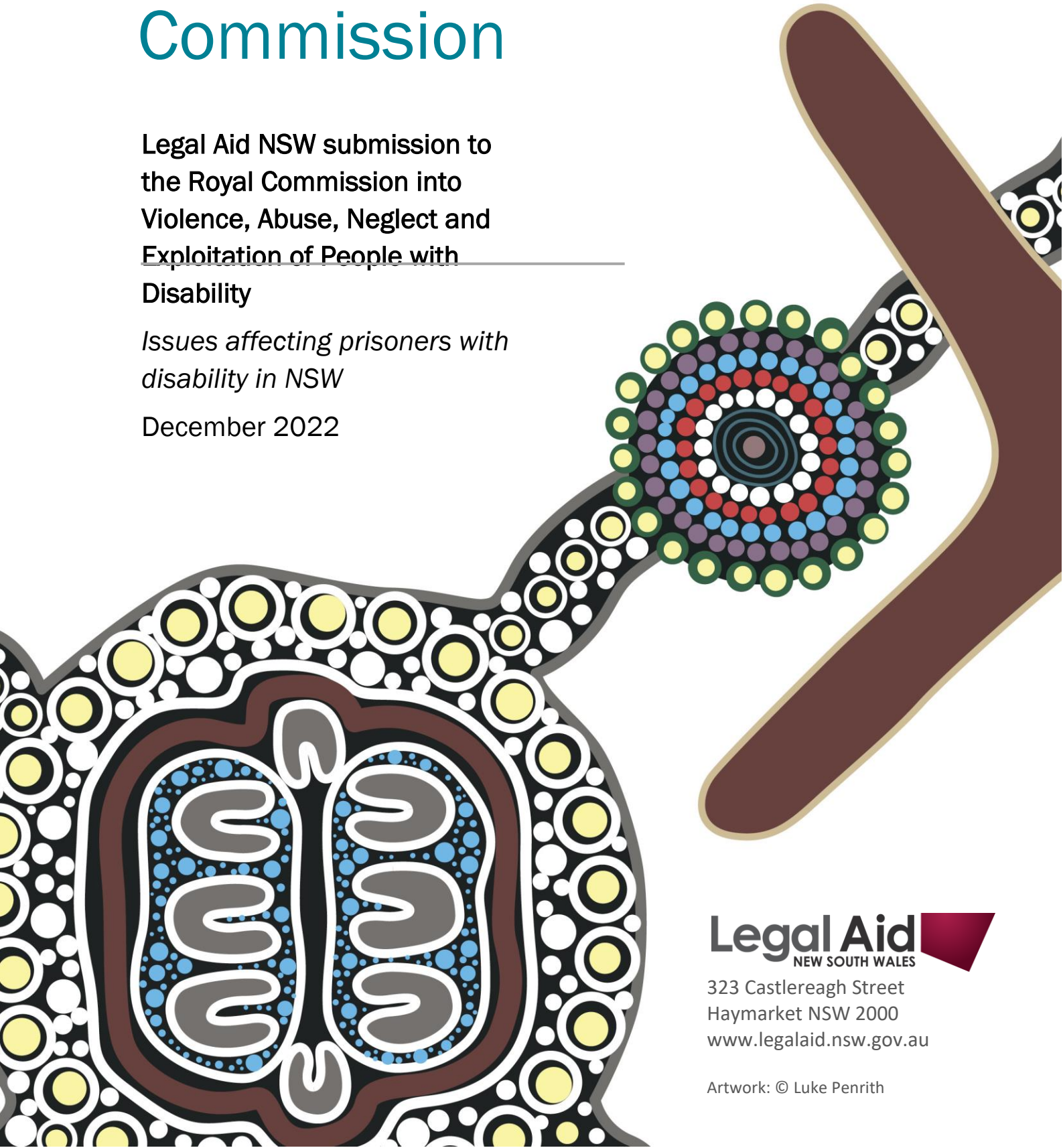
Submission to the Disability Royal Commission

Legal Aid NSW submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability

Issues affecting prisoners with disability in NSW

December 2022



Legal Aid NEW SOUTH WALES
323 Castlereagh Street
Haymarket NSW 2000
www.legalaid.nsw.gov.au

Acknowledgement

We acknowledge the traditional owners of the land we live and work on within New South Wales. We recognise continuing connection to land, water and community.

We pay our respects to Elders both past and present and extend that respect to all Aboriginal and Torres Strait Islander people.

Legal Aid NSW is committed to working in partnership with community and providing culturally competent services to Aboriginal and Torres Strait Islander people.

1. About Legal Aid NSW

Our service delivery

Legal Aid NSW is an independent statutory body established under the *Legal Aid Commission Act 1979* (NSW). It provides legal services across NSW through a state-wide network of 25 offices and 243 regular outreach locations, with a particular focus on the needs of people who are socially and economically disadvantaged.

Legal Aid NSW assists with legal problems through a comprehensive suite of services across civil, criminal and family law. Services range from legal information, education, advice, minor assistance, dispute resolution and duty services, through to an extensive litigation practice. Legal Aid NSW also works in partnership with private lawyers who receive funding from Legal Aid NSW to represent legally aided clients. It maintains close partnerships with community legal centres, the Aboriginal Legal Service (NSW/ACT) Limited and pro bono legal services.

Legal Aid NSW provides state-wide civil law services through the in-house Civil Law Division and private practitioners. Civil law services cover a range of civil matters before state and federal conciliation bodies, the Local Courts, District Court, Supreme Court of NSW, Federal Circuit and Federal Court, Administrative Appeals Tribunal, NSW Civil and Administrative Tribunal, Mental Health Review Tribunal and the High Court of Australia.

Working with prisoners

Legal Aid NSW is the largest single legal service provider to prisoners in NSW. In 2020-2021, the Criminal Law Division provided over 224,000 in-house legal services (excluding information services), about two-thirds of which were provided by the in-house practice.

Legal Aid NSW delivers a wide range of civil law services to people in custody through the Prisoners Legal Service, Mental Health Advocacy Service and through regional and specialist civil lawyers working across NSW advising on issues such as housing, debts, fines, immigration, discrimination, NDIS, consumer protection, Stolen Generations Reparations Scheme, powers of attorney, freedom of information, and complaints concerning agencies and service providers. In particular, the Human Rights Group specialises in legal assistance with complaints about health care in custody.

Working with people with disability

Legal Aid NSW recognises that people with disability are from diverse cultural groups and backgrounds and have needs, priorities and perspectives related to their age, sex, gender, sexual orientation, race, cultural and linguistic backgrounds, among other factors. We acknowledge the diversity of disability and experience among people with disability.

Legal Aid NSW is a member of National Legal Aid which represents the eight independent state and territory legal aid commissions in Australia. Your Story Disability

Legal Support (**Your Story**) is a service of National Legal Aid (**NLA**) providing services to people with disability through state and territory legal aid commissions and community controlled Aboriginal and Torres Strait Islander legal services, including Legal Aid NSW.

Your Story supports people with disability to make submissions to the Disability Royal Commission, provides accessible community legal education, social work support and comprehensive referrals for specialist legal assistance with criminal, civil and family law matters including domestic violence and child protection. Since 2019, Your Story has received over 8000 calls and provided over 10,000 legal and social work services.[1]

Your Story has established a phone line for people with disability in all adult and correctional facilities across Australia which has received over 2,000 calls. Your Story has provided over 800 legal advice, private session, and submission support services to people in closed environments in Australia (prison, juvenile detention and forensic mental health facilities). Your Story has also delivered a range of accessible resources and education activities including for people with disability in custody. Your Story works closely with its legal service partners, including Legal Aid NSW, to meet the needs of people with disability across Australia.

Legal Aid NSW is therefore well positioned to comment on the impact of issues affecting prisoners with disability in NSW.

[1] Your Story turns three: Our impact – Your Story Disability Legal Support.

2. Introduction

Legal Aid NSW welcomes the opportunity to make a submission to the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (**Disability Royal Commission**).

This submission is provided in addition to the contributions made by Legal Aid NSW to the National Legal Aid submission to the Disability Royal Commission. The purpose of this submission is to focus more closely on issues affecting adults with disabilities in NSW custody which were not detailed in the national submission. While it draws primarily on the direct practice experience of solicitors at Legal Aid NSW, it includes observations and case studies from our collaboration with NLA's Your Story on disability issues and through regular referrals.

Research and national data confirm that people in custody have a much poorer health profile than the general population[2] and that the proportion of people in custody with disabilities is higher than that of the general population.[3] According to Justice Health and Forensic Mental Health Network[4] (**Justice Health**), prisoners are a "highly vulnerable patient population whose health needs are often numerous and more complex than the wider community."[5] Many prisoners are 'people with disability' as defined in the Disability Royal Commission terms of reference. It is common for a person to enter custody with multiple, complex, and untreated health issues. People with disability often have invisible disabilities which include mental health issues, forms of neurodiversity such as ADHD, dyslexia, autism or significant trauma. In addition, it is estimated that there are over 1,000 aged prisoners in custody and this figure continues to increase.[6]

There are two important principles that underpin this submission. The first is that a prisoner has an inherent right to adequate health care on par with community standards. The second is that a prisoner who leaves prison healthy is less likely to come back. A prisoner's poor health may adversely affect their emotional resilience, likelihood of substance use, level of engagement with services, employment prospects, and access to housing. Positive health interventions in prison are crucial to an individual's prospects

[2] See AIHW, The health of Australia's prisoners 2015; Anne Grunseit et al, Law and Justice Foundation of New South Wales, *Taking Justice into Custody: The Legal Needs of Prisoners* (2008) 279; Maria Borzycki, Australian Institute of Criminology, *Interventions for prisoners returning to the community* (2005) 34.

[3] In 2018 Human Rights Watch reported that almost 50% of Australian prisoners had a disability compared with 18% of the Australian population. The Disability Royal Commission commissioned a report which found that while only 2.9% of people in Australia have an intellectual disability, 15% of people in custody do. That proportion increases to 30% when accounting for borderline intellectual disability

[4] Justice Health is a Specialty Network Governed Statutory Health Corporation constituted under the Health Services Act 1997 (NSW). It is guided by both NSW Ministry of Health Policies and its own policies. More information about the structure, functions and responsibilities of Justice Health can be found on the agency homepage: http://www.justicehealth.nsw.gov.au.

[5] See *Overview of our Network* – 'What we do': <http://www.justicehealth.nsw.gov.au/about-us/jh-fmhn-profile/OverviewofJHFMHN.pdf>.

[6] Based on the Disability Royal Commission's terms of reference, the term 'people with disability' is defined as people with any kind of impairment, whether existing at birth or acquired through illness, accident or the ageing process, including cognitive impairment and physical, sensory, intellectual and psycho-social disability (including mental health issues): Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (Interim Report, October 2020), 557.

of rehabilitation and social reintegration. Prison therefore has the potential to address health inequalities for the benefit of both the prisoner and the broader community.

For those who enter the custodial environment with a pre-existing disability, there are multiple factors which place them at risk of exposure to violence, abuse, neglect and/or exploitation. These include structural and systemic barriers to accessing appropriate disability supports, lack of access to timely, appropriate, and quality healthcare and potential mistreatment.

Moreover, compromised healthcare can mean that those who experience a temporary disability due to a short-term condition go on to develop longer term or chronic conditions especially if untreated for significant periods.

3. Healthcare and disability support in prison

3.1 The right to health care and needs of prisoners with disability

3.1.1 The right to timely and appropriate health care

Everyone has an inherent right to the highest attainable standard of physical and mental health.[7] The right to health care has been interpreted to include care which is timely and appropriate.[8] The UN Committee on Economic, Social and Cultural Rights also states that health facilities, goods and services should be available, accessible, acceptable and of good quality. These are described as being essential, interrelated elements of the right to health.[9]

This inherent right to health care is not diminished by reason of a person's incarceration. Delivering health care in custody is based on the principle of 'equivalent care', which is enshrined in a number of international human rights standards.[10] Where people with a disability are deprived of their liberty, Article 14 of the Convention on the Rights of Persons with Disabilities (**CRPD**) requires States Parties to ensure that this deprivation is lawful, non-discriminatory and in full compliance with the CRPD.[11] Guidelines released by the CRPD Committee aid in interpreting this provision and its scope. They stipulate that States Parties must take all relevant measures to ensure adequate conditions of detention for people with disabilities such that they can live independently and participate fully in all aspects of daily life.[12] This includes their equal access to various areas and services including bathrooms, yards, libraries and medical and legal services.[13] A failure to provide accessible and reasonable accommodation for prisoners with disability is inconsistent with Article 17[14] of the CRPD, and may constitute a breach of Article 15(2).[15]

---

[7] This right to the highest attainable standard of physical and mental health is protected by Article 5 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights (**CESCR**) and Article 25 of the Convention on the Rights of Persons with Disabilities (**CRPD**). Australia is a party to all three instruments.

[8] CESCR General Comment 14, paragraph 11.

[9] CESCR General Comment 14, paragraph 12.

[10] In particular, the United Nations Standard Minimum Rules for the Treatment of Prisoners (known as the Nelson Mandela Rules) establish the international minimum standards for the treatment of prisoners. See CESCR General Comment 14, paragraph 34 and the decision of the European Court of Human Rights in *Salakhov and Islyamova v Ukraine [2013] ECHR, Application No. 28005/08*.

[11] United Nations (2006), *Convention on the Rights of Persons with Disabilities*, United Treaty Series (UNTS), vol. 2515, p. 3 (entered into force 3 May 2008), Article 14. <https://treaties.un.org/doc/Publication/UNTS/Volume%202515/v2515.pdf> *(Convention on the Rights of Persons with Disabilities)*.

[12] Committee on the Rights of Persons with Disabilities, *Guidelines on the right to liberty and security of persons with disabilities* (see Annex to Bi-Annual Report A/72/55) page 19-20 <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=A/72/55&Lang=en>.

[13] Ibid.

[14] Article 17 of the CRPD states that every person with disabilities has a right to respect his or her physical and mental integrity on an equal basis. *Convention on the Rights of Persons with Disabilities*, Article 17.

[15] Article 15(2) of the CRPD notes that States Parties shall take all effective legislative, administrative, judicial or other measures to prevent persons with disabilities from being subjected to torture or cruel, inhuman or degrading treatment or punishment. *Convention on the Rights of Persons with Disabilities*, Article 15(2).

3.1.2 The legislative context in New South Wales

In NSW, these specific human rights protections are not incorporated into the statutory regime which applies to custodial health.[16] Instead, section 72A of the *Crimes (Administration of Sentences) Act 1999* states that:

> *an inmate must be supplied with such medical attendance, treatment and medicine as in the opinion of a medical officer is* ***necessary for the preservation of the health of the inmate****. (emphasis added)*

Multiple superior courts have established that the government's duty of care towards prisoners under its control is clear.[17] In the NSW context, the Supreme Court of NSW has commented that a patient has a right to "reasonable professional care in the interests of the patient's health and wellbeing" in the circumstances.[18] Cases in other jurisdictions have helped develop the meaning of a prisoner's right to health as it is expressed in provisions equivalent to section 72A, and medical treatment that qualifies as being "necessary for the preservation of a prisoner's health" is also likely to be reasonable or appropriate.[19]

In practice, this means that the context of the prison environment is a factor when determining what is "necessary care" for a prisoner.[20] The right to health care is not a right to any and all treatment that a prisoner could possibly want or that he or she could access if not imprisoned.[21] What is reasonable or appropriate will depend on the personal circumstances of the prisoner in question, and the prevailing medical and therapeutic standards applying generally in the community.[22] Nevertheless, Legal Aid NSW's experience is that prisoners with disabilities report difficulty in accessing timely, appropriate and quality healthcare and disability support.

The dependency and vulnerability of prisoners means that even the most minor deficiencies or oversights in the screening, assessment or review process can have serious consequences for a person's well-being. A prisoner is reliant on correctional staff to access health care, and their lack of control and consumer choice places additional responsibility on those delivering health services to ensure care is patient centred.

---

[16] In Victoria, see section 47, *Corrections Act 1986* which enshrines the right to have access to reasonable medical care and treatment; in ACT, see section 53, *Corrections Management Act 2007* which mandates a standard of health care equivalent to that available to other people in the ACT; in the Northern Territory, see similarly section 82, *Correctional Services Act 2014*.

[17] See *Howard v Jarvis* [1958] HCA 19; (1958) 98 CLR 177); *Kirkham v Chief Constable of the Greater Manchester Police* [1989] EWCA Civ 3; [1990] 2 QB 283; *Hall v Whatmore* [1961] VicRp 35; [1961] VR 225; *Dixon v Western Australia & Lees* [1974] WAR 65.

[18] *Application of Justice Health; re a Patient* [2011] NSWSC 432 [at 6]. The ACT Supreme Court has made similar comments in *obiter* in relation to an equivalent provision. In considering an interlocutory application, the ACT Supreme Court stated that "there is an obligation to provide access to appropriate and timely medical treatment" subject to reasonable constraints in custody: *David Harold Eastman v Chief Executive Officer of the Department of Justice and Community Safety* [2010] ACTSC 4, per Refshauge J.

[19] *Castles v Secretary to the Department of Justice* [2010] VSC 310 (9 July 2010).

[20] Ibid, [137].

[21] Ibid, [120].

[22] *El-Jalkh v R* [2011] NSWCCA 236 at [33].

3.1.3 The health needs of prisoners with disability

The Justice Health Annual Report 2022 aptly summarises the complex health status of people in custody:

> *Our patients have complex and diverse health needs. When compared with the broader Australian population, our patients have considerably higher rates of mental illness and are much more likely to have previously attempted suicide. People in custody have been exposed to high rates of intergenerational incarceration and are likely to have suffered a traumatic event in their lifetime*.[23]

As the United Nations notes in its *Handbook on Prisoners with Special Needs*, the difficulties associated with coping in the prison environment, including bullying and violence, also mean that prisoners with disabilities are also likely to need specialist mental health care.[24]

Prisoners tend to have a disproportionately high prevalence of:

- chronic diseases such as diabetes, cardiac, respiratory and renal
- mental health conditions
- neurodiversity, including autism, ADHD and dyslexia
- blood borne diseases, such as Hepatitis C
- alcohol, illicit drug and smoking disorders
- dental conditions.[25]

Given these well-known health needs, it is imperative that prison health care is timely and appropriate. Timely care not only ensures a person's health does not deteriorate, but it may also contribute to the safety and good order of prisons by helping to manage conditions that might otherwise engender conflict between prisoners and staff. As our case studies demonstrate, a lack of access to timely, appropriate and quality health care may expose prisoners to increased risk of violence, abuse, neglect and/or exploitation.

3.2 Structure of delivering healthcare and disability support in prison

Delivering primary health care in a correctional environment is understandably complex as it involves the coordination of multiple agencies and service providers. Health services for prisoners in NSW are the exclusive responsibility of the state government, and therefore differ from the general community where there is a mix of state and federal services. In practice, prisoners are also excluded from both Medicare and the

[23] Justice Health and Forensic Mental Health Network (JH&FMHN) 2022 Year in Review, page 14.
[24] United Nations Office on Drugs and Crime, *Handbook on Prisoners with special needs,* Criminal Justice Handbook Series, New York, 2009, page 51.
[25] These conditions were noted to be the most prevalent in the standard 76.1, *Inspection standards: For adult custodial services in New South Wales*, Inspector of Custodial Services, NSW Department of Justice, August 2014, page 63. The updated standards from 2020 no longer contain a comparable list.

Pharmaceutical Benefits Scheme by virtue of section 19(2) of the *Health Insurance Act 1973* (Cth).[26]

Corrective Services NSW (**CSNSW**) and Justice Health share responsibility for the delivery and management of health services in custody in publicly operated gaols.[27] These agencies have a close working relationship in respect of the delivery of health care, which the Inspector of Custodial Services (**ICS**)[28] has described as "complex and interdependent".[29] In practice, CSNSW manages psychological services, dietary needs, cell placements, and plays a role in approving and implementing reasonable adjustments for prisoners with disabilities. Justice Health employs most frontline clinical staff including nurses, general practitioners (**GP**s) and psychiatrists.[30]

A prisoner's first level of contact with health services in NSW is through nurses rather than GPs. During time out of cells, prisoners can access nurse-led care by attending a clinic operated by Justice Health inside the prison. Most correctional centres have a central clinic, and many also have satellite clinics (smaller clinics located in specific wings or units), although the capacity of these clinics varies from prison to prison.

The NSW prison health system also includes the Long Bay Hospital, an 85-bed hospital facility located within the Long Bay Correctional Complex (**LBCC**), and the Forensic Hospital, Malabar which is a 135-bed mental health facility. These two facilities service nearly 14,000 adult prisoners across the state.[31]

To address the additional support needs of prisoners with disability in custody, CSNSW operates the State-wide Disability Services (**SDS**). The SDS is a multidisciplinary team that provides assessments, supports, assistive devices, case management, pre-release planning and training in relation to prisoners with specific disabilities. The SDS is based at LBCC but can travel to conduct assessments at other locations in NSW. It also oversees three Additional Support Units located at LBCC, containing a total of 57 beds.

---

[26] For recent commentary on the issue of exclusion, see Plueckhahn, Tessa M et al., 'Are some more equal than others? Challenging the basis for prisoners' exclusion from Medicare', 2015, *Medical Journal of Australia*: https://doi.org/10.5694/mja15.00588.

[27] As under the *Crimes (Administration of Sentences) Act 1999* (NSW). Section 236A of the Act sets out the functions of Justice Health, while Part 18 of the *Crimes (Administration of Sentences) Regulation 2014* (NSW) establishes the reporting obligations between prescribed health officers and prescribed correctional officers.

[28] The Inspector of Custodial Services is appointed by state government to inspect adult correctional centres and juvenile justice centres in NSW, and report to Parliament on the findings of its inspections. The Inspector may also choose to report on an issue of public interest, or they may be requested by the Minister to report on a particular issue. To date, several of the Inspector's reports have addressed health care in prison.

[29] Inspector of Custodial Services, *Full House: The growth of the inmate population in NSW*, April 2015, paragraph 5.42.

[30] These arrangements differ in the three privately operated prisons – Clarence Correctional Centre, Junee Correctional Centre and Parklea Correctional Centre.

[31] According to publicly available information, Long Bay Hospital has three distinct units: a 40-bed Mental Health Unit, a 30-bed Medical Subacute Unit, and a 15-bed Aged Care and Rehabilitation Unit.

4. Barriers to accessing appropriate health care in prison

In Legal Aid NSW's practice experience, prisoners in NSW encounter various structural, systemic and operational barriers to accessing timely and appropriate health care. These barriers can prevent prisoners with a disability from accessing appropriate supports and subject prisoners with disabilities to long delays in accessing GPs, psychiatrists and other specialists.

The experience of Legal Aid NSW reveals a range of factors which may impact upon the ability or willingness of prisoners to access health services. These include:

- the number of correctional staff on shift to enable 'out-of-cell' hours
- unscheduled lockdowns, for example, due to emergencies, COVID-19 pandemic outbreaks or staff shortages
- correctional staff availability for medical escorts between cell accommodation and clinics, or between prison and hospital
- the effectiveness of prison intercom systems to notify prisoners that they have been called to the clinic, and the capability for such announcements to be heard in all parts of the prison
- the prospect of a prisoner losing his or her cell/bed placement by attending an external appointment in another location
- the ratio of correctional staff to nursing staff to ensure safe consultation
- the availability of certain prescription medications in custody
- the availability of specialist services such as psychiatrists and psychologists, mental health nurses, allied health and oral health practitioners
- the availability of hospital beds and mental health facilities in the prison system
- the availability of services and programs including addiction, literacy and other education programs
- lack of access to external advocacy and support services
- limited education and understanding among correctional staff about disabilities, including mental health
- behaviours relating to disability, including requests to access, refuse or change treatment being interpreted as non-compliance
- language barriers
- lack of information for prisoners about how to arrange access to private health services
- lack of privacy during health consultations.

People in prison also face several barriers in applying for and gaining access to the National Disability Insurance Scheme (**NDIS**). These include problems with identifying prisoners eligible for the NDIS, lack of advocacy services, difficulties in gathering supporting information and the level of expertise within the National Disability Insurance Agency in working with prisoners, notwithstanding recent efforts by staff in the SDS to work more closely with the agency.

For those prisoners who are NDIS participants, access to adequate planning presents challenges. Our experience suggests prisoners often do not have appropriate supports in place when they transition into the community. Failure to adequately plan increases the risk of reoffending or breaching terms of bail or parole, and in turn, the risk of returning to prison.

While detailed discussion of the NDIS is beyond the scope of this submission, Legal Aid NSW has made previous public submissions highlighting these issues.[32]

4.1 Strict eligibility requirements for State-wide Disability Services

Prisoners must have one of the following disabilities to qualify for help from the SDS:

- Intellectual disability or low cognitive functioning
- Acquired Brain Injury (including traumatic brain injury and Alcohol/Drug Related Brain Injury)
- Autism Spectrum Disorder
- Dementia
- Sensory disability (Hearing or Vision Impairment)
- Physical disability
- Frail Aged

Many of Legal Aid NSW's clients have disabilities which do not fall within these seven categories or are considered insufficiently serious to justify formal support. In such cases, our clients must liaise directly with local correctional staff if they need facilities or adjustments or rely on other prisoners for help. This shifts the burden for assistance onto a cohort already in a vulnerable situation, rather than on those legally responsible for their care. Clients report feelings of heightened stress and anxiety when requesting support from officers who may lack the training necessary to recognise or meet legitimate needs, have limited capacity or time to help, or who may perceive such requests as forms of prevarication.

[32] See Submission 93 to the Commonwealth Joint Standing Committee on the National Disability Insurance Scheme, 'An inquiry into the market readiness for provision of services under the NDIS', 2018; see also Submission 351 to the NSW 'Inquiry into implementation of the National Disability Insurance Scheme and the provision of disability services in New South Wales', 21 June 2018.

An additional issue for accessing SDS support is that some non-physical disabilities may be hidden by prisoners out of shame or fear of showing vulnerability in the prison setting. Many prisoners may have only partial insight into their disability due to factors such as incomplete diagnosis, inconsistent access to health care, incapacity or lack of education, many of which are magnified in prison. Mental health disabilities such as schizo-affective disorder, bipolar or learning disabilities can also impact on a prisoner's ability to effectively self-advocate and act as a further barrier to accessing support.

Mental health and learning disabilities may present in ways which can be misinterpreted by CSNSW staff as aggression, defiance or rule-breaking, when in fact they may be manifestations or symptoms of a disability.

Even when a prisoner's disability is physical and therefore qualifies for support, our experience is that their needs are not consistently met. We are aware of cases in which prisoners in wheelchairs or with limited mobility received no disability support and had no contact with the SDS. Some were unable to access audio visual link (**AVL**) facilities and telephones to speak to a lawyer because they could not climb or descend stairs in their wing. In other cases, their lack of access was because the AVL suites were not disability accessible [33] or because correctional officers were allegedly unwilling to facilitate access by transporting them there safely.

The case study below illustrates the impact of these factors, including the human right to have adequate time and facilities to communicate with a lawyer.[34]

Case Study: Duy - delayed access to hearing aids in custody

Duy is a client from a culturally and linguistically diverse background who entered custody on remand in May 2019. He had great difficulty communicating in English and is profoundly deaf. Duy needed an interpreter for most interactions to communicate at a basic level.

After entering custody, Duy began lodging 'Self-Referral Request for Health Review' forms asking to see a doctor about his hearing loss. Duy needed hearing aids to:

- communicate safely and effectively in the prison environment
  - to hear his name being called in his wing or unit, and
  - to understand instructions/directions
- communicate with his criminal lawyer during AVLs
- participate in, and understand, court proceedings via AVL, including his trial in September 2021
- use telephones in prison
- communicate with health staff (Justice Health records confirm these difficulties)

[33] For example, at Parklea Correctional Centre.
[34] See Article 14(3)(b), ICCPR.

- engage in psychiatric assessment (a Psychiatric Report notes *"there were some limitations as* [Duy] *is hard of hearing and did not have hearing aids, complicating an AVL assessment with an interpreter."*).

Duy requested help to obtain hearing aids **29 times** between entering custody in 2019 and his release in September 2021. His criminal lawyer made five of those requests on his behalf in writing. Only one of those written legal requests was acknowledged on his medical file. A clinical notation in December 2019 confirmed that Duy was on an ENT (Ear Nose and Throat) waiting list for a hearing check at hospital and that he had already been waiting for 46 days.

Documents obtained by Legal Aid NSW showed no record of contact with an assistive technology provider such as EnableNSW and there was no evidence of steps taken to secure a medical clearance.

Throughout this period, Duy complained to health staff in writing, saying things like "*pod officer call my name but I can not hear it. My cell guy help me hearing call my name"* and *"when I went to the court I can not hear what's a judge say".* [sic]

When Duy was moved to another Correctional Centre in early 2020, a Clinical Nurse Specialist wrote: *"Patient has limited English and I used Google translate in Vietnamese."*

Following Duy's and Legal Aid NSW's persistent advocacy, Duy received his hearing aids just prior to his release and removal to his home country in September 2021. This occurred more than two years after Justice Health and Corrective Services NSW knew about his disability-related needs.

Duy's case raises issues with the policies and practices designed to support people with disability in custody which warrant further review. CSNSW maintains a disability policy which applies to people in custody with both physical and other kinds of disabilities.[35] Under that policy, the SDS undertakes to "supply…equipment to assist with program participation and general living".[36] In Duy's case, clinical notes acknowledged as early as June 2019 that he needed hearing aids. In late August, Justice Health obtained an audiology report which confirmed profound hearing impairment in both ears and recommended bilateral hearing aids pending medical clearance. Despite this recognition, it took more than two years to secure the equipment Duy needed to meet his general living needs.

Duy's reception records also contained deficiencies. Although staff recorded his preferred language as 'Vietnamese' on the Reception Screening Assessment, they

[35] Corrective Services NSW, *Custodial Operations Policy and Procedures (COPP), 6.9 Inmates with disabilities* (16 December 2017) < https://correctiveservices.dcj.nsw.gov.au/csnsw-home/correctional-centres/custodial-operations-policy-and-procedures-copp.html>.

[36] Ibid, page 4.

indicated that he did not need an interpreter and was not a person from a Culturally and Linguistically Diverse background. Both assertions were incorrect.

While hearing impairment is listed as an identified disability in the OIMS Intake Screening Questionnaire, there was no question on the Reception Screening Assessment form about 'History of Hearing Condition' as there is for 'Eye Condition'. It is therefore unclear whether Duy was asked about his hearing loss during the reception process and what further enquiries or steps this may have triggered.

In addition, Duy was unable to use any kind of assistive technology to communicate with his lawyers at Legal Aid NSW. Towards the end of his time in custody, and only after he lodged a formal complaint through his lawyers, Justice Health suggested obtaining a "sound amplifying product" to "relieve [Duy's] difficulties whilst awaiting specialised assessment". We are unaware why that device was not offered sooner.

Further, there appears to be no provision on the Common Auto Dial List (**CADL**) for prisoners to call the National Relay Service (**NRS**) and they cannot otherwise call 1300 numbers. Lawyers from our Prisoner's Legal Service report that prisoners must contact a Service and Programs Officers (SAPO) to refer them to staff at Legal Aid NSW who in turn book an appointment with a third-party relay service. A further barrier is that telephone calls on the CADL system are capped at 10 minutes and the relay service is generally slow, so a prisoner is unable to effectively use the service.

As far as Legal Aid NSW is aware, there are no targeted additional support units in SDS that offer specialised assistance to women despite the increase in the female prison population[37] and the distinct health and wellbeing needs of women with disability. Some female offenders with disability are housed in the Mum Shirl Unit (**MSU**) which aims to provide safe and humane management for inmates that cannot be safely managed across other NSW prisons. However, in the Women on Remand report, the ICS observed that:

> *[w]omen with severe cognitive and intellectual disability are currently accommodated at the Mum Shirl Unit (MSU) at Silverwater, which also accommodates women with personality disorders, challenging behaviours, self-harm and suicidal behaviours. The inspection team heard that there were difficulties associated with housing these two cohorts of women together, as they had very different care needs, putting strain on staff members' capacity to provide*

[37] Over the period of 2009 – 2019 the female prison population has increased by 64% while the population of men has grown increased by 45%. Aboriginal and Torres Strait Islander women account for 33% of the total prisoner population and are incarcerated at a rate of approximately 18 times higher than non-Indigenous women. See Australian Institute of Health and Welfare, *The Health and Welfare of Women in Australia's Prisons* (November 2020) < https://www.aihw.gov.au/getmedia/32d3a8dc-eb84-4a3b-90dc-79a1aba0efc6/aihw-phe-281.pdf.aspx?inline=true>.

adequate care for all residents. The Inspector recommends that women with severe cognitive impairment should be accommodated in their own unit.[38]

This gap in health services for female prisoners is further complicated where there is a concurrent need to address sexual or reproductive health issues in a trauma-informed manner.

The needs of prisoners with complex and multiple disabilities present particular challenges, as illustrated by the following case study.

Case Study: Daniel - lack of access to hygiene products

Daniel is a 50-year-old male with multiple physical and mental disabilities. He entered custody with a history of bowel polyps, hereditary cancers, and faecal incontinence. He had also been diagnosed with mental health conditions, a neurological disorder, and an intellectual disability.

As a result of his bowel condition, Daniel wears incontinence pads or 'adult diapers' at all times and frequently needs access to a toilet, including during escorts. Corrective Services staff initially kept the pads in a storeroom and Daniel had to ask for them when he needed more. Sometimes, his intellectual disability made this difficult. He wanted to keep some in his cell to make it easier.

Daniel complained to Legal Aid NSW that he had run out of incontinence pads on many occasions. He had to wear soiled pads for days while waiting for Corrective Services and Justice Health to obtain more. He also finds it hard to manage his personal hygiene during the day, because the shower heads in custody are not detachable. At one point, Daniel decided to cancel a periodic bowel check-up because he felt anxious about being unable to prepare properly or have access to adequate facilities.

In response to his concerns, Legal Aid NSW requested Daniel's medical records from Justice Health. The clinical notes included notations such as "issues with access to incontinence pads" and "low stock pads" which confirmed Daniel's complaints.

Legal Aid NSW advocated to allow Daniel to keep a supply of pads in his cell and to ensure that staff from both agencies always had a sufficient supply of pads available in case he ran out.

Daniel later reported that he was still not able to keep pads in his cell, and there was no change in the type of shower facilities available to him. Despite Legal Aid NSW's

[38] Inspector of Custodial Services, *Women on Remand* (February 2020) page 15 < https://inspectorcustodial.nsw.gov.au/inspector-of-custodial-services/reports-and-publications/inspection-reports/adult-reports/women-on-remand.html>.

advocacy, Daniel received no formal disability support or adjustments to meet his complex needs in custody.

4.2 Delay in accessing medical treatment

Achieving 'timely, appropriate and quality' health care in custody is a longstanding challenge. In 2008, in the first ever census of quality and safety policies for Justice Health, the Clinical Excellence Commission (NSW) identified areas for improvement. One of its key recommendations was the need for both Justice Health and CSNSW to work together to *"ensure that procedures are in place to allow Justice Health staff timely and reliable access to patients for the provision of effective health care interventions"*.[39]

The most common concern arising in our casework with prisoners is delay in accessing medical treatment. Of the 180 prisoners who contacted Legal Aid NSW about their health care between 2014 and 2020, many instructed that 'delay' or 'lack of access' was a major issue. For example, our clients reported significant delay in:

- correctional officers responding to requests for assistance
- accessing the clinic to see a nurse
- consulting with a GP
- consulting with a psychiatrist or psychologist
- receiving medications prescribed prior to entering custody
- accessing diagnostic tests, facilities or equipment.

We provide case studies based on these reports in the next section.

4.2.1 Delay in responding to requests for assistance

Meeting the complex health needs of prisoners depends on effective collaboration between health and correctional staff. Prison officers are responsible for many operational functions which facilitate access to health care, such as responding to 'knock up' calls for help and facilitating planned and unplanned medical escorts to public hospitals. However, systemic issues such as staff shortages[40] and overcrowding (magnified by COVID-19 related issues) can make lockdowns more frequent and generally reduce the capacity of staff to offer timely health services.

During lock-in times (usually after 3pm and before 8am), prisoners must use their cell's internal buzzer or 'knock up' system if they have an urgent health issue and need medical intervention. Because prisoners spend significant time locked in their cells, they are

[39] Clinical Excellence Commission (CEC), Quality Systems Assessment December 2008: Summary of findings for Justice Health NSW, Data submitted February – April 2008, 2008, page 9.

[40] We note that CSNSW has recently piloted a dedicated medical escorts unit as reported by the Inspector of Custodial Services in its report *Health Services in NSW correctional facilities, https://inspectorcustodial.nsw.gov.au/inspector-of-custodial-services/reports-and-publications/inspection-reports/adult-reports/health-services-in-nsw-correctional-facilities.html*

heavily reliant on correctional staff to listen to, inquire about, and action requests for help with a medical emergency.[41]

Delay in responding to a prisoner knocking up – or a failure to respond – can have serious consequences for a prisoner's welfare. The coronial *Inquest into the death of Eric Whittaker*[42] illustrates the importance of the knock up system in responding effectively to medical emergencies. Mr Whittaker was a 35-year-old Kamilaroi man who passed away at Westmead Hospital from a brain haemorrhage. He had been on remand at Parklea Correctional Centre (**CC**) until he became seriously unwell in his cell in the early hours of 2 July 2017.

Although Parklea CC is a privately managed prison, concerns regarding the "knock up system" are by no means unique to private prisons.[43] Both CSNSW and GEO Group (the former operator of Parklea CC) have cell alarm policies which stipulate what a correctional officer should do when they receive a knock up call from a prisoner presenting in a clearly emotional, distressed or disoriented state.[44] The current CSNSW Policy – *Custodial Operations Policy and Procedures (COPP) Section 5.5: Cell security and alarm calls* – provides that officers must immediately go to a cell in circumstances where a prisoner knocks up in physical or mental distress. The officer is also obliged to escalate calls raising concerns by immediately notifying the gaol's Officer in Charge. In Mr Whittaker's case, neither of these actions took place.

We are aware of cases in which our clients allege that correctional officers either ignored or dismissed their knock up calls which then led to negative health outcomes. That is the case in circumstances where existing policies already mandated a degree of welfare checks, escalation and reporting.

Like Mr Whittaker's case, the following case studies reveal how delays in treatment can impact upon prisoner welfare.

Case Study: Tadhg – spider bite leading to permanent impairment

Tadhg is a middle-aged man who was in custody at Junee Correctional Centre. Tadhg instructs that he was bitten by a venomous spider in his cell at Junee. He 'knocked up'

[41] According to a report by the Productivity Commission, NSW has the lowest number of hours of time out-of-cells per prisoner per day: see Figure 8.8, *Report on Government Services*, 2018, Chapter 8 – Corrective Services.
[42] *Inquest into the death of Eric Whittaker*, 28 February 2020, 2017/020885.
[43] See, for example, the Findings in the *Inquest into the death of Fenika Junior Tautuliu Fenika* (Junior Fenika) dated 13 July 2018, < http://www.coroners.justice.nsw.gov.au/Documents/Findings%20-%20Junior%20Fenika%2013%20July%202018%20(2).pdf>.
[44] Parklea Correctional Centre is now operated by MTC-Broadspectrum. At inquest, CSNSW submitted that MTC-Broadspectrum's local policies cannot be inconsistent with overarching CSNSW policies: *Inquest into the death of Eric Whittaker*, para. 129, p.29.

three times using the emergency cell intercom to ask officers to take him to the health clinic, including twice between 12am and 4am, and a third time at about 4am.

These attempts did not result in Tadhg receiving medical attention.

During this time, Tadhg says he became nauseous, his eyes were rolling back in his head and he had difficulty walking.

At about 7am, he was let out of his cell and staggered to the health clinic. He noticed a round circle on his leg the size of a 50-cent piece. It felt hot and was spreading. He waited approximately one hour to see a nurse, lying on the ground for some of that time due to lethargy. He was given antibiotics and an anti-nausea injection to stop him vomiting and returned to his wing. Thirty minutes later he vomited and passed out. His leg was very swollen and had blisters on the back.

Later that afternoon, Tadgh was admitted to the Local Area Health Service, where he was diagnosed with severe cellulitis and oedema in his right leg with sepsis. Due to the seriousness of Tadhg's condition, he was initially admitted to the ICU. He spent 12 days in hospital, during which time he alleges officers pressured him to return to prison due to the cost of hospitalisation.

After returning to custody, Tadhg continued to complain of persistent infection, which has left him with a large visible scar and discolouration on his leg. Two years after the emergency, he continued to receive treatment for an oedema and infection on his ankle and wears a compression bandage around his right calf. He now reports having difficulty walking, an inability to run, constant pain and throbbing in his leg, numbness and circulation problems. Consequently, he has also gained considerable weight due to physical inactivity which raises other health risks.

Case Study: Chioke – history of heart attack & chest pain

Chioke had a history of cardiac issues dating back to 2016 when he suffered a heart attack in custody at Parklea CC. On that occasion, he instructs that he knocked up "four or five times" with no response.

Two years later, Chioke was in his cell when he again experienced cardiac distress and chest pains. He says he spent hours trying to get help via the intercom system in his cell. Eventually, he claims officers buzzed him back to tell him 'We don't care about your distress'. Later that night, he was admitted to hospital.

When Legal Aid NSW requested cell buzzer records on behalf of Chioke, the prison advised that due to a "technical malfunction", they were not available. This meant that

Legal Aid NSW was unable to verify the sequence of Chioke's calls or obtain evidence of the alleged delay.

Case study: Inquest into the death of Fenika Junior Tautuliu Fenika[45]

Junior had a long and complex history of mental health and substance abuse issues. Justice Health first noted possible psychotic illness in October 2008 when he was 17 years old. By May 2014 Junior had been diagnosed with polysubstance abuse, post-traumatic stress disorder, prolonged sensory deprivation, pseudo auditory hallucinations, paranoid ideation, psychotic disorder and anti-social personality disorder.

On 11 September 2015, Junior used a razor to cut himself on his left wrist, left hand, the right side of his neck and his left elbow. He first activated the knock-up system to inform officers that he had *"slashed up*" at 9:17pm. The responding officer ended the call as he purportedly did not hear Junior correctly. No officers attended Junior's cell and he knocked up again at 9:23pm. The responding officer believed Junior was asking about his property and told Junior that officers would visit his cell shortly. At 9:40pm, two officers conducted a check of Junior's cell and formed the view there were no issues.

Between 9:46pm on 11 September 2015 and 4:21am on 12 September 2015, officers were observed to walk over a mixture of water and blood flowing from Junior's cell. No action was taken. It was not until 8:30 am on 12 September 2015 that correctional officers entered Junior's cell and discovered his injuries. At around 8:47 am, Junior was declared deceased.

The Coroner concluded that Junior's death could have been prevented at any time up to the early hours of 12 September 2015 if correctional officers were aware that he was in need of medical attention. The Coroner noted that the critical issue arising from the inquest is why no officer understood that Junior required medical assistance, notwithstanding that he used the knock-up system twice to alert the officers to this fact. In considering this issue, the Coroner specifically noted that:

- "The knock-up system is the only available way for an inmate to communicate an emergency and the risks of not responding to a call are evidenced in this inquest"
- "[I]f corrective services officers had reverse knocked-up Junior from the control room or the officers' station in Unit 7 on 11 September 2015 it is likely they would

[45] State Coroner's Court of New South Wales, 2015/268972, 13 July 2018.

have discovered that he was in need of medical attention and taken appropriate action" and that

- There was a clear failure on the part of correctional officers in not reverse-knocking up Junior's call to clarify the reason for his contact. This was an obvious step that was neglected by the officers and was deserving of censure.

Junior's story illustrates prisoners' high level of dependency on correctional officers to facilitate the provision of medical assistance.

4.2.2 Delay in accessing appropriate specialist care

Legal Aid NSW's clients also report experiencing delay in accessing appropriate specialist care.

One difficulty in assessing the timeliness of care in prison is the lack of available comparative data for custodial and community-based patients. However, data on delay gathered and published by the ICS in 2021 helps to paint a picture of a system in which waiting times may be significantly out of step with community standards.[46] The ICS report indicated that the range of waiting time for prisoners to access different medical services for all correctional centres in NSW were as follows:

Medical Service	**P1**	**P2**
GP	0-48	0-59
Primary Health Nurse	0 – 216[47]	0- 35
Mental Health Nurse	0 – 72	0-112
Psychiatrist	0-172	0-245
Drug & Alcohol Nurse	0-133	0-37

The report notes that there can be considerable delay between being placed on a waitlist and being seen by a health practitioner. The delay depends in part on the patient's assessed priority level. P1 is considered the most urgent level and P3 is for non-urgent issues. P1 should be seen within 1-3 days; P2 in 3-14 days; P3 14 days to three months;

[46] This table shows the range of waiting time (in days) for primary health care and clinical streams during 2017-2018. See Inspector of Custodial Services, *Health Services in NSW Correctional Facilities* (March 2021) pages 114-115 and 117-118 <https://www.inspectorcustodial.nsw.gov.au/content/dam/dcj/icsnsw/documents/Health_Services_in_NSW_Correctional_Facilities.pdf>.

[47] The second highest waiting time was a period of 39 days.

P4 is for routine appointments within 12 months and P5 for follow up appointments. Data from the Mental Health Review Tribunal suggests that admission wait times for forensic patients is between 18 months and 2 years after their court proceedings have finished.[48]

While statistics derived from direct comparison with community waiting times may not be available in NSW, we can point to data which indirectly suggests wait times in adult custody are significantly longer. Research conducted by the ANU in 2013 showed that Australians living in rural areas waited an average of 6 days to see their preferred GP compared to 3.1 days in metropolitan areas. The worst performing region nationally was New England, where patients waited an average of 13.8 days to see their GP.[49] Leaving aside that prisoners receive nurse-led healthcare, it is unlikely that a person in the community would wait 48 days for first-line medical attention, even in the worst performing areas of NSW.

Delay in accessing appropriate specialist care, particularly for older prisoners[50] and those who enter custody with pre-existing chronic diseases or conditions can have serious consequences. Clients have reported to Legal Aid NSW that they could not access timely specialist care, for diagnosis, monitoring or treatment of diseases and conditions that in some cases could become terminal or debilitating if left untreated. At the time of writing, we are aware of a diabetic client detained at Parklea CC who is unable to access insulin doses as per his needs and medical guidance. Our client told us that:

- he needs three shots of insulin per day but is only receiving two
- there are days when he does not receive insulin at all. On one occasion, he received no insulin for 4 days
- on some days he misses his dose because he is being moved or has an AVL (to access lawyers or participate in court) and there is no provision to ensure he receives insulin while in transit
- he says he currently has dangerous blood-glucose levels.

Such reports are not unusual and have been received over many years of legal service delivery to prisoners.

The risks associated with substandard care for chronic diseases increase for the elderly prison population. In NSW, there are just 38 beds to cater to the unique needs of over 1,000 aged prisoners. In its report, *Old and Inside*, the ICS observed that "[i]n contrast to inmates in mainstream centres, who reported difficulty accessing nurses for ailments or over-the-counter medications, inmates at the Aged Care Rehabilitation Unit and Kevin

[48] See page 8, MHRT Annual Report 2018/2019.
[49] Australian National University, "Double trouble with rural waiting times", Newsroom, 20 November 2014; http://www.anu.edu.au/news/all-news/double-trouble-with-rural-waiting-times (accessed on 16 October 2018). For all available data, see the Medicine in Australia, Balancing Employment and Life (MABEL) survey: http://graphc.anu.edu.au.
[50] During the period 2010 to 2014, men in prison aged over 65 years increased by approximately 225 per cent in NSW. It is estimated that there are over 1,000 aged prisoners in custody and this figure continues to increase. According to the ICS' 2015 report 'Old and Inside', older prisoners have "higher chronic and complex health needs than the younger population". The extent of these health needs is often obscured by "aged inmate passivity, the routine and order in centres, assistance from other prisoners and the support from well-meaning, but untrained, correctional officers".

Waller Unit appear to be having their pain managed effectively."[51] The report asserts that effective aged care in custody has the potential to avoid unnecessary suffering or further harm.

4.2.3 Delay in accessing medication

Lack of access to prescription medication is one of the most common complaints made by prisoners to Legal Aid NSW about their health care. Unsurprisingly, given the health profile of prisoners, many enter custody with long-standing prescriptions for medication. We also receive reports of prisoners missing medications in custody upon transfer between prisons because different clinics stock different medications. The following case study illustrates this issue.

Case Study: Harriet – missing prescription medication

Harriet is a woman in her 40s with a long history of chronic back pain due to a degenerative condition. She entered custody on Fentanyl patches, but these were taken away during reception screening. She also presented with multiple other serious factors affecting her physical and mental health. During one attendance at a custodial health clinic, Harriet expressed concern about some of the pain medication causing her acid reflux. The GP told her "we can use PPI to protect the stomach", referring to a proton pump inhibitor which works by reducing the amount of stomach acid. The GP then recorded a plan which included an anti-inflammatory drug and a daily dose of Pariet, a PPI medication used to manage acid reflux.

A month later, Harriet was transferred to another prison. On arrival, she was reviewed at the clinic where an attending nurse recorded "Do not stock 10 mg rabeprazole" (an

[51] Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (September 2015) page 11.

alternative to Pariet containing the same active ingredient), despite this being on the patient's chart. The Nurse apologised and put in an order for the drug.

During this period, Harriet consistently complained about extreme back pain which she recorded on both 'Patient Self-Referral' and 'Sick in Cell' Referral forms. On one of them she wrote:

> *"At no time was I consulted or even seen to discuss these decisions or the side effects this would have."*

She also complained that she was on a GP waiting list to discuss her issues, but due to a staff strike, the appointment did not take place.

4.3 Lack of access to allied health care

Allied health care in custody includes various services such as social workers, dieticians, physiotherapy, psychology, occupational therapy, radiography and sonography, diversional therapy and podiatry. The professionals in each discipline work as part of a multidisciplinary team intended to collaborate with medical and nursing staff. From our practice experience, the availability of these services is relatively limited, and clients report difficulties in accessing essential diagnostic and therapeutic care.

The following case studies illustrate some of the barriers to ensuring that prisoners who suffer injuries in custody receive timely and effective diagnosis and allied health treatment, including geographical barriers, centre lockdowns and delayed escorts.

Case Study: Cory – delay in access to medical imaging

Cory is a 30-year-old man who injured his lower back while playing football in custody.

He says the pain was initially tolerable but over the next few days it steadily increased. Two days after the incident, he presented at the clinic with lower back pain which he rated at 8 out of 10. He told the nurse that the pain was consistent and radiating from his right buttocks down through his right leg. A nurse gave him Ibuprofen, placed him on a

GP waiting list and recorded the issue in clinical notes as “semi-urgent”. Cory returned to his cell.

Seven days later, Cory saw a GP and reported that the pain was now shooting down his other leg.

Twenty-eight days after the accident, Cory returned to the clinic. This time, he said that his left leg had begun to go numb. Clinical notes confirm:

“Big toe completely numb, with reduced sensation in the rest of his toes, little to no sensation up to half…”

A nurse recommended Cory do gentle stretches and exercises such as walking and placed him on the GP waiting list for review that week or “asap”. Two weeks later, Cory saw another GP and said his left foot was numb.

Almost 10 weeks after the accident, Cory was escorted to hospital radiology for a spinal scan. An MRI revealed that he had a moderate sized disc herniation. This explained why he had difficulty moving and was favouring one side.

While he was detained in a regional prison, Cory was referred for physiotherapy at Long Bay Hospital. But due to his level of pain, he was unwilling to travel several hours by truck, so he has never received physiotherapy treatment.

Three years after the incident, Cory reported that he was still suffering from back pain. He consistently receives opioid-based pain killers used to treat moderately severe pain.

Case Study: Ashley – unable to access physiotherapy

Ashley was in a car accident in November 2012 which left her with multiple broken bones, including a fractured right shoulder and collarbone. She entered custody soon after where she received various orthopaedic treatments between 2013 and 2017, including three corrective surgeries.

After the third surgery, Ashley developed a noticeable lump on her right clavicle. A doctor who reviewed her thought she may have another fracture and documented the need for X-ray. Around this time, Ashley was transferred between four prisons in different parts of

NSW. She complained to staff of constant pain in her shoulder, which made it difficult for her to sleep or complete daily tasks like making her bed.

It took 18 days to order the X-ray, which in late April revealed a fresh fracture. Between April and August, Ashley was seen by the visiting doctor and at two orthopaedic clinics but did not receive any substantive treatment of her injury.

Following an orthopaedic review in mid-August 2018, the specialist recommended physiotherapy for muscle strengthening and exercises, with a follow up appointment in two months. Records show that appointments were booked with the Network physiotherapist in late August and mid-September 2018, but both were cancelled due to centre lockdowns.

Another five months passed before Ashley was able to access physiotherapy for the fracture. She otherwise had no access to therapeutic services to help manage her pain and improve her strength to aid recover. She continued to struggle with everyday tasks. She felt particularly distressed when a specialist told her that her collarbone would never heal properly and that she could not have any more surgeries. Ashley believes this outcome could have been avoided if she had received timely care and treatment.

4.4 Continuity of care

Continuity of care is a common issue when prisoners enter, leave or transfer between prisons. This engenders challenges with communication and information exchange between clinics, and between Justice Health, privately operated prisons and community health services. Our case studies illustrate that this is especially problematic for complex conditions which require consistent monitoring such as Type 1 diabetes. Clients also report being released and presenting to community health services without adequate discharge planning, including essential information about their recent treatment or medication. Health professionals at Local Area Health Districts have reported similar issues to lawyers from Legal Aid NSW.[52]

Aboriginal prisoners face additional barriers in accessing culturally safe care in custody with flow-on effects for their social and emotional wellbeing on release. Even where Aboriginal Health Workers are employed, clients report a reluctance to frankly disclose their health issues to Justice Health staff.

The following case studies illustrate the consequences that can arise from a lack of continuity of care when a person enters custody or is transferred between prisons. They highlight the importance of procedures to enable the swift and accurate exchange of health information as a person moves through the system. The case study of Winston is

[52] Such feedback occurred in the context of lawyers supporting clients on release from custody to re-engage with community health services.

also an example of delay in accessing appropriate specialist care, particularly for older prisoners[53] and those who enter custody with pre-existing conditions.

Case Study: Winston – delay in following community treatment plan

Winston was an elderly man in his late 80s who arrived in custody with a history of bladder cancer that required regular monitoring. He also arrived with a skin lesion on his right cheek that continued to worsen while he was incarcerated. Despite Winston's repeated requests for medical attention for both concerns, he was told he would have to wait several months for the necessary appointments.

In January 2018, Legal Aid NSW wrote to Justice Health raising concerns about Winston's lack of access to medical treatment. Shortly afterward, Legal Aid NSW obtained instructions to contact Winston's treating doctor in the community and request his medical records. Winston's medical records revealed that he was supposed to receive cystoscopies to monitor his cancer every 3-6 months. At that point in time, the procedure was already well overdue, as it appeared Winston still had not received a cystoscopy after almost 12 months in custody.

In March 2018, Justice Health responded to Legal Aid NSW's correspondence, acknowledging that for reasons beyond their control, including a lack of medical escorts to take him to specialist appointments, significant delays had occurred. This included the care he needed to monitor both his bladder cancer and the lesion on his face.

In April 2018, Legal Aid NSW again contacted Justice Health to share information about Winston's outside care and enquire about developments in his treatment. In June 2018, Justice Health confirmed that Winston's first cystoscopy and an appointment with a specialist doctor to assess the lesion on his face had taken place. They also said that they were not previously aware of Winston's outside treatment, but that as a result of the information provided, they had requested all necessary medical records.

In July 2018, Winston was diagnosed with bladder cancer and commenced chemotherapy. He died a few months later in hospital.

Case Study: James – unable to access mental health medication

James lives with multiple, complex mental health disabilities, including schizo-affective disability.

[53] During the period 2010 to 2014, men in prison aged over 65 years increased by approximately 225 per cent in NSW. It is estimated that there are over 1,000 aged prisoners in custody and this figure continues to increase. According to the ICS' 2015 report 'Old and Inside', older prisoners have "higher chronic and complex health needs than the younger population". The extent of these health needs is often obscured by "aged inmate passivity, the routine and order in centres, assistance from other prisoners and the support from well-meaning, but untrained, correctional officers".

James was in custody in the maximum-security section of a prison. He behaved well in prison and followed all prison rules and regulations. As a result, he was re-classified and moved to a minimum-security section of a prison, enjoying more freedoms and improved conditions.

When James moved sections, he was informed by the CSNSW staff that his medical paperwork had not yet been transferred and as a result, they did not yet have the authority to give him his prescribed medications.

Within two weeks of not being able to access his medication, James' mental health deteriorated. He repeatedly asked for access to his medication. During this time, he started to experience delusions and became psychotic, harassing prison guards and putting himself and other prisoners at significant risk of harm.

As a result of his behaviours, James was placed in isolation and then returned to the maximum-security section of the prison. Since being placed back in maximum security, his mental health has deteriorated.

4.5 Lack of access to external advocacy and support services

In our practice experience, people with disability in prison can have difficulty accessing external advocacy and support services, which in turn can exacerbate barriers to accessing health care.

For example, in October 2022 a delegation of the United Nations subcommittee on the Prevention of Torture were denied access to NSW prisons despite it being a requirement under the *UN Optional Protocol to the Convention Against Torture and other Cruel, Degrading or Inhuman Treatment or Punishment* to which Australia is a party.[54] As the head of the delegation to Australia observed, "the SPT is neither an oversight body, nor does it carry out investigations or inspections. It is a mechanism that makes confidential recommendations to State Parties on establishing effective safeguards against the risk of torture and ill-treatment in places of deprivation of liberty." Given the SPT's preventative mandate, this offered an opportunity to implement proactive measures in the NSW prison system.

Whilst National Legal Aid through Your Story has enabled many people in prison to share their experience with the Disability Royal Commission, we also note that Your Story was not permitted to meet with groups of prisoners about the Royal Commission in public

[54] OHCHR, *UN torture prevention body suspends visit to Australia citing lack of co-operation* (23 October 2022) < https://www.ohchr.org/en/press-releases/2022/10/un-torture-prevention-body-suspends-visit-australia-citing-lack-co-operation>. Tamsin Rose, *NSW's refusal to allow UN inspectors in prisons 'raises questions', human rights commissioner says* (The Guardian, 18 October 2022) <https://www.theguardian.com/australia-news/2022/oct/18/nsws-refusal-to-allow-un-inspectors-in-prisons-raises-questions-human-rights-commissioner-says >.

prisons in NSW. This was in contrast to arrangements in NSW's private prisons and in all other public prisons across Australia. There was also delay in establishing free prison phone lines for prisoners in NSW to access the Disability Royal Commission, as well as free legal and counselling support.

4.6 Treatment by correctional staff

Legal Aid NSW has received reports of prisoners being subjected to humiliating treatment by some correctional officers. Prisoners with intellectual and physical disabilities have reported to Legal Aid NSW that they are referred to as 'spastics' and 'retards'. Those with mental health conditions such as schizophrenia or bi-polar also report being referred to by both correctional officers and other prisoners as 'spinners'.

Case Study: Franco – humiliating treatment during legal visit [55]

In late 2016, a Legal Aid lawyer travelled to a correctional centre for a legal visit with Franco who was suffering from multiple, complex medical conditions that included symptoms of dementia and incontinence.

A corrections officer escorted the lawyer to an interview room near reception where she then waited for Franco to arrive. From where she was seated, she was unable to see reception, but could clearly hear conversations taking place in the area.

When Franco arrived, he spoke to the corrections officer on duty. The officer began to yell at him using words to the effect of:

*"Oh, that's horrible. You've come for a legal visit and you've s**t yourself!"*

The officer continued to speak to Franco in a belittling manner before sending him back to the cell block unaccompanied to clean up.

Shortly afterwards, two other officers arrived. The on-duty officer then began a loud exchange with them about the incident, ridiculing Franco and laughing about his incontinence. The three officers shared the story with other staff, two public visitors and another prisoner who was sent to clean the floor.

Franco returned 30 minutes later at the same time as two new visitors. The same officer announced that the prisoner had "*s**t himself*" and began recounting the incident in front of him.

The Legal Aid NSW lawyer observed that none of the officers in the vicinity displayed concern for Franco's wellbeing or respect for his privacy.

[55] All case studies in this submission have been de-identified, except for those drawing on published decisions from coronial inquests. The above case study about Franco is based on a Statutory Declaration prepared & signed by the visiting lawyer after returning from her legal visit with the client.

When the legal visit commenced, the lawyer asked Franco how he felt about being treated in that way by prison staff. Franco said words to the effect of *"It's normal - not unexpected"*. He then recounted how he had not received incontinence bags because the prison had run out.

Legal Aid NSW is concerned that prisoners with disability are at an increased risk of inhuman and degrading treatment, especially when they experience ongoing health complications.