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ORIGINAL RESEARCH

What can coronial cases tell us about the quality of emergency healthcare for prisoners in Australia?

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Abstract

Objective: This research aimed to examine the legal and regulatory obligations of authorities and healthcare professionals in the provision of prison emergency health services and to identify problems in the provision of emergency care to prisoners by using case examples from coronial findings.

Methods: Review of legal and regulatory obligations and a search of coronial cases for deaths related to the provision of emergency healthcare in prisons in the past 10 years in Victoria, New South Wales and Queensland.

Results: The case review identified several themes – issues with prison authority policies and procedures that delay access to timely healthcare or compromise the quality of care, operational and logistical factors, clinical issues and stigmatic issues including prison staff attitudes to prisoners requesting urgent healthcare assistance.

Conclusion: Coronial findings and royal commissions have repeatedly identified deficiencies in the emergency healthcare provided to prisoners in Australia. These deficiencies are operational, clinical and stigmatic and not limited to a single prison or jurisdiction. Applying a health quality of care framework focussed on prevention and chronic health management, appropriate assessment and escalation when urgent medical assistance is requested, and a structured audit framework could avoid future preventable deaths in prisons.

Key words: *coroner, emergency, healthcare, prison.*

Key findings

- Coronial findings and royal commissions have repeatedly identified deficiencies in emergency health care for prisoners in Australia.
- We found that deficiencies could be classified as operational, clinical and stigmatic.
- The use of technology and a health quality of care framework could contribute to the avoidance of future preventable deaths in prisons.

Introduction

Australia has a rising prison population with prisoner numbers at an all-time high of more than 42 000.[1] Prisoners are generally more vulnerable and tend to have greater healthcare needs than others in the community.[2] Importantly, they are unable to freely access emergency health services and rely completely on the prison authority to meet their emergency health needs. In Australia, the provision of healthcare in prisons is the sole responsibility of state and territory governments, although the model of delivery varies.[3] Challenges to providing healthcare in prisons include security and compliance needs, overcrowding, resourcing and funding issues.[4,5] Concerns have been raised in royal commissions and coronial findings about the quality of healthcare provided to prisoners.[6,7]

This research aims to examine the legal and regulatory obligations of authorities and healthcare professionals in the provision of prison emergency health services and to identify issues in the provision of emergency care to prisoners by using case examples from coronial findings in New South Wales (NSW), Victoria (VIC) and Queensland (QLD).

Legal and regulatory obligations

Human rights obligations

Australia is a party to international human rights treaties that require signatory countries to respect, protect and fulfil human rights obligations.[8,9] These treaties impose obligations regarding how prisoners are treated, including in relation to their health. The *United Nations Standard Minimum Rules for the Treatment of Prisoners* (also called the 'Mandela

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Rules') state that prisoners should enjoy the same standard of healthcare that is available in the community.[10]

Australia has not enacted legislation incorporating these treaties. However, the Australian Capital Territory, VIC and QLD have enacted human rights legislation.[11–13] All three human rights acts provide that persons deprived of liberty (such as people in prison or police custody) be treated with humanity and respect for the inherent dignity of the human person. Courts have held that protection of human dignity covers the right to medical treatment.[14]

State legislation, policies and guidelines

In addition to human rights treaties and legislation, specific state laws also regulate the provision of healthcare to prisoners, such as correctional services acts.[15–17] Other non-legislative policies and guidelines relating to prisoner healthcare also operate at national and state levels.[18–22] Although these guidelines and policies are not enforceable laws, they set out minimum standards or guiding principles for custodial healthcare. They stipulate that prisoners are to be provided with respectful and culturally appropriate healthcare of a standard equal to services available in the community.

Civil liability in negligence and the duty of care

Prison authorities owe a duty of care to prisoners to take reasonable care for their safety while they are imprisoned.[23] Since prisoners are unable to freely access medical services themselves, that duty naturally extends to the provision of medical care, including emergency care.[6] Furthermore, all health professionals, including those providing healthcare to prisoners, owe a duty of care to their patients to exercise reasonable care and skill in the provision of that care.[24]

Negligence is conduct which falls short of the standard required for the protection of others against unreasonable risk of harm.[25] In a prison setting, the standard of care is measured by what the reasonable prison authority, officer, nurse or medical professional of ordinary prudence would do in such circumstances.[25] This requires consideration of relevant statutory, professional and customary standards relating to the risk-creating activity. To determine whether the standard has been breached, courts consider whether the risk was foreseeable and not insignificant and whether a reasonable person in such circumstances would have taken precautions against the risk. In deciding whether a reasonable person would have taken precautions, courts will take into account the probability of harm occurring, the likely seriousness of the harm, the burden of taking precautions and the social utility of the activity that creates the harm.[26] In addition, prison authorities must also balance their duty to ensure the safety of prison officers and employees against the duty of care to provide healthcare to prisoners.[27]

We were unable to identify any case involving a claim in negligence arising from a death in custody in relation to a prisoner's access to healthcare for which a court decision has been published. However, in Australia, about 97% of civil claims generally are settled without a final judicial determination and details of such settlements are not generally in the public domain.[28] Therefore, it is possible that civil claims have been made against authorities for harm caused to prisoners due to alleged negligence in the provision of healthcare but have been settled out of court.

Offences under occupational health and safety legislation

Occupational health and safety laws create an indictable offence for an employer to fail to ensure, so far as is reasonably practicable, that persons other than their employees are not exposed to risks to their health or safety arising from the conduct of the undertaking of the employer.[29] This could apply to prisoners under the care of prison authorities. Recently, a provider of health services was referred for consideration of prosecution under Victorian legislation related to the death of Veronica Nelson.[7]

Health professional regulation

Health professions, including doctors and nurses, are regulated by the *Health Practitioner Regulation National Law Act 2009*. Where care provided falls below a reasonable standard or is a threat to patient safety, the Australian Health Practitioner Regulation Agency (AHPRA) can investigate and take action, ranging from warnings and educational interventions to de-registration. Coroners in most jurisdictions have the power to refer matters relating to clinicians to AHPRA. Recently, two clinicians were referred to AHPRA related to the death in custody of Veronica Nelson.[7]

Coronial case review

Search methods

To identify issues with the provision of healthcare in prisons, we searched coronial findings in NSW, VIC and QLD for deaths related to the provision of healthcare in prison in the past 10 years. These states were chosen because they cover the majority of the prison population. The legal information database *Austlii* and the website Media Monitors were accessed for inquest findings and information about recent inquests pending release of findings. Searches were done using a combination of keywords: 'death' and 'custody' or 'prison' or 'correctional centre'. We excluded deaths caused by suicide and hanging or as a result of violence or an accident. From the cases, we identified several themes by consensus. Themes relating to emergency medicine including inadequate emergency healthcare and inadequate chronic healthcare to prevent serious potentially fatal illness were identified. Case examples were chosen to illustrate these themes. The examples do not represent all cases where there were significant problems identified.

Themes identified

Four themes were identified:

1. Prison authority policies and procedures that delay access to

timely healthcare or compromise the quality of care (especially clinical assessment).
2. Operational issues and logistical factors.
3. Clinical issues, including the type, content and completeness of a clinical assessment.
4. Stigmatic factors relating to attitudes towards prisoners requesting urgent healthcare assistance.

Case examples are shown in Box 1.

An additional issue commonly identified has been reliance on nursing assessment rather than assessment by a doctor, even when serious symptoms were reported or there were multiple calls for assistance.[7,30–32] There are also other examples in coronial cases of the failure of prison officers or nurses to act on calls for assistance in a timely and appropriate fashion.[7,30,32,33]

BOX 1. *Case examples – inadequate emergency and chronic healthcare*

Coronial case	Condition	Issues identified
Nathan Reynolds[30]	Acute severe asthma	Prison authority's policies and procedures delaying access to timely emergency healthcare: • A minimum of three officers must be present to respond to a call for emergency assistance after lockdown • Prison officers must assess the situation themselves before calling a nurse or an ambulance Operational issues: • When the nurse is called, he/she must travel between the three campuses of the prison Clinical issues: • Inadequate reception assessment of a person with known severe asthma, including lack of an asthma action plan • Delay in calling an ambulance • Incorrect treatment Stigmatic factors: • Lack of urgency in prison officer response to call for emergency assistance
Damien Nobile[31]	Acute epiglottitis	Prison authority policies and procedures delaying access to timely healthcare: • Inadequate assessment of Mr Nobile through a locked door via a 'trap' in the door Clinical issues: • Failure of a nurse to carry equipment to measure vital signs • Inadequate assessment, including failure to consider other cell mates' report of events • Delay in calling an ambulance Stigmatic factors: • Failure to respond to repeated calls for assistance, including by a concerned cell mate • Tendency to not take requests for urgent assistance seriously
Veronica Nelson[7]	Complications of withdrawal from chronic opiate use and Wilkie Syndrome in the setting of malnutrition	Policies and procedures delaying access to timely healthcare: • Overnight, officer on post can only access a cell by asking for the supervisor who has the keys to co-attend • Disconnect between Correct Care Australasia (private company) providing medical care and Corrections Victoria staff and lack of formal process for information sharing Clinical issues: • Inadequate reception medical assessment by medical centre doctor who also rejected the nurse's recommendation of hospital transfer

Continued

BOX 1. *(continued)*

Coronial case	Condition	Issues identified
		• Standard one size fits all withdrawal management programme and lack of opioid pharmacotherapy options, regardless of level of dependency or severity of withdrawal symptoms • Blood tests could not be performed on a public holiday • Not placed on observations upon transfer to prison from medical centre even though patient had been vomiting and ill • Inadequate assessment through 'trap' on locked prison door • No escalation from prison officer and nurse, despite repeated request for assistance and vomiting Operational issues: • Intercom in the prisoner's cell are directed to a prison officer's post who is responsible for making health assessment with no access to underlying health information • A prison officer failed to physically check on Ms Nelson after she became unresponsive Stigmatic factors: • Desensitised to patients with acute health issues resulting from drug-use and withdrawal • Not taking patient's complaints seriously

Discussion

This analysis shows that relevant authorities and their delegates, through international human rights conventions, state human rights law, other relevant legislation and professional obligations are responsible for the provision of adequate healthcare, including emergency healthcare, to prisoners. They also owe a common law duty of care to prisoners.

Our search of coronial cases identified several recurrent themes, relating to policies and procedures, clinical issues, operational factors and stigmatic factors within prisons. On review of these cases, and of the legal obligations on prison authorities, we suggest a number of changes that could help avoid future adverse health outcomes and avoidable deaths in custody for prisoners, and manage liability for prison authorities. They are based on healthcare quality and safety principles. Our recommendations are:

1. Detailed and accurate admission health assessment including the development of a management plan for chronic health conditions and a schedule for regular medical follow-up.
2. As recommended by Magistrate Derek Lee,[32] all calls for medical help should require a prison officer-clinician co-response, rather than that responsibility being left to a prison officer without training in healthcare.
3. Clinician assessments of prisoners reporting acute health problems should be structured, and conducted in a way such that the clinician can assess/examine the whole patient.
4. Clinician assessments of prisoners reporting acute health problems should always include a full set of vital signs.
5. When vital signs are abnormal or the prisoner is reporting a potentially serious symptom (such as chest pain, severe shortness of breath, etc), a medical officer assessment of the prisoner should be required. In the past, the lack of an on-site medical officer, especially after office hours, was a barrier to this. Now, readily available telehealth services could provide this support.
6. After a clinical assessment for an acute health problem, there must be clear, structured documentation of the problem, the assessment and the management plan, including a plan for specific timely follow-up to ensure that the acute health problem is resolving and triggers for escalating the response.
7. When a prisoner has contacted prison officers for help for an acute medical condition repeatedly, a clinical assessment should occur on each occasion and, unless there is clear evidence that the condition is improving, a medical officer consultation should occur.
8. Empowerment of prison officers to call ambulance services when there is clear evidence of serious illness, without waiting for a nurse review.
9. An adverse event monitoring programme, including structured investigation of serious adverse events with reporting to a designated health authority.
10. Oversight of prison health services by Departments of Health, similar to other public health services.

Conclusion

Coronial findings and royal commissions have repeatedly identified deficiencies in the emergency healthcare

provided to prisoners in Australia. These deficiencies are operational, clinical and stigmatic, and not limited to a single prison or jurisdiction. Applying a health quality of care framework focussed on prevention, appropriate assessment and escalation and a structured audit framework could avoid future preventable deaths in prisons. The Australasian College for Emergency Medicine and the College of Emergency Nursing Australasia are well placed to inform changes to improve patient care and outcomes.

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Competing interests

AMK is a section editor for *Emergency Medicine* Australasia.

Data availability statement

Not applicable.

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