Investigation Women Prisoners' Access to Health Services

In mid 2014 Ms A contacted the HCSCC complaining that she had been unable to see a doctor at the Prison Health Service (PHS) despite repeated requests. She reported that she had been suffering dizzy spells and headaches, urinating multiple times per night and had sore and swollen legs. She was pregnant when she was admitted to prison, however the blood test which would have confirmed her pregnancy status was lost and never followed up. Eventually after many complaints and contacts with the HCSCC, Ms A saw a doctor. She was then taken to the Royal Darwin Hospital and found to be 8 months pregnant. Up until this time, she had received no antenatal care and was taking a medication contraindicated during pregnancy.

A second complaint was received from Ms B in early 2015. Ms B reported that from early 2014 she had complained of pain to her right wrist and shoulder and requested medical attention. Four months after reporting the pain, she was x-rayed and found to have a wrist fracture. She continued to be in pain, alleging that she did not receive proper treatment after the fracture was diagnosed.

These complaints were referred directly for investigation under Part 7 of the Act on the basis of the seriousness of the allegations and the systemic issues raised. The complaints were consistent with the large proportion of complaints received by HCSCC about the PHS, which raised similar concerns about: the management of medical request forms; triage processes; waiting periods; communication with patients; access to specialist medical services; and medical follow-up and recall systems.

The HCSCC found that the PHS failed to provide an adequate health care service to Ms A by failing to follow up pathology results for her pregnancy test; failing to exercise due care and skill in responding to Ms A's requests for medical assistance; failing to provide adequate antenatal care to Ms A and her unborn child; and by administering a medication to Ms A which could have been harmful to her and her unborn child.

In relation to Ms B, the HCSCC found that the PHS failed to provide an adequate health care service to Ms B by failing to diagnose her wrist fracture; failing to provide adequate treatment for her wrist injury; and failing to coordinate Ms B's treatment of her wrist injury.

In relation to systemic issues with the quality of care provided by the PHS, the HCSCC found that PHS did not have satisfactory systems in place for the management of requests for medical assistance; satisfactory clinical follow up procedures were not in place; adequate processes to coordinate services with Corrections were not in place; adequate processes to coordinate external services were not in place; the service was not meeting its responsibility to communicate with patients about their health care; and there were substantial failings in access to women's health at PHS.

Recommendations to address issues identified in the report are currently being implemented by PHS (now known as the Prison Primary Healthcare Service).