Submission
No 628

INQUIRY INTO HEALTH OUTCOMES AND ACCESS TO HEALTH AND HOSPITAL SERVICES IN RURAL, REGIONAL AND REMOTE NEW SOUTH WALES

Organisation: National Justice Project

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National Justice Project

Submission to the Portfolio Committee No. 2 – Health Inquiry into Health Outcomes and Access to Health and Hospital Services in rural, regional, and remote New South Wales

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"She should still be here today. Our family will never be the same"[1]

Sharon Williams (mother of Naomi Williams, who died along with her unborn baby, on 1 January 2016 from a preventable death)

[1] Amy McQuire, 'Our Family Will Never Be The Same', *Primer* (online 24 October 2020) <https://primer.com.au/naomi-williams-family-racism-health-system/>.

National Justice Project

ABOUT THE AUTHORS

WARNING: First Nations readers should note that we are using the name of a deceased person with the permission of her family.

This submission has been drafted in honour and respect of the family of Naomi Williams, a Wiradjuri woman from Tumut, New South Wales (NSW), and all First Nations people that have experienced inadequate healthcare and are subjected to discrimination and prejudice. The submission is based on these experiences.

We acknowledge the advice and expertise of Dr Chelsea Bond, Munanjahli and South Sea Islander woman, Indigenous health researcher and Associate Professor at the University of Queensland.

THE NATIONAL JUSTICE PROJECT

The National Justice Project (**NJP**) is a not-for-profit human rights legal service that works to eradicate institutional discrimination through advocacy, education and legal action. We apply our expertise to advancing human rights by representing and providing a platform to amplify the voices of our First Nations clients who would otherwise be unable to find legal representation.

We acknowledge and celebrate the unique lore, knowledges, cultures, histories, perspectives and languages that Australia's First Nations Peoples hold. The NJP recognises that throughout history the Australian health and legal systems have been used as an instrument of oppression against First Nations Peoples. The NJP seeks to strengthen and promote dialogue between the Australian legal system and First Nations laws, governance structures and protocols. We are committed to achieving social justice and to bring change to systemic problems of abuse and discrimination.

We have represented, and continue to represent, many clients who have been directly impacted by negligent and inadequate medical treatment, often as a result of discrimination. The Inquest into the death of Naomi Williams was the first time a judicial officer found that implicit bias within the health care system had contributed to the death of a First Nations person, but the traumatic effects of inadequate health care have been felt broadly across First Nations communities and through generations. It is from this perspective that we make this submission.

ACKNOWLEGDEMENT OF COUNTRY

The NJP pays its respects to First Nations Traditional Owners and Elders, past and present, and extends that respect to all First Nations peoples. The NJP acknowledges the diversity of First Nations cultures and communities and recognises First Nations peoples as the traditional owners and ongoing custodians of the lands on which we work and where this report was written.

Contents

RECOMMENDATIONS 4
TERMS OF REFERENCE 4
RECOMMENDATIONS 4
1. OVERVIEW 6
CONTEXT 6
CASE STUDY – NAOMI WILLIAMS 9
THEMES EMERGING FROM NJP CASES 12
2. DISCRIMINATION AND A LACK OF CULTURAL SAFETY IMPACTING ACCESS TO AND QUALITY OF HEALTH CARE 14
Consequences in Naomi's case: 14
RACISM IMPACTING HEALTH OUTCOMES 15
Consequences in Naomi's case: 16
CULTURAL SAFETY 17
Consequences in Naomi's case: 18
DISABILITY 18
Consequences in Naomi's case: 20
PATIENT ADVOCACY 22
Consequences in Naomi's case: 22
MONITORING AND AUDITING 23
RECOMMENDATIONS 25
Appendix A: Recommendations from the Inquest into the death of Naomi Williams 27

RECOMMENDATIONS

TERMS OF REFERENCE

The Portfolio Committee No. 2 – Health Inquiry was established on 16 September 2020 to inquire into and report on health outcomes and access to health and hospital services in rural, regional and remote New South Wales. This submission broadly addresses a number of issues defined by the Terms of Reference, focusing on the impact on First Nations people. We have used the case study of Naomi Williams to emphasise the real life, devastating impact of the inadequacies in healthcare.

RECOMMENDATIONS

1. Engage with local First Nations community organisations, national representative peaks, and health experts in strategizing and implementing all recommendations that relate to First Nations communities.
2. Review and move to implement with urgency the recommendations of the Royal Commission into Aboriginal Deaths in Custody that relate to healthcare.
3. Work with First Nations communities to implement all recommendations from the Inquest into the Death of Naomi Williams through a place-based model across NSW, including:
    a. Implement safety alerts (Recommendation 1)
    b. Nurse Directed Emergency Care policy (Recommendation 2)
    c. Strengthen the Aboriginal Health Liaison Worker program in hospitals (Recommendation 3)
    d. Local employment and retention of First Nations health care professionals (Recommendation 4)
    e. Measure institutional racism and implicit bias (Recommendation 5 & 6)
    f. First Nations representation on leadership boards and committees (Recommendation 7)
    g. Develop strong localised models for culturally safe health care (Recommendations 8 & 9)
4. Increase resourcing and support for Aboriginal Community Controlled Organisations.
5. Explore ways to place First Nations people at the forefront of systemic and policy health system reform, including by resourcing First Nations-led research.
6. Consider the critical intersections of race, gender, class and disability and make suggestions for reform.
7. Consideration and prioritisation of health care for First Nations people with disability and complex needs.
8. Resource and support the priorities of the First Peoples Disability Network.
9. Consider the findings of the Australian Human Rights Commission's 2020 *Wiyi Yani U Thangani* inquiry as a critical source of insight into the experiences of First Nations communities and

strategies to improve services in non-metropolitan areas, including investment in digital infrastructure, prioritisation of on-country care and healing, improvement of transport infrastructure and improving disability, dialysis, detox and rehabilitation services.

10. An Aboriginal Liaison Officer and a doctor meet with all First Nations patients prior to discharge from hospital.
11. Urgently review the provision of and access to mental health services, including detox and rehabilitation, in rural, regional and remote NSW and take action to improve access to and the quality of these services.
12. Strengthen the Aboriginal Health Liaison Officer program and support the development of community-led culturally appropriate patient advocacy opportunities.
13. Support, resource and implement the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.
14. Work with First Nations leaders to develop and maintain community-defined, objective, quantitative and qualitative measurements of institutional racism and implicit bias, with the results published and utilised to implement evidence-based reforms.

1. OVERVIEW

CONTEXT

1.1 In this section of submission, we will highlight the entrenched discrimination within the health system leading to negligent and inadequate health care for First Nations people. Racial discrimination and cultural safety are priority areas that must be urgently addressed to improve health outcomes for First Nations people.

1.2 It is well documented that First Nations peoples living in rural, regional and remote NSW suffer poorer health outcomes,[2] and we do not propose to repeat those established facts here.

1.3 Racism and discrimination is an endemic problem in Australia, and since colonisation has been used as an apparatus of oppression of First Nations peoples. Racism often functions as a series of implicit biases.[3] A recent study found that 2 in 3 Australians hold negative views towards First Nations people.[4]

1.4 We submit that these attitudes permeate into our health system. There is a growing and substantial body of evidence to establish racism, discrimination and disempowerment as determinants of poorer health outcomes.[5] Discrimination in the health system can present as either systemic barriers preventing or deterring individuals from accessing health care or as unsafe and inconsistent provision of health services.[6]

1.5 A systemic review of First Nations peoples experiences accessing healthcare revealed that almost a third of First Nations peoples are subjected to institutional and direct racism, most commonly in the form of racist commentary, stereotyping and exclusion. [7]

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[2] Australian Institute of Health and Welfare, 'Indigenous Health and Wellbeing' (2020) *Australia's Health 2020: Snapshot* <https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing>; Margaret Scrimgeour and David Scrimgeour, *Health Care Access for Aboriginal and Torres Strait Islander People Living in Urban Areas, and Related Research Issues: A Review of the Literature* (Discussion Paper No. 5, Cooperative Research Centre for Aboriginal Health, May 2008) <https://www.lowitja.org.au/content/Document/PDF/DP5_final-pdf.pdf >; Judith Healy et al, 'Australia: Health system in review' (2006) 8(5) *Health Systems in Transition* 1-158 <Australia: health system review (who.int)>.

[3] Siddharth Shirodkar, 'Bias against Indigenous Australians: Implicit association test results for Australia' (2019) *Journal of Australian Indigenous Issues* 22(3-4) 3, 4 <https://search.informit.com.au/fullText;dn=150032703197478;res=IELIND>.

[4] Shirodkar (n 3) 4.

[5] Yin Paradies et al, 'Racism as a Determinant of Health: A Systematic Review and Meta-Analysis' (2015) *PLoS One* 10(9) <Racism as a Determinant of Health: A Systematic Review and Meta-Analysis (plos.org)>; NSW Nurses & Midwives' Association, 'Prejudice Impacts Aboriginal Health' (online article, 30 June 2017) <http://www.nswnma.asn.au/Staging/prejudice-impacts-aboriginal-health/>; Kalinda Griffiths et al, 'How colonisation determines social justice and Indigenous health - a review of the literature' (2016) 33(1) *Journal of Population Research* 9-30; Yin Paradies, 'Colonisation, racism and indigenous health' (2016) 33(1) *Journal of Population Research*, 83-96.

[6] Yin Paradies et al, 'Racism as a Determinant of Health: A Systematic Review and Meta-Analysis' (2015) *PLoS One* 10(9) <Racism as a Determinant of Health: A Systematic Review and Meta-Analysis (plos.org)>.

[7] Warren Jennings, Chelsea Bond and Peter Hill, 'The Power of Talk and Power in Talk: A Systematic Review of Indigenous Narratives of Culturally Safe Healthcare Communication' (2018) 24(2) *Australian Journal of Primary Health* 110.

1.6 The Australian Government itself has acknowledged the existence of racism and discrimination and the need to improve cultural safety in their Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023.[8]

1.7 Governments have a responsibility to ensure the highest attainable standard of health and wellbeing of their people through the provision of adequate health services and social measures, an internationally recognised and fundamental requirement.[9] The United Nations Declaration on the Rights of Indigenous Peoples (**UNDRIP**) specifically provides that First Nations peoples have the right to access health services free of discrimination.[10] Adequate healthcare provision for First Nations peoples requires culturally safe health services that are capable of providing safe and appropriate care.

1.8 Dr Chelsea Bond has highlighted that the health system has thus far escaped the same level of scrutiny applied to the justice system through the Black Lives Matter movement resurgence, but importantly, we should be as outraged by "the deaths in the hospital, in the ambulance, as we are in the watch house and the prison".[11]

The Historical Context:

1.9 The experiences of First Nations people and healthcare cannot be properly considered without acknowledgement of the historical context in which health has operated. Australia as a colony was built on the social construction of race as a divisive power and we do not minimise its power by ignoring it.[12] Many regional hospitals were segregated, some as late as the 1960s and most First Nations peoples are aware and continue to feel the impacts of this history.

1.10 The idea that people can be organised and graded by race in the development of modern medical science legitimised the socio-political structure that still exists today, in which white bodies are centralised and nation-building was based on racial purity.13 As summarised by Christopher Mayes, embedded in the foundational policies of colonial Australia is the historical and yet persisting operation of health for First Nations peoples as an oppressive tool; "medicine provided justification

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[8] Department of Health, *Implementation Plan for the National Aboriginal and Torres Strait Islander Health Plan 2013–2023* (2015) ('*NATSIHP*') 1, 3, 11. The vision of NATSIHP is "a health system free of racism and inequality".
[9] *Constitution of the World Health Organisation*, opened for signature 22 July 1946 (entered into force on 7 April 1948); UNDRIP art 24(2); *International Covenant on Economic, Social and Cultural Rights,* opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976), art 12 ('*ICESCR*').
[10] UNDRIP art 24(1).
[11] McQuire (n 1).
[12] Chelsea Bond, 'Fifty Years on from the 1967 Referendum, It's Time to Tell the Truth About Race' *The Conversation* (Online, 30 May 2017) <https://theconversation.com/fifty-years-on-from-the-1967-referendum-its-time-to-tell-the-truth-about-race-78403>.
[13] Christopher Mayes, 'White Medicine, White Ethics: On the Historical Formation of Racism in Australian Healthcare' (2020) 44(3) *Journal of Australian Studies*, 287-302 <White Medicine, White Ethics: On the Historical Formation of Racism in Australian Healthcare (tandfonline.com)>.

for racial liberalism. Leading scientists and medical institutions helped sustain a sociopolitical reality in which white bodies occupied the centre, and where ideals of equality, freedom and individuality were openly and unashamedly racially coded".[14]

1.11 Research on First Nations peoples prior to the 1960s was towards a greater understanding of white Australians health problems and capturing information before the expected extinction of First Nations peoples, rather than improving their health.[15] Even today, we have amassed information on Indigenous body parts and behaviours, but are yet to invest significantly in a research agenda into the impacts of race in the production and persistence of health disparities.[16]

1.12 Western medicine, healthcare and disease were introduced with colonisation, prior to which First Nations people managed their own health and methods of care and healing, a fundamental, continuing right.[17] Despite efforts in recent times, the system continues to devalue First Nations culture and knowledge.[18]

Health care in the Justice System:

1.13 Health care provision within the prison system is inadequate, irrespective of geographic division. It is well documented that First Nations individuals are incarcerated at a disproportionate rate to the rest of the population. Since the 1991 Royal Commission into Aboriginal Deaths in Custody (**RCIADIC**), there have been at least 434 deaths of First Nations people in custody.[19] The sub-standard health care within prisons, and the lack of cultural safety afforded to First Nations individuals within that system, is one of many contributing factors to the unacceptably high rate of First Nations deaths in custody. Mental health support within the prison system is also absent, culturally inappropriate or insufficient.[20]

1.14 We refer the Committee to the Recommendations from the RCIADIC that relate to healthcare provision,[21] many of which are yet to be implemented. In particular, recommendation 242 regarding liaison and involvement with Aboriginal Health Services "in the provision of health and medical

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[14] Christopher Mayes, 'White Medicine, White Ethics: On the Historical Formation of Racism in Australian Healthcare' (2020) 44(3) *Journal of Australian Studies*, 292 <White Medicine, White Ethics: On the Historical Formation of Racism in Australian Healthcare (tandfonline.com)>.

[15] David Thomas, 'The upsurge of interest in Indigenous health in the 1950s and 1960s' (2004) 180(521) *Medical Journal of Australia* <tho10616_fm.fm (mja.com.au)>.

[16] Chelsea Bond and David Singh, 'More than a refresh required for closing the gap of Indigenous health inequality' (2020) 212(5) *Medical Journal of Australia* 198-199.

[17] *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UN Doc A/RES/61/295 (2 October 2007, adopted 13 September 2007) art 24 ('*UNDRIP*').

[18] Australian Human Rights Commission, *'Wiyi Yani U Thangani (Women's Voices): Securing Our Rights, Securing Our Future'* (Report, 2020) 483 <https://wiyiyaniuthangani.humanrights.gov.au/report> ('*Wiyi Yani U Thangani*').

[19] Lorena Allam et al, 'Aboriginal deaths in custody: 434 have died since 1991, new data shows', *The Guardian* (Online 6 June 2020) <Aboriginal deaths in custody: 434 have died since 1991, new data shows | Australia news | The Guardian>.

[20] Australian Human Rights Commission, (n 18), 203

[21] *Royal Commission into Aboriginal Deaths in Custody* (National Report, 1991) vol 5, 57-64, 75-80, 86 ('*RCIADIC*'), specifically recommendations 246-271.

advice, assistance and care with respect to Aboriginal detainees and the funding arrangements necessary" and recommendation 278 that health care in correctional institutions "should be of an equivalent standard to that available to the general public".[22]

1.15 We implore that the Committee appreciate this intersection and call upon it to address the issues as interrelated, and not isolated, systemic failures. **We recommend the Committee review and move to implement the recommendations of the RCIADIC that relate to healthcare.**

1.16 The NJP submits that the lack of progress in the provision of indiscriminate health care to First Nations peoples is not due to a lack of practical, workable solutions but because of an absence of political will. The Portfolio Committee must not allow yet another opportunity for reform presented by this Inquiry to lapse without consequence. We call upon the NSW Parliament to take immediate, specific and meaningful steps to improve the health outcomes of First Nations people by addressing the racism that exists in the delivery of health services.

CASE STUDY – NAOMI WILLIAMS

1.17 Naomi Jane Williams (**Naomi**), a Wiradjuri woman from Tumut in regional NSW, died on 1 January 2016 at nurse-led Tumut Hospital (**the Hospital**). A passionate community woman, social worker and an award-winning disability worker,[23] Naomi was 27 years old and 22 weeks pregnant with her first child when she died.[24]

1.18 Naomi's mother, Sharon describes her daughter as a loving, caring and community-oriented person with a creative and passionate spirit. Naomi and her partner Michael were overjoyed at the impending birth of their first child and were preparing for a life together.[25] Naomi's death was nothing short of a tragedy and a loss not only for her family, but also for the broader community.

1.19 Naomi's cause of death was determined to be septicaemia, caused by the bacteria *Neisseria meningitides*,[26] an infection preventable by antibiotics. However, despite at least eighteen (18) presentations to hospital, Naomi unnecessarily passed away due to a lack of adequate treatment or referral to a specialist. Naomi's treatment was impacted by racism and implicit bias.[27]

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[22] *Royal Commission into Aboriginal Deaths in Custody* (National Report, 1991) vol 5, 58, Recommendation 3.
[23] McQuire (n 1).
[24] *Inquest into the death of Naomi Williams* (29 July 2018) 2016/2569 (State Coroner, NSW, 2018) [1], [117] (*'Coroner's Report'*) <[Inquest into the death of Naomi Williams (nsw.gov.au)]>.
[25] Coroner's Report (n 24) [2]-[3].
[26] Coroner's Report (n 24) [118].
[27] Coroner's Report (n 24) [108]-[111].

1.20 In December 2016 Naomi's family, represented by the NJP, petitioned the State Coroner for a Coronial Inquest into the Death of Naomi Williams (**the Inquest**). The family hoped that an inquest would provide clarity as to why Naomi died, with the hope that in pursuing accountability for Naomi's death, the treatment of First Nations people within the health system could improve for the benefit of the entire community.[28] Naomi's family believes that without accountability, there will be no systemic change and the discriminatory treatment of First Nations people in the health system will continue with significant consequences.

1.21 Naomi presented to the Hospital eighteen (18) times or more in the period from May 2015 to 1 January 2016.[29] Naomi repeatedly complained of vomiting, severe abdominal pain and dehydration. Naomi also suffered weight loss and extremely high blood pressure throughout her pregnancy.

1.22 Naomi's concerns were repeatedly undermined by referrals to Drug and Alcohol and Mental Health services, or by the provision of Panadol despite her longstanding and persistent symptoms. The drug and alcohol referrals continued notwithstanding that on 1 July 2015, a review confirmed that Naomi had no need for those services.

1.23 On 16 July 2015, Naomi's mother, Sharon Williams, emailed a complaint to the Acting Multi Service Manager of the Hospital, raising concerns about the repeated Drug and Alcohol service referrals and the nature of Naomi's care at the Hospital. Sharon specifically stated that "*she* [Naomi] *feels her illness is being overlooked and she is being stereotyped*". The nurse responded to Sharon's complaint claiming that the hospital provided "*world class care*" and included words to the effect that if Naomi was not comfortable with the service, she could seek support or care elsewhere.

1.24 Despite Naomi's frustration at the racial bias and stereotyping she experienced, she continued to present at the Hospital as living in a rural area, it was difficult for her to access medical care elsewhere. The same nurse was present the next time Naomi attended the Hospital. Naomi clung to that nurse, pleading for adequate care. Despite Sharon's letter and Naomi's clear distress, she was referred yet again to Drug and Alcohol and Mental Health services. Naomi was never referred to a specialist.

1.25 On New Year's Eve 2015, Naomi drove herself to the Hospital as she had been suffering extreme generalised pain, fever and headaches, describing it as "*the worst I've ever felt*". Naomi was triaged

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[28] Coroner's Report (n 24) [5], [7].
[29] Coroner's Report (n 24) [114].

in the Emergency Department at 12:19AM on 1 January 2016 but discharged almost immediately (at 12:53AM) with two Panadol and no plan for extended care.[30]

1.26 Naomi then drove home, where her symptoms worsened and she suffered a seizure. At 3:08PM on New Year's Day 2016, Naomi passed away. Her unborn baby died with her.[31]

1.27 A number of critical indicators were missed on the day of Naomi's death, including:

- Naomi driving herself to the hospital on New Year's Eve;
- multiple re-presentations (3 in total) in 24 hours;
- Naomi's symptoms were on the border of the yellow zone;
- Naomi had a high-risk pregnancy, suffering weight loss;
- Naomi presented to the Emergency Department (**ED**) with low blood pressure and a high heart rate (abnormal especially when compared to her records); and
- the failure of hospital staff to access and consult Naomi's paper records when she attended the ED on the day she died. [32]

1.28 At the Inquest, Deputy State Coroner Magistrate Grahame considered evidence of the medical care that was provided to Naomi from May 2015 to her death on 1 January 2016.[33] The Coroner's Report identified that the medical staff at the Hospital:

- failed to properly assess the pain Naomi was experiencing;
- failed to properly investigate Naomi's high heart rate and low blood pressure;
- failed to recognise Naomi had a high-risk pregnancy;
- failed to check Naomi's record which would have identified that she had repeatedly presented to the ED at the Hospital over the past year; and,
- failed to have her care escalated by referral to an obstetrician and gastroenterologist, as was required in the circumstances.[34]

1.29 Coroner Grahame made nine recommendations to Tumut Hospital (**Appendix A**), seven of which were aimed at reducing "implicit bias".[35] The Coroner's findings represented the first time a judicial officer found that implicit bias and prejudice within a health service contributed to the death of a First Nations person.

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[30] Coroner's Report (n 24) [115-116], [122], [180-181], [184].
[31] McQuire (n 1); Coroner's Report (n 20) [204], [207].
[32] Coroner's Report (n 24) [179], [183], [186], [240].
[33] Coroner's Report (n 24) [13].
[34] Coroner's Report (n 24) [1.42], [103], [147], [162]-[165], [172].
[35] McQuire (n 11); Coroner's Report (n 24) [278].

1.30 In September 2020, the NSW Health Minister, Brad Hazzard, confirmed his support for the nine recommendations made by the Deputy State Coroner to the Hospital at the Inquest into the Death of Naomi Williams.[36] **We recommend that all recommendations from the Inquest into the death of Naomi Williams are implemented through a place-based model across NSW.**

1.31 For Naomi's family, the Coroner's findings represent vindication and opportunities to reform the health system to prevent other families suffering unnecessary loss. However, Naomi was not the first or last First Nations person to suffer from discrimination and culturally unsafe care in our health system.

THEMES EMERGING FROM NJP CASES

1.32 Between 2016 and 2020, NJP has worked on at least 18 cases related to negligent or inadequate health care of First Nations people. In this period, NJP has lodged or is in the process of lodging at least 10 complaints relating to the sub-standard health care and/ or medical treatment of First Nations individuals.

1.33 Significant and disturbing themes are emerging from these cases. We illustrate these below and humanise them with a de-identified case studies from our files as a reminder of the real, detrimental impacts upon First Nations individuals, families and wider communities.

Theme	**Example from our case files**
a) Turned away without proper assessment and subsequent medical treatment	A First Nations woman presenting with extreme pain was turned away on five occasions. Failure by medical professionals properly assess her condition and admit her into care resulted in her never receiving adequate treatment and she has been left with permanent disabilities. A First Nations man presented to the prison medical service ten (10) times over a 2-month period with serious abdominal pain and severe symptoms and was continually turned away. After months of suffering, he was eventually taken to hospital where a large, dangerous ulcer was removed and he was left with a 30cm scar and serious mistrust for the system.

[36] Letter from Brad Hazzard MP, Minister for Health and Medical Research, to Hon. Mark Speakman SC, MP Attorney General, dated 2 September 2020 (reference 2016/2569 and COR19/6).

Theme	Example from our case files
b) Individual's view of their condition is often ignored and delegitimised	A First Nations man with cancer requiring palliative care expressed he was in extreme pain. He was told by a doctor to drink more fluids and exercise. He died a week later. Prison nursing staff dismissed a First Nations woman (who was on remand) complaining of crushing chest pains. She had a cardiac arrest and died.
c) Lack of clear communication with patient, especially regarding treatment options or follow-up plans	A First Nations man with bowel cancer presented to the hospital with his sister due to ongoing abdominal pain. He rated the pain 10/10 on this occasion. He was given some pain medication but no plan for ongoing management was discussed with him or his family despite their specific requests. The pain continued. Five days later, the man passed away. Hospital staff did not discuss his death with his family.
d) Dismissive, derogatory and/or degrading attitudes from health professionals	During a critical time in her treatment, a nurse told a First Nations woman in pain to "*stop being pathetic.*" The woman and her family had reduced expectations of care following her treatment, and she ultimately had to undergo amputations. A First Nations man with serious, ongoing abdominal pain was told by medical staff, "*there is nothing wrong with you, it is all in your mind*". He ultimately had to undergo surgery and be admitted to hospital for 5 days.
e) Racist stereotyping leading to avoidance of medical institutions due to fear of discrimination and a lack of trust	A First Nations woman did not complete her course of cancer treatment course because she felt staff treated her like a drug addict when she sought pain relief. A First Nations man, in need of medication following surgery, felt that he was stereotyped by the nursing staff as a drug addict due to his race.
f) Inadequate and/or inappropriate treatment	A pregnant First Nations woman suffering with abdominal pains was in hospital for 6 days before an ultrasound was ordered. Her baby was stillborn.

2. DISCRIMINATION AND A LACK OF CULTURAL SAFETY IMPACTING ACCESS TO AND QUALITY OF HEALTH CARE

2.1 Though Aboriginal Community Controlled Health Organisations (**ACCHOs**) are best placed to be deliver health services in their communities, mainstream services also need to be accessible and culturally safe.[37] First Nations communities have highlighted the importance of choice in accessing services.[38]

2.2 Continued experiences of racism and lack of adequate care can lead to an expectation of discrimination and avoidance of certain situations and institutions altogether. First Nations disability expert and researcher, Worimi man, Dr Scott Avery has described this concept as 'apprehended discrimination', relating to a rational fear of discrimination, based on experience, which can lead to an avoidance of situations in which a person would be further exposed to discrimination.[39] A fear of accessing health services can impact on health outcomes of First Nations people, particularly when it prevents essential follow up treatment. These risks are exacerbated in rural, remote and regional areas where there are limited alternative options.

Consequences in Naomi's case:

- During the Inquest, a number of witnesses provided statements to the Coroner's Court about their perceptions of local racism and second rate care at the Hospital. Robert Bulger stated that a lot of Aboriginal people "feel they cannot go up to the Hospital as they won't get the treatment they need."[40]
- In December 2015, Naomi visited Winunga Nimityjah Aboriginal Health Service and she felt listened to at that service.[41]

2.3 ACCHOs are uniquely placed to provide culturally appropriate, trauma-informed, prevention, early-intervention focused wrap-around support and care for First Nations communities.[42] This approach diverts from the mainstream crisis-driven model, to a more holistic model of service provision that

[37] Hannah Bulloch, William Fogarty, Kate Bellchambers, Lowitja Institute, *Aboriginal Health and Wellbeing Services: Putting community-driven, strength-based approaches into practice* (Report, 2019) 14 <Aboriginal_Health_and_Wellbeing_services_DD3_FINALwith_links.pdf (lowitja.org.au)>; National Aboriginal Community Controlled Health Organisation, *Annual Report 2018-2019* (Report, 2019) < NACHHO0043-Annual-Report-18-19-web-version.pdf (naccho.org.au)>.
[38] Australian Human Rights Commission, (n 18), 265.
[39] Scott Avery, *Culture is Inclusion: a narrative of Aboriginal and Torres Strait Islander people with disability* (First Peoples Disability Network, 2018) 43.
[40] Coroner's Report (n 24) [224].
[41] Coroner's Report (n 24) [232].
[42] Australian Human Rights Commission, (n 18), 395.

appropriately responds to the needs of First Nations communities.[43] We support the structural reforms recommended in the Australian Human Rights Commission's 2020 *Wiyi Yani U Thangani* report, focusing on the increased resourcing and support for ACCHOs to enable them to deliver appropriate services for First Nations peoples, including in prisons and youth detention facilities.[44]

RACISM IMPACTING HEALTH OUTCOMES

2.4 Racism in health care systems is often understood as a series of individual behaviours, implicit biases, prejudices and attitudes from health service providers toward people of distinct cultural backgrounds.[45]

2.5 There is a growing body of work exploring the concept of 'Whiteness' as the invisible norm inherent in the law, policy, decision-making and institutions. This approach maintains that racism is not an aberration but inherent in how institutions operate, which explains its entrenched nature despite decades of attempting to reduce discrimination.[46]

2.6 Combating systemic racism in NSW and beyond will require a more conscious, reflective and widespread analysis of the inherent white racial dominance within the health care system, similar to the audit undertaken in Queensland.[47]

2.7 The Australian Human Right's Commission's 2020 *Wiyi Yani U Thangani* Report provides comprehensive insight into First Nations women and girls experiences of both direct and systemic racism, describing the rarely acknowledged or addressed impacts on the health and wellbeing.[48]

2.8 Despite the broad acknowledgement that racism exists in health care, there is a paucity of research in Australia into how race operates to produce health inequalities. Professor Paradies (et al) carried out a systemic review and meta-analysis of research from 1983 to 2013 into racism as a health determinant. Of the 333 articles in their study, only 9 were Australian[49], highlighting the limited Australian-based data, research and analysis available.

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[43] Australian Human Rights Commission, (n 18), 259-286.
[44] Australian Human Rights Commission, (n 18), 104-5.
[45] NATSIHP (n 8) 56.
[46] See as examples: Aileen Moreton-Robinson, 'Towards a New Research Agenda? Foucault, Whiteness and Indigenous Sovereignty' (2019) *Seeing Race Again* 299, 302; Chelsea Bond et al 'Beyond the pipeline: a critique of the discourse surrounding the development of an Indigenous primary healthcare workforce in Australia' (2019) 25(5) *Australian Journal of Primary Health* 392; Chelsea Bond and David Singh, 'More than a refresh required for closing the gap of Indigenous health inequality' (2020) 212 (5) *Medical Journal of Australia* 199.
[47] Bond et al, 'Now we say Black Lives Matter but … the fact of the matter is, we just Black matter to them' (2020) 213(6) *MJA* 248, 249 <https://www.mja.com.au/system/files/issues/213_06/mja250727.pdf>; Moreton-Robinson (n 45); Coroner's Report (n 24) [229].
[48] Australian Human Rights Commission, (n 18), 390.
[49] Paradies (n 9).

2.9 Discussion into root causes of poorer health outcomes in First Nations communities generally ‘blames the victim’ by focusing on cultural factors and ‘choices’ made.[50] However, that framework ignores the impact of colonialism, institutional racism and structural inequalities. Solutions have often focused on reducing individual expressions of racism, such as attitudinal change and training, rather than a systemic change. It is imperative that institutional racism is brought forward in this discussion.[51]

2.10 Racial prejudice can be magnified by intersectionality with other forms of difference such as gender, class or disability – and in such situations the risk of harm is compounded. **We recommend that the Committee consider these critical intersections in its investigations and make suggestions for reform.**

2.11 Dr Chelsea Bond describes racism within healthcare and the impacts in preventing First Nations people from receiving appropriate treatment and care as a form of “colonial violence” requiring urgent, structural and individual reform.[52]

2.12 To reform the current system and elicit meaningful change, Bond (et al) recommends foregrounding First Nations sovereignty with the strength and capability First Nations peoples in all health policy formation and implementation, “not as partners but as architects”.[53]

2.13 **We recommend the Committee explore ways to place First Nations people at the forefront of systemic and policy health system reform, required for First Nations people to access culturally safe and effective healthcare, including investing in First Nations-led research into how racism operates and the necessary pathways forward.**

2.14 **We recommend localised implementation of the Coroner’s recommendations in the Inquest into the Death of Naomi Williams across NSW, including establishing mandatory targets for proportionate representation of First Nations peoples on Local Health Advisory Committees and District Boards (Recommendation 7) and ongoing consultation within local communities to develop a strong local model for providing culturally safe health care (Recommendation 8).**

Consequences in Naomi’s case:

- As at 1 January 2016, not all staff at the Hospital had completed all components of the Respecting the Difference training, a course designed to improve cultural competency and understanding of

[50] Bond et al (n 47).
[51] Bond et al (n 47).
[52] McQuire (n 1).
[53] Bond et al (n 47).

health professionals. Both registered nurses who assessed Naomi on 1 January 2016 had completed at least some components.[54]

- In evidence provided at the Inquest, Professor Paradies advised that one-off training is insufficient and that there must be ongoing dialogue and relationships with all sectors of the Aboriginal community, and their differing concerns acknowledged.[55]
- The Coroner's Report discussed the difficulties in establishing that individual decisions were directly related to racism but highlighted how individual decisions were "consistent with a pattern", and made recommendations for systemic improvement.[56]

CULTURAL SAFETY

2.15 The concept of cultural safety is drawn from the work of Maori nurses in New Zealand and can be defined as: "An environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening".[57]

2.16 In health settings, culturally safe practice is the ongoing critical reflection of health practitioner knowledge, skills, attitudes, practising behaviours and power differentials in delivering safe, accessible and responsive healthcare free of racism.[58] Importantly, it is the responsibility of a health practitioner but is judged and perceived by the patient.[59]

2.17 The Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (**CATSINaM**) explains the potential benefits of cultural safety in a health context, as providing a "decolonising model of practice based on dialogue, communication, power sharing and negotiation, and the acknowledgement of white privilege. These actions are a means to challenge racism [and other forms of discrimination] at personal and institutional levels, and to establish trust in health care encounters."[60] CATSINaM maintain, as adopted by the Nursing and Midwifery Board of Australia's

[54] Coroner's Report (n 24) [114], [228]. Note: RN Brewis completed both online and face-to-face components. RN Adams completed the online but not the face-to-face training.
[55] Coroner's Report (n 24) [228]-[229].
[56] Coroner's Report (n 24) [111], [233], [235].
[57] Robyn Williams, 'Cultural Safety – what does it mean for our work practice?' (1999) 23(2) *Australian and New Zealand Journal of Public Health* 213.
[58] Australian Health Practitioner Regulation Agency, *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*, 9 <https://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy/health-and-cultural-safety-strategy.aspx>
[59] Simon Brascoupe and Catherine Waters, 'Cultural Safety: exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness' (2009) 5 *Journal of Aboriginal Health* 28.
[60] CATSINaM, 2017, *The Nursing and Midwifery Aboriginal and Torres Strait Islander Health Curriculum Framework (Version 1.0)*, CATSINaM, Canberra. P11.

Code of Conduct for Nurses, that cultural safety is as important for First Nations patients as clinical care.[61]

2.18 **We recommend the Committee explore opportunities to implement the Coroner's Recommendations in the Inquest into the Death of Naomi Williams related to developing a strong local model to providing cultural safe care (Recommendations 8 and 9) broadly across NSW.**

Consequences in Naomi's case:[62]

- Naomi was uncomfortable and reluctant to return to the Hospital as she felt she was not being heard by the staff and that they were not investigating what was really wrong with her health by looking to underlying causes and issues. Instead, she was provided symptomatic care, if any.
- Naomi consequently planned to have her baby at the Hospital in Canberra where she would have access to a local Aboriginal Medical Service, despite the much further distance to travel.
- The Coroner also found Naomi's low expectations of the Hospital affected her decisions relating to medical care leading up to her death, and acknowledged her concerns as legitimate.
- The Coroner's Recommendations included immediate consultations to develop a strong local model to providing cultural safe care (Recommendations 8 and 9).

DISABILITY

2.19 The intersection of disability, race and healthcare is critical for this Inquiry to consider. First Nations people with disability experience deepened levels of disadvantage, exacerbated by limited access to health and disability services in rural, regional and remote areas. The National Disability Strategy recognises that First Nations people with disability "are among the most disadvantaged members of the Australian community".[63]

2.20 First Nations disability expert and researcher, Worimi man, Dr Scott Avery, explains that First Nations people with disability experience 'double disadvantage' related to the power imbalance which causes First Nations people with disability to experience the dual impacts of both ableism and racism.[64]

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[61] Nursing and Midwifery Board of Australia (NMBA), Code of Conduct for Nurses (Melbourne, VIC: NMBA, 2018), 5, <www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx>.
[62] Coroner's Report (n 24) [109]-[111].
[63] Department of Social Services, *National Disability Strategy 2010–2020* (February 2011), 27 < https://www.dss.gov.au/sites/default/files/documents/05_2012/national_disability_strategy_2010_2020.pdf>.
[64] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability*, Transcript, Scott Avery, Public hearing 4, 24 February 2020, P-459 [5-6] [14-15].

2.21 A disproportionate number of First Nations people live with a disability or some form of long term health condition, are more likely to have poorer health outcomes than other Australians with disability and to have experienced problems accessing health services.[65] More than 1 in 5 First Nations children and almost 1 in 2 (48%) of First Nations adults live with disability and it is accepted that these figures are under-representative.[66]

2.22 We draw the Committee's attention to the State Coroner's findings in the Inquest into the death of Shona Hookey, a young Aboriginal woman with complex conditions, including severe intellectual disability.[67] While Ms Hookey passed away in a metropolitan hospital, the circumstances of her passing provide important insight into improvements that must be made to the delivery of health services for people with disability and complex needs.

2.23 **We recommend that the Committee prioritise and pay particular attention to the complexities of delivering health care for First Nations people with disability and complex needs, particularly in rural, regional and remote locations.**

2.24 The recently released Interim Report of the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability has highlighted the specific challenges of First Nations people with disability living in regional, rural and remote areas. Difficulties in accessing support and medical care are exacerbated for First Nations people living away from metropolitan areas and can create barriers for First Nations people with disability to access the supports that they require.[68]

2.25 The First Peoples Disability Network Australia ('**FPDN**') is the national, peak organisation of and for First Nations people with disability/ FPDN works within a social model of disability[69], which focuses on the complexities of external influences, social structures, barriers and attitudes, and the intersectionality of race, which exclude or disempower people, in contrast to a medical model of disability focusing on individual diagnosis.[70]

2.26 The FPDN launched a 10-point-plan for the implementation of the National Disability Insurance Scheme in First Nations communities in 2013 (updated in 2018), with a critical requirement being

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[65] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Issues Paper, June 2020) 1, 4 <https://disability.royalcommission.gov.au/system/files/2020-06/First%20Nations%20Issues%20Paper.pdf>.
[66] *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Interim Report, October 2020) 451. <Interim Report (royalcommission.gov.au)>. ('*Royal Commission Interim Report'*).
[67] State Coroner's Court New South Wales, Inquest into the death of Shona Hookey, 22 December 2016, 2013/221800.
[68] *Royal Commission Interim Report* (n 66) 458-459, 463.
[69] First Peoples Disability Network, *About Us* (Webpage, 2019) <https://fpdn.org.au/about-us/>.
[70] *Royal Commission Interim Report* (n 66) 11, 345-346.

the availability and accessibility of services over the long term.[71] **We recommend that the priorities of FPDN be resourced and supported, with particular attention given to rural, regional and remote areas.**

ACCESS TO CARE IN RURAL, REGIONAL AND REMOTE AREAS

2.27 We understand that there are limited medical professionals available in rural, regional and remote areas of NSW, and some health services and hospitals are sometimes forced to operate without qualified Doctors on duty. Across NSW, there are different protocols regarding the need for doctors to examine a patient prior to discharge.[72]

2.28 We submit that the failure to staff hospitals with qualified Doctors or follow policies and procedures to monitor for patients requiring consultation with a Doctor or Specialist places patients at serious risk.

Consequences in Naomi's case:[73]

- Tumut Hospital is a small facility and as such, there are times when only nurses, and no doctor, would be staffing the Hospital.
- On the day she died, Naomi was discharged from the Hospital by a registered nurse, without consultation with a Medical Officer.
- Tumut Hospital had not implemented the Nurse Directed Emergency Care policy (Inquest Recommendation 2) or provided Hospital staff with training on a safety alert system (Inquest Recommendation 1), which would have alerted staff that Naomi was in need of medical review as she had re-presented multiple times and was a high risk pregnancy.

2.29 **We recommend that the Recommendations from the Inquest into the Death of Naomi Williams directly related to improving policies and procedures in the Hospital be applied broadly across NSW, including safety alerts (Recommendation 1), implementing a Nurse Directed Emergency Care policy (Recommendation 2), strengthening the Aboriginal Health Liaison Worker program (Recommendation 3) and the local employment and retention of First Nations health care professionals (Recommendation 4).**

2.30 **We also recommend that in all hospital settings prior to discharge, where a patient identifies as Aboriginal and/or Torres Strait Islander, that an Aboriginal Liaison Officer and a doctor**

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[71] First Peoples Disability Network, *Ten Priorities to Address Disability Inequality* (2018) <https://fpdn.org.au/wp-content/uploads/2018/10/FPDN-ten-priorities-2018.pdf>.
[72] Coroner's Report (n 24) [178].
[73] Coroner's Report (n 24) [115]-[116], [155], [165], [186-187].

meet with them face to face to ensure (a) that they are fit to be discharged (b) that discharge documents go the appropriate Aboriginal Medical Service or the elected health service, (c) that the individual is informed of their illness or disorder and they know what to do if it reoccurs and what medicines to take and how and when to take them and (d) to determine and resolve any outstanding questions.

2.31 The Australian Human Rights Commission's 2020 *Wiyi Yani U Thangani* Report provides important insight and pathways forward to improve access to services for First Nations people living away from metropolitan areas, including increasing digital infrastructure to bridge service gaps, a greater focus on on-country care and improving transport support and transport infrastructure to increase access to services.[74] **We implore the Committee to consider the findings of the Australian Human Rights Commission's 2020 *Wiyi Yani U Thangani* inquiry as a critical source of insight into the experiences of First Nations communities in accessing healthcare.**

MENTAL HEALTH

2.32 Findings from Paradies (et al) 2015 analysis of more than 250 national and international studies confirmed a clear link between racism and poorer mental health, including depression, anxiety and psychological stress, in addition to poorer general and physical health.[75] Research focusing specifically on the impact of racism on the health of Aboriginal and Torres Strait Islander peoples supports those findings.[76]

2.33 The Australian Government Senate Inquiry into the accessibility and quality of mental health services in rural and remote Australia noted the unique barriers faced by those living in rural and remote areas despite similar prevalence of mental disorders in metropolitan areas. Generally, rural populations suffer higher rates of suicide. First Nations people are disproportionately impacted by these barriers, as they have higher rates of suicide and of hospitalisation from mental illness than non-Indigenous Australians.[77]

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[74] Australian Human Rights Commission, (n 18), 106, 280-286.
[75] Yin Paradies et al, 'Racism as a Determinant of Health: A Systematic Review and Meta-Analysis' (2015) *PLoS One* 10(9) <Racism as a Determinant of Health: A Systematic Review and Meta-Analysis (plos.org)>.
[76] Stella Artuso, 'Factors influencing health care utilisation among Aboriginal cardiac patients in central Australia: a qualitative study' (2013) 13(83) *BMC Health Services Research* <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-83>; Australian Indigenous Doctors' Association, *Policy Statement* <https://www.aida.org.au/wp-content/uploads/2017/08/Racism-in-Australias-health-system-AIDA-policy-statement_v1.pdf>.
[77] Community Affairs References Committee, *Accessibility and quality of mental health services in rural and remote Australia* (Report, 4 December 2018) 19. <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/MentalHealthServices/Report>.

2.34 **We recommend urgent review of the provision of and access to mental health services, including detox and rehabilitation services in rural, regional and remote NSW and action to improve access to and the quality of these services.**

PATIENT ADVOCACY

2.35 Linked to the social model and cultural safety approaches to health, patient advocacy is important in countering social and attitudinal barriers to appropriate health care. This can range from educating people on what services are available, organising appointments and transport and cultural translation, to pressing for better responsibility and accountability.[78]

2.36 Community-controlled organisations often provide the support and advocacy for First Nations peoples to navigate mainstream systems and services.[79] **We recommend increasing resourcing of community-controlled organisations to undertake their critical role in supporting First Nations peoples.**

2.37 In NSW, the REACH program was developed by the Clinical Excellence Commission ('**CEC**') to assist patients and their families and carers escalate concerns about a patient's condition. We support this program as an interim measure until First Nations-led health advocacy measures are developed and implemented.

2.38 **To improve opportunities for patient advocacy within rural, regional and remote health services, we support the implementation of the Coroner's recommendation in the Inquest into the Death of Naomi Williams that the Aboriginal Health Liaison Officer program be strengthened in hospitals and that the development of community-led, culturally appropriate patient advocacy is resourced and supported.**

Consequences in Naomi's case:[80]

- On 16 July 2015, Sharon Williams wrote to the Acting Multi Service Manager of Tumut/Batlow to express concerns that Naomi's illness was being overlooked. She specifically raised the need for specialist referral but this was not escalated. Instead, she was told that Naomi could seek health care elsewhere if she was not satisfied, a completely inappropriate and insensitive response, compounded by the lack of alternative health services in the rural town of Tumut.

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[78] Bulloch et al (n 37) 48-49.
[79] Australian Human Rights Commission, (n 18), 263-264.
[80] Coroner's Report (n 24) [61], [108], [250]-[252], [267].

- Many opportunities were missed to involve an Aboriginal Liaison Officer in Naomi's care.
- The importance of advocates was raised in the Coroner's Report with the recommendation that the Aboriginal Health Liaison Worker program be strengthened by making the service available 24 hours a day and ensuring all staff were aware of the policy and how to apply it.[81]
- The REACH program was only available in Tumut Hospital from September 2016 and (based on the CEC website) is still not available in all hospitals.[82]

2.39 The NJP works with First Nations communities to support people who experience discrimination, professional misconduct or negligence within the health system. By delivering outreach services, community education in health justice, supporting complaint or legal pathways and promoting community and collective advocacy, we seek to challenge the discrimination experienced by First Nations people within the health system and seek the necessary reforms.

MONITORING AND AUDITING

2.40 Some potential measures of systemic racism are more readily accessible and provide important insight into racially motivated structural barriers, such as reports on time delays in seeing a clinician by race. A recent complaint submitted in Western Australia titled, 'Different treatment for different patients" reports First Nations people waiting substantially longer than non-Indigenous people at a COVID testing clinic.[83] This experience is not uncommon for First Nations peoples at hospitals and mainstream services.

2.41 Importantly, in NSW there needs to be accountability measures through the transparent, publicly available reporting of complaints and any responses received. We recommend that the Committee consider the importance of transparent accountability measures for health services.

2.42 Key performance indicators (**KPIs**) have become the predominant way to measure public policy. However, the use of KPIs can have unintended consequences and there are often disconnects between what is measured in standardised state KPIs and what is valued by local communities. In addition, they can be reflective of the structural racism[84], including in the absence of transparent data.

[81] Coroner's Report (n 24) [263]-[266], [279.3].
[82] Clinical Excellence Commission, *Deteriorating Patient Program – REACH* (Online, 25 November 2020) <REACH - Clinical Excellence Commission (nsw.gov.au)>; Coroner's Report (n 24) [258].
[83] Anonymous, Care Opinion Australia, December 2020 <https://www.careopinion.org.au/79323>.
[84] Bulloch et al (n 37) 3-4, 37, 57-59.

2.43 In their 2020 article, Bond (et al) highlights how the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025[85] sets out a clear pathway for structural and individual reform to address racism and implement culturally safe care. The plan articulates KPIs and timelines across various initiatives, including consistent guidelines and standards in relation to cultural safety, targets for representation and participation and a community education strategy.[86] **We recommend that the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025 be supported, resourced and implemented.**

2.44 Local community health providers have noticed the trend towards measuring success in statistical terms, which is not able to reflect their efforts towards preventative and holistic health. Statistics based metrics are reflective of a medical model of health rather than a social and inclusive model. **We support the recommendation that, in order to provide a balanced view of success, KPIs need to include qualitative assessments on the experiences of patients and communities.**[87]

2.45 Queensland is the first and only state in Australia to audit its 16 Health and Hospital Services for institutional racism, with all 16 scoring 'High' or 'Very High' levels of institutional racism. Since the release of the report in 2017, Queensland Health has worked with the Queensland Human Rights Commission and the Queensland Aboriginal and Islander Health Council to address institutional racism.[88]

2.46 The Australian Human Rights Commission's 2020 *Wiyi Yani U Thangani* report calls for urgent and critical reform across all service providers that provide services to First Nations peoples to implement KPIs on cultural safety and responsiveness, and further recommended developing a national framework on antiracism, including measurable targets and accountability measures, ensuring adequate data collection across all governments and supporting independent research and analysis to identify systemic or institutional racism.[89] Importantly, methods of data collection, monitoring and evaluation of service delivery must be controlled by First Nations communities[90].

2.47 **In support of the recommendations of the Australian Human Rights Commission's 2020 *Wiyi Yani U Thangani* report, and linked to Recommendation 5 and 6 from the Inquest into the**

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[85] Australian Health Practitioner Regulation Agency and National Boards 2020, *The National Scheme's Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025*. Melbourne: AHPRA <https://www.ahpra.gov.au/About-AHPRA/Aboriginal-and-Torres-Strait-Islander-Health-Strategy.aspx>.
[86] Bond et al 2020 (n 44); NATSIHP (n 8) 10-15.
[87] Bulloch et al (n 37) 3-4, 57-59, 63.
[88] Queensland Aboriginal and Islander Health Council, 'Audit finds high levels of institutional racism in Queensland's health system, but experts hopeful of brighter future' (media release 4 December 2018). (https://www.qaihc.com.au/media/audit-finds-high-levels-of-institutional-racism-in-queensland-s-health-system-but-experts-hopeful-of-brighter-future)
[89] Australian Human Rights Commission, (n 18), 100, 127.
[90] Australian Human Rights Commission, (n 18), 105, 127.

Death of Naomi Williams, we recommend that the Committee work with First Nations leaders such as Dr Chelsea Bond, to develop community-defined, objective, quantitative and qualitative measurements of institutional racism and implicit bias, through indicators such as (a) delay times before seeing a clinician in emergency by race (b) critical incidents by race (c) deaths in hospital by cause & race and (d) negligence by race. Once implemented, reporting mechanisms should be maintained and the results should be published and reviewed with First Nations leaders, the National Health Leadership Forum[91] and its members including the National Aboriginal Community Controlled Health Organisation[92], the Lowitja Institute[93] and other relevant Aboriginal Community Controlled Organisations to implement evidence-based reforms.

RECOMMENDATIONS

1. Engage with local First Nations community organisations, national representative peaks, and health experts in strategizing and implementing all recommendations that relate to First Nations communities.
2. Review and move to implement with urgency the recommendations of the Royal Commission into Aboriginal Deaths in Custody that relate to healthcare.
3. Work with First Nations communities to implement all recommendations from the Inquest into the Death of Naomi Williams through a place-based model across NSW, including:
    a. Implement safety alerts (Recommendation 1)
    b. Nurse Directed Emergency Care policy (Recommendation 2)
    c. Strengthen the Aboriginal Health Liaison Worker program in hospitals (Recommendation 3)
    d. Local employment and retention of First Nations health care professionals (Recommendation 4)
    e. Measure institutional racism and implicit bias (Recommendation 5 & 6)
    f. First Nations representation on leadership boards and committees (Recommendation 7)
    g. Develop strong localised models for culturally safe health care (Recommendations 8 & 9)
4. Increase resourcing and support for Aboriginal Community Controlled Organisations.

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[91] The National Health Leadership Forum (NHLF) (https://www.nhlf.org.au) is a collective partnership of national organisations who represent a united voice on Aboriginal and Torres Strait Islander health and wellbeing with expertise across service delivery, workforce, research, healing and mental health and social and emotional wellbeing.
[92] The National Aboriginal Community Controlled Health Organisation (NACCHO) (https://www.naccho.org.au) is the national peak body representing 143 Aboriginal Community Controlled Health Services (ACCHSs) across the country on Aboriginal health and wellbeing issues.
[93] The Lowitja Institute (https://www.lowitja.org.au) is Australia's national institute for Aboriginal and Torres Strait Islander health research, working for the health and wellbeing of Australia's First Peoples through high impact quality research, knowledge translation, and by supporting Aboriginal and Torres Strait Islander health researchers.

5. Explore ways to place First Nations people at the forefront of systemic and policy health system reform, including by resourcing First Nations-led research.
6. Consider the critical intersections of race, gender, class and disability and make suggestions for reform.
7. Consideration and prioritisation of health care for First Nations people with disability and complex needs.
8. Resource and support the priorities of the First Peoples Disability Network.
9. Consider the findings of the Australian Human Rights Commission's 2020 *Wiyi Yani U Thangani* inquiry as a critical source of insight into the experiences of First Nations communities and strategies to improve services in non-metropolitan areas, including investment in digital infrastructure, prioritisation of on-country care and healing, improvement of transport infrastructure and improving disability, dialysis, detox and rehabilitation services.
10. An Aboriginal Liaison Officer and a doctor should meet with all First Nations patients prior to discharge from hospital.
11. Urgently review the provision of and access to mental health services, including detox and rehabilitation, in rural, regional and remote NSW and take action to improve access to and the quality of these services.
12. Strengthen the Aboriginal Health Liaison Officer program and support the development of community-led culturally appropriate patient advocacy opportunities.
13. Support, resource and implement the Aboriginal and Torres Strait Islander Health and Cultural Safety Strategy 2020-2025.
14. Work with First Nations leaders to develop and maintain community-defined, objective, quantitative and qualitative measurements of institutional racism and implicit bias, with the results published and utilised to implement evidence-based reforms.

Appendix A: Recommendations from the Inquest into the death of Naomi Williams[94]

The Inquest into the death of Naomi Williams recommended the following to the Murrumbidgee Local Health District (MLHD):

1. That consideration is given to providing a training session to all staff on the importance of safety alerts (such as “re-presentation calls for medical review” or “high risk pregnancy”) and a consistent method for implementing alerts is communicated to all staff.
2. That consideration is given to implementing a Nurse Directed Emergency Care (NDEC) policy as a matter of urgency.
3. That consideration is given to strengthening the Aboriginal Health Liaison Worker program by ensuring Aboriginal Health Liaison Workers are available 24 hours a day, and ensuring that staff are aware that the NSW Health Policy ‘Notification/Referral of Aboriginal Inpatients’ (MLHD PROC208) applies to patients who present at the Emergency Department as well as those who are admitted.
4. That consideration is given to adopting targets within the MLHD for the employment and retention of Indigenous health care professionals in numbers at least equivalent to the number of Indigenous residents in the local area.
5. That consideration is given to auditing the possibility of implicit bias by recording statistics for Indigenous and non-Indigenous patient triage categories, discharge against medical advice, triage times and referrals for drug and alcohol reviews for patients presenting to the Emergency Department at Tumut Hospital.
6. That consideration is given to identifying other assessment tools to measure the existence of implicit bias in the provision of health care and commit to making such tools available to Tumut Hospital.
7. That consideration is given to establishing targets for the proportionate representation of Indigenous people (by population and no less than two) on the Local Health Advisory Committee and Murrumbidgee Local Health District Board.
8. That consideration is given to establishing an ongoing consultation process with the HEAL (Healthy Enriched Aboriginal Living) Mawang (Together) Group with a view to developing a strong local model for providing culturally safe health care, in line with initiatives implemented by Hunter New England Health.
9. That consideration is given to seeking immediate consultation with Hunter New England Health in relation to strategies for developing culturally appropriate care, in line with the detailed model they have developed.

[94] Coroner’s Report (n 23) [279].