Additional submissions from Reynolds family to the *Select Committee on the High Level of First Nations People in Custody and Oversight and Review of Deaths in Custody*

As part of our initial submissions, we expressed the little cooperation between organisations that are involved with a death in custody. This issue was also evident during the inquest into Nathan's death.

It was disappointing and upsetting having to walk past the Correctional Officers that were on duty the night Nathan died, every day of the inquest. I would also say some families would feel intimidated, although my family did not. We heard the officers giving excuses, not remembering events and showing little remorse from their lack of care/response to Nathan's call for help.

Staff that were witnesses to the death should not be allowed in the corridor where families have to see them.

During the inquest, my family was told that we had to be cautious in the courtroom of saying anything or making sounds under our breath when something disgraceful was said by an officer.

In addition, I had male family members that wanted to attend the inquest but the days they were available to attend were the days that the correctional officers were giving evidence and because our family was warned about our words and actions, the officers should not be sitting in the corridor where families have to constantly pass.

We have attached a copy of our recommendations that we provided to the coroner, this could be valuable to other affected families.

Recommendations for Inquest

Employment and Training

Medical assessment upon employment and routine medical assessments completed – All staff that are required to attend to a medical emergency need to be fit and healthy to have the ability to perform the requirements of the job. As highlighted in the inquest CO Fifta was unable to move a pace that was needed to respond to the emergency. In addition, Fifta relied on inmates to provide emergency first aid, as he could not kneel to ground to assist.

Cultural Awareness Training – Families impacted by a death in custody should deliver a component of the cultural awareness training that details the lasting effects of inaction and/or inappropriate behaviours when dealing with Aboriginal inmates. This training then should become mandatory for all staff (from the Commissioners level to entry level staff) that work with the Department of Justice/Corrective Services. This information also needs to highlight the consequences of prejudice towards inmates and the effects such prejudices have e.g. There are a number of conflicting stories related to Nurse Kacey's remarks, however a number of people have stated that she immediately asked what drugs Nathan had taken, despite the fact that she was told he was having an asthma attack.

Specific training for nurses around asthma – Staff currently receive training but it is was evident that nursing staff missed warning signs that Nathan's Asthma was out of control and needed urgent attention. Asthma Australia

Training for Corrections Officers that a "knock up" call is to be treated as an emergency until they can prove otherwise – Throughout the inquest multiple CO's expressed their doubts over the authenticity of knock-ups and minimised their sense of urgency.

Training for Medical Staff – Medical staff should be provided with more training opportunities that highlight a number of high-risk situations they could find themselves in.

> The AHNM that attended to Nathan stated *'During my employment I attended the basic life support training day run by JH….The training did not prepare me for the incident I attended on 31 August 2018'.*

Increase in Medical Staff - Medical staff should be at each individual site (not one staff member across multiple sites) in all correction facilities 24 hours a day, 7 days a week. This allows Justice Health staff to 'provide and facilitate timely health interventions to inmates' (as per policy 6.1.2.1 JH&FMHN notifications).

> https://www.correctiveservices.justice.nsw.gov.au/Documents/copp/jhfmhn-notifications.pdf

A survey of 914 inmates from NSW Department of Corrective Services showed that 4 out of 5 women and almost 7 out of 10 men had at least one chronic health condition.

> (Ref: Kariminia, A., Butler, T., & Levy, M. (2007). Aboriginal and non-Aboriginal health differentials in Australian prisoners. *Australian and New Zealand Journal of Public Health*, *31*(4), 366-371.)

Review of Corrective Officers involved in 'treatment' of Nathan – [redacted]

Review of Justice Health Staff – [redacted]

Resources

First Aid Kits - Nursing staff should have a first aid bag on hand that they can take with them when they are attending to an inmate, instead of going via a clinic – It is our understanding that nurses only have first aid bags in the medical clinic.

Create Asthma Action Plan that takes into account prison settings and challenges – Asthma Australia have reached out to our family and offered their support to advocate reform.

Defibrillators – It was highlighted in the inquest that staff were led to believe that the defibrillator was on the crash cart, however this not the case. This caused more delays in providing emergency care to Nathan. Therefore, a number of defibrillators need to be installed throughout the correctional facilities, in locations that are accessible to all staff on the premises.

"Knock up" intercom system with cameras - We were advised that there are no camera's in a minimum-security wings to allow inmates to have privacy. If there was a camera, the Correctional Officers could have seen the desperation/body language and they could have acted faster and called for an ambulance after the first "knock up" call. I would recommend intercoms with cameras to be installed. I would also recommend a minimum of three intercoms with camera's to be installed, one installed on the communal area, one installed between the cells on one side of the wing and the third one installed on the other side of the wing between the cells.

Mobile Phones – Mobile phones should be available to staff when dealing with a medical emergency. This will ensure that the staff member responding to a medical emergency will be able to call triple zero and give accurate up to date information on the inmate's medical situation rather than relying on radioing to a guard that is in another area of the complex/facility. This issue was raised at the inquest and it was suggested by Corrective Services NSW that they were apprehensive in using them because the phones have SIM cards and inmates could steal the phone. I would recommend that they have mobile phones with no SIM cards, as this will still allow staff to call 000.

Peak Flow Meters – Every medical clinic in a correction setting should have a peak flow meter and easily accessible to all staff. Staff that would be required to use it need to be trained.

The use of a peak flow meter has been linked to significant improvements in the quality of life of asthma sufferers as it allows a greater understanding of the condition to inform treatment.

(Ref: Justice Health and Forensic Mental Health Network. (2017). Network Patient Health Survey. Malabar: Justice Health and Forensic Mental Health Network. SHPN: (JH) 160526, ISBN (print) 987-1-76000-568-9, ISBN (online) 978-1-76000-569-6.)

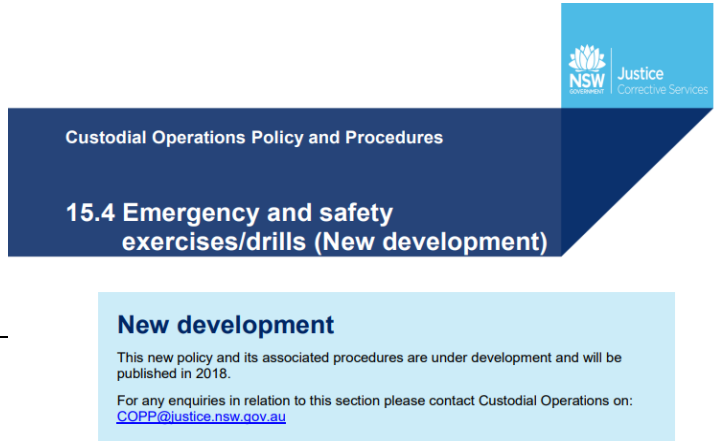
Policies and Procedures

Corrective Services and Ambulance NSW – Development of procedures/policies to address how emergency personnel are received at a corrections facility. For example, the attending paramedics were required to exit their vehicle to find a guard to confirm the location of the medical emergency. In all future call outs, it is recommended that a staff member meet paramedics on arrival to take them directly to the medical emergency. This will avoid time wasted and could mean the difference between life and death.

Corrective Services NSW – When a knock up occurs and an inmate indicates that they cannot breathe, an ambulance should be called immediately. Additionally, CO's need a consistent way of communicating; for example the inquest highlighted the fact that some CO's communicate critical information by phones, others use walkie talkies, in doing this vital information is not conveyed and can be missed by other Officers passing on information to emergency personnel. CO's have stated that they do not believe the majority of knock ups are legitimate, however had there been a policy of calling 000 for a knock up stating an inmate cannot breathe, the worst outcome would have been that an ambulance call out fee would have been charged to Corrective Services NSW, or the ambulance cancelled. In this case, the cost of an ambulance call out fee would have been far more cost effective compared to the cost of this inquest.

Audits – It is recommended that random audits be done on the medical information that is held by Justice Health and Corrective Services. This information should be reflected in the handover document when shift change occurs.

Drills – Drills are to be conducted on the process of locking down wings and ensuring inmates are secured when dealing with a medical emergency. This drill should include the checking of doors/entries that need to be used by medical staff including paramedics. Inmates need to be made aware of the medial emergency drills that will take place, so they understand the importance of complying with such drills. Website information still has not been updated as of 18/01/2021 (screenshot attached below)



Independent body to investigate a death in custody – Not having police investigate police/corrective service staff on death in custody matters. There needs to be an independent investigation. Having the departments investigated by an independent body, will assist in closing the gap between Aboriginal people and Government agencies.