The Inspector of Custodial Services, Neil Morgan, has voiced serious concerns about a birth at Bandyup Women’s Prison on 11 March 2018.

Despite pleading for help multiple times for over an hour, a woman (‘Amy’) gave birth alone in a locked cell at 7.40pm. Staff observed events through a hatch in the cell door, but the door was not unlocked for several minutes after the birth.

On releasing a summary of his report into the birth, Mr Morgan said:

I wanted to know how such an event could occur in a 21st Century Australian prison and to prevent it happening again.

We found that human, procedural and systemic failings had combined to create serious and avoidable risks to both mother and child.

First, staff were slow to act even though they knew Amy was in the late stages of pregnancy. We listened to recordings of numerous cell calls in which her pain and distress were obvious. Staff who came to talk to her during this time would also have been very aware of her escalating condition.

I find it inexcusable that Amy did not have medical staff with her when giving birth, and that it was only after her child was born that staff called a ‘Code Red’ emergency. This was clearly an emergency well before then.

I also find it inexcusable that it took somewhere between seven and 12 minutes for the cell door to be opened after the Code Red was called. In a prison a delay of seven minutes, let alone 12, in responding to a medical emergency could be fatal. In Amy’s case, many things could have gone wrong.

Procedural weaknesses also played a role. Communication between staff was poor, cell keys were not readily available, and staff shift changes seemed to take priority over caring for Amy.

On top of this, records were incomplete. Staff had not bothered to log cell calls from Amy and other distressed women, in clear disregard of local orders. We were also unable to confirm the time it took to open Amy’s cell because, according to the Department, Bandyup’s CCTV and other records are not synchronised.

Finally, the prison downplayed the seriousness of the events when reporting to head office. It is not clear if this was because staff had become desensitised to risk and duty of care, or if it was an attempt to mislead.
Mr Morgan also drew attention to long term failures in strategic planning for women in prison:

In the last decade, planning for female prisoners in general has been poor. It follows that there has been no proper planning for women in the late stages of pregnancy, whether at Bandyup or other prisons. As a result, Amy was in a wholly unsuitable cell when she gave birth.

Pregnant women will continue to come into custody and the Department of Justice has an obligation to ensure the health and safety of mothers, unborn children and babies.

Mr Morgan said that the Department had accepted the report’s findings and agreed that improvements are needed to infrastructure, operational processes, staff culture and training. A number of measures have been implemented but many remain a ‘work in progress’.

Mr Morgan also said that his full report would not be released because it includes sensitive details about Amy and also highlights some security issues: ‘the summary that we are releasing gives ample indication of the failings and of the matters requiring attention.’

Neil Morgan
Inspector

For Further Media Information
The Inspector, Neil Morgan, will be available for comment from 12 noon on Wednesday 12 December 2018 and can be contacted on 0427 426 471.

The report’s summary will be available on the Inspector’s website (www.oics.wa.gov.au)