Social Factors checklist form.” (page 161)

- 12.67 As a result the Committee recommended that the Ministry *“implement the use of more comprehensive drug and alcohol assessment questionnaires and other appropriate measures as part of the reception process each time a prisoner enters the State’s prison system.”*(Recommendation 63)
- 12.68 Although none of the submissions to my inquiry has raised concerns about the adequacy of the assessment procedure itself, several members of the nursing staff have complained about restrictions on the length of time which they are allowed to complete both the medical assessment form **and** the lengthy *At Risk Assessment* form, given that most new arrivals tend to arrive from court late in the afternoon when the nursing staff have other routine duties to perform (such as medication rounds and other nursing administrative duties). More importantly, many nursing staff told me that they are frequently placed under unreasonable pressure by prison officers to complete these important duties quickly to fit in with the officers’ operational duties at the end of the day.
- 12.69 The Government’s tabled response to the Select Committee’s Interim Report acknowledges the importance of *“comprehensive assessment”* in determining the *“individual criminogenic factors of each offender”*, and states that *“MOJ [the Ministry] has been examining alternative options to determine the most appropriate vehicle to achieve this outcome”*.
- 12.70 The DMSP report (at page 39) confirms the concerns expressed by nursing staff. It agrees that *“cell allocation and other daily prison management concerns take precedence over medical assessment”* and that it appears that *“there is no appreciation by custodial staff of the legitimate role of Health Services in the initial intake phase.”* The DMSP report concludes that this situation:-
- “.....can result in brief, rushed assessments by nursing staff, because this is usually one of the last functions in the reception process. The content of these assessments is crucial as there is a primary need for the risk assessment elements to be performed in a timely, considered manner. **This impacts on the effectiveness of the immediate management and placement of the prisoner with an increased probability of incidents.**”* (my emphasis)
- 12.71 Recommendation 22 in the DMSP report proposes that *“Nursing personnel should be afforded immediate access to newly arrived prisoners following the completion of essential reception tasks as a priority function of the reception process.”* The DMSP report does not, however, appear to consider the Select Committee’s concerns about the adequacy of the current questionnaire or recommend that it be reviewed to ensure that more detailed information about an offender’s substance use history is obtained on admission to prison.
- 12.72 Unquestionably, the initial assessment of prisoners on reception is vital to their subsequent management and forms an integral component of the Ministry’s duty of care to prisoners. Errors or omissions at this early stage in a prisoner’s sentence can be serious, if not fatal, because it is commonly accepted as the time when a prisoner will be feeling most hopeless, helpless and vulnerable.

- 12.73 The 1999 review of the *DMSP* report states that communication of a policy direction to all prisons “to ensure [that] access to new receivals by nursing staff at the earliest practical point” has been endorsed and compliance ensured “through active monitoring of reception processing activities”. The Ministry is also of the view that the establishment of the reception/reception centre at Hakea will ensure “direct functional relationship between health services and reception”.
- 12.74 It is to be hoped that the Ministry’s response to and implementation of *DMSP* Recommendation 22 will have the effect of re-emphasising the importance of the initial assessment process and resolve any conflict between health and prison staff. In my view it is of grave concern when such a conflict has the potential to interfere with the duty of care required of both parties and the ultimate treatment provided to prisoners. Because of concerns about this conflict I urge the Ministry to ensure that prison officers are fully informed of the rationale behind Recommendation 22.
- 12.75 In relation to the Select Committee’s concerns about the adequacy of the content of the assessment form, I am satisfied from my discussions with members of the nursing staff at all prisons that they are capable of asking – and do so - the ‘right’ questions even if those questions do not appear on the form itself. The limiting factor is the time constraint placed on them. The Ministry should, however, compare the content of its form with those currently used in the community to ensure parity. At the same time, I think that most health services staff would agree that they (and prisoners) would benefit from specific training in the area of substance abuse. Current training opportunities for health services staff in clinical fields of particular relevance to prisoners are minimal.²⁴

RECOMMENDATION 12.2

That in the interests of the welfare and better management of offenders entering prison in withdrawal or suffering from the effects of substance abuse the Ministry should:-

- (a) review the initial medical assessment form to ensure that it provides adequate data for the management of prisoners;**
- (b) provide health staff and other interested staff with specialised training in the management of substance abuse problems; and**
- (c) ensure that medical and nursing staff gain access to newly-admitted prisoners early enough to complete all assessments without pressure from operational considerations.**

Initial assessment – data to increase knowledge for forward planning

- 12.76 The Select Committee commented on the value of a “system of routine data collection” as an “an invaluable ‘early warning’ system and [to] provide prevalence trends” and recommended a variety of data collection and monitoring systems including:-
- the mandatory and anonymous monitoring of drug use by offenders at the time they first enter the criminal justice system (R60);
 - the collation and publication of urinalysis testing to establish indicators of drug abuse to be utilised by health service providers and other relevant groups such as the Substance Use Resource Unit (R66);
 - analyses of prevalence and trends in indices of drug abuse in prisons (R67);
 - an integrated information system to routinely collate information with respect to offenders under community based orders in terms of their compliance with orders and outcomes from interventions (R68).

- 12.77 The Ministry, on its own admission, has no current data on the extent of the problem of drug abuse in prisons or by persons serving community based orders and has conducted no evaluation of the treatment programs provided to prisoners in terms of their effectiveness in reducing offending behaviour or drug dependency. As far as I am aware, there is also no statistical analysis of the information obtained from a prisoner on admission to prison. In response to my draft report, however, the Ministry has advised me that it has engaged a consultant to produce a report based on current Health Services statistics and to advise the Ministry on means of improving the ongoing collection of data from prisoners for the purpose of continual statistical monitoring.
- 12.78 The Government's tabled response accepted the merits of the Select Committee's suggestion for useful objective data but did not support Recommendation 66 on the ground that current national methodologies are inconsistent and can produce misleading results, such as a conclusion that Western Australia has a significantly higher incidence of substance abuse by prisoners than other states. The Ministry similarly rejected Recommendation 68 because of the prohibitive cost and stated that its new database – Total Offender Management System – would not be able to provide the detail envisaged by the Committee.
- 12.79 Nevertheless, the *DMSP* report recommended (R16) the establishment of “*a central record for the collection of all detection strategies data to assist in the evaluation of the effectiveness of the initiatives*” and the development of “*a standardised, validated substance use assessment instrument for implementation statewide*” (R39). It appears from the 1999 review that no action has been taken in relation to R16 - which is “*dependent on funding success*”. However, there has been a more positive response to the recommendation for a standardised assessment instrument in the form of progress with the receipt and assessment centre at Hakea and the development of “*a single assessment instrument for treatment program suitability, as part of the comprehensive Individual Management Plan.*”
- 12.80 It seems to me that the Ministry's rejection of the Select Committee's recommendations for the development of a comprehensive database on the prevalence of drug use by prisoners before, during and after their imprisonment ignored the undeniable benefit of such statistics in the planning, staffing and nature of future prison requirements. Although I am aware that funding for prisons is not limitless, it seems to me that the long term benefit for forward planning from the compilation of reliable and comprehensive data should be a powerful incentive, particularly if the extent of the problem of drug abuse is as great as that suggested in the Smith Report – about which I have no doubts.
- 12.81 As was noted in Chapter 6²⁵ the JJ/HIDC was critical of the Ministry's lack of an effective information system in 1996. The Smith Report concluded that the disturbance at Casuarina in 1998 “*reflects the delay in tackling the growing drugs crisis in prisons*” and that the “*growing use of prescription drugs was not monitored and it was well known but no concerted action was taken.*”²⁶ Elsewhere the report refers to the Ministry's lack of “*systematic planning*”, and “*management ability and vision.*”²⁷ - criticisms which had already been raised in the report of the Wanneroo Royal Commission in 1996 and in a Cabinet research paper commissioned from Australian Correctional Services, also in 1996.
- 12.82 Although the Smith Report²⁸ refers to the growing use of drugs as being a factor outside the Ministry's control, it also expressed the view that “*understanding, anticipating and addressing these problems are a responsibility of the Ministry of Justice and particularly the Offender Management Division.*” I agree.

- 12.83 As discussed in Chapter 7 on medication, the Ministry has advised me that it recently commenced regular three-monthly reviews of prescription charts in order to ascertain the level of usage of psychoactive medications and that the results of the reviews indicate a significant decrease – up to 50% - in the prescription of Benzodiazepines and psychotropic medications. Although the true extent of drug usage within the prison community will be difficult to ascertain other than through urine and other forms of testing, greater use could be made of information which may be more willingly provided by prisoners on admission to prison to establish the likely extent of the problem and the implications for health services.

RECOMMENDATION 12.3

That the Ministry take steps to produce reliable statistical data on the prevalence of drug use in the interests of the welfare of prisoners, the safety of staff and the efficient planning of its future prison requirements and management strategies.

Pharmacotherapies – Methadone and Naltrexone

- 12.84 Health Services Policy 5.19 - *Drug and Alcohol Withdrawal* – provides:-

*“The treatment of drug and alcohol withdrawal is largely symptomatic and involves medication use and therapeutic medical/nursing interventions. Careful observation and assessment are vital to the provision of adequate medical/nursing care. All medical/nursing actions **must** be documented.”*

- 12.85 The *Principles of Management* in Policy 5.19 include:-

- obtaining a complete history of drug and alcohol use;
- treatment according to the dominant drug use;
- the option of placement in the nearest public hospital if there is not 24 hour nursing coverage and the prisoner is experiencing severe symptoms or is unstable;
- documentation of all assessments, interventions and treatments.

Methadone

- 12.86 Policy 5.19 refers to methadone, but as one of the drugs from which a prisoner may be withdrawing and advises “*Treat as per opiate withdrawal.*” There is no methadone management program generally available within the prison system. Methadone ‘maintenance’ programs are restricted to prisoners who are already participating in a community methadone program prior to admission and who are pregnant, HIV positive or short term remand with a good prospect of bail. On 12 November 1998 there were 20 male prisoners and four females receiving methadone. Eleven of those prisoners were on remand and one was pregnant; four were serving short sentences. As at 18 October 1999 there were 34 male prisoners and 13 female prisoners on a methadone program. In April 2000 51 prisoners were receiving methadone. The sentence or health status of these prisoners is not known but it is presumed that they were primarily prisoners who fell within the criteria listed above.
- 12.87 The absence of a “*credible chemical substitute programme*” (that is a methadone maintenance program) was criticised by the Coroner and the then Manager of the SNT, (now the FCMT) following the deaths of Darren **Boyle**, Ronald **Hill** and Ryan **Kennedy** within 11 days at the Remand Centre in 1994. The Coroner said:-

“It is the policy of the prison authorities that gaols will be free of illicit drugs. Accordingly persons who had previously been taking part in a methadone maintenance program before entering the prison system are given a chemical substitution treatment. There are very limited exceptions to this policy. However, it seems that this policy is in conflict with a credible program sponsored by a Government authority and is excessive in its effect on a person, as yet unconvicted and on remand.

If a person has entered the methadone maintenance program and has made a commitment to comply with that regime, the opportunity to continue with this program, if released from remand custody, will be effectively destroyed by the present policy.

While it is true that some persons may be held on remand for inordinate periods of time, this may often not be the fault of the individual who is detained.

The provision of methadone in the prison setting may well cause difficulties, particularly if the person is held on remand for a long time, but expediency should not be allowed to override the rights of the individual.”

- 12.88 In a report reviewing the circumstances of the deaths of the above prisoners the Manager of the SNT expressed her agreement with the Coroner’s views and suggested:-

“If the remand prisoner was on the ADA [Alcohol and Drug Authority] programme and this could be verified, then they should be allowed to continue the proscribed [sic] regime throughout the remand period. Those remand prisoners who do end up with a custodial sentence could then be withdrawn off methadone in reducing doses.”

- 12.89 There was no change to the Ministry’s policy following the three deaths at the Remand Centre in spite of the comments by the Coroner and the Manager of the SNT.

- 12.90 At page 162 of its 1997 Interim Report, the Select Committee was critical of the Ministry’s management of “opioid dependent individuals” stating:-

*“There is not a standard approach to the management of opioid dependent persons. **Indeed it is believed that few dependent prisoners receive adequate care**, aggravated bya low value placed on pharmacotherapies and the connotations of punishment if prisoners are placed in medical observation cells.” (my emphasis)*

- 12.91 At page 163, the Committee noted the Ministry’s limited methadone policy for remand prisoners and stated:-

“Given the chronic nature of the abuse of heroin by a significant minority of prisoners, it is logical that there is a need to provide appropriate pharmacotherapies to those prisoners who wish to achieve an abstinence from drugs, by the use of drugs such as Naltrexone.”

- 12.92 In light of its conclusions, the Select Committee recommended:-

“That the Ministry of Justice establish appropriate pharmacotherapies to address the rehabilitative and treatment needs of prisoners with established histories of serious opioid abuse, with appropriate legal coercion, with the ultimate aim of prisoners being drug free at the time of their release from prison.” (Recommendation 64)

- 12.93 In its tabled response to the Select Committee²⁹, the Government supported Recommendation 64 “in principle” and stated that it would:-

“.....work in conjunction with the WA Drug Abuse Strategy Office and the Health Department to investigate and consider the introduction of new pharmacotherapies as they become registered for general use in Australia with a view to providing the most appropriate short term and long term management within the prison context and upon release.”

12.94 The DMSP report includes some discussion of the Prison Methadone Program in NSW prisons where approximately 15% of the prison population are engaged in the program.³⁰ The program was described in the DMSP report (at page 45) as showing “*....mixed evidence of success. There is good evidence that prisoners comply with methadone dosing and do not divert methadone, and there are low rates of illicit injecting drug use among prisoners on the methadone program. There is no evidence that the program has reduced recidivism after release from prison.*”³¹

12.95 The DMSP report goes on to state:-

“Considerable discussion at sub-committee level has occurred on the issue of extending methadone availability within WA prisons. At no time was consideration given to adopting the NSW model where methadone dispensing is now an extensive program within prisons.....The major focus of that program has been to reduce the potential for blood-borne virus infections, by illicit drug use within prisons.

On this public health basis alone there are strong arguments for an expansion of methadone availability within prison environments.”

12.96 On the other hand, the DMSP report notes some support for the view of a 1996 Queensland Commission of Inquiry that if the clear objectives of a community-based methadone program are the reduction of opiate drug usage and criminal activity, imprisonment of an offender should achieve both those objectives and obviate the necessity for a custodial methadone program.

12.97 Consideration was given to expanding the provision of methadone to prisoners who were already involved in a methadone program on admission to prison based on:-

“.....public health factors and the need to promote a safe environment for methadone recipients moving to an unstable status, because of the need to detoxify upon admission. In addition there is an expectation of a significant increase in the number of methadone recipients entering prisons, because of this State’s move to community assessing and dispensing program for methadone.”

12.98 An expanded program would provide methadone recipients with access to a short maintenance program before implementing a reduction regime not exceeding eight weeks duration. This was seen as “*reflecting acceptable community based practices*” and as a means of reducing “*attempts by methadone recipients to traffic in alternative (self) medications, as a consequence of enforced detoxification.*”

12.99 However, the proposal was defeated by the majority view of the project team subcommittee which favoured no expansion of the current policy, fearing an increase in “*trading between prisoners*”. Although it was agreed that detoxification from methadone is “*a particularly unpleasant experience*”, the majority were of the view that “*there is no medical reason for reduction in the first instance to be preferred*”. As a result the sub-committee agreed there should no change in the Ministry’s methadone policy although developments in other jurisdictions would be closely monitored.

- 12.100 The Ministry advised me in December 1998 that its reluctance to expand its methadone program was based on a number of medical issues and resource implications. For example, it was considered that there would be an increased risk associated with overdose and that methadone could create insensitivity to pain possibly masking symptoms of other health problems.³² The Ministry also cited difficulties in “*monitoring compliance with taking the medication, identifying and preventing diversion of doses; secure modes of distribution and administration and secure storage of the stock.*”
- 12.101 Although I note that the DMSP report indicates an intention to “*closely monitor.....more liberalised policies on pharmacotherapies*” in other jurisdictions, I find the reluctance to conduct a controlled trial in Western Australia and its conclusions somewhat surprising given the data on which they are based – which appears to be primarily a 1993/94 study in New South Wales. Again the Ministry appears to have no data of its own to support its continued restrictive methadone policy.
- 12.102 I would have thought that the positive results from the New South Wales study – namely clear evidence of compliance by prisoners and a reduction in illicit drug injecting - were persuasive at least in terms of improvement to prison management and safety. The Ministry’s apparent objections on the basis of the lack of evidence to support a consequential reduction in recidivism are rather unexpected given its own lack of data to support the success or otherwise of any of its own current programs.
- 12.103 Although there is some debate about the long term effectiveness of methadone in the treatment of heroin addiction - not only in relation to prisoners but in the broader community - proponents of community methadone programs emphasise that the official supply of methadone at very least tends to reduce the criminal behaviour which for many addicts is primarily motivated by the need to finance a continuous source of the drug of addiction. I also note that participants in community programs are provided with counselling and other means of support which can only be of long term benefit in reducing illicit drug dependence.
- 12.104 Fear of bullying and violence is considered to be one of the prime causes of suicide and self harm.³³ Furthermore, prison health staff attributed a decrease in self harm and suicide during the ‘lockdown’ at Casuarina following the disturbance in December 1998, to the limited opportunities for bullying and standover tactics under such a restrictive regime. In the custodial setting I would have thought that the possibility of being able to reduce the violence, bullying and standover tactics associated with drug demand by means of pharmacotherapies would have been an outcome which the Ministry would have considered persuasive.
- 12.105 I also find the practical reasons cited by the Ministry for not expanding the methadone program - namely difficulties in “*monitoring compliance with taking the medication, identifying and preventing diversion of doses; secure modes of distribution and administration and secure storage of the stock*” - somewhat surprising as I would have thought that those concerns applied to all psychotropic medications, Schedule 4 and Schedule 8 drugs and potent analgesics.
- 12.106 Leaving aside the merits or otherwise of the provision of methadone to *all* prisoners willing to participate, it seems to me that the Coroner’s comments about the desirability of an expanded program for *remand* prisoners have merit. In the circumstances, I would have thought that the seriousness and extent of drug abuse among prisoners and the associated problems were at very least grounds for a controlled methadone trial on the lines of the trial Naltrexone program conducted at Bandyup. Although I am aware that Health Services held a methadone maintenance forum in May 1998 to discuss the issue, there appear to have been no operational developments in this area apart from the formulation of draft guidelines for a methadone program.

RECOMMENDATION 12.4

That the Ministry reconsider its decision not to expand its methadone program and conduct a pilot study for the purposes of assessing its effectiveness in Western Australian prisons.

Naltrexone

- 12.107 In December 1998 five prisoners (all males) were receiving Naltrexone. The Ministry advised me that six prisoners at the Remand Centre and two-six at Canning Vale had received it in the previous six months and that:-

“Prisoner access to naltrexone within the Ministry of Justice is currently managed on an individual case basis. Prisoners who were participating in a naltrexone program prior to imprisonment are eligible to continue access within the prison environment. These prisoners are required to authorise release of information from their practitioner to allow the Ministry of Justice to verify that they are currently involved in a program in the community.

Prisoners who meet this requirement have their medication dispensed daily in tablet form, which must be crushed and swallowed under the supervision of staff. The cost of the medication is borne by the offender (or their family).”

- 12.108 Early in 1999, following three heroin overdoses in the prison in seven months, it was decided to conduct a trial program at Bandyup. Eight prisoners were selected to participate on the basis that they were chronic heroin users both outside and inside prison and that they wanted to overcome their addiction. Medication guidelines for the program were provided in a draft Health Services Policy and ongoing counselling and support by a dedicated member of the FCMT who is currently preparing counselling protocols.
- 12.109 Although there were found to be problems with the program (for example, Naltrexone is not psychologically suitable for all those with heroin addiction; there was found to be incompatibility with partners on a methadone program; and the fear of detection of cannabis usage with compulsory urine testing) and three of the eight dropped out, the Ministry was encouraged by the positive response to the trial by both participants and staff and has recommended a further pilot program using different selection criteria.
- 12.110 In the latest proposal, participants from Wooroloo have been chosen on the basis that they are in the last three months of their sentence; are motivated and have expressed the intention to enter the *Next Step* community rehabilitation program after release. Funding has been allocated to the trial and the medication will be provided at no cost to the prisoner. There are to be three components in the program – administration of Naltrexone; groupwork and individual counselling provided by the Ministry’s Project Officer.
- 12.111 The Ministry’s recommendation and commitment to a further pilot Naltrexone program is encouraging. In view of the success of this program, however, it is perhaps surprising that the Ministry remains concerned about introducing a trial methadone program.

(iii) Reducing the problems - non-medical management

Rehabilitation and treatment programs

- 12.112 Available research indicates a high probability of repeat offending of all kinds, not only drug-related, among offenders with a history of substance abuse. As far as I am aware, the consensus of opinion among experts experienced in treatment of persons with a substance abuse problem is that therapeutically appropriate counselling and support programs are *essential* to any effective drug rehabilitation strategy. It is also widely accepted that it is virtually impossible for a dependent drug user to become 'drug free' without assistance and without the occasional relapse.
- 12.113 However, because of high musters and the increasing number of prisoners with substance abuse problems in the system, the requirement and demand for treatment programs are so high that the Ministry has made a conscious decision to focus its resources on rehabilitation/treatment programs towards the *end* of a prisoner's sentence, prior to his or her release into the community, and generally for the primary purpose of satisfying a condition of parole eligibility.
- 12.114 Even so, I have been told that the Ministry's current level of program provision cannot cater for the number of prisoners who are assessed as needing substance abuse programs - with the result that some will find that they remain in prison beyond their eligibility date for no reason other than that they have been unable to complete the required program. Although I am aware that an 'eligibility date' should be seen only as an indication of when a prisoner can expect to be released, the psychological effect on a prisoner of passing that date through no fault of his or her own can generate feelings of hopelessness and increase vulnerability to suicide and self harm; cause serious management problems for prison administrations; and unnecessarily exacerbate the muster levels.
- 12.115 More importantly, it seems to me that this approach represents a lost opportunity to tackle the problem from the start of a prisoner's sentence, with the potential to minimise the management problems associated with drugs in the prison system and to increase the chances of a prisoner with a history of substance abuse being released from prison 'drug free' and having overcome the problems associated with his or her offending behaviour.
- 12.116 The Ministry currently offers the following substance abuse treatment programs:-

Intensive Substance Abuse Program

A combination of individual counselling, groupwork and written assignments, conducted one day a week over a period of 5-6 weeks. The groupwork component occupies 20-25 hours in a two week period. The program takes 12 participants and is run 16 times a year at all metropolitan prisons plus Bunbury and Greenough, and Albany and Roebourne to a lesser extent. Intensive programs for women at Bandyup and Nyandi are run one day a week for five consecutive weeks. Ongoing individual sessions to support progress made in groups are offered to women who wish to continue their rehabilitation (see below).

Pre-release Substance Use Counselling

For prisoners whose substance abuse is problematic but less serious than those on the Intensive program. It comprises 4-5 individual counselling sessions tailored to suit an individual prisoner's needs and is available at all prisons.

Substance Abuse Women's Program

Individual counselling to address the skills and relapse issues covered in mainstream programs as well as issues specific to the antecedents and consequences of substance abuse by women.

Prison to Parole – Substance Use

This program offers counselling by community treatment agencies before release to increase prisoner involvement after release. It includes relaxation and stress management, cognitive skills, costs and benefits of substance use and alternatives to the use of alcohol and drugs for handling issues.

Mawarankarra Substance Use Education Program

An alcohol education program provided by the Mawarankarra Aboriginal Corporation for Aboriginal prisoners at Roebourne Prison.

Kimberley Offender Program

Addresses issues of violence and substance use for Aboriginal prisoners in an integrated format using Aboriginal presenters where possible. The program is run at Broome Prison but is currently under review.

Remand Class Prisoners with Substance Use issues

An orientation and interventions program for remand prisoners at the Remand Centre.

“Ending Offending”

An internationally accredited alcohol education program, developed in conjunction with South Australia. It was hoped that the program would be developed to run continuously in all prisons to reduce the waiting list for current substance use programs. However, I understand that it has been used primarily as a module in one of SURU's other programs.

- 12.117 The importance of treatment programs in the management of prisoners with substance abuse problems was highlighted by the Select Committee at page 163 of its Interim Report:-

“Experience from other jurisdictions indicates that a significant number will successfully complete abstinence oriented programs which are well-resourced and address their specific needs. These programs appear to be particularly successful if they are able to create a drug free environment, which involves motivated prisoners and if conducted by committed staff....”³⁴

- 12.118 The potential value of providing prisoners with rehabilitation programs during their sentence is not new. A study completed in 1993³⁵ noted that:-

“Gaols provide an opportune time to intervene with offenders who have often experienced little contact with substance abuse services. Distrust of social services agencies, lack of funds, or unfamiliarity with community treatment agencies often deter inmates from seeking substance abuse treatment. The severity of substance abuse problems is often not acknowledged among these individuals, their family members and peers. The initial period of incarceration often serves to focus an inmate's attention on the negative consequences of substance use and can mobilise internal motivation to address longstanding lifestyle problems through treatment.”

This study also found a positive connection between participation in custodial treatment programs and a prisoner's greater willingness to continue with the program after release and the corresponding beneficial effects on recidivism.

- 12.119 The *DMSP* report refers to identification of a prisoner's "*criminogenic need*" (the relationship between that prisoner's drug use and his or her offending behaviour) and the targeting of programs to such needs as essential components in successful interventions. It acknowledges that it is unrealistic to expect prisoners with drug problems to stop when they are imprisoned without help in the form of treatment programs, but concedes that the Ministry has a current lack of treatment options. The *DMSP* report also refers to the absence of a "*universal, validated recidivism risk-needs assessment*" tool which has made it "*difficult to quantify program needs and prioritise prisoners for engagement in appropriate programs. In this light it is difficult to determine the effectiveness of present drug and alcohol interventions in custody.*"³⁶
- 12.120 To address these deficiencies the Ministry proposes a restructuring of its non-medical treatment options, shifting the focus from pre-release programs in order to "*utilise the "window of opportunity" at the beginning of a period of incarceration, to generate motivation to change.*" This 'new' approach to treatment options will, however, remain predicated on the Western Australian Government's *Drug Abuse Control Strategy* which is based on the primary principle of "*opposition to drug use*". The principle of "*harm reduction*" based on strategies which reduce harm to the user and the community is seen as secondary and must not "*encourage or normalise drug abuse*".
- 12.121 For example, in a reversal of previous policy, the Ministry now proposes to offer remand prisoners the opportunity to participate in substance abuse treatment programs, but only those prisoners identified as medium to high risk and motivated to change will be informed of the availability of such programs. Participation will be on a voluntary basis in recognition of the "*unique status of remand class prisoners*".
- 12.122 The programs offered will be 'brief intervention' based on the current pre-release program for short term remand prisoners and an intensive program based on the current SURU program for long term remand prisoners expecting a sentence of imprisonment. Specific programs to address alcohol abuse, possibly including a program specifically for recidivist drink drivers, will also be developed.³⁷ The *DMSP* report estimates that an additional FTE would be required to provide programs to remand prisoners at the Remand Centre.
- 12.123 In addition, substance abuse treatment programs for newly sentenced prisoners will be provided as part of the standard orientation program. Such programs will include coping strategies, harm minimisation techniques and relapse prevention strategies and will be designed to "*influence a behavioural change that may culminate in a reduction in substance use or even abstinence.*" Programs would be available throughout a prisoner's sentence culminating in a pre-release unit which prepares the prisoner for successful reintegration into the community.
- 12.124 The current lack of treatment options and the focus on pre-release programs are a continuing source of complaint to my Office and one which creates anger and frustration in prisoners who, because they are unable to gain a place on the program, spend longer in prison and exacerbate the current crowding situation.
- 12.125 As discussed elsewhere in this report, in my opinion the current focus, scope and quantity of pre-release drug treatment programs are inadequate to properly prepare prisoners – and the community – for their release. Of equal - or perhaps greater - significance the lack of any rehabilitation programs before pre-release presents a wasted opportunity to assist in the management of prisoners *during* their sentence and deprives the prison system as a whole of a number of benefits. For example, although recidivism rates are high, it seems to me that prisoners who are provided with some form of education and counselling programs early in their sentence when they may feel some remorse for their actions and when pressure from their families to address the substance abuse problems which resulted in their imprisonment may well be more influential, may have a better chance of returning to the community,

if not drug free, at least with fewer problems. The public health interests of this outcome alone should be a significant motivating factor. As far as I am aware, the Ministry has undertaken no research in this area to evaluate the success of the programs it does provide.

- 12.126 In relation to the provision of compulsory programs to prisoners (remand or sentenced), I was advised by the Western Australian Drug Abuse Strategy Office (WADASO) that there was no indication from research that prisoners who were coerced into participating in programs were less likely to succeed than those who volunteered and that there was great advantage in ‘tapping’ into the remorse and motivation for change of newly-admitted prisoners. In fact it was considered that the high level of motivation exhibited by prisoners at the end of their sentence (suspected to be generated by a desire to satisfy parole pre-conditions) may well be not as genuine as at the beginning of the sentence. I have no doubt that the apparent lack of confidence in the effectiveness of compulsory programs is merely a reflection of the lack of funding to provide sufficient programs for the large number of prisoners in need of them.
- 12.127 Although the Ministry acknowledges in the report of the *DMSP* that it has insufficient treatment options, from information provided to me in the course of my inquiry, it seems to me that it has also been reluctant to utilise the services of specialist community-based organisations such as Holyoake, Palmerston and Cyrenian House which are willing and able to provide programs to prisoners. These organisations seem to receive little encouragement from the Ministry and have told me that they often encounter hostility from some prison staff.
- 12.128 For example, I was informed that Holyoake conducted a very successful 10-week program at Bandyup focussing on the effect of drugs in pregnancy and on families and children, including domestic violence issues. The program cost the Ministry around \$2000 but Holyoake was advised that there was no more funding to repeat the program. I understand that lack of space at Bandyup because of the current high muster level was cited as an additional limiting factor.
- 12.129 Similarly, I was also told of another very successful initiative organised by Outcare and conducted by Holyoake at Canning Vale - an 8-week program involving both prisoners and their families. The program produced tangible results, with prisoners and their families continuing with counselling after their release, significant and sustained reduction particularly in relation to alcohol consumption and a reported improvement in the mental health of prisoners’ partners. The program was conducted as a pilot at no cost to the Ministry but no further programs have been requested. This is not the only example brought to my attention where the Ministry has used the services of individuals and organisations to provide a program on a trial basis at no cost but then decides not to repeat the program if it is required to pay for it-even if the program has been a success.
- 12.130 Holyoake, Palmerston and Cyrenian House are also contracted to conduct the Prison to Parole Program. Although aimed at prisoners who are to be released within the next three months, prisoners who have longer to serve are frequently allowed by the community organisations to participate because of the lack of availability of other programs and their concern that failure to complete a required program will adversely affect eligibility for work release, home leave and parole.³⁸
- 12.131 Funding for provision of treatment programs in adult prisons by community organisations comes from WADASO. The Ministry provides funding to community groups such as Holyoake only in relation to programs for juveniles. WADASO has advised me that there is insufficient funding to properly cater for the demand for programs and that this shortfall was the prime reason for the decision to focus funding on pre-release programs.

- 12.132 SURU programs which are resourced and funded by the Ministry³⁹ are aimed primarily at those with the worst problems and whose offences are related very closely to substance use. These criteria leave large numbers of prisoners with identifiable problems who are unable to access any kind of rehabilitation program. Furthermore, these programs do not generally contain basic life skills or guidance in alternative ways of dealing with the underlying problems which frequently lead to substance abuse.
- 12.133 Although the proposals in the report of the *DMSP* for the restructuring of its substance abuse program delivery are encouraging, particularly for new prisoners, implementation will need to be afforded a high priority if the substance abuse problem within the prison system is as serious as suggested in the Smith Report and if the alleged inadequacy of the Ministry's previous approach contributed to the "*tinderbox*" which became the Casuarina riot.
- 12.134 In my view, to properly address the problem, treatment programs will need to be made available to prisoners from the beginning of, and throughout, their sentence in addition to 'refresher' programs prior to their release. Of equal concern is that program availability is insufficient to meet the needs of prisoners eligible under the current criteria. For example, I was advised in August 1998 by the Ministry that at that time there were 529 prisoners waiting to participate in its substance abuse programs and that nine of those had remained in prison after the date of their earliest eligibility for release. Although numbers waitlisted for substance abuse programs have fallen significantly since 1998 – there were 125 awaiting placement and/or assessment as at 16 August 2000 - it seems to me that simply to keep pace with the demand for current program participation, without introducing new programs, there will need to be a considerable increase in resources and funding for program delivery.

RECOMMENDATION 12.5

That in recognition of the extent and seriousness of the problem of drugs in prisons the Ministry provide adequately funded and resourced substance use treatment programs for all affected prisoners from the beginning of their sentence.

Facilities for prisoners suffering the effects of substance abuse.

- 12.135 On admission to prison a prisoner will usually be placed in a mainstream unit unless there are strong indications from the initial assessment that the level of risk of self harm is acute or immediate or he or she is suffering from extreme withdrawal symptoms. As discussed in Chapter 11, placement options are inevitably limited by increasing muster levels (particularly at Casuarina and Bandyup). In prisons where most cells are already shared because of pressure of numbers the possibility of placing a prisoner with a friend or relative also becomes more difficult. If placement in a mainstream unit is not considered appropriate because the prisoner is considered to be a high risk of self harm, in most prisons the only other option is the universally hated medical observation cell; currently only Casuarina is able to offer alternative placement in either the Crisis Care Unit or the Infirmary.
- 12.136 On the basis of my discussions with prison Health Services staff, it is not considered to be ideal or even reasonable that prisoners experiencing the physical trauma of withdrawal (typically vomiting and diarrhoea) should be placed in a cell by themselves or with another person. This kind of placement makes it difficult for health staff to monitor the prisoner, particularly if the unit is unstaffed at night, requiring special arrangements for access to be made. The degrading experience of going through the physical symptoms of withdrawal in a cell with another person – for whom the experience is equally unpleasant and a health risk – may well increase the likelihood of self harm.

12.137 This point is well illustrated by the death of Carl **Jackson** in Casuarina in 1996. Mr Jackson, a first time remand prisoner withdrawing from heroin, was placed in a shared cell in an unstaffed mainstream unit and committed suicide on the night of his admission. Although given medication by nursing staff once during the night, it was not possible for them to observe him because of difficulty of access to the unit after lockup.

12.138 Similarly, Huy Van **Le** was admitted to the Remand Centre on the evening of 13 February 1998 suffering withdrawal from heroin. He was placed in a single cell in a mainstream unit and was found hanging in his cell on the evening of 14 February. He died after his admission to Fremantle Hospital.

12.139 The *DMSP* report at page 41 states:-

“Drug and/or alcohol withdrawal is common with newly incarcerated prisoners. Current practice within the Ministry of Justice consists of a plethora of detoxification regimes or practices with significant differences. Furthermore, there is inconsistency in the threshold for withdrawal treatment to occur. These practices need to be standardised and should reflect best practice benchmarks in withdrawal treatment.

It is accepted that a prison setting is not an ideal environment for withdrawal, and duty of care requirements do not appear to have been consistently implemented.”

12.140 The *DMSP* report goes on to describe effective withdrawal treatment as comprising:-

- *Supportive Care* - regular monitoring with recording of “observations to determine progress”;
- an environment which reflects a “minimisation of stress” and considers the “physical comfort of the individual”; and
- *Medical Care* - the process of “illness screening to identify health problems directly related to the withdrawal”.

12.141 It recommended that the Ministry:-

“Provide discrete detoxification areas in all major reception prisons to enable prisoners with moderate to severe withdrawal symptoms to be accommodated in a supportive care setting.” (Recommendation 26)

12.142 On the evidence before me, I consider that current prison facilities are inadequate and do not allow prison health staff to properly manage the physical symptoms of substance abuse. Although I am aware that it has been proposed to convert the wing of the Infirmary at Casuarina currently occupied by the Intensive Sex Offender Treatment Program into a detoxification unit, there appears to have been no further progress on this initiative.

12.143 It goes without saying that, even if a detoxification unit were to be established at Casuarina, it would only be of benefit to male prisoners. Given the high involvement of female prisoners with drugs, it is disturbing that there are currently *no* facilities for female prisoners at Bandyup other than medical observation cells which are located with the punishment cells. There is no indication in the *DMSP* report whether funding has been sought to implement Recommendation 26. However, I am pleased to note that the planned refurbishment of Bandyup includes an enhanced health centre and a Crisis Care Unit.

RECOMMENDATION 12.6

That the Ministry provide funding for the provision of discrete detoxification areas in all major reception prisons, particularly within the proposed refurbishment at Bandyup.

Ongoing support and counselling by trained staff

12.144 The Select Committee commented on the employment of “*skilled personnel*” in other jurisdictions, notably Victoria and New South Wales -

“.....to treat drug problems in the prison context. The approach adopted by the NSW Department of Corrective Services, where medical and related health services in prisons are provided under the administrative control of the NSW Health Department, has much to commend it. The involvement of community based health providers wherever possible has a number of advantages, including that:

- this maximises the perception that health care providers working in correctional settings are independent of prison administrators.....;*
- community based health care workers are less likely to become isolated compared to those who work only within a correctional context;*
- it encourages the provision of methadone and other pharmacotherapies in prison settings; and*
- the ongoing medical management of prisoners can be maintained after release from prison.”⁴⁰*

12.145 In Western Australia, the FCMT provides counselling for prisoners in withdrawal who have been assessed as a high risk of self harm but is precluded by lack of resources from becoming involved in routine or regular monitoring of lower risk prisoners in withdrawal. It is left to those prisoners to approach the FCMT themselves.

12.146 Following the death in January 1996 of Carl **Jackson**, the IIU recommended that “*prisoners withdrawing from drugs on admission to prison be routinely assessed by a member of the FCMT to identify ‘at risk’ prisoners who may self harm*”. Although in-principle approval to this recommendation was given, the Ministry confirmed that, following the routine medical and at risk assessment conducted when a prisoner is first admitted, a referral to the FCMT would only be made when “*offenders experience problems or crises during withdrawal from drug abuse.*” I interpret this to mean that there is only crisis management and *no routine monitoring* by the FCMT of prisoners in withdrawal. Although they believe that it is an important part of their role, FCMT staff have told me that this is the case.

12.147 The proposal to use Unit Managers and other custodial staff in program delivery (*DMSP* report at page 52) is seen as having the dual benefit of providing cost-effective delivery of the information component of the programme and fostering better prisoner/officer relations in the spirit of the *At Risk Management System*. There has been no progress with this initiative.

12.148 On the basis of information provided to me about the lack of facilities and staff at most institutions, I suggest that it would rarely be possible for health staff to provide ‘supportive care’ as envisaged in the *DMSP* report. Even with the increased resources now available, it seems to me that prison health services in general and the FCMT in particular are only able to provide ‘crisis care’ with no ability to become involved in crisis *prevention*, whether it be related to prisoners withdrawing from substance abuse or those with severe behavioural disorders. Although I realise the cost implications of providing sufficient resources to perform this function, having looked at systems in other jurisdictions within Australia, it seems to me that this type of ‘front end’ management has the potential to be of benefit to both the prisoner and the prison in reducing the need for *crisis* care. In addition, it is of concern that there are few health services staff with specific qualifications in the treatment of substance abuse and that there are limited opportunities for training of prison health staff in this field.

12.149 Given the accepted link between the effects of substance abuse and the increased potential for self harm, and the increasing numbers of dependent drug users entering the prison system, it is perhaps surprising that *ARMS* does not appear to specifically encompass this issue.

RECOMMENDATION 12.7

- (a) That the FCMT be provided with sufficient resources to enable it to routinely monitor prisoners suffering the effects of drug abuse and provide the counselling considered essential to the success of any intervention; and
- (b) that the opportunity for training in this specialist field be made available to health staff and other interested prison staff.

12.150 In summary, I am encouraged by the initiatives proposed in the Report of the *DMSP* and the action taken following the 1999 review. Essentially, however, the success of any of the proposed strategies will depend on the Ministry's willingness to provide adequate funding and resources for their implementation.

SUMMARY OF RECOMMENDATIONS

- 12.1 That the Ministry allocate funds and resources to facilitate implementation of Recommendations 5 and 6 in the Report of the *Drug Management Strategy Project* as a matter of priority.
- 12.2 That in the interests of the welfare and better management of offenders entering prison in withdrawal or suffering from the effects of substance abuse the Ministry should:-
 - (a) review the initial medical assessment form to ensure that it provides adequate data for the management of prisoners;
 - (b) provide health staff and other interested staff with the opportunity for specialised training in substance abuse problems; and
 - (c) ensure that medical and nursing staff gain access to newly-admitted prisoners early enough to complete all assessments without pressure from operational considerations.
- 12.3 That the Ministry take steps to produce reliable statistical data on the prevalence of drug use in the interests of the welfare of prisoners, the safety of staff and the efficient planning of its future prison requirements and management strategies.
- 12.4 That the Ministry reconsider its decision not to expand its methadone program and conduct a trial program for the purposes of assessing its effectiveness in Western Australian prisons.
- 12.5 That in recognition of the extent and seriousness of the problem of drugs in prisons the Ministry provide adequately funded and resourced substance use treatment programs for all affected prisoners from the beginning of their sentence.
- 12.6 That the Ministry provide funding for the provision of discrete detoxification areas in all major receipt prisons, particularly within the proposed refurbishment of Bandyup Women's Prison.
- 12.7
 - (a) That the FCMT be provided with sufficient resources to enable it to routinely monitor prisoners suffering the effects of drug abuse and provide the counselling considered essential to the success of any intervention; and
 - (b) that the opportunity for training in this specialist field be made available to health staff and other interested prison staff.

- ¹ The Ministry's Director, Health Services has advised that the estimated figure of Hepatitis C carriers in Western Australian prisons is approximately 20%
- ² Indermaur and Upton *Alcohol and drug use patterns of prisoners in Perth* (21 Australian and New Zealand Journal of Criminology 144-167)
- ³ See also paragraphs 12.64-75
- ⁴ Allen (1996) *Drug and Alcohol Programmes in NSW Prisons: Culture, Context and Change* (paper presented to the 7th International Conference on the reduction of Drug Related Harm)
- ⁵ Kevin, *Women in prison with drug related problems. Part 1: background characteristics*
- ⁶ Kevin, *The alcohol & other drug screen with inmate receptions in New South Wales. A pilot initiative*. NSW Department of Corrective Services, 1997
- ⁷ *Education/prevention strategies for people who use drugs illicitly in prison: What can be done realistically?* By Ken Quayle of the NSW Users and AIDS Association
- ⁸ at page 13
- ⁹ Paragraphs 5.2.7.6 and 5.2.7.7
- ¹⁰ *Violent property crime*, Annandale, NSW, Federation Press, 1995 at page 55
- ¹¹ Lipton: *The effectiveness of treatment for drug abusers under criminal justice supervision*, National Institute of Justice, US Department of Justice, 1995 at page 4
- ¹² *ibid* at page 131
- ¹³ *ibid* at page 132
- ¹⁴ Extract from a submission to the Committee by Dr S Rajaratnam and Professor Redman, Department of Psychology, Monash University
- ¹⁵ Panel members included the Medical Director, Sexual Health Services HDWA, the Chairman, Hepatitis C Council of WA and the Ministry's Project Officer for BBCD
- ¹⁶ See paragraph 12.86
- ¹⁷ See also paragraphs 12.135-12.143
- ¹⁸ Paragraph 5.2.7.6
- ¹⁹ Paragraph 5.2.7.1
- ²⁰ Paragraph 5.2.7.12
- ²¹ *Australian Medicine*, 13 October 1998
- ²² Report of the *Drug Management Strategy Project* April 1998; 6.1 at page 28
- ²³ See Chapter 5, paragraphs 5.73-5.87 for a detailed consideration of the initial assessment
- ²⁴ See Chapter 6, paragraphs 6.96-6.100
- ²⁵ Paragraph 6.150
- ²⁶ Paragraph 5.2.7.12
- ²⁷ Paragraph 5.2.8.1
- ²⁸ Paragraph 5.2.10.1
- ²⁹ at page 24
- ³⁰ This would equate to around 450 prisoners in Western Australian prisons
- ³¹ Hall, Ward and Mattick (1993) *Methadone Maintenance Treatment in Prisons: The New South Wales Experience*. Drug and Alcohol Review, 12, pp193-203
- ³² In the inquest into the death of Winifred Michael who was admitted to Bandyup withdrawing from drugs but subsequently died from a perforated appendix, the Coroner stated "This case has highlighted the fact that withdrawal symptoms may mask or be similar to symptoms caused by serious illness and so in cases where symptoms such as "cramps" are described abdominal examination may be important."
- ³³ Page 14 of the *Report on Suicide Prevention Strategies for Prisons in Western Australia* and paragraph 5.2.2.8 of the Smith Report
- ³⁴ Taken from *Correctional treatment helps offenders stay drug and arrest free*; R Mathias; *NIDA Notes* July/August 1995
- ³⁵ Peters; *Examining the Effectiveness of In-Jail Substance Abuse Treatment*; *Journal of Offender Rehabilitation* Vol 19
- ³⁶ At page 47
- ³⁷ Report of the *Drug Management Strategy Project* at pages 47-54
- ³⁸ I note from the response to a Parliamentary Question by the Minister for Family and Children's Services on 9/3/99 that 231 prisoners participated in the pre-release Prison to Parole Programme in 1997/98
- ³⁹ The Substance Use Resource Unit was allocated \$530,000 in 1998/99
- ⁴⁰ Interim Report, page 162

CHAPTER 13 PROGRAMS

THE IMPORTANCE OF PROGRAMS IN PRISONER MANAGEMENT

THE ADEQUACY OF PROGRAMS AVAILABLE TO WESTERN AUSTRALIAN PRISONERS

EDUCATION, TRAINING AND EMPLOYMENT

RECREATION

TREATMENT/REHABILITATION PROGRAMS

SUMMARY OF CONCLUSIONS ON THE ADEQUACY OF EDUCATION, EMPLOYMENT, RECREATION AND TREATMENT PROGRAMS

SUMMARY OF RECOMMENDATIONS

THE IMPORTANCE OF PROGRAMS IN PRISONER MANAGEMENT

- 13.1 For the purposes of this section I have interpreted ‘programs’ to include any activity which might be considered ‘constructive’ such as education, vocational training, industry, recreation and rehabilitation.
- 13.2 In her 1992 study of prison suicide¹, Dr Alison Liebbling referred to a review of suicide prevention procedures by Judge Tumim, the UK Chief Inspector of Prisons, in 1990 which concluded that “*Confinement in prison under conditions of inactivity and the lack of any purpose, can only serve to emphasise extremes of human feeling, such as boredom and despair.*”
- 13.3 Liebbling found that her own research into the causes of suicide and self harm by young (under 21) prisoners supported that view, having identified the lack of constructive activity as a factor likely to impact on a prisoner’s ability to cope with and adjust to imprisonment. As previously discussed in Chapter 3, Liebbling links poor coping ability to the level of a prisoner’s vulnerability to self harm and suicide:-
- “In hopeless young people, with the least available skills and resources for coping with adversity and stress, confinement, isolation and boredom.....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.”² (my emphasis)*
- 13.4 By comparing a ‘subject group’ of prisoners who had attempted suicide with a ‘comparison group’ of similar prisoners who had not she found a marked difference in the subject group’s level of activity both prior to the suicide attempt and in prison generally -
- “The most significant point to emerge from the responses to these questions [could you find something rewarding to do in the institution in which you are imprisoned?] is the **consistency** with which the subject group are (and feel) worse off than their fellow inmates in terms of the availability and desirability of work, education, PE and other methods of occupation. They do not see as many opportunities for themselves in prison, nor do they seem to be able to make constructive use of their time. The combination of constraints and their own lethargy leaves them helpless and resourceless in the face of hours of unfilled time. It is their inability to occupy themselves constructively, combined with ‘enforced idleness’.....that increases their vulnerability to both impulsive acts of self-harm and suicidal thoughts.”³*
- 13.5 Liebbling referred to the colloquial term for serving a term of imprisonment – ‘doing time’ – as being more closely associated with ‘surviving’ the sentence than describing an opportunity for improvement and a means of avoiding future offending. She cited the UK Chief Inspector of Prisons, who argued in 1990 that “*inmates should be encouraged to **use** time, not just **do** it, and that constructive occupation may relieve some of the frustration common to young anxious prisoners.*”
- 13.6 She found, however, that although less than half of both the subject and comparison groups thought they were using the sentence to achieve something constructive for themselves, the majority expressed a desire to -
- “get fitter, become more intelligent and ‘wise’ and better qualified; they wanted to give up drugs, reorganise their lives, change their personalities and ‘sort their heads out’. Significantly more of the subject group wanted to change personal things about themselves.”⁴*
- 13.7 Liebbling concluded that a basic understanding of the problems identified by prisoners themselves was a useful tool for prison officers as a strategy for reducing the prison stresses which were seen to be significant contributory factors in self-harming and suicidal behaviour. For example, the discovery that a prisoner was unable to occupy himself in his cell after lockup or rarely took advantage of opportunities for activity during ‘unlock’ might be a useful indicator of that prisoner’s poor coping ability. Similarly,

officers should consider whether a prisoner's reluctance to participate in team sporting activities could be based on his difficulties with other prisoners rather than laziness. She notes:-

“It is interesting to note how an attitude towards an everyday prison feature may indicate other important feelings. Prison officers could be encouraged to make these sorts of enquiries as part of their general ‘welfare’ role, taking an interest in all inmates without ‘boring in’ on the suicidal.....Lack of socialisation within the prison may be another indicator of risk, particularly if the inmate has few friends inside, spends a lot of time on his own, has difficulties with other inmates.....Importantly, inmates who present disciplinary problems to the staff cannot be assumed to be (just) manipulative, or obvious trouble-makers. Their disciplinary problems may be another feature of the difficulties they are experiencing in coping with prison.”

13.8 She concluded that *“Vulnerability can be recognised and alleviated in simple ways. Education, activity, contact and concern might avert many crises”* and also advocated the provision of *“‘coping skills’ courses, which address both sentence and post-sentence survival.”*

13.9 The UK Prison Reform Trust said 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.”* (my emphasis)

13.10 In a more recent report on suicide and self harm in UK prisons⁵, HM Chief Inspector of Prisons referred to the concept of a ‘healthy’ prison and identified the ‘key constituents’ of a ‘healthy’ institution as:-

- a safe environment
- treating people with respect
- a full, constructive and purposeful regime
- resettlement training to prevent reoffending

13.11 One of the ‘tests’ of a healthy prison formulated by HM Chief Inspector (‘Test 3’) is that *“Prisoners are fully and purposefully occupied and are expected to improve themselves”*. He went on to state at paragraph 7.27:-

“There is nothing worse for the mental well-being of those who find it difficult to cope with life in prison than being idle. A healthy prison provides a range, variety and choice of activity in which prisoners can be involved. The aim must be to motivate prisoners towards improving themselves. It is not sufficient to provide opportunities for education, employment, exercise and physical education, access to library and other activities. It is just as important to ensure that staff have the skills to encourage prisoners to take up these opportunities.....Healthy establishments provide prisoners with opportunities to gain qualifications and also the help and support they need to take advantage of them. Prisons are full of people who have achieved little in their lives and who have had little experience of praise and encouragement. The opportunity to do something of which they can be proud can have an important influence on their mental well being, their views of other people and on their attitude to future offending.” (my emphasis)

- 13.12 The positive effect of suitable programs was highlighted in a recent review of the high rate of suicide by Maori prisoners in New Zealand prisons⁶ which found:-

“The Maori suicide review group believes that the risk of self-harm and suicide can be reduced through the provision of programmes to inmates that assist in the development of coping skills, communication and problem solving skills, and self esteem. The current focus of programmes in prisons is on the particular causes of offending, or skills needed to live in the community, rather than development of skills which mitigate against the risk of self-harm or suicide. The review group recommends that criteria be developed for the provision of programmes to at-risk inmates. Participation in programmes also allows inmates to constructively use their time. The review group supports the recommendation of the 1995 suicide review group for a system that identifies and addresses the need of remand inmates including the delivery of programmes for the constructive use of time.”

- 13.13 Apart from the psychological and behavioural benefits of constructive activity and “full, varied and relevant” regimes, its importance is endorsed by United Nations *Standard Minimum Rules for the Treatment of Prisoners* in the following rules:-

- *“Every prisoner who is not employed in out-door work shall have at least one hour of suitable exercise in the open air each day.”* (Rule 21(1))
- *“Sufficient work of a useful nature shall be provided to keep prisoners actively employed for a normal working day.”* (Rule 71(3))
- *“Vocational training in useful trades shall be provided for prisoners able to profit thereby and especially for young prisoners.”* (Rule 71(5))
- *“The interests of the prisoners and of their vocational training, however, must not be subordinated to the purpose of making a financial profit from an industry in the institution.”* (Rule 72(2))
- *“Provision shall be made for the further education of all prisoners capable of profiting thereby.....The education of illiterates and young prisoners shall be compulsory and special attention shall be paid to it by the administration.”* (Rule 77(1))
- *“Recreational and cultural activities shall be provided in all institutions for the benefit of the mental and physical health of prisoners.”* (Rule 78)

- 13.14 *Standard Guidelines for Corrections in Australia* includes the following “guiding principles.....intended to show the spirit in which correctional programs should be administered and the goals towards which administrators should aim” in relation to work, recreation, education and activities:-

“All prisoners should have access to productive work, education, recreation and leisure programs and facilities which provide them with the opportunity to utilise their time in prison in a constructive and beneficial manner.” (5.57)

“The Manager of the institution has a responsibility to encourage prisoners to participate in such programs.” (5.58)

“Weather permitting, prisoners should be allowed access to open air for at least one hour each day.” (5.62)

13.15 In addition the RCIADIC made a number of recommendations in relation to constructive activity:-

Recommendation 184 - All Aboriginal prisoners should have the opportunity to perform meaningful work and to undertake educational courses in self-development, skills acquisition, vocational education and training including education in Aboriginal history and culture.

Recommendation 185 - The Department of Education, Employment and Training should be responsible for the development of a comprehensive national strategy designed to improve the opportunities for the education and training of those in custody.

Recommendation 186 - Prisoners, including Aboriginal prisoners, should receive remuneration for work performed. Those who pursue education or training courses during the hours when other prisoners are involved in remunerated work should receive the same level of remuneration.

Recommendation 187 - Experiences in and the results of community corrections rather than prisons should be closely studied by Corrective Services and communities and Aboriginal organisations should be more involved in correctional processes.

THE ADEQUACY OF PROGRAMS AVAILABLE TO WESTERN AUSTRALIAN PRISONERS

Education, Training and Employment

13.16 Each prison has an Education Centre at which attendance by prisoners is voluntary. Courses range from basic literacy to Year 10 level competency. Prisoners are able to study to tertiary level at their own expense. The Ministry now employs 30 full-time Education Officers, comprising a full-time permanent Senior Education Officer at each Education Centre assisted by full-time permanent Education Officers at most prisons – depending on prisoner numbers – as follows:-

Albany/Pardelup	2
Bunbury	1
Casuarina	4
Hakea Prison	3
Hakea Remand	1
Greenough	1
Roebourne	1
Wooroloo	1

13.17 In 1997 the Ministry, in conjunction with the Western Australian Department of Training, established a Taskforce “*to review the provision of institutional-based education and training*” at the 13 prisons then in operation. The Taskforce found that the Educational and Vocational Training Unit was isolated from the “*main business*” of each facility “*with the result that educational effectiveness relies heavily on the personal conviction of local custodial management.*”

13.18 The Taskforce recommended that “*the education and training of offenders must be regarded as a core business of the organisation*” by the following means:-

- The special educational training needs of the offender be afforded high priority and accommodated in Case Management planning decisions regarding program placement and access. All educational activity should be prioritised against an agreed set of criteria consistent with the strategic direction of the OMD. (Rec 3)
- That each prison site become registered as a training provider of accredited programs so that the OMD can maximise existing skills and abilities of staff. (Rec 6)
- That the OMD, offender population permitting and within the principle of *through care*, establish the structure of an integrated articulated pathway between prisons and from prisons to the community with a view to developing “best practice” models. (Rec 7)
- That an assured funding arrangement commensurate with rising prisoner populations be committed by the State Government to support the increased demand in education and training. (Rec 8)
- That discussions should occur within the Parole Board regarding the possibility of it taking a pro-active stance in acknowledging offenders’ participation in literacy programs as a genuine attempt at self-improvement. (Rec 9)
- That, in accordance with the OMD focus on offender development, education and training of offenders be included in the accountability and performance requirements of prison superintendents so that in each prison, the education and training of offenders is a key element of the strategic planning process. (Rec 11)
- The accountability and performance requirements of Education Officers in each prison will include:
 - (a) the development of an annual operation plan with the Education and Vocational Training Unit’s policy framework;
 - (b) an assessment/orientation process of all offenders on admission;
 - (c) a demonstrated commitment to information exchange to support the OMD Integrated Case Management model. (Rec 12)
- That an effective Management Information System be developed in relation to education and training of offenders between all prisons and from prisons to the community. (Rec 13)
- That all Education/Vocational Training staff in the Ministry be paid a salary level commensurate with their qualifications, experience and standing in mainstream education systems. (Rec 14)
- That the Ministry adopt a limit of 12 months on all staff secondments. (Rec 15)
- That existing services be adapted to better meet the needs of offenders with disabilities. (Rec 16)
- That the gratuity system be redeveloped to reward behaviour and accord all education and training programs equal status and remuneration with other prison occupation areas. (Rec 17)
- That relevant legislation under Section 94 of the *Prisons Act 1981* - “Approved Absences” - be reviewed and amended to include education and training opportunities. (Rec 18)

13.19 A new model for education and vocational employment was proposed by the Taskforce on the basis that:-

“.....prison operations cannot operate in isolation if the goal of reducing recidivism is to be achieved. They must provide value for offenders post release and so must translate to the community. It is imperative then, that prison activity should only be determined after full consultation with relevant players from both within the system and outside community agencies?”.

13.20 ‘Relevant players’ were identified as:-

- *prison administration* - because the Superintendent controls the work/training industry at the prison;
- *individual prisoners* - in order to identify meaningful and relevant activities;
- *therapeutic program staff* - to establish the available time for more education for each prisoner;
- *education and vocational staff* - responsible for the assessment and identification of individual needs;
- *peer support and community corrections officers.*

13.21 The Taskforce report refers to the need to *“take into account the offender’s experience of a lifetime of educational deficit An offender choosing industry employment may need education support At all times, education/training and industry should adopt the case management approach to mutual clients.”*

13.22 It was envisaged that the new model would remove day to day operational issues and duplication of services by ‘Head Office’, and that, in the interest of efficiency, the skills, aptitudes and abilities of staff should be identified and applied *“to gain optimum effect and value for the educationally disadvantaged offender in the short time available.”*

13.23 The Taskforce also proposed the establishment of an OMD Alliance Board *“to provide advice to the Director General of the MOJ [the Ministry] and the CEO of the Department of Training on policy, training needs, priorities, resource allocation and service delivery of correctional education and training”*. The Board was to be responsible for, inter alia:-

- preparation of an annual Ministry education and training plan;
- endorsing policy for the implementation of education and training programs including delivery of accredited programs and gaining recognition for industry training programs;
- development of strategies to ensure equal opportunity in training for Aboriginal and female prisoners; and
- monitoring outcomes to ensure compliance with the Code of Practice.

13.24 The ‘Code of Practice’ would provide, *inter alia*:-

- the maintenance of high professional standards for the delivery of occasional education and training services which safeguard the interests and welfare of students; and
- a learning environment conducive to the success of course participants and ensure capacity to deliver nominated courses, provide adequate facilities and use appropriate methods and materials.

13.25 The Ministry has advised me that almost all of the recommendations of the Taskforce have been either implemented or are under consideration. In particular:-

- in October and December 1997, July 1998, October 1999 and September 2000 additional full-time permanent Level 2/4 and 5 positions were created to cater for rising prisoner numbers – the number has risen from 19.5 in 1997 to the current establishment of 30 plus 95-100 contract tutors (*Rec 8*);

- in July 1998 former Level 2/4 positions were reclassified into Level 5 positions as a strategy to make correctional education salaries commensurate with mainstream education. Salaries for the Level 2/4 positions are, however, still under ongoing negotiation due to “*an across public sector equity issue*” (Rec 14);
- imposed a 12 month limit on all staff secondments in October 1997(Rec 15).

13.26 On the basis of the Ministry’s response to my draft Report it would appear that there has been no progress in relation to *Recommendation 9*, namely that it should initiate discussions with the Parole Board about the possibility of it taking a more proactive stance in acknowledging participation in literacy programs as an a genuine attempt at self improvement.

13.27 Although the majority of the recommendations have been accepted, I have decided to include in this Report a summary of the Taskforce’s findings which were drawn from the results of their observations and of interviews and surveys conducted during visits to each prison in the system at that time (Nyandi and Riverbank were not in operation) because the comments made to me in the course of this inquiry and my own observations are very similar to those made by the Taskforce a year earlier. To the extent that I continue to receive complaints about the availability of programs (in the broad sense) I believe some of the problems identified by the Taskforce still remain. The dates in brackets are the dates the audits were completed. The findings are set out below.

Albany Regional Prison (May 1997)

13.28 Nominated hours for training needs and shorter semesters following the introduction of new operational guidelines for TAFE Colleges meant that four to five weeks additional tutor time had to be provided to enable students to complete the modules. The number of prisoners accessing some form of education – 177 out of a prison population of 193 – was described as “*remarkable*” by the Taskforce which found that at that level of participation, available space was fully utilised. The Taskforce commented:-

“once again, it is evident that where enthusiastic and hard-working education staff “team” with a supportive and encouraging prison administration, the MOJ education \$ is utilised more effectively”.

13.29 Albany was inspected by the Custodial Inspection Team in September 1999. The Report which was tabled in Parliament early this year stated:-

- the team was “*impressed to see that a Needs and Risks Assessment system was used by each prisoner’s Case Manager to evaluate comprehensively each prisoner’s programme needs*”;
- at the time of the inspection, of the 227 prisoners, 136 prisoners were involved in education programs - 24 full time, 82 part time, 22 enrolled in external studies and eight prisoners were involved in apprenticeships. Aboriginal prisoners (24% of the prison population) represented 32% of part time but only 16% of full time students. The small number of full time students out of a capacity in the Education Centre of 40 was described as “*disappointing given the number of prisoners idle in the units*”;
- the Gratuities Policy restricted the ability to attract and reward students because of the relatively low pay scales for students compared to payments for industry.

- 13.30 In relation to numbers of prisoners engaged in education, the Ministry has advised me that it - in common with other jurisdictions - has a deliberate policy to restrict full-time student numbers to between five and ten per cent so that a greater proportion of the prison population are afforded the opportunity to access education. In the Ministry's view "*Education Centres should not be filled with a few full-time students. New educational trends look to "on the job" training as a "shift" from the old classroom based system. Education/vocational training students are now at various sites all over the prison (gardens, cleaning parties, industry workshops, kitchens, abattoirs etc).*"
- 13.31 Although I accept that education does not have to be classroom based and that the provision of 'on the job' training is a valuable educational tool, I am not convinced that the Ministry's response entirely addresses the concerns of the Albany Custodial Inspection Team whose main criticism seems to me to be that there was spare capacity in the Education Centre *and* there were prisoners idle in the units. Clearly, even if there were prisoners engaged in 'on the job training', the Inspection Team observed an Education Centre not operating at its full capacity and prisoners who were not engaged in any activity.

Bandyup Women's Prison (February 1997)

- 13.32 The Taskforce found that:-

*"...the opportunity to develop new skills while at Bandyup Prison is **restricted to occupations that generally reflect the traditional and cultural roles of women.** The women are restricted to kitchen laundry, gardening and textile shop duties, essentially those occupations that are required to support the functioning of the prison. They have limited relevance to the labour market outside the prison". (my emphasis)*

- 13.33 The main impediment in 1997 was seen to be "*the lack of appropriate facilities to run courses*" and the Taskforce recommended the establishment of a skills development centre which could facilitate both vocational and developmental courses. In particular the audit team recommended that the OMD should:-

- "*support women to develop and fulfil their aspirations for employment and training, and have a maximum choice of options available to them on release;*
- *recognise the impact of society's gender values and expectations and promote an affirmative and positive view of each woman's potential;*
- *ensure that women have equal opportunity for access to relevant services and programs within the prison system; and*
- ***ensure that women offenders are not a "forgotten minority"***. (my emphasis)

- 13.34 Out of a prison population of 90 at Bandyup Prison at the time of the audit in 1997 there were:-

- 7 full time and 40 part-time students
- 54 employed as follows:- textiles (10); gardens (14); laundry (6); cleaning (12); and the kitchen (12)
- an average of 8 per day attended treatment programs.

- 13.35 The Ministry has advised me that the opening of a new Industrial Skills Workshop at Bandyup has meant that prisoners now have the opportunity to participate in training in a number of non-traditional trades areas such as building and construction, plastering, carpentry and joinery, forklift driving and welding. The women were involved in the construction of the Workshop and will assist in its re-establishment following its re-location due to the extensive rebuilding of the prison. There is now a full-time Vocational Skills Officer who plans the training schedule and is also actively involved in the delivery of some of the courses. During the refurbishment of Bandyup and the temporary closure of the Skills Workshop, he is performing the same function at Nyandi. The courses are designed to allow flexible

‘entry and exit’ in recognition of movement of prisoners within the system and to cater for a small number of participants so that each person has the opportunity to, for example, drive the forklift. Training in plastering was provided to enable prisoners to become involved in the building of the Workshop and will be repeated so that prisoners can assist in the rebuilding program.

- 13.36 In addition, hospitality, computing, horticulture and art are amongst other accredited training options available at Bandyup and a Landcare program for prisoners at Nyandi who will be working in one of the workcamps which have been so successful for male prisoners. The women’s training program is recognised as being one of the most progressive in Australia and Education staff were fully funded by the Australian National Training Authority to present a paper on two “best practice” Women in Non-Traditional Trades models at a national conference in Melbourne in early 1999.

Broome Regional Prison (December 1996)

- 13.37 The Taskforce noted the following impediments to access to education:-

- Facilities for delivering educational programs to prisoners confined in the “security” area were unsuitable and inadequate;
- the physical design limitations of Broome Prison made the involvement of more prisoners in education/vocational training impossible;
- court appearances entailing 2-3 weeks off-site caused disruption to program delivery;
- although 53% of the predominately Aboriginal prisoner population expressed interest in some form of educational program, only 26% actually accessed education. This was considered significant given the view that inadequate education was seen as a major contributory factor in recidivism by Aboriginal offenders;
- there was a need for constructive employment for 80 prisoners. However, at the time of the review, only 10% of prisoners were employed – 5 in the kitchen and 3 in the agriculture area.

- 13.38 In response to my draft Report, the Ministry informed me that an extra classroom was built in Broome Prison in October 1998 and that there are now available a “*number of innovative programs in partnership with Commonwealth and State agencies (including Indigenous community groups) where an ever increasing number of prisoner students are involved in traineeships and “on the job training” at venues off-site*”. I have also been advised that a special program for women - *New Opportunities for Women* – to prepare prisoners for re-entry into the workforce is run at an Aboriginal Community Hall off-site.

Bunbury Regional Prison (October 1996)

- 13.39 The Taskforce noted that the Superintendent was both “*supportive and pro-active in increasing prisoner access to programs*” and that he was a “*strong advocate for the notion that improving education and vocational training attainment levels greatly reduces the risk of recidivism. This positive attitude “at the top” has a “filtering down” effect and is evident in established practice*”, namely the stable roster of prison officers in the Education Centre which enhances their understanding of the education program.
- 13.40 Polling of prisoners to establish their educational needs found that the notion of “*self-improvement*” was a common theme for the majority of prisoners and the desire to improve literacy and computer skills “*so employment prospects could be improved and/or enhanced once released.....Approximately 70% of polled prisoners expressed the desire to do more study and training at this point in time with a view to entering the workforce.*”

- 13.41 The Taskforce was critical of the limited work opportunities for minimum security prisoners, who were restricted to the 'market garden' and the lack of accredited training available in this and other industrial areas of work in the prison. It also recommended the urgent provision of a vocational training classroom and the need for expansion of facilities in the Education Centre.
- 13.42 Bunbury was the first prison to be inspected by the Custodial Inspection Team in July 1999. The inspection report which was tabled in Parliament in November 1999 found that:-
- “education at Bunbury was an example of good practice” on the basis that “high priority was afforded to literacy and numeracy students”;
 - there was high participation by prisoners;
 - the range of educational programs on offer was “varied and appropriate ranging from basic literacy and numeracy to creative writing, Aboriginal studies, human development, life skills, computing, nutrition, yoga... and art therapy”;
 - education staff had good links with the community; and
 - students enrolled in tertiary studies were utilised as “peer-tutors”.
- 13.43 However, the inspection team also noted that the Education Centre was “clearly overcrowded and there was a shortage of classrooms and study areas” and expressed disappointment that there were no Aboriginal education staff in spite of the “numerically significant number” of Aboriginal students who were actively involved in education programs. The Ministry has since informed me that a permanent Aboriginal Education Officer commenced in August 2000 and that an Aboriginal contract tutor is also now employed.

Canning Vale Prison (February 1997)

- 13.44 The Taskforce stated:-

“Increasing prisoner participation rates in education and vocational training in Canning Vale Prison is largely dependent on changing the focus of prison industry and re-examining the programme direction of education to ensure it meets the needs of the majority of prisoners”.

- 13.45 The following impediments to access to education were identified:-
- shortage of prison officers beginning a shift frequently led to the closure of the Education Centre and the turning away of externally funded agencies/presenters;
 - staff shortages meant that prison officers were not released to participate in ‘train the trainer’ courses to enable them to deliver accredited vocational training;
 - late ‘unlocks’ reduced education contact time.
- 13.46 As at 31 August 1996 the prison muster was 315 of which 58% were aged 20-29 and 36% were Aboriginal. Seventy nine per cent of the prison population at that time was recorded as having “nil education” - realistically, this was found to be Year 9 or less. Nevertheless, in spite of the clear education needs of prisoners, the Taskforce found that:-
- **53%** were not involved in any type of program;
 - **40%** expressed no interest in any study;
 - **35%** were interested in full-time work upon release.

13.47 The lack of participation in educational programs was seen as a reflection of:-

- unhappy experiences at school;
- lack of support at home;
- fear of ridicule from other prisoners;
- frequency of prisoner movements.

13.48 In terms of employment a maximum of 175 prisoners (out of 315) were occupied as follows:-

- 30-35 - kitchen⁷)
- 20 - automotive paint shop) No vocational
- 20 -automotive repairs) training offered
- 20-25 – upholstery)

- 20 - metals – “jobbing” shop) Limited vocational
- 11-20 - woodwork/cabinetmaking) training available

- 15 – horticulture) The level of training was not
- 20 - concrete products) specified by the Taskforce

Involvement of Aboriginal prisoners in the “trade” shops was negligible. However, almost all workers in the laundry were Aboriginal.

13.49 In its response to my draft Report the Ministry advised me that there has been a significant improvement in educational opportunities and access by prisoners at Hakea Prison as illustrated by an increase in Student Contact Hours from 89,680 in 1998/99 to 108,160 in 1999/2000 while prisoner numbers remained relatively stable. In addition, following the delivery of the first prison-based traineeship in Australia in 1998 by Ministry education staff, prison industrial officers and the Department of Training and Employment, prison officers are now more actively involved in the delivery of training courses to prisoners.

Casuarina (May 1997)

13.50 Casuarina was seen as having “*enormous potential*” for education and employment because of its facilities and the Taskforce referred to the stated Casuarina philosophy that “*by making life more “normal” within prison prisoners have a better chance of making a successful return to life back in the community*”. The education officers were applauded for their “*re-vamping*” of the system. However, the Taskforce found that the ‘philosophy’ did not translate in practical terms and there was insufficient employment for the large prison muster at that time. Impediments to access to education access were seen as:-

- the acoustics of rooms in the Education Centre which prohibited the running of programs involving “noise” such as music;⁸
- the lack of air-conditioning/ventilation which made education rooms unbearable in summer;
- inadequate capacity – the Centre could accommodate 75-80 prisoners but demands required at least 100 places and there was only one toilet and one lunchroom. The Art Room could accommodate only 13 full-time students;
- Education staff were required to provide education services to the Infirmary, the Sex Offender Treatment Unit, Unit 6 (protection unit), the Induction and Orientation Unit, and the Special Handling Unit;
- lower gratuities for participation in education and training were a disincentive;
- lack of co-operation from industries staff in releasing prisoners for education programs;

- “Core production functions” in industrial workshops were considered more important than education and training. Industrial staff were reluctant to take on more prisoners to allow for release to educational training without disruption to production;
- prison officers were not found to be proactive in offering education as an integral component of prisoner development and had a negative attitude to the concept of training;
- methods for recruitment to education/training were ineffective;
- lack of consistency in rostering of officers in the Education Centre;
- there was no prisoner feedback on course content or delivery;
- Art was identified as a therapeutic activity because of its known value in enhancing self-esteem and confidence and as a vehicle to channel aggression. However, the ‘Art’ budget was considered insufficient, the facilities were inadequate, and transfer of prisoners to other prisons where there was no tuition or space disrupted courses; and
- competing program demands on the Education Centre which also houses a number of treatment programs means that education needs had a lower priority - a finding which was strongly disputed by prison management.

13.51 Prison industry occupied 138 prisoners at the time of the audit (the daily average muster for 1996/97 was 483) as follows:-

• Metals shop	15
• Cabinet Shop	20
• Projects	7 (maximum 10)
• Bakery	16 (maximum 20)
• Bookshop	20
• Garments	20
• Textiles	20-21
• Print Shop	20
• Auto Shop/Industrial Skills Centre	20 ⁹

Each industry offered limited to nil vocational training

13.52 Significantly, the Taskforce made the following findings:-

- “Perhaps the most significant need of Casuarina Prison is a clear and definitive policy regarding the roles of education, vocational training and industry. Applicable to all prisons, is the request for a clear policy statement from the Ministry’s executive enunciating program priority over production”;
- the gratuity system which acted as a disincentive to participation in education or training needed an urgent review;
- the fact that 140-160 prisoners were unemployed each day “reinforces the necessity for effective prisoner management”;
- the unacceptable number of prisoners not engaged in any type of activity reinforced the problem of inadequate staffing numbers and the priority that must be given to supervision and security;
- a more strategic, holistic approach to program participation which avoided “ad hoc” prisoner transfers was needed;
- a public relations campaign, promoting the activities of the Education Centre was “imperative” to overcome the negative attitudes of some prison officers.

13.53 I was advised in a submission that when Casuarina was first opened in 1991 the Education Centre was intended to offer a new custom-designed Introductory Studies Course comprising basic adult education, life skills and personal development units to be completed by all prisoners who aspired to prison employment higher than gratuity Level 4 and who had not completed Year 10 schooling. The course was based on the premise that prisoners would stay at Casuarina for at least three years.

13.54 Shortly after opening, however, the workshops began to employ prisoners at a higher gratuity level than Level 4 regardless of the educational level of the prisoners. In addition, rising prison musters meant that Casuarina became a short term receiptal prison. Prisoners were transferred long before the anticipated three year stay with the result that few prisoners were able to complete a lengthy period of study or even successive semesters. Originally designed and staffed to cater for 370 prisoners, the Education Centre was unable to accommodate prisoner surplus to industry requirements and no additional educational staff were employed. In an attempt to make educational programs available to as many prisoners as possible, courses were delivered outside the Centre in special placement units such as Unit 6 (for protected prisoners), the Special Handling Unit and the Industries area and attendance at the Centre became part time.

C W Campbell Remand Centre (February 1997)

13.55 The Taskforce noted:-

“The fact that remand incarceration periods can be measured in years appears to escape the “powers that be” in WA correctional building decisions and so the administrators of these centres are faced with the unenviable task of managing anxious, and often bored prisoners without the physical resources to provide meaningful occupation. Over half the remand population will remain at this site for at least six months with little or no “real” work to do.”

13.56 The Taskforce found that 50% of remand prisoners remained at the Centre for eight months or longer and identified the following impediments to access to education:-

- limited facilities;
- low staffing levels;
- the multi-purpose function of the Education Centre and the attitude towards education meant that education programs tended to be afforded a lower priority for accommodation than other programs or functions such as ‘hair-cutting’;
- staffing shortages at the prison led to withdrawal of staff in the workshops, library and Education Centre and the consequential closure of the Centre.

13.57 There was no vocational training at the Remand Centre in 1997 although it had been proposed to hold cooking classes. There were no industries and the Industrial Skills Officer was occupied full-time with maintenance of the complex.

13.58 A survey of prisoners conducted by the Taskforce revealed that the “*major deterrent to program participation was the type of course on offer*”. Sixty six percent of the prison population did not access education programs although 46% of those who were not engaged in educational programs expressed the desire to work on release. The Taskforce recommended that education programs should have priority in the Education Centre timetable; that training through a video-link with TAFE Colleges should be seriously considered and that future planning for the Remand Centre acknowledge the difficulties posed by the lack of facilities and examine “*innovative options*” including utilising Canning Vale Prison facilities.

Eastern Goldfields Regional Prison (May 1997)

- 13.59 The Taskforce noted positive developments in the Education Centre, which provided an area conducive to learning for 12 students in spite of the “*design difficulties*” at the prison. However, only minimum rated prisoners were allowed to access the Education Centre and education staff were required to deliver programs in the maximum security wing which, in their absence, effectively limited access to the Education Centre for minimum security prisoners. There was no study area other than a prisoner’s cell. Negative staff attitudes and a lack of collaboration in getting prisoners to the Education Centre on time were again identified as impediments to effective delivery of educational programs. Again the Taskforce found that education was not generally well-promoted by staff.
- 13.60 It noted that the prison population is a “*unique group and requires specialist programs to cater for its specific needs/situation*”. There was insufficient constructive employment for prisoners within the prison and a noticeable lack of communication with the community to assist prisoners after release. The prison was only able to employ 20 prisoners in the workshop, kitchen and wholesale nursery respectively. No women were employed in industry. The nursery (gardening), which was a “*first*” for prisons in Western Australia was noted to be “*no longer thriving*” and “*in urgent need of attention*” although it was an area which could easily absorb “*bored and unoccupied*” prisoners.
- 13.61 The Taskforce concluded that the priority requirement was for educational and vocational programs to develop prisoner self-management in parenting, hygiene, literacy and numeracy while at the same time increasing self-esteem through the development of employment related skills.

Greenough Regional Prison (June 1997)

- 13.62 The Taskforce found that the Education Centre was too small and that the number of prisoners participating in education (18 full time and 30 part time) was “*disappointing*”. It stated that “*it is crucial that education services are presented in a favourable light.*” It was critical of access to education for maximum security prisoners and for women whose access was described as “*severely impeded*”. Vocational training opportunities were found to be restricted due to “*inappropriate resources*”.
- 13.63 An operational audit conducted in May 1998 endorsed the criticisms of the Taskforce in relation to access to education by maximum security and female prisoners and recommended that:-
- recreational activities be managed by prison officers to improve the quality and level of interaction between prisoners and officers;
 - the expansion of employment opportunities for prisoners through increased community involvement; and
 - the payment of a bonus gratuity to prisoners who successfully complete an education or training course.
- 13.64 The Ministry has advised me that there has been some improvement in the opportunities for male Aboriginal prisoners who are now able to undertake a TAFE building skills course and to use their skills in any building projects at the prison. Opportunities remain limited for female prisoners, largely because the prison is a medium security facility and they are segregated from the men.

Karnet Prison Farm (May 1997)

- 13.65 The team found that education and vocational training was “*high on the agenda*” at Karnet and that the prison was making optimum use of its facilities.

Pardelup Prison Farm (May 1997)

- 13.66 Pardelup was able to offer *100% employment* for prisoners. However the Taskforce noted the “*disinterest of the Farming Officers towards training*”; frequent transfer or movement of staff and the short stay of prisoners as impediments to the full education vocational potential of the prison. It was hoped that the “*commitment and enthusiasm of the administration/education team and the granting of “accredited training provider”*” would overcome these problems.

Roebourne Regional Prison (December 1996)

- 13.67 The Taskforce noted that the Education Centre could cater for 40-45 students and its recent expansion made it an environment conducive to learning. However, the only vocational training was for five prisoners in seed propagation. The lack of encouragement given by officers to prisoners to participate in educational programs and the exclusion of the Education Officer from prison “debrief” were considered problems.
- 13.68 A survey of the prison population, which comprised primarily Aboriginal men (90%), showed considerable interest in improving literacy skills to increase employment opportunities - 50% said they wanted to work on release and 33% wanted assistance with literacy and numeracy. The review noted “*part of rehabilitation is to give the offender a means of being able to support himself and his family upon release and literacy classes can play an important role in achieving this.*” Participants in the survey also indicated a desire to overcome boredom and to become independent as motivating factors. The team was concerned, however, that the high percentage of those expressing interest in education (72%) was not reflected in the **actual** numbers accessing full-time education, which was 10. In addition, the prison’s three trade workshops were well-equipped but “*empty of prisoners*” at the time of the audit.
- 13.69 Continuing the theme of opportunities for women, the team found that female prisoners were “*seriously disadvantaged*” in terms of access to education and training although the prison had attempted to contact community women’s groups to establish a program of visits, craft, parenting and self-esteem development programs. The lack of opportunities for women remains a problem although there are now special courses in carpentry and small tools.

Wooroloo Prison Farm (May 1997)

- 13.70 It was found that a pro-active orientation program designed by staff at the prison and their positive attitude to education had significantly improved the numbers accessing the Education Centre. The prison also endorsed the premise that working prisoners must be allowed to attend education without pressure from work instructors. Nevertheless the principle that production overrides education was still evident. The need for a multi-purpose skills development centre as recommended for other prisons was repeated.
- 13.71 The prison was inspected by the Custodial Inspection Team in August 1999. Because of the critical comments of the prison as a whole, it was agreed that a second inspection would take place in November 1999 to enable some of the problems to be addressed. The report of both inspections was tabled in Parliament on 16 August 2000. The team’s findings included the following:-

- There was a “*significant lack of constructive work activities. Workshops were being under-utilised and not enough use was being made of prisoners to clean, paint and re-furbish the prison*”. “*Serious*” employment (including education) was available to only 100 prisoners out of a total prison population of around 200. “*Having healthy prisoners lying in bed at mid-day is not a sign of a good prison.*”
- The farm employed only five prisoners and offered no accredited training. The only commercial workshop¹⁰ was the laundry but the laundry workers were not working to capacity and there was no accredited training. The industrial workshops (carpentry, steel fabrication/mechanical, paint and vocational skills) employed only 18 prisoners but had a capacity of 44. At least 38 prisoners were without allocated work and the 59 employed in the gardens, cleaning, recreation, recycling and stores were under-employed.
- The Education Centre was full and education staff actively pursued prisoners to attend. However, because the Centre was too small it could not realise its full potential. The low gratuity rate for students was a disincentive to participate in education programs. Literacy and numeracy screening was undertaken on all prisoners who had not been previously screened and there was a focus on these core skills together with computing, small business management and Aboriginal studies. There were separate courses for Aboriginal prisoners and a third of all Aboriginal prisoners were involved in part time education. There were no Aboriginal staff and attempts at recruitment had been unsuccessful.
- Programs included Skills Training for Aggression Control, Substance Abuse, Driver Education and Training and Transition to Parole Release programs were run on a regular basis and prisoners were encouraged to participate to enhance their prospects of release on parole.

13.72 By the time of the second inspection in November, the team noted a significant improvement in the level of activity for prisoners, a large proportion of whom were involved in maintaining and refurbishing the prison. However, the team believed that although this helped defray the cost of imprisonment, the work undertaken was not productive in terms of enhancing prisoners’ skills or in facilitating re-integration after release. The prison management were taking steps, however, to organise training in tiling to facilitate refurbishment of the ablution blocks.

13.73 The team found that there had been no progress in increasing accommodation in the education centre nor had funding been allocated to do so in the future. There was concern that “*education funding constraints were inhibiting the engagement of tutors and therefore the provision of programmes*”. Outcare had, however, commenced a new program of drug and alcohol counselling. The team was concerned to find that a large number of prisoners were arriving at Wooroloo from other prisons without completing any programs.

Conclusions of the Taskforce

- 13.74 There were a number of consistencies in the findings of the review team in relation to the majority of prisons inspected:-
- (i) the low priority of education was reinforced by the negative and unsupportive attitude of some officers; by prison regimes; and by the inadequacy of education facilities and resources;
 - (ii) the existence of significant disincentives to participation in education and vocational programs including:-

- (a) lower gratuities for education than for work;
 - (b) difficulties in obtaining release from work parties or industries workshops to attend education and training;
 - (c) fear of ridicule from officers and fellow prisoners because of inadequate orientation programs which could promote education;
 - (d) the likelihood of unscheduled transfers to other prisons which may not have the same educational opportunities;
- (iii) the absence of sufficient constructive employment for all prisoners at most prisons;
- (iv) the lack of multi-purpose skills development centres at most prisons to encourage work-related training;
- (v) a lack of communication with the community to identify and promote employment opportunities and related training needs;
- (vi) difficulties in accessing educational opportunities caused by security ratings; and
- (vii) the lack of opportunities for all women prisoners across the system leading to their serious disadvantage.

13.75 Similar concerns about the adequacy and suitability of education and training were expressed during the course of my inquiry. Particular reference was made to the low level of education of many prisoners; the insensitivity of some prison officers to illiterate prisoners and their lack of support for educational programs. It was suggested that prison officers should be more involved in the delivery of educational programs. A number of submissions questioned the low priority of education and suggested that it should be part of the sentence planning process. Concerns were also expressed about the lack of culturally appropriate educational programs; that music and art were not generally encouraged as accredited programs and that most prisons have inadequate educational facilities.

13.76 I regret to say that, despite the passage of time since the Taskforce reported, it was apparent from my observations when visiting prisons that many of the deficiencies identified by the Taskforce - which were echoed in submissions to my inquiry and in the recent reports of the Custodial Inspection Team following inspections of Bunbury, Albany and Wooroloo Prisons - remain. A number of those issues are considered further in this chapter.

PRISON INDUSTRIES

13.77 The issue of prison industries was debated further at a *Prison Industries Workshop* held at Casuarina in November/December 1998 and attended by operational industry supervisors and managers and executive staff responsible for the development of policy relating to prison operations. During the course of this workshop, the Ministry's focus in relation to industry and employment was defined as:-

- providing job satisfaction to officers organising prison industries;
- giving prisoners hope for their future, sound work habits and the necessary skills; and
- making the prison system more effective and less costly to run.

13.78 Workshop participants agreed with the following propositions relating to employment in the prison environment:-

- all prisoners should work;
- some prisoners cannot or will not work;
- security issues will always override industry needs;
- industries can operate with an identified level of risk;
- prison industry makes a significant non-monetary contribution to the community;
- Superintendents manage and control the industries in their prisons;
- ‘troublemakers’ must be kept in the system and given work opportunities;
- Industrial Officers and offenders can get a normalised working relationship;
- offenders want to work;
- offenders respond to incentives; and
- Industrial Officers are not capable of managing a budget.

13.79 However, they did not agree with the following propositions:-

- Each workshop has a stable workforce;
- prison systems support prisoners using their time productively;
- production and education/training are complementary;
- all prisoners work a full day in a shop without disruption;
- all offender development programs should be delivered at the end of the sentence;
- key decision makers in industries have business training;
- the system provides incentives for production;
- prisoners are unable to cope with skilled work;
- workshop managers cannot make workshop policy decisions;
- staffing levels will keep pace and be appropriate;
- all offenders can be offered work in prisons;
- prisoners cannot be used as peer trainers;
- the prison schedule complements industries and recreation;
- the prison system allows prisoners to stay in one place;
- the gratuity system is fair and equitable; and
- Aboriginal workers do not want skilled work.

13.80 The key issues which emerged from the workshop were that:-

- procedures and programs within prisons are designed primarily with security in mind;
- gratuities were counterproductive to industry productivity;
- Industrial Officers feel undervalued compared to “*disciplinary*” prison officers. They are unable to reward themselves or prisoners and face significant problems getting investment in necessary machinery and equipment; and
- prison industries appear to be undervalued by the system, Government and the community.

13.81 A suggestion put forward at the workshop to “*make industries work*” was to ensure that reception staff emphasise the importance of education, industry and training and that these components are included in on Individual Management Plan (IMP) for each prisoner. Changes to the way in which industries are managed and funded and the structure of gratuities were proposed. Daily prison routine should be modified to include:-

- full-time education until the required level for industry was achieved;
- a 10 hour working day which includes 8 hours' work and 2 hours' training;
- greater communication between industries and education;
- identified productivity incentives; and
- visits and medical parades after work.

13.82 The Ministry's "*Industries Policy*" (presumably incorporating some or all of the views expressed at the workshop) dated 14 April 1999 and implemented in October 1999 states:-

"Prisoners will be given the best possible opportunity to model and practise behaviour and attitudes that reflect normal community standards. This will be done in a realistic, business-like work environment that replicates as closely as possible, the outside world.

To achieve the stated outcomes of the Offender Management Division the following industries policy objectives will be pursued concurrently and with equal weighting.

Development of opportunities for prisoners to acquire vocational and work skills to enhance their opportunity to gain and retain employment upon their release.

Continuous and meaningful activity for prisoners as a basis of securing more effective management of prisons.

Opportunities for prisoners to undertake productive work that contributes to reduce the cost of prisons to the taxpayer."

- 13.83 Strategies for attaining the goals of the policy are to include established hours of work; a gratuities system which rewards attendance and work performance; normalised employer/employee relations between officers and prisoners; minimisation of interruptions to working hours; no unnecessary prisoner turnover; a complementary approach between work programs and vocational education; training programs and conscious monitoring of programs addressing offending behaviour in the work setting.
- 13.84 The Ministry advised me that prison superintendents are encouraged to identify opportunities for industries provided they are cost-neutral or considered suitable for allocation of additional funding. Prison industries reviews were undertaken in 1989, 1993 and 1996 and have resulted in a number of unspecified "*incremental improvements*". A further review completed in June 1997 resulted in the appointment of an Industries Manager who is responsible for implementing and coordinating the Ministry's industry policy.
- 13.85 With the rise in muster levels, the Ministry is well aware that it is unable to provide constructive work for all prisoners in the system. It estimates that work for approximately 1000 more prisoners is needed. To this end the Ministry has established a Prison Industries Advisory Committee chaired by the Hon Ray Halligan MLC with representatives from the Chamber of Commerce and Industry, the Small Business Development Corporation, CCA, Prison Services Division, the OMD and the Ministry's Policy and Legislation Section to assist it to seek commercial contracts and partnerships to fund new industry opportunities. An important breakthrough has been agreement that any profits made in the course of prison industries can be retained by the industry to create more employment for prisoners. However, the Ministry still considers itself constrained by the requirement of the *State Trading Concerns Act 1916* that prisoners can only be provided with work opportunities which assist in rehabilitation.
- 13.86 I have made no attempt to examine what legal restrictions may exist by virtue of that or any other Act. However, it seems quite clear to me that the acquisition of any form of work skills or work ethic as a result of engagement in gainful employment while in prison must be rehabilitative. There should, in my opinion, be no doubt about what industries the Ministry can and cannot engage in. If there is, the Ministry should seek clarification and take steps to address any problems that are identified.

- 13.87 In spite of the development of an industries policy and the apparent acceptance by the Ministry of most of the recommendations made by the Taskforce examining education and training, the views expressed in submissions and interviews and my own observations during visits to all prisons in the State indicated a residual lack of commitment to providing adequate education, training and/or employment opportunities for prisoners at most prisons.
- 13.88 I was told that the Ministry offers no 'central' advice on the availability of funding or grants from other sources such as TAFE (Technical and Further Education), ATAS (Aboriginal Tutoring Assistance Scheme) or VEGAS (Vocational Education Guidance Assistance Scheme) to supplement education budgets at individual prisons. The Education Officers at some prisons independently access such funding and grants and told me that they would be unable to operate without those contributions. The Ministry has advised me that this is no longer the case and that "... 'one-off' grant funding, funding arrangements with ATAS, IESP, Department of Training, DETYA, TAFE Colleges are now negotiated centrally with great benefit to the Unit. Currently, the "value" (time and/or \$) coming in from external State and Commonwealth sources is in excess of \$1.3 million annually..."
- 13.89 It was also suggested to me that not only was there a lack of 'central' support but attempts were made to control and standardise all education programs with the result that local needs were often overridden. The criticism that the central administration of programs consumes a disproportionate amount of resources (with the creation of new highly paid positions) and that staff numbers in the prisons remain static¹¹ despite rising musters levels was a familiar theme which was raised consistently throughout my inquiry.
- 13.90 A further obstacle drawn to my attention during the course of my inquiry was a policy directive that prisons should only run courses which lead to employment, making the running of life-skills courses such as financial management, self-esteem, positive parenting, form filling etc at very least 'unofficial'. The Ministry has advised me that these courses have been part of the Ministry's accredited certificate courses and traineeships delivered in Education Centres for the past ten years. However, following a review of education in 1996 it was decided that a number of the 'life-skills' units were out of date and needed to be made more relevant to employment in the 90s. The policy directive was therefore "...aimed at reducing delivery in "old" courses for which there are no longer employment opportunities in WA".
- 13.91 Concerns about the adequacy of strategies to educate, train or merely 'occupy' prisoners were also raised in the Smith Report, which, in its analysis of the causes of the Casuarina Christmas Day riot, made the following observations:-

"A significant number of prisoners did not seem to have access to constructive activities and many passed their time not actively engaged – unhealthy for any establishment and in direct contrast to the stated aims of the prison regime. On Christmas Day the prison was 164 activity places short. The programmes being run for prisoners were unable to deal with all referrals – a source of tension for prisoners whose parole is often dependent on attending such programmes. The social/psychological effects of having no job/occupation can reinforce negative self esteem perceptions and increase hostility and negative feelings towards authority." (paragraph 5.2.4.9)

National comparison of prisoner participation in education, training and employment

13.92 Information about the level of ‘engagement’ of Western Australian prisoners in education, training and employment in 1997/98 and 1998/99 compared with those in other States is published in the Commonwealth Government *Report on Government Services 1999* and 2000, respectively. The figures for Western Australia compared with the highest and the lowest figures for the States and the national figure are set out in the following tables.

TABLE 13.1		National comparison of prisoner engagement in employment, education & training 1997/98			
1997/98	WA	Highest	Lowest	Australia	
Employment	78%	VIC – 81.6%	NT – 54.1%	73.0%	
Education – overall	31.1%	VIC – 62.2%	WA – 31.1%	51.5%	
• Basic skills*	12.3%	QLD – 25.5%	WA – 12.3%	18.7%	
• Secondary	11.1%	VIC – 42.3%	WA – 11.1%	21.0%	
• Tertiary	4.7%	QLD – 8.0%	TAS – 2.5%	5.7%	
• Vocational	3.0%	SA – 4.8%	VIC – 2.3%	3.0%	

* remedial/preparatory courses in literacy, numeracy and personal development courses

TABLE 13.2		National comparison of prisoner engagement in employment, education & training 1998/99			
1998/99	WA	Highest	Lowest	Australia	
Employment	78.3%	NSW – 79.5%	NT – 55.8%	73.4%	
Education – overall	39.0%	NT – 61.7%	TAS – 25.4%	45.5%	
• Basic skills*	5.3%	NT – 30.7%	WA – 5.3%	17.7%	
• Secondary	4.6%	NSW – 17.1%	NT – 3.6%	9.1%	
• Tertiary	3.3%	SA – 8.5%	NT – 1.0%	3.3%	
• Vocational	25.8%	NT – 45.3%	SA – 12.1%	24.2%	

*remedial/preparatory courses in literacy, numeracy and personal development courses

13.93 The employment figures for Western Australia show that in 1997/98, 26% of prisoners were employed in commercial industries and 40% in service industries, with 12% engaged in work release. The 1998/99 figures show an increase in both commercial and service industries to 33.6% and 44% respectively. There were no figures for work release in that reporting period.

- 13.94 In relation to education the Ministry advised me that it considered the figure of 31% for 1997/98 to be an unfair representation of the educational involvement of prisoners as it was based on numbers in the Education Centre on a given day and did not account for all prisoners enrolled in educational programs, both full and part time, which it estimated to be around 38% of the prisoner population in that period. I was told that the 1997/98 percentage figure also excluded those who were on a waiting list for enrolment in educational programs.
- 13.95 In response to my draft Report the Ministry also raised concerns about discrepancies in the way in which different States compile their figures – for example, it claims that New South Wales records non-intensive treatment programs as education delivery whereas Western Australia does not and notes that “the Ministry of Justice will continue to figure poorly in comparison”. This would clearly make a difference in a comparison with New South Wales. However, I note that although the overall level of engagement in education in Western Australia for 1998/99 had increased to 39%, it was still lower than that in Victoria (56.6%), Queensland (45.6%) and South Australia (42.5%) and the national level (45.5%).
- 13.96 In early 1999, at my request, the Ministry collected figures for the level of engagement in education on a prison by prison basis for the period 31 January to 31 March 1999. Education figures were also provided for 1-31 October 2000. Both sets of figures are set out in **Table 13.3**.

**TABLE 13.3 Percentage education engagement by WA prisoners
31 Jan-31 Mar 1999 and Oct 2000**

	Average Daily Muster		% Full Time		% Part Time	
	Jan-Mar	October	Jan-Mar	October	Jan-Mar	October
	1999	2000	1999	2000	1999	2000
Albany	220	218	13	18	38	32
Bandyup	165	137	7	8.7	43	56
Broome	105	111	23	0	60	47.7
Bunbury	225	207	11	12	33	39
Hakea	330	329	9	10	32	32.8
Casuarina	660	657	4	4	11	38.8
Remand Centre	175	349	0	0.2	57	46
Eastern Goldfields	110	109	3	0	98	62
Greenough	205	236	39	12.7	9	38
Karnet	145	187	12	4	32	39.6
Nyandi	Included in Bandyup	42	0	0	Included in Bandyup	35.7
Pardelup	75	79	9	10	39	41.7
Riverbank	90	55	9	22	23	31
Roebourne	211	175	13	14	17	20.6
Wooroloo	200	222	11	9	60	29

- 13.97 These figures translate to an overall education engagement level of approximately 47% for the period January to March 1999 and 48% for October 2000. The Ministry has also provided me with monthly overall engagement figures for April 2000 through to August 2000 which indicate only minor variations – 46% in April and May; 47% and 48% in June and July respectively and 50% in August. The figures for September are not available.

- 13.98 These figures show a significant improvement in the level of education across the system – except at Broome, Eastern Goldfields and Wooroloo where there has been a marked decrease. The Ministry provided the following reasons for the decrease:-

Broome

“[The] Indonesian population is choosing not to access education at the moment. They have participated in functional english classes but now this group consider they have enough english and choose not to attend, (We are currently surveying their needs, interests etc to see if we can offer anything else that may interest them).”

Eastern Goldfields

[the earlier figures may overstate the position because] “... it is likely.....that [the Education Officer] ran some short first aid, music, art and health courses. Sometimes these can attract the whole population for a limited time.....If a couple of these were run end to end, then a large accessing percentage is possible. These are valuable when you are a new EO [Education Officer] and need to break the ice and/or coax reluctant students into the Ed Centre for more formal education.”

Wooroloo

“ - (the Senior Education Officer who is on extended sick leave) was in the midst of a dormitory building program (with training), had chainsaw programs operating [and] forklift courses (very popular). High turnover in this prison will always mean that the numbers will fluctuate dramatically. Recently the figures were 58% serving six months or less – this means the ed[ucation] numbers will reduce.”

- 13.99 The Ministry also advised me:-

“.....numbers in education fluctuate all the time for a number of reasons:-

1. Population doesn't choose to attend (all education is voluntary)
2. Prison building programs – Bandyup upgrade has closed the vocational training workshops for at least 6 months – our % out there is sure to reduce dramatically in the next 6 months.
3. Hakea's good figures are already being affected badly by the change to that prison's population profile in readiness for its new assessment function.
4. When the medium security prisoners move to Acacia, our figures will fall at all prison sites because that is the most productive education/training period (prisoners are more settled during this time).
5. At release prisons (eg Wooroloo), there can often be the need for prisoners to participate in the mandated treatment programs to meet parole conditions. If limited time is available then there is no time for education access.
6. If a prison's numbers rise, the % accessing education can fall because of available education places. ”

- 13.100 Encouragingly, the level of engagement appears to have remained relatively consistent in spite of an increase in the muster from 2990 in April 2000 to 3113 in October 2000. I have also been advised that the number of Student Contact Hours has increased from 250,000 in 1996/97 to 890,000 for the year ended 30 June 2000. Presumably the figures for Western Australia in the *Report on Government Services 2001* will reflect these improvements.

- 13.101 The Ministry also collected figures of levels of engagement in employment during its survey of prisons in early 1999 and provided me with the following information:-

TABLE 13.4 Levels of engagement in employment 1 January-31 March 1999

	Average Daily Muster	%Employed	% Full-time	% Part-time (4 hrs per day)	% Casual (1-2hrs per day)
Albany	220	87	65	14	8
Bandyup/Nyandi	165	82	48	6	28
Broome	105	100	10	50	40
Bunbury	225	85	85	0	0
Canning Vale	330	90	73	0	17
Casuarina	660	40	40	0	0
Remand Centre	175	60	0	60	0
Eastern Goldfields	110	100	15	45	40
Greenough	205	100	10	50	40
Karnet	145	90	90	0	0
Pardelup	75	94	94	0	0
Riverbank	90	90	0	0	0
Roebourne	211	94	45	49	0
Wooroloo	200	70	70	0	0

13.102 These figures equate to an employment level of approximately 73% across the system. Although the Ministry collects employment figures for each prison on a quarterly basis, the type of employment (full-time, part-time or casual) is not routinely differentiated. However it has provided me with the number of prisoners employed and the 'prisoner count' as at 14 November 2000 taken from TOMS. These are set out in **Table 13.5**.

TABLE 13.5 Levels of engagement in employment as at 16 November 2000

	Average Daily Muster	%Employed
Albany	209	78
Bandyup	142	86
Broome	99	88
Bunbury	204	80
Casuarina	651	53
Eastern Goldfields	121	81
Greenough	227	57
Hakea (inc Remand)	666	85
Karnet	199	95
Nyandi	48	83
Pardelup	71	95
Riverbank	53	70
Roebourne	182	70
Wooroloo	229	91

13.103 On the basis of these figures the overall employment level appears to have remained relatively stable at 74.6%.

Summary of conclusions on education, training and employment

- 13.104 On the basis of the available literature and research, and as a matter of common sense, it is quite clear that employment in constructive activity has benefits for the mental and physical health of prisoners; “for the good government and good order” of prisons; and ultimately for the community because the acquisition of any educational, vocational or work skills is likely to lower the risk of reoffending after release. Conversely, a lack of constructive activity has been found to increase boredom, anxiety and tension by increasing feelings of helplessness and hopelessness and exacerbating the “pains of imprisonment”. Such feelings frequently result in self harm and suicide or aggression towards other prisoners and staff.
- 13.105 The evidence gathered during the course of my inquiry has led me to the conclusion that, there were generally insufficient educational, training and employment opportunities for prisoners at most prisons in Western Australia. It is obvious that the Ministry has made significant improvements in this area in the past 12-18 months and that opportunities for education and employment work at most prisons are increasing. However, there are exceptions. In particular, the low level of engagement in both education (43%) and employment (53%) at Casuarina is of concern. A lack of constructive activity at Casuarina was highlighted by both the 1997 Taskforce and by the Smith Inquiry into the disturbance on Christmas Day 1998. Similarly, there have been few improvements in the conditions and services available to women held in regional prisons and, in my view, in relation to education and employment they are particularly disadvantaged.
- 13.106 Although this was partly due to a lack of facilities and staff for these functions, in my view – as with the provision of health services - the underlying reason for the shortfall arose from the perception that education and training were not *core activities*, with the consequence that funding requests suffered in competition with more security-focussed and prison operational requirements.
- 13.107 In response to my draft Report the Ministry has advised me that “the 2000 Draft Business Plan for Prison Services recognises education/training as “core” business in that SCH [Student Contact Hours] numbers and prisoner participation rates are two of its performance measures”. I note that the Plan is a “draft” and although I do not doubt that the Ministry is serious in its desire to enhance the value of education and training, I suspect that a number of the obstacles identified in this Chapter will need to be overcome before it is able to achieve its goal. At this stage, therefore, I am not entirely satisfied that the range and availability of education and employment programs currently offered at *some* prisons is yet adequate for the purposes of the ‘healthy prison’ test suggested by HM Chief Inspector of Prisons, namely that “prisoners are fully and purposefully occupied and are expected to improve themselves.”
- 13.108 The active promotion of education is of particular importance given that prisoner statistics for the year ended 30 June 1999 show that around 74% of prisoners had less than three years’ secondary education (68% of non-Aboriginal prisoners and 85.4% of Aboriginal prisoners) on admission to prison. A similar bleak picture emerges from the statistics on employment status produced by the Ministry - only 27% of prisoners were employed at the time of arrest (15.7% of Aboriginal males and 7.5% of Aboriginal females and 34% of non-Aboriginal males and 20% of non-Aboriginal females).¹²
- 13.109 The Ministry has advised me that it is aware of this situation but that:-
- “Prisoners with an unhappy educational history often have to be “persuaded” to engage in education/training. Experience has shown that very few can cope with full-time education and so the part-time option is very popular. When the vast majority of prisoners have significant literacy deficits it is not realistic to expect them to be engaged in “secondary schooling”. The most successful way to entice them to the education environment has proven to be through “on the job” training. Prison education follows the principles of Adult Learning – voluntary, relevant to their needs, interests, career aspirations and individual student input to the education program.”*

- 13.110 I am quite sure that this is true and that many prisoners may also be reluctant to admit to poor or non-existent literacy and numeracy skills because they feel it increases their vulnerability in an environment where any form of weakness could be used against them. In my view this is all the more reason for promulgation by all parts of the prison system of the notion that education and training are important and valid activities which are of real benefit to prisoners, the prison system and the community, and the complete discrediting of any suggestion that education or training is a “*soft option*” for prisoners who do not want to work.
- 13.111 In my view, given the generally poor level of education and the lack of work skills among the majority of prisoners, the low priority accorded to education and training reflected in the Ministry’s apparently reactive approach for some years to the provision of adequate education, training and employment has impacted on the overall effectiveness of its suicide prevention strategies and the rehabilitation of prisoners prior to release.
- 13.112 I have no doubt that recognition of education and training as important *management tools*, rather than ‘soft options’, would result in a significant improvement in both the efficiency and effectiveness of the prison system and allocation of the “*education \$*”. It is encouraging to note, therefore, that the new assessment process, which commenced in the form of a ‘pilot’ on 20 November 2000 at Hakea, is designed to provide a comprehensive assessment of a prisoner’s total needs in relation to programs (including education, training and employment).¹³
- 13.113 Under the new process the program and education needs of each prisoner will be assessed by Reception and Education Officers, using consistent assessment ‘tools’. Because all prisoners will be asked the same questions, it is believed that some needs – such as lack of basic literacy and numeracy skills – will be easier to identify and less embarrassing for prisoners to reveal. To ensure the best outcome from its new assessment process, the Ministry will, of course, need to ensure that it has sufficient resources to cater for the program needs identified.

RECOMMENDATION 13.1

That the Ministry should:-

- (a) acknowledge the importance of constructive activity in the prevention of suicide and self harm and in the rehabilitation of prisoners and ensure that all prisoners are provided with adequate opportunities for education, training, employment and treatment programs throughout their sentences at all prisons;**
- (b) take steps to remove the disincentives to participation in education identified by the Taskforce and in the course of my inquiry;**
- (c) provide funding, resources, trained staff and facilities to increase the opportunities for education (in its broadest sense), training, employment and rehabilitation throughout the sentence at all prisons; and**
- (d) obtain legal advice as to whether the *State Trading Concerns Act 1916* or any other legislation prevents the Ministry from offering particular forms of gainful employment to prisoners, and consider seeking amendment if it is found that there are legislative restrictions.**

RECREATION

- 13.114 Only Casuarina and Hakea have dedicated Recreation Officers. All other prisons have an Activities Officer who is responsible for recreational activities as *part* of other duties.¹⁴ Recreation/Activities Officers are generally not required to possess specific qualifications and do not receive any internal or external training for the position. Essentially the responsibilities of the Recreation Officer positions are to:-

“...develop recreation programmes which will provide a maximum opportunity for prisoners’ participation and utilisation of recreation facilities, and as far as possible, cater for the whole spectrum of prisoners’ interests.

Consistent with the management philosophy of the prison, recreation activities will be after working hours Monday to Friday, weekends and public holidays as per daily routine.

Therefore, programmes should be developed, with an opportunity for prisoners’ input in order to promote a sense of responsibility, motivation of recreation interests and a degree of self-management which is consistent with the Departmental recreation policy.”

I understand that the classification and duties of the Recreation Officer positions are currently under review.

- 13.115 Recreational activities include ‘active pursuits’ such as team sports, (primarily football, soccer, basketball, badminton and volleyball) and ‘passive pursuits’ (which include television, videos, art work, music (guitar), board games, pool, table tennis, darts and reading). Bandyup had access to a swimming pool – this will be removed in the planned refurbishment of the prison - and was the only prison to receive additional funding for recreation purposes in the past five years for a tennis court and community centre. The recreation budget at Eastern Goldfields was cut in 1999.
- 13.116 In its report on Bunbury Regional Prison (July 1999), the Custodial Inspection Team found that there were no organised sporting activities, nor formal passive and active recreation programs. The team was critical of the fact that the Sports Coordinator was a prisoner and found the recreational facilities to be inadequate. The Sports Oval is closed at weekends except between 9.30am and 11.30am. Minimum security prisoners were able to use the small adjacent oval only when staff were available to supervise and although they had been provided with cricket nets they were “*not allowed bats and balls*”!
- 13.117 The team recommended the immediate cessation of the practice whereby, prior to issue of recreational equipment, prisoners were required to sign a blank “Request to Transfer Cash” form to facilitate deduction of money from the prisoner’s account to cover loss or damage to equipment.
- 13.118 In the Albany Inspection Report (September 1999), the team found that “*organised sport evolved from the needs of prisoners and they had ample input into recreation activities*”. Overall facilities were good and it observed “*many prisoners using the oval both at the weekend and during the week day evening*”. The oval was accessible each day between 4pm and 5pm (5.30pm in the summer). The team found a wide range of activities in the accommodation units but was critical of the use of home-made weights. There were inter-unit sports ‘carnivals’ during holiday periods. Football was popular and well-organised with three teams and a drafting system. One of the few complaints from prisoners was that they had to buy football boots through the prison shop which was “*beyond the means of many prisoners*”. The team recommended that boots be made available on request.

- 13.119 The team noted that videos were shown every night and during the day at weekends, that Vietnamese language videos were available and that the library was well-stocked. The team was critical of the fact that the Recreation Officer did not hold a dedicated rostered position and that responsibility for recreation was part of the role of the Activities Officer, who was also required to perform other duties such as washing vehicles, daily town runs, mail and the delivery of blood samples to the hospital. He was only rostered every second weekend. The team recommended that “*Staff responsible for recreation should be rostered on duty for the majority of prisoners’ recreational times.*”
- 13.120 The first Custodial Inspection of Wooroloo Prison in August 1999 noted “*extensive*” recreational facilities both outdoor and indoor but described the recreation hall as “*seriously neglected*”. There appeared to be no organised sporting activities and the Recreation Officer “*appeared to dedicate most of his time to a few prisoners participating in community sporting activities to the detriment of the vast majority of the prisoner population.*” Prisoners were left to organise their own internal sports arrangements despite concerns that prisoners could monopolise facilities and a prisoner was responsible for sports equipment although it exposed him to intimidation from other prisoners. By the time of the second inspection in November 1999, a comprehensive recreational plan had been developed but was not in operation. The prisoner was still responsible for sports equipment and there had been no improvement in the greater involvement of the Recreation Officer in activities for the majority of prisoners.

Conclusions on recreation

- 13.121 On the basis of my observations during my visits to prisons, those prisons with a younger population such as Casuarina and Canning Vale who were able to participate in team sports, particularly football, soccer and basket ball, could be said to meet some of the physical needs of the majority of prisoners, *provided* prisoners have access to those sporting activities. Prisoners at Casuarina were, of course, unable to take advantage of any exercise or active pursuit for almost the whole of 1999.
- 13.122 Other smaller prisons and those with an older population offer relatively little in recreational activities. I found that Bandyup and Eastern Goldfields had a particularly poor range of both active and passive pursuits. Recreation rooms at Bandyup had been converted into cells to address the serious overcrowding problem. Special category prisoners such as ‘protected’ prisoners and women in predominantly male prisons were particularly disadvantaged.
- 13.123 There are very few organised exercise activities for prisoners who are unable or unwilling to participate in team sports at any prison and I found the lack of involvement of prison officers in many sporting and recreational activities disappointing, given that this appears to me to offer an ideal means of improving relations between prisoners and prison officers.
- 13.124 Space for art, craft and music is at a premium at most prisons in spite of the acknowledged therapeutic effect of such activities in reducing stress and offering alternative strategies to violence and aggression.
- 13.125 In line with community practices, I would not expect the participation of prisoners in recreation and exercise to be given priority over education, training and employment or treatment programs. Nevertheless, the benefits of exercise and recreation for both the physical and the mental health of prisoners are, from my observations, neither properly appreciated nor fully utilised in the management of prisoners at most prisons. For the most part, this was due to a lack of resources; a shortage of trained and qualified staff and a general lack of commitment by the Ministry.

RECOMMENDATION 13.2

That, in line with United Nations *Standard Minimum Rule 77(1)*, in the interests of the mental and physical wellbeing of prisoners and as a means of creating better prisoner/officer relations, the Ministry:

- (a) employ a full time Recreation Officer/Sports Coordinator at each prison;
- (b) ensure that each prison provides adequately resourced and appropriately staffed recreational and exercise opportunities for all prisoners; and
- (c) encourage prison officers (by internal recognition and additional remuneration) to take responsibility for particular recreational activities for which they have appropriate qualifications and/or aptitude.

RECOMMENDATION 13.3

That in recognition of the acknowledged therapeutic benefits of music and art for all prisoners, and particularly Aboriginal prisoners, the Ministry:-

- (a) ensure that adequate resources and facilities are available at all prisons for these activities; and
- (b) accord art, music and cultural activities program status.

TREATMENT/REHABILITATION PROGRAMS

13.126 The Offender Management Division Outcome Statement specifies “*Protection of the community and to direct offenders towards the adoption of law-abiding lifestyles*” as one of the desired outcomes of the Division. An integral part of its obligations in this regard is the provision of treatment/rehabilitation programs including the following:-

1. Anger and Violent Offender Programs

Skills Training for Aggression Control (STAC)

An introductory 20-hour cognitive behavioural anger management program which is available at all prisons, except the Remand Centre, and Broome, on an “as needs” basis. During 1997/98 the program was run on more than 80 occasions with over 700 participants. The optimum number per group is 10 offenders.

Violent Offenders Treatment Program (VOTP)

An intensive cognitive behavioural anger management intervention which runs for six months. The program was developed by the Ministry in conjunction with Edith Cowan University to address the offending behaviour of up to 12 seriously violent offenders per program. It is co-facilitated by a human services professional (who may be a clinical psychologist) and a prison officer. Four programs were completed in 1998, two at Casuarina and two at Canning Vale.

Kimberley Offender Program

This program is available at Broome Prison and addresses issues of violence and substance use in an integrated format using, where possible, Aboriginal presenters from local agencies and groups. Approximately five programs per year of seven weeks duration are held with 10 to 12 participants each. The program is currently under review.

2. Sex Offender Treatment Programs

Sex offender treatment programs are managed and presented by the Sex and Violent Offender Treatment Unit (SVOTU) which is also responsible for assessing a prisoner's need and eligibility to participate in a program. The programs available are:-

Intensive Sex Offender Treatment Program

An intensive treatment program of approximately 38 weeks' duration for up to 12 prisoners assessed as posing the greatest risk of re-offending and the most damage to victims. Participants selected for this program will have committed a diverse range of offences including rape, wilful murder, paedophilia and intrafamilial sexual abuse. It is run at both Casuarina and Bunbury Prisons two or three times per year, depending on need.

Pre-Release Program for Sex Offenders

A program for sex offenders considered to present a significant risk of re-offending, but with less severe offending characteristics than those listed for the intensive program. These prisoners will usually have committed offences involving a significant level of aggression. The program consists of 36 x 3-hour sessions with additional out of hours homework completed between sessions. Five or six programs per year are usually run at Karnet Prison Farm with a maximum group size of 10 individuals.

Pre-Release Program for Sex Offenders at Greenough

A pre-release program designed for Aboriginal sex offenders run at Greenough Regional Prison approximately twice per year with 10 participants. The program content is similar to the program run at Karnet but is adapted to ensure that it is culturally relevant.

Intellectually Disabled Sex Offenders Program

A program for sex offenders with low levels of intellectual ability run on an "as needs" basis in both the community and prison. The content is adjusted to ensure comprehension and duration of the program is open-ended in acknowledgement of the fact that those with an intellectual impairment will take longer to acquire new skills to effectively manage their inappropriate behaviour.

For sex offenders in denial

A program for sex offenders in denial or who have shown reluctance to participate in a treatment program for some reason. The program is based on motivational interviews both one-to-one and in a group to encourage prisoners to talk about the issues underlying their denial (eg, fear of assault in the prison; the effect on self-esteem) and to point out the possible consequences of denial (eg, refusal of parole; loss of family and friends; difficulty in adjusting after release). The first program was run in the protection unit at Hakea early in 2000 and a second is currently in progress at Casuarina.

Sex Offender Maintenance Group

An ongoing program in the community for those who have completed prison-based programs.

3. Substance Use Programs

Substance use programs are co-ordinated by the Substance Use Resource Unit (SURU) which is also responsible for individual assessments of prisoners and the presentation of programs at metropolitan prisons. The following programs are offered:-

Intensive Substance Use Program

A intensive program which runs once a week for five to six weeks. It is designed for prisoners who have experienced the most significant negative consequences of their past use in terms of offending and are motivated to make changes in their substance use. It consists of a combination of individual counselling, written assignments and group-work which occupies 20-25 hours in a two week period. The program is held about 16 times a year at all metropolitan prisons plus Bunbury and Greenough with 12 participants and now at Albany and Roebourne. Programs for women are also run once a week for five consecutive weeks together with ongoing individual sessions to support progress made in groups for women who wish to continue with their rehabilitation.

Pre-Release Substance Use Counselling

This service consists of 4-5 individual counselling sessions with a flexible content so that a prisoner's individual needs may be covered. The target group for this form of intervention is prisoners for whom substance use is problematic, but less so than those included in the Intensive Program. Individual counselling sessions are continuous at all prisons.

Substance Use Women's Programs

Individual counselling is provided to address the skills and relapse issues covered in the mainstream programs as well as issues specific to the antecedents and consequences of women's substance use. Counselling is continuous as required.

Prison to Parole Program - Substance Use

A program designed to increase prisoner engagement with treatment agencies upon release by utilising those agencies to provide individual counselling with the prisoner before release.

Mawarankarra Substance Use Education Program

Essentially an alcohol education program for Aboriginal prisoners at Roebourne Regional Prison provided by Mawarankarra Aboriginal Corporation. The six week program is run on a continuous basis.

Remand Class Prisoners with Substance Use issues

Development and implementation of an orientation program and appropriate interventions for remand prisoners commenced in late 1997 followed by a needs analysis and piloting of a range of services at the Remand Centre in April 1998.

4. Other programs

- 13.127 An internationally accredited alcohol education program - "*Ending Offending*" – has been developed in conjunction with the South Australian prison authorities. It was hoped to run the program continuously in all prisons to reduce the length of the waiting list for substance use programs which are required by a large proportion of prisoners. I understand, however, that the Ministry has incorporated the program into existing SURU programs.

- 13.128 The Ministry has made considerable progress in introducing a *Cognitive Skills Program* (CSP) developed by Canadian company T3¹⁵ for application in Western Australia and which is to be piloted in late 2000. Essentially, CSP aims to teach prisoners to overcome and modify certain behavioural deficits such as lack of self-control, the inability to recognise problems and to think and reason rationally through:-
- problem awareness and problem solving;
 - creative and positive thinking;
 - social skills;
 - values enhancement;
 - emotion management; and
 - self control and coping strategies.
- 13.129 The focus is based on changing the ‘thinking’ process, not the content, through encouragement to practice, maintain and sustain the skills they have learnt and by allowing offenders to become responsible for their own changed behaviour. Poor interactions between two people generally reflect an imbalance in the level of cognitive skills which frequently leads to conflict. Interactions between prison officers and prisoners are thought to be no different. Evaluation of programs run in other jurisdictions over the past ten years indicates that CSP can decrease the likelihood of reoffending by up to 30%.
- 13.130 T3 has found that delivery to offenders by prison staff is the most effective means of presentation *provided* suitable staff with appropriate skills are selected and properly trained. In particular, it has been found that:-
- “...with the introduction of the prisoner program (Reasoning and Rehabilitation), the prisoners were developing skills that were enhancing their cognitive skills and conflict was arising with officers who had not shared similar training. The ideal is to enhance the cognitive skills of both prisoners and prison officers. To do only the prisoner program without the other will ultimately result in conflict.”*
- 13.131 The training provided to the program deliverers (ie prison officers) will enable those staff to do their job better and to interact more positively with colleagues and prisoners. The Ministry believes that by emphasising the delivery of the program by prison officers, it will become a vehicle for change within the system and will lead to better communication and interaction between officers and prisoners and *vice versa*.
- 13.132 CSP has been found to be particularly successful with indigenous offenders in Canada, New Zealand and South Australia, although it has not yet been trialled with traditional Aboriginals from remote communities. T3 has found from their experience in Canada that the style and cultural context – rather than the program content - may need to be modified to facilitate delivery to traditional populations and has been contracted by the Ministry to work with both Ministry staff and representatives from indigenous communities in Western Australia to examine how the program can be made more culturally appropriate.
- 13.133 The Ministry expects prison officers involved with the program to find CSP useful as a motivational tool for positive intervention with prisoners and to provide them with a better understanding of prisoners’ behaviour. The program will provide prisoners with an opportunity early in the sentence to become constructively involved in challenging their offending behaviour. The simple, practical presentation of the program is also expected to motivate prisoners to challenge their offending behaviour and to participate in other programs early in the sentence - rather than at the end when ‘motivation’ is primarily generated by the prospect of parole.
- 13.134 For the most part prisoners participate in treatment programs towards the end of their sentence. Programs are generally designed to equip prisoners with the skills to function in the community after release and to enable them to put their skills into practice in a community setting within a reasonable period of time.

THE ADEQUACY OF TREATMENT PROGRAMS

13.135 In the course of my inquiry many comments and concerns about treatment programs were expressed in submissions and interviews by prisoners, prison staff and community groups. The main themes are summarised below. I should add that these concerns are also a source of regular complaint to my Office by prisoners and their families.

Availability, funding and resources

- Programs are under-resourced and under-funded;
- programs are not available at all prisons, which means that prisoners may be transferred in order to participate, making family contact difficult or impossible.

Timing

- Programs are provided too late in a prisoner's sentence;
- long waiting lists;
- de-institutionalisation and resocialisation programs are more important at the end of a sentence than treatment programs;
- uncertainty of being able to participate prior to a prisoner's earliest eligibility for release date;
- inconsistency in eligibility criteria resulting in prisoners who have been advised that they should complete the treatment program towards the end of their sentence being overlooked in favour of others with a longer period left to serve.

Course content

- There is a need for more appropriate rehabilitation programs;
- programs do little to assist in gaining employment after release which leads to reoffending;
- programs are dull and pointless and eligibility for parole or work release is the prime motivating factor for most prisoners;
- first offenders are more likely to attend courses than repeat offenders;
- some programs may not be suitable or are pitched at too high an intellectual level which deters those prisoners most in need of personal development from participating;
- the Violent Offender Treatment Program is poorly constructed;
- there is no quality control of course content or presentation; and
- involvement in programs increases a prisoner's 'safety'.

Miscellaneous comments

- Art and music programs are important aids to rehabilitation;
- visits are so important to a prisoner's rehabilitation that they should be accorded program status; and
- the Ministry is reluctant to accept a holistic program approach.

13.136 I must emphasise that the statements summarised in paragraph 13.135 are a sample of submissions received in the course of my inquiry and represent the views of prisoners, prison staff, prisoner support groups and community groups. To that extent, they are neither right nor wrong but are opinions - some first-hand from prisoners who have participated in programs, and others from interested parties who have subsequently had contact with those prisoners - which reflect personal experience or perceptions of the Ministry's range of programs.

13.137 On the basis of my own observations and discussions during the course of my inquiry it was quite clear that the availability, timing and content of treatment programs were, in some instances, unable to satisfy the needs of prisoners; the requirements of the Parole Board; and the expectations of the community that most prisoners will be released having addressed their offending behaviour.

13.138 I am aware that the Ministry has made some considerable effort in the past 12 months to improve the range and number of programs available; in particular, programs for remand prisoners, the introduction of a program for sex offenders in denial and the development of the Cognitive Skills Therapy program. The Ministry has advised me that the Parole Board has indicated its satisfaction with the programs now being offered, particularly the intensive ones. I am also aware that the new assessment process combined with the enhanced case management system should improve the timeliness of programs and ensure that programs are suitable and complementary.

13.139 The recent improvements to program accessibility and delivery are encouraging. However, my concerns in relation to a number of issues remain and I consider in more detail some of the main issues below.

(a) Availability of programs

13.140 A constant source of anxiety to prisoners and of complaint to my Office is that there are insufficient programs to enable all prisoners to participate in those which are prerequisite to their release on parole before the earliest eligibility date. This concern was also noted by the Custodial Inspection Team following its inspection of Albany Regional Prison. The team was critical of the range of programs available - particularly the absence of both sex offender and violent offender treatment programs despite a demand for such programs and commented "*Having implemented a holistic needs and risk assessment process without then providing the programmes to meet the range of needs that has been identified was not good policy.*"

13.141 The Ministry told me that in August 1998, there were 149 prisoners on the waiting list for participation in, and/or assessment for, sex offender treatment programs and 529 for substance use programs. It has been explained to me by the Director of Operational Services, however, that the number on the waiting lists included those still awaiting assessment - not all of whom would be assessed as eligible to undertake a program - and those for whom the Parole Board has decided to defer its decision on parole eligibility until a later date. Prisoners in this category remain on the waiting list although they would not generally participate in the program until closer to the time of review by the Board.

13.142 I understand that since 1998 the waiting lists for sex offender and substance abuse programs have decreased significantly - for example, the waiting list for SURU programs has more than halved. However, of the 1200 violent offenders in the system in August 2000, only 24 have completed or are undergoing the Violent Offender Treatment Program - in August 1998 there were 105 on the waiting list. This program, which is expensive to run, is held twice per year with 12 participants per program. In spite of the large number of violent offenders in the system who have been assessed as needing to participate in the program, no funding has been provided to run more programs or to offer the program earlier in the sentence. In my view, in spite of the improvement in the availability of sex offender and substance use programs the shortfall in the number of places for violent offenders is an important deficiency in the Ministry's suite of programs given the community's concerns about violent offences. It also illustrates the problems which can occur when there has clearly been no forward planning to ensure program availability keeps pace with demand.

13.143 In response to the concern that programs are not available at all prisons (see paragraph 13.135), the Ministry advised me:-

"The Ministry is of the view that it is necessary to ensure that programs are available across the system, but not necessarily that every program is available in every prison. This is consistent with practice in other Australian correctional facilities. The more intensive treatment programs are generally located in specific prisons but programs such as STAC, substance use programs and education are provided across the system. Prisoners will, from time to time, need to be transferred to facilitate program inclusion; however this should be flagged at the assessment stage so that the prisoner has a knowledge and understanding of the need for such a transfer."

- 13.144 I appreciate that the provision of a full range of programs at each prison would have cost implications. However, the basis of this concern is that the need to participate in a program which is not available at the prison where they are housed means that prisoners may be transferred to a location where it is difficult for them to receive visits and maintain contact with their community. This would invariably be the case for prisoners who need to complete the Intensive Sex Offender Treatment program which is run at Casuarina and Bunbury. Relocation to Perth or Bunbury would cause significant difficulties for prisoners from the north west of the State. In my view there is a real need for the Ministry to consider the feasibility of running such a program at Greenough or Roebourne.

(b) Timing

- 13.145 My views on the timing of substance use treatment programs at the end of a prisoner's sentence have been documented in Chapter 12 (*Drugs in Prisons*). Those views apply equally to other types of rehabilitation programs available to prisoners. Essentially, I consider that substance use programs and those designed to assist prisoners deal with violent and impulsive behaviour are scheduled too late in a prisoner's sentence given the management problems caused by the presence and demand for illegal drugs in the prison system, and by prisoners who may be ill-equipped to control their behaviour while in prison.
- 13.146 In this regard, I note that the Custodial Inspection Team was critical of the timing of substance use programs at Albany and stated:-

“the selection and assessment of prisoners for SURU programmes during the latter part of their sentence is wasteful of an opportunity to develop prisoners’ skills and understanding about matters critical to their offending lifestyles.”

- 13.147 None of the evidence provided to me convinces me that the timing of substance use programs at the end of the sentence is motivated by anything other than the Ministry's budgetary limitations. Given the continued presence of drugs and the inherent costs in spite of the emphasis on detection and deterrence, I would suggest that a greater focus on reducing *demand* is long overdue. Although I accept that it is virtually impossible to eliminate both supply and demand from the system entirely, it seems to me that commitment to reducing demand through the provision of programs and counselling throughout a prisoner's sentence merits at least equal priority. In my view the provision of additional funding for *ongoing* programs to address drug dependency is required in the interests of the wellbeing of the prisoners, the good management of prisons and the safety of the community.
- 13.148 In relation to anger management, it seems to me that there are tangible benefits for the prison population and prison staff in providing prisoners who have committed violent offences with programs and counselling which offer alternatives to violence and other coping strategies at a very early stage in their sentence. Without early treatment, the management of persons who have in the past dealt with problems using violent means (leading to their imprisonment) will inevitably present prison administrators with problems during incarceration and provide the community no assurance that prisoners will be able to better cope with life 'on the outside'.
- 13.149 Although disciplinary measures for dealing with assaults, violence and 'difficult' prisoners will continue to be necessary in some cases, it seems to me that they also create additional work for staff; frequently do not address the underlying problems of the prisoner involved in the aggression; and lead to poor prisoner/officer relations. I should add that it has also been suggested to me in more than one submission that the provision of anger management courses and training in conflict resolution for prison officers would be of considerable benefit to them and would improve the general harmony of the prison.

- 13.150 In response to the claim that eligibility criteria are inconsistent and result in prisoners not completing programs at the appropriate time, the Ministry advised me:-

“The timing of programs relates mainly to the content and purpose of the program. For instance, if the program is focused on assisting in release then it is best placed towards the end of the sentence. The SOTP is a particular program that is designed for delivery towards the end of the prisoner’s sentence. The Violence [sic] Offender Treatment Program is intended for delivery earlier in the prisoners’ sentence.

The Ministry does not support the view that there is an “Inconsistency in eligibility criteria”. Eligibility criteria remain constant, however, the capacity to meet all program demands will change depending upon the prisoner profile at any one time.”

- 13.151 In this regard, because the Skills Training for Aggression Control program (STAC) is seen as a management tool, Hakea has made a particular effort to schedule extra programs and target prisoners early in their sentence in order to reduce the waiting list for this course. The Ministry has also expressed the view that demand for programs must be balanced against available resources.
- 13.152 In my view, providing prisoners with alternative strategies to deal with anger or substance abuse problems which they will be able to put into practice while incarcerated can only help to alleviate management problems and enhance the skills which they will eventually take into the community on release.

(c) Content of programs

- 13.153 In response to the criticisms of the content of programs set out in paragraph 13.135, the Ministry provided the following comments:-

- **Need for more appropriate rehabilitation programs**

“The programs provided by the Ministry are those that are provided almost universally in prison settings with an emphasis on alcohol/drugs, violent and sexual offending. The program content has been developed to ensure that they are appropriate for the participants and the key customers. The Ministry is always seeking to improve the range of programs presented to improve their relevance to offenders. The cognitive skills program, among others, is an example which will be further enhanced through consulting with relevant Aboriginal people to ensure the program is culturally relevant for aboriginal people.”

- **Programs do little to assist in gaining employment after release**

“Successful program participation will inevitably result in increased knowledge, skills and self awareness, all pre-requisites for gaining and maintaining employment. The increased focus on the development of industry and associated vocational and educational training is expected to enhance both specific and generic employment skills of prisoners.”

- **Programs are dull and pointless and eligibility for parole or work release is the prime motivating factor for most prisoners**

“The Ministry seeks to develop programs that are interesting but also there is a requirement for prisoners to genuinely wish to deal with their issues rather than just undertaking the process to facilitate work release or parole”

- **First offenders are more likely to attend programs than repeat offenders**

“Not Accurate. Program participation is based primarily upon risk and need assessments. The Ministry questions the source of this information.”

- **Programs are not suitable or pitched at too high an intellectual level which deters prisoners most in need of personal development from participating**
“Not Accurate. Programs are designed to meet the needs of the target group and ...programs are developed to address the specific needs of those prisoners with intellectual disability.”
- **The Violent Offender Treatment Program is poorly constructed**
“Not Accurate. The program was designed and constructed by one of the most respected international practitioners and academics in the field of violent offending.”
- **There is no quality control of course content or presentation**
“There is extensive quality control of programs, particularly for the intensive programs.”

13.154 As I have stated above, the comments in paragraph 13.135 were made to me in the course of my inquiry by prisoners, prison staff, and community groups. I have not considered or investigated their ‘accuracy’. However, in my opinion, they are the sorts of views which the Ministry might well encourage and receive in the course of evaluating the effectiveness of its courses – an activity which I believe is under-emphasised – and which it should consider as constructive criticism. If a prisoner or a member of the prison staff believes that a program is boring and pointless; unsuitable; unlikely to be of assistance in gaining employment; or that eligibility criteria are inconsistent, in my view that is useful feedback. It is precisely the sort of feedback which most training courses in both the public and private sectors seek at the end of every course. Proper evaluation of programs is an essential measurement of both efficiency and effectiveness and should be an integral part of the Ministry’s performance indicators.

RECOMMENDATION 13.4

That the Ministry ensure that sufficient resources and funding are provided to enable prisoners to participate and complete the treatment programs identified in the assessment process on admission to prison or prescribed by the Parole Board prior to their release date.

RECOMMENDATION 13.5

That the Ministry provide rehabilitation programs at an early stage in and throughout the sentence with refresher courses at the end.

(d) Dissatisfaction with Sex Offender Treatment Programs

13.155 I received a large number of comments and complaints about the Ministry’s sex offender treatment programs in submissions and interviews during the course of my inquiry, including the following:-

- To be eligible for participation in the Sex Offender Treatment Program (SOTP), a prisoner must acknowledge his guilt and be genuinely willing to address his offending behaviour. Prisoners who claim that they are not guilty or who are intending to lodge an appeal against conviction are therefore ineligible for the program and are unlikely to be granted parole because of a perceived failure to address their offending behaviour.¹⁶
- Some sex offenders who are willing to participate are reluctant to join programs attended by paedophiles.
- Several submissions about the SOTP at Bunbury raised concerns about the content and administration of the program and that the program needed to be independently reviewed.

- Apparent confusion and inconsistency among course administrators. For example, one prisoner told me that he agreed to transfer from Albany Prison to Bunbury to participate in a SOTP that he believed to be starting shortly. On arrival at Bunbury he was interviewed by a part-time prison psychologist who did not appear to know about the imminent program and referred him to the full-time psychologist who advised that the course was going to be run by an outside contractor. The prisoner claimed that it then took two months for him to get an interview with the contractor, who advised him to do a pre-release course which might not be available until after his earliest eligible date for parole. This apparent uncertainty, delay and misinformation caused a great deal of confusion and distress for this prisoner.

13.156 The report by the Custodial Inspection Team following its inspection of Bunbury Regional Prison in July 1999 supported a number of those concerns. It noted:-

*“We were impressed with [the staff’s] commitment and enthusiasm.....But several aspects of the programme gave us cause for concern and did not fit into what we know about best practice. There was for example...no manual for tutors to follow and a **lack of effective supervision on the content** of individual sessions....These factors made the likelihood of programme drift high (i.e. tutors drift away from the original treatment objectives) and must affect consistency of delivery. Both tutors felt their **training was poor**. The high drop out rate of sex offenders participating in the programme (some 50% of the current course) was a particular concern as evidence suggests that these offenders are more likely to re-offend in the future. **Risk assessments appeared at times subjective and naïve**. Neither was there an obvious differentiation between offenders entering the programme. Nor had the programme been independently evaluated for its effectiveness...We were also disappointed to find that there was **no apparent effective strategy for dealing with prisoners either minimising or denying their offence**.”* (my emphasis) (paragraphs 4.28-4.31)

13.157 The Ministry has taken issue with a number of the concerns about its sex offender treatment programs which were put to me in submissions. Specifically it has advised:-

- **Reluctance to participate**

“Sex offenders as a broad category of prisoner are always reluctant to participate in treatment programs and will use all available means to change the focus from them as sexual offenders. They have real and valid issues for this approach; firstly; being identified as a sex offender because of the fear this creates in the prison system and secondly; to acknowledge sexual offending particularly against young children brings the shame and disgrace accompanying such crimes. This needs to be acknowledged in any review of programs and, measures taken to ensure that an accurate holistic perspective is taken rather than just acknowledge the views of a vocal minority.”

- **Reluctance to participate in mixed groups**

“...most programs in Australia, UK, USA, Canada etc have mixed groups [of sex offenders] and use this issue as a critical treatment issue. To ignore this issue would be professional negligence and in fact the majority of programs proceed successfully with this mixture of rapists and child molesters and have done so for the past 15 years. It is not considered to be a valid therapeutic approach to construct groups around an individual’s bias.”

- **Concerns about the program at Bunbury**

“Concerns identified within the Bunbury SOTP were addressed during the course of 1999 responding to previous reviews and the Custodial Inspection Services report.”

- **Apparent confusion and inconsistency among program administrators**

“This appears to be an unverified complaint. The general administration of these programs is considered to be sound and in reviews of the Unit (Thomas-Peter, 1995; Stanton Partners, 1997; Boer, 1998; Greenberg, ongoing) program administration is identified as a strength of the Unit.”

13.158 I am aware that the Ministry's range of sex offender programs is nationally regarded as 'cutting edge' and has been used as a model by other jurisdictions. I have noted its comments and have not explored the concerns raised about the SOTP in detail as they largely relate to offenders' eligibility for, and the content of, the programs, issues which I consider to be outside my expertise and beyond the scope of this Report. It appears that the concerns about the administration of the program – particularly at Bunbury – were considered to be valid, however, as the Ministry has taken steps to address the similar concerns raised by the Custodial Inspection Team. I also understand that the Ministry has commissioned an external review of the effectiveness of its current range of sex offender treatment programs and an analysis of recidivism rates. In the circumstances, I do not believe that I need to make recommendations about this point.

(e) A lack of programs designed to cater for the specific needs of certain groups of prisoners

13.159 As identified in the preceding chapters relating to health, there are in my view several groups of prisoners within the prison population which pose distinct management problems because of their special needs. In relation to their health needs, I identified the elderly; Aborigines; women; long term prisoners; and prisoners suffering from the effects of substance abuse as having special needs. For the purposes of their 'program' needs, Aborigines; women; long term prisoners; and prisoners suffering from the effects of substance abuse also have special requirements together with remandees and those with behavioural disorders. Significantly, these groups of prisoners are also known to present a high risk of suicide and self harm.

Aborigines

13.160 I received a submission from an Aboriginal prisoner who expressed his concerns about the number of Aboriginal prisoners who were illiterate; that their illiteracy was the main reason for the over-representation of Aborigines in prison; and that little was done to address this problem while they were imprisoned. He said:-

“Help us Aborigines to “read and write” to better our culture.....Then when these Aboriginal men come before the parole board or the judge, they can understand what these men are talking [about].....

The reason I am writing is that...parole sends them forms and they don't know what to do about it. The department has got the schools while in jail but they don't know how to go about it.....Remember please ask these Aboriginal men (by themselves) not when they are in a mob because they will say nothing. Respect them and they will respect you.....These men will reoffend if you don't help them.”

13.161 According to the Ministry's census of prisoners on the night of 30 June 1999, 85.4% of Aboriginal prisoners had less than three years' secondary education. Although a low level of education is not confined to Aboriginal prisoners – 68.4% of non-Aboriginal prisoners and 74% of all prisoners had less than three years' secondary education - I acknowledge the cultural obstacles for Aboriginal men in this position.

13.162 In the community, lack of literacy and numeracy skills amongst adults is generally handled in confidence by specialised staff who are trained to address not only learning difficulties but also to show sensitivity to the embarrassment often felt by adults who are unable to read and write. From my observations there is a marked lack of confidentiality in the reception process at most prisons where newly admitted prisoners are not interviewed in private and are unlikely to reveal any information which might increase their vulnerability.

13.163 I was told that the content and presentation of some treatment programs, particularly drug and alcohol and sex offender programs, which are primarily presented by young, white females, is considered to be culturally inappropriate for many male Aboriginal prisoners, who are unlikely to reveal their problems or reap the full benefit from treatment programs. It was also alleged that programs designed in 'Perth' do not cater for the special needs of prisoners from rural or remote areas.

13.164 The Ministry had advised me that it does not support these views on the ground that:-

“[F]eedback from prisoners on the program indicates that Indigenous sex offenders are more likely to talk about their key personal issues with a non-Indigenous person than they will with an Indigenous person. Although the facilitation of some programs is dictated by the fact that there are program facilitators who are based on one site, careful consideration is given to the fact that all staff within program areas need to have the professionalism, knowledge, sensitivity and interpersonal skills required to meet the challenges of program assessment and delivery. In the case of intensive programs, particular care is taken to ensure that wherever possible the mix of the groups and the program facilitators are matched.

The use of Indigenous staff in sex offender programs is acknowledged by those who have knowledge of the area as being extremely problematic for a number of reasons. For most Indigenous people there is almost a certainty that if they are facilitating a program (particularly in regional areas) that they will have family, kin, or other relationships with program participants. For these people to then challenge participants on matters of personal significance presents major difficulties and in some instance may pose significant moral and ethical dilemmas.”

13.165 In spite of these comments – which I consider to be valid – the Ministry has told me that it has taken steps to use Aboriginal presenters wherever possible on programs for Aboriginal prisoners such as the Kimberley Offender Program¹⁷ at Broome; the pre-release program for sex offenders at Greenough; and the Mawarankarra Substance Use Education Program at Roebourne. The Ministry also advised me that the STAC program is delivered in the metropolitan area by an Aboriginal facilitator in an effort to ensure that it is culturally appropriate.

13.166 As discussed in paragraph 13.144, prisoners are frequently transferred between prisons for the purposes of participating in a program required by the Parole Board. This is an issue of particular relevance to Aboriginal prisoners and appears to me to conflict with the spirit of RCIADIC **Recommendation 168** that the placement and transfer of Aboriginal prisoners should be “*according to the principle that, where possible, an Aboriginal prisoner should be placed in an institution as close as possible to the place of residence of his or her family.*”

13.167 The Ministry has advised me that although it supports the principle of:-

“...placing Indigenous people close to their homes....to have a total program coverage available for all prisons would require a significant increase in funding and the cost effectiveness of such a move would be doubtful. Additionally, as there are no maximum security prisons north of Perth and many of these programs are run at maximum security prisons it is appropriate to expect that Indigenous people are given the opportunity to participate when they are completing this part of their sentence.”

13.168 I accept that Western Australia presents different problems because of the 'tyranny' of distance. However, given that 80% of the population of some prisons is Aboriginal, there is clearly an opportunity at those prisons to provide a wider range of programs for Aboriginal prisoners and I believe that progress has been and is being made in this area.

- 13.169 However, I also believe that there is room for a wider range of programs for Aboriginal prisoners that combine strategies to address offending behaviour with literacy and numeracy, occupational health and safety training, cultural issues, history, art, craft and music. These can be very effective in reducing future offending by providing a sense of identity and ‘place’ and a more positive view of the future. Successful models of such programs in operation in other States include:-
- **New South Wales** - the Girrawaa Creative Work Centre at Bathurst; the *Second Chance* substance use programs;
 - **Northern Territory** - *Ending Offending – Our Message* and *Gurma Bilni – Change your Life* (sex offending treatment);
 - **Queensland** - *Inside-Dreaming* which uses prisoners’ families as a support mechanism during and after imprisonment in conjunction with anger management, substance use and cognitive skills programs;
 - **South Australia** - *Reclaiming our Future* which also includes training in strategies to reduce depression, suicide and self harm; and
 - **Victoria** - the Aboriginal Cultural Immersion Program.
- 13.170 Comprehensive programs for Maori prisoners in New Zealand were developed following the findings of the Maori Suicide Review Group that participation in programs which offered the development of coping skills, constructive use of their time, communication, problem-solving skills and self-esteem and involved Maori elders and local communities was particularly effective in reducing the high risk of self harm and suicide among Maori prisoners.
- 13.171 A submission to my inquiry referred to a similar initiative which operated in Boggo Road Prison in Queensland in 1986-89 (known as “*Life Force*”). During the operation of this program there was a marked reduction in self harm and suicide by Aboriginal prisoners. The submission attributed the program’s success to the development of “*a sense of community*”, the individual’s “*sense of identity*” and to the emergence of a “*collective responsibility*”, achieved by getting in touch with the “*life force*” - the spirit of the land and heritage.
- 13.172 I note that the Ministry has recently appointed a Manager, Aboriginal Services with specific responsibility for assessment of the program needs of Aboriginal prisoners and the development of a suite of programs to meet those needs. The Ministry has advised me that it is confident that the new comprehensive assessment procedure which will commence once the Reception Centre at Hakea is operational will be more successful in identifying prisoners with a low level of literacy and numeracy skills because all prisoners will be asked the same questions and prisoners who acknowledge that they are unable to read and write will feel less isolated. It has advised me that a Senior Education Officer and three Education Officers will be an integral part of the Hakea Assessment Team.
- 13.173 These new initiatives are very encouraging. However, the Reception and Education Officers will still require the appropriate communication skills to encourage prisoners to admit to a deficiency in their education. It will also be essential that the Ministry is both willing and able to provide adequate funding for the delivery of programs to meet the needs identified.

RECOMMENDATION 13.6

That the Ministry ensure that participation in culturally appropriate basic literacy and numeracy courses is encouraged in a sensitive way at all prisons.

RECOMMENDATION 13.7

That the Ministry provide appropriate cultural programs for Aboriginal prisoners at all prisons, involving local community and tribal elders, on the lines of those available elsewhere in Australia and New Zealand.

Female prisoners

- 13.174 The Taskforce looking at education and training was critical of the range of educational and training opportunities for female prisoners at Bandyup and observed that:-

“...the opportunity to develop new skills while at Bandyup Prison is restricted to occupations that generally reflect the traditional and cultural roles of women....., essentially those occupations that are required to support the functioning of the prison. They have limited relevance to the labour market outside the prison.”

- 13.175 Similar criticisms were levelled at the facilities and opportunities at regional prisons housing female prisoners and the Taskforce recommended a number of measures which should be taken to “ensure that women offenders are not a “forgotten minority””.¹⁸ In my visits to all prisons in the course of my inquiry, however, I found that little had been done to improve the situation for women since the Taskforce reported.
- 13.176 Although female prisoners are in a minority, the number of women receiving custodial sentences is increasing; and their offences are becoming more serious, resulting in an increase in the length of the sentences being handed down. If this trend continues the Ministry will need to accept that the prison population is likely to include an increasing number of female prisoners for longer periods of time.
- 13.177 Facilities and program opportunities for women in all prisons housing female prisoners are, in my view, significantly deficient and require urgent attention to meet both international and Australian standards. I believe that the Ministry has been aware of the problem for some time. However, it has only very recently sought funding to refurbish Bandyup and it is unlikely that facilities for women in regional prisons will improve in the short or medium term. In addition, it will also be necessary for the Ministry to significantly enhance its commitment to the program needs of women prisoners throughout the State if there is to be any meaningful improvement in the circumstances of its female prisoner population.

RECOMMENDATION 13.8

That the Ministry address the current inequality of education, training and employment opportunities for female prisoners throughout the State by providing a wider range of programs designed specifically to cater for their needs and ensuring that they are adequately staffed and funded.

Long term prisoners

- 13.178 I have commented on this issue in some detail in Chapters 5 and 6 of this Report in relation to the health needs of long term prisoners. This group of prisoners is increasing in size due to sentencing changes and the handing down of longer sentences. Because long term prisoners have committed the most serious offences, are most in need of rehabilitation, and remain in the system for significant periods of time, their program needs and requirements; their general management; their health; and risk of self harm and suicide; present the system with a range of problems. Given these special needs and problems, it is in my view essential that management of their sentences be comprehensive (including education, training, employment, rehabilitation and progression through the system), coordinated and possess an element of certainty that components of any sentence ‘plan’ *will* occur unless there are compelling reasons to the contrary.

- 13.179 The Ministry has conducted a review of its case management system with a view to providing all prisoners, both new and serving, with individual management plans based on a comprehensive assessment of individual needs and consistent standard principles. The new system is to be piloted at Albany, Bunbury and Casuarina following commencement of the assessment procedure pilot at Hakea and prison officers at each of those prisons are being invited to volunteer to receive training in case management. The aim is for long term prisoners to be reviewed every 12 months until three years prior to their statutory review date when reviews will be conducted six-monthly.

Prisoners suffering the effects of substance abuse

- 13.180 As stated in a number of sections of this report, and also in the Smith Report, the program needs of this large and growing group of prisoners present the Ministry with a range of resource-intensive and costly problems. In addition to their health needs and the security risks which they pose to the system, other prisoners and staff, the ultimate danger which they present to the community if released with the same substance dependency (and sometimes more acute) as when they were admitted to prison is a significant concern. In my view, the program needs of this group are a priority which should be addressed upon their admission and on an ongoing basis throughout their sentence.
- 13.181 The Substance Use Resource Unit (SURU) is responsible for the assessment and treatment of prisoners with substance use problems. Because of its limited resources, however, it is restricted to providing programs to prisons in the metropolitan area. Services to other prisons have generally been outsourced and are provided under contract by private bodies. Comments received during my inquiry suggest that fewer programs are provided to some prisons under the outsourced service. I was also told that utilisation of community groups such as Holyoake and Palmerston is not considered viable because of the cost.
- 13.182 However, in response to my draft Report, the Ministry advised me that the employment of a prison-based SURU Programs Officer at Albany during 1999 enabled the delivery of sufficient substance use programs to meet prisoner demand and at an earlier stage of the sentence – at least a year prior to the earliest eligibility date (EED) compared to an average of six months elsewhere. In some cases the Programs Officer works with a prisoner two to three years prior to the EED in order to assist them to progress to a minimum security rating and transfer to a minimum facility such as Pardelup, Karnet or Wooroloo.
- 13.183 The Ministry also advised me that earlier this year it experienced some difficulty in recruiting new SURU staff. The restructure of staffing requirements, delays in the advertisement, selection and appointment process all exacerbated the situation and it was forced to advertise twice before it was able to fill eight of the eleven vacancies. It is hoped that the new staff will enable the delivery of a broader range of programs.
- 13.184 In my view, the large number of prisoners entering the system with problems associated with use of drugs and alcohol, the consequential problems for their management and the community interest in the rehabilitation of prisoners upon release make it imperative for the Ministry to provide a comprehensive range of programs throughout the sentence.

Remand prisoners

- 13.185 In line with the principle that a person is innocent until proven guilty, it is universally accepted that untried and unsentenced prisoners are a special group which should be treated differently from those who have been convicted and sentenced. Significantly, remand prisoners are also widely known to present one the highest risks of suicide and self harm.

13.186 The Taskforce examining the provision of education and training commented on the lack of treatment programs for remand prisoners and the poor range of opportunities for remand prisoners for work, education and recreation attracted criticism from the Auditor General in his 1997 performance examination report “*Waiting for Justice*” in which he stated (at page 32):-

“Despite the Remand Centre providing some activities such as table tennis, basketball, art and the use of a library, prisoners often chose to remain unoccupied. Remand prisoners cannot be made to work and in any event, work opportunities are limited and mostly menial. While the Remand Centre has a small workshop it only employs six prisoners. Casuarina and Bandyup have substantial prison industries but work is mostly assigned to sentenced prisoners.

The provision of meaningful work opportunities is thought to have some clear benefits:

- *fewer injuries to prisoners from assault by other prisoners;*
- *reduced tension within the prison leading to lower prison staff costs through reduced stress related or prisoner assault related sickness absence and worker’s compensation payments; and*
- *assisting prisoners to obtain employment upon release by improving their work skills. A 1995 prison census found that 74 per cent of remand prisoners were unemployed prior to arrest.”*

13.187 The Auditor General also confirmed that “*Prison management and medical staff advise that reducing the risk of assault, injury and stress amongst remand prisoners can be achieved by reducing boredom and inactivity...*”.

13.188 In support of this view, I have been told that the initiative “*Making the Remand Centre a Safer Place*”, commenced at the Remand Centre in 1992 by the then Acting Superintendent,¹⁹ involved extending recreational time for prisoners; increasing the number of activities and educational opportunities available; instituting management strategies for prisoners; and inviting active participation by prisoners in the renovation and maintenance of buildings, gardens and facilities. A 1994 study of incidents of self harm at the Remand Centre between January 1990 and December 1994 reported a noticeable drop in the number of self-harming incidents between July and December 1993 when the initiative was in place.

13.189 I understand that there was an attempt to resurrect the strategy at the Remand Centre in 1996. However, it was never fully reinstated and, as noted, the lack of activity for remand prisoners attracted further criticism from the Auditor General in 1997 who recommended that the Ministry “*investigate ways to provide remand prisoners with work skills that will aid them to return to or find work on release.*”

13.190 Although I have been told that the provision of television sets and access to video games in 1998 resulted in a significant fall in the number of self harm incidents and prisoner assaults, the Ministry advised me in June 1999 that there were no educational opportunities at the Remand Centre and only limited work related to the maintenance of the prison. There have, however, been significant improvements at the Remand Centre since August 1999 including the provision of increased funding; the appointment of a second full time Education Officer; and the introduction of a comprehensive suite of education programs including:-

- ‘Information’ programs – providing advice on debt management while in prison; communication with the Ministry of Housing regarding rent; court procedures and what to expect during a trial;
- Literacy and numeracy;
- Speaking in public – in preparation for appearing in court and including self-confidence and organised thinking;
- Career counselling – including the establishment of realistic goals with short achievable steps;

- Recognition of prior learning – assessment of skills and abilities; advice on addressing any deficiencies; providing certificates for levels already attained;
- Driver education program developed in conjunction with Murdoch University; and
- Courses/programs available in other prisons and short ‘orientation’ videos.

- 13.191 The modular courses have been designed to be flexible and fluid to allow for entry and exit at any time and to provide nationally accredited qualifications which are transportable. If offenders have been involved in TAFE courses or other study programs prior to remand, the Education Officers negotiate with the community providers to enable prisoners to continue with their studies.
- 13.192 There are some difficulties on the present site in offering vocational training but with the opening of the Hakea Receiving and Assessment Centre, remandees will be offered the opportunity to take courses in occupational health and safety and small tool handling so that if they return as sentenced prisoners they will be prepared to commence work programs.
- 13.193 The progress made in increasing work and study opportunities for remand prisoners at Hakea is commendable. However, it is unlikely that similar opportunities will be made available to remand prisoners held in other prisons. In particular, there do not appear to be any specific plans for separate accommodation for female remand prisoners within the refurbishment of Bandyup. Although I have been advised that many female prisoners have been in prison before and may not need to be placed in separate facilities, this group of female prisoners should not become another ‘forgotten minority’. Given that five of the seven apparent suicides this year have been by remand prisoners (including a remand prisoner at Roebourne), it is clear that this group of prisoners continue to present special problems.
- 13.194 The Ministry has expressed the view that *“the availability of treatment programs in a remand prison is contentious and complex. Participation in such programs would be voluntary and would in most instances be an indication that the offender was guilty, which if an offender intended to plead not guilty is a disincentive to participation. Also the majority of therapeutic programs are at least 4 months in duration and many would not be able to complete these in time.”*
- 13.195 Although I accept that there is some validity in these comments particularly in relation to sex offender programs, it seems to me that they do not apply to SURU programs which are designed to assist with problems associated with substance abuse and are unlikely to impact upon a person’s innocence or guilt and I understand that a 1-day Alcohol and Drug Awareness workshop is now provided every Friday. I also find it difficult to believe that there are no therapeutic programs which are less than four months’ in duration based on the fact that most of the Ministry’s own treatment programs are much shorter than four months. I am not sure how the Ministry has attempted to gauge demand if no therapeutic programs are offered and I also note that the Taskforce found that a survey of prisoners found that the *“major deterrent to program participation was the type of course on offer”*.

RECOMMENDATION 13.9

That the Ministry take steps to review program provision for remand prisoners at Bandyup and at regional prisons and ensure that they have access to a range of education, meaningful employment and rehabilitation opportunities.

‘Difficult’ prisoners

- 13.196 As discussed elsewhere in this report, the behaviour of disruptive young prisoners who continue to flout authority is considered by psychological researchers to be as indicative of a lack of coping abilities as those who attempt serious self harm and suicide. However, the problems they cause to prison authorities frequently mask the risks which they present to themselves and others and their need of counselling and alternative management strategies. As Liebling has said²⁰ :-

“Importantly, inmates who present disciplinary problems to the staff cannot be assumed to be (just) manipulative, or obvious trouble-makers. Their disciplinary problems may be another feature of the difficulties they are experiencing in coping with prison.”

13.197 In my view there is a need for therapeutic behaviour modification programs for prisoners who present as major “*management problems*”. As far as I am aware, the current range of programs offers nothing of this nature other than anger management programs. This means that prison officers and other prisoners generally bear the brunt of the disruptive behaviour of ‘difficult’ prisoners for the majority of their incarceration. With no alternative strategies available, prison officers tend to respond with disciplinary measures which frequently exacerbate rather than address the situation and increase stress levels for both officers and prisoners. I understand that the Cognitive Skills Program is believed to be of benefit in assisting such prisoners to develop alternative problem-solving skills and I would encourage the Ministry to consider a pilot program for prisoners with type of ‘coping’ difficulty.

RECOMMENDATION 13.10

That the Ministry develop appropriate programs to assist ‘difficult’ prisoners address their behavioural problems as alternatives to progressively more severe disciplinary measures.

Compliance with International and National Standards and RCIADIC Recommendations

13.198 At paragraphs 13.12-13.14 I set out the international and national standards relating to prisoner activity and the relevant recommendations made by the RCIADIC. In light of my observations and findings, I consider that the Ministry does not fully meet the following standards:-

United Nations *Standard Minimum Rules for the Treatment of Prisoners*²¹

Rule 71(3)

“Sufficient work of a useful nature shall be provided to keep prisoners actively employed for a normal working day.”

- Although some prisons are better able to provide work opportunities than others, there is not “*sufficient work*” for all prisoners at all institutions. Female, Aboriginal and remand prisoners are particularly disadvantaged.

Rule 72(2)

“The interests of the prisoners and of their vocational training, however, must not be subordinated to the purpose of making a financial profit from an industry in the institution.”

- Although the preference for the establishment of employment activities which make the prison less costly to run could be justified provided prisoners were usefully occupied, the acknowledged reluctance of officers to release prisoners from work for education and training and the lack of promotion of education casts doubt on the Ministry’s commitment to the spirit of this rule.

Rule 77(1)

“Provision shall be made for the further education of all prisoners capable of profiting thereby.....The education of illiterates and young prisoners shall be compulsory and special attention shall be paid to it by the administration.”

- The level of engagement of Western Australian prisoners in education and training in 1998/99 reported in the *Report on Government Services 2000* was the second lowest in the nation and lower than the national average.²² As discussed at paragraph 13.95, the Ministry considers these figures to be an unfair representation of the educational involvement of prisoners and that comparisons with other States are unhelpful because of discrepancies in methods of recording. I agree that comparisons are only useful to a degree. Of greater relevance is whether opportunities for education in Western Australian prisons meet the needs of prisoners. Although there have clearly been improvements in the past two years, in my view more needs to be done. In particular, positive steps need to be taken to raise the profile and priority of education and to address the low standard of education and the high incidence of illiteracy among a large proportion of prisoners.

Rule 78

“Recreational and cultural activities shall be provided in all institutions for the benefit of the mental and physical health of prisoners.”

- I noted a shortfall in the provision of both recreational and cultural activities at most prisons in the course of my inquiry.

Standard Guidelines for Corrections in Australia

Guideline 5.57

“All prisoners should have access to productive work, education, recreation and leisure programs and facilities which provide them with the opportunity to utilise their time in prison in a constructive and beneficial manner.”

Guideline 5.58

“The Manager of the institution has a responsibility to encourage prisoners to participate in such programs.”

- In my view, for the reasons set out in this chapter, I am not convinced that this “responsibility” is taken sufficiently seriously in a number of prisons.

RCIADIC Recommendations

- 13.199 In my view the Ministry has not fully implemented the spirit of the following recommendations made by the RCIADIC²³:-

Recommendation 184

“...all Aboriginal prisoners in all institutions have the opportunity to perform meaningful work and to undertake educational courses in self- development, skills acquisition, vocational education and training including education in Aboriginal history and culture...”

- The Ministry does not provide sufficient resources to ensure that the spirit and intent of this recommendation is properly implemented at all prisons where there are Aboriginal prisoners. Aboriginal women are, in my view, particularly disadvantaged.

Recommendation 185

“That the Department of Education, Employment and Training be responsible for the development of a comprehensive national strategy designed to improve the opportunities for the education and training of those in custody. This should be done in co- operation with State Corrective Services authorities, adult education providers (including in particular independent Aboriginal-controlled providers) and State departments of employment and education...”

- The Ministry has advised me that there is cohesive involvement of the State Education or Education and Training Departments in the provision of education and training to prisoners “...*although not to the level desired by the Ministry of Justice*”. It is, however, “...*actively engaged in the work of trying to increase the Department of Training & Employment’s responsibility for prisoners*”. The Ministry has also advised me that the DETYA document – *National Strategy to Improve Education and Training for Adult Indigenous Australians in the Custody of Correctional Authorities* has recently arrived in Western Australia.

Recommendation 186

“That prisoners, including Aboriginal prisoners, should receive remuneration for work performed. In order to encourage Aboriginal prisoners to overcome the educational disadvantage, which most Aboriginal people presently suffer, Aboriginal prisoners who pursue education or training courses during the hours when other prisoners are involved in remunerated work should receive the same level of remuneration...”

- Although a prisoner undertaking educational programs does receive a gratuity, if he has the opportunity to *work* at a higher gratuity there would be little incentive to choose education rather than employment. Given that the majority of prisoners rely on their gratuities to enable them to maintain telephone contact with their families there would be little incentive to take up educational opportunities if it resulted in a lower ‘income’. The Ministry has advised me that a recommendation that prisoners who undertake training or education while working will receive an additional gratuity is currently being considered by a Steering Committee.

Recommendation 187

“That experiences in and the results of community corrections rather than institutional custodial corrections should be closely studied by Corrective Services and that the greater involvement of communities and Aboriginal organisations in correctional processes be supported.”

- From my observations, the involvement of community organisations in most aspects of prison life is met with a degree of resistance and sometimes hostility by prison staff who often cite potential breaches of security as a justification. The Ministry has advised me, however, that the Indigenous Education and Training Programs Coordinator is “...*as a matter of priority, pursuing a policy of increasing the numbers of Indigenous tutors, increasing Indigenous participation rates and expanding community involvement. To date the Coordinator has been highly successful in all three aspects.*”

SUMMARY OF CONCLUSIONS ON THE ADEQUACY OF EDUCATION, TRAINING, EMPLOYMENT, RECREATION AND TREATMENT PROGRAMS

13.200 Although in general I found that most prison administrators were supportive of programs (in which I have included education, training, employment and recreation as well as treatment programs), and accepted their value as a management tool and in creating a safe and ‘healthy’ environment for prisoners and prison staff, it was also quite clear that programs were not considered a *core* prison activity. The Ministry has advised me that its draft *2000 Business Plan for Prison Services* recognises education/training as a “core” business in that Student Contact Hours and prisoner participation rates are two of its performance measures. Nevertheless, I note that the Plan is a draft and that there will need to be a shift in prison culture to ensure that the principle is embraced in practice.

- 13.201 The focus in Western Australian prisons has been – and still is in my opinion - on ‘security’ with the result that – similar to the situation of health services – programs have, to a large extent, been starved of funding. Programs have been unable to satisfy prisoner needs and the potential benefits for the system of active and constructively occupied prisoners have not been, in my opinion, fully realised. This approach has also ignored the beneficial effect of constructive activity on a prisoner’s general wellbeing and the fact that the inter-dependence of parole eligibility and the completion of treatment programs is without doubt a source of great stress and anxiety to prisoners.
- 13.202 The Taskforce looking at education and training found that most prisoners indicated a need and a willingness to improve themselves in order to avoid a return to prison. My own observations also support the findings of the Taskforce. A prisoner at Bunbury Regional Prison wrote in the 18 February 2000 edition of *Odyssey* – a statewide fortnightly newsletter produced “*by prisoners for prisoners*”:-

“Using Time Wisely

Time in prison can be one of two things, used to benefit yourself or wasted. Once in prison it is inevitable that the time will be used, how it is up to the individual.

While in prison your beliefs and way of thinking that culminated in being here can be maintained without any form of internal reassessment or recognition of life choices. This may very well lead to another stint as a guest of the Queen.

The alternative is to study a subject that we are all find interesting, ourselves. Our lives can basically be broken up into three categories. Most stories have a beginning, middle and end. We are not a whole lot different. We have a past, a present and a future. We can all learn from our past, use the present and influence our future. Out of these three areas the present is the active, or important stage. We live the present everyday of our lives. How we live these days determines the quality of our future, that is, what we do, say achieve today affects tomorrow, next week, next year and so on.....”

- 13.203 A prison psychologist told me that the Education Centre and workshops where apprenticeships were available are considered by prisoners as “*areas of hope*” in the prison environment. Successful completion of a course is a major ego boost for prisoners and involvement in these areas encourages prisoners to take positive steps to improve their lives, for example, by reducing drug dependency and the desire to self harm.
- 13.204 The timing of this involvement is, however, paramount, as is the need to encourage prisoners to participate in courses as part of a genuine attempt to improve themselves rather than as merely a means of gaining parole eligibility. Concentration of rehabilitation initiatives at the end of the sentence prior to review of parole eligibility almost certainly also deprives the prison system of the benefits of possible modification of a prisoner’s behaviour while incarcerated, particularly those prisoners charged with offences involving violence or substance abuse. It seems to me that it would be far more productive for prisoners themselves and for the prison system if they were provided with the opportunity to use the skills they acquire from treatment and counselling programs in a situation where they are able to seek further assistance and guidance rather than in the community where, realistically, they are very much ‘on their own’.
- 13.205 An additional disadvantage of scheduling programs at the end of the sentence is that it frequently leaves the Ministry little leeway to cater for unforeseen delays resulting from cancellation or re-scheduling of programs or simple over-subscription. The prospect of serving additional time due to an inability to participate in appropriate programs through no fault of their own is a cause of significant frustration for prisoners who may have limited coping skills. Academic opinion - and basic common sense – indicate that frustrated prisoners are more difficult to manage and are likely to vent their frustration on other prisoners or staff or themselves.

- 13.206 In making these comments I do not under-estimate the value of pre-release programs. However, in my view, such programs should be designed to not only reinforce the skills learned in earlier programs but also to provide resocialisation and life skills to maximise a prisoner's chances of succeeding in the community. There are a number of more holistic programs run by community-based organisations such as the Prisoners' Advisory and Support Service and Outcare which merit further consideration by the Ministry.
- 13.207 Prisoners have a number of ideas on the type of assistance which they need to equip them for life in the community. For example, a letter from a prisoner at Bunbury Regional Prison published in the 7 January 2000 edition of *Odyssey* suggests modification of the “*day to day monotony of the prisoner's day in aid of better preparing prisoners for release into the community*” and refers to the prison regime - which involves notification by loud speaker when it is time to go to work; eating only when told to; checking in at ‘home’ at lunch time (muster check) and before recreation and must be ‘home’ before 4.45pm.
- 13.208 Although I agree that routine may be necessary for the smooth-running of a prison, by the time a prisoner has progressed through the system and he or she is considered ready for release into the community, the focus of that prisoner's daily life should be preparation for a life where there are no “*such regimented restrictions*”. In his letter to *Odyssey*, the prisoner referred to in paragraph 13.207 states:-
- “...it makes no sense to turn people into robots and then release them into the community. This is particularly true for those who have been incarcerated for some years. There have been many accounts given over the years by those who have been released from prison of the unawareness regarding the regimental day. For some time after they still expected to be woken up, or jump up at the sound of rattling keys, inexplicably go to their room at 7.00pm.....*
- How about unlocking prisoners in the morning and leaving it up to individuals to get to work on time, make individuals responsible for logging in at work or they don't get paid.”*
- 13.209 In my view, given that most prisoners are in minimum security prisons prior to their release on parole, the prisoner's suggestions for ‘normalising’ life prior to release have merit. There is an urgent need for a more practical approach to pre-release programs in order to increase a prisoner's chance of success in the community; to reduce the likelihood of re-offending, thereby improving the cost-effectiveness of the prison system. A smooth transition to release may also reduce the risk of self harm for those long term prisoners who are apprehensive about fitting in to ‘life on the outside’.
- 13.210 To show true commitment to suicide and self harm prevention, it is essential that the Ministry takes steps to address the causes of a prisoner's ‘immediate stress’, to which boredom and inactivity are major contributors,²⁴ by taking a holistic and cohesive approach to the education and treatment of prisoners in its care. The Ministry's current commitment to programs in general is, in my opinion, questionable given that programs of all types remain largely under-staffed and under-funded and are almost universally unable to cater for the needs and demands of prisoners.
- 13.211 There are, of course, significant cost implications in a number of the recommendations which I have made regarding program provision. I make no apology for that based on the view – previously stated – that there are greater benefits for the prison system and for the community if prisoners are released better educated and trained and having been given the opportunity to address the offending behaviour which led to their imprisonment.
- 13.212 In the long term, there could also be significant cost-savings for the prison system (and the tax-payer) if the rate of reoffending is reduced. Given that a large number of prisoners reoffend²⁵ and return to prison I cannot say with any confidence that programs currently provided are cost-effective. In this regard, I agree with the view expressed in the AIC Trends and Issues paper “*The Economics of Implementing Intensive In-prison Sex-offender Treatment Programs*” published in November 1999, which stated:-

“Society must choose how to allocate limited resources most efficiently and in a manner that maximises social welfare. Resources can be said to be used efficiently if it is impossible to reallocate in any other way that would increase the overall benefits derived. The analysis of economic efficiency involves comparing the costs of using scarce resources against the resulting benefits.” (my emphasis)

- 13.213 As a final comment on programs, I am aware that the Ministry has recently completed its *Integrated Prison Regime Project* which it describes as -

“.....a major vehicle for improvement across Prison Services in Western Australia. The project seeks to integrate and maximise the impact of all relevant services and interventions for prisoners in a manner which increases efficiency and effectiveness.

The major elements of the project remit are:

- *The revitalisation of Unit Management within public prisons²⁶*
- *The development and introduction of a model of Case Management for prisoners*
- *The introduction of Cognitive Skills training for prisoners complemented by Interpersonal Skills training for prison officers*
- *The development of a Constructive Day for all prisoners*
- *The development of an integrated ‘Incentives and Earned Privileges’ system to encourage prisoners to engage with the prison regime in a positive manner.*

Given the scope of this project it is expected that the time frame for completion will be three years.”

- 13.214 As part of this project, the concept of ‘case management’ has been reviewed and improved. The Ministry has described case management as:-

“.....the process by which prisoners within Western Australian prisons will be assisted to achieve the goals identified in their Individual Management Plans. The aim of Case Management is the provision of integrated and coordinated services that assist offenders to address their offending behaviour. Case Management facilitates access to planned interventions within a supportive environment.

The steps involved in Case Management include comprehensive assessment, service planning and delivery, regular monitoring and review. Central to effective Case Management is the cooperative relationship established between the prisoner and designated Case Officer.”

- 13.215 In my opinion, this initiative should have a significant impact on the effectiveness of the Ministry’s program delivery, and the rehabilitation of offenders – *provided* that prison officers are adequately trained; that there are sufficient resources to meet the program needs identified; and the Ministry is prepared to evaluate its programs and address any deficiencies to ensure the best value for its ‘welfare \$’.

RECOMMENDATION 13.11

That the Ministry subject all of its programs to ongoing monitoring and evaluation as part of an assessment of efficiency and effectiveness to ensure that they meet prisoner and community needs.

SUMMARY OF RECOMMENDATIONS

- 13.1 That the Ministry should:-
- (a) acknowledge the importance of constructive activity in the prevention of suicide and self harm and in the rehabilitation of prisoners and ensure that all prisoners are provided with adequate opportunities for education, training, employment and treatment programs throughout their sentences at all prisons.
 - (b) take steps to remove the disincentives to participation in education identified by the Taskforce and in the course of my inquiry;
 - (c) provide funding, resources, trained staff and facilities to increase the opportunities for education (in its broadest sense), training, employment and rehabilitation throughout the sentence at all prisons; and
 - (d) obtain legal advice as to whether the *State Trading Concerns Act 1916* or any other legislation prevents the Ministry from offering particular forms of gainful employment to prisoners, and consider seeking amendment if it is found that there are legislative restrictions.
- 13.2 That, in line with United Nations *Standard Minimum Rule 77(1)*, in the interests of the mental and physical wellbeing of prisoners and as a means of creating better prisoner/officer relations, the Ministry:
- (a) employ a full time Recreation Officer/Sports Coordinator at each prison;
 - (b) ensure that each prison provides adequately resourced and appropriately staffed recreational and exercise opportunities for all prisoners; and
 - (c) encourage prison officers (by internal recognition and additional remuneration) to take responsibility for particular recreational activities for which they have appropriate qualifications and/or aptitude.
- 13.3 That in recognition of the acknowledged therapeutic benefits of music and art for all prisoners, and particularly Aboriginal prisoners, the Ministry:-
- (a) ensure that adequate resources and facilities are available at all prisons for these activities; and
 - (b) accord art, music and cultural activities program status.
- 13.4 That the Ministry ensure that sufficient resources and funding are provided to enable prisoners to participate and complete treatment programs prescribed identified in the assessment process on admission to prison or by the Parole Board prior to their release date.
- 13.5 That the Ministry provide rehabilitation programs at an early stage in and throughout the sentence with refresher courses at the end.
- 13.6 That the Ministry ensure that participation in culturally appropriate basic literacy and numeracy courses is encouraged in a sensitive way at all prisons.
- 13.7 That the Ministry provide appropriate cultural programs for Aboriginal prisoners at all prisons, involving local community and tribal elders, on the lines of those available elsewhere in Australia and New Zealand.

- 13.8 That the Ministry address the current inequality of education, training and employment opportunities for female prisoners throughout the State by providing a wider range of programs designed specifically to cater for their needs and ensuring that they are adequately staffed and funded.
- 13.9 That the Ministry take steps to review program provision for remand prisoners at Bandyup and at regional prisons and ensure that they have access to a range of education, meaningful employment and rehabilitation opportunities.
- 13.10 That the Ministry develop appropriate programs to assist ‘difficult’ prisoners address their behavioural problems as alternatives to progressively more severe disciplinary measures.
- 13.11 That the Ministry subject all of its programs to ongoing monitoring and evaluation as part of an assessment of efficiency and effectiveness to ensure that they meet prisoner and community needs.

¹ *Suicides in Prison* Routledge 1992

² *ibid* at page 165

³ *ibid* at page 145

⁴ *ibid* page 159

⁵ *Suicide is Everyone's Concern* 1998

⁶ *Review of Maori Suicides, Executive Summary* at page 2

⁷ The kitchen provides meals for other prisons

⁸ I understand that accredited music programs are now run at different times in the Education Centre

⁹ In response to a parliamentary question the Attorney General advised that as at 5 May 2000, 397 of a total muster of 609 prisoners at Casuarina were involved in full time work or programs.

¹⁰ The laundry handles the prison laundry and a contract for the cleaning of uniforms from an abattoir

¹¹ The number of Education Officers has increased from 19.5 in 1997 to the current figure of 30

¹² Census on the night of 30 June 1999

¹³ It will also assess the level of each prisoner's risk of self harm and health needs (both physical and mental)

¹⁴ Such as those identified in the Albany Custodial Inspection Report. See paragraph 13.118

¹⁵ A Criminal Justice Consulting Organisation which specialises in providing training and technical assistance in correctional settings worldwide. The CSP has been successfully introduced in Canada, the UK, Scotland, the USA, Sweden, Germany, New Zealand and South Australia

¹⁶ In January 2000 the Ministry developed an appropriate program for prisoners who are in denial.

¹⁷ This program is currently under review

¹⁸ See paragraph 13.33

¹⁹ See Chapter 8 paragraphs 8.42-8.43

²⁰ “*Suicides in Prison*”, at page 159

²¹ **UN Rule 21(1)** - “*Every prisoner who is not employed in out-door work shall have at least one hour of suitable exercise in the open air each day.*” and **Standard Guideline 5.62** - “*Weather permitting, prisoners should be allowed access to open air for at least one hour each day.*” – was not applied during the lockdown at Casuarina prison for many months after the riot in December 1998.

²² See paragraph 13.95

²³ See Appendix 1 for full text of the RCIADIC recommendations

²⁴ See also Chapter 8

²⁵ See Chapter 6, paragraphs 6.12-6.13 and Table 6.1

²⁶ See also Chapter 15, paragraphs 15.31-15.43

CHAPTER 14 JUSTICE ISSUES

PAROLE ISSUES

BAIL ISSUES AND COURT APPEARANCES

REVIEW OF SENTENCE LAWFULNESS AND CALCULATION

REPRESENTATION OF FAMILIES AT INQUESTS

SUMMARY OF RECOMMENDATIONS

- 14.1 This chapter contains comments about a number of aspects of the overall administration of justice in Western Australia that have arisen, in one way or another, in the deaths of prisoners. Some issues have directly impacted on prisoners in custody while others are more relevant to how offenders (or alleged offenders) get into prison. The latter point is not the focus of this Report, but is discussed to reinforce the idea that imprisonment must always be the last resort for any person - and any unnecessary imprisonment can only increase the chances of deaths in prisons occurring, as well as exacerbating the consequential impact of imprisonment on the families of prisoners.

PAROLE ISSUES

- 14.2 Eligibility for parole and gaining release on parole at the earliest opportunity are matters of great importance for almost all prisoners. I receive numerous complaints from prisoners when a decision is made by the Parole Board to defer or deny an application for parole. Some do not appear to understand the relationship between the courts, the Ministry and the Parole Board. For example, the court might hand down a sentence including eligibility for parole, but with no explicit requirement for particular rehabilitation programs to be completed. However, Ministry staff will assess whether the prisoner needs to undertake certain rehabilitation courses before it will advise the Parole Board of the degree of risk of re-offending by the prisoner. Many prisoners have difficulty in understanding and accepting this.
- 14.3 Many prisoners also complain that although they do everything required of them in regard to programs and their parole plan, and are considered suitable for parole by prison and FCMT staff, their applications are not supported by the Ministry or approved by the Parole Board. They argue that the prison staff know them best, whereas to the rest of the Ministry and the Board, they are just “*a photo and a file*”. Many prisoners have difficulty in coping with this situation. The problem is particularly acute when Ministry staff decide that a prisoner need not do a particular program but the Parole Board subsequently requires that he/she should.
- 14.4 In most cases my involvement, if any, has been limited to ensuring that the Board has been given accurate and adequate information by the Ministry on which to base its decisions. In general, I would not attempt to investigate a complaint about the merits of the Board’s decision in a particular case. However, there have been several aspects of the Board’s role which were of concern to me and which I have discussed with successive Chairmen of the Board.

Reasons for Board decisions

- 14.5 First, the complaint is often made by prisoners that the Board does not provide the prisoner with adequate written reasons for its decision. This contention was the subject of a 1996 decision of the Supreme Court of Western Australia in which the Court stated¹ that

“...the Board is required to provide not only its conclusion, eg that there is not an appropriate parole plan, or that the prisoner is at a high risk of reoffending, but also the material which led the Board to that conclusion and, if relevant, the criteria against which the Board judged the information available to it. The reasons should be sufficiently specific to enable a prisoner to understand what aspects of his previous offending, his conduct within prison, or plans which may have been made for his release, caused the Board to have the concerns which gave rise to its determination.”

- 14.6 Some time before my inquiry commenced, having considered the Board's policy, the decision in the case referred to above, and the standard letter of decision sent to prisoners by the Board, I expressed the view to the then Chairman that the issue of adequacy of reasons given might still result in complaints to my Office. Following discussions, I was advised that a more explanatory form of letter had been introduced. While I commend the Board on doing so, I continue to receive complaints about this issue from prisoners. I can appreciate the resource implications for the Board if detailed reasons were always provided, but recent examples of letters I have seen from the Board to prisoners conveying the decision about parole or work release continue to provide little or no information about why a particular conclusion was reached. For example, phrases such as "*unaddressed offending behaviour*" or "*poor prison conduct record*" provide the prisoner with little specific information to help him/her understand what aspect of their offending behaviour or prison record caused the Board to form those opinions. Given that the Board presumably discusses in some detail the reasons for reaching the conclusion that a prisoner has failed to address offending behaviour or has a poor prison conduct record, I would have thought that it would not be too difficult to extract that detail from the Board's Minutes.
- 14.7 The Chairman of the Parole Board has acknowledged that the Board's inability to provide detailed reasons in the first instance is a problem. He has advised me, generally, as follows:-
- "In respect to parole issues I fully share with you the concerns that you have raised and assure you that the Parole Board has every intention of continuing to address these matters.*
- I am acutely aware of the restrictions under which the Board operates due to lack of resources and have made strong representations to the Ministry of Justice to provide the additional staff which are urgently required. The need for additional staff was identified in a recent review and we now await implementation of the recommendation by the Ministry of Justice. Most of the matters in your draft report have already been considered by the Board which has resolved that they be dealt with expeditiously upon the restructuring of the Secretariat."*
- 14.8 In relation to the provision of more detailed reasons for decisions the Chairman has advised as follows:-
- "I acknowledge that this is a problem and also that the Board has every intention of addressing it as soon as we have the resources to do so. The number of cases being considered by the Board at each meeting is increasing and there is an expectation that the decisions reached will be communicated as quickly as possible. With additional staff it should be possible for more detailed letters to be drafted without undue delay.*
- I agree that phrases such as "unaddressed offending behaviour" or "poor prison conduct" ideally require more detailed explanation. However, should a more detailed letter be sent it is vital that the information contained in it is accurate. This requires a great deal more staff time than is currently available to the Board."*
- 14.9 Second, at the time of my initial discussions the then Chairman advised me that there were no sessions of the Board at which a prisoner was able to appear and to be heard, and to hear first-hand from the Board the reasons for its decision. The Board had applied for funding from the Attorney General to provide the resources to hold hearings at Casuarina, and sought my support for its application, which I was happy to provide in the form of a letter to the Attorney General. Some funding was provided subsequently and the Board does now hold sessions at Casuarina at which prisoners who have been refused parole can "appeal" in person - but only if the Board agrees to grant such a "hearing". This initiative will assist some prisoners considerably to understand the basis for a decision made by the Board.
- 14.10 The Chairman has clarified when the Board will grant a "hearing". The Board has adopted a policy of allowing any prisoner who has been denied parole or deferred for more than six months to seek a personal hearing. All prisoners who meet this criterion are granted a personal hearing if it is sought.

The Parole Board's Expectations

- 14.11 On a number of occasions I have received complaints from prisoners who have been assessed by Ministry staff as not eligible for, or not needing to do, a particular program - only to have the Parole Board decide subsequently that parole or work release cannot be granted at that time because the prisoner has not adequately addressed offending behaviour, as evidenced by the failure to do the program. When these issues arise they are usually followed by a 'scramble' to fit the prisoner onto a program at short notice - often with consequential adverse affects on another prisoner who is removed from the program to make room.
- 14.12 In such cases I have no reason to question the merits of the Board's assessment of the need for the prisoner to undertake the program. My concern is that the need was not identified at an earlier stage - which would assist Ministry staff and the prisoner to know what expectations the Board may have.
- 14.13 I appreciate that, because circumstances and people change over time, it will not be possible in every case to specify with certainty in advance the Board's future requirements. Inevitably, therefore, cases may arise where reasonably based expectations must be altered. The challenge to all concerned must be to keep such cases to a minimum. I have been informed that the Victorian Parole Board operates a system whereby every prisoner is assessed by that Board early in the sentence and pre-requisites for parole identified - which are then used to guide the prisoner's management and rehabilitation efforts during the sentence. At the time a parole decision is made it is apparently relatively rare for any unaddressed issues to delay parole.
- 14.14 I have no doubt that the Victorian model is resource intensive and that the Western Australian Parole Board could not hope to emulate such a system with its present limited resources.
- 14.15 On the issue of determining what should be required of prisoners before a parole or other decision can be made, the Chairman of the Board has advised me as follows:-

"When considering whether or not a prisoner should be released on parole, the Board has before it information from a number of sources, including in some cases psychological and psychiatric reports. This material, taken in conjunction with the Judge's sentencing remarks, prison assessments, reports from the Victim Mediation Unit, Community Corrections Officer's assessment, the criminal record of the prisoner and their community supervision record, may lead the Board to decide that a particular programme should be undertaken prior to release on parole.

I understand that at the beginning of a sentence the prison authorities develop a plan for each prisoner which identifies the need for programmes to address their offending behaviour. The providers of the relevant programmes then carry out an assessment but in some cases the prisoner refuses to admit that they have a need for such a programme. In other cases the prisoner may incur, late in the sentence, a prison charge which indicates their need for a programme. Either case may lead the Parole Board to require programme participation prior to release.

It should also be stressed that currently in cases where a prisoner has been unable, through no fault of their own, to access the relevant programmes, the Board considers releasing that prisoner with the condition that they undertake a suitable programme in the community.

You have noted that the WA Parole Board could not hope to emulate the Victorian model and I do not think that, even with a massive increase in resources we would be able to consider the programme needs of each prisoner in the manner suggested. Nor does the Board possess the expertise necessary for the professional assessment of treatment needs. The Board's preferred option is effective assessment of prisoners by the Ministry of Justice at an early stage in their sentence and effective programme provision. In the Board's view it is the lack of programme availability which most frequently creates the problems. In addition, I emphasise some prisoners are unwilling to undertake programmes."

- 14.16 Finally, the view was expressed to me that the Board's practice of meeting on Fridays caused operational problems within the prisons in terms of providing appropriate support and counselling for prisoners who received adverse decisions late on a Friday afternoon. During the course of my inquiry the Board changed its meeting day to Thursday, which has been of assistance in this regard.
- 14.17 I had intended to recommend that the Board be better resourced so that it could conduct an assessment of every prisoner eligible for parole early in the sentence with a view to specifying (non-binding) expectations of what the prisoners should do to maximise the likelihood of gaining parole at the earliest date. However, in light of the Chairman's advice of the Board's preferred position as set out in paragraph 14.15 above, I make the following recommendations:-

RECOMMENDATION 14.1

- (a) **That the Ministry of Justice respond to the Parole Board's request for additional resources as soon as possible. In particular, the Parole Board should be resourced so that it can provide detailed reasons for its decisions to prisoners; and**
- (b) **that, with a view to maximising the effectiveness of the Ministry's assessment process for prisoners, the Board and the Ministry review:-**
- **how the Board's expectations about what prisoners should be required to do during a sentence can be better understood by the Ministry; and**
 - **the nature and extent of programs to be offered by the Ministry and the timing of their delivery.**

Communicating Parole Board decisions to prisoners

- 14.18 The way in which Parole Board decisions are communicated to prisoners was considered to be a factor in the deaths of two prisoners - Shane **Hitchcock** (Canning Vale; June 1993) and Alessandro **Leone** (Casuarina; April 1998).
- 14.19 Mr Hitchcock, who committed suicide on 15 June 1993, was eligible for parole on 24 June 1993. When his application for parole was considered by the Parole Board on 11 June, parole was deferred pending further psychological and psychiatric reports. As the Coroner subsequently reported, the usual practice following a Board decision to defer parole was for a Board staff member to telephone a designated officer at the prison the same day to advise of the decision. The information should then be passed on to the prisoner's accommodation unit where the Unit Manager or the Wing Officer would advise the prisoner of the Board's decision. The officer is supposed to remain available to provide counselling and assistance to the prisoner, if necessary, because it is recognised that the prisoner might be under stress and that the news would inevitably be disappointing, at the least.
- 14.20 On Friday 11 June there was, apparently, a disturbance in Mr Hitchcock's Unit which distracted the officers from conveying the Board's decision personally to Mr Hitchcock and he did not find out about the Board's decision until the following Tuesday (15 June) when he received a formal letter from the Board. The Coroner suggested that the formal style of the letter might not have been easily understood by Mr Hitchcock as he took it to a prison officer who then spent some ten minutes explaining the situation to him. Mr Hitchcock reportedly appeared subdued and disappointed and was found hanging in his cell at approximately 9.45pm that night.

- 14.21 Both the Coroner and the IIU investigator concluded that the unexpected news of his parole deferral and the manner in which it was communicated to him were factors - although not the only factors - in his decision to take his own life.
- 14.22 The system for notifying prisoners required the Coordinator, Sentence Planning to leave a written message containing the relevant Board decisions in a designated place for collection by an officer from each Unit. According to the Coroner, the prison administration acknowledged that the system failed on this occasion. The IIU report stated that the procedure had now been rectified to prevent any recurrence –

“The Coordinator Sentence Planning will now advise each Unit Manager personally of Parole Board decisions and it will be the responsibility of each Unit Manager to personally advise the prisoner in his Unit and record that the prisoner has been advised in the Unit occurrence book.”

I am reasonably satisfied that this response by the Ministry was appropriate.

- 14.23 However, it appears that similar circumstances may have arisen in the death of Alessandro **Leone** who committed suicide in Casuarina in April 1998. His statutory review date for consideration of parole was 26 March 1998. On 20 March 1998 the Board reviewed Mr Leone’s suitability for inclusion in a pre-release program and for parole. The Board resolved to defer the matter and to review it again in July 1998. From the information that I was able to review, there is no record in the Unit occurrence book for 20 March 1998, or the subsequent days, that the Unit Manager notified Mr Leone - or any other prisoner in that unit who had been considered by the Board on that day - of the Board’s decisions.
- 14.24 The Parole Board’s procedure in 1998 was to fax ‘decision slips’ relating to each prisoner considered at its meeting to each prison - and then to telephone the designated officer at the prison to check that the correct numbers of slips had been received. The Board keeps no records of this confirmation and the Coroner subsequently found that “... *it would appear that on this occasion the prison did not receive a copy of the decision*”. In any event, it seems clear that Mr Leone was not advised by prison staff of the outcome of the Board’s consideration of his case on the day it made its decision - even though, presumably, prison personnel were aware that the Board would be considering Mr Leone that day.
- 14.25 It is clear that Mr Leone received the letter of advice from the Board the following week, (in the same manner as Mr Hitchcock received his letter) because it is known that he expressed his disappointment with the decision to the Superintendent and was advised to write directly to the Board. It appears that Mr Leone was aware that the Casuarina Unit Conference meeting of 12 March 1998 had decided to recommend against parole because of his “*ongoing psychiatric problems*” because he wrote to the Board on 29 March 1998 disputing that he had psychiatric problems and appealing against the Board’s decision not to grant him parole.
- 14.26 The Secretary of the Board replied to Mr Leone on 1 April 1998, explaining that “...*the professional psychiatric advice to the Board is that you do suffer from a psychiatric disorder and one which requires further investigation*” and reiterated the Board’s decision to review the case in July 1998. It appears that the Secretary considered Mr Leone’s letter was seeking clarification of the Board’s decision, which he provided. Because he did not regard it as a formal appeal against the Board’s decision, he did not consider it necessary to instigate a similar notification procedure to that followed when the Board’s decisions are conveyed to prisoners. That view was reasonably open to the Secretary to take. However, in hindsight, it might have been better if the usual notification procedure had been followed because it is likely that, in Mr Leone’s mind at least, he expected a reply granting him release on parole.

- 14.27 From enquiries which I have made with the administration at Casuarina Prison, I understand that incoming mail for prisoners is scrutinised but not recorded. I have also been advised that scrutiny of the letter from the Board would not have resulted in an FCMT staff being alerted that they may need to monitor Mr Leone's reaction to the Board's response. Mr Leone was found hanging in his cell at approximately 8am on 8 April and the Coroner found that the cause of his death was suicide. In my view, the decision not to grant him parole was a factor in his decision, but not the only factor.
- 14.28 Although it appears unlikely that Mr Leone was orally advised of the Board's decision on 20 March 1998 in accordance with the established procedure, it seems unlikely that any lack of counselling or monitoring on that particular day would have affected his decision three weeks later. In this regard, I note that it was Mr Leone's psychiatrist who recommended that his parole be deferred. The psychiatrist does not appear to have considered Mr Leone at risk of self harm and consequently did not alert the 'appropriate authorities'. It is not clear whether prison officers who saw Mr Leone on a daily basis might have expected him to react adversely to a deferral of parole. Nevertheless, it is, in my opinion, significant that there was no reaction by the prison administration to the possibility that Mr Leone may have reacted badly to the Board's letter of 1 April 1998.

RECOMMENDATION 14.2

That the Ministry and the Parole Board review the procedures by which Board decisions and other correspondence from the Board are conveyed to prison staff and to prisoners to ensure that:

- (a) prison personnel are aware that the prisoner is to receive advice from the Board;**
 - (b) a prison officer personally delivers the correspondence or oral advice to the prisoner, thereby having the opportunity to observe the impact of the advice on the prisoner; and**
 - (c) the records of both the Board and the prison document whether information about decisions or other correspondence has been conveyed to and received by, the prison and the prisoner in every case.**
- 14.29 In response to my draft report, the Board has advised me that it has already sought to improve its procedures for communicating its decisions to prisoners and has resolved to undertake a further comprehensive review when the new administrative arrangements are in place. For example, the Chairman has pointed out that:-
- as already noted, the Board now meets on a Thursday to ensure that staff are available at the prison to discuss the Board's decision with prisoners and monitor their reaction to adverse decision;
 - prior to each meeting of the Board, an agenda is circulated to each prison so that prison staff are fully aware of who is to be considered by the Board at that meeting. A check is made to ensure that the agenda has been received; and
 - the Board maintains a record of decisions and correspondence sent to each prison and checks to ensure that the decisions and correspondence have been received.
- 14.30 Circulation of Board agendas will, of course, inform prison staff of which prisoners will be considered at formal Board hearings, but will not cover prisoners who correspond with the Board.

Aboriginal prisoners

- 14.31 The Aboriginal Legal Service (ALS) submitted to my inquiry that Aboriginal prisoners experience particular difficulty in accessing parole and work release, stating that less than 30% of parolees and only 8.5% of prisoners given work release orders in 1996 were Aboriginal. The ALS told me that many Aboriginal prisoners believe they are unfairly denied work release and that *“Clearly systematic denial of parole and work release to Aboriginal prisoners contributes to their continued over-representation in Western Australian prisons.”*
- 14.32 Ministry statistics about parole and work release orders (which do not match exactly Parole Board statistics but are sufficiently similar to be reasonably comparable) are shown in **Table 14.1**.

TABLE 14.1		Parole and Work Release Orders for the years ending 30 June 1996-1999		
		Aboriginal	Total	Aboriginal as % total
Parole	1996	409	1401	29.2%
	1997	402	1379	31.4%
	1998	459	1431	32.1%
	1999	430	1266	34.0%
Work Release	1996	18	179	10.0%
	1997	19	180	10.6%
	1998	10	123	8.1%
	1999	9	97	9.3%

Source: Ministry of Justice Statistical Reports, 1996-1999

- 14.33 Table 14.1 shows that, in relation to parole orders, those made for Aboriginal prisoners represent about one-third of all orders - which is consistent with the proportion of the total prison population represented by Aborigines. That seems to be appropriate. Parole Board statistics for 1998 (the latest available) show that 82.9% of Aboriginal males are granted parole on the first consideration - virtually identical to the 82.8% of other male prisoners. However, female Aboriginal prisoners gained parole on the first consideration in only 73.8% of cases compared to 92.3% for other female prisoners. Comparable figures for 1997 are not available. The much smaller number of cases for women prisoners means that percentage differences may be exaggerated in a given year and may not reflect the longer term position.
- 14.34 In relation to work release orders, Table 14.1 clearly suggests that Aboriginal prisoners have consistently benefited from such orders to a disproportionately smaller extent than non-Aboriginal prisoners. Why this might be so is beyond the scope of this Report, but the anecdotal information given to me by prisoners and Ministry staff is that the work release system and criteria for eligibility is weighted heavily against Aboriginal prisoners - particularly because they often have long records of previous convictions.

14.35 In response to those comments, the Chairman of the Parole Board has advised me:-

“The two main areas of concern appear to be work release orders and female Aboriginal prisoners. With respect to work release orders, the Board can only operate within the Statutory criteria. These require the person to be no more than a minimum risk to the safety of people in the community. This means that work release orders are of very limited application generally and cannot be made where a person has a significant record of violence. The Board is aware however of pending legislation changes that will re-word minimum risk to low risk and may therefore provide the opportunity for more prisoners to meet the Statutory criteria for release.

Another mitigating factor that may influence the apparent discrepancy in figures between work release orders for aboriginal and non-aboriginal offenders is the imprisonment sentence length. In order to be eligible for work release a prisoner must have served 12 months in custody prior to release. This means that the initial head sentence must have been greater than 3 years, with parole eligibility, or 18 months if there was no parole eligibility. Terms above these limits tend to be imposed for the more serious violent or sexual crimes, or drug trafficking.

As a general observation it would appear that aboriginal offenders tend to be imprisoned for lesser charges, usually relating to minor assaults, alcohol and vehicle related offences and therefore do not receive a lengthy term of imprisonment qualifying them for a work release order. This however would obviously need to be investigated by the Ministry of Justice to statistically compare the percentage of prisoners eligible for work release against the number of orders being granted.

The position of Aboriginal women is clearly a matter which requires further investigation. However, without expressing a final view, two points may be made. First, as you say, the number of such cases is relatively small and therefore more open to statistical variation. Secondly, the Board considers every case on an individual basis. Experience suggests that Aboriginal women who are serving lengthy and (therefore parole-eligible) sentences tend to face particularly difficult issues with respect to substance abuse and psychological and/or psychiatric problems.”

14.36 In light of the Board’s response to my comments, the important point is that there is a need for the Ministry to commence a study of parole and work release statistics to be undertaken to establish reliable data and identify any apparent anomalies in current procedures.

RECOMMENDATION 14.3

That the Ministry and the Parole Board institute a review of available data, current assessment procedures and eligibility criteria to determine whether female Aboriginal prisoners and Aboriginal prisoners generally are, or are likely to be, disadvantaged in relation to parole and work release orders respectively. Action to rectify any imbalance found should be taken, including the reconsideration of any legislated eligibility criteria.

BAIL ISSUES AND COURT APPEARANCES

Changes to the *Justices Act* and the *Bail Act*

14.37 The death of Paul **Vincent** (June 1992; Remand Centre) caused the Coroner to make a recommendation that consideration be given to amending section 79 of the *Justices Act* and/or the *Bail Act* in order to avoid unnecessary court appearances by prisoners on remand. At the time of Mr Vincent's death the *Justices Act* required that a person in custody in respect of either a simple or indictable offence should be brought before a court each thirty days.

14.38 Mr Vincent had been charged with a number of offences in different locations and was required to appear in both the Perth and Fremantle Courts of Petty Sessions. He had previously been on probation and had also been released on bail, but he was eventually remanded in custody. In April 1992 he appeared in the Perth Court of Petty Sessions at which time an application was made under section 656A of the *Criminal Code* so that all charges against him could be heard simultaneously. This was to take place in July 1992. The following day in April he appeared in court in Fremantle, was committed to appear in the Perth District Court in July 1992 and was remanded in custody because of the other pending charges. Mr Vincent appeared in the Fremantle Court of Petty Sessions again on 4 May 1992, due to the provisions of section 79 of the *Justices Act*, and was remanded for a further thirty days (until 2 June). He also appeared in the Perth Court of Petty Sessions on 26 May 1992 in connection with the transfer to Perth of the charges previously heard at Fremantle. He appeared again in the Fremantle Court of Petty Sessions on 2 June 1992.

14.39 The Coroner commented that the appearance on 2 June:-

"...was necessary in a strict legal sense...The provisions of s79 of the Justices Act required him to be brought before a Court at least every 30 days on every indictable charge, or group of charges. In practical terms there was no sense in having the deceased brought up in Court again. Such appearances simply overload already hard pressed Court and Prison resources and on the evidence before me, causes distress to prisoners."

The evidence before the Coroner was that Mr Vincent had been very angry and upset over the Fremantle Court appearance on 2 June.

14.40 The Coroner's finding was that Mr Vincent died as a result of attempted suicide by hanging. He also found that the "*key factor*" which prompted the suicide was the notification over the prison's public address system on 7 June 1992 that Mr Vincent was required to attend court the following day. It appears that Mr Vincent had been angry and upset over the impending court appearance, had expressed his anger and frustration to fellow prisoners and a prison officer, and was found hanging in his cell later that evening. The tragedy of the case is that this notification was incorrect - as he was not in fact required to attend court. It appears that his prison records were mistakenly endorsed with the details of another prisoner named Vincent who was required to appear in Court on 8 June. The Coroner stated that this "*...simple error led, indirectly, to quite tragic consequences.*"

14.41 The Coroner expressed the view that there was a need to reconsider whether a person in custody should be required to be brought before a court every thirty days and recommended accordingly in regard to the *Justices Act* and/or the *Bail Act*. In a letter to Mr Vincent's mother in August 1993, the then Attorney General advised that the Coroner's recommendations had been noted and would be "*...considered in due course.*" As part of this inquiry I wrote to the Ministry to request its advice as to whether or not that consideration did take place. The Ministry advised me that the *Justices Act* has not been amended in the way suggested and that defendants on charges of indictable offences are still required to attend court on either an eight or a thirty day cycle.²

- 14.42 The Coroner referred specifically to the *Acts Amendment (Jurisdiction and Criminal Procedures) Bill 1992*. I understand that the proposed amendments to the *Justices Act* to allow for “fast-tracking” – the process of expediting the committal of cases in the District Court where the defendant intends to plead guilty – came into force on 1 March 1993 and has drastically reduced the length of time defendants who wish to plead guilty spend on remand.
- 14.43 The Coroner also recommended changes to the *Bail Act* following his inquest into the death of Russell **Gibson** (also known as Green) (October 1992; Remand Centre), having expressed concern at the procedures involved in obtaining and approving a surety.
- 14.44 Mr Gibson was charged with a number of offences for which the maximum penalty was eight years imprisonment. Under the provisions of the *Criminal Code*, these charges could not be heard by a magistrate and were dealt with as indictable matters under the *Justices Act*. On 21 October 1992 Mr Gibson appeared in court to make a bail application. Bail was granted on terms of a personal undertaking of \$10,000 and a surety of \$7,500, the latter to be approved by a JP, but he was remanded in custody until such time as those undertakings could be met. If they were not met by 29 October, then Mr Gibson was required to reappear in Court on that date.
- 14.45 On Friday, 23 October, while in custody at the Remand Centre, Mr Gibson arranged for a friend, Mr R, to act as surety. However, Mr R was deemed to be unacceptable as a surety because a check of police records carried out by prison staff showed that there were outstanding warrants against him, totalling fines of \$186 which, it was discovered, were parking fines plus costs incurred by Mr R’s son while he was driving Mr R’s car, and were unknown to Mr R. The Justice of the Peace who contacted Mr R to determine his suitability, advised him to pay the warrants on the following Monday at which time he could then be approved. Unfortunately, as the Coroner reported, Mr R was unable to attend to this on the Monday and on Tuesday, 27 October, he heard that Mr Gibson had hung himself the previous evening.

Bail Act procedures

- 14.46 The Coroner expressed concern at two levels. First, he concluded that the correct administrative procedures required by the *Bail Act* were not followed on 23 October when Mr R attended the Remand Centre. The Coroner referred specifically to sections 37(2) and 40, which provide, respectively, that an applicant to be a surety must complete a declaration in the prescribed form **before** a decision is made by an authorised person about the applicant’s suitability, and that the authorised person may only make enquiries about the applicant **after** receiving the declaration.
- 14.47 The essence of his concern was that a decision had been made that Mr R was unsuitable as a surety before he had completed a declaration. According to the Coroner, that declaration would have shown that Mr R would have been an acceptable surety. The Coroner concluded that the declaration (Form 8) was not given to, or completed by, Mr R because a decision had already been made that the outstanding warrants rendered him unsuitable. The Coroner stated that the procedure described in the Act was:-

“...the clear intent of Parliament. It is not lawful for anyone to ‘invent’ a new procedure to suit the convenience of Justices, members of the public or prison officers. Unfortunately there is no statutory duty on any person to ensure a Form 8 is handed to a proposed surety.”

- 14.48 The Coroner recommended that the Act be amended to overcome the situation. He also recommended that the Ministry “...review the practice of...checking with the Police Department’s computer records on proposed sureties as a matter of some priority.” The then Executive Director advised the Attorney General on 31 March 1993 that a review would be carried out “without delay.”

- 14.49 When asked whether the Act had been amended and what were the outcomes of the above review, the Ministry advised me that there was no evidence that a formal review had been carried out. Changes had, however, been made to bail procedures. The Ministry's advice then described the bail procedures at metropolitan and country prisons, namely that the superintendent or officer-in-charge should contact the police, advising the name of the proposed surety and the name of the defendant seeking bail. The police response is then conveyed to the Justice of the Peace who has been asked to assess the application. It was clear from the Ministry's response that these steps are taken **before** the surety completes the Form 8 declaration. In other words, the procedure as described is the **same** procedure which the Coroner found to be incorrect, and which was supposed to be reviewed in 1993 by a directive from the Executive Director - but apparently was not.
- 14.50 Although the Ministry advised me that there are two Bail Coordinators employed at the Remand Centre, my understanding is that there is, in fact, only one. However, the described bail procedure at the Remand Centre appears to be the correct procedure in that the proposed surety completes the required declaration *before* any enquiries are made with the police.
- 14.51 I was concerned to receive advice from the Ministry to the effect that the incorrect procedures are still in place. Moreover, information given to me during the course of my inquiry suggests that the administration of bail and surety conditions remains haphazard and dependent to some extent on the wishes and habits of individual Justices of the Peace. For example, it appears that some Justices insist that prison staff make enquiries with police about prospective sureties before they will come to a prison to assess an application. In view of the voluntary role of Justices it is understandable that they would not want to use their time and resources making wasted journeys. However, as the Coroner stated, the procedure required by the Act is "...*the clear intent of Parliament.*" The Ministry has advised me that it has instigated a review of the *Bail Act* which is being carried out by the Crime Research Centre of the University of Western Australia. The review will consider the arrangements for bail in light of the procedure in New South Wales where, for most offences, a range of conditions can be imposed on the offender rather than seeking surety.
- 14.52 I also understand that prison staff are generally inexperienced in the bail process and tend to avoid processing enquiries from prospective sureties if possible. It appears that sureties are still, on occasion, informed by telephone, either by officers or the bail coordinator, that they are unlikely to be approved by a Justice of the Peace. Often, no Form 8 is filled in; no record of the enquiry or advice is recorded; and in many cases, a Justice has never been consulted. If my understanding is correct, this is a quite unacceptable situation.

RECOMMENDATION 14.4

That the Ministry:

- (a) review the procedures followed in all Western Australian prisons to determine the level of knowledge officers have of the requirements of the *Bail Act* and the working arrangements between prison officers, police and Justices of the Peace;**
- (b) ensure that the requirements of the *Bail Act* are being complied with, in practice, in all prisons; and**
- (c) complete the review of the *Bail Act* as quickly as possible.**

Approvals outside normal hours

- 14.53 The Coroner's second expression of concern was about the arrangements for obtaining approval of a surety after normal office hours or at weekends. He stated that this revolved around "...*the availability and idiosyncrasies of various JPs...*" The Coroner viewed Mr R as an acceptable surety and believed that he should have been judged as such on 23 October. In his view, the existence of the warrants was only one relevant factor to be considered and should have been outweighed by Mr R's overall financial position.
- 14.54 Following his detailed observations on the operation of the *Bail Act*, the Coroner considered that "...*specific persons, appropriately trained, should be appointed as a Bail Justice for each Petty Sessions Court throughout the State...who should be paid an appropriate on call allowance for after hours attendances.*" In his view, this would end the system of "*justice on the cheap.*"
- 14.55 I also received a submission from an advocacy group to the effect that there has been a general erosion of the right to bail for accused persons, and that community pressure and Government ideology have resulted in more people being sent to prison. This had led to an increase in the number of prisoners remanded in custody and the added risk of suicides. It was submitted that there should be greater use of alternatives to bail, such as home detention, that the Bail Hostel should be re-opened (this was a "*half-way house*" facility for people who were unable to raise a surety or provide suitable accommodation for themselves while on bail), and that there should be less emphasis on the requirement for a surety.
- 14.56 I wrote to the Ministry as part of this inquiry to obtain up to date information about these matters. Its advice was that the *Bail Act 1982* had not been amended but that the *Bail Amendment Bill 2000* seeks to broaden the range of persons with the authority to approve surety. The categories of authorised persons will be amended to include "*any person for the time being in charge of a prison*" and that this will ensure that even after normal working hours, an officer will be available to approve surety applications.
- 14.57 The Ministry also advised that:-
- "As a condition of their appointment, prospective Justices of the Peace have been required to successfully complete a tertiary level training course preparing them for their new duties and responsibilities. This training course includes specific emphasis on the Bail Act 1982, in particular the procedures involved in obtaining and approving a surety.*
- Issues associated with the practices of Justices of the Peace have been recently identified as part of a review initiated by the Attorney General. Officers from the Court Services Division of the Ministry of Justice are currently preparing a proposal for the Attorney General suggesting changes to improve the current situation. The review will seek to improve consistency of practices and the availability of JPs, relating to bail and surety matters."*
- 14.58 Because the *Bail Amendment Bill 2000* is still under consideration by Parliament and it is not certain what changes will result from the review mentioned above, I am not inclined to make specific recommendations regarding this issue. Nevertheless, I believe that it is appropriate to record disappointment that it is only now, some seven years after the Coroner's comments about the death of Mr Gibson that concrete action is proposed that may improve the situation.

Court appearances by prisoners

- 14.59 Since the death of Mr Vincent and the recognition by the Coroner that court appearances can be stressful and distressing times for remand prisoners, the Ministry has introduced a video communications link between the Remand Centre and the courts in Perth. I was able to observe the system in operation during one of my visits to the Remand Centre as part of this inquiry. In my view, its operation clearly provides a less stressful experience for prisoners and a more efficient and effective use of the Court's time.
- 14.60 A trial video link was established in March 1996 between the Remand Centre and the Central Law Courts. It has since been further developed and, in January 1999, the facility was relocated to a purpose built area at Hakea Prison. The link has since been extended to the Kalgoorlie Courthouse and I understand that it is planned to extend it to courthouses at Bunbury, Geraldton, South Hedland and Fremantle. The *Acts Amendment (Audio and Video Links) Act 1998* broadened the powers of Western Australian courts to deal with various matters by video and the link was expected to process about one hundred remand prisoners per week in 1999.
- 14.61 Although the video-conferencing facility is a welcome innovation, it is again disappointing that it took some three years after the Coroner's inquest on Mr Vincent's death for the facility to be implemented.

Notification of Court appearances

- 14.62 Following the Coroner's inquest into Mr Vincent's death, in February 1993 the Ministry issued a directive to superintendents – to take effect immediately - that staff were to notify prisoners individually of forthcoming court appearances the day before the appearance; that the public address system was not to be used; that records were to show a prisoner's first names, not just initials; and that all requests for transfers to court were to be in writing. The Ministry has confirmed that the directive was implemented and that it remains in force. I am, therefore, satisfied that appropriate steps have been taken to amend the relevant administrative procedures.

REVIEW OF SENTENCE LAWFULNESS AND CALCULATION

- 14.63 The death of David **Metcalf** (1991; Casuarina) resulted in a lengthy report from the Coroner which contained a bizarre account of incorrect charges laid, unlawful sentencing by country Courts of Petty Sessions and incorrect sentence calculation. The Coroner described Mr Metcalf as “*simple*” and “*socially inadequate*” and expressed the view that he was “*not a vicious criminal*” and that “*society was not prepared to tolerate [his] annoying behaviour...*”.
- 14.64 Mr Metcalf had been admitted to Graylands Hospital for assessment of his mental state on several occasions but there had been insufficient evidence to support a diagnosis of mental illness. The Coroner referred to his sense of “*outrage that the deceased, with no real ability to exercise those rights which the well educated and wealthy take for granted, became enmeshed in the system of Government and suffered the consequences.*” He was unsure whether Mr Metcalf had intended to take his own life by hanging and returned a verdict of accidental death which “*...arose from want of care.*” However, this last phrase appears to be a general comment on societal issues, rather than a direct reference to the day to day care in Casuarina Prison, which he described as “*adequate...within the resources which were available...*”. Mr Metcalf was seen regularly by prison medical staff, psychologists and a consultant psychiatrist and was eventually diagnosed as schizophrenic, a diagnosis which the Coroner attributed to Mr Metcalf's becoming better able to communicate with those assessing him in prison.

- 14.65 The IJU report into the death referred to the fact that Mr Metcalf had applied on 20 November 1991 for ten days' early discharge. The application was approved by the Superintendent and Mr Metcalf was advised that he would be released on 25 December 1991. However, on 24 December 1991 he was advised by the manager of his accommodation unit that he would not be eligible for such a discharge because his prison sentence was in place of outstanding fines and that his date of release would now be 1 January 1992. On Christmas Day Mr Metcalf was visited by the Superintendent and Assistant Superintendent. An internal department report stated that the latter did so because of his particular personal interest in Mr Metcalf's situation and that he commiserated with him over the ineligibility of his application. The IJU report also stated that Mr Metcalf "...made no complaints and appeared to have accepted that he was to be released on January 1, 1992." It would be conjecture to try and assess the impact, if any, of this reversed decision on Mr Metcalf's state of mind at the time of his death. The Coroner did not do so but concluded that there was insufficient evidence to make a finding of suicide.
- 14.66 The Coroner made the following recommendations:
- *"That the Department of Corrective Services review each sentence of imprisonment being served for an aggravated prison offence to ensure that the proceedings were duly authorised.*
 - *That the Department of Corrective Services carries out a similar review in respect of any such future sentence.*
 - *That there be a comprehensive review of sentences of imprisonment by the Courts of Petty Sessions in this State to determine what is the range of sentences for particular offences, the composition of the Court imposing the sentences of imprisonment, the pleas entered by the persons accused, and whether or not the persons accused are legally represented. This suggested review should not be seen as an abstract exercise but should represent a real examination of the administration of justice in Courts of Petty Sessions."*
- 14.67 The (then) Department responded to the recommendations by expressing the view that it was not its role to question the actions of magistrates, judges or the courts generally, that it did not have the legal mandate or the resources to provide legal assistance to prisoners, and that its prison staff did not have the knowledge or experience to conclude that a charge had been incorrectly laid or that a penalty was excessive. In my opinion, that was a reasonable view of the Department's function; any remedial action for the problems which arose in this case would have to be addressed as part of a wider strategy.
- 14.68 Following the Coroner's inquest in December 1992, the then Attorney General wrote to Mr Metcalf's mother in April 1993 and stated that she would be "...instituting a review of administration of justice in such circumstances by country courts in the near future. It is my concern as Attorney General to attempt to ensure that there is no repetition in the future of the sort of tragic events which led to your son's death."
- 14.69 As part of my inquiry, I sought the Ministry's advice about whether such a review took place and, if so, what was its outcome. The Ministry advised me as follows:
- "Since Mr David Metcalf's death, the Western Australian Government has undertaken a number of significant measures to facilitate sentencing, provide information on sentencing to the judiciary, review existing legislation, review the criminal and civil justice systems, and improve the management of offenders. Some measures include:*
- *The Government introduced a sentencing package consisting of the **Sentencing Act 1995**, the **Sentence Administration Act 1995** and the **Sentencing (Consequential Provisions) Act 1995** which came into effect in November 1996. The sentencing package consolidated existing sentencing provisions, provided a wider range of sentencing options, clarified the effect of sentences and simplified the sentencing process. It also facilitated the administration of sentences.*

- The **Sentencing Act** abolished sentences of three months or less, provided that sentences of imprisonment by Justices of the Peace must be reviewed by a Magistrate within three months, requires the court to set a commencement date so that time spent on remand may count towards service of the sentence, and requires written reasons for sentences of less than three months.
- A review of remission and parole was commissioned by the Attorney General in 1996 under the chairmanship of the Chief Judge of the District Court, Judge Hammond.
- The **Sentence Administration Bill** and the **Sentencing Legislation Amendment and Repeal Bill** were recently introduced into Parliament. These two pieces of legislation provide a clear, consistent sentencing regime that the public will be able to understand, make the courts more accountable and consistent in sentencing, and give Parliament more control over sentencing. This legislation also provides for a review of the **Sentencing Act**.
- The Ministry of Justice is also currently arranging for an interim review of the **Sentencing Act**. Expressions of interest will shortly be sought from the private sector. This review will examine the operation of the Act, and in particular how key stakeholders view important aspects of the Act such as the introduction of suspended sentences, the general abolition of prison sentences of three months or less, etc.
- The Attorney General gave the Law Reform Commission of Western Australia a reference to review the criminal and civil justice system and make recommendations for a more accessible, less complex, more efficient and more cost effective system of justice. The Commission is due to report by 30 April 1999.
- The Government has made a commitment to provide sentencing statistics. The Ministry will commence publishing quarterly statistics early in 1999. These statistics will include data on offences, sentence types and sentence length. Initially, these statistics will relate to the Higher Courts but will be expanded to include the Court of Petty Sessions and the Children's Court. This will provide sentencing information to judges and magistrates."

14.70 In my view, the above outcomes represent a reasonable response by Government to the Coroner's recommendations on the administration of justice issues which arose in Mr Metcalf's case, particularly the abolition of sentences of three months or less and the review by magistrates of decisions made by Justices of the Peace. I make only the following observations:

- The time taken to effect a number of the above outcomes is again disappointing. The provision of sentencing information, for example, was discussed internally by the then Department in December 1992, in response to the Coroner's findings. It took over six years to get to the point where the relevant statistics will be available to judges and magistrates.
- In light of Mr Metcalf's personality difficulties, eccentricities, and itinerant and isolated lifestyle, it is questionable whether prison was the most appropriate place for him to be kept while in custody. The only alternative which was tried at various times was Graylands Hospital, where it was concluded that there was insufficient evidence to substantiate a diagnosis of mental illness. The only other reference to post-release care for Mr Metcalf was a reference by the Coroner to an expression of hope by the consultant psychiatrist that Mr Metcalf might be contacted after his release and receive ongoing treatment for his condition from a community based clinic. Obviously, that did not take place but it raises a general concern about how society deals with people in Mr Metcalf's situation and what resources are made available by Government for that purpose.

- 14.71 It is worth mentioning that staff of the department obviously felt somewhat aggrieved at the Coroner's reference to Mr Metcalf's death arising from "*want of care*." An internal report to the Director of Prison Operations suggested that "*the prison was perhaps the most caring influence in this man's life and although there is no evidence to this effect, there is some thought amongst prison circles that he committed suicide at the thought of the prospect of leaving the prison – a syndrome commonly referred to as 'Gate fever'.*" I am not prepared to dismiss this suggestion. However, it is a sad comment on society, in my opinion, if prison is the best it can offer people such as Mr Metcalf.
- 14.72 The Coroner also expressed some concern over the fact that Mr Metcalf had been arrested on one occasion under section 65(1) of the *Police Act*, for the offence of having "*no visible or lawful means of support.*" Mr Metcalf subsequently failed to satisfy the single Justice of the Peace who heard his case that he had a means of support and was sentenced to six weeks imprisonment. The Coroner questioned the appropriateness of such an offence and whether the imposition of a fine or a term of imprisonment would alleviate the situation complained of. He noted that the Western Australian Law Reform Commission had recommended repeal of the sub-section of the *Police Act*. I understand that new legislation to replace the *Police Act 1892* has been in the course of preparation for several years and that it is possible that section 65(1) will be repealed and not replaced in the new legislation. However, as the new legislation has not yet been introduced into Parliament, the repeal of this provision is by no means certain. I can only voice my support for any consideration of that repeal.

Sentence calculation

- 14.73 Although the Coroner acknowledged that "*Where a person has been sentenced in respect of a number of offences, the calculation of the release date may be complex and difficult*" he concluded that Mr Metcalf "*...was detained for one day short of 12 months when he should have been free, and that the Department should have been aware of that fact.*" The Coroner's view was that the country Court of Petty Sessions had no jurisdiction to deal with the charges against Mr Metcalf of escaping legal custody and that those proceedings should have been nullified. To further complicate the matter, the administration at Casuarina Prison misinterpreted certain aspects of Mr Metcalf's sentence and wrongly calculated his release date as 3 January 1992. Prior to the Coroner's inquest, a Legal Officer within the department recalculated the release date as being 28 December 1991. Mr Metcalf died on 27 December 1991. As the Coroner commented, "*No one will know what the deceased would have thought had he been informed that he was to be released on the following day, 28th December 1991.*"
- 14.74 In its response to the Coroner's findings, the then Executive Director reported to the Attorney General in March 1993 that there was a "*...dire need for a Sentence Calculation Unit located in Perth where there is access to legal advice*". He added that the department was in the planning stages of setting up such a Unit and I am aware that it has been operational for some time now. As part of this inquiry, I wrote to the Ministry seeking information about the procedures which were in place to ensure that sentences are correctly calculated. Its response confirmed that the Unit was established in 1993 and described its method of operation. It also advised that "*In a recent audit by the Office of the Auditor General the Sentence Information Unit was found to have a 100% accuracy rate in regard to its [sic] data entry and sentence calculation details*" the audit being a random sample of current prisoners.
- 14.75 However, I am aware that periodic reviews of long term prisoners by the Unit have discovered two miscalculations in sentences, which have been to the detriment of the prisoners concerned, both of whom transferred to Western Australia under the provisions of the *Prisoners (Interstate Transfer) Act 1983*. One of the errors was actually made before the Unit was established and was discovered by the Unit; the other was made in 1994 and discovered in 1997. Since the latter incident, a verification function has been introduced by the Unit, and I am now reasonably satisfied that procedures are in place to prevent a recurrence of that situation. Despite the above two errors, I am satisfied that the Ministry has responded appropriately to the issue of sentence calculation.

REPRESENTATION OF FAMILIES AT INQUESTS

- 14.76 In recognition of the importance of families of deceased prisoners being legally represented at coronial inquiries - to become better informed about the circumstances of death and to raise issues of possible concern - the RCIADIC recommended in **Recommendation 23**:-

“That the family of the deceased be entitled to legal representation at the inquest and that government pay the reasonable costs of such representation through legal aid schemes or otherwise.”

- 14.77 The Ministry responded in the 1995 Government of Western Australia Implementation Report that:-

“This recommendation is supported in principle as the Coroner’s Act provides that any person who in the opinion of the Coroner has sufficient interest in the subject or result of an inquest may appear at and be represented by a legal representative at the inquest.

Such persons may apply for legal aid in the usual manner through the Legal Aid Commission or ALS and it is a matter for those agencies to decide if such aid will be given.”

- 14.78 The “*status of implementation*” in 1995 was reported as:-

“Implemented – the Coroner’s Bill will enable the family of the deceased to be represented. Such persons may apply for Legal Aid in the usual manner through the Legal Aid Commission or ALS.”

- 14.79 In spite of the Ministry’s response, of the 32 inquests held into the deaths of prisoners between June 1991 and May 1998 considered by my Office in the course of this inquiry, the family of the deceased was not legally represented in 21 cases; representation was provided by the ALS in only five cases and by other members of the legal profession - usually *pro bono* - in the remaining six cases. The Ministry and its employees were represented in all cases.

- 14.80 I sought clarification of the current situation from both Legal Aid Western Australia and the Aboriginal Legal Service (the ALS) and was disturbed to find that it is the view of Legal Aid WA that assistance for representation at inquests is presently, and has **always** been, outside its guidelines for approval except where it is likely that the applicant may be the subject of criminal charges or a civil action or could derive a significant benefit from the outcome of the inquest. These circumstances clearly do not apply to the families of deceased prisoners.

- 14.81 The ALS advised me that although it has opened a large number of files regarding deaths in custody since February 1991, its 1994 request for additional funding to be able to represent the families of deceased Aboriginal prisoners to date remains unanswered by government.

- 14.82 Although I am aware that it is possible - and encouraged - for the family of a deceased prisoner to raise issues and put questions through Counsel Assisting the Coroner at an inquest, this does not, in my view, offer the family the same ability to question the actual treatment of a prisoner prior to his or her death as would representation by their own counsel.

- 14.83 From my examination of the Ministry's files relating to deceased prisoners it become clear that in a number of cases concerns about a prisoner's management were identified by the Ministry with the expectation that it would be criticised by the Coroner. However, these issues were not explored during the subsequent coronial inquiry. For example, the then Director, Health Services stated in relation to the death of Paul **Vincent** in 1992 that he expected the Coroner to be critical of the standard of care provided to him. This did not occur. Similarly, the Ministry's concern that it would be criticised for failing to conduct a psychiatric review of Shane Hitchcock, who died in 1993, does not appear to have been considered at the inquest. I cannot, of course, express any view about how the particular inquests were conducted or whether evidence was given which would have justified comment about or criticism of the Ministry.
- 14.84 Nevertheless, I cannot agree that **Recommendation 23** has been implemented. It is apparent that reliance on the ALS or Legal Aid Western Australia to represent or fund representation for all families is illusory - those bodies simply are not funded for the purpose and the approval guidelines will almost never be satisfied. Representation of most families of deceased simply will not occur unless some alternative arrangement is made.

RECOMMENDATION 14.5

That the Ministry reconsider its response to RCIADIC Recommendation 23 and accept an obligation to make funds available - to the families of deceased prisoners directly or to legal aid organisations - to enable legal representation at inquests in all cases.

SUMMARY OF RECOMMENDATIONS

- 14.1 (a) That the Ministry of Justice respond to the Parole Board's request for additional resources as soon as possible. In particular, the Parole Board should be resourced so that it can provide detailed reasons for its decisions to prisoners; and
- (b) that, with a view to maximising the effectiveness of the Ministry's assessment process for prisoners, the Board and the Ministry review:-
- how the Board's expectations about what prisoners should be required to do during a sentence can be better understood by the Ministry; and
 - the nature and extent of programs to be offered by the Ministry and the timing of their delivery.
- 14.2 That the Ministry and the Parole Board review the procedures by which Board decisions and other correspondence from the Board are conveyed to prison staff and to prisoners to ensure that:
- (a) prison personnel are aware that the prisoner is to receive a decision or correspondence from the Board;
- (b) a prison officer personally delivers the correspondence or oral advice to the prisoner, thereby having the opportunity to observe the impact of the advice on the prisoner; and
- (c) the records of both the Board and the prison document whether information about decisions or other correspondence has been conveyed to and received by, the prison and the prisoner in every case.

- 14.3** That the Ministry and the Parole Board institute a review of available data, current assessment procedures and eligibility criteria to determine whether female Aboriginal prisoners and Aboriginal prisoners generally are, or are likely to be, disadvantaged in relation to parole and work release orders respectively. Action to rectify any imbalance found should be taken, including the reconsideration of any legislated eligibility criteria.
- 14.4** That the Ministry:
- (a) review the procedures followed in all Western Australian prisons to determine the level of knowledge officers have of the requirements of the *Bail Act* and the working arrangements between prison officers, police and Justices of the Peace;
 - (b) ensure that the requirements of the *Bail Act* are being complied with, in practice, in all prisons; and
 - (c) complete the review of the *Bail Act* as quickly as possible.
- 14.5** That the Ministry reconsider its response to RCIADIC Recommendation 23 and accept an obligation to make funds available - to the families of deceased prisoners directly or to legal aid organisations - to enable legal representation at inquests in all cases.

¹ *The Queen against the Parole Board ex parte Michael Wayne Forbes* (960732 19 December 1996 at page 9)

² See also paragraph 14.60 for comments on the *Acts Amendment (Video and Audio Links) Act 1998*.

CHAPTER 15 PRISON LIFE - ADMINISTRATIVE ARRANGEMENTS

ATTITUDES TO IMPRISONMENT AND TREATMENT OF PRISONERS

PRISONER AND PRISON OFFICER RELATIONS

UNIT MANAGEMENT

PRISON DISCIPLINE AND PUNISHMENT

PRISONER COMPLAINTS AND GRIEVANCES

TRANSFER OF PRISONERS

VISITS TO PRISONERS

SUMMARY OF RECOMMENDATIONS

- 15.1 Throughout this Report references have been made to many aspects of prison life that in some way or another can impact on the care and welfare of prisoners. In this chapter a number of other aspects of prison life and the administrative practices and procedures that are employed in prisons are considered. Integral to all this is an understanding of how prisoners and prison life are perceived from various points of view - and the starting point for that exercise is how “*the community*” appears to view prisoners.

ATTITUDES TO IMPRISONMENT AND TREATMENT OF PRISONERS

- 15.2 Most people who made submissions to me perceived that governments generally were not committed to addressing the social causes of crime and that the community is increasingly calling for tougher punishment for criminals. With regard to the former, a chaplain submitted that the long term solution is early intervention in families at risk, but governments are reluctant to do so because it does not generate immediate results and no-one ever looks at why a person breaks the law in the first place or tries to prevent young people from going to prison. With regard to punishment, most comments I received acknowledged that prison may well be the only place for people who commit violent crimes. However, in many other cases, tougher punishment was “...akin to burning of the witches to solve the problem of poor crop performance,” as one prisoner put it. That prisoner commented that prison is not a solution to crime and that the present system actually increases the criminal potential of the inmate. A prison psychologist agreed, saying that some prisoners have preferred to use prison as a training ground in criminal life skills and future “*business*” contacts.
- 15.3 Numerous prisoners and others expressed a strongly held view that prisoners must be treated as human beings deserving of rehabilitation, arguing that greater attention should be paid to first time prisoners in terms of induction and orientation, access to peer support prisoners, and segregation from long term, violent prisoners. It was also said that the prison system should be productive in terms of giving prisoners opportunities for resocialisation, education and rehabilitation, with long term prisoners being assisted on an ongoing basis, rather than being neglected and ignored for long periods. The prisoner quoted in the preceding paragraph also commented that “*It is rare to find a prisoner who leaves the institution with the social, educational skills or vocational training and emotional well being suited to finding accommodation, employment and the social skills to fit back into society.*” He also quoted from an article entitled *A Vision for Criminal Justice:-*

“In Sweden, there is recognition that those who must be sent to prison are there for a limited period, that they still continue to be members of society, and must be prepared for effective re-entry into that society. For this reason, all prisoners have the availability of professional treatment, the right to a weekly conjugal visit with their wife or husband, and, for all except the highest security inmates, frequent access to temporary leave from prison after the first half of their sentence is completed.”¹

- 15.4 The following selection of comments by prison chaplains are, in my view, worth quoting:

- *A humane, compassionate and just system is the only way to rehabilitation and change;*
- *If imprisonment is to be used, and for some few it is necessary, each prisoner should have a rigorous daily programme of work, education, sport, craft, counselling, to be offered on many levels according to the needs of the individual;*
- *I am concerned that imprisonment is not being used as a last option, but as the ultimate answer, knowing that more creative, cheaper and beneficial alternatives could be used. The present system is based on retribution and punishment and is an abject failure because it guarantees a high re-offending rate, it perpetuates an anti-social culture, it fails victims as no one is satisfied, and it is expensive to the taxpayer;*
- *I quote the Catholic New Zealand Bishops who described imprisonment as an affront to human dignity, responsible for destroying partially or totally, temporarily or permanently, those confined. They found it hard to imagine a more destructive or wasteful method of spending public funds.*

- 15.5 As noted elsewhere in this Report, there was a widely held perception (shared by many prison staff) that there are increasing numbers of older and mentally unstable prisoners, yet resources to deal with them seem to be diminishing and alternatives to prison are not being explored. Prisoners who are management problems are frequently treated in a repressive manner rather than by efforts to assist them to address their underlying problems.
- 15.6 According to some longer term prisoners, ill-founded and “*foolish*” policies - such as the twelve-hour shifts for prison officers - have been introduced over the years and have not been reviewed. Some prisoners expressed the view that prison officer numbers have increased disproportionately to prisoner numbers, but that this had not led to overall improvement to the system. They suggested that the Ministry has suffered from complacency and a lack of leadership and accountability from the very top, and has become an unbalanced and top-heavy bureaucracy.
- 15.7 It was also argued that change to the whole system is needed because staff and prisoners are being systematically ‘ground down.’ Conditions were said to have deteriorated over the years as evidenced by increased incidences of assaults, rapes, deaths, the numbers of paedophiles in prison, and the use of drugs. Doubts were expressed as to whether the Government was meeting internationally recognised standards and covenants and whether it had implemented many of the recommendations of the RCIADIC. Submissions stated that there is an urgent perceived need for a complete review of all prisons from the perspectives of administration, health and welfare. The prisoners’ support group, PASS, submitted that prisons clearly do not reduce crime. Its view is that the culture is one of “*systemic brutalisation*” in which there are “*...horrific accounts of blatant abuse...emotional traumatising and unforgivable neglect.*”
- 15.8 Whatever one may think about the merits of the individual points of view summarised above, it cannot be denied that the persons who have expressed them have, in virtually all cases, experienced prison life personally in one way or another - whether as a prisoner, prison staff member, chaplain or the member of a prisoner’s family. I was impressed by the sincerity of all those who shared their experiences with me and my investigating team and have no doubt that, for them, the perceptions are indeed their realities.
- 15.9 I have to say that I agree with many of the comments and views expressed to me along the lines of those above. However, in my opinion the total picture is not as bleak as those views would suggest. There are many fine people working within prisons and with prisoners, who have been able to achieve much in terms of prisoner welfare and rehabilitation - sometimes against considerable odds. It must also be acknowledged that many prisoners are ready to give credit to those people. Prisoners are, on the whole, very demanding “customers” - but quite a few were prepared to acknowledge the efforts and achievements of those who work within the prison system and who are prepared to deal with prisoners “as human beings.”
- 15.10 The issue of whether prisoners should have the benefit of a statement of “rights” – which would better define their minimum entitlements has been debated both nationally and internationally.
- 15.11 The standards which correctional authorities in Australia should meet are contained in *Australian Standard Guidelines for Corrections*. In its **Recommendation 329**² the RCIADIC recommended that these guidelines, containing a statement of rights for prisoners, should be given legislative effect.
- 15.12 The Royal Commission suggested that in legislating a statement of prisoner rights consideration should be given to the Victorian *Corrections Act*, which sets out in section 47 a list of fifteen rights to which every Victorian prisoner is entitled – ranging from the right to be in the open air for at least one hour per day (s47(1)(a)) to the right to take part in educational programs (s47(1)(o)).

- 15.13 The Western Australian Government's 1995 Implementation Report in relation to Recommendation 329 records that the recommendation was "*Not implemented. Conference of Correctional Ministers determined not to implement by way of legislation.*"
- 15.14 It is clear that many aspects of prison life in Western Australia - such as the ability to receive visits; to make telephone calls; to have certain items in one's cell; to participate in educational or other programs; or to purchase items through the prison canteen – are regarded only as privileges by prison managers and staff. As such they can be, and frequently are, taken away from prisoners by prison staff without any, or sufficient, process to determine whether the removal is justified or necessary.
- 15.15 It seems to me that the major advantage of having a statement of prison "standards" and prisoner "rights" incorporated in legislation is that they would be taken more seriously. Prisoners would be better informed about the nature of their "rights" and those who may wish (perhaps for very good reason) to take away the rights in a particular case would be required to adhere to procedures prescribed in the legislation (or subordinate legislation) for doing so.
- 15.16 The Ministry has advised me that a recent review of the Western Australian *Prisons Act* did not support the concept of legislated rights and standards. In my opinion that is unfortunate.

RECOMMENDATION 15.1

That the Ministry reconsider its position regarding RCIADIC Recommendation 329 and consider incorporating a statement of prisoner rights into the *Prisons Act*.

PRISONER AND PRISON OFFICER RELATIONS

- 15.17 I have touched on the important and difficult role that prison officers can and should play in the identification and management of prisoners who are at risk of self harm in Chapters 10 and 11 of this Report. This chapter considers more generally the issue of the relationship between prisoners and officers and some of the factors that can get in the way of a healthy relationship.
- 15.18 This subject inevitably generates somewhat emotional responses from those who feel strongly about it. To my mind, this strength of feeling serves only to underline how central the issue is to the 'health' of the prison environment. A prison in which there is a good working relationship between prisoners and prison officers will be a far more normal and healthy place for all concerned. Conversely, where that relationship does not exist the prison environment will be characterised by management, disciplinary and health problems - for both prisoners and staff alike.
- 15.19 In my opinion the RCIADIC "put its finger on" the issue well in its **Recommendation 182**, which states:-
- "That instructions should require that, at all times, correctional officers should interact with prisoners in a manner which is both humane and courteous. Corrective Services authorities should regard it as a serious breach of discipline for an officer to speak to a prisoner in a deliberately hurtful or provocative manner."*
- 15.20 I agree with that recommendation in that it identifies the need for interaction that is humane and courteous - and that it should be regarded as a serious disciplinary offence if that requirement is not met. However, it seems to me that, although the objective of courteous and humane interaction is obviously desirable, it is highly unlikely that it will be achieved only – or primarily - by a threat of a disciplinary sanction. Such a threat would only achieve the behavioural outcome sought if the chances of every

breach being detected and the offending officer being dealt with accordingly were overwhelming. In a prison environment, where the balance of power relationships and credibility of individuals are by no means equal, this will simply, in my opinion, never be the case.

- 15.21 The Ministry responded to RCIADIC Recommendation 182 in the 1995 *Government Implementation Report* by stating that it had been implemented through section 13(2)(d) of the *Prisons Act*, which contains an officer's oath of engagement and includes the phrase "*I will deal with prisoners fairly and impartially.*" I am unwilling to accept that this section of the Act alone is an adequate response to Recommendation 182. Obviously, such an oath can be important in emphasising to new prison officers that courtesy, humanity, fairness and impartiality are essential attributes that must underpin the prisoner/prison officer relationship. What is needed, in my opinion, is that prisoners and prison officers must actually *want* to deal with each other with humanity and courtesy. That can only occur when prisoners and prison officers are able to have a necessary degree of mutual respect (even if not affection), confidence and trust in an environment and culture that expects and supports those qualities.
- 15.22 I believe that it is possible to achieve that state of affairs in a prison - indeed some prisoners told me that it is achieved in some parts of the system. One prisoner submitted to me that, in general;
- "...officers treat you as you treat them. If you don't give them any trouble, they are more likely to be more friendly to you. Don't be confrontational and they won't either (though some will be more distant and firm than others). Don't try to rot the system and you will get more free space. Don't put tension into the system and the system will be more relaxed about you."*
- 15.23 Another prisoner commented that, provided an individual prisoner behaves well and adheres to the rules, the relationship with officers is one of mutual respect and objectivity, in which the majority of officers behave in a compassionate, considerate, helpful and understanding manner.
- 15.24 I was pleased to receive those comments because they provide a degree of balance to the very many other submissions and comments made to me in which a much more negative picture of prisoner/prison officer relationships was painted. A sample of comments is set out below. I should say that I have not attempted to establish whether the particular allegations are true because it would be impossible to do so with any degree of certainty. I do not, therefore, make any assertion that they are true and I am not suggesting in any way that the following comments are typical of the majority of prisoner/prison officer relations. I am, however, of the opinion that the type of interactions which they describe represents the attitude of a *small* number of prison officers at *some* prisons. I also have no reason to doubt that the situations described were believed to be true by the persons drawing them to my attention.
- A number of prisoners asserted that some officers 'harass' prisoners. They are alleged to make inappropriate and inflammatory remarks to 'stir up' prisoners, often at times when prisoners are most vulnerable, such as when they have received bad news or when they have relationship or family problems. These prisoners claim that such officers impart no feeling that they genuinely care about the welfare of prisoners. On the contrary, they appear to take a perverse pleasure in playing "*mind games*" with prisoners in order to make life more difficult. Several prison officers (including one Assistant Superintendent at a metropolitan prison) told me that they agreed that complaints of this kind about a relatively small minority of prison officers were justified. The Assistant Superintendent told me that by looking at the daily roster of prison officers on duty he could reasonably predict whether there would be "*problems*" in the prison that day.

- Submissions alleged that one of the ways that prison officers could ‘stir up’ prisoners was by divulging confidential information, or deliberately giving misleading information about a prisoner, to other officers or prisoners. Several prisoners (and officers) gave examples of officers who, while censoring incoming mail, would read parts aloud to other officers in order to embarrass a prisoner. A person who has had a long involvement with prisoners and their families through a church included the following anecdote in a submission:

“A mother was writing to her son. He was a first offender. She ended her letter ‘No matter what, you will always remain my little boy.’ The officer handed the letter with the words ‘So you’re Mummy’s little boy, are you?’ and an accompanying sneer. That man told his mother never to write to him again. It’s remarks like that and ‘you’ll be back’ as a repeat offender leaves prison which add to the cruelty of life ‘inside.’”

- Several prisoners and programs staff told me that there had been occasions when some officers ridiculed prisoners who attend programs and personal development courses - which is obviously extremely unhelpful. Some staff members told me that they had the impression that some officers were apathetic about, and non-supportive of, the value of education for prisoners and that some officers would not release prisoners from their workplace to attend programs. A programs staff member also relayed feedback from some prisoners that they continually got no response from officers when they made requests to see individuals or agencies who could assist with particular concerns. It was the staff member’s view that lack of supportive interaction with prison officers was one of the main causes of prisoner frustration.
- Two alleged incidents were cited to my staff by prisoners:-
 - A prisoner asked how long he would be kept in a particular cell. The answer given by a Superintendent was *“I f—g own you now. You’re mine until I say different and you’ll do as you’re told.”*
 - Remand prisoner to officer - *“Excuse me, can I ask you a question?”*. First officer - *“No, f— off?”*. Prisoner - *“You can’t speak to me like that?”*. Second officer, who was adjacent - *“Yes he can, because he’s a gentleman and you’re just a c—. Now f— off.”*
- A prisoner complained to me that he had needed, but could not get, help to deal with certain psychological problems that were preventing him sleeping. In desperation he had attempted to speak to a prison officer on the night shift about his problems but was allegedly told by the prison officer - *“I think you are mistaking me for someone who gives a shit.”*

That prisoner subsequently escaped from the prison to gain the help he believed he needed, leaving behind a letter (which I confirmed did exist) explaining the above reason for his escape.

- A prisoner alleged that a prison officer had abused and threatened him, saying *“I’ll drive you crazy until you slash up or neck yourself and I will put you in observation.”*

I received a report about the incident from the Ministry which, in my opinion, failed totally to address the substance of the allegation. I informed the Ministry (in November 1999) that its response:-

- made no reference to the existence of potential witnesses known to the Ministry;
- made no reference to the fact that one of those witnesses had (to the knowledge of the Ministry officer investigating the complaint) corroborated the prisoner’s allegation; and
- failed to address the merits of the allegation.

The Ministry informed me that it would investigate the incident further, but no further advice has been forthcoming. The matter continues.

15.25 Other similar allegations could be cited, but it is not necessary to labour the point. What is important is that senior prison officers, prison managers and senior Ministry executives have told me that they accept that a proportion - unquantified, but thought to be a minority - of prison officers are unable and/or unwilling to interact with prisoners in a constructive and beneficial way.

15.26 In response to the dot points in paragraph 5.24 and on the general issue of prisoner/prison officer relations, the Ministry provided the following comments:-

“The allegations clearly indicate purported inappropriate behaviour on the part of officers. There is also reference to the ‘insensitivity’ of officers, and to case studies of prisoners placed in medical observation cells.....”

These statements together with other statements in the report, collectively depict prison officers as generally behaving inappropriately and in non-supportive ways with prisoners as well as not having appropriate skills.

The Ministry is of the view that it is neither accurate nor beneficial to the future of the prison system to depict officers in this manner. It is accepted that some prison officers may not consistently have appropriate and supportive interactions with prisoners. However, it is not considered reasonable for the inference that prison officers, in general, do not have appropriate and supportive interactions with prisoners, to remain in the report.”

15.27 To avoid any doubt, I emphasise that it is not my wish to portray all prison officers in a negative light. As this and other chapters of this Report make clear, many prison officers and other prison personnel do their utmost to deal with prisoners positively, many are good at it – and their efforts are, on the whole, appreciated by most prisoners. I believe that this Report represents a balanced view of the good and not-so-good aspects of prisoner/prison staff relationships. What cannot be overlooked, however, is that incidents do occur that, rightly or wrongly, are perceived to be caused - or at least aggravated by – inappropriate staff conduct. The Ministry acknowledges as much.

15.28 Although the making of a complaint about a prison officer does not, of course, mean necessarily that it is justified, it is worth noting that in the four years to June 2000 the number of allegations raised in formal complaints received by my Office that are categorised as alleging “harassment by prison officers” rose from 52 in 1996/97 to 113 in 1999/2000.

15.29 I am well aware that the dynamics of the prison officer ‘culture’ have been subjected to significant and pivotal changes in the past two years. However, it is clear to me that it will be some time before those changes erode the fixed ideas on how prisoners should be managed apparently held by some prison officers – and, I might add, by certain sections of the community.

15.30 Whatever the deficiencies in the system might be, however, it would not be fair to place all the responsibility on the shoulders of prison officers. It is equally clear, in my opinion, that the Ministry has been remiss for many years in not establishing an infrastructure, appropriately and adequately staffed, based on ‘best practice’ operational practices and systems and an ethic of continuous improvement.

UNIT MANAGEMENT

- 15.31 The failings of the Ministry in this context are best illustrated by what I consider to be the abject failure of the concept of unit management in the State's prisons. This concept was embraced in Western Australia during the 1980s. A typical description of what is meant by the concept is:

“A prisoner management system which involves constructive interaction between prison officers and prisoners. It provides a more normal living and working environment for both groups. Under Unit Management the muster of a prison is divided into groups which are managed by a Unit Manager and a team of officers for an assigned period. Constructive interaction between officers and prisoners involves the use of interpersonal, custodial and case management skills within a framework of delegated decision making power and authority.”

- 15.32 The Ministry cite the principles of Unit Management as the means by which the welfare needs of prisoners would be met in its response to a number of welfare-orientated recommendations of the RCIADIC, namely:-

- **Recommendation 122** - duty of care generally;
- **Recommendation 174** - employment of Aboriginal welfare officers;
- **Recommendation 179** - simplification of procedures for dealing with prisoners' requests.

In addition, it would seem apparent that the “*constructive interaction*” component of Unit Management would be integral to the implementation of the RCIADIC **Recommendation 182** - interactions with prisoners to be courteous and humane.

- 15.33 The Ministry did not support Recommendation 174 because “*in prisons, welfare services are provided by prison officers.*” In response to Recommendation 179, the Ministry stated that:-

“Unit management principles are important in the content of the implementation of this Recommendation. These principles emphasise the need for higher levels of interaction between prisoners and officers (and provide the opportunities for those higher levels to develop familiarity and trust by having prisoners and officers in various stable groups). Additionally, each prisoner has ready access to the Unit Manager.”

- 15.34 It is clear that, under the principles of Unit Management - as it was expected to operate - prison officers were required to interact with prisoners in order to assess their welfare needs and to assist them in addressing concerns about such things as family matters, safety conditions, difficulties with visits or telephone calls, and so on. That is not to say that prison officers were expected to be able to resolve personally every matter of concern to prisoners, but they would be expected to know what external resources (whether in other parts of the prison system, or external to it) were available to assist a prisoner to resolve problems.

- 15.35 There was almost complete unanimity amongst prisoners, prison officers and prison administrators that the concept of unit management is a good one in theory but that it was doomed to fail and, in reality, was never really given a serious chance of succeeding. However, depending on whom one asks, the reasons why this might be so vary considerably. Some of the factors put forward as contributing to the ‘inevitability’ of failure were as follows:

- prison officers were not assessed for their suitability to perform a welfare role;
- more importantly, prison officers never received any significant training to enable them to take on the welfare role successfully. Consequently, many prison officers found it very hard to make the transition from a role where the main function was to “*turn keys*” to one where a vital function was to build relationships with prisoners;
- the increasing prisoner numbers during the 1990s, with no corresponding increase in the number of prison officers and other staff, meant that there were never enough prison officers to perform the expected role;
- the changing nature of the prisoner population - and changes to the type of persons recruited to be prison officers - meant that there were many prison officers who lacked confidence in their ability to interact with prisoners. It was argued that many officers were afraid of prisoners and, hence, were far more likely to resort to authoritarian methods of management and were too ready to charge prisoners with disciplinary offences or use restraint measures to deal with insignificant situations;
- some prison officers and prisoners argued that in the existing culture of division between officers and prisoners (“*the khaki and the green*” as it is referred to) which exists in Western Australian prisons, it is unreasonable to expect a prison officer to combine the welfare and the disciplinary roles;
- with the introduction of 12-hour shifts and the rostering arrangements which accompanied that change, officers rarely spend more than three consecutive days in one place. This means that prison officers are frequently unable to spend sufficient time in a Unit to enable good relationships to develop and it was a constant source of complaint from prisoners that it was impossible to find an officer who would be around long enough to resolve a problem;
- as a corollary of the rostering changes referred to above, it was argued that an increasing number of prison officers have chosen to regard their job as a part-time one - with many having a second occupation and, consequently, considerably less interest in, and commitment to, the prison officer’s role; and
- the Ministry has made no meaningful attempt (except in very recent times) to in any way monitor or enforce the underlying expectations of Unit Management.

15.36 I have no doubt that there is validity in all or the vast majority of the above comments to a considerable extent and that such factors - and probably others - will have contributed to the failure of Unit Management. The Ministry has advised me that it disagrees with the view that unit management has been “*an abject failure*”. In my opinion, however, it is fair to say that the concept simply did not work – except in one prison referred to below. I believe that was partly because nobody within the Ministry - at all levels – appeared to take much interest in whether it worked or not. There was certainly no attempt to evaluate the system and therefore no steps were taken to address shortcomings in the way it was operating in practice. The fact that ‘Head Office’ was out of touch with the ‘coal face’ was a common theme in submissions to my inquiry. Ultimately, it is difficult to conclude that the introduction of unit management improved conditions for either prisoners or prison officers or interactions between them. Moreover, in my opinion, to the extent that other prisoner support mechanisms (such as welfare officers) were withdrawn in favour of Unit Management, the situation may have actually contributed to the deterioration in prisoner/prison officer relationships.

- 15.37 Throughout this Report reference has been made to situations where “the system” failed to identify prisoners at risk or failed to manage identified risks. In my opinion, there is little doubt that a lack of “*constructive interaction*” between prisoners and some prison officers has been a contributing factor to prisoner deaths and self harm. As I have stated elsewhere in this Report, it is also my view that some prisoners who have been identified as at risk of suicide or self harm have been placed in medical observation cells because it is an easier option than sitting down and talking to a prisoner to establish what was the cause of his/her distress.
- 15.38 The Ministry has also told me that it acknowledges “*that unit management works at different levels at different prisons.*” I agree and in making the observations in the preceding paragraphs it is not my intention to devalue the good work done by the majority of prison officers and other staff members who are both willing and able to relate to prisoners well and who assist prisoners in many ways. In particular, I believe that it is appropriate to mention specifically Albany Prison - which has been acknowledged as the ‘shining light’ in an otherwise very dull landscape, despite being a maximum security prison with some of the most serious offenders.
- 15.39 I received a number of submissions specifically about Albany. A prisoner wrote that, in his opinion, the Unit Management system had failed at Casuarina but worked well at Albany. He stated that:-
- “...staff at this prison can and do perform extremely well in the ‘Unit management’ role and go out of their way to help prisoners with personal problems...On a whole, both prison staff and prisoners live and work in a positive environment. The prison staff are thoroughly professional in their approach to dealing with prisoners and the problems that they may be having. Unlike Casuarina, if a prisoner has a genuine personal crisis here, the staff act on it promptly and are not indecisive...In this manner, possible major crises 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 prisons will drop dramatically.”*
- 15.40 Other prisoners told me:-
- “*Albany jail is one of the best in WA...more laid back officers don’t give you so much of a hard time?*”;
 - the officers at Albany are “*human*”;
 - the Superintendent cared for the wellbeing of prisoners and had implemented a duty of care and a higher standard of compassion among the staff which meant that officers were willing to listen and to try to help prisoners in need;
 - Albany had a culture of “*togetherness*”, in contrast to other prisons where the general attitude was one of ‘them and us’;
 - officers exhibit understanding, flexibility and responsiveness, and new officers have to adapt to that way of operating;
 - there do not seem to be any officers who actively promote trouble among the prisoners or subject individual prisoners to pressure;
 - unlike other prisons, there are two hourly checks at Albany throughout the day and the night;
 - “*Many officers working in residential areas come out of the security of their office to share in recreation and play sport with the prisoners and to engage them in ‘small talk’ which establishes a friendly atmosphere where there is less paranoia and more trust, while enabling officers to be more likely to identify anyone at risk?*”;
 - Albany Prison is “*very well run...the officers were happy to talk to prisoners and vice versa. Older prisoners look after other prisoners and sort out problems, and peer support works really well.*”

- 15.41 An Albany Prison Visitor commented on the good management of the prison and the belief that the small number of deaths there is a reflection of the quality of the staff. A recent death there was, in the Visitor's view, a case of someone who couldn't live with the shame or consequences of his crime. He believed that "...most tellingly, prisoners feel able to talk to the staff without breaching the tacit rules of 'prison culture'." In other words, "...talking to the screws' does not automatically bring suspicions among fellow prisoners of being an informer." He also expressed the opinion that the wider sense of a stable community in Albany itself was reflected in the attitude of prison administrators and officers. He observed that the prison holds the highest percentage of prisoners serving life terms and sentences of over fifteen years, and that those prisoners tend to develop stable routines and to be the least troublesome.
- 15.42 During our visit to Albany Prison my staff and I observed a considerable difference in the prison environment compared to that of the major metropolitan prisons, and we agree with the comments expressed above. The situation raises the obvious question – can the factors which make Albany different from other prisons be identified and isolated? I have little doubt that a number of the following factors have contributed to the generally favourable opinion of Albany Prison:
- The prison is small enough for prisoners and officers to get to know each other. I was told by the former Superintendent that when it was first established as a prison many staff were recruited locally and (at least initially) the prison had many local prisoners. Consequently, there were many existing relationships and these were able to be maintained and a "culture" of inter-action between officers and prisoners established.
 - Unlike other prisons, there have been relatively stable prisoner and officer populations, with few changes at prison management level.
 - Prison management has insisted on a form of case management - whereby each prison officer is allocated several prisoners to manage, in the sense of preparing sentence plans and being accessible if the prisoner has problems.
 - Most importantly, in my opinion, prison management has insisted on the principles of Unit Management being observed. "Constructive interaction" has been the "Albany way" of running a prison and prison officers and prisoners have been expected to play their parts. Significantly, the prisoners appear to have been prepared to meet the prison management and officers half way - to the credit and, in my opinion, to the benefit of all concerned.
- 15.43 In my view the very complex and difficult issue of deaths in prisons requires an evaluation of not only what has gone wrong but also what seems to have been done right. In this respect, I believe that the situation at Albany Prison provides a model of a management style which seems to have worked to the benefit of all concerned - and the reasons why this may be so should not be lost.

RECOMMENDATION 15.2

That as part of its current internal review of prison deaths the Ministry commission an independent comparative study of the management of Albany Regional Prison and other prisons in order to identify any practices or other factors which should be more widely applied in the prison system.

- 15.44 The Ministry has recognised that it faces a formidable task in attempting to develop prisoner/officer relations to an adequate and 'healthy' level. As a first step it has developed the "*Integrated Prison Regime*" to "...*revitalising the concept and operation of unit management*" and is working on the introduction of a system of Case Management for prisoners as part of that regime. The "*Integrated Prison Regime*" will be introduced initially into five prisons and then across the system. The Ministry is well aware, however, that without constructive relationships between prisoners and officers, neither unit management nor case management will achieve the necessary improvements.
- 15.45 As part of the process the Ministry has contracted with a Canadian firm to provide both a Cognitive Skills Program for prisoners and a program of Interpersonal Skills Training for prison officers.³ Both of these are important, but overdue, steps in the right direction - and I am pleased that they will occur. In the light of these initiatives - reflecting as they do the Ministry's acceptance of the importance of "*constructive interaction*" and the need to address the shortcomings of the existing situation - I do not believe that it is necessary for me to make any other specific recommendations.
- 15.46 I will, however, observe that programs alone will not automatically guarantee achievement of the desired outcomes. Without the complete commitment of the Ministry at all levels - reflected in very clear statements of what is expected of prison personnel and systems and strategies to evaluate initiatives and highlight any deficiencies - the system will limp along as it has done in the past. With this proviso, I am optimistic that the initiatives already underway within the Ministry will change the system for the better.

PRISON DISCIPLINE AND PUNISHMENT

- 15.47 The ways in which prisoners can be disciplined or punished for prison offences is a very important feature of prison life in Western Australia. It is an issue which is acknowledged to be a significant cause of stress and distress for many prisoners. In the light of the comments made in this Chapter about the shortcomings of the relationships between prisoners and officers it is not surprising that many observers believe that officers are far too ready to resort to discipline and punishment of prisoners for matters that could and should be managed in a more positive and productive way. A phrase often heard in interviews during my inquiry was that prisoners are in prison "*as punishment*", not "*for punishment*", but many feel that this is not what happens in practice.
- 15.48 The *Prisons Act 1981* provides that a prisoner can be charged with the "*minor*" or "*major*" prison offences specified in the Act - which range from disobeying an order of an officer, being "*idle, negligent or careless*" in work or pretending injury, to assault, using drugs or possessing weapons. Prisoners charged with such offences are invariably dealt with by a "visiting justice" (of the Peace) - a "VJ".
- 15.49 Penalties which can be imposed by prison superintendents and VJs include separate confinement, confinement in sleeping quarters, restitution and, importantly, forfeiture of days of remission of sentence. In addition, a prison superintendent or officer can remove various "*privileges*" - such as contact visits, telephone calls, having electrical items in the cell, canteen spends etc. - by an administrative or management action. Such a penalty can be imposed without any form of "trial" or finding of guilt.

- 15.50 Prisoners are generally ready to accept punishment handed out by the superintendent or VJ if they believe that they deserved it. However, I received numerous comments - and receive many written complaints from prisoners - about the “*double jeopardy*” of the loss of privileges as well as the forfeiture of remission or other penalty arising from a prison charge. Prisoners seem unwilling to accept that the giving of privileges is a management option which can be taken away by the prison administration on suspicion of an offence, without a charge being laid or before it is heard. This is perceived to be another form of punishment, and one which can be imposed arbitrarily. The loss of privileges can also lead to “standover” tactics, where a prisoner who has lost canteen spends, for example, might bully another prisoner into giving up some of the latter’s purchases or property.
- 15.51 The withdrawal of contact visits (where prisoners and their visitors sit with each other at the same table) or the imposition of non-contact visits (where prisoner and visitor communicate by means of a ‘telephone’ through a window in a booth) causes much distress, particularly to prisoners who value receiving visits from their children. A further cause of stress is when a prisoner believes that a visitor is being harassed, perhaps by being targeted for strip searches. Prisoners have also told me of instances where a visitor has arrived at the prison only to be told that a visit has been cancelled for some unspecified reason, with resulting distress to all concerned.
- 15.52 There have been two deaths where the Coroner has commented on the significance of the loss of privileges for the deceased prisoner. James **Reynolds** (Remand Centre; June 1991), was classified as a high security prisoner and had been denied use of the prison oval. His visitors were strip searched prior to each visit and Mr Reynolds was strip searched after each visit. Mr Reynolds appealed to the Superintendent and to one of my predecessors for restoration of privileges but was unsuccessful. Other prisoners testified that Mr Reynolds became frustrated over these issues. The Coroner accepted that the loss of privileges caused distress to Mr Reynolds but he was unable to conclude positively that this factor was a determining cause in his decision to commit suicide.
- 15.53 In the case of Victorino **Vivas** (Wooroloo; July 1996), the Coroner expressed concern about the perceived double punishment imposed on Mr Vivas after he had been involved in an incident in which he refused to carry out an order of a prison officer. Mr Vivas was to be charged with a prison offence over the incident and was also removed from his shared room to dormitory accommodation - the loss of a significant privilege. The Coroner stated:-
- “While the deceased was clearly upset following a relatively minor dispute with a prison officer and a decision which had been made that he should be removed from his 2 Up Cell to the dormitory, those events at most could only amount to precipitating factors for his actions.”*
- 15.54 Nevertheless, the Coroner added the following rider to his findings:-
- “That while it is accepted that the housing of prisoners in different accommodation within a particular prison is a matter to do with the good management of the prison, where a decision is made to remove a prisoner from accommodation which is regarded as being of significantly higher standard than the accommodation to which the prisoner is to be placed as a result of disciplinary issues, a senior officer, before acting on the recommendation of a prison officer, should where practicable form an independent assessment of those issues in order to provide a check in the system and to ensure that the recommendation was reasonable in all of the circumstances.”*
- 15.55 The Ministry advised me in 1998 that the Coroner’s rider “*has been given effect from November 1996 with the adoption of the formal hierarchy system at Wooroloo. This requires review and discussion by the ASPM before any such loss of privileges can be implemented.*”

- 15.56 Some chaplains referred to the distress experienced by prisoners at times because of heavy-handed “punishment” for petty incidents, which frequently arose as a result of prisoners’ frustration over the difficulty in having simple requests met. The chaplains referred to a perception by prisoners that punishment was imposed on the basis of suspicion and innuendo and because officers were not prepared to listen to them. They commented on inconsistency in the reactions of officers, some of whom, they believed, “*made up the rules as they went along*”. I was told that some officers made little attempt to use conflict resolution, mediation or understanding to deal with a problem.
- 15.57 The regime for prisoners in punishment varies according to the nature of the offences and the superintendent’s discretion, but can include no smoking, no electrical items and no mattress or other furniture during the day. Some books and writing materials may be allowed but they are of little or no value to prisoners who are illiterate. I have been told by prisoners’ family members that prisoners in punishment are occasionally treated in a degrading manner, such as being left in restraints for far longer than necessary and having to eat meals off the floor while in restraints. I have not received complaints from prisoners or seen first hand evidence about the latter issue.
- 15.58 A number of submissions and interviews made reference to the punishment cells themselves, describing both the environment and the punishment regime as “*inhumane*” - some described the conditions as sufficiently inhumane to prompt some prisoners to contemplate suicide. These submissions questioned whether there was not a better way of dealing with prisoners who infringe prison discipline.
- 15.59 The effect of the use of separate confinement as punishment was considered by the Coroner in the case of Gregory **McIntosh** (15 July 1998; Albany) who had apparently expressed concern to other prisoners about being placed in separate confinement as punishment for a prison disciplinary charge. The Coroner said in his findings:-
- “While there is no reference to the deceased’s concerns about solitary confinement contained in the suicide note discovered in his cell after his death.....in the light of the significant number of occasions on which the deceased raised concerns in respect of this matter immediately prior to his death, it was clearly a factor which was causing him concern at the time. It cannot, therefore, be excluded as a possible precipitating factor in the deceased taking his own life.*
-For some prisoners solitary confinement does not appear to constitute a very severe punishment....For others, however, solitary confinement can cause great distress.*
- In the case of the deceased, while it would appear that he did not suffer from claustrophobia as such, it is clear that he was concerned that he would have difficulty in coming to terms with being locked in a cell with very little to occupy his time.*
- The deceased was a young man, only 18 years of age, and this was to be his first experience of solitary confinement.”*
- 15.60 The Coroner also referred to the Attorney General’s decision to replace Justices of the Peace at three of the metropolitan prisons as VJs with a magistrate (for a short term) who had also been asked to prepare an independent report on “*issues surrounding prison disciplinary procedures*” and noted that the documentation which had been provided by the Ministry relating to this decision included the comment that “*....disciplinary procedures could affect the health and well being of prisoners and in some circumstances unfair treatment could have critical consequences.*”
- 15.61 The Coroner recommended that “*the review of Prison Disciplinary Procedures currently being conducted include a review of punishment options available in relation to such charges.*”

- 15.62 Prisoners also raised concerns about the perceived unfairness of the visiting justice system, which they describe as a “kangaroo court”. They clearly perceive that the system is ‘stacked’ against them in terms of the procedures involved, such as the difficulty in calling witnesses; the fact that they are not entitled to legal representation and have no right of appeal. One VJ told me, however, that he did not believe legal representation was necessary because most prisoners are “streetwise” when it comes to ‘court’ proceedings.
- 15.63 Some VJs themselves complain that there is a lack of flexibility and innovation in sentencing options which means that punishments often do not ‘fit the crime’. They are not given (and, apparently, do not generally ask for) background reports of behavioural, medical or social issues relevant to a prisoner and some told me of their concerns that a penalty handed down may ‘tip the scales’ for a vulnerable prisoner and lead to self harm. Some VJs would welcome the power to suspend sentences and told me that they had been seeking – unsuccessfully – for some years appropriate amendments to the *Prisons Act* to include this and other sentencing options. In contrast, one VJ expressed the view that life in prison is too easy, that there is no real deterrent to offending, and that some prisoners have lists of prison offences which are pages long, partly because some VJs are “*too lazy*” to do their job properly.
- 15.64 The Coroner commented on the “*fairness*” of the prison disciplinary system in the inquest into the death of Dean **Lauder** (May 1998; Canning Vale) as follows:-

“While in the present case the deceased had experienced the punishment of separate confinement on a number of previous occasions and does not appear to have been very distressed as a result of that punishment being imposed, it is clear that shortly before his death on the night of 31 May, 1998 he expressed concerns to fellow prisoners... about the punishments which had been imposed and he was of the view that the punishments were unfair.

In this case for each of 2 charges of using cannabis the deceased received the maximum penalty available to the Visiting Justice pursuant to Section 78 of the Prisons Act 1981.

While it would not be appropriate for me to make comments in respect of the penalties which were imposed in this case, evidence at the inquest hearing indicated that it was the view of a number of prison officers that the maximum penalties are regularly imposed by Visiting Justices in relation to such charges because of a view that such an approach would lead to greater consistency in sentencing.

If this is the case, I would have concerns about the way in which current practices and procedures are used to implement the disciplinary provisions of the Prisons Act 1981.”

- 15.65 The Coroner recommended that the independent review referred to above examine whether “*the maximum penalties provided for by the Prisons Act 1981 are in fact being routinely imposed*”.
- 15.66 In my 1999 Annual Report⁴ I voiced my concerns about the prison justice system as follows:-

“For some time now I have made my views and concerns known about the Visiting Justice function and its part in the prison discipline and punishment process (see page 50 of my 1997 Report and page 50 of my 1998 Report). As in previous years a number of complaints about this aspect of prisoner management were received. These continue to strengthen my belief that the current prison discipline regime is unsatisfactory. The complaints received raise much the same issues as in the past and include the way prison charges are laid; the basis for the charge; the relevance of the charge to the alleged offence; the manner in which the proceedings are conducted; the decision itself; and the nature and extent of the punishment imposed. These complaints cause concern about natural justice and other procedural aspects of the hearings, the consistency and relevance of the decisions and the effect of these on the management of the prisoner. In deciding to approach the Ministry with my concerns about this issue in the broader sense there was also a need to review the question of my jurisdiction in relation to Visiting Justices and their actions and decisions. As there has long

been an element of uncertainty in respect of this, an opinion from the Crown Solicitor was sought. Two questions needed to be answered: - (1) whether the office of 'Visiting Justice' was an 'authority' to which the Parliamentary Commissioner Act 1971 applied; and (2) would a complaint about the conduct of a hearing by or the decision of a Visiting Justice relate to a 'matter of administration' as is referred to in the Act - or should such a hearing be considered a judicial matter over which I have no investigatory powers. In short, despite an opinion and a subsequent qualifying comment from the Crown Solicitor's Office the position remains unclear - with the general understanding being that the position could be reasonably argued either way.

I subsequently met with Ministry officials to discuss the general topic of Visiting Justices in the hope of identifying the relevant issues and reaching some broad agreement about how we might proceed to improve the current disciplinary process, regardless of the legal position. An independent review of the process and the principles upon which the prison disciplinary system is based has since been commissioned by the Ministry. I welcome that development."

15.67 The independent review mentioned in paragraphs 15.60 and 15.65 above commenced in early 2000 when a magistrate, Mr Paul Heaney SM, was appointed. He replaced the VJs at three metropolitan prisons and heard all charges at those prisons as well as reporting to the Ministry on the operation of the prison disciplinary system generally. Mr Heaney's report is presently being considered by the Ministry. As this Report was being finalised for printing I was provided with a copy of Mr Heaney's report. It recommends wide-ranging changes with respect to legislation, regulations, and the Director General's Rules *"in order to meet criteria of normalisation, certainty, transparency, accountability, efficiency and professionalism."*

15.68 It must be noted in this context that RCIADIC **Recommendation 180** recommended:-

"That where a prisoner is charged with an offence which will be dealt with by a Visiting Justice, that Justice should be a Magistrate. A charge involving the possibility of affecting the period of imprisonment should always be dealt with in this way. All charges of offences against the general law should be heard in public courts."

15.69 In the 1995 *Government Implementation Report* the Ministry's 1994 *Summary Response* was that the recommendation was *"partially implemented in Corrective Services; fully implemented in Juvenile Justice Division"*. In relation to the *"status of implementation"* in 1995, the Ministry stated:-

"Recommendation not supported in Corrective Services – sections 54, and 56 of the Prisons Act apply. Justices of the Peace currently bear prison charges; there are no plans to change the current procedures in the immediate future."

The 1997 *Implementation Report* repeated the 1994 *Summary Response*.

15.70 The Ministry has advised me that the change in the status of the implementation of Recommendation 180 was overlooked when it provided information for the 1997 *Implementation Report*. However, regardless of the Ministry's apparently contradictory statements in the 1995 *Implementation Report*, it is quite clear that Recommendation 180 has not been implemented in Western Australia. In my opinion – and on the basis of investigations into the numerous complaints received by my Office about the prison disciplinary system - prisoners can and have been seriously disadvantaged by deficiencies in the disciplinary system (as illustrated by comments in my last three Annual Reports).

- 15.71 I support the Coroner's comments in the inquests into the deaths of Messrs McIntosh and Lauder, and Dr Liebling's conclusions in her examination of prison 'stressors',⁵ that fear of solitary confinement, and a perception that the system for dealing with prison offences is unfair and biased against them, are significant stressors for prisoners and can become precipitating factors in a decision to self harm or suicide. In this regard, it is of concern that the Ministry stated that it had implemented RCIADIC **Recommendation 181** which recommends, *inter alia*, 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*"⁶ when separate confinement is a frequently used punishment for *all* prisoners. In my view it is disappointing that the prison disciplinary system was not reviewed some time ago.

RECOMMENDATION 15.3

That the Ministry complete its review of the independent report on prison disciplinary procedures as a matter of urgency and implement its recommendations. If implementation is delayed by a need to amend the *Prisons Act* or other legislation then RCIADIC Recommendation 180 should be implemented in the meantime by continuing the role of magistrates or experienced legal practitioners as visiting justices at all prisons.

PRISONER COMPLAINTS AND GRIEVANCES

- 15.72 An important part of the broader general issue of Unit Management and the relationship between prisoners and prison officers is the procedure for handling prisoner grievances about an aspect of prison life or about decisions affecting them - and how well the Ministry is able to resolve such problems.
- 15.73 The RCIADIC recognised the importance of this issue in its **Recommendation 176** which recommended the establishment of a "*Complaints Officer*" who would regularly attend the prison to hear, and attempt to settle, any complaints and would be responsible to the Ombudsman, Attorney-General or Minister for Justice. **Recommendation 179**⁷ recommended that officers should deal with prisoner requests as simply and as quickly as possible.
- 15.74 In the 1995 *Government Implementation Report* the Ministry said that Recommendation 176 was implemented because "*adequate provisions exist*" in the *Prisons Act*, DGR 2G and through Aboriginal Visitors. It claimed that Recommendation 179 was also implemented, stating:-

"Unit Management Principles are important in the content of the implementation of this recommendation.

These principles emphasise the need for higher levels of interaction between prisoners and officers (and provide the opportunities for those higher levels to develop familiarity and trust by having prisoners and officers in various stable groups). Additionally each prisoner has ready access to the Unit Manager."

- 15.75 DGR 2G prescribes the procedure to be followed when a prisoner makes a "*request or complaint*" - including a hierarchy of consideration by Unit officers, other authorised persons, the Superintendent, the Director, Prison Management and ultimately to the Executive Director, OMD. The Rule also provides an avenue of consideration by an unspecified higher authority if a prisoner remains dissatisfied after exhausting the hierarchy of approaches.

- 15.76 In my opinion it is not an overstatement to say that, despite the theory and principles set out above, the Ministry did not have any form of efficient or effective grievance handling system throughout the 1990s. Obviously, many prisoner problems and grievances will have been resolved in an *ad hoc* way by individual prison officers and other staff members - but there was no system or consistent process that would give prisoners confidence in the integrity of the grievance-handling process.
- 15.77 One consequence of that deficiency is that the number of complaints made to my Office in recent years has increased substantially, increasing from around 200 in 1996/97 to 500 in 1998/99. The number of complaints increased again in 1999/2000 to 515 with approximately the same number of telephone inquiries that were able to be dealt with informally. I have for several years recommended to the Ministry that it should establish a comprehensive internal complaint-resolution process - to enable a majority of prisoner problems to be resolved at the lowest possible level (within the Unit or prison) so that those who make – or fail to make - decisions about prisoners have the primary responsibility for attempting to resolve their problems.
- 15.78 The Ministry finally took action to set up such a system in early 2000 and I have had input into how it should operate. The objective of the new system, as described in the *Prisoner Grievance Resolution Manual*, is to provide “...a transparent and credible prisoner grievance process that will facilitate the resolution of prisoner grievances at the lowest possible level and within the shortest possible time.”
- 15.79 The system provides a hierarchy of review of a prisoner grievance in a consistent, fair and timely manner commencing with the Unit Manager (or Nurse Manager if a health issue is involved) and progressing to review by the superintendent (or delegate) followed by consideration by the Grievance Manager and ultimately by the Grievance Review Panel. The new system does not in any way detract from a prisoner’s right to complain to the Ombudsman or any other external complaint-handling body at any point. A pilot of the system was commenced at Bunbury at the end of October 2000 and is shortly to be introduced at Woorlooloo.
- 15.80 Obviously, how well the system will work in practice will depend upon a number of factors, including:
- the adequacy of, and the extent to which, information about the system and the procedures for using it are disseminated to prisoners and prison staff;
 - how “user-friendly” it is for prisoners and those trying to resolve the grievance;
 - how well grievance “resolvers” are trained and encouraged to objectively review the decisions and actions complained about;
 - how quickly decisions can be made at the various review levels; and
 - how well the decisions that are made, and the reasons for them, are explained to those affected by the decision.
- 15.81 The indications are that the Ministry is committed to making the grievance resolution process work in a way that has never existed before. Turning that commitment into reality will not be easy - but I am optimistic that the system can be made to work. There really is no alternative.

RECOMMENDATION 15.4

That the Ministry:

- (a) finalise and implement the proposed grievance resolution process as quickly as possible; and**
- (b) ensure that prison officers and all those persons expected to be involved in resolving grievances are adequately trained in the aims and principles of the system and the skills needed to objectively evaluate and resolve grievances.**

TRANSFER OF PRISONERS

- 15.82 Inter-prison transfer is an issue which regularly generates complaints from prisoners and their families. Prison transfers occur frequently - often with very little warning – with the result that a prisoner can be placed in a prison hundreds of kilometres away from family and other forms of external support. The issue was identified by the RCIADIC in **Recommendation 168**⁸ as being of particular importance for Aboriginal prisoners - for whom a particular location may have cultural importance as well as being where family support is located. As a result, the RCIADIC recommended that *“Where an Aboriginal prisoner is subject to a transfer to an institution further away from his or her family the prisoner should be given the right to appeal that decision.”*
- 15.83 DGR 2B deals with the issue of security ratings, placements and transfers of prisoners. In line with the principle of an appeal recommended by the RCIADIC, DGR 2B 1.1.4 requires that prisoners be given the opportunity to make personal representations up to the level of the Ministry’s Assistant Director, Prison Placement, about placement and the reasons for the decision and be afforded a right to appeal against a placement decision – although an appeal does not necessarily operate as a stay on a transfer. Not surprisingly, issues about placement and transfer have arisen in prison deaths.
- 15.84 Reference has previously been made to the death of Michael **McMahon** (Casuarina; April 1996) in the context of the Ministry’s failure to follow up on issues which arise from particular deaths in custody. The issue of an inter-prison transfer was also considered relevant.
- 15.85 On 4 April 1996 the prison administration decided under the provisions of DGR 2B that Mr McMahon would be transferred to Albany on Tuesday 9 April, primarily because of the high muster at Casuarina at that time, but also because of allegations of disruptive behaviour and bullying on his part. Mr McMahon first found out about the pending transfer on 5 April (Good Friday), when he asked a prison officer about the funds in his gratuities account and was told that no funds were available because his account had already been transferred to Albany. (I am told by prisoners that this is a frequent occurrence.) It is apparent that the requirement that he be given reasons for the transfer and an opportunity to appeal the decision were not complied with. To compound the situation, any representations made by Mr McMahon would not have been considered until the following Tuesday (because of the Easter holidays) and he would not have been able to contact his family by telephone over that weekend (because there were no funds in his Casuarina telephone account).
- 15.86 The Coroner commented that, in making its decision, the administration had assessed the impact of the transfer on Mr McMahon’s visits as *“minimal”*. The Coroner considered that this assessment was inaccurate as Mr McMahon received regular visits from his mother and other family members, and observed:-
- “None of the senior officers concerned in the decision making process appears to have taken responsibility for ensuring that Director General’s Rule 2B was applied...the whole issue of prison visits was misunderstood...Mr McMahon was not given any opportunity to make representations relating to his placement. Had any representations been allowed, the error relating to prison visits would have been discovered.”*
- 15.87 It is clear that Mr McMahon was extremely upset about the proposed transfer and threatened to react violently and unpredictably. At his request, he was relocated to a cell in the IOU on 5 April for his own protection and that of other prisoners. Later that day he saw a member of the FCMT who advised him of his appeal rights and ensured that he was provided with writing materials so that he could write a letter of appeal against the decision. Mr McMahon apparently told the FCMT member that he was not contemplating suicide or self harm. However, he was found hanging from a grille in the exercise yard adjacent to his cell in IOU at approximately 5pm on 7 April.

- 15.88 The Coroner concluded that Mr McMahon was upset as a result of the proposed transfer but suggested that:-

“One possible scenario is that the deceased wished to delay his transfer to Albany Prison in the hope that a decision would be made that he should remain in the Perth area. Mr McMahon could have feigned a suicide attempt in the hope that his transfer would be delayed.

.....On the other hand Mr McMahon’s history indicates that over a long period of time he had been subject to strong emotional outbursts.....At the time of his death Mr McMahon was an impulsive 22 year old who was taking both anti-psychotic and ant-depressant medication.

It is possible that, very distressed at the thought of his proposed transfer, Mr McMahon decided to take his own life.

While there is some evidence that the deceased may have had an intention to take his own life, the possibility that the death arose by way of accident cannot be excluded.”

- 15.89 As a result, the Coroner made an open finding about the manner of death. He did, however, add two riders to his findings, as follows:

“I recommend that the Ministry develop procedures which would ensure that in cases where a decision is made to transfer a prisoner from one prison to another, where practicable the prisoner be advised of the transfer by an officer with some knowledge about the reasons for the transfer who would be in a position to monitor the prisoner’s response to the decision.

I recommend that the Ministry develop procedures which would provide that, in the case of non-urgent transfers and subject to necessary security considerations, a sufficient time period be allowed between the time of notification and the time of movement to allow the prisoner to contact his visitors to advise them of the transfer and to make any necessary arrangements and to forward to the relevant officer any documents appealing against the decision in sufficient time to allow proper consideration of those documents prior to any movement being effected.”

- 15.90 The Ministry convened a review group to consider the findings and riders. In its report, dated 29 August 1997, the group acknowledged that there had been “breakdowns in the system”, including references to “confusion”, “failures”, and “inaccuracies”. It also identified a systemic problem at Casuarina in relation to inter-prison transfers of prisoners, characterised by:

“...very heavy workload carried by the Assistant Superintendent which reduces or eliminates discussion about a possible transfer with the prisoner;

low levels of knowledge by Unit Managers in the assessment and placement process, which reduces their capacity to give the best advice to prisoners;

Unit officers have a similarly low level of knowledge and assessment and placement which reduces their capacity to manage these prisoners whose cases are under review.”

- 15.91 The report also stated that “The 12 hour shift system and high prisoner musters at Casuarina Prison contribute to a lack of staff continuity and failure at times to resolve matters which are causing prisoner dissatisfaction.”

- 15.92 The review went on to identify principles which should be integral to all placement decisions - including the need for accurate and complete information; the interview of prisoners prior to decisions being taken; advice on rights of appeal being made known to prisoners; consideration of appeal by a competent authority – and the steps needed to ensure a better process. It made the following recommendations to bring about “early improvements” to the system:-

“At any time that a management-initiated prisoner transfer is contemplated, the Unit Manager shall be advised, and where appropriate, assume responsibility for investigating and processing the decision.

Any decision to transfer a prisoner shall be preceded by discussion with him, unless it has been demonstrated, in writing, that consultation will clearly jeopardise security.

Unless it has been demonstrated in writing that such action will jeopardise security, the decision slip shall be handed in person to the prisoner who will sign for its receipt. The officer will be identified. The officer shall advise the prisoner of any right of appeal.

In the event that the prisoner is not in agreement with a transfer the officer shall note his reaction and ensure that such information is logged to advise officers on succeeding shifts.

Any appeal documentation shall be considered by the designated superintendent or a delegate properly trained in assessment procedures, who shall decide whether the transfer shall proceed pending final determination of the appeal. This interim decision shall be communicated to the prisoner by an officer conversant with appeal procedures, prior to effecting the transfer.

In the longer term the following arrangements should be investigated:

Appoint a dedicated Unit Manager to each Living Unit.

Establish an assessment and classification system which is specialised for the initial assessment and sentence planning process for each prisoner. Subsequent assessments should be undertaken by unit officers.”

- 15.93 In my view, it would be reasonable to conclude that Mr McMahon’s death was avoidable and that it occurred after a serious flaw in administrative procedures, namely as identified by the Coroner, the failure of senior officers to take responsibility for ensuring that the provisions of DGR 2B were applied. There is no indication that any disciplinary action was considered against the staff involved, either by the Ministry or by the Coroner. For my part, I see little value in recommending that such be considered more than four years after the event. I am reasonably satisfied that the administrative shortcomings have been acknowledged by the Ministry and that the above recommendations represent a reasonable response by the Ministry to them, albeit not entirely in the manner suggested by the Coroner. However, I have a significant reservation.
- 15.94 Put simply, there is little point in making recommendations and endorsing them for implementation if the administrative structures are not in place to follow the matters through. For example, in Mr McMahon’s case, the provisions of DGR 2B should have been adequate to deal with the transfer - *if* they had been followed. A new DGR containing the above recommendations may well be ineffective unless staff are suitably trained about its requirements and their responsibilities and committed to ensuring compliance. I understand that the incorporation of the recommendations in existing DGRs has been superseded by the preparation of new DGRs by the Operational Standards Directorate of the Ministry and that the recommendations are included in a proposed new Rule. The Ministry confirmed that this was the case and advised me that the recommendations would also be included in an Operations Manual which was being developed.
- 15.95 In relation to the training to be provided to staff, the Ministry advised me that *“There is no specific training... planned at this stage. It is envisaged that the Operations Manual being developed will be self-explanatory. If further training is required following the introduction of this manual, it will be addressed at that time”*. The Ministry also referred to the training of new prison officers in *“Special Needs Awareness”* and to the *“At Risk Management System”*, to which about half of prison officers have been exposed. The Ministry believes that these initiatives will ensure adherence to the required procedures relating to the transfer of offenders.

- 15.96 It seems clear to me that the principles reflected in DGRs and the techniques for risk assessment and management can become lost all too easily without constant reinforcement by ongoing training. I presume that, in the absence of specific training, the new Operations Manual will be distributed to staff in the manner currently used for the distribution of new or amended DGRs. This involves circulation of the material to all relevant and interested parties, including prison superintendents. It is then the responsibility of the Superintendent to ensure that copies of the new or amended rule are placed in each 'work place' (unit, workshop, education centre, library, medical centre, gatehouse etc). Officers are expected to familiarise themselves with DGRs, although there is no uniform method for doing so.

RECOMMENDATION 15.5

That the Ministry:

- (a) ensure that the new DGR relating to prisoner transfers is strictly complied with by prison staff; and
- (b) implement a uniform procedure whereby all prison officers and prison management are made aware of the contents and requirements of all amendments to DGRs, Standing Orders and other instructions.

VISITS TO PRISONERS

- 15.97 It is universally acknowledged that the maintenance of a prisoner's links with family and friends is crucial to the prisoner's well-being and ability to cope while in prison as well as to his/her chances of re-establishing normal relationships with those other people on release from prison. Prisoners and prison personnel all agree that visits are one of the most fundamental and sensitive issues affecting the state-of-mind of prisoners - a missed or unhappy visit can generate erratic behaviour and precipitate self harm risks, whereas a prisoner who is able to maintain a regular and harmonious relationship with significant persons on the outside via visits and other forms of contact is far more likely to be able to cope with the pressures of prison life. This is one of the reasons why the issue of transfer of prisoners discussed above is so important.
- 15.98 The RCIADIC made two recommendations of direct relevance to this subject. **Recommendation 169** proposed that financial assistance should be given to the family of a prisoner placed in a prison some distance from his family and **Recommendation 170** recommended that all correctional institutions should have adequate visits facilities which enable relatively normal family interaction to occur and that the intervention of prison officers in the conduct of such visits should be minimal.⁹
- 15.99 In relation to Recommendation 169 the Ministry responded by adopting the practice of temporarily transferring prisoners to the prison nearest to the location of family members, rather than the recommended approach of providing financial assistance to the family. Although temporary visits can sometimes be disruptive for prisoners who have commitments at their usual prison (such as for education or employment), it seems to me that the Ministry's alternative approach is entirely reasonable. Delays can occur in arranging the temporary transfer at times because of muster levels but I understand that when a prisoner is transferred to facilitate visits it is usually for an extended period and arrangements are made for special extra visits during the time.

- 15.100 In relation to Recommendation 170, it is apparent that the standard of visiting facilities varies considerably between prisons - ranging from very good to poor. Visiting areas are often partly in the open air - which is acceptable when the weather is fine but quite unusable when that is not the case. On the basis that I now receive relatively few complaints about visiting facilities, I think it would be fair to say that improvements made at a number of prisons have been effective. However, I would also add that increasing prison musters must also at times place those facilities under stress.
- 15.101 The Ministry has contracted with several welfare agencies to operate "visitor centres" at a number of prisons. These agencies provide an invaluable service by acting as an interface between visitors and prison staff (thereby, at times, reducing tension); providing storage for visitors' belongings that could not be taken into the prison; by providing care for children of visitors; and, generally, helping to maintain connections between prisoners and their families.

RECOMMENDATION 15.6

That the Ministry contract appropriate welfare organisations to operate visitor centres at all prisons.

- 15.102 The issue of visits arose in the deaths of Darren **Boyle** (CWCRC; 5 September 1994) and Stephen **Maslin** (Casuarina; February 1997).
- 15.103 As discussed in Chapter 10, there was confusion over a visit to Mr Boyle by his mother on 3 September (Saturday). It appeared that, because he had not expected her to visit, he had arranged for other friends to visit him on that day. When his mother's request that he be allowed two shorter sessions rather than receiving one visitor was refused by a prison officer, Mr Boyle's mother cancelled her visit so that his other friends could visit him, with the intention that she would arrange another visit for either 4 or 5 September. She was, unfortunately, unable to visit him as planned and arranged a visit for 6 September (Tuesday). However, Mr Boyle was not advised of the change and, it is alleged, was also refused permission to telephone his mother on the Monday afternoon - although this is denied by the officers on duty - and hanged himself later that day.
- 15.104 In my view, this incident raises two concerns. First that the apparent denial of the request to have two visits of shorter duration seems somewhat inflexible and unhelpful and second, that there appears to be some uncertainty as to whether prisoners are notified when visits are booked or cancelled, and whether telephone messages are taken for prisoners if a visitor is unable to visit at a prearranged time. I was particularly interested in whether the denial of the request for two shorter visits was in accordance with established procedure.
- 15.105 The Ministry advised me that remand prisoners are allowed one visit period per day during the times promulgated by each prison. The length and frequency of visiting periods are determined by overall prison operations and availability of staff. Sentenced prisoners are permitted one visit on each scheduled visiting day at the times promulgated by each prison. Officers may use discretion for additional visits in cases where visitors have travelled long distances, or a genuine emergency occurs, or an 'at risk' prisoner would benefit from an additional visit. The exercise of this discretion depends on the number of visitors and space available during a scheduled visits time. It also advised that "...*the provision of services to prisoners and their visitors is limited only by the resources available to carry them out.*"

- 15.106 On the matter of booking and cancellation of visits, the Ministry advised that, in prisons where a visits booking system operates, prisoners are notified of booked or cancelled visits. In other prisons, prisoners can only be notified if staff are contacted and advised. Where visits are cancelled, prisoners are informed as soon as possible by prison staff. I mention in passing that the above response is typical of the Ministry's tendency to answer questions by describing general procedures rather than answering the specific question asked.
- 15.107 Nevertheless, as the Coroner noted, the introduction of the "Arunta" telephone system, which was intended to overcome difficulties experienced by prisoners in making telephone calls, should enable prisoners to make calls to nominated telephone numbers without officer intervention. It also facilitates contact between prisoners and family members, and to that extent, should assist in the resolution of misunderstandings about visits.
- 15.108 The death of Stephen **Maslin** was found by the Coroner to be an accident, having occurred after Mr Maslin obtained access to heroin and inhaled a quantity of it. The Coroner concluded that Mr Maslin obtained the heroin while he was in Casuarina and that it was most likely obtained as a result of visits. It was not possible to establish conclusively from the prison records who exactly had visited Mr Maslin on the day of his death or the day before, and the Coroner was not prepared to make a finding as to who supplied the heroin or the circumstances in which it was supplied. Two of the persons who could be identified as having visited denied any involvement. The Coroner commented that "*...the failure to have a reliable means of recording prison visits appears unsatisfactory*". He therefore added a rider to his finding, that :
- "The Ministry of Justice should implement a system which would record with some reliability the identity of visitors having contact visits with prisoners. Such a system could, for example, require each adult visitor to sign a Daily Visits Report form against an entry of the name and address of the visitor."*
- 15.109 The Ministry reviewed the Coroner's findings and supported the rider. It noted that visitor recording systems are in place in all prisons but that none appeared to record reliably the identity of visitors. It was therefore recommended that the viability of implementing a formal system of visitor identification utilising motor vehicle licences or other similar accepted forms of identification should be investigated. During this inquiry I asked the Ministry about the status of this recommendation.
- 15.110 The Ministry responded by describing some of the practical difficulties involved, such as when visitors to prisons are "*...traditional or semi-traditional indigenous people...[very few of whom]...would be able to present any kind of formal identification. Many are also illiterate and would therefore be unable to complete or understand the legal responsibility associated with forms such as Statutory Declarations.*" It also commented that the envisaged level of visitor identification might not be necessary at minimum security prisons. To my knowledge, no further action has been taken in relation to this recommendation.

SUMMARY OF RECOMMENDATIONS

- 15.1 That the Ministry reconsider its position regarding RCIADIC Recommendation 329 and consider incorporating a statement of prisoner rights into the *Prisons Act*.
- 15.2 That as part of its current internal review of prison deaths the Ministry commission an independent comparative study of the management of Albany Regional Prison and other prisons in order to identify any practices or other factors which should be more widely applied in the prison system.
- 15.3 That the Ministry complete its review of the independent report on prison disciplinary procedures as a matter of urgency and implement its recommendations. If implementation is delayed by a need to amend the *Prisons Act* or other legislation then RCIADIC Recommendation 180 should be implemented in the meantime by continuing the role of magistrates or experienced legal practitioners as visiting justices at all prisons.
- 15.4 That the Ministry:
- (a) finalise and implement the proposed grievance resolution process as quickly as possible; and
 - (b) ensure that prison officers and all those persons expected to be involved in resolving grievances are adequately trained in the aims and principles of the system and the skills needed to objectively evaluate and resolve grievances.
- 15.5 That the Ministry:
- (a) ensure that the new DGR relating to prisoner transfers is strictly complied with by prison staff; and
 - (b) implement a uniform procedure whereby all prison officers and prison management are made aware of the contents and requirements of all amendments to DGRs, Standing Orders and other instructions.
- 15.6 That the Ministry contract appropriate welfare organisations to operate visitor centres at all prisons.

¹ (Norden, P. - Australian Social Justice Council, Sydney 1996)

² See Appendix 1

³ See Chapter 13, paragraphs 13.130-13.133

⁴ at page 45

⁵ See Chapter 8

⁶ See Chapter 10, paragraphs 10.183-205

⁷ See Appendix 1

⁸ *ibid*

⁹ *ibid*

APPENDIX 1

RECOMMENDATIONS OF THE ROYAL COMMISSION INTO ABORIGINAL DEATHS IN CUSTODY

Post Death Investigations

RECOMMENDATION 23 – Legal representation for families at inquests

That the family of the deceased be entitled to legal representation at the inquest and that government pay the reasonable costs of such representation through legal aid schemes or otherwise.

Custodial Health and Safety

RECOMMENDATION 122 – Legal duty of care of persons in the custody of Police Services, Corrective Services and authorities in charge of juvenile centres

That Governments ensure that:

- a. *Police Services, Corrective Services, and authorities in charge of juvenile centres recognize that they owe a legal duty of care to persons in their custody;*
- b. *That the standing instructions to the officers of these authorities specify that each officer involved in the arrest, incarceration or supervision of a person in custody has a legal duty of care to that person, and may be held legally responsible for the death or injury of the person caused or contributed to by a breach of that duty; and*
- c. *That these authorities ensure that such officers are aware of their responsibilities and trained appropriately to meet them, both on recruitment and during their service.*

RECOMMENDATION 124 – Police and Corrective Services establish procedures for the conduct of de-briefing sessions following incidents of importance such as deaths, medical emergencies or actual or attempted suicides

That Police and Corrective Services should each establish procedures for the conduct of de-briefing sessions following incidents of importance such as deaths, medical emergencies or actual or attempted suicides so that the operation of procedures, the actions of those involved and the application of instructions to specific situations can be discussed and assessed with a view to reducing risks in the future.

RECOMMENDATION 130 – Establishment of protocols for the transfer between Police and Corrective Services of information about the physical and mental condition of an Aboriginal person which may create or increase the risks of death or injury to that person when in custody

That:

- a. *Protocols be established for the transfer between Police and Corrective Services of information about the physical or mental condition of an Aboriginal person which may create or increase the risks of death or injury to that person when in custody;*
- b. *In developing such protocols, Police Services, Corrective Services and health authorities with Aboriginal Legal Services and Aboriginal Health Services should establish procedures for the transfer of such information and establish necessary safe-guards to protect the rights of privacy and confidentiality of individual prisoners to the extent compatible with adequate care; and*
- c. *Such protocols should be subject to relevant ministerial approval.*

RECOMMENDATION 140 – Installation of cell alarms in all cells

That as soon as practicable, all cells should be equipped with an alarm or intercom system which gives direct communication to custodians. This should be pursued as a matter of urgency at those police watch-houses where surveillance resources are limited.

RECOMMENDATION 145 – Implementation of cell visitor schemes in consultation with Aboriginal communities and their organizations

That:

- a. In consultation with Aboriginal communities and their organizations, cell visitor schemes (or schemes serving similar purposes) should be introduced to service police watch-houses wherever practicable;*
- b. Where such cell visitor schemes do not presently exist and where there is a need or an expressed interest by Aboriginal persons in the creation of such a scheme, government should undertake negotiations with local Aboriginal groups and organizations towards the establishment of such a scheme. The involvement of the Aboriginal community should be sought in the management and operation of the schemes. Adequate training should be provided to persons participating in such schemes. Governments should ensure that cell visitor schemes receive appropriate funding;*
- c. Where police cell visitor schemes are established it should be made clear to police officers performing duties as custodians of those detained in police cells that the operation of the cell visitor scheme does not lessen, to any degree, the duty of care owed by them to detainees; and*
- d. Aboriginal participants in cell visitor schemes should be those nominated or approved by appropriate Aboriginal communities and/or organizations as well as by any other person whose approval is required by local practice.*

RECOMMENDATION 150 – Prison health services equivalent to community standards and available 24 hours a day

That the health care available to persons in correctional institutions should be of an equivalent standard to that available to the general public. Services provided to inmates of correctional institutions should include medical, dental, mental health, drug and alcohol services provided either within the correctional institution or made available by ready access to community facilities and services. Health services provided within correctional institutions should be adequately resourced and be staffed by appropriately qualified and competent personnel. Such services should be both accessible and appropriate to Aboriginal prisoners. Correctional institutions should provide 24 hour a day access to medical practitioners and nursing staff who are either available on the premises, or on call.

RECOMMENDATION 152 – Review of prison health services

That Corrective Services in conjunction with Aboriginal Health Services and such other bodies as may be appropriate should review the provision of health services to Aboriginal prisoners in correctional institutions and have regard to, and report upon, the following matters together with other matters thought appropriate:

- a. The standard of general and mental health care available to Aboriginal prisoners in each correctional institution;*
- b. The extent to which services provided are culturally appropriate for and are used by Aboriginal inmates. Particular attention should be given to drug and alcohol treatment, rehabilitative and preventative education and counselling programs for Aboriginal prisoners. Such programs should be provided, where possible, by Aboriginal people;*
- c. The involvement of Aboriginal Health Services in the provision of general and mental health care to Aboriginal prisoners;*
- d. The development of appropriate facilities for the behaviourally disturbed;*
- e. The exchange of relevant information between prison medical staff and external health and medical agencies, including Aboriginal Health Services, as to risk factors in the detention of any Aboriginal inmate, and as to the protection of the rights of privacy and confidentiality of such inmates so far as is consistent with their proper care;*

Appendix 1 Recommendations of the Royal Commission into Aboriginal Deaths in Custody

- f. *The establishment of detailed guidelines governing the exchange of information between prison medical staff, corrections officers and corrections administrators with respect to the health and safety of prisoners. Such guidelines must recognize both the rights of prisoners to confidentiality and privacy and the responsibilities of corrections officers for the informed care of prisoners. Such guidelines must also be public and be available to prisoners; and*
- g. *The development of protocols detailing the specific action to be taken by officers with respect to the care and management of:*
 - i. *persons identified at the screening assessment on reception as being at risk or requiring any special consideration for whatever reason;*
 - ii. *intoxicated or drug affected persons, or persons with drug or alcohol related conditions;*
 - iii. *persons who are known to suffer from any serious illnesses or conditions such as epilepsy, diabetes or heart disease;*
 - iv. *persons who have made any attempt to harm themselves or who exhibit, or are believed to have exhibited, a tendency to violent, irrational or potentially self-injurious behaviour;*
 - v. *apparently angry, aggressive or disturbed persons;*
 - vi. *persons suffering from mental illness;*
 - vii. *other serious medical conditions;*
 - viii. *persons on medication; and*
 - ix. *such other persons or situations as agreed.*

RECOMMENDATION 153 – Prison health services should be the subject of ongoing review

That:

- a. *Prison Medical Services should be the subject of ongoing review in the light of experiences in all jurisdictions;*
- b. *The issue of confidentiality between prison medical staff and prisoners should be addressed by the relevant bodies, including prisoner groups; and*
- c. *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 to prison administrators.*

RECOMMENDATION 154 – Availability of cross-cultural training for all prison health staff; employment of Aboriginal persons in delivery of health services

That:

- a. *All staff of Prison Medical Services should receive training to ensure that they 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;*
- b. *Prison Medical Services consult with Aboriginal Health Services as to the information and training which would be appropriate for staff of Prison Medical Services in their dealings with Aboriginal people; and*
- c. *Those agencies responsible for the delivery of health services in correctional institutions should endeavour to employ Aboriginal persons in those services.*

RECOMMENDATION 155 – Availability of training for prison officers in cross-cultural matters and in identification of persons at risk of self harm

That recruit and in-service training of prison officers should include information as to the general health status of Aboriginal people and be designed to alert such officers to the foreseeable risk of Aboriginal people in their care suffering from those illnesses and conditions endemic to the Aboriginal population. Officers should also be trained to better enable them to identify persons in distress or at risk of death or harm through illness, injury or self-harm. Such training should also include training in the specific action to be taken in relation to the matters which are to be the subject of protocols referred to in Recommendation 152 (g).

RECOMMENDATION 156 – Initial medical assessment on admission to prison

That upon initial reception at a prison all Aboriginal prisoners should be subject to a thorough medical assessment with a view to determining whether the prisoner is at risk of injury, illness or self-harm. Such assessment on initial reception should be provided, wherever possible, by a medical practitioner. Where this is not possible, it should be performed within 24 hours by a medical practitioner or trained nurse. Where such assessment is performed by a trained nurse rather than a medical practitioner then examination by a medical practitioner should be provided within 72 hours of reception or at such earlier time as is requested by the trained nurse who performed such earlier assessment, or by the prisoner. Where upon assessment by a medical practitioner, trained nurse or such other person as performs an assessment within 72 hours of prisoners' reception it is believed that psychiatric assessment is required then the Prison Medical Service should ensure that the prisoner is examined by a psychiatrist at the earliest possible opportunity. In this case, the matters referred to in Recommendation 151 should be taken into account.

RECOMMENDATION 157 – Records of previous medical history to be obtained by prison health staff

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

RECOMMENDATION 158 – First priority on finding an apparently dead person

That, while recognizing the importance of preserving the scene of a death in custody for forensic examination, the first priority for officers finding a person, apparently dead, should be to attempt resuscitation and to seek medical assistance.

RECOMMENDATION 159 – Prisons and police watch-houses should have resuscitation equipment and trained staff

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

RECOMMENDATION 160 – Training in resuscitative measures

That:

- a. All police and prison officers should receive basic training at recruit level in resuscitative measures, including mouth to mouth and cardiac massage, and should be trained to know when it is appropriate to attempt resuscitation; and*
- b. Annual refresher courses in first aid be provided to all prison officers, and to those police officers who routinely have the care of persons in custody.*

RECOMMENDATION 163 – Training in restraint techniques

That police and prison officers should receive regular training in restraint techniques, including the application of restraint equipment. The Commission further recommends that the training of prison and police officers in the use of restraint techniques should be complemented with training which positively discourages the use of physical restraint methods except in circumstances where the use of force is unavoidable. Restraint aids should only be used as a last resort.

RECOMMENDATION 165 – Elimination and/or reduction of potentially dangerous items including hanging points

The Commission notes that prisons and police stations may contain equipment which is essential for the provision of services within the institution but which may also be capable, if misused, of causing harm or self-harm to a prisoner or detainee. The Commission notes that in one case death resulted from the inhalation of fumes from a fire extinguisher. Whilst recognizing the difficulties of eliminating all such items which may be potentially dangerous the Commission recommends that Police and Corrective Services authorities should carefully scrutinize equipment and facilities provided at institutions with a view to eliminating and/or reducing the potential for harm. Similarly, steps should be taken to screen hanging points in police and prison cells.

RECOMMENDATION 166 – Exchange of information

That machinery should be put in place for the exchange, between Police and Corrective Services authorities, of information relating to the care of prisoners.

The Prison Experience

RECOMMENDATION 168 – Placement and transfer of Aboriginal prisoners

That Corrective Services effect the placement and transfer of Aboriginal prisoners according to the principle that, where possible, an Aboriginal prisoner should be placed in an institution as close as possible to the place of residence of his or her family. Where an Aboriginal prisoner is subject to a transfer to an institution further away from his or her family the prisoner should be given the right to appeal that decision.

RECOMMENDATION 169 – Financial assistance to family for visiting purposes

That where it is found to be impossible to place a prisoner in the prison nearest to his or her family sympathetic consideration should be given to providing financial assistance to the family, to visit the prisoner from time to time.

RECOMMENDATION 170 – Facilities for visits

That all correctional institutions should have adequate facilities for the conduct of visits by friends and family. Such facilities should enable prisoners to enjoy visits in relative privacy and should provide facilities for children that enable relatively normal family interaction to occur. The intervention of correctional officers in the conduct of such visits should be minimal, although these visits should be subject to adequate security arrangements.

RECOMMENDATION 174 – Employment of Aboriginal welfare officers

That all Corrective Services authorities employ Aboriginal Welfare Officers to assist Aboriginal prisoners, not only with respect to any problems they might be experiencing inside the institution but also in respect of welfare matters extending outside the institution, and that such an officer be located at or frequently visit each institution with a significant Aboriginal population.

RECOMMENDATION 175 – Transition period for prisoners entering a custodial setting

That consideration be given to the principle involved in the submission made by the Western Australian Prison Officers' Union that there be a short transition period in a custodial setting for prisoners prior to them entering prison routine.

RECOMMENDATION 176 – Establishment of a Complaints Officer

That consideration should be given to the establishment in respect of each prison within a State or Territory of a Complaints Officer whose function is:

- a. To attend at the prison at regular (perhaps weekly) intervals or on special request for the purpose of receiving from any prisoner any complaint concerning any matter internal to the institution, which complaint shall be lodged in person by the complainant;*
- b. To take such action as the officer thinks appropriate in the circumstances;*
- c. To require any person to make enquiries and report to the officer;*
- d. To attempt to settle the complaint;*
- e. To reach a finding (if possible) on the substance of the complaint and to recommend what action if any, should be taken arising out of the complaint; and*
- f. To report to the complainant, the senior officer of the prison and the appointing Minister (see below) the terms of the complaint, the action taken and the findings made.*

This person should be appointed by, be responsible to and report to the Ombudsman, Attorney-General or Minister for Justice. Complaints receivable by this person should include, without in any way limiting the scope of complaints, a complaint from an earlier complainant that he or she has suffered some disadvantage as a consequence of such earlier complaint.

RECOMMENDATION 177 – Implementation of cross-cultural education to Corrective Services officers

That appropriate screening procedures should be implemented to ensure that potential officers who will have contact with Aboriginal people in their duties are not recruited or retained by police and prison departments whilst holding racist views which cannot be eliminated by training or re-training programs. In addition Corrective Services authorities should ensure that all correctional officers receive cross-cultural education and an understanding of Aboriginal-non-Aboriginal relations in the past and the present. Where possible, that aspect of training should be conducted by Aboriginal people (including Aboriginal ex-prisoners). Such training should be aimed at enhancing the correctional officers' skills in cross-cultural communication with and relating to Aboriginal prisoners.

RECOMMENDATION 178 – Recruitment of Aboriginal staff

That Corrective Services make efforts to recruit Aboriginal staff not only as correctional officers but to all employment classifications within Corrective Services.

RECOMMENDATION 179 – Simplification of procedures for making of requests by prisoners

That procedures whereby a prisoner appears before an officer for the purpose of making a request, or for the purpose of taking up any matter which can appropriately be taken up by the prisoner before that officer, should be made as simple as possible and that the necessary arrangements should be made as quickly as possible under the circumstances.

RECOMMENDATION 180 - Dealing with prisoners who are charged with offences

That where a prisoner is charged with an offence which will be dealt with by a Visiting Justice, that Justice should be a Magistrate. A charge involving the possibility of affecting the period of imprisonment should always be dealt with in this way. All charges of offences against the general law should be heard in public courts.

RECOMMENDATION 181 – Isolation or segregation of Aboriginal prisoners

That Corrective Services should recognize that it is undesirable in the highest degree that an Aboriginal prisoner should be placed in segregation or isolated detention. In any event, Corrective Services authorities should provide certain minimum standards for segregation including fresh air, lighting, daily exercise, adequate clothing and heating, adequate food, water and sanitation facilities and some access to visitors.

RECOMMENDATION 182 – Interaction with prisoners

That instructions should require that, at all times, correctional officers should interact with prisoners in a manner which is both humane and courteous. Corrective Services authorities should regard it as a serious breach of discipline for an officer to speak to a prisoner in a deliberately hurtful or provocative manner.

Training for Prisoners

RECOMMENDATION 183 – Establishment of Aboriginal support groups within institutions

That Corrective Services authorities should make a formal commitment to allow Aboriginal prisoners to establish and maintain Aboriginal support groups within institutions. Such Aboriginal prisoner support groups should be permitted to hold regular meetings in institutions, liaise with Aboriginal service organisations outside the institution and should receive a modest amount of administrative assistance for the production of group materials and services. Corrective service authorities should negotiate with such groups for the provision of educational and cultural services to Aboriginal prisoners and favourably consider the formal recognition of such bodies as capable of representing the interests and viewpoints of Aboriginal prisoners.

RECOMMENDATION 184 – Opportunity to perform meaningful work and education

That Corrective Services authorities ensure that all Aboriginal prisoners in all institutions have the opportunity to perform meaningful work and to undertake educational courses in self-development, skills acquisition, vocational education and training including education in Aboriginal history and culture. Where appropriate special consideration should be given to appropriate teaching methods and learning dispositions of Aboriginal prisoners.

RECOMMENDATION 185 – Development of a comprehensive national strategy for education and training of those in custody

That the Department of Education, Employment and Training be responsible for the development of a comprehensive national strategy designed to improve the opportunities for the education and training of those in custody. This should be done in co-operation with state Corrective Services authorities, adult education providers (including in particular independent Aboriginal-controlled providers) and State departments of employment and education. The aim of the strategy should be to extend the aims of the Aboriginal Education Policy and the Aboriginal Employment Development Policy to Aboriginal prisoners, and to develop suitable mechanisms for the delivery of education and training programs to prisoners.

RECOMMENDATION 186 – Prisoners should receive remuneration for work performed

That prisoners, including Aboriginal prisoners, should receive remuneration for work performed. In order to encourage Aboriginal prisoners to overcome the educational disadvantage, which most Aboriginal people presently suffer, Aboriginal prisoners who pursue education or training courses during the hours when other prisoners are involved in remunerated work should receive the same level of remuneration. (This recommendation is not intended to apply to study undertaken outside the normal hours of work of prisoners.)

RECOMMENDATION 187 – Involvement of Aboriginal communities and organisations in correctional processes

That experiences in and the results of community corrections rather than institutional custodial corrections should be closely studied by Corrective Services and that the greater involvement of communities and Aboriginal organisations in correctional processes be supported.

Conforming with International Obligations

RECOMMENDATION 328 – Maintenance of humane prison conditions

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

RECOMMENDATION 329 – Legislation for Standard Guidelines

That the National Standards Body comprising Ministers responsible for corrections throughout Australia give consideration to the drafting and introduction of legislation embodying the Standard Guidelines and in drafting such legislation give consideration to prisoners' rights contained in Division 4 of the Victorian Corrections Act 1986.

APPENDIX 2

SUMMARY OF RECOMMENDATIONS

CHAPTER 4

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

CHAPTER 5

- 5.1 That the Ministry:
- (a) in the short term, formalise the current procedure for sending a prisoner's medical records with him/her on transfer to another prison to ensure the minimum risk of a breakdown in communication between prison staff; and
 - (b) in the medium to long term, give a high priority to the introduction of a computerised system of storing medical records to ensure that they are accessible at all prisons to authorised personnel without delay.
- 5.2 That the Ministry:
- (a) ensure that there is an efficient and effective system in place so that an appropriate record is made of every telephone consultation concerning the health care of a prisoner and that such record is placed on the prisoner's medical file; and
 - (b) monitor regularly, by audit or other means, the quality of record-keeping by health services personnel and implement a strategy of action for any staff member not meeting the required standard.
- 5.3 That the Ministry make a greater effort to encourage the involvement of Aboriginal medical services, nursing staff and health workers at all prisons to assist in making prison health services more culturally appropriate and therefore more accessible to Aboriginal prisoners.
- 5.4 That the Ministry include regular health reviews of certain groups of high health risk prisoners, such as long term prisoners (perhaps over the age of 40) and those who have been identified as having chronic health problems, as a matter of routine in a formal health management plan for each prisoner.
- 5.5 That the Ministry examine the possibility of including an assessment by a medical practitioner at the initial reception of all new prisoners.
- 5.6 That the Ministry ensure that officers are provided with sufficient training and guidance to ensure the sensitive and proper use of their discretion in relation to the application of restraints to prisoners in hospitals.
- 5.7 That the Ministry ensure that a culture prevails within prisons that permits health services personnel to make decisions about the health care of prisoners which pay proper regard to non-health issues but which are, essentially, based only on an assessment of what is in the best medical/health interests of the prisoner.

- 5.8 That the Ministry constantly monitor the standard of prison diet and ensure that it meets the needs of those groups of prisoners for whom an appropriate diet is essential in the management of their health.
- 5.9 That the Ministry include in its future accommodation plans for the prison system the likely requirement to house and care for an increasing number of elderly and geriatric prisoners and provide appropriate resources and facilities.
- 5.10 That as a priority all prison staff be given initial or refresher first aid training, including the use of resuscitation techniques and equipment.

CHAPTER 6

- 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.
- 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.

CHAPTER 7

- 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 That:
- (a) 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) 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.

CHAPTER 8

- 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.

CHAPTER 10

- 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.

CHAPTER 11

- 11.1 That the Ministry provide all health services staff with appropriate and ongoing training in the assessment of prisoners to establish any self harm or suicidal tendencies – both on admission to prison and during the term of imprisonment.
- 11.2 That the Ministry take all steps necessary to ensure that prison regimes are organised to permit sufficient time for the initial medical and risk assessment process to be completed properly.
- 11.3 That, recognising the importance of good prisoner/prison staff relations, the Ministry review its selection and recruitment process for all prison-based staff to ensure that sufficient priority is given to high level communication and interpersonal skills as basic requirements for all staff dealing with prisoners.
- 11.4 That the Ministry’s operational rules require that:
- (a) the Director, Health Services and relevant health staff are consulted and involved in proposals and decisions relating to the health of prisoners and the management and placement of prisoners considered at risk; and that
 - (b) decisions made by qualified health professionals must not be over-ruled by unqualified prison staff.
- 11.5 That the Ministry provide the FCMT with sufficient resources to enable it to:
- (a) become involved in harm minimisation and self- help educational programs for prisoners; and
 - (b) monitor and regularly review long term prisoners, those with severe behavioural disorders and/or suffering from the effects of substance abuse.
- 11.6 That the Ministry review the adequacy of its psychiatric services to prisoners and provide sufficient resources to cater for identified needs.
- 11.7 That the Ministry:
- (a) encourage the Peer Support Group to make suggestions for improvements to the reception and orientation process for new prisoners;
 - (b) pay peer support prisoners a gratuity for performing the role;
 - (c) ensure that prison superintendents have regular meetings with the Peer Support Group and the Prisoner Support Officer and encourage their involvement in the planning of new initiatives aimed at improving prisoner welfare; and
 - (d) ensure that the prison superintendents, administrative staff and prison officers accept the concept of peer support as a serious and integral part of prisoner welfare.

- 11.8 That the expertise of all relevant community support organisations be utilised and that the assistance of family members be sought wherever possible in the management of at risk prisoners. In particular, the Ministry should re-open discussions with The Samaritans to establish whether and how that organisation could become involved in prisoner welfare.
- 11.9 That:
- (a) the recommendation of the Custodial Inspection Team in relation to the cost of calls from Albany Prison be extended to all prisoners who, because of their prison placement, are unable to call their family at local rates; and
 - (b) that the number of telephones be increased in line with rising muster levels to provide all prisoners with a reasonable opportunity to contact their families.
- 11.10 That the Ministry as a matter of priority provide therapeutically appropriate placement options for all categories of at risk prisoner including:
- (a) rehousing the Intensive Sex Offenders Treatment Program to facilitate use of the vacated facilities within the Casuarina Infirmiry as a detoxification centre for prisoners suffering the effects of substance abuse or to house psychiatrically disturbed prisoners;
 - (b) developing and providing alternative therapeutic facilities for at risk prisoners in need of 'observation' at all prisons; and
 - (c) discontinuing the confinement of at risk prisoners in medical observation cells as currently configured and operated at all prisons.

CHAPTER 12

- 12.1 That the Ministry allocate funds and resources to facilitate implementation of Recommendations 5 and 6 in the Report of the *Drug Management Strategy Project* as a matter of priority.
- 12.2 That in the interests of the welfare and better management of offenders entering prison in withdrawal or suffering from the effects of substance abuse the Ministry should:
- (a) review the initial medical assessment form to ensure that it provides adequate data for the management of prisoners;
 - (b) provide health staff and other interested staff with the opportunity for specialised training in substance abuse problems; and
 - (c) ensure that medical and nursing staff gain access to newly-admitted prisoners early enough to complete all assessments without pressure from operational considerations.
- 12.3 That the Ministry take steps to produce reliable statistical data on the prevalence of drug use in the interests of the welfare of prisoners, the safety of staff and the efficient planning of its future prison requirements and management strategies.
- 12.4 That the Ministry reconsider its decision not to expand its methadone program and conduct a trial program for the purposes of assessing its effectiveness in Western Australian prisons.
- 12.5 That in recognition of the extent and seriousness of the problem of drugs in prisons the Ministry provide adequately funded and resourced substance use treatment programs for all affected prisoners from the beginning of their sentence.

- 12.6 That the Ministry provide funding for the provision of discrete detoxification areas in all major receiptal prisons, particularly within the proposed refurbishment of Bandyup Women's Prison.
- 12.7. That:
- (a) the FCMT be provided with sufficient resources to enable it to routinely monitor prisoners suffering the effects of drug abuse and provide the counselling considered essential to the success of any intervention; and
 - (b) the opportunity for training in this specialist field be made available to health staff and other interested prison staff.

CHAPTER 13

- 13.1 That the Ministry:
- (a) acknowledge the importance of constructive activity in the prevention of suicide and self harm and in the rehabilitation of prisoners and ensure that all prisoners are provided with adequate opportunities for education, training, employment and treatment programs throughout their sentences at all prisons.
 - (b) take steps to remove the disincentives to participation in education identified by the Taskforce and in the course of my inquiry;
 - (c) provide funding, resources, trained staff and facilities to increase the opportunities for education (in its broadest sense), training, employment and rehabilitation throughout the sentence at all prisons; and
 - (d) obtain legal advice as to whether the *State Trading Concerns Act 1916* or any other legislation prevents the Ministry from offering particular forms of gainful employment to prisoners, and consider seeking amendment if it is found that there are legislative restrictions.
- 13.2 That, in line with United Nations *Standard Minimum Rule 77(1)*, in the interests of the mental and physical wellbeing of prisoners and as a means of creating better prisoner/officer relations, the Ministry:
- (a) employ a full time Recreation Officer/Sports Coordinator at each prison;
 - (b) ensure that each prison provides adequately resourced and appropriately staffed recreational and exercise opportunities for all prisoners; and
 - (c) encourage prison officers (by internal recognition and additional remuneration) to take responsibility for particular recreational activities for which they have appropriate qualifications and/or aptitude.
- 13.3 That in recognition of the acknowledged therapeutic benefits of music and art for all prisoners, and particularly Aboriginal prisoners, the Ministry:
- (a) ensure that adequate resources and facilities are available at all prisons for these activities; and
 - (b) accord art, music and cultural activities program status.
- 13.4 That the Ministry ensure that sufficient resources and funding are provided to enable prisoners to participate and complete treatment programs prescribed identified in the assessment process on admission to prison or by the Parole Board prior to their release date.
- 13.5 That the Ministry provide rehabilitation programs at an early stage in and throughout the sentence with refresher courses at the end.

- 13.6 That the Ministry ensure that participation in culturally appropriate basic literacy and numeracy courses is encouraged in a sensitive way at all prisons.
- 13.7 That the Ministry provide appropriate cultural programs for Aboriginal prisoners at all prisons, involving local community and tribal elders, on the lines of those available elsewhere in Australia and New Zealand.
- 13.8 That the Ministry address the current inequality of education, training and employment opportunities for female prisoners throughout the State by providing a wider range of programs designed specifically to cater for their needs and ensuring that they are adequately staffed and funded.
- 13.9 That the Ministry take steps to review program provision for remand prisoners at Bandyup and at regional prisons and ensure that they have access to a range of education, meaningful employment and rehabilitation opportunities.
- 13.10 That the Ministry develop appropriate programs to assist 'difficult' prisoners address their behavioural problems as alternatives to progressively more severe disciplinary measures.
- 13.11 That the Ministry subject all of its programs to ongoing monitoring and evaluation as part of an assessment of efficiency and effectiveness to ensure that they meet prisoner and community needs.

CHAPTER 14

- 14.1 (a) That the Ministry of Justice respond to the Parole Board's request for additional resources as soon as possible. In particular, the Parole Board should be resourced so that it can provide detailed reasons for its decisions to prisoners; and
- (b) that with a view to maximising the effectiveness of the Ministry's assessment process for prisoners, the Board and the Ministry review:-
- how the Board's expectations about what prisoners should be required to do during a sentence can be better understood by the Ministry; and
 - the nature and extent of programs to be offered by the Ministry and the timing of their delivery.
- 14.2 That the Ministry and the Parole Board review the procedures by which Board decisions and other correspondence from the Board are conveyed to prison staff and to prisoners to ensure that:
- (a) prison personnel are aware that the prisoner is to receive a decision or correspondence from the Board;
- (b) a prison officer personally delivers the correspondence or oral advice to the prisoner, thereby having the opportunity to observe the impact of the advice on the prisoner; and
- (c) the records of both the Board and the prison document whether information about decisions or other correspondence has been conveyed to and received by, the prison and the prisoner in every case.
- 14.3 That the Ministry and the Parole Board institute a review of available data, current assessment procedures and eligibility criteria to determine whether female Aboriginal prisoners and Aboriginal prisoners generally are, or are likely to be, disadvantaged in relation to parole and work release orders respectively. Action to rectify any imbalance found should be taken, including the reconsideration of any legislated eligibility criteria.

- 14.4 That the Ministry:
- (a) review the procedures followed in all Western Australian prisons to determine the level of knowledge officers have of the requirements of the *Bail Act* and the working arrangements between prison officers, police and Justices of the Peace;
 - (b) ensure that the requirements of the *Bail Act* are being complied with, in practice, in all prisons; and
 - (c) complete the review of the *Bail Act* as quickly as possible.
- 14.5 That the Ministry reconsider its response to RCIADIC Recommendation 23 and accept an obligation to make funds available - to the families of deceased prisoners directly or to legal aid organisations - to enable legal representation at inquests in all cases.

CHAPTER 15

- 15.1 That the Ministry reconsider its position regarding RCIADIC Recommendation 329 and consider incorporating a statement of prisoner rights into the *Prisons Act*.
- 15.2 That as part of its current internal review of prison deaths the Ministry commission an independent comparative study of the management of Albany Regional Prison and other prisons in order to identify any practices or other factors which should be more widely applied in the prison system.
- 15.3 That the Ministry complete its review of the independent report on prison disciplinary procedures as a matter of urgency and implement its recommendations. If implementation is delayed by a need to amend the *Prisons Act* or other legislation then RCIADC Recommendation 180 should be implemented in the meantime by continuing the role of magistrates or experienced legal practitioners as visiting justices at all prisons.
- 15.4 That the Ministry:
- (a) finalise and implement the proposed grievance resolution process as quickly as possible; and
 - (b) ensure that prison officers and all those persons expected to be involved in resolving grievances are adequately trained in the aims and principles of the system and the skills needed to objectively evaluate and resolve grievances.
- 15.5 That the Ministry:
- (a) ensure that the new DGR relating to prisoner transfers is strictly complied with by prison staff; and
 - (b) implement a uniform procedure whereby all prison officers and prison management are made aware of the contents and requirements of all amendments to DGRs, Standing Orders and other instructions.
- 15.6 That the Ministry contract appropriate welfare organisations to operate visitor centres at all prisons.

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