



Despite pleading for help, a woman gives birth alone in a cell

On 30 January 2018, a woman we will call 'Amy' appeared in court. She was in the late stages of pregnancy and was granted bail subject to a number of conditions. However, she was unable to meet the conditions and was taken to the Melaleuca Remand and Reintegration Facility (Melaleuca).

On 17 February 2018, Amy was moved to Bandyup Women's Prison (Bandyup). She spent the first few days in the orientation unit but then moved to a cramped cell, in a double story unit, on the first floor, up a flight of stairs. Between 17 February and 11 March 2018, she received medical care from prison health staff and transfers to hospital for outpatient care.

At around 5:30 pm on 11 March 2018, Amy made a cell call. She used phrases that showed she was distressed and believed she was going into labour. She was taken to the Bandyup Health Centre for assessment, but information from the initial call was not passed on to the nurses. She complained to the nurses of abdominal pain but denied being in labour. She was given paracetamol and returned to her cell.

At around 6:00 pm, the night lock down occurred and at around 6.30 pm, Amy began to make a series of cell calls. Again, she was audibly distressed, and indicated she was in labour.

For the next hour, custodial staff talked to Amy intermittently through her cell door. However, due to poor prioritisation, communication and decision making, nursing staff did not arrive to assess her until approximately 7:35 pm.

By this time, Amy's distress was palpable, and she clearly needed help. However, the nursing staff could only assess her through the locked cell door, because the only person with cell keys was a senior staff member in the gatehouse.

At around 7.40 pm, Amy gave birth, alone, inside the locked cell. Nursing and custodial staff watched on, and attempted to support her through a hatch in the door but could offer no physical support.

This was obviously a high-risk situation for Amy and her child. She was in a cell, not in a sterile environment, and none of the standard perinatal checks for a mother and newborn were available. And staff would have been unable to administer first-aid had it been required.

Excessive delays continued even after Amy had delivered her child. Due to poor record keeping, we cannot put a precise time on it, but it took somewhere between seven and 12 minutes before the officer from the gatehouse arrived with the keys, and the cell door was opened. This finally allowed assistance to be provided.

Amy and her baby were transferred to hospital that evening.

Why did we do this review?

I wanted to understand how such a distressing, degrading and high risk set of events could have occurred in a 21st Century Australian prison.

I also wanted to know what the Department of Justice was doing to improve its practices, to mitigate the risks to pregnant women and their unborn and newly-born children, and to ensure there was no repeat of what happened to Amy.

More broadly, I was concerned about the risks to other prisoners, including people who might have suffered an in-cell heart attack, stroke or other medical emergency. In such cases, delays of the length that occurred in Amy's case could well prove fatal, or cause permanent injury.

Immediately after this incident, I sent the Department of Justice a list of questions on which it provided advice. It also launched its own reviews into the incident, and developed an action plan. The plan included updating policy, better

processes for treating and managing pregnant women, and improved staff training.

While the Department's steps were positive, we believed that further investigation was warranted, and therefore conducted this review.

I have given the full report of this Review to the Standing Committee on Public Administration, the Minister for Corrective Services, and the Director General of the Department of Justice. But I will not be releasing it publicly as it contains distressing and sensitive information, and I will not compromise Amy's right to privacy.

Instead, I have chosen to publish this summary of our conclusions and findings. It gives ample indication of the failings on the night, and the matters to which attention must be given.

Conclusion: systemic, human and procedural failings created serious and avoidable risk

We found that cascading and intersecting failures put Amy, her unborn child, and her newborn baby at high risk.

The situation was avoidable. It was the result of systemic, procedural, and human failings. They included:

- inadequate infrastructure for women in late stages of pregnancy
- inaction or slow action by some staff
- poor communication
- poor processes.

I hope never to see such a situation, and such failings, repeated.

Findings

There is not enough accommodation for pregnant women

There has been no proper planning or investment for female prisoners. It follows that there has been no proper planning for pregnant women.

In 2009, the Department of Corrective Services (as it then was) was given over \$600 million for new prison accommodation. Despite rising numbers of female prisoners, it gave almost all of it to men.

In a belated response to overcrowding at Bandyup, women were then given some 'leftovers' from the male estate. In 2013, a unit at Greenough Regional Prison was converted for use by women, but it was always problematic and never appropriate for those in late pregnancy.

Melaleuca opened in late 2016, but again it was carved out of a male prison (Hakea) and was not purpose-built. It comprises two double story accommodation blocks. It is a loud and stressful environment, and has no facilities for women in the later stages of pregnancy.

The Bandyup Nursery is used by women in the late stages of pregnancy and mothers with young babies. It can hold only eight women and is often full, as was the case when Amy was in custody.

We have been raising this issue for many years and in 2017 we recommended an expansion of accommodation for mothers and their babies. The Department said it would create additional housing by early 2018. That has not happened.

When we asked for an update during this review, we were told that additional housing was no longer necessary because, at the time, there were vacancies in the nursery. This was a wholly inadequate response: demand fluctuates and provision must be made.

Amy's accommodation was particularly unsuitable

Given the lack of suitable accommodation when Amy was in custody she was placed in a cell with bunk beds, up a flight of stairs, in a standard double story block (Unit 2).

Her placement appears to have been 'routine', with little or no consideration of her particular needs. The Department now acknowledges that it was not suitable. The Unit 2 cells are very cramped, and the double bunk hindered the ability to provide emergency medical care. Staff reported that they were unable to lie her down and provide assistance in the cell.

In response to this incident, the Department has decided to house women in the late stages of pregnancy in Unit 6 if there is not enough space

in the Nursery. Unit 6 offers more daily comfort because it has air-conditioning and access to a separate bathroom. However, the cells are even smaller than Unit 2 and, again, bunk beds block the provision of emergency care. The Unit 6 rooms also open directly onto an open walkway. This means there is nowhere a person can be moved without being exposed to the elements. If Amy had given birth in Unit 6, staff would have had even more difficulty providing emergency medical care.

In this review, we again recommend expanding housing for women in the late stages of pregnancy and new mothers. The Department has supported this, noting that scoping work is being undertaken.

We understand the fiscal pressures the Department is facing but the financial and reputational costs of doing nothing will outweigh the cost of doing something.

Bandyup has inadequate medical observation facilities

Bandyup has a room called an observation room in the health centre. It has two beds and an adjoining bathroom with a shower and toilet, but no CCTV. Staff are nearby but do not have a line of sight into the room. Therefore, if someone needs 'observation' this cannot be facilitated.

The lack of observation facilities was one of the reasons Amy returned to her cell prior to lockdown. It was also one of the reasons her move to the health centre after lockdown was delayed.

This review has recommended that the Department builds an infirmary for the women's prison system. The infirmary would not just cater for observation, but would allow more timely medical interventions, and reduce the costs of transferring women to hospital when they are unable to remain in their cell.

Communication was poor

Bandyup knew Amy was in the late stages of pregnancy and, on the night itself, she gave substantial and credible information to many staff to indicate she was in labour.

This information was either not passed on to the right people, or was passed on in a way that did not convey the urgency of the situation. When information was passed on, the nurses and senior staff did not seek further information in order to make an accurate assessment of Amy's situation and of the risks to her and her unborn child.

Staff were slow to act

Every single person on night shift on 11 March was aware that Amy was in pain and distress for at least an hour before the birth. The situation escalated without anyone apparently realising that an emergency situation was developing or taking appropriate action.

We also found that the management of shift changes took precedence over the provision of care and the management of risk.

We find it inexplicable that nobody called a Code Red emergency until after the baby was born.

The response to the code red was also inexplicably slow. It should never have taken 7–12 minutes for the cell door to be opened. The only keys to the cell were held by an officer in the gatehouse, at most a 2–3 minute walk away.

Staff culture and training need to be improved

Staff had both an individual and a shared responsibility to take earlier action, but failed to do so. It is not clear whether this was because they had become desensitised to the needs of Amy and other women in custody, lacked the requisite knowledge or skills, or assumed someone else would take responsibility. It was probably a combination of all three, none of which is acceptable.

We have previously drawn attention to issues of desensitisation at Bandyup and this review recommends that the Department implements a strategy to improve understanding and response to distress and pain management.

The Department has supported this and says it is providing trauma informed training to all staff, accompanied by training sessions on

professional standards, integrity, team work and communication.

We have also recommended that the Department implement strategies to ensure night shift staff have the skills and confidence for the role. Again, this was supported.

Record keeping and incident reporting was flawed

It is imperative for the Department to have accurate records so it can investigate incidents and allegations, and for accountability to external agencies.

In Amy's case, there were major flaws in record keeping and incident reporting.

- Bandyup staff were not logging all cell calls, despite a Departmental requirement to do so. The logs record Amy making three calls on 11 March. But audio records show she made seven calls. Staff also failed to log three calls made by other concerned women while Amy was in labour. The Department says it has provided reminders to staff and will implement random audits to ensure compliance.
- Incident reporting was not accurate. This was clearly a 'critical' incident, but was not initially recorded as such. It is not clear if this was a deliberate attempt to mislead, or whether staff were so desensitised that they did not recognise the risks and seriousness of the event.
- It was impossible to establish a clear timeline of events because, according to the Department, the time stamps on its records, including CCTV footage, are not synchronised. This does not meet basic record keeping practices and would not withstand scrutiny in the event of a death in custody.

Too little support was given to other prisoners

Other women in the prison, particularly in Amy's unit, were affected by the birth. They were very well aware of her pain and distress, and of the slow response.

The Department did not respond adequately to this. It relied on an already overstretched counselling system to support prisoners, but these services are prioritised for high risk people. Access to general counselling is very limited. No additional services were injected.

Amy's case generated understandable fear on the part of prisoners that medical emergencies at Bandyup will not result in a proper response. Many prisoners told us that they felt that staff did not care about their welfare.

Prisoners have a right to feel safe, and people who do not feel safe can react in a volatile way. Bandyup therefore needs to work with the prisoners to turn this belief around in order to ensure good order and safety, particularly after lockdown.

The Department supported our recommendation to implement strategies to ensure prisoners feel safe at Bandyup, but stated that processes for support and complaints are already in place. They did not acknowledge the likelihood that these support services were too stretched to provide support.

The health and safety of mothers and babies must be ensured

Pregnant women will continue to come into custody. The Department has a responsibility to ensure the health and safety of the mother and child are not compromised, even if resources are stretched.

There was no justification for what happened in Amy's case, and it must not be repeated.