Inspector of
Custodial Services

Inspection of the Long Bay Correctional Complex 2023–24

December 2025

Acknowledgement of Country

The Inspector of Custodial Services acknowledges the Traditional Custodians of the lands where we work and live. We celebrate the diversity of Aboriginal peoples and their ongoing cultures and connections to the lands and waters of NSW.

We pay our respects to Elders past, present and emerging and acknowledge the Aboriginal and Torres Strait Islander people that contributed to the development of this report.

We advise this resource may contain images, or names of deceased persons in photographs or historical content.

Inspection of the Long Bay Correctional Complex 2023–24

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Inspector's overview

Although inspected previously as part of thematic reviews, this is the first inspection focused on all aspects of the three correctional centres on the Long Bay Correctional Complex – Long Bay Hospital (LBH), the Special Purpose Centre (SPC) and the Metropolitan Special Programs Centre (MSPC). MSPC includes some of the oldest infrastructure still in use in NSW, dating back to 1909.

This was a complex inspection, reflected in the length and breadth of this report. The correctional centres comprising the Long Bay Correctional Complex have varied purposes and functions and consequently hold a very diverse inmate population with wide ranging, and often high, needs. This population includes significant numbers of people with disability, people with serious mental illness, people who are aged and frail, people experiencing ill health and terminal illness, and LGBTIQA+ people. It also includes people undertaking intensive programs to address serious sex and violent offending.

This was also a challenging inspection due to operational changes implemented while it was underway. We announced the inspection of the Long Bay Correctional Complex in August 2023. In early January 2024, Corrective Services NSW (CSNSW) announced a bed consolidation project that significantly impacted the Long Bay Correctional Complex, including the temporary closure of all inmate accommodation in LBH Area 2 and the Kevin Waller Unit (KWU) and an accommodation wing located in MSPC Area 1. LBH Area 2 and the KWU both reopened soon after the main onsite components of the inspection were completed. Despite the inspection examining these changes, we remain at a loss to understand the intention of these temporary closures and what, if anything, they achieved.

We believe the temporary closures should have been permanent as the MSPC, KWU and LBH Area 2 are dilapidated, unsafe, and not fit for purpose. CSNSW maintains these correctional centres 'remain important infrastructure for the management of inmates and the delivery of highly specialist correctional and health services'.[1] We do not dispute the importance of LBH and MSPC or the need for correctional centres located in close proximity to hospitals and health services. However, the conditions that inmates reside in, and staff are expected to work in, must be addressed.

In my view, the continued reliance on such old and unfit infrastructure for the delivery of critical services is the problem. Planning should have commenced decades ago to phase out the use of MSPC and LBH 2. Delaying inevitable decisions does not make these decisions or their implementation any easier. It is important to emphasise that not all infrastructure on the Long Bay Correctional Complex is old and unsuitable. LBH Area 1 and the SPC are fit for purpose.

Fiona Rafter
Inspector of Custodial Services
December 2025

1 Information provided by Corrective Services NSW, 23 September 2025.

Glossary of terms and acronyms

Aboriginal	'Aboriginal' when used in this report is inclusive of Aboriginal and Torres Strait Islander people
ACBD Committee	Aged Care Bed Demand Committee
ADL	Activities of daily living
AVL	Audiovisual link
AVO	Apprehended Violence Order
CAS Act	*Crimes (Administration of Sentences) Act 1999*
CAS Regulation	*Crimes (Administration of Sentences) Regulation 2014*
CMHS	Custodial Mental Health Service
CMHWP Committee	Custodial Mental Health Waitlist Prioritisation Committee
CMU	Case Management Unit
CPT	Classification and Placement Team
COPP	*Custodial Operations Policy and Procedures*
CP	Commissioner's Placement
CSI	Corrective Services Industries
CSNSW	Corrective Services NSW
D&A	Drug and alcohol
DAA	Dose administration aid
EN	Enrolled nurse
GP	General practitioner
HCC	Health centre clerk
HPNF	Health Problem Notification Form
ICS	Inspector of Custodial Services
ICS Act	*Inspector of Custodial Services Act 2012*
IRM	Incident Reporting Module
JH&FMHN	Justice Health and Forensic Mental Health Network
LBH	Long Bay Hospital
Let-go	The process of letting inmates out of their cells, usually in the morning
LGBTIQA+	Lesbian, gay, bisexual, transgender, intersex, queer, asexual people
Lockdown	In this report, the term 'lockdown' refers to instances where inmates are secured in their cells during the day, when ordinarily they would not be
Lock-in	The process of securing inmates in their cells, usually at the end of the day
MEU	Medical Escorts Unit
MHPF meeting	Mental Health Patient Flow meeting
MIN	Master Index Number
MPU	Multipurpose Unit
MRRC	Metropolitan Remand and Reception Centre
MSPC	Metropolitan Special Programs Centre

NDIS	National Disability Insurance Scheme
NUM	Nursing unit manager
OPD	Outpatient Department
OIMS	Offender Integrated Management System
OS&P	Offender Services and Programs
Patients	This report uses the term patients, rather than inmates, when discussing the provision of health services to people in custody
PRLC	Pre-release Leave Committee
PRNA	Protection Non-Association Area
RAPO	Regional Aboriginal pathways officer
RIT	Risk Intervention Team
RN	Registered nurse
SAPO	Services and programs officer
SHU	Segregated Housing Unit
SMAP	Special Management Area Placement, also known as protection
SPC	Special Purpose Centre
SORC	Serious Offenders Review Council
VOTP	Violent Offender Therapeutic Program

Executive summary

The Long Bay Correctional Complex is located in Matraville, around 14km south of the Sydney CBD. The complex consists of three correctional centres – the Metropolitan Special Programs Centre (MSPC), Long Bay Hospital (LBH), and the Special Purpose Centre.

The Long Bay Correctional Complex provides services specific to the needs of different groups within the inmate population. LBH is a key location for the Justice Health and Forensic Mental Health Network (JH&FMHN), delivering specialist inpatient and outpatient health services to people in custody across NSW. MSPC includes units with support services for aged and frail inmates, inmates with intellectual and cognitive disability and mental illness. It is also a location for intensive programs for sex and violent offenders.

This inspection

We previously inspected the correctional facilities on the Long Bay Correctional Complex as part of various thematic inspections. However, this is the first inspection that has focused on all areas of each correctional centre. Consequently, we decided to undertake the inspection in two parts:

- **Inspection part 1**: Consisted of site visits and reviewing information and data from the agencies to define the scope of the inspection and identify any relevant expertise required.
- **Inspection part 2**: Consisted of the primary onsite component of the inspection in May 2024 and analysis of follow-up information and data from the agencies.

In August 2023, this inspection was announced and part 1 commenced. During part 1 of the inspection, we identified several inmate cohorts with significant populations on the Long Bay Correctional Complex (particularly MSPC) – people with disability, people who are aged and frail and LGBTIQA+ people. We engaged consultants to provide expertise in relation to the needs of these groups. We also engaged consultants to examine health service provision and correctional centre operations and security.

In January 2024, Corrective Services NSW (CSNSW) announced a bed consolidation program, involving the temporary closure of some areas. This included the Kevin Waller Unit (KWU), a unit for aged and frail men, and 9-wing in MSPC Area 1 (MSPC 1) and all the inmate accommodation in LBH Area 2 (LBH 2). Consequently, we added further visits to this inspection to understand the implementation and outcomes of these changes, including to the Metropolitan Remand and Reception Centre (MRRC) where a number of inmates were relocated.

During the primary onsite component of this inspection in May 2024, all these areas remained closed. All of LBH 2 was reopened in June 2024, followed by KWU in July 2024. At the time of writing, 9-wing remained closed. Consequently, we conducted further visits to monitor the implementation and impact of the reopening of these units.

Long Bay Hospital

LBH is a gazetted correctional centre with two distinct areas. Area 1 (LBH 1) is a modern, secure, fit for purpose hospital-style facility consisting of a declared mental health unit, medical unit and an aged care unit. LBH 2 is an older facility, currently used to hold remand inmates. Since our last inspection, a separate gazetted correctional facility called the Special Purpose Centre has been integrated into the management structure of LBH and is now known as Area 3 (LBH 3). These three distinct areas are the responsibility of a single governor.

Long Bay Hospital Area 1

Medical Unit

The Medical Unit (MU) holds patients with subacute medical needs, including palliative care, pre- and post-operative care, medical observation, and dialysis. Staff reported the JH&FMHN Palliative and Aged Care Service had made a significant difference to the management of palliative and end-of-life patients. We also heard about initiatives to maximise palliative patients' access to health staff and family visits and we commend CSNSW and JH&FMHN for providing this support. We were also impressed with the JH&FMHN dialysis service. JH&FMHN are implementing other initiatives to increase the scope of clinical service provision in the MU, reducing the need to transfer patients to external hospitals. This is good practice.

At the time of this inspection, the MU held a number of patients with disability. They included several patients with spinal cord injuries, a patient with frontotemporal dementia and four aged and frail patients. These patients did not require medical care and therefore did not need to be in the MU. However, they required a high level of support with activities of daily living (ADL), including showering, toileting, eating and dressing. There were no other placement options that could provide for the needs of this group at this time, creating a 'bed block'. The MU is designed for short term placements and is not equipped with the amenities often available to people in more typical correctional environments. It also limits the capacity of the MU and its staff. Consequently, we have recommended that CSNSW work with JH&FMHN to provide facilities adequate to meet the needs of people with disability with very high support needs.

It was positive to see that the same custodial staff were consistently rostered to the MU, which helped in the efficient provision of health care. However, it was unfortunate to observe multiple occasions where custodial staff were physically in the room during the provision of health care to patients. We were made aware of multiple instances of custodial staff interjecting into conversations between health staff and their patients. This is inappropriate and unprofessional and patients have a right to privacy and confidentiality of their health information. We have recommended that CSNSW, in consultation with JH&FMHN, review the presence of custodial staff during the provision of health care and ADL support in the MU.

Aged Care Rehabilitation Unit

The Aged Care Rehabilitation Unit (ACRU) is an inpatient unit for aged and frail patients with high needs. It provides a specialised environment for older patients with complex needs including dementia, Alzheimer's disease, acquired brain injury or significant physical frailty. Some patients are placed in the ACRU for a short period for assessment before being discharged to a different location. However, the majority will become long term placements until their death or release from custody.

Similar to the MU, a regular group of custodial staff were rostered in the ACRU. We were impressed with the processes in the ACRU, particularly concerning medication management and diet and nutrition. We also commend JH&FMHN on developing relationships with internal and external service providers, particularly with respect to identifying suitable post-release community placements. However, despite this effort finding appropriate post-release placements remains a challenge.

Chapter 4 on the treatment of aged and frail people in custody provides more detail about the ACRU and its role in the broader framework for managing the health and care needs of aged and frail inmates.

Mental Health Unit

At the time of the inspection, the Mental Health Unit (MHU) operated as an inpatient unit providing services for voluntary and involuntary patients with serious mental illness including schizophrenia,

drug induced psychosis, bipolar disorder and severe depression or suicidality.[2] Involuntary treatment in the MHU included 'enforced medication', which refers to the coercive administration of psychotropic medications by clinical staff. Patients were admitted to the MHU for assessment to determine a mental illness diagnosis or due to the deterioration of a previously diagnosed mental illness. G-ward held the most acutely unwell patients, including those requiring enforced medication. E-and F-wards were used as step-down units for patients who were more stable.

During the inspection we were informed that JH&FMHN were undertaking a project to cease involuntary mental health treatment, including enforced medication, in custody. This was instead to take place in the Forensic Hospital. We support the cessation of involuntary mental health treatment in custody. However, we acknowledge the significant challenges of achieving this, including managing the security concerns related to some patients and the capacity of the Forensic Hospital.

We observed that the Custodial Mental Health Waitlist Prioritisation Committee had established strong systems to assist in the triaging of patients, ensuring patients are moved to the appropriate location for assessment and treatment as soon as possible. We acknowledge the significant work undertaken by JH&FMHN in managing the high demand for custodial mental health placements.

Routine & time out of cell

As noted in the sections on each unit, we estimated that health staff had access to patients for around six-and-a-half hours per day. While health staff reported that CSNSW generally facilitated access outside these hours, this was by prior agreement. We consider this level of patient access to be inadequate for an environment with a primary function of providing inpatient health care. In this context, it would make more sense for out of cell hours to correspond with standard business hours for health care professionals, at a minimum for morning and evening shifts.

G-ward was a particularly restrictive environment. We acknowledge it can be an extremely challenging workplace for custodial and health staff. However, this approach is not therapeutic and does not align with the National Safety and Quality Health Service Standards regarding restrictive practices and minimising patient harm.[3] The *Crimes (Administration of Sentences) Regulation 2014* (CAS Regulation) requires that all inmates except those confined to cell as a penalty for a correctional centre offence, should be allowed two hours each day for 'exercise in the open air'.[4] It seemed unlikely that this was being consistently offered to G-ward inmates, despite the apparent best efforts of custodial staff.

We have recommended that CSNSW increase time out of cell hours for LBH 1. This will facilitate greater access to health care for the patients in the MU, ACRU, and MHU.

Long Bay Hospital Area 2

Closure and reopening

LBH 2 consists of units that were built in the 1960s. Unlike LBH 1, it bears no resemblance to a hospital facility. When we visited during part 1 of this inspection in August 2023 it was accommodating men with mental health conditions in dilapidated, ageing infrastructure.

Shortly before part 2 of our inspection, CSNSW implemented the temporary closure of all LBH 2 inmate areas in March 2024. This meant inmate accommodation areas were empty at the time of our inspection in May 2024. Immediately following our inspection, CSNSW announced LBH 2 would reopen in June 2024.

2 Long Bay Hospital Area 1 (LBH 1) was a declared 'mental health assessment and inpatient treatment facility' under section 109 of the *Mental Health Act 2007*. This meant the full range of inpatient functions could be performed at LBH 1. See Secretary of the NSW Ministry of Health, 'Mental Health Act 2007 – Section 109 – Declaration of a Mental Health Facility' in New South Wales, *Government Gazette of the State of New South Wales*, No 93, 23 August 2019, 3334; 'Declared Mental Health Facilities', *NSW Health* (Web Page, 21 August 2019) <https://www.health.nsw.gov.au/mentalhealth/services/consumers/Pages/facilities.aspx>.

3 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (May 2021).

4 *Crimes (Administration of Sentences) Regulation 2014* cl 53(1).

We believe the closure and reopening of LBH 2 is indicative of poor planning and a reactive approach to the management of the custodial estate in NSW. It is difficult to understand the decision to reopen unfit inmate accommodation, particularly given the staffing challenges. It is also unclear to us what was achieved during the three to four month closure. This infrastructure is incapable of providing safe and humane conditions. We have recommended that the inmate accommodation in LBH 2 be closed permanently.

Although no staff were made redundant, the number of positions was reduced and some positions were taken offline. Understandably, the temporary closure of LBH 2 was a source of significant uncertainty and anxiety for staff and inmates. Many of the staff we spoke with felt the announcement and temporary closure process were poorly managed by CSNSW. There were mixed messages about whether staff could relocate to a different correctional centre and the smaller inmate population in LBH 1 and LBH 3 led to reduced overtime for staff, impacting staff morale. To the credit of LBH management, there was an increased focus on staff training during this period. However, this alone could not mitigate the negative impacts.

Our concerns about the reopening

Following the reopening, we conducted a further visit to LBH 2 in July 2024 to observe its operation. At this time over 80% of LBH 2 inmates were on remand. We found the physical environment of the inmate areas in LBH 2 to be generally poor. Consistent with its age, many cells contain ligature points.

The reopening of LBH 2 also created a larger and more complex inmate population and a more challenging security environment. There have also been difficulties fully staffing all areas due to vacancies and both long term and short term absences. Unsurprisingly there was a notable increase in lockdowns due to short staffing after the reopening.

We were also concerned about access to legal representatives and resources with such a large remand population. LBH 2 had five professional audiovisual link (AVL) suites with capacity for 45 bookings per day, with court appearances taking precedence. There was also an AVL suite near the Multipurpose Unit (MPU) that was out of order. A busy day with a number of court hearings could result in professional visits being delayed.

CSNSW claims that the 'utilisation rate of the centre's studios show that the current demand is adequately managed within these existing studio resources' and the loss of the MPU AVL studio 'has not affected the centre's ability to manage video conferencing appointments for court appearances for inmates housed in the MPU'. CSNSW's AV, Strategy and Business Links team were also assisting LBH to organise repairs to the MPU studio.[5] We note that this indicates the studio has been inoperable since LBH 2 reopened in June 2024.

The LBH 2 MPU holds inmates on segregation orders. Cells in the MPU do not contain showers or have secure rear yards for time out of cell. MPU inmates must shower in one of five outdoor holding yards. These holding yards are also the only place MPU inmates can spend time out of cell. The condition of the yards is unsatisfactory – they are sparse, exposed to weather conditions and, during our visit in July 2024, toilets in four of the yards were blocked. Access to fresh air and exercise is particularly important for mitigating the negative impact of isolation for this group of inmates. The infrastructure of this MPU is incapable of providing inmates with decent conditions and should be closed.

Outpatient Department

The Outpatient Department (OPD) provides specialist health services to predominantly male inmates across NSW and all health services for inmates in LBH 2 and LBH 3. It continued to operate during the temporary closure of the inmate areas in LBH 2. Although the OPD was located in an old building, we found it to be clean and organised with well-equipped consultation and treatment rooms, including modern dental and radiology facilities and physiotherapy equipment.

5 Information provided by Corrective Services NSW, 23 September 2025.

Metropolitan Special Programs Centre

Physical environment

The age and condition of MSPC means it simply cannot provide a safe environment for people in custody, particularly those with needs arising from disability, age and frailty and mental illness. This physical environment frustrates good initiatives that aim to support inmate rehabilitation and wellbeing. We have no choice but to recommend its closure.

The facility now known as MSPC opened in 1909. It consists of three areas – MSPC 1 (maximum security), MSPC 2 (maximum and minimum security units) and MSPC 3 (minimum security). Its age is evident in almost every inmate and staff area. We observed ligature points in cells across all areas. Consistent with their age, cells are rundown and small, with little natural light or ventilation. The accommodation wings are susceptible to weather conditions and extreme temperatures. We observed mouldy walls, rusted furniture and evidence of vermin. The dimensions and doorways of most cells are too small to accommodate some mobility aids, meaning people relying on walking frames or wheelchairs must leave these outside their cells and make do without them while they are secured in their cells.

Shower blocks across all areas are unsafe and in poor condition. In the MSPC 1 wings, the showers have no privacy barriers. The drainage is ineffective, causing flooding. The damaged and broken tiles in 7-wing were particularly concerning as these showers are used by inmates at-risk of self-harm.

During the inspection in May 2024, we observed the temporarily closed wings in MSPC, 9-wing and the KWU. At that time the wings had been empty for several months (from February 2024). These wings were described as 'mothballed' and CSNSW instructed MSPC to leave them in a state that would allow for them to be reopened at short notice. Consequently, inmate clothing, mattresses, pillows, and linen were stored in cells and appliances and other common use objects were left in the wings. It was difficult to understand the decision to store so many high demand essentials in unsanitary conditions when they could have been used and may have helped mitigate shortages in other parts of MSPC.

Neither KWU nor 9-wing were in a fit state to be reopened without significant work. Despite having only been closed for just over three months, we found both wings to be filthy. There was evidence of one or more stray cats residing in KWU, including faeces and fur. In both wings we observed dead cockroaches and rubbish. Perishable food was abandoned to rot in staff fridges. A toilet in a staff area had been urinated in and left unflushed, presumably for the period of the closure, creating a foul smell.

Hard copy inmate records were abandoned in staff offices, including accommodation journals, identification cards, and movement orders. In the Acute Crisis Management Unit (ACMU), closed since June 2023, this information included inmate behaviour management guidelines. Documents with inmate information that needed to be retained should have been accounted for and securely stored. Anything else should have been securely destroyed. Nothing should have been deserted in unused office space.

While we were on site in May 2024, a group of inmates was moved into the upper landing of 4-wing. This landing had been vacant for some time and was in a similarly poor condition to 9-wing and KWU. The cells and furniture were dirty and mouldy. Nothing was cleaned prior to the arrival of this group of inmates, which included aged and frail men who were unable to clean their cells themselves.

Given what occurred in 4-wing, we raised our concerns about the conditions of the closed wings with the governor of MSPC and emphasised that, should either 9-wing or KWU be reopened, they needed to be thoroughly cleaned. We were relieved that this feedback was actioned prior to the reopening of KWU in July 2024. During subsequent visits we found this unit to be very clean and tidy and noted that the hygiene issues we previously observed had been remedied.

As highlighted in previous reports, the 2016–17 NSW Budget included an investment of $3.8 billion over four years to create around 7,000 new beds in NSW correctional centres.[6] This included the construction of Clarence, Hunter and Macquarie correctional centres and additional maximum and minimum security accommodation for male inmates. We cannot understand why more of this funding was not utilised with the specific goal of decommissioning old and unfit infrastructure.

At MSPC, there has been some investment in discrete projects. The Segregated Housing Unit is an entirely new unit that opened in May 2018, at a cost of $2,837,172.20. A refurbishment of the ACMU was completed in March 2023 at a cost of $1,050,000 (excluding GST).[7] The ACMU was closed several months later. It is difficult to understand the decisions to approve these projects in the context of an otherwise derelict correctional centre.

Staffing

We found MSPC staff to be respectful and facilitative of the inspection. However, we have concerns about the staff culture, specifically in relation to staff attitudes towards inmates and standards of professionalism.

During the multiple periods we were on site in this inspection, we heard widespread reports of inmates being threatened, intimidated, and assaulted by custodial staff. Although we did not receive allegations of misconduct specific enough to refer for investigation, we received these reports from different inmates in different areas of MSPC. Strikingly similar reports were made during separate conversations with different members of our inspection team. Similarly, staff reported that some correctional officers treat inmates poorly, including with name calling and threats.

Custody

Gate security

We found the gate security at MSPC to be extremely lax. Strong gate security is crucial for preventing the introduction of contraband or other unauthorised items into correctional centres. Gates for maximum security areas typically require staff and visitors to go through a metal detector and have their belongings scanned by an x-ray machine (similar to the checks conducted at an airport). Staff and visitors are identified before entry using a biometric scan of their eyes or fingerprints. The person's eyes or fingerprints are also scanned when they leave the correctional centre, creating a digital record of who is behind the secure perimeter and the period for which they were present.

The gates in MSPC 1 and MSPC 2 did not have a walk-through metal detector, x-ray machine or access to the biometric system. Instead, gate staff used a handheld metal detector (known as a wand) to check staff and visitors for metal objects. Visitors were also required to sign in and out of a paper-based logbook. No checks were conducted of the bags people were taking behind the secure perimeter. We have recommended that CSNSW review gate security at MSPC.

Contraband

Given the limitations of MSPC's gate security, it was unsurprising that contraband was a significant issue. The most frequently located types of contraband were drugs and drug paraphernalia. There were notable trends in the types of drug-related contraband across the different areas of MSPC. We found Buprenorphine and syringes were more commonly located in MSPC 1. The drugs and drug paraphernalia found in MSPC 3 more frequently concerned tobacco/brown vegetable matter and smoking-related items.

We were alarmed at some of the other items located during searches. In March 2023, a CSNSW issued 911 tool was located hidden in an inmate's cell. These tools have a curved, metal blade and are used by officers to cut material that may be harming an inmate, such as a hanging ligature. In its original form it cannot be used to slash or stab. However, it is not unusual in correctional

6 NSW Government, 'NSW Budget: New Prisoner Beds, Record Corrections Funding' (Media Release, 16 June 2016).
7 Information provided by Corrective Services NSW, 27 February 2025.

environments for seemingly innocuous items to be fashioned into weapons or used in ways that can create a safety and security risk. From April 2025, correctional centres began providing each custodial staff member in contact with inmates with a personally issued 911 tool. This will hopefully ensure the timely identification of any lost or misplaced 911 tools.[8]

Assaults and fights

Data and information we obtained in relation to assaults and fights in MSPC suggest that MSPC 1 is a particular safety and security concern. It also suggests that the closure of 9-wing and the reduction of the size of the MSPC 1 population has not improved safety and security within MSPC 1. Most assaults and fights occurred in MSPC 1, frequently in yard areas. Consistent with the number of fights and assaults occurring in MSPC 1 there were a significant number of gaol-made weapons in this area. This suggests inmates are arming themselves as they do not feel safe.

Strip searches

Given the level of contraband in the centre, including drugs and weapons, there was a need for increased searching of cells and inmates.

We had significant concerns about strip searching practices at MSPC. Inmates at MSPC were being instructed by correctional officers to pull back their foreskins during strip searches. We heard multiple complaints about this practice during the inspection by inmates, across all areas of MSPC. It had also been raised by inmate delegates in Inmate Development Committee (IDC) meetings. Staff acknowledged to us that this practice was occurring. We were informed that staff had been directed to cease this practice. However, it was unclear if staff were following this direction. CSNSW has since revised its searching policy and procedures to explicitly prohibit this practice.[9]

We also heard complaints about other invasive strip search practices, including correctional officers instructing inmates to 'squat and cough' and using a torch to visually examine the anus/between their buttock cheeks while they were spreading their buttock cheeks.

The lack of a strip search register makes monitoring compliance with the legislation and policy concerning strip searching extremely difficult. In previous reports, we have recommended that reasons for strip searches be recorded. CSNSW have claimed that this would place an administrative burden on staff. We do not accept this explanation. We have recommended that CSNSW review the legislation and policy regarding strip searches, ensure strip search practices used by custodial staff comply with legislation and implement effective accountability and monitoring processes, including a record of reasons for strip searches.

An important accountability measure that protects both inmates and staff has been the introduction of body-worn cameras. However, we had some concerns about how these were being used. We observed staff wearing body-worn cameras attached to their belts, rather than the chest area. We have serious concerns about the quality of footage and audio captured from this angle. Staff should be directed to wear their body-worn cameras on their chest area to ensure footage and audio are properly recorded. We also noted that, although there was some body-worn camera footage in relation to most of the use of force incidents we examined, there were some staff who had failed to activate their body-worn cameras. Some of these use of force incidents occurred following the pat searches routinely conducted on selected MSPC 1 inmates when they are let out of their cells. We have recommended that CSNSW instruct custodial staff on the use of body-worn cameras, including that they must be worn on the chest area and must be turned on during searches and incidents.

Inmate discipline

We have concerns about the imposition of penalties for correctional centre offences at MSPC. We also noted the number of times access to phone calls and contact visits were withdrawn both in the sample we reviewed and data provided by CSNSW, despite CSNSW providing that these are

8 Deputy Commissioner Security and Custody, *Deputy Commissioner's Memorandum: Order 911 Rescue Tool (911 RT) for Personal Issue of Custodial Staff* (2025/09, 2 April 2025).

9 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 13; Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.4 Internal Concealment of Contraband* (version 1.3, 17 July 2025) 4.

penalties of last resort.[10] In August 2024, the NSW Ombudsman released an investigation into inmate discipline in NSW correctional centres.[11] We support the recommendations from this investigation and will continue to monitor this area.

JH&FMHN services

Compared with other male correctional centres, MSPC has larger numbers of complex patient cohorts, including higher acuity mental health patients, aged and frail patients, patients with intellectual disability and patients on medical hold because they have complex and/or serious health issues requiring ongoing access to specialist outpatient services.

Each area of MSPC has a health centre. MSPC 1 and MSPC 2 have additional smaller satellite health centres. Although some of the infrastructure was dated, we found the health centres at MSPC to be in good condition. The main health centres were clean and well-maintained. The satellite health centres in MSPC 2 were also in good condition. However, the satellite health centre in MSPC 1 was dirty and untidy and had not been cleaned for several months due to the closure of KWU.

MSPC has 24-hour medical coverage, with two nursing staff located in MSPC 1 overnight (from 9.30pm to 7.30am). However, the distance and secure gates between the three areas could delay the response of the night duty nurses to a health-related emergency in MSPC 2 or MSPC 3. Although health staff undertake mandatory emergency management training, we were advised no interagency health-related emergency management exercises were currently conducted in MSPC. We have recommended JH&FMHN and CSNSW consider undertaking joint scenario training on the management of health-related emergencies at MSPC to ensure that both staffing groups work well together in an emergency.

In all three areas, we observed health staff engaging politely with patients and demonstrating a commitment to providing the optimum level of care. However, we observed numerous occasions across all three health centres where custodial staff were physically in the room during the provision of health care to patients. Patients have a right to privacy and for information about their health to be confidential and this should be maintained unless there is a known or perceived risk to the safety and security of staff or patients. We have recommended that CSNSW, in consultation with JH&FMHN, review the presence of custodial staff in treatment and consultation rooms when health care is being provided to patients at MSPC.

Daily life and support

Routine and time out of cell

For the 2022–23 financial year, the average time out of cells at MSPC was 6.36 hours per day for inmates in secure custody and 11.02 hours per day for inmates in open custody.[12] NSW-wide, inmates in secure custody had 7 hours of time out of cell per day and inmates in open custody had 9.4 hours of time out of cell per day. In each category, these figures were the lowest of every jurisdiction in Australia.[13]

Time out of cell in MSPC 1 was also impacted by the process for letting inmates out of their cells. This process should commence at 7.15am. We reviewed the times when inmates were let out of their cells over a week in May 2024. The earliest time the process commenced was 7.40am and the earliest time it was completed was 8.07am. This was consistent with our observations during the inspection.

Management of inmates at risk of self-harm

MSPC held a significant number of inmates with histories of mental illness or at risk of self-harm. As at 31 August 2024, there were 55 inmates at MSPC with a history of mental illness (8.2%) and 111

10 Corrective Services NSW, *Custodial Operations Policy and Procedures: 14.1 Inmate Discipline* (version 1.2, 9 August 2024) 15.
11 NSW Ombudsman, *Investigation into Inmate Discipline in NSW Correctional Centres: A Special Report under Section 31 of the Ombudsman Act 1974* (Report, 21 August 2024).
12 Information provided by Corrective Services NSW, 17 January 2025.
13 Productivity Commission, *Report on Government Services 2024: Justice (part C)* (29 January 2024) data table 8A.13. The total time out of cell was 7.6 hours per day, ahead of only Tasmania which recorded a total of 7.3 hours per day.

inmates who have been managed by a Risk Intervention Team (RIT) (16.5%).[14]

Our biggest concern in relation to the management of inmates at risk of self-harm was the placement of people managed by a RIT in camera cells in 7-wing in MSPC 1 or the Integrated Support Unit in MSPC 2. Multiple staff members expressed significant concern about the conditions experienced by inmates at-risk, particularly those in 7-wing. One described the 7-wing cells as 'medieval'. The physical environment was widely thought to contribute to the distress of inmates at-risk, rather than support improved mental health. Many could not understand why money was spent on refurbishing the ACMU only for it to be closed soon after that refurbishment. At the time of writing, CSNSW advised that consultation was underway to reopen the ACMU, however the outcome of this was unclear.[15] We were surprised by this as CSNSW gave evidence to the Coroners Court of NSW that the ACMU had been permanently closed.[16]

This further highlights the inadequacy of MSPC's infrastructure in providing a modern and safe correctional environment. We reiterate the recommendation that MSPC should be closed.

During the inspection we were informed that there were four vacant psychologist positions and another psychologist would be moving to a new position in July 2024. A recruitment to fill these positions was close to being finalised. However, the recruitment and retention of psychology staff was reported to be an ongoing issue due to lower salaries than those paid to other public sector psychologists. This issue was also observed in relation to sex offender programs.

Support for Aboriginal inmates

As at 31 August 2024, the proportion of Aboriginal inmates at MSPC was 23.6%.[17] In December 2024, across NSW 32.3% of adults in custody were Aboriginal people.[18] Some effort has been made at MSPC to improve cultural safety for Aboriginal inmates. While this is encouraging, more work is needed.

Cultural support for Aboriginal inmates at MSPC was primarily provided by two Aboriginal services and programs officers (SAPOs). The Aboriginal SAPOs provided support to Aboriginal men in all areas of MSPC, including family liaison, funeral applications and funeral attendance. They were also facilitating a First Nations Creative Group for Aboriginal men in MSPC 1. This seemed to be a great local initiative, offering Aboriginal men with some support, cultural connection and meaningful activity. MSPC also has four Yarning Circles, one in each ASU and one in MSPC 3. These were easily accessible for inmates and were in good condition.

Inmate advocacy and complaints mechanisms

Inmates from all areas told us they were reluctant to seek help for fear of being punished or transferred to a different correctional centre. These concerns are reminiscent of evidence presented by inmates at the *Special Commission of Inquiry into Offending by Former Corrections Officer Wayne Astill at Dillwynia Correctional Centre* where it was recognised by Commissioner Peter McClellan AM KC that fear of reprisal can make it difficult for inmates to trust the 'system'.[19] It is difficult to know the extent to which this perception is a consequence of rumour and speculation or actual threats and intimidation or both. However, it was clear that the fear was genuine and work is required to create an environment where people feel safe to make complaints and raise concerns.

MSPC had two IDCs – one for inmates in MSPC 1 and a combined IDC for MSPC 2 and MSPC 3. Meetings for both appeared to be occurring monthly. However, we found the combined MSPC 2 and MSPC 3 IDC perplexing given the diversity of cohorts and needs across these areas. The mixture of protection and mainstream inmates from those areas is not ideal and requires careful selection of the inmate delegates. MSPC should review this arrangement and consider if two separate IDCs would

14 Information provided by Corrective Services NSW, 17 January 2025.
15 Information provided by Corrective Services NSW, 23 September 2025.
16 *Inquest into the Death of Alfonso Ceniccola* (Coroners Court of New South Wales, Deputy State Coroner Elizabeth Ryan, 24 February 2025) 7.
17 Information provided by Corrective Services NSW, 17 January 2025.
18 Bureau of Crime Statistics and Research, *NSW Closing the Gap Quarterly Update December 2024* (April 2025).
19 *Special Commission of Inquiry into Offending by Former Corrections Officer Wayne Astill at Dillwynia Correctional Centre* (Final Report, February 2024) 31.

be more appropriate and efficient. CSNSW has advised that MSPC find this to be the most effective approach.[20]

Contact with family and friends

The availability of in-cell tablets and phones in yards and units help ensure that inmates have easy access to phone calls. However, inmates reported finding phone calls expensive. This was particularly challenging for inmates with no options for work who relied on family or friends for money. The financial burden was significant for those with family residing overseas. We have previously reported on and made recommendations concerning the cost of phone calls for inmates.[21] Consequently, we will not be making a further recommendation in this report. However, we reiterate the importance of CSNSW looking at ways to make phone calls more affordable for inmates. CSNSW has advised that it has renegotiated its contract with Telstra, resulting in reduced call costs for inmates from September 2025 (see section 2.6.8).[22] We commend CSNSW on achieving this outcome.

Inmates at MSPC have access to in-person and virtual visits on weekends.

We were concerned about the accessibility of visit areas. Visitors convene at the main entrance gate of the Long Bay Correctional Complex (known as the boom gate) and then walk to the relevant visits area, which is approximately 600 metres away and includes a short but steep hill. It is difficult for people with limited mobility to negotiate this walk, especially in poor weather conditions. Parking within the Long Bay Correctional Complex requires approval, however, we heard there is a lack of clarity around the steps required for people to obtain this approval and information from staff could vary. It is also not an option for people travelling by public transport. We note this is also applicable for visits at LBH. Therefore, we have recommended CSNSW undertake a review of the accessibility of visit areas on the Long Bay Correctional Complex.

The MSPC 1 visits area consists of a single visits room and three non-contact visits suites. It is located in a demountable building that was described to us as a temporary visits area that had been in place for around 20 years. The visits room is small, basic and dilapidated. There is no area for child visitors. Of particular concern, the fire exits were secured shut and could not be opened in an emergency. There is a ramp leading to the visitor's entrance of the building but the inmate entrance has stairs and is inaccessible for anybody in a wheelchair or relying on mobility aids. Inmates who cannot use this entrance go through a sterile zone area to access the ramp.

The MSPC 3 visits area is old infrastructure that, like other parts of MSPC, poses safety concerns for people with disability or limited mobility. We observed staff doing their best to assist visitors requiring help. However, the facilities remain inadequate.

Access to courts and legal representatives

MSPC's only AVL area is located in MSPC 1. We were concerned that MSPC's AVL facilities were insufficient to meet demand due to their age and condition.

MSPC 1 has six AVL suites for court appearances and professional visits (including with legal representatives) and six inmate holding cells. There are also two dedicated phones for scheduled legal calls and two rooms for in-person legal visits. Additional AVL suites are located in the Segregated Housing Unit (SHU), used for inmates placed in the SHU.

Inmates were brought to the AVL area in MSPC 1 at around 9am and could spend lengthy periods waiting for court, which could take all day, before being returned to their unit following the conclusion of their matter. MSPC staff aim to hold inmates receiving professional visits in the area for around 15 minutes.[23] We observed the holding cells to be substandard, with only some having a toilet and washbasin, and others exposed to the climate.

20 Information provided by Corrective Services NSW, 23 September 2025.
21 Inspector of Custodial Services, *Inspection of John Morony Correctional Centre 2023* (Report, March 2024) 44–5; Inspector of Custodial Services, *Inspection of Cessnock Correctional Centre and Shortland Correctional Centre* (Report, June 2024) 48–9; Inspector of Custodial Services, *Inspection of Mid North Coast Correctional Centre 2023* (Report, December 2024) 52–3.
22 Information provided by Corrective Services NSW, 23 September 2025.
23 Information provided by Corrective Services NSW, 23 September 2025.

For inmates with mobility issues, the AVL area presents many challenges. A removable ramp allows for inmates in wheelchairs and walkers to enter the area. The space is tight and has narrow doorways to AVL suites, making it difficult for people with mobility aids to manoeuvre. The AVL area is unsafe, unfit for purpose and does not meet the expectations of a modern correctional environment.

CSNSW has advised that the demand for video conferencing at MSPC is manageable within current resourcing. However, it noted that it is aware of the age and demand for AVL at MSPC and is investigating options to manage this locally, including improvements to AVL suites and holding cells.[24]

Mail

CSNSW commenced the practice of photocopying inmate mail in 2020. During this inspection we received many complaints from inmates around mail. There were reports of inmates receiving opened legal mail and having difficulty sending legal correspondence. Legal practitioners are exempt persons under the CAS Regulation.[25] Inmates should not be receiving opened legal mail. If sent in the specified manner, legal mail should be given to the inmate unopened or, if not, it should be returned to the sender.

With respect to privileged mail to and from exempt bodies and persons, we consider it is now clear that accountability measures are required to ensure compliance with the legislation. We have recommended that CSNSW implement a privileged mail register. This could record incoming and outgoing privileged correspondence and when it was received or posted, including inmate verification that privileged mail received was unopened.

Rehabilitation

Programs

In MSPC 1, the Offender Services and Programs (OS&P) team facilitated remand-focused programs (Remand Addictions and Remand Domestic Violence, Mini Dads at a Distance) and coordinated Narcotics Anonymous and Alcoholic Anonymous sessions. In MSPC 3, OS&P staff delivered programs to sentenced inmates including the EQUIPS suite, RUSH and CONNECT. MSPC is also the location of intensive programs – sex offender programs, based in MSPC 2, and the Violent Offender Therapeutic Program, based in MSPC 1.

Short staffing reduced service provision capacity and increased the workload for the sex offender programs team. This has not improved since our previous inspection of sex offender programs. That inspection found that vacant psychology positions were negatively impacting the capacity of CSNSW to deliver intensive programs and recommended CSNSW explore innovative recruitment initiatives to fill vacancies. In response to that inspection, CSNSW reported engaging with the Department of Communities and Justice Strategic Human Resources team and conducting significant recruitment activity for psychology positions.[26] We acknowledge CSNSW's efforts to address this issue but unfortunately, they do not appear to have had a lasting impact on psychology staffing levels for the sex offender programs team.

Improving recruitment and retention of psychologists in the sex offender programs team is essential for the delivery of programs for sex offenders before they are released from custody, in line with the expectations of the State Parole Authority and the community. We have made several recommendations in other inspections concerning the recruitment and retention of psychology staff, including that CSNSW review pay scales for psychologists to assist with recruitment and retention.[27]

In our previous inspection, we recommended that CSNSW review the accommodation and placement of intensive programs in MSPC. In response, CSNSW agreed to conduct a review.[28] However, participants in these programs remain in an unfit environment with no plans to relocate them.

24 Information provided by Corrective Services NSW, 23 September 2025.
25 *Crimes (Administration of Sentences) Regulation 2014* cl 3.
26 Inspector of Custodial Services, *Programs, Employment and Education Inspection* (Report, February 2020) 47.
27 Inspector of Custodial Services, *Inspection of South Coast Correctional Centre 2023* (Report, November 2025).
28 Inspector of Custodial Services, *Programs, Employment and Education Inspection* (Report, February 2020) 49.

We consider the continued reliance on MSPC a reflection of a profound failure in estate planning. MSPC is an unsuitable location for intensive criminogenic programs and placement of inmates with high needs due to disability, illness or age and frailty.

CSNSW has advised that a strategic population bed management project is underway, led by executive staff. It noted that staffing intensive programs is challenging and one of the reasons intensive programs continue to be located at MSPC is because recruitment efforts are more successful in metropolitan facilities.[29]

Employment and education

At the time of this inspection, there were a number of Corrective Services Industries (CSI) business units and service industries operating at MSPC, providing a total of 458 inmate jobs. MSPC staff reported there were insufficient inmate workers to operate MSPC's industries. This was largely attributed to the number of aged and frail inmates and inmates on medical holds placed in MSPC, particularly in MSPC 3, who were unable to work or had limited capacity to work.

Staff across different disciplines considered staffing inmate work locations to be the priority and expressed frustration at being unable to transfer aged and frail inmates elsewhere. These concerns were reflected in MSPC's 2024 Strategic Review of Correctional Industries and Education. This meeting determined that JH&FMHN would conduct a review of current inmates on medical holds to identify who could work and at what capacity and to notify classification and placement staff to prioritise the ratification of classification and placement decisions relating to 'suitable inmates to maintain worker numbers'.[30] However, we were also told that a lack of placement options in the Sydney metropolitan area for minimum security inmates on protection was an ongoing issue.

As unsuitable as MSPC's physical infrastructure is for aged and frail inmates, there is not currently another location in the Sydney metropolitan area that meets their needs. CSNSW needs to prioritise creating such a location. But until this is resolved, the placement of aged and frail inmates in MSPC, where this is deemed to be the most suitable location, should take precedence over inmate workers.

Treatment of people with disability in custody

MSPC has high numbers of inmates with disability. Our inspection considered the conditions and treatment experienced by inmates with disability, particularly inmates with intellectual or cognitive disability accommodated in the Additional Support Units (ASUs) in MSPC. Statewide Disability Services (SDS), a specialist unit of CSNSW that provides statewide support to inmates with disability is situated on the Long Bay Correctional Complex.

Generally, inmates with disability are identified through the reception screening process. However, referrals to the SDS can be made at any time an inmate is in custody. However, while SDS considered the referral process to be working well, the inspection found that frontline reception processes need review to ensure all inmates with disability are identified when they enter custody, including information sharing about inmates with disability already identified at police and court cells with CSNSW reception staff.

We were impressed by the efforts of SDS to identify people requiring more support. This is a time-consuming exercise, but SDS staff considered it to be important as inmates can be masking a disability or their disability may be related to challenging behaviour.

The physical environment of MSPC has many limitations, particularly for people with disability, and this was evident in the ASUs in 5-and 6-wings. We observed many areas that were inaccessible and in need of repair. The inaccessible environment compels inmates with physical disability to rely on mobility, access, and personal care support from peers. Hearing and sight impaired inmates found it difficult to negotiate call buttons, watch television and use tablets and, in some cases, relied on other inmates to help with forms and phone calls. With their independence removed these inmates

29 Information provided by Corrective Services NSW, 23 September 2025.
30 Information provided by Corrective Services NSW, 15 November 2024.

are placed in a vulnerable position, at risk of manipulation and standover. We have recommended CSNSW review the use of 5-wing and 6-wing as ASUs.

Disability training is essential for all staff. SDS has a staff member who provides training to new custodial officers and CSNSW staff (on request). We have recommended that CSNSW deliver compulsory disability awareness training to all custodial staff and consider more intensive training options for selected staff working with inmates with disability.

ASU inmates expressed concern around employment and pay. CSI must set equitable work standards and ensure ASU inmates have access to the same pay rates, bonuses, work and vocational training opportunities available to other inmates. Overt discrimination against inmates with disability must cease. We have recommended that CSNSW review CSI policies to ensure they are inclusive and provide equitable access to employment and education.

While we were impressed by SDS and the dedication of this team to their work, it was evident their workload was considerable and needed to be addressed. We observed that limited resources and high demand required SDS to prioritise its work and respond to critical issues and inmates with very high needs, primarily those with intellectual disability. This limited their capacity to meet the fundamental needs of all inmates with disability. Increasing SDS' capacity is essential to meet the need for services for inmates with disability. We have recommended that CSNSW review the resourcing of SDS to ensure it is adequate to deliver statewide cross-disability services.

We also emphasise the importance of cultural and attitudinal change regarding how the needs of people with disability are understood and prioritised. This cannot be achieved by staff training alone and requires leadership and commitment from CSNSW's executive staff and local management teams.

CSNSW is developing a Disability Framework that aims to provide a consistent approach to disability across CSNSW and outlines current strategies and future aims for enhancing inclusion via targeted initiatives and ensuring a disability perspective is evident more broadly.[31] At the time of writing, the document was waiting agency approval. We have recommended that CSNSW ratify a Disability Framework and create a disability access and inclusion plan to support the implementation of its key principles.

Treatment of aged and frail people in custody

The growing number of aged and frail people in custody has been of concern for nearly two decades. We previously considered the ageing prison population in NSW in our *Old and Inside* report, published in 2015. Accommodating a growing aged inmate population in suitable facilities remains a considerable challenge. We have recommended that CSNSW urgently provide fit for purpose accommodation for aged and frail inmates.

Specialist units for people identified as requiring additional supports include the ACRU in LBH and the KWU in MSPC. Other accommodation options include 4-wing in MSPC 2 and the Hamden Aged Care POD in MRRC. We visited all these units as part of this inspection and found the conditions to be unsuitable in all locations, except for the ACRU, although it lacks sufficient beds. The physical environment of the KWU and 4-wing are particularly poor. Both are part of the original MSPC infrastructure. Although grab rails and ramps are installed in key areas, a number of accessibility limitations remain. These modifications cannot rectify the accessibility limitations inherent to a correctional centre constructed in the early 1900s, including cells that are too small for wheelchairs and walking frames, which must be left outside when inmates are locked in their cells.

In January 2024, CSNSW announced that the KWU would be closed. A dedicated location for aged and frail inmates was to be established at MRRC. Although there had been some consultation and planning about the establishment of an Aged Care POD in MRRC, there appeared to be little input from JH&FMHN on the closure of KWU and the risks and consequences of this decision. In addition, prior to the initiation of inmate transfers, there was insufficient opportunity for JH&FMHN to make

31 Information provided by Corrective Services NSW, 26 November 2024.

recommendations about alternative placements for KWU inmates or for CSNSW to make previously recommended modifications to MRRC. This created a challenging operational environment for JH&FMHN and CSNSW staff and significant distress for impacted inmates. The lack of planning was evident when we visited MRRC on two occasions in March 2024 and we observed that CSNSW appeared to be wholly unprepared for managing this frailer cohort of inmates. Given the very complex health needs of some aged and frail inmates, we have recommended that JH&FMHN and CSNSW make all decisions about dedicated accommodation options and the implementation of new arrangements collaboratively.

Shortly after part 2 of our inspection, CSNSW made the decision to re-open the KWU in June 2024. The KWU has many limitations as a location for housing aged and frail inmates. Despite this, it has become a key part of the framework for managing aged and frail people in custody. The experience of closing and reopening the KWU within a six-month period highlights the significant level of planning required to change accommodation for aged and frail inmates. It is essential that future alternate placements for this cohort consider their health, care, and accommodation needs and ensures the facility meets these needs *prior* to their transfer.

Adaptive ageing is a concept that not only views ageing as a process of personal adjustments, compensation, and modifications as people age, but also requires those engaging and interacting with older persons to be 'adaptive' in order to best suit their individual needs.[32] JH&FMHN advise that they are moving towards an adaptive ageing approach in their management and care of aged patients. We support this approach and have recommended that CSNSW support the implementation of the JH&FMHN Adaptive Ageing model of care.

There is often the assumption that support for aged inmates is purely a healthcare function. While we observed some supportive CSNSW staff, it was evident that others were ill-equipped to manage aged and frail inmates. This sometimes manifested as resentment or frustration about the provision of supports and adjustments. There was a general lack of understanding of the need for these inmates to be close to medical specialists for appointments or treatment and of the want of other placement options.

During the inspection we engaged with multiple aged and frail inmates who reported being hand cuffed and ankle cuffed on medical escorts. We consider that the policy and procedure in this area requires review and amendment to support better decision making. Given medical escorts involve transporting inmates to a community setting, it is understandable that a higher level of restraint may be required. However, it is less clear why exceptions based on age and frailty are available for medical escorts but not general escorts.[33] We have recommended that CSNSW review policies and procedures for inmates on escort and ensure they are fit for purpose for aged and frail inmates and the adequacy of special transport vehicles.

Treatment of LGBTIQA+ people in custody

At the time of the inspection, relevant CSNSW policy and procedures included dedicated chapters on the management of transgender and intersex people in custody. We note that at the time of writing, these policies and procedures were under review and may be subject to change following the publication of this report.

Although there were positives regarding the policy framework concerning transgender and intersex people in custody, we considered it required more work. It was largely concerned with people entering custody and their initial placement and provided only minimal guidance regarding their ongoing management and safety considerations. In theory, a transgender person had the right to be placed in a correctional centre of their gender identity. However, the relevant policies allowed for

32 Australian Association of Gerontology, *Moving from Successful or Positive Ageing to Adaptive Ageing* (Position Paper, 23 December 2021).

33 Corrective Services NSW, *Custodial Operations Policy and Procedures: 19.1 General Escort Procedures* (version 1.11, 5 July 2024) 18; Corrective Services NSW, *Custodial Operations Policy and Procedures: 19.6 Medical Escorts* (version 1.17, 15 July 2024) 9–11.

considerable discretion.[34] CSNSW senior executive staff are the sole decision-makers for placement decisions for transgender and gender diverse inmates whose placement has been discussed at an interagency meeting with JH&FMHN.[35] We have recommended that CSNSW review and revise all policy and procedures concerning transgender, gender diverse and intersex people in custody and create timelines and an accountability framework for these senior executive decisions to prevent delays.

During the inspection, we observed some good examples of initiatives to support the health and wellbeing of LGBTIQA+ inmates, particularly trans inmates. Gender affirming clothing was generally available, although there were reports of delays providing this to inmates. There were also examples of access to support and awareness raising that we felt could be enhanced. JH&FMHN and CSNSW also had policies concerning access to gender-affirming health care for trans inmates.

The LGBTIQA+ inmates we engaged with spoke positively about some custodial staff, reporting that some officers are considered 'LGBTIQA+ friendly' and approachable when LGBTIQA+ inmates require assistance. However, we were disappointed to hear reports of intentional misgendering by staff and the use of language designed to demean, intimidate, and humiliate LGBTIQA+ inmates. This conduct enables and permits the abuse of LGBTIQA+ inmates more broadly. It creates the impression that staff will not act to protect LGBTIQA+ inmates, making inmates reluctant to report threats to their safety and tacitly approving bullying and intimidation by other inmates. We have recommended CSNSW take action to address violence, harassment and abuse directed to LGBTIQA+ inmates.

34 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 5–6; Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021) 4–5.

35 Corrective Services NSW, *Placement Practice Guide* (version 1.0, 24 May 2025) 33.

Recommendations

Long Bay Hospital

The Inspector recommends:

1. The Justice Health and Forensic Mental Health Network remind Medical Unit nursing staff of:
    a. the 'no touch' technique for handling medications and to use a tablet cutter when breaking a tablet in half
    b. the requirement to lock the medication trolley when it is not under the direct supervision of a nurse
    c. their responsibility to ensure the pharmacy room is kept locked at all times.
2. Corrective Services NSW work with the Justice Health and Forensic Mental Health Network to provide facilities adequate to meet the needs of people with disability with very high support needs.
3. Corrective Services NSW, in consultation with the Justice Health and Forensic Mental Health Network, review the presence of custodial staff during the provision of health care or activities of daily living support to patients in the Medical Unit, with a view to maintaining patient privacy and the confidentiality of patient health information.
4. The Justice Health and Forensic Mental Health Network remind Mental Health Unit nursing staff of the requirement to check an approved form of patient identification when they are preparing and administering medications.
5. Corrective Services NSW increase time out of cell for inmates in Long Bay Hospital Area 1.
6. Corrective Services NSW permanently close the Long Bay Hospital Multipurpose Unit.
7. Corrective Services NSW permanently close inmate accommodation in Long Bay Hospital Area 2.

Metropolitan Special Programs Centre

The Inspector recommends:

8. Corrective Services NSW cease the practice of 'mothballing' 1800s and early 1900s infrastructure and commit to permanently closing the Metropolitan Special Programs Centre.
9. Corrective Services NSW implement a 12-hour shift model for custodial staff.
10. Corrective Services NSW review gate security at the Metropolitan Special Programs Centre.
11. Corrective Services NSW review the legislation and policy regarding strip searching and ensure strip search practices comply with legislation.
12. Corrective Services NSW implement effective accountability and monitoring processes in relation to strip searching, including maintaining a record of reasons for strip searches.
13. Corrective Services NSW instruct custodial staff on the use of body-worn cameras, including that they must be worn on the chest area and must be turned on during searches and incidents.
14. The Justice Health and Forensic Mental Health Network and Corrective Services NSW consider undertaking joint scenario training on the management of health-related emergencies in the Metropolitan Special Programs Centre.

15. The Justice Health and Forensic Mental Health Network review the supervision requirements for telehealth specialist appointments undertaken within a health centre.

16. The Justice Health and Forensic Mental Health Network ensure all health staff are aware of its new preventive health screening and chronic disease assessment and management processes.

17. Corrective Services NSW remind custodial staff of their responsibilities, as outlined in the *Custodial Operations Policy and Procedures,* in relation to opioid agonist treatment administration.

18. Corrective Services NSW, in consultation with the Justice Health and Forensic Mental Health Network, review the presence of custodial staff in treatment and consultation rooms when health care is being provided to patients, with a view to maintaining patient privacy and the confidentiality of patient health information. This review should capture all applicable care areas, including the main health centres and satellite health centres in all areas of Metropolitan Special Programs Centre.

19. The Justice Health and Forensic Mental Health Network formally remind health staff of the requirement to refer to patients by their full name or a title followed by their last name and not by their last name and/or identification number.

20. Corrective Services NSW should transfer responsibility and requisite funding for inmate dietary needs and meal menus to the Justice Health and Forensic Mental Health Network.

21. Corrective Services NSW review the accessibility of visits areas on the Long Bay Correctional Complex.

22. Corrective Services NSW implement a privileged mail register.

23. Corrective Services NSW review pay scales for psychologists to assist with attraction and retention of those staff.

Treatment of people with disability in custody

The Inspector recommends:

24. Corrective Services NSW review the use of 5-wing and 6-wing at the Metropolitan Special Programs Centre as Additional Support Units to identify and address accessibility and safety concerns for inmates with disability or find an alternative location.

25. Corrective Services NSW deliver compulsory disability awareness training (including refresher training) to all custodial staff and consider more intensive training options for selected staff working with inmates with disability.

26. Corrective Services NSW formalise and expand inmate peer to peer disability support in the Additional Support Units, with access to training and qualifications.

27. Corrective Services NSW review policies and procedures concerning inmate discipline to ensure they are inclusive of inmates with disability.

28. Corrective Services NSW review:

    a. Corrective Services Industries policies around disability inclusion and equitable access to employment and education

    b. the operation and work practices of technology and assembly workshops at the Metropolitan Special Programs Centre with particular attention to safe work environments, induction and inmate wages.

29. Corrective Services NSW review the resourcing of Statewide Disability Services to ensure it is adequate to deliver statewide cross-disability services.

30. Corrective Services NSW ratify a Disability Framework and review and amend existing policy, procedures and practice to align with its key principles.

31. Corrective Services NSW develop a disability access and inclusion plan.

Treatment of aged and frail people in custody

The Inspector recommends:

32. Corrective Services NSW urgently provide fit for purpose facilities for aged and frail inmates that have capacity for the projected growth of this cohort.

33. Future decisions about the accommodation of aged and frail inmates should be made jointly by Corrective Services NSW and the Justice Health and Forensic Mental Health Network.

34. Corrective Services NSW and the Justice Health and Forensic Mental Health Network improve systems for sharing information relevant to the placement of aged and frail inmates in a correctional centre or particular cell.

35. Corrective Services NSW support the implementation of the Justice Health and Forensic Mental Health Network Adaptive Ageing model of care.

36. Corrective Services NSW provides custodial staff working in aged and frail units and Long Bay Hospital Area 1 with appropriate training in the management of delirious, confused or disoriented people in custody.

37. Corrective Services NSW review policies and procedures for inmates on escort to ensure they are fit for purpose for aged and frail inmates and the adequacy of special transport vehicles.

38. Corrective Services NSW and the Justice Health and Forensic Mental Health Network jointly develop procedures which delineate each agency's responsibilities for the discharge of aged and frail patients to residential aged care facilities and resource this process accordingly.

Treatment of LGBTIQA+ inmates in custody

The Inspector recommends:

39. Corrective Services NSW review and revise all policy and procedures concerning transgender, gender diverse and intersex people in custody.

40. Corrective Services NSW create timelines and an accountability framework for senior executive decisions concerning the placement of transgender and gender diverse inmates.

41. Corrective Services NSW remind custodial staff of their obligations regarding the strip and pat searching of trans and gender diverse inmates and ensure practices are closely monitored by local management teams.

42. Corrective Services NSW include clothing that aligns with a person's gender identity in their standard clothing allocation.

43. Corrective Services NSW support LGBTIQA+ inmates and staff to recognise days of significance for the LGBTIQA+ community and explore ways to enhance the LGBTIQA+ inmates' access to services specific to their needs.

44. Corrective Services NSW take action to address the violence, harassment and abuse directed at LGBTIQA+ inmates.

45. Corrective Services NSW provide staff training on LGBTIQA+ awareness and associated legislative and policy obligations.

46. This report is made public immediately upon being tabled in NSW Parliament, in accordance with section 16(2) of the *Inspector of Custodial Services Act 2012*.

Inspection process

The office of the Inspector of Custodial Services (ICS) was established by the *Inspector of Custodial Services Act 2012* (the ICS Act) in October 2013. The mandate of the office is to provide independent scrutiny of the conditions, treatment and outcomes for people in custody, and to promote excellence in staff professional practice. The Inspector is required to inspect each adult custodial centre at least once every five years and report on each such inspection to the NSW Parliament with relevant advice and recommendations.[36]

Inspection provides independent information gathering and analysis concerning what is working well and which areas require improvement.

The Long Bay Correctional Complex consists of three correctional centres – the Metropolitan Special Programs Centre (MSPC), Long Bay Hospital (LBH), and the Special Purpose Centre – and a residential facility – Nunyara Community Offender Support Program (Nunyara). The only facility on the Long Bay Correctional Complex within our jurisdiction that we did not include in this inspection was Nunyara. This was included in our inspection of residential facilities, tabled in June 2025.[37] Due to Nunyara's role in supporting people released from custody, we considered it was better examined in the context of similar facilities rather than the correctional centres considered in this inspection. This also allowed for reflection on our previous inspection of Nunyara.[38]

The JH&FMHN's Forensic Hospital is located adjacent to the Long Bay Correctional Complex. The Forensic Hospital is a separate, standalone health facility, not a custodial facility. Adults and young people in custody may be transferred to the Forensic Hospital for treatment but it is not part of the adult or youth custodial systems. It is not subject to ICS inspections.

As noted in the relevant chapters, we have previously inspected the correctional facilities on the Long Bay Correctional Complex as part of various thematic inspections. This is the first inspection that has focused on all areas of each correctional centre. Consequently, we decided to undertake the inspection in two parts:

- **Inspection part 1**: Consisted of site visits and reviewing information and data from the agencies to define the scope of the inspection and identify any relevant expertise required.
- **Inspection part 2**: Consisted of the primary onsite component of the inspection in May 2024 and analysis of follow-up information and data from the agencies.

Due to the work of inspection part 1, we concluded that three thematic chapters would be necessary to provide specific focus on three inmate cohorts with significant populations on the Long Bay Correctional Complex (particularly MSPC) – people with disability, people who are aged and frail and LGBTIQA+ people. This enabled us to examine the treatment and conditions they experienced in MSPC or LBH alongside the statewide frameworks for managing and supporting these inmates and providing for their unique needs.

The inspection was announced, and inspection part 1 commenced, prior to CSNSW's announcement of the temporary closure of parts of MSPC (the Kevin Waller Unit (KWU) and 9-wing in MSPC 1) and LBH (all the inmate accommodation in LBH 2). Consequently, we undertook additional visits to understand the impact and implementation of this transition. This included visits to the newly established Hamden Aged Care POD at the Metropolitan Remand and Reception Centre (MRRC), where a number of aged and frail men from KWU were transferred following its closure.

Most of the temporarily closed areas reopened following the primary onsite component of the inspection (inspection part 2). Subsequent visits were undertaken to these areas to understand the impact and implementation of the reopening. At the time of writing, only 9-wing in MSPC 1 remained

36 *Inspector of Custodial Services Act 2012* s 6.
37 Inspector of Custodial Services, *Inspection of the Residential Facilities and the Compulsory Drug Treatment Correctional Centre 2024* (Report, June 2025).
38 Inspector of Custodial Services, *Inspection of the Residential Facilities and the Compulsory Drug Treatment Correctional Centre* (Report, February 2020).

closed. A complete timeline of these visits and inspections is included below (see Inspection timeline).

We gathered a range of information during our inspections and visits including from observation of the operations and physical environment of each correctional centre, review of records and documents and conversations with inmates and CSNSW and JH&FMHN staff. We also requested data and documents from CSNSW and JH&FMHN prior and subsequent to these visits and inspections.

The primary onsite component of the LBH inspection was conducted in May 2024 by the Inspector, two principal inspection and research officers, and a research assistant. The primary onsite component of the MSPC inspection was conducted in May 2024 by the Inspector, three principal inspection and research officers, a senior inspection and research officer, an Aboriginal inspection and liaison officer and a research assistant.

We engaged the following consultants to assist us with this inspection: Craig Gear (aged and frail inmates), Maureen Hanly (health service provision), Matthew Bowden (people with disability and LGBTIQA+ people) and Neil McAllister (correctional centre security and operations). They attended the onsite components where relevant. We acknowledge and thank them for their contribution to this inspection.

Following the main onsite inspection, separate debriefs were held with the governors of LBH and MSPC. Both meetings took place in June 2024. Debriefs provide an opportunity for local management to address any immediate concerns and to be aware of the initial findings of the inspections and likely medium to longer term recommendations.

The inspection considered sensitive information and methodologies. In accordance with section 15 of the ICS Act, the Inspector must not disclose information in a report to Parliament if there is an overriding public interest against disclosure of the information. This is where there are public interest considerations against disclosure and, on balance, those considerations outweigh the public interest considerations in favour of disclosure. Section 15(3) of the ICS Act provides that there are public interest considerations against disclosure of information if disclosure of the information could reasonably be expected to have one or more of the following effects:

> a) prejudice the supervision of, or facilitate the escape of, any person in lawful custody or detention,
>
> b) prejudice the security, discipline or good order of any custodial centre,
>
> c) prejudice national security (within the meaning of the *National Security Information (Criminal and Civil Proceedings) Act 2004* of the Commonwealth),
>
> d) reveal or tend to reveal the identity of an informant or prejudice the future supply of information from an informant,
>
> e) identify or allow the identification of a person who is or was detained at a juvenile justice centre or in custody in a juvenile correctional centre,
>
> f) endanger, or prejudice any system or procedure for protecting, the life, health or safety of any person who is in custody, detained or residing at a custodial centre (including but not limited to systems or procedures to protect witnesses and other persons who may be separated from other persons at the centre for their safety),
>
> g) identify or allow the identification of a custodial centre staff member or endanger, or prejudice any system or procedure for protecting, the life, health or safety of such a staff member.

A draft report or relevant parts thereof were provided to CSNSW, JH&FMHN and the NSW Police Force in accordance with section 14(2) of the ICS Act. Submissions were received from CSNSW, JH&FMHN and the NSW Police Force. In accordance with section 14(1) of the ICS Act, the Inspector provided the Hon. Anoulack Chanthivong, Minister for Corrections, with the opportunity to make a submission in relation to the draft report. In accordance with section 14(3)(b) of the ICS Act, each submission and the Minister's response was considered before the finalisation of the report for tabling.

Inspection timeline

Date	Event
4 August 2023	Formal announcement of the inspection
22 to 23 August 2023	MSPC inspection part 1 (see Inspection process)
24 to 25 August 2023	LBH inspection part 1 (see Inspection process)
10 January 2024	CSNSW announces the temporary closure of parts of MSPC and LBH
9 February 2024	Visit to Kevin Waller Unit before closure
21 February 2024	Visit to MSPC
22 February 2024	Visit to LBH
Late February 2024	Temporary closure of parts of MSPC and LBH
12 and 22 March 2024	Visits to the MRRC's aged and frail unit
29 April to 1 May 2024	MSPC inspection part 2 – health services (see Inspection process)
8 and 13 May 2024	Engagement with MSPC inmates
13 to 18 May 2024	LBH inspection part 2 (see Inspection process)
22 May 2024	Engagement with MSPC inmates with disability
27 to 31 May 2024	MSPC inspection part 2 (see Inspection process)
Late May 2024	CSNSW decision to reopen LBH 2
3 June 2024	LBH 2 reopened
Early June 2024	CSNSW decision to reopen the Kevin Waller Unit
16 June 2024	MSPC inspection part 2 – in-person visits
20 June 2024	Visit to MRRC – reception screening processes
15 July 2024	Kevin Waller Unit reopened
19 and 30 July 2024	Visit to the Kevin Waller Unit post-reopening
29 July 2024	Visit to LBH 2 post-reopening
12 June 2025	Visit to LBH

1 Long Bay Hospital

1.1 Long Bay Hospital profile

1.1.1 Inspection history

We previously inspected Long Bay Hospital (LBH) as part of the following thematic inspections:

- *Old and Inside: Managing Aged Offenders in Custody*. The inspection took place in May 2015 and the report was published in September 2015.
- *Health Services in NSW*. The inspection took place in July 2018 and the report was published in March 2021.

1.1.2 Function and capacity

LBH is a maximum security correctional centre consisting of two distinct areas – LBH Area 1 (LBH 1) and LBH Area 2 (LBH 2). Together both areas can hold up to 403 people: 87 patients in LBH 1 and 316 inmates in LBH 2. On 28 July 2024, there were 74 patients in LBH 1 and 261 inmates in LBH 2.[39]

The Special Purpose Centre, also known as LBH Area 3 (LBH 3), is gazetted as a separate correctional centre but shares the same management structure as LBH.

LBH 1 resembles a hospital and its primary purpose is to provide inpatient or bed-based health care for people in custody. These people require a higher level of clinical care and access to medical, nursing and allied health services than generally provided in a correctional centre. LBH 1 is managed by an agreement between Corrective Services NSW (CSNSW), the Justice Health and Forensic Mental Health Network (JH&FMHN) and PPP Solutions, a partnership responsible for the building and facilities management of LBH 1.[40] LBH 1 consists of three units, outlined in Table 1.

Table 1: LBH 1 units[41]

Ward	Capacity	Function
Aged Care and Rehabilitation Unit (ACRU)	15	The ACRU holds aged and frail patients with high support needs.
Medical Unit (MU)	29	The MU holds patients with subacute medical needs, including palliative care, pre-and post-operative care, medical observation, and dialysis. It includes seven pressurised cells for patients with contagious disease.
Mental Health Unit (MHU)	40	The MHU holds patients with sub-acute mental health conditions. It consists of three wards: • G-ward: Up to 10 patients in camera cells. The only unit in the NSW correctional system where health staff administer enforced medication. Includes an additional three seclusion cells used for de-escalation or for people managed by a Risk Intervention Team (RIT). • E-and F-wards: Step-down wards for patients from G-ward. Up to 30 patients across both wards (15 each). There is one observation cell in each ward.

39 Information provided by Corrective Services NSW, 29 July 2024.
40 'Long Bay Prison and Forensic Projects', *NSW Treasury* (Web Page, undated) <https://www.treasury.nsw.gov.au/projects-research/public-private-partnerships/awarded-projects/long-bay-prison-projects>.
41 Information provided by Corrective Services NSW, 10 January 2024.

LBH 2 is a more typical correctional environment. In January 2024, CSNSW announced that it would temporarily close the LBH 2 accommodation wings from February 2024. This was part of a broader bed consolidation project. LBH 2 was reopened from 3 June 2024. The purpose of LBH 2 has varied over the course of our inspection, as outlined in Table 2.

Table 2: LBH 2 wings[42]

Wing	Capacity	Function
12-wing	150	In November 2022, 12-wing was largely closed, holding only a small group of hygiene workers until it was fully closed in February 2024. After the reopening in June 2024, it was used to hold mainstream inmates who were either on remand or had a scheduled medical appointment or treatment in Sydney.
13-wing	150	Prior to the February 2024 closure, 13-wing was a mental health step-down unit. After the reopening in June 2024, it was used to hold Special Management Area Placement (SMAP)/protection inmates who were either on remand or had a scheduled medical appointment or treatment in Sydney. 13-wing includes camera cells for inmates at-risk of self-harm being managed by a RIT.
Multipurpose Unit (MPU)	16	The MPU adjoins 12-wing. It holds inmates in segregated or protective (non-association) custody. It was closed from February to June 2024.

1.1.3 Inmate profile

The inmate profile of LBH has altered significantly during the inspection due to the operational changes described above. On 31 August 2023 (prior to the closure, with only a small group of inmates in LBH 2), there were 159 people in LBH. Of those:

- There were five women. From September 2022 to August 2023, the daily average number of women (by month) at LBH fluctuated between six and nine.[43]
- Most people were sentenced (84 or 52.8%), 74 (46.5%) were on remand, and one was appealing.
- A significant proportion of people were aged 45 years and over (66 or 41.5%).[44] The age of people at LBH on 31 August 2023 is shown in Figure 1.
- Nearly half (78 or 49.1%) had a maximum security classification, including four women. The security classifications of men in LBH on 31 August 2023 are shown in Figure 3.
- A significant number were SMAP/protection inmates (30 or 18.9%).
- There were 25 inmates (15.7%) managed by the Serious Offenders Review Council (SORC)[45] and 18 inmates (11.3%) managed by the Pre-Release Leave Committee (PRLC).[46]

42 Information provided by Corrective Services NSW, 10 January 2024.
43 Women can be held in the Medical Unit as needed.
44 As at March 2025, the average age of male inmates in NSW was 38.8 years: See Bureau of Crime Statistics and Research, *New South Wales Statistics Quarterly Update March 2025* (Report, 21 May 2025) 25.
45 SORC provides advice, recommendations and reports regarding the management of serious offenders: *Crimes (Administration of Sentences) Act 1999* s 3 (definition of 'serious offenders') and pt 9.
46 The PRLC is a sub-committee of SORC that reviews and makes recommendations regarding applications by public interest inmates: Corrective Services NSW, *Inmate Classification and Placement: Serious Offenders Review Council (SORC) and Subcommittee Managed Inmates* (version 2.6, 8 April 2022) 17–22.

- There were 32 people (20.1%) recorded as being an Aboriginal person.
- Most were born in Australia (109 or 68.6%) and most spoke English at home (140 or 88.1%). There were four people who required an interpreter.[47]

Figure 1: Inmate age profile, 31 August 2023[48]

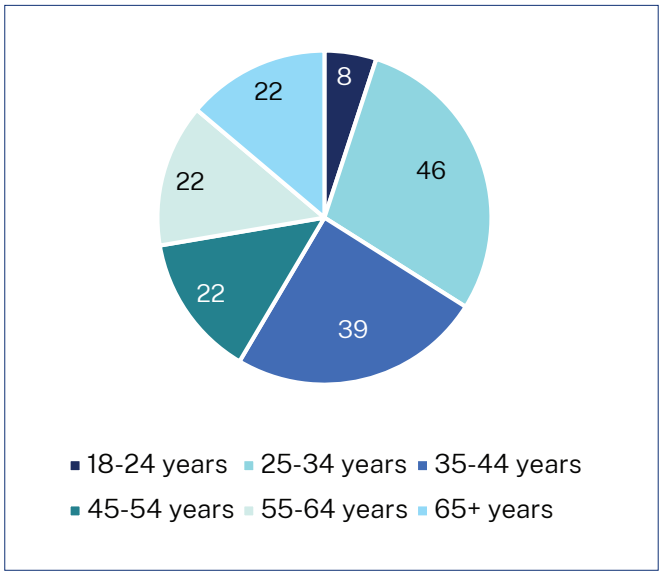
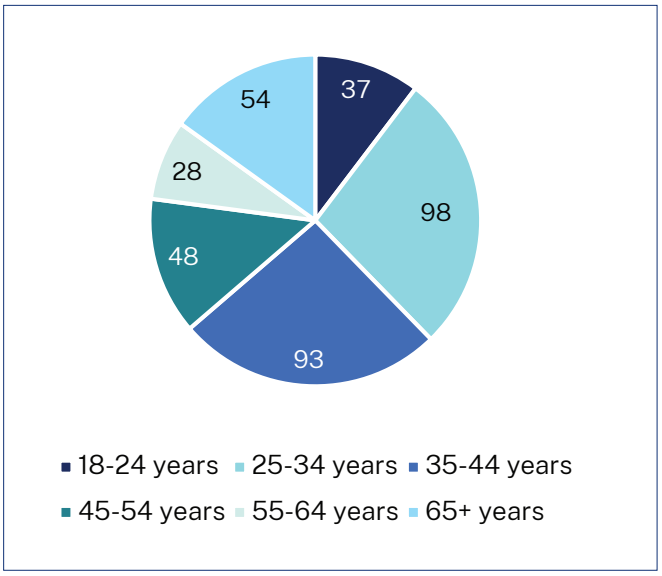


Figure 2: Inmate age profile, 31 August 2024[49]



On 31 August 2024 (after the complete reopening of LBH 2), the LBH population had more than doubled to 358 inmates. Of those:

- There were nine women. From September 2023 to August 2024, the daily average number of women (by month) at LBH fluctuated between five and eight.
- Nearly three-quarters of inmates were on remand (268 or 74.9%), 84 (23.5%) were sentenced, and six (1.7%) were appealing.
- Most inmates (228 or 63.7%) were aged under 45 years. The age of people at LBH on 31 August 2024 is shown in Figure 2.
- Over half (192 or 53.6%) had a maximum security classification, including five women. The security classifications of men in LBH on 31 August 2024 are shown in Figure 4.
- Nearly half were SMAP/protection inmates (163 or 45.5%).
- There were 21 inmates (5.9%) managed by SORC and 36 inmates (10.1%) managed by the PRLC.
- A quarter of inmates (91 or 25.3%) were recorded as being an Aboriginal person.
- Most were born in Australia (230 or 64.2%) and most spoke English at home (289 or 80.7%). There were four people who required an interpreter.[50]

47 Information provided by Corrective Services NSW, 17 November 2023.
48 Information provided by Corrective Services NSW, 17 November 2023.
49 Information provided by Corrective Services NSW, 17 January 2025.
50 Information provided by Corrective Services NSW, 17 January 2025.

Figure 3: Male classifications, 31 August 2023[51]

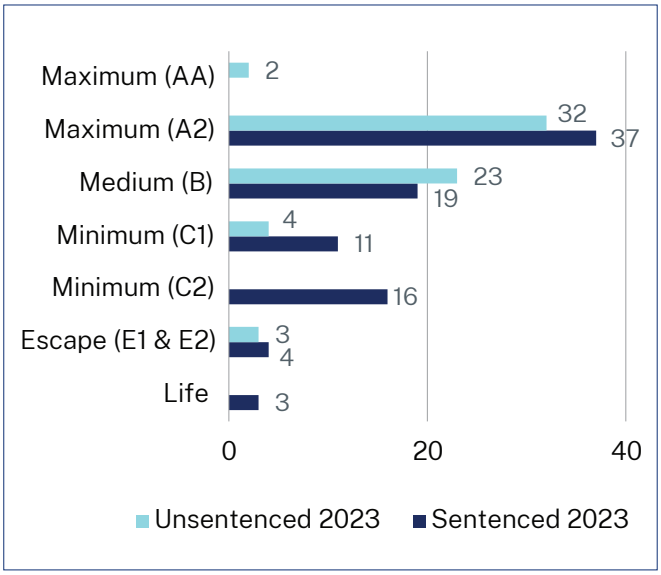
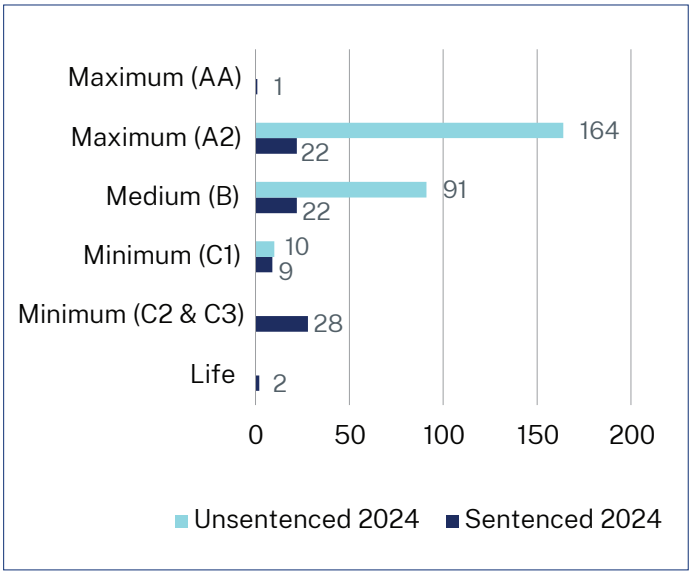


Figure 4: Male classifications, 31 August 2024[52]



Following the reopening of LBH 2, the LBH inmate population increased in both size and complexity. The inmate profile shifted from largely sentenced inmates to predominantly remand inmates, who have more need for legal resources and welfare support.[53] It also included a greater proportion of protection inmates, which can lead to the development of hierarchies within this group and subsequent safety risks for people due to their vulnerability or (alleged or proven) offending.[54] Although the proportion of younger inmates increased, there was still a significant proportion of inmates aged 55 years and over (27.7% in 2023 and 22.9% in 2024).

1.2 CSNSW staffing

The CSNSW staffing establishment at LBH is detailed in Table 3.

Table 3: CSNSW staffing profile at Long Bay Hospital[55]

Area	Position	Approved FTE
Custodial	Governor	1
	Manager of security (MOS)	1
	Functional managers (FM)	9
	Senior correctional officers (SCO)	42
	Correctional officers	183
Corrective Services Industries (CSI)	Overseer	1
	Assessment and planning officer	2
Offender Services and Programs (OS&P)	Services integration manager	1
	Services and programs team leader	1
	Services and programs officer (SAPO)	12
	Psychologist	5

51 Information provided by Corrective Services NSW, 17 November 2023.
52 Information provided by Corrective Services NSW, 17 January 2025.
53 See Inspector of Custodial Services, *Inspection of Parklea Correctional Centre* (Report, June 2022); Inspector of Custodial Services, *Inspection of Silverwater Women's and Dillwynia Correctional Centres 2022* (Report, November 2023); Inspector of Custodial Services, *Inspection of the Metropolitan Remand and Reception Centre* (Report, February 2024).
54 See Inspector of Custodial Services, *Inspection of Shortland Correctional Centre and Cessnock Correctional Centre* (Report, June 2024) 29–30; Inspector of Custodial Services, *Inspection of Mid North Coast Correctional Centre* (Report, December 2024) 86–7.
55 Information provided by Corrective Services NSW, 5 December 2024.

Classification	Classification and placement officer	1
Case Management Unit	Senior case management officer	1
	Case management officer	2
Administration	Various positions	13
Total		**275**

As at 15 October 2024, 29 of LBH's 236 custodial staff were categorised as long term absences, with most (17 staff) off work and receiving workers compensation. In addition, there were eight substantive vacancies and 12 temporary vacancies.[56] These vacancies and long term absences totalled a fifth (49 or 20.8%) of LBH's custodial workforce.

The significant number of lockdowns that occurred in the months after LBH 2 reopened suggests that such significant deficiency within the custodial workforce is unsustainable when LBH is fully operational. From 1 September 2022 to 31 August 2023, there were 57 lockdowns of all or part of LBH.[57] This increased in the following 12-month period to 92 lockdowns of all or part of LBH, nearly half of which occurred in June, July and August 2024 (44 or 47.8%), after the reopening of LBH 2.[58]

We reviewed two samples of Incident Reporting Modules (IRMs) for the four-month period from May to August in 2023 and 2024, which offered insight into the cause and impact of these lockdowns. From 1 May to 31 August 2024, there were 47 restricted movement (lockdown) IRMs for LBH, a significant increase on the 17 restricted movement IRMs for the same period in 2023. This equates to an average of 2.6 lockdowns per week. Of the 47 IRMs in 2024, more than half (28 or 59.6%) were due to insufficient available custodial staff to fill every custodial position. Of these 28 IRMs, most (22) were for the whole day and 18 involved the lockdown of at least one of the wards in the MHU.

We can understand the logic of opting to lockdown wards in LBH 1 rather than wings in LBH 2. It impacts fewer inmates and inmates in LBH 1 can access showers in their cells. However, the detrimental impacts of spending long hours in cells are well known, particularly for inmates who are already unwell with serious mental illness.[59] It is almost certainly impacting health outcomes for people in LBH 1, who are only there to receive inpatient health care or have high support needs.

1.3 Safety and security

1.3.1 Incidents

The larger and more complex inmate population resulting from the reopening of LBH 2 has created a more challenging security environment. We reviewed two samples of IRMs detailing incidents including fights, assaults, use of force, self-harm (actual, threat and assessed), and located contraband. These samples consist of IRMs from June, July and August in 2023 and 2024. The number of incidents detailed in those IRMs is shown in Table 4.

56 Information provided by Corrective Services NSW, 5 December 2024.
57 Information provided by Corrective Services NSW, 17 November 2023.
58 Information provided by Corrective Services NSW, 17 January 2025.
59 Sharon Shalev, 'Solitary Confinement as a Prison Health Issue' in Stefan Enggist et al (eds), *Prisons and Health* (World Health Organization, 2014) 27, 29.

Table 4: Incidents from three-month samples of LBH IRMs in 2023 and 2024[60]

IRM category	June, July, August 2023	June, July, August 2024
Assault (inmate)	0	11
Assault (staff)	3	8
Fight	2	10
Contraband	2 items	35 items
Self-harm (actual)	9 (4 relating to one inmate)	17 (8 relating to one inmate)
Use of force[61]	17	16

Table 4 highlights a notable increase in violent incidents (fights and assaults) and located contraband in the 2024 period. In 2024, most contraband items (31) were found in LBH 2 and, of the total 19 assaults, 12 occurred in LBH 2, including seven in the yards. All but one of the 10 fights occurred in LBH 2, including eight in the yards.[62]

Clearly, incidents will increase when the inmate population more than doubles. The comparison in Table 4 is not suggesting that this increase reflects how staff perform their duties. Rather its purpose is to highlight the challenges associated with the operation of LBH when all of its areas are in use, particularly given the physical environment of LBH 2 (see section 1.5.2) and custodial staffing issues (see section 1.2).

Despite these additional challenges, use of force figures did not increase. Our review of use of force IRMs from the 2024 period found that the responses detailed were generally appropriate and proportionate to risk. We also observed improvements in documentation between the 2023 and 2024 samples. It should be noted that use of force figures at LBH may vary depending on the presence of patients in G-ward requiring enforced medication, a use of force that is automatically considered by CSNSW's Use of Force Review Committee.[63]

1.3.2 Inmate discipline

From 1 September 2023 to 31 August 2024, the five most common categories of institutional offences were charges against good order (51), fighting or assault (32), drug charges (28), abusive behaviour (17) and property damage (16). The most common penalties imposed for these institutional offences were being restricted from purchasing buy-ups (38), loss of contact visits (25), and confinement to cells (24).[64]

We reviewed a sample of adjudication paperwork relating to alleged breaches of correctional centre regulations in May, June, and July 2024. During this period, there were 45 adjudications relating to 56 charges for which 60 penalties were imposed.[65]

In most cases, penalties were proportionate to offences and did not exceed the limitations outlined in the *Crimes (Administration of Sentences) Act 1999* (CAS Act). However, we noted that for several matters multiple penalties were imposed for a single offence. The CAS Act clearly provides that only one penalty can be imposed for a correctional centre offence.[66] This issue was raised by the NSW Ombudsman's investigation into inmate discipline in NSW correctional centres, published in August 2024.[67] We acknowledge that this occurred in only a small number of instances but take this opportunity to remind LBH staff of their legislative obligations in relation to penalising inmates.

60 Information provided by Corrective Services NSW, 6 December 2023 and 5 December 2024.
61 Use of force figures include the administration of enforced medication.
62 Information provided by Corrective Services NSW, 5 December 2024.
63 Corrective Services NSW, *Custodial Operations Policy and Procedures: 13.7 Use of Force* (version 1.15, 5 December 2024) 26–7, 33.
64 Information provided by Corrective Services NSW, 17 January 2025.
65 Information provided by Corrective Services NSW, 5 December 2024.
66 *Crimes (Administration of Sentences) Act 1999* s 53(1).
67 NSW Ombudsman, *Investigation into Inmate Discipline in NSW Correctional Centres: A Special Report under Section 31 of the Ombudsman Act 1974* (Report, 21 August 2024) 54.

In the sample we reviewed, all inmates were found guilty, except one whose charge was dismissed due to incapacity. Inmates pleaded not guilty in relation to five institutional charges. There were additional instances where comments from inmates (recorded in the paperwork) indicated that they denied the charge but were pleading guilty anyway. For these cases, it was unclear what investigations were undertaken or on what basis the adjudicating officer could have been satisfied of the inmate's guilt beyond reasonable doubt, as required by the CAS Act.[68] For some, a penalty of reprimand/caution was imposed, including one instance where the inmate appeared not to understand the charge and disciplinary process, or the penalty was deferred on the condition that the inmate was of good behaviour for a period.

Imposing a minor penalty is not an alternative to dismissing a charge. The CAS Act provides that where, after an inquiry, the governor is not satisfied beyond reasonable doubt that the inmate is guilty of a correctional centre offence, the charge should be dismissed.[69] Where an inmate complies with a condition of good behaviour, the charge should be dismissed at the end of the good behaviour period.[70] However, in all other cases, the charge and the penalty will remain on the inmate's Offender Integrated Management System (OIMS) record and may be considered in decisions about the inmate's management. Therefore, it is important that inmate disciplinary processes are followed carefully.

The NSW Ombudsman raised concerns that findings of guilt are being made in some cases despite not being proven beyond reasonable doubt.[71] The investigation recommended that CSNSW develop 'comprehensive, Plain English guides for delegates on elements of offences that need to be proven for offences to be proven beyond reasonable doubt,' including examples.[72] We support this recommendation.

CSNSW has advised that, following the NSW Ombudsman's investigation, it is:

> committed to reforming inmate discipline systems. Initial reform will focus on improving compliance with currently applicable legislation and policy and, in due course, a comprehensive review of the policy and legislative framework will consider more substantial system-level reform.[73]

1.3.3 Segregated custody

The CAS Act provides that an inmate may be held in segregated custody where necessary to secure:

a. the personal safety of any other person, or

b. the security of a correctional centre, or

c. good order and discipline within a correctional centre.[74]

There were no inmates in segregated custody at the time of the inspection. This was largely due to the closure of LBH 2, including its MPU. From 1 September 2022 to 31 August 2023, 30 periods of segregated custody were initiated.[75] For the same 12-month period in 2024, 32 periods of segregated custody were initiated, 22 of which commenced in June, July and August, after the reopening of LBH 2.[76]

During our visit in July 2024, there were six inmates in segregated custody. Our concerns about the physical environment of the MPU are discussed further in section 1.5.2.

68 *Crimes (Administration of Sentences) Act 1999* s 53(1).
69 *Crimes (Administration of Sentences) Act 1999* s 53(3).
70 *Crimes (Administration of Sentences) Act 1999* s 53(2)(b).
71 NSW Ombudsman, *Investigation into Inmate Discipline in NSW Correctional Centres: A Special Report under Section 31 of the Ombudsman Act 1974* (Report, 21 August 2024) 54.
72 NSW Ombudsman, *Investigation into Inmate Discipline in NSW Correctional Centres: A Special Report under Section 31 of the Ombudsman Act 1974* (Report, 21 August 2024) 56.
73 Information provided by Corrective Services NSW, 23 September 2025.
74 *Crimes (Administration of Sentences) Act 1999* s 10.
75 Information provided by Corrective Services NSW, 17 November 2023.
76 Information provided by Corrective Services NSW, 17 January 2025.

1.4 Long Bay Hospital Area 1

1.4.1 JH&FMHN staffing and operations

Health services in LBH 1 operate 24 hours per day, seven days per week. A majority of nursing staff in LBH 1 work 12-hour shifts.[77] The nursing staff profile for each ward in LBH 1 is in Table 5.

Table 5: JH&FMHN staffing profile at LBH 1[78]

Position	MU	ACRU	MHU
Nursing unit manager (NUM)	1.0 FTE	1.0 FTE	2.0 FTE
Registered nurse (RN)	8.4 FTE	6.6 FTE	19.4 FTE
Enrolled nurse (EN)	4.4 FTE	Nil	2.2 FTE
Assistant in nursing	2.2 FTE	2.2 FTE	Nil
Health centre clerk (HCC)	1.0 FTE	1.0 FTE	1.0 FTE

In addition to the above staffing profile, a number of specialty staff based at the Long Bay Correctional Complex/LBH have a significant role in the care provided to patients in LBH.[79] This included:

- **Nurse manager, Operations, Access and Demand Management**: a statewide role responsible for patient flow, integrated care, after-hours nurse managers and LBH operations.
- **Operational nurse manager:** responsible for the operational management of LBH, except the MHU.
- **Palliative and Aged Care Service**: consisting of the **manager, Palliative Care, Cancer, Aged and Chronic Care**, a social worker, an occupational therapist, a physiotherapist, a dietician, an Aboriginal health worker, a high risk foot podiatrist, a service development officer and two allied health assistants (one for diet and speech and one for physiotherapy and occupational therapy). This team has a statewide remit for palliative and aged care.
- **Career medical officer**: responsible for the coordination of clinical care to patients in the MU working closely with the NUM in the management of the patients. Also provides medical officer support to the ACRU and MHU for primary/general health matters.
- **Clinical director, Aged Care**: responsible for the coordination of clinical care to patients in the ACRU, working closely with the NUM in the management of the patients. The clinical director also has a specialist consultation role for older patients in custody across NSW.
- **Clinical director, Custodial Mental Health Service**: responsible for the coordination of clinical care to patients in the MHU, working closely with the NUMs in the management of the patients.

Data provided by JH&FMHN indicates that from around March to August 2023, the scheduled clinic hours detailed in Table 6 were delivered in LBH 1 (including the Kevin Waller Unit (KWU) as this is managed by LBH-based health staff). During the same period, some clinic hours were delivered for most of the services scheduled as required. Table 7 shows that, for the 12-month period from 1 September 2022 and 31 August 2023, over 96% of all patients in LBH 1 (including KWU) were seen on time.[80]

77 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
78 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
79 Consistent with its role and function, JH&FMHN describe people in custody receiving health services as patients. This report will also use the term patients in the context of those receiving health services.
80 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.

Table 6: Scheduled and delivered clinic hours and delivery format in LBH 1, March to August 2023[81]

Clinic	Scheduled	Delivered	Format
Career medical officer	40 hours per week	40 hours per week	In person
Clinical director, Aged Care	50 hours per month	50 hours per month	In person
Drug and alcohol (D&A) nurse	As required	4 hours per week	In person
D&A doctor/nurse practitioner	As required	2 hours per week	In person
General practitioner (GP)	40 hours per week	40 hours per week	In person
Psychiatrist	24 hours per week	24 hours per week	In person
Oral health	As required	16 hours per month	In person
Physiotherapy	8 hours per week	8 hours per week	In person
Optometry	As required	2 hours per month	In person
Population health nurse	As required	As required	In person

Table 7: LBH 1 – care provided within and outside the recommended wait time by triage category, from 1 September 2022 to 31 August 2023[82]

Clinical priority[83]	Total arrived appointments	Seen on time	Seen outside recommended time
P1 (urgent)	10	8 (80%)	2 (20%)
P2 (semi-urgent)	94	80 (85%)	14 (15%)
P3 (non-urgent)	224	218 (97%)	6 (3%)
P4 (routine)	134	134 (100%)	0
P5 (follow-up)	108	No timeframe	No timeframe
Total	570	548 (96%)	22 (4%)

1.4.2 Medical Unit

Physical environment and routine

The MU consists of 22 cells across two wards (C-and D-wards). One of the cells has been repurposed as a dialysis room with four dialysis machines. For proximity to nursing staff, the three cells closest to the staff desk are used for palliative care patients or patients with very high needs. There is also one consultation room and two treatments rooms, all of which are equipped with virtual care functionality, and one camera cell.[84]

The cells are a mix of single and double occupancy. They are similar to a hospital room and designed to be fully accessible for wheelchair users and bulky equipment such as patient lifters. The cells include an adjustable bed, a bathroom with a shower and toilet, a television and shelving. Each ward has a common area with a kitchenette, television, telephone, books, and an outdoor yard space.

We found the physical environment of the MU to be clean and well-maintained. LBH 1 units were cleaned by patient service assistants employed by JH&FMHN. The cells and health care facilities of the MU were fit for its purpose of providing inpatient health care.

81 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
82 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023. Note: this table does not include data for oral health waiting times.
83 The following timeframes apply for each clinical priority: P1 = 1 to 3 days, P2 = 3 to 14 days, P3 = 14 days to 3 months, P4 = 3 to 12 months, P5 = no timeframe: Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
84 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.

MU single cell, August 2023

MU cell bathroom, August 2023

C- and D-wards are separated across three different wings (with D-ward split across two wings). These disconnected wings are used to manage different patient cohorts. At the time of the inspection, C-ward was used to hold SMAP inmates and the larger wing of D-ward was used for mainstream inmates. The other D-ward wing could be used to hold up to five women inmates.

Although the three wings assisted with the management of different inmate cohorts, we observed that this remained a challenge. At the time of the inspection, there were more SMAP inmates than available cells in C-ward. This was due in part to a small group of aged and frail men placed in the MU following the closure of KWU because they were too frail for placement at MRRC (see chapter 4). Consequently, those inmates were housed in cells in D-ward and moved to the C-ward common area during their time out of cell, meaning they had no access to their cells during the day. Staff informed us that any women in the MU would typically only have one hour out of cell.

The MU is designed to be a short term placement. Consequently, the common areas do not provide the level of amenity often available to people in more typical correctional environments. We observed that the kitchenette facilities were limited and did not include a toaster or kettle. In one area, the microwave was placed on a shelf that was difficult for wheelchair users to access. The threshold of the doorway leading to the outdoor areas created a small bump and a potential trip hazard, particularly for those using a wheelchair or a mobility aid. The outdoor area was small and bare and contained no toilets or equipment to support any exercise recommendations from health staff.

MU common room, May 2024

MU dialysis room, May 2024

This environment is particularly challenging for a group of patients in the MU with spinal cord injuries who are unlikely to be placed elsewhere during their time in custody. Unless they are too unwell to leave their cells, people in the MU spend their time out of cell in a common area. CSNSW should consider addressing some of the shortcomings of these spaces to improve the living conditions of

longer term MU patients, including the provision of suitable exercise and recreation equipment and basic kitchen appliances.

Model of care and health service provision

The MU is an inpatient unit for patients who require a higher level of health care and clinical observation than would be provided within a typical correctional centre. Patients admitted to the MU include those who:

- have been discharged from hospital but require ongoing higher levels of healthcare and observation (post scheduled or emergency surgery, burns care, post cardiac event, certain cancer treatments)
- cannot be placed in a correctional centre because of their required level of healthcare or clinical observation (spinal patients and patients with unstable chronic disease requiring investigation)
- have acute health presentations which require further assessment (people with delirium, decreased cognitive functioning and acute management of chronic diseases).

The Operations, Access and Demand Management team are responsible for the operational management of the MU and the ACRU. Primary care, led by the career medical officer, are responsible for the coordination of clinical care provided to patients in the MU. Health service provision within the MU is coordinated and managed locally by the NUM. The career medical officer and the NUM work closely together to manage patients. All speciality streams, such as mental health, alcohol and other drug, population health, aged care, palliative care, and Aboriginal health workers are accessible to MU patients, usually referred by the career medical officer or nursing staff as needed. Nursing staff provide assistance with activities of daily living (ADLs), such as showering, dressing, meals, and toileting.

Health staff had access to patients for routine services from 7am to 2.20pm, seven days a week. Patients were locked into their cells for an hour at lunch. This equated to around six-and-a-half hours of patient access a day. The NUM arranged access after patients were locked in their cells with the functional manager by way of an agreed schedule. After-hours care included assistance with feeding, pressure care, assistance with ADLs, clinical observations and other monitoring. While staff tried to schedule most specialist appointments within the structured day, some specialty appointments may be scheduled after 2.30pm. If this occurred, the NUM facilitated these appointments with the functional manager. There was also an agreement between local CSNSW and JH&FMHN management for the provision of essential services in the MU during lockdowns or when there were reduced custodial staff on duty. We were advised that health care provided after hours or during lockdowns was never routinely undertaken through closed cell doors.

There were a number of custodial staff consistently rostered to the MU. We heard that their familiarity with the MU and its unique role greatly assisted in the efficient provision of health care. Non-regular officers, especially those who come from a typical maximum security correctional centre, could be a barrier as they lacked an understanding of the special health needs and required routines of an inpatient population. Custodial staff also undertook 'staggered' meal breaks in the MU which maximised health service provision throughout the day.

During the inspection we were informed of initiatives to increase the scope of clinical service provision in the MU, reducing the need to transfer patients to external hospitals. Following the completion of specialised training, the career medical officer could insert percutaneous endoscopic gastrostomy (PEG) tubing, a surgical procedure that places a feeding tube inside a person's stomach. Previously patients requiring PEG feeding tubes were transferred to Prince of Wales Hospital. The MU was also able to provide iron transfusions. There were plans to create capacity for MU staff to undertake bladder irrigations for patients with catheters and sleep studies for patients with sleep apnoea. We congratulate JH&FMHN on these initiatives.

We were also impressed with the JH&FMHN dialysis service. The four dialysis chairs could operate in two shifts per day (mornings and afternoons), six days per week. From 1 September 2023 to 29

February 2024, 330 haemodialysis sessions were performed at the MU.[85] Most patients attended two to three days a week, depending on their dialysis management plan. The service was accessible to male and female patients. JH&FMHN had dedicated nursing staff working with dialysis patients. This team worked closely with the Prince of Wales Hospital renal team to manage each patients' dialysis regimen and with local health centre staff, predominantly in the Metropolitan Special Programs Centre (MSPC), to ensure coordinated care.

Admission and bed management

From 1 September 2023 to 29 February 2024, 65 patients were admitted to the MU.[86]

The nurse manager, Operations, Access and Demand Management is responsible for the coordination and management of admissions to the MU. They work closely with the NUM and career medical officer regarding bed management, advising them of patients in external hospitals and correctional centres requiring admission. The afterhours nurse manager coordinates bed management and patient flow into the MU outside of business hours.

The career medical officer has clinical responsibility for accepting a patient to the MU. They liaise with medical staff in correctional centres and external hospitals to determine when it is clinically safe and appropriate for a patient to be admitted to the MU. Typically, there is not a long wait for a patient to be admitted to the MU.

Once a patient is accepted to the MU, the nurse manager, Operations, Access and Demand Management provides the acceptance form to CSNSW who facilitate the movement of the patient to the MU from a correctional centre or external hospital. Usually, admissions are accepted by 4pm from Monday to Friday to allow the career medical officer to conduct an admission assessment. Nursing staff also conduct an admission assessment, and the NUM meets with the patient. If a patient is admitted on the weekend, which is unusual, nursing staff conduct an admission assessment and discuss the patient with the Remote On-call Afterhours Medical Service on-call GP. The career medical officer completes their admission assessment the next business day.

For dialysis patients, the nurse manager, Operations, Access and Demand Management coordinates with CSNSW to move a patient to MSPC. Once the patient is transferred to MSPC the dialysis nursing team work with the JH&FMHN Medical Appointments Unit and the CSNSW Medical Escort Unit (MEU) to move the patient to the MU for their scheduled dialysis sessions.

Nursing and custodial staff jointly determine the most suitable bed placement for patients in the MU, taking into consideration their acuity, care requirements as well any security requirements, such as whether they are on protection or cannot associate with another patient. Any patient placement or management requirements for CSNSW are communicated by nursing staff using an updated Health Problem Notification Form (HPNF).

Medication management

Similar to the ACRU and MHU, patients in the MU received their medications via imprest stock or as an individual patient use medication, an individually dispensed medication that is non-formulary and requires approval of a specialist stream's clinical director. Medications were not provided to any patients in dose administration aids or as part of the self-medication program. Health staff reported that JH&FMHN provided a good pharmacy service, including a pharmacist attending the MU when required.

Medication management was the responsibility of the nurse in charge each shift. The nurse in charge prepared and administered morning medications. Any other medications required throughout the day were provided by nursing staff.

Medications were prepared from a medication trolley transported around the MU during medication preparation and administration times. Medications were prepared for one patient at a time. During our inspection we observed the preparation and administration of medication to patients by the nurse

85 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.
86 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.

in charge. On all occasions, the patient was identified by the nurse using the cell identification card and this was checked against the patient details in the e-MEDs system. The patient's medication was selected from imprest and/or individual patient use stock and placed in a medicine cup. The e-MEDs system was signed at the time of preparing the medication. These processes complied with the JH&FMHN Medication Guidelines.

However, we noted there were multiple occasions when medications were handled with bare hands, for example when cutting a tablet in half or taking a tablet from a medication bottle. A 'no touch' technique should be used when removing medication from a container and placing it in a medicine cup for a patient. Medication is meant to be removed from containers in a manner where there is no direct contact between a nurse's fingers and the medication. If medication must be handled, then hand hygiene practices must be observed (washing hands and putting on gloves). As much as possible the correct strength of tablets should be used to avoid the requirement to cut tablets. If, however, a tablet does need to be cut in half, to ensure a clean and accurate break, a tablet cutter should be used.

We also observed the medication trolley left unattended and unlocked outside cells when nursing staff were administering medication to patients. Medication should be kept secure at all times. When the medication trolley is not under the direct supervision of a nurse, it must be locked. In addition, we observed occasions when the pharmacy room door was left open. Pharmacy rooms are required to be locked at all times, irrespective of the presence of nursing staff in the room.

We note that we raised these issues with the NUM during our inspection.

Recommendation: JH&FMHN remind MU nursing staff of:

a. **the 'no touch' technique for handling medications and to use a tablet cutter when breaking a tablet in half**

b. **the requirement to lock the medication trolley when it is not under the direct supervision of a nurse**

c. **their responsibility to ensure the pharmacy room is kept locked at all times.**

End-of-life care

The MU appeared to have well developed systems and processes for the management of end-of-life patients. Health staff praised the JH&FMHN Palliative and Aged Care Service. This service was developed and implemented over the two years prior to the inspection, and we heard they have made a significant difference to the management of palliative and end-of-life patients.

Palliative patients were usually placed in one of the cells closest to the MU staff desk. The doors were left open to allow easy access for health staff. Families were also able to visit palliative patients in the MU once they were too unwell to attend the visits area. We commend CSNSW and JH&FMHN for these initiatives to support patients nearing the end of their lives.

When an end-of-life patient dies, CSNSW and JH&FMHN work together to determine which agency is the most appropriate to advise the family. For example, if the Palliative and Aged Care Service's social worker has been involved with the family and has developed a good relationship with them, they provide the notification.

In some instances, palliative or end-of-life patients may be released on parole pursuant to section 160 of the CAS Act. The nurse manager, Operations, Access and Demand Management liaises with CSNSW where early release to parole is considered appropriate for health-related reasons.

Eligible people in custody may also seek access to voluntary assisted dying. Like people in the community, applications and decisions regarding voluntary assisted dying for people in custody are made pursuant to the *Voluntary Assisted Dying Act 2022.* JH&FMHN have developed pamphlets to provide information to patients on voluntary assisted dying and a policy to guide staff on providing advice and support to patients. In July 2025, JH&FMHN advised that no patients had commenced the voluntary assisted dying process since it became available in November 2023, although a number

had enquired about it and were provided with information.[87] Subsequent to this advice, in late August 2025 the first person in custody in NSW died by voluntary assisted dying.

Management of patients with disability

At the time of this inspection, the MU held a number of patients with disability. They included several patients with spinal cord injuries, a patient with frontotemporal dementia and four aged patients who were too frail to be held at MRRC following the closure of KWU. These patients did not require medical care and therefore did not need to be in the MU. However, they required a high level of support with ADLs, including showering, toileting, eating and dressing. There were no other placement options that could provide for the needs of this group at this time, creating a 'bed block'.

People who would be eligible for National Disability Insurance Scheme (NDIS) support in the community are not eligible for the same support while they are in custody, only those supports that are not the responsibility of custodial agencies or where the provision of supports is considered appropriate in the circumstances. Custodial agencies are responsible for day-to-day care and support needs and general services, including ADL supports, disability-related and other health supports and medical care, accessibility adjustments to the built environment, and access to Auslan interpreters.[88] This is why establishing required NDIS supports must be done before a person in custody with a disability is released to the community.

Nursing staff were responsible for providing ADL support for MU patients. They raised concerns about their capacity, and the resourcing available in the absence of NDIS support, to provide the level of care required for very high needs patients alongside their other responsibilities. In the community, ADL support would be undertaken by disability professionals, not health professionals, and funded by the NDIS or Home Care (for older adults). Similar to the collaborative work required to plan for the growing aged and frail population in custody (see chapter 4), CSNSW and JH&FHMN need to consider if existing facilities and staffing are adequate to meet the needs of people with disability with very high support needs. Appropriate staffing includes both the number of staff and staff with the mix of skills to provide disability support, such as allied health services and behaviour support practitioners.

JH&FMHN highlighted that most patients with disability would be best placed in a supported living setting, with NDIS support from existing packages. This also applies to patients with non-permanent disability including orthopaedic, burns, and neuro patients who have been discharged but have no suitable placement alternative. The diversion of people with significant disability from the criminal justice system to community placements where possible would help ensure that these patients receive appropriate services, however this would require the involvement of the court system and the Commonwealth Government.[89]

JH&FMHN also suggested that expansion of the bed availability, remit and support available in Additional Support Units (ASUs) could assist with providing facilities and support for people with disability with very high support needs, including provision for a small number of women in custody. However, we note our concerns with the current location of the ASUs (see section 3.4). This would be supported by funding for Statewide Disability Services to provide for correctional centre based disability liaison officers and disability support workers for people in custody requiring ADL support.[90]

Recommendation: CSNSW work with the JH&FMHN to provide facilities adequate to meet the needs of people with disability with very high support needs.

Discharge planning

Planning for a patient's discharge from the MU to a correctional centre usually commences several weeks prior to ensure suitable placement and optimal patient outcomes. MU health staff work

87 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.
88 'Who Funds the Supports You Need When You're in Custody?', *National Disability Insurance Scheme* (Web Page, 22 April 2025) <https://ourguidelines.ndis.gov.au/how-ndis-supports-work-menu/justice-system/who-funds-supports-you-need-when-youre-custody#:~:text=from%20court%20hearings.-,What%20NDIS%20supports%20can%20you%20get%20while%20you're%20in,NDIS%20to%20provide%20the%20supports>.
89 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.
90 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.

closely with CSNSW to determine placement options for patients. Once a patient has been identified as ready for discharge, documentation is generated by MU nursing staff advising CSNSW of their discharge requirements. CSNSW organises the movement of the patient and any special transport requirements. The length of time it takes for a patient to be moved from the MU varies and depends on whether they are on remand or sentenced and their discharge location. We were informed that on average this takes a few days.

The career medical officer prepares a discharge summary, recorded in the patient's electronic medical record, detailing the reason for admission, investigations, results, diagnosis/es and ongoing care requirements. Nursing staff also prepare a nursing discharge summary and provide a clinical handover to the nursing staff in the receiving correctional centre. When complex patients are discharged to another correctional centre, the MU NUM contacts the NUM of the receiving correctional centre and provides a verbal handover.

Planning for a patient being released into the community varies depending on their ongoing health care requirements. The career medical officer and nursing staff prepare discharge summaries for all patients. Families, carers or guardians may also be involved in discharge or release planning. Patients with outstanding specialist appointments at Prince of Wales Hospital may attend appointments after release or have their specialist care transferred to a local health district closer to their home.

The Integrated Care Service refers patients with chronic diseases to relevant services in the community and the NDIS coordinator is involved in referring NDIS patients to services on release. Specialist streams are also involved in release planning as clinically indicated, for example drug and alcohol services assist in arranging post-release opioid agonist treatment (OAT) services and for Nyxoid (Naloxone) nasal spray to be included in a patient's property prior to release. Some patients also have the involvement of their local health district's Aged Care Assessment Team to assist in arranging home care services or their transfer to an aged care facility. Palliative care patients are referred to services in the community by the JH&FMHN Palliative and Aged Care Service.

A specialised taxi service or the NSW Health Patient Transport Service is engaged for patients with special transport requirements at discharge or release. We were pleased to note such transport arrangements are equivalent to what is used in the community.

Unwell patients released from custody requiring ongoing inpatient care are usually referred to Prince of Wales Hospital if they are from the Sydney metropolitan area or the closest to home regional hospital. We heard that in recent years work has been undertaken between JH&FMHN and local health districts to arrange for patients to be released to their local area. This coordination improves continuity of care for patients being released from custody and is an excellent initiative by JH&FMHN and the local health districts.

Patient dignity and privacy

During the inspection of the MU, we observed multiple occasions where custodial staff were physically in the room during the provision of health care to patients. Examples included the administration of medication, recording of a patient's blood glucose level, clinical review of a patient by the career medical officer, transfer of a patient on a hoist from their bed to a wheelchair, transfer of a patient on a hoist from their bed to a commode chair to have a shower and turning a patient in their bed.

On some occasions, patients were not fully dressed or the care provided required them to undress. There were instances where patients were partially clothed while custodial staff of the opposite sex were in the room. We note that people must not be strip searched by or in the presence of a person of the opposite sex, except in an emergency.[91] We consider that the same principle should apply where a person needs to be partially clothed while receiving health care or ADL support in the presence of custodial staff.

Privacy curtains and window blinds were not always utilised to help preserve patient privacy. Some

91 *Crimes (Administration of Sentences) Regulation 2014* cl 46(2); Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 4.

cells in the MU had privacy curtains surrounding the patient's bed and blinds to block the view of people in the corridor. These curtains and blinds should be used when procedures or physical examinations are being undertaken with a patient and their privacy is compromised.

More broadly, we were concerned about the presence of custodial staff during the provision of health care in the MU. This was unusual compared to other correctional centres we have inspected with similar security levels, where custodial staff often stood at the doorways of consultation/treatment rooms or in the corridor unless the patient was agitated or considered a security risk. Staff also reported multiple instances of custodial staff interjecting into conversations between health staff and their patients, providing opinions on matters related to the clinical discussion. This is inappropriate and unprofessional.

Patients have a right to confidentiality of their health information. In addition, they have a right to privacy when they are being provided with health care or ADL assistance and are semi-naked. Unless there is a known or specific perceived risk to the safety and security of staff and other patients, custodial staff should not be present when health care is being provided to a patient.

We also observed health staff referring to patients using only their surnames. This is discussed in more detail in section 2.5.9. That discussion and related recommendation are also relevant to the MU and the MHU. We noted that this was not the case in the ACRU, where when patient surnames were used, it was with a prefix. We also observed that whiteboards and documentation respectfully referenced patients in the ACRU.

Recommendation: CSNSW, in consultation with the JH&FMHN, review the presence of custodial staff during the provision of health care or ADL support to patients in the MU, with a view to maintaining patient privacy and the confidentiality of patient health information.

1.4.3 Aged Care and Rehabilitation Unit

Physical environment

The ACRU consists of 15 single cells across two wards (A-and B-wards). It is equipped with one consultation room and one treatment room, both of which have virtual care functionality.[92] More information about the physical environment of the ACRU can be found in chapter 4 on the treatment of aged and frail people in custody.

Model of care and health service provision

The ACRU is an inpatient unit for aged and frail patients with high needs. It provides a specialised environment for older patients with complex needs including dementia, Alzheimer's disease, acquired brain injury or significant physical frailty. Some patients are placed in the ACRU for a short period for assessment before being discharged to a different location. However, the majority will become long term placements until their death or release from custody.

Health staff had access to patients in the ACRU for routine services from 7am to 2.20pm, seven days a week. Patients were locked into their cells for around an hour at lunch. This equated to around six-and-a-half hours of patient access a day.

During the inspection we were informed that nursing and custodial staff had developed a regular routine for service delivery to optimise access hours. Access after 2.30pm to patients requiring assistance with feeding, pressure care, assistance with ADLs, clinical observations and other monitoring was arranged, in advance, with the functional manager. We were advised that access to patients after hours or during lockdowns was provided with the cell door open.

Often a consistent group of custodial staff were rostered in the ACRU. We heard this greatly assisted in the efficient provision of health care. Custodial staff taking 'staggered' meal breaks also helped optimise time out of cell for health service provision. However, health staff noted that some custodial staff are not suited to this environment and those with less experience in the ACRU can be difficult to work with.

92 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.

The Aged Care team, led by the clinical director, aged care, is responsible for the coordination of clinical care to the patients in the ACRU. All specialty streams are accessible to the patients, with the Older Persons Mental Health Service actively involved with patients. Referral to specialist streams is undertaken by the geriatrician, Older Persons Mental Health Service psychiatrist, career medical officer or nursing staff. Nursing and administrative staff are managed by the Operations, Access and Demand Management team, who is responsible for the operational management of the ACRU. Health service provision within the ACRU is coordinated and managed locally by a NUM from Monday to Friday and the nurse in charge at other times.

We were told that there was little in the way of diversional activities or exercise to provide meaningful activity and support patient health and wellbeing. As the ACRU is a long term placement for many of its patients, it is not acceptable that there is not a structured daily program provided, similar to what is provided in an aged care facility, which encourages social interaction, cognitive stimulus, physical movement and promotes emotional wellbeing.

Some staff suggested the original role of the ACRU, which included rehabilitation of older people should be revisited. It was suggested a small number of ACRU beds should be available for older patients who require intensive rehabilitation assessment and intervention by allied health staff. They believed that with this intervention and post discharge supports these patients could return to independent living in correctional centres.

Admission and bed management

From 1 September 2023 to 29 February 2024, 14 patients were admitted to the ACRU.[93]

All referrals to the ACRU are made through the Aged Care Bed Demand (ACBD) Committee which meets weekly. More information about the ACBD Committee can be found in chapter 4 on the treatment of aged and frail people in custody.

When a patient is accepted as an admission to the ACRU, the nurse manager, Operations, Access and Demand Management arranges for the acceptance form to be provided to CSNSW, who facilitate the movement of the patient to the ACRU. Admissions to the ACRU are accepted Monday to Friday. Nursing staff conduct an admission assessment and the NUM meets with the patient. The clinical director, Aged Care usually completes the medical officer admission however, if they are not available it will be done by the career medical officer.

Nursing staff recommend bed placement or any patient bed movements within the ACRU. We were told that these recommendations were largely supported by CSNSW. Bed placement considers a patient's level of acuity or confusion and need for supervision or assistance. Security and association arrangements are less of a consideration for most of the patients in the ACRU.

Due to the high demand for inpatient beds for older men, the ACRU is often full and the MU is used as a placement option when there are no available beds (see section 1.4.2).

Medication management

ACRU patients received their medications via imprest stock or as an individual patient use medication. Medications were not provided to any patients in the ACRU as dose administration aids or as part of the self-medication program. Medication management was the responsibility of a RN. ACRU health staff reported having a very good pharmacy service provided by the JH&FMHN pharmacy team, including a pharmacist attending the ACRU when required.

Medications were prepared from a medication trolley which was transported around the ACRU during medication preparation and administration times. Medications were prepared for one patient at a time. We observed the preparation of medication for patients by the RN. On all occasions, the patient was identified by the nurse using a copy of the patient's identification card, which was attached to the medication trolley. This was checked against the patient details in the e-MEDs system. The patient's medication was selected from imprest or individual patient use stock and placed in a medicine cup. The e-MEDs system was signed at the time of preparing the medication. The processes

93 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.

used by the RN complied with the JH&FMHN Medication Guidelines.

Attaching a copy of each patients' identification card to the medication trolley is an excellent idea and a sensible failsafe measure to ensure the correct identification of patients when preparing and administering medication. This is a good initiative by the nursing staff in the ACRU.

We also observed the administration of medication and on all occasions, the correct procedure was followed. The RN ensured medication was provided to the correct patient by checking the copy of the patient's identification card attached to the medication trolley with the patient's cell identification card, they advised the patient they had their medication, handed the medication to the patient and observed them taking the medication. Nursing staff observed all patients taking their medications regardless of it being a supervised or non-supervised medication. Nursing staff also advised that cell doors were opened when patients were provided medication during lockdowns or after hours.

During our observations, the medication trolley was locked or in the presence of a nurse and the pharmacy room was secured.

Diet and nutrition

Each patient admitted to the ACRU has a nutritional assessment completed by the dietitian. In addition, all patients have a weekly nutritional screen and the health team monitor if patients are receiving an acceptable nutritional uptake. Patients are weighed weekly and if there are any concerns regarding weight loss or gain, they are referred to the dietitian for further assessment. Patients are provided with therapeutic diets as clinically indicated and may be provided with dietary supplements if experiencing weight loss. Patients with swallowing difficulties are referred to the speech pathologist for assessment of their swallowing and gag reflex and recommendations are made regarding their most suitable diet/nutritional intake.

Discharge planning

ACRU nursing staff are responsible for coordinating the planning requirements for ACRU patients discharged to a correctional centre or released to the community. ACRU staff work with the other specialty streams and service providers to ensure continuity of health care.

Decisions regarding the discharge of an ACRU patient to a different location are oversighted by the ACBD Committee. Part of this process may include an occupational therapist assessing the suitability of the proposed placement and advising of any necessary adjustments, such as mobility or shower aids. If approved, the ACRU NUM contacts the NUM at the receiving correctional centre and provides a clinical handover on the patient. The clinical director, Aged Care and ACRU nursing staff each complete a discharge summary.

When an ACRU patient is released from custody to their home, the Integrated Care Service is involved in referring the patient to services in the community and scheduling GP appointments. The aged care assessment team of the patient's local health district assists in providing any required home care services. With the patient's consent, families and carers are encouraged to be involved with discharge planning.

A significant planning period is required where a patient is being considered for a residential aged care placement following release from custody. This is necessary to ensure the My Aged Care and Centrelink processes are completed and a residential aged care facility placement is identified. Once a placement is identified, ACRU staff and staff from the aged care facility meet to discuss the patient's current and ongoing health and care needs. See chapter 4 for more discussion on the challenges of planning the release of aged and frail inmates to residential aged care facilities.

We commend JH&FMHN on their development of relationships with internal and external services providers, optimising service provision to ACRU patients. This promotes clear understanding of the unique requirements of ACRU patients which has assisted in achieving suitable placement arrangements for them, especially at discharge or release. Due to the demand for this type of community placement, the aged care team continue to seek out other aged care providers for patients in the ACRU. Where considered clinically appropriate and legally possible, patients in the ACRU should be transitioned to placement in the community. However, despite this effort,

appropriate post-release placements can be challenging to identify and secure.

1.4.4 Mental Health Unit

Physical environment

The MHU consists of three wards: E-ward, F-ward and G-ward. It has 40 beds in total, 10 in G-ward and 15 each in E-and F-wards. The MHU also includes three seclusion cells (in G-ward) and two observation cells (one each in E-and F-wards), seven consultation rooms and four treatment rooms, all of which are equipped with virtual care functionality.[94]

The cells in all three wards are single occupancy, containing a bed, shower and toilet, an enclosed television and shelving. The 10 cells in G-ward all contain cameras. Each ward contains indoor common areas and outdoor yards. The common areas in E-and F-wards include recreation items, for example a table tennis table, television, seating and board games.

During the inspection we observed the MHU wards to be clean and well maintained.

F-ward common room, May 2024

F-ward cell, May 2924

G-ward cell, August 2023

G-ward seclusion cell, May 2024

94 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.

Model of care and health service provision

At the time of the inspection, LBH 1 was a declared 'mental health assessment and inpatient treatment facility' under section 109 of the *Mental Health Act 2007*.[95] This meant the full range of inpatient functions could be performed at LBH 1.[96]

The MHU is an inpatient unit providing services for voluntary and involuntary patients with serious mental illness including schizophrenia, drug induced psychosis, bipolar disorder and severe depression or suicidality. Patients are admitted to the MHU for assessment to determine a mental illness diagnosis or due to the deterioration of a previously diagnosed mental illness. G-ward holds the most acutely unwell patients, including those requiring enforced medication. E- and F-wards are step-down units for patients who are more stable.

The services provided at the MHU include enforced medication, which refers to the coercive administration of psychotropic medications by clinical staff to patients detained in mental health facilities. Although the ACRU, MU and MHU are all declared mental health facilities, it is JH&FMHN policy to only administer enforced medication in the MHU.[97]

During the inspection we were informed that JH&FMHN were undertaking a project to cease involuntary mental health treatment in custody. This project remained underway at the time of writing. Its phases included the:

- cessation of enforced medication in the MHU/LBH 1
- cessation of all involuntary treatment in LBH following the establishment of acute care pathways with local health districts, enabling the transfer of high acuity, lower risk patients to declared civil mental health facilities, and
- the MHU transitioning from an inpatient model to a mental health screening unit model, with any patients needing involuntary treatment to be transferred to the Forensic Hospital.[98]

We support the cessation of involuntary mental health treatment in custody.

At the time of the inspection, one bed in the Forensic Hospital was allocated for patients from the MHU who required involuntary treatment. Once a patient had received treatment and was considered stable enough, they were returned to the MHU.

The coordination and provision of clinical care to MHU patients is led by the clinical director, Custodial Mental Health Service (CMHS). MHU staff include mental health nurses, psychiatrists, psychiatric registrars and a small number of allied health staff. Other specialty streams are also accessible to the patients in the MHU.

MHU health staff had access to patients from 7am to 10.30am and 11.30am to 2.30pm, seven days per week. This equated to around six-and-a-half hours of patient access per day.

Health staff informed us that all nursing care provided afterhours was undertaken through the cell door hatch. The only time a cell door would be opened afterhours was in an emergency or by way of a prior agreement between the NUM and the officer in charge of the MHU. Due to the potential volatility of people in G-ward (where people spend most of their day in their cells), the majority of health care was provided through the cell door hatch. Patients would only be moved from their cell to a consultation room if CSNSW staff deemed it safe. Health staff were concerned that these arrangements were not conducive to developing a therapeutic rapport with patients and hampered their ability to thoroughly clinically assess patients. It also meant that health staff could not fully implement JH&FMHN policy on MHU patient observation and engagement. However, they were optimistic that this would improve as the changes in the MHU were implemented.

95 Secretary of the NSW Ministry of Health, 'Mental Health Act 2007 – Section 109 – Declaration of a Mental Health Facility' in New South Wales, *Government Gazette of the State of New South Wales*, No 93, 23 August 2019, 3334.
96 'Declared Mental Health Facilities', *NSW Health* (Web Page, 21 August 2019) <https://www.health.nsw.gov.au/mentalhealth/services/consumers/Pages/facilities.aspx>.
97 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.
98 Information provided by the Justice Health and Forensic Mental Health Network, 5 July 2024.

We were advised that regular custodial staff, particularly senior correctional officers, were consistently rostered to work in the MHU and were allocated to particular wards for a set period. Health staff observed that consistent custodial staffing was important for the safe and effective operation of the MHU.

Admission and bed management

From 1 September 2023 to 29 February 2024, 54 patients were admitted to the MHU (19 voluntary admissions and 35 involuntary admissions).[99]

Patients may be admitted to the MHU from police cell complexes, correctional centres, the Mental Health Screening Unit at MRRC and on some occasions from external hospitals. The MHU is part of the 'stepped' mental health management model used within the CMHS. This model creates a pathway for patients requiring mental health services along a continuum of mental health service and accommodation options ranging from mental health step-down units in correctional centres (such as 3-wing in MSPC 2), the Mental Health Screening Unit, the MHU and the Forensic Hospital. The stepped model was designed to increase or decrease the level of mental health service based on patient need.

The Mental Health Patient Flow (MHPF) meeting is responsible for the timely management of mental health service interventions. The MHPF meeting is chaired by the nurse manager, CMHS and attended by all correctional centre NUMs. The meeting occurs three times a week and considers patient referrals, bed availability, patient escalation on the waiting list, and the assignment of patients to recommended mental health locations. It determines the location that can best provide for the assessment and ongoing management of referred patients. The recommended location is determined by the patient's level of acuity, perceived risk to self and others and bed availability. Some patients remain at the referring correctional centre until the pre-determined mental health bed becomes available. Other patients, if considered higher in acuity/risk are moved as a priority to the mental health bed.

The Custodial Mental Health Waitlist Prioritisation (CMHWP) Committee is responsible for prioritising the management and placement of patients requiring intensive mental health service intervention either in an inpatient unit, screening unit or designated mental health unit. The CMHWP Committee meets to review and prioritise patients on the wait list for the MHU, mental health screening units, and mental health step-down units. After the patients are discussed, the CMHWP Committee reviews priority determinations and moves patients higher or lower on the wait list on the basis of their acuity and risk.

During the inspection we observed a CMHWP Committee meeting. It was evident there was a high demand for intensive mental health services. The CMHWP Committee have established strong systems to assist in the triaging of patients, so as to ensure they are moved to the appropriate location for assessment and treatment as soon as possible. We acknowledge the significant work undertaken by JH&FMHN in managing the high demand for custodial mental health placements.

When a patient is accepted as an admission to the MHU, a mental health bed flow manager arranges for an acceptance form to be provided to CSNSW, who facilitate the transfer of the patient to the MHU. Admissions to the MHU are accepted seven days a week. When an admission is expected the NUM briefs the officer in charge of the MHU on the patient. When a patient arrives, nursing staff conduct an admission assessment and the NUM meets with the patient. A psychiatric registrar completes the medical admission of the patient. A consultant psychiatrist is assigned to the patient and conducts a review of the patient the next time they attend the MHU. Nursing staff complete a HPNF which includes recommendations on the perceived level of risk of the patient, placement requirements and management approaches.

Placement of a new patient is determined jointly by nursing and custodial staff and on most occasions, they are initially placed in G-ward. The internal movement of patients between G-ward and E-or F-wards is determined by MHU health staff and the functional manager and officer in charge of the MHU.

99 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.

Medication management

MHU patients received their medications via imprest stock or as an individual patient use medication. Medications were not provided in dose administration aids or as part of the self-medication program. Medication management was the responsibility of the nursing staff assigned to each of the wards. MHU health staff reported having a very good pharmacy service provided by the JH&FMHN pharmacy team, including a pharmacist attending the MHU when required.

In E-and F-wards, when patients were let out of their cells, medications were prepared from a medication trolley transported by nursing staff from the pharmacy room to the officer's desk. Medications were prepared for and administered to one patient at a time. Patients either approached nursing staff at the medication trolley or were called by nursing staff. In the afternoons and evenings or any other time patients were locked in their cells, medications were administered by taking the medication trolley around the relevant ward, preparing the medication and administering the medication to each patient through the cell door hatch. Medications were administered to all G-ward patients through the cell door hatch.

During the inspection we observed the preparation and administration of morning medications. In E-and F-wards, health staff did not have access to patient identification cards or cell identification cards. Instead, patients were identified by the patient providing their name and date of birth. This issue was unique to mornings because patient identities could be verified by cell identification cards during afternoon and evening medications administered after hours.

Identifying patients by asking them their name and date of birth does not comply with the JH&FMHN Medication Guidelines or NSW Health policy on the principles of safe medication administration. To ensure the correct identification of patients, health staff in correctional centres should refer to the person's identification card that includes their photo, full name and MIN. Patients in the MHU were not permitted to retain their identification card. CSNSW maintains a book with photo identification of each person held in a unit, used for inmate counts. To facilitate the correct identification of patients, nursing staff could use this book to identify people during the administration of medication. Another simple solution would be to implement a similar process to that used in the ACRU, where copies of identification cards were attached to the medication trolley.

With the exception of the patient identification process, medications were prepared and administered to patients using the correct procedure. This included patient medication being selected from imprest and/or individual patient use stock and placed in a medicine cup, which was then handed to the patient who took their medication with a cup of water. All medication administration was supervised by nursing staff who watched each patient swallowing their medications. The patient opened their mouth afterwards for the nursing staff to check the medication had been swallowed. The e-MEDs system was signed at the time of preparing the medication.

Recommendation: JH&FMHN remind MHU nursing staff of the requirement to check an approved form of patient identification when they are preparing and administering medications.

Discharge planning

The MHU treating team oversights decisions about patient suitability for discharge to a correctional centre. The patient is presented at the MHPF meeting, where a determination is made about the most appropriate placement. Relevant considerations include the patient's mental health history, including episodes of and reasons for deterioration/relapse, level of vulnerability within a correctional environment, history of compliance with medication and considered need for more intensive monitoring by the CMHS.

For patients considered stable, with a good history of medication compliance and who have previously been managed safely within a correctional environment, the recommendation is usually that they be transferred to a correctional centre and managed by the onsite/outreach CMHS. Some patients requiring more intensive monitoring are recommended for placement in one of the designated mental health accommodation units. All patients discharged from the MHU to a correctional centre must be reviewed by the CMHS within seven days. The psychiatrist/psychiatric

registrar completes the medical discharge summary. Nursing staff also complete a discharge summary and provide a clinical handover to the receiving correctional centre.

Health staff reported that the closure of the LBH 2 13-wing mental health step-down unit had decreased options for 'trial' discharges for E-and F-ward patients. The proximity of 13-wing to the MHU had allowed for closer observation and monitoring of this group and enabled their prompt return to the MHU if they began to deteriorate.

When a patient is released from custody, nursing staff refer them to the NSW Health statewide 1800 mental health referral line, used by all public mental health service providers. The referral details the patient's home address and the referral is forwarded to the relevant local health district community mental health team. A copy of the patient's discharge summary is sent to the referral service.

Some patients may be subject to a community treatment order, which requires them to attend a community mental health service to receive their prescribed depot mental health medication injections within a specified period. Appointments are made with their local health district community mental health service prior to release to coincide with the next injection to ensure continuity of treatment.

Some patients may be considered too mentally unwell to be managed in the community and will be transferred to a public hospital mental health facility under the *Mental Health Act 2007*. The proposed transfer is discussed between the MHU treating psychiatrist or psychiatric registrar and the public mental health facility medical team. Discussions also occur between nursing staff from the MHU and the public mental health facility, where they advise if a patient is being transferred under the *Mental Health Act 2007* for ongoing assessment and treatment. The transfer is conducted by the NSW Ambulance Service, usually with the assistance of NSW Police. Discharge summaries are prepared by nursing and medical staff and are provided to the public mental health facility via the NSW Ambulance Service. A clinical handover is also undertaken between the MHU nursing staff and the NSW Ambulance Service prior to the patient transfer.

1.4.5 Routine and time out of cell

As noted in the sections on each ward, we estimated that health staff had access to patients for around six-and-a-half hours per day. While health staff reported that CSNSW generally facilitated access outside these hours, this was by prior agreement. We consider this level of patient access to be inadequate for an environment with a primary function of providing inpatient health care and a higher level of care than that provided in a correctional centre due to the complexity or acuity of the patient cohorts. In this context, it would make more sense for out of cell hours to correspond with standard business hours for health care professionals, at a minimum for morning and evening shifts.

LBH 1 is a maximum security correctional centre and therefore has the ability to hold inmates of all security classifications. It operates in accordance with a typical maximum security routine. In all wards, people were let out of their cells from around 7.15am and locked in from around 2.15pm. Inmates were also locked in their cells from 11am to 12pm each day. This amounted to around six hours out of cell. Inmates in the MU and G-ward were provided with lunch in their cells. Those in the ACRU, E-and F-wards ate lunch in the community areas after the lunch 'lock-in'.

During the inspection we observed the 'let-go' and 'lock-in' processes[100] for patients and found that actual time out of cell could vary. In E-and F-wards, inmates were not let out of their cells until JH&FMHN staff administered depot injections or conducted pathology collection. On one day 'let-go' for F-ward commenced at around 7.55am and on another at 7.35am. In the MU, 'let-go' commenced after medication administration or after the career medical officer had completed their rounds.

The routine for G-ward was more restrictive. Patients in G-ward have acute mental illness and may be at risk to themselves or others. G-ward inmates generally did not mix with each other and spent their time out of cell in a yard alone. Records we reviewed during the inspection indicated the actual

100 'Let-go' refers to the process of letting inmates out of their cells, usually in the morning. 'Lock-in' refers to the process of securing inmates in their cells, usually at the end of the day.

time each inmate spent out of cell varied, but most spent around an hour out of cell, and there were days when some inmates were able to have periods out of cell in the morning and afternoon. It should be noted that some inmates decline to spend time out of cell or may choose to go back to their cells earlier than required.

We understand that the routine in G-ward was the preferred approach of CSNSW and was considered the safest way to manage a cohort that includes people with histories of violent behaviour who may be volatile. We acknowledge that G-ward can be an extremely challenging workplace for custodial and health staff. However, this approach is not therapeutic and does not align with the National Safety and Quality Health Service Standards regarding restrictive practices and minimising patient harm.[101] The *Crimes (Administration of Sentences) Regulation 2014* (CAS Regulation) requires that all inmates except those confined to cell as a penalty for a correctional centre offence, should be allowed two hours each day for 'exercise in the open air'.[102] It seemed unlikely that this was being consistently offered to G-ward inmates, despite the apparent best efforts of custodial staff. The changes to the function and operation of G-ward should address these concerns. This is an area we will continue to monitor.

Positively, we were advised that a few months before the inspection a trial had commenced for additional time out of cell for people in E-and F-wards. This was to occur from 3.30pm to 6.30pm on alternating evenings for each ward. We were informed that CSNSW was reviewing the hours of access in LBH 1 and considering extending out of cell hours. We support an extension of out of cells hours for the LBH 1 population. This will facilitate greater access to health care for the patients in the MU, ACRU, and MHU.

Recommendation: CSNSW increase time out of cell for inmates in LBH 1.

1.5 Long Bay Hospital Area 2

1.5.1 Closure and reopening

LBH 2 has undergone a number of changes over the course of this inspection. At the time of the first part of the inspection in August 2023 it held 76 inmates. Most of these inmates (63) were in 13-wing, which was operating as a mental health step-down unit. The inmates were undertaking programs and receiving support with an aim to integrate into a more typical custodial environment after a period of acute mental illness. Except for inmates in the MPU and a small number of hygiene workers, 12-wing was empty and had been since 2022.

In January 2024, CSNSW announced the temporary closure of all LBH 2 inmate areas.[103] During our visit in February 2024, LBH 2 inmates were being transferred to other correctional centres and only 32 inmates remained. Many were placed in the Hamden 18-wing at MRRC. There was also a reduction in staffing numbers. Although no staff were made redundant, the number of custodial positions was reduced from 236 to 172 and some positions were taken offline. The temporary closure was to be fully implemented by March 2024.

Understandably, the temporary closure of LBH 2 was a source of significant uncertainty and anxiety for staff and inmates. Many of the staff we spoke with felt the temporary closure announcement and process were poorly managed by CSNSW. Initially staff understood that they could relocate to a different correctional centre if they wished. However, they were later informed that they would have to stay at LBH. The reduction in inmates and associated posts led to reduced overtime and increased boredom for many custodial staff, which had an evident impact on staff morale. To the credit of LBH management, there was an increased focus on staff training during this period. However, this alone could not mitigate the negative impacts.

101 Australian Commission on Safety and Quality in Health Care, *National Safety and Quality Health Service Standards* (May 2021).
102 *Crimes (Administration of Sentences) Regulation 2014* cl 53(1).
103 The JH&FMHN Outpatient Department continued to operate. See section 1.5.4.

During the second part of our inspection in mid May 2024, there were no inmates held in LBH 2. At the end of May 2024, CSNSW decided to reopen LBH 2 accommodation units. At that time, we were on site at MSPC having completed a week on site at LBH around two weeks prior. Staff at MSPC were required to identify any remand inmates with medical holds or upcoming medical appointments located in MSPC 1. These inmates (approximately 20) were to be moved to LBH 2, with movements commencing the following week. We understand that less than a week passed between the announcement of the reopening and the transfer of inmates. LBH 2 began holding inmates again from 3 June 2024.

At the end of July 2024, we conducted a further visit to LBH 2 to observe its operation following the reopening. As noted previously, at this time over 80% of LBH 2 inmates were on remand. On 2 August 2024, of the 255 inmates in LBH 2, 21 (8.2%) were subject to a medical hold.[104] Therefore, it appears that the primary purpose of the reopening of LBH 2 was to provide another placement option for remand inmates, relieving pressure on the primary remand and reception centres, MRRC and Parklea Correctional Centre.

CSNSW has advised that its Staff Support, Culture and Wellbeing (SSCW) directorate, which provides support to leadership, staff and teams during times of change or disruption to business as usual, has been working with the LBH leadership team throughout 2025 to 'provide wellbeing support in future change management circumstances'.[105]

1.5.2 Physical environment

LBH 2 opened in 1967. It consists of two accommodation wings (12-wing and 13-wing). Each wing contains a ground, middle and upper landing. The middle and upper landings are only accessible by stairs. There are showers on each landing. The upper and middle landings also have programs and education rooms, and the ground landings have a kitchenette. However, as outlined in section 1.5.3, inmates had limited access to these communal amenities. The cells in LBH 2 include a bunk bed, toilet and sink, shelving and a desk but did not contain showers.

Although some efforts have been made to maintain the accommodation areas in LBH 2, such as fresh paint, both wings have aged poorly. We observed mould on the ceilings and rusted furniture. The units and cells are prone to very high and low temperatures and become draughty and damp from wind and rain. Consistent with the age of LBH 2, many cells contain hanging points.

104 Information provided by Corrective Services NSW, 2 August 2024; Information provided by the Justice Health and Forensic Mental Health Network, 16 September 2024.

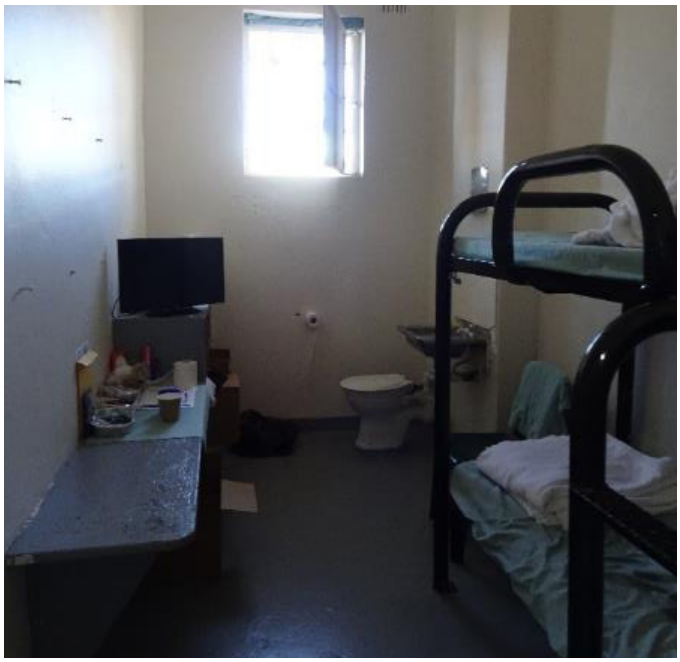
105 The work of the SSCW directorate includes collaborating with leadership on change management and communication strategies, focusing on supporting managers to understand potential impacts and concerns for staff culture and wellbeing and how these can be minimised; providing avenues for staff to seek external support; and providing team-based support prior to, during or following challenging periods: Information provided by Corrective Services NSW, 23 September 2025.

LBH 2 contains four separate yard areas. There are two large, concreted yards near the accommodation wings (upper yards) and two larger grassed areas located further away (lower yards). These contained communal showers and some exercise equipment.

LBH 2 upper yard, February 2024

LBH 2 lower yard, August 2023

12-wing cell, July 2024



13-wing camera cell, February 2024

Mould on 13-wing ground landing ceiling, February 2024

12-wing ground landing, February 2024

1.5.3 Our concerns about the reopening

LBH 2 routine

Inmates in LBH 2 spent their days in one of the four yards. To minimise crowding, inmates were split into four groups, with those from one wing divided across the two concreted yards and those from the other wing divided across the two grassed yards. Wings would rotate between the concreted and grassed yards on alternating days.

Inmates went straight to the yards when they were let out of their cells at around 7.30am and went straight to their cells when they were locked into their cells at around 2.30pm. Only hygiene workers spent time in the communal areas of the wings. Consequently, although indoor showers were available, they were not used. Instead, inmates showered using facilities located in the yards.

As highlighted in section 1.2, LBH experienced frequent lockdowns in the months following the reopening of LBH 2 due to short staffing. While those lockdowns particularly impacted the MHU in LBH 1, LBH 2 was also regularly affected. Between its reopening in June to the end of August 2024, there were 21 IRMs detailing the lockdown of all or part of LBH 2. Of these, 12 lockdowns were due to short staffing and four were due to staff training, events or meetings. There were also several occasions where excess water in the grassed yards from heavy rainfall made them unusable, resulting in partial lockdowns to enable staff to manage four groups of inmates in the two remaining yards.[106]

Supports for remand inmates

When the re-opening occurred in mid-2024, LBH 2 had not been fully operational for around two years due to the partial closure of 12-wing followed by the full closure of LBH 2. This was apparent in our visit in July 2024, approximately two months after the reopening. Although LBH 2 was operating at close to capacity, the supports and services for remand inmates were inadequate to meet their needs.

There were an insufficient number of services and programs officers (SAPOs) to support the immediate needs of remand inmates. The staffing establishment for SAPOs was reduced from nine to five positions during to the temporary closure. This was increased from five to eight positions when

106 Information provided by Corrective Services NSW, 5 December 2024.

LBH 2 reopened. At the end of July 2024, five of these positions were filled, a sixth person was due to commence soon, and two positions required a recruitment process. Relevant staff managed this limited resourcing by prioritising urgent work including crisis interventions, induction and orientation for new inmates, and RIT work.

Access to inmates for SAPOs was also challenging. SAPOs could only speak with those inmates held in the two yards closest to the accommodation units. Those in the lower yards would have to wait until the following day. This was an added barrier for a small team attempting to prioritise their workload according to need and urgency. During a subsequent visit in July 2025, this had reportedly been addressed by the movement of inmates from the yards to meet with SAPOs in the LBH 2 programs area as needed.

Access to legal representatives and resources was a further concern. LBH 2 has five professional audiovisual link (AVL) suites. At the time of our visit, an AVL suite near the MPU was out of order after being damaged by an inmate in early 2024. This meant inmates in the MPU had to be taken to the reception area for court appearances and legal visits. The remaining AVL suites had capacity for 45 bookings per day, with court appearances taking precedence. A busy day with a number of court hearings could result in professional visits being delayed, although it appeared there was capacity to rebook any cancellations for the following day.

CSNSW has advised that the 'utilisation rate of the centre's studios show that the current demand is adequately managed within these existing studio resources' and the loss of the MPU AVL studio 'has not affected the centre's ability to manage video conferencing appointments for court appearances for inmates housed in the MPU'. CSNSW's AV, Strategy and Business Links team were also assisting LBH to organise repairs to the MPU studio.[107] We note that this indicates the MPU's AVL studio has been inoperable since LBH 2 reopened in June 2024 until the publication of this report.

Inadequate facilities

There are fewer cells on the ground floors of both wings than on the middle and upper landings. This is due to the MPU being on the ground floor of 12-wing and camera cells being on the ground floor of 13-wing, as well as kitchen facilities and programs/interview rooms. This means there are very limited placement options for inmates with mobility issues who cannot climb stairs to the middle or upper landings. We observed that some of these inmates were instead occupying camera cells for lack of other options. Some inmates with mobility issues would remain in cell when their wing was using the lower, grassed yards as these were further away from the accommodation wings and this was too far for them to walk. On these days, time out of cell was simply inaccessible for this group.

Unlike more modern facilities, the cells in the MPU do not contain showers or have secure rear yards for time out of cell. MPU inmates shower in one of five outdoor holding yards. These holding yards are also the only place MPU inmates can spend time out of cell. The condition of the yards is inadequate. Although they are largely enclosed, the bars at the front mean they are exposed to poor weather. They contain a shower, toilet, sink and seating. However, during our visit in July 2024, toilets in four of the yards were blocked.

All inmates should have easy access to a shower and a toilet. Inmates subject to segregation or protective custody orders who are placed in MPUs can have very limited time out of cell. Access to fresh air and exercise is particularly important for mitigating the negative impact of isolation for this group of inmates. The infrastructure of this MPU is incapable of providing inmates with decent conditions and should be closed immediately.

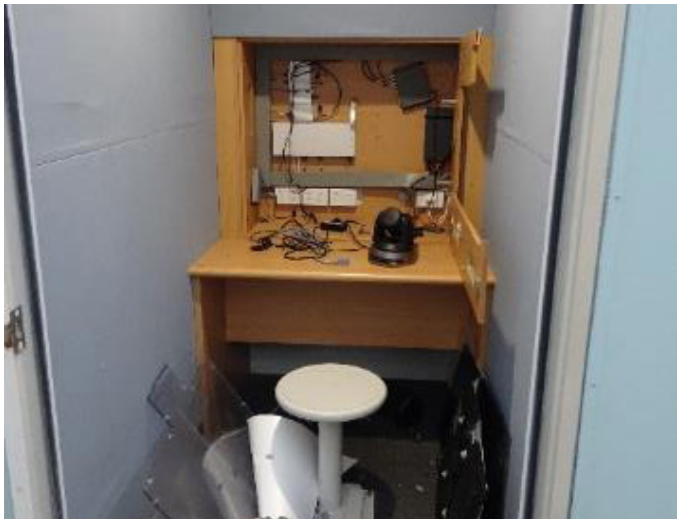
Recommendation: CSNSW permanently close the Long Bay Hospital MPU.

107 Information provided by Corrective Services NSW, 23 September 2025.

MPU cell, July 2024

MPU outdoor holding yard & shower, July 2024

Vandalised MPU AVL suite, July 2024



Blocked MPU holding yard toilet, July 2024

Unlike other correctional centres with a predominantly remand population, LBH 2 does not have a dedicated AVL area. AVL suites adjoin the reception area and several are located near the reception area's indoor holding cells. There are limited spaces for inmates to speak with their legal representatives confidentially using a cordless telephone, as is often required before or after a court appearance. Inmates with an AVL court appearance or professional visit wait in holding cells outside the reception area. CSNSW has advised that unused video conferencing rooms and other rooms are used for confidential phone calls between lawyers and their clients during, before or after court appearances. It also noted that LBH is 'proactively seeking funding for essential maintenance of the AVL studios'.[108]

108 Information provided by Corrective Services NSW, 23 September 2025.

Holding cell for inmates attending AVL, July 2024

The lack of planning with respect to staffing and services at LBH 2 prior to its reopening is indicative of a reactive approach to the management of the custodial estate in NSW. It is difficult to understand the decision to reopen such dilapidated and unfit inmate accommodation, particularly given the staffing challenges. JH&FMHN expressed a preference that LBH 2 be refurbished and quarantined for the placement of medically transient patients.[109] However, it is our view that this infrastructure is incapable of providing safe and humane conditions and the inmate accommodation in LBH 2 should be closed permanently.

Recommendation: CSNSW permanently close inmate accommodation in LBH 2.

1.5.4 Outpatient Department

The Outpatient Department (OPD) is located in LBH 2, providing specialist health services to predominantly male inmates across NSW and all health services for inmates in LBH 2 and LBH 3. It continued to operate during the closure of the LBH 2 inmate accommodation areas.

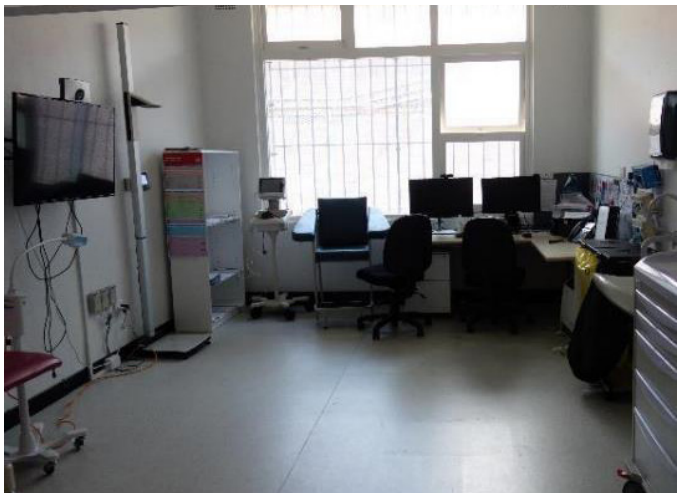
Health centre infrastructure

The OPD includes a dental suite, radiology facilities and seven consultation and treatment rooms (including a purpose-built physiotherapy room and minor procedure room). There is also a health centre in 13-wing that includes a treatment room and is used for medication administration and routine monitoring. LBH 3 has a satellite health centre that includes a dental suite and a treatment room. All treatment and consultation rooms have myVirtualCare facilities.

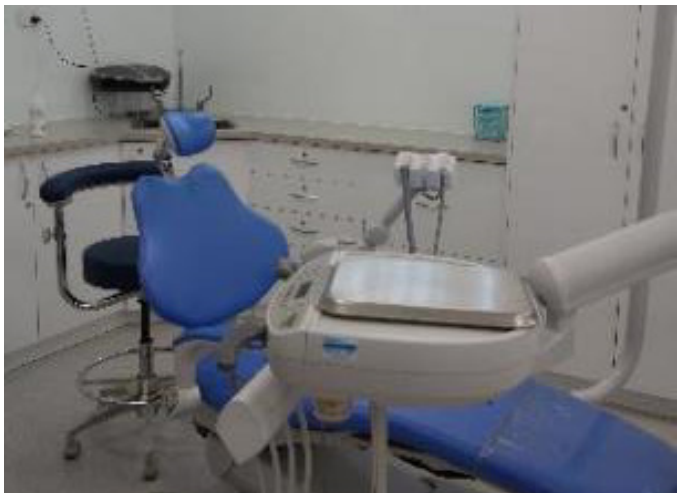
The OPD building is the same age as the rest of LBH 2. Although the building has been well maintained, its age and limitations are apparent, particularly in the holding areas which do not have toilets or taps. Therefore, moving people in and out of the OPD as quickly as possible needs to be a foremost priority in its operations. However, it should be emphasised that JH&FMHN have done well with the available space. We found the OPD to be clean and organised with well-equipped consultation and treatment rooms, including modern dental and radiology facilities and physiotherapy equipment. Both the OPD and the LBH 3 health centre were cleaned by inmate hygiene workers.

109 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.

OPD consultation room, August 2023



OPD dental room, August 2023



OPD patient holding yards, August 2023

Staffing and operations

The OPD operates 24 hours per day, seven days per week. Health staff in the OPD also provide services in LBH 3 from 7am to 7.30pm, seven days per week.[110] Table 8 details the LBH 2 and 3 health services staffing profile and roster.

Table 8: JH&FMHN staffing profile and roster at LBH 2 & LBH 3[111]

Position	FTE	Nursing shifts
NUM	1.0	8am to 4.30pm (weekdays)
RN	11.4	6am to 2.30pm: 1 RN (weekdays) 7am to 7.30pm: 3 RNs (7 days) 7pm to 7.30am: 1 RN (7 days)
EN	0.6	6am to 6.30pm: 1 RN/EN (7 days)
HCC	1.0	8am to 4.30pm (weekdays)

On weekdays the OPD is also staffed by five correctional officers from 7am to 3pm (including a supervising correctional officer). There are also two correctional officers on duty from 6am to 2pm, seven days per week for facilitating health clinics.[112]

110 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
111 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
112 Information provided by Corrective Services NSW, 5 December 2024.

Health service provision

Health services in the OPD are provided by JH&FMHN staff and contracted service providers from Prince of Wales Hospital or by individual arrangement. Specialist outpatient services included an orthopaedic surgeon one day a fortnight, an ophthalmologist one day a fortnight, a dermatologist one to two days a month, a respiratory specialist one day a fortnight, an immunologist one day a month and hepatologist one day a week. Patients attend specialist appointments from the OPD either in person or via myVirtualCare facilities.

Radiology/medical imaging services provided at the OPD include plain x-rays, ultrasounds and orthopantomograms (an x-ray of the teeth and jaw). Radiology services were provided in the OPD two to three days a week with the staff also providing radiology services in other correctional centres. The images are reviewed by a contracted radiologist who provides reports to JH&FMHN.

Oral health services were provided in the OPD dental suite two to three days a week to all patients in LBH 1 and LBH 2 and to any maximum or medium security patient in MSPC 1 and MSPC 2. The LBH 3 health centre also has a dental suite.

Table 9 shows the very high number of appointments and patients managed by the OPD. For the 12-month period from 1 September 2022 and 31 August 2023, 94% of all patients (excluding LBH 3 patients) were seen on time.[113] However, we note the significant proportions of urgent (43%) and semi-urgent (38%) patients who were seen outside the recommended timeframes (one to three days for urgent and three to 14 days for semi-urgent patients).[114] This is something JH&FMHN will have to monitor as the OPD's workload increases with the reopening of the LBH 2 accommodation units.

Data provided by JH&FMHN indicates that from around March to August 2023, most of the scheduled clinic hours detailed in Table 10 were delivered in the OPD (excluding LBH 3 patients). During the same period, some clinic hours were delivered for all of the services scheduled as required. This was also the case for LBH 3 patients.[115]

Table 9: LBH 2 – care provided within and outside the recommended wait time by triage category, from 1 September 2022 to 31 August 2023[116]

Clinical priority[117]	Total arrived appointments	Seen on time	Seen outside recommended time
P1 (urgent)	127	73 (57%)	54 (43%)
P2 (semi-urgent)	646	398 (62%)	248 (38%)
P3 (non-urgent)	1,351	1,253 (93%)	98 (7%)
P4 (routine)	3,844	3,844 (100%)	0
P5 (follow-up)	707	No timeframe	No timeframe
Total	6,675	6,275 (94%)	400 (6%)

113 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
114 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
115 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.
116 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023. Note: this table does not include data for oral health waiting times or waiting times for patients in LBH 3.
117 The following timeframes apply for each clinical priority: P1 = 1 to 3 days, P2 = 3 to 14 days, P3 = 14 days to 3 months, P4 = 3 to 12 months, P5 = no timeframe.

Table 10: Scheduled and delivered clinic hours and delivery format in LBH 2, March to August 2023[118]

Clinic	Scheduled	Delivered	Format
D&A doctor/nurse practitioner	6 hours per week	6 hours per week	In person
D&A nurse	8 hours per week	8 hours per week	In person
GP	8 hours per week	8 hours per week	In person
Mental health consultation liaison nurse	As required	4 hours per month	Telehealth
Mental health nurse	171 hours per week	99 hours per week	In person
Oral health	As required	4 hours per month	In person
Physiotherapy	8 hours per week	8 hours per week	In person
Optometry	As required	4 hours per month	In person
Population health nurse	8 hours per week	8 hours per week	In person

Outpatient specialist services

The JH&FMHN Medical Appointments Unit coordinates all specialist medical appointments for patients held in NSW correctional centres. The Medical Appointments Unit consisted of four administrative staff who worked with external hospitals to manage wait lists for specialist appointments and coordinate patient transport to and from appointments with CSNSW's MEU.

Most specialist appointments are provided to male patients at Prince of Wales Hospital, with a small number provided at Westmead Hospital. Female patients attend either Westmead or Nepean Hospitals for specialist appointments. A number of specialist services are also provided to male patients at the OPD. At the time of the inspection, the outpatient specialist services model required the majority of male and female patients to be transferred from their correctional centre of classification to a metropolitan correctional centre. Women were accommodated at Silverwater Women's Correctional Centre or Dillwynia Correctional Centre and men were usually placed in MSPC 1 or LBH 2. A small number of appointments were conducted by external hospital specialist services and the OPD using myVirtualCare to patients at correctional centres.

During the inspection we observed the MEU transporting patients held in MSPC 1 to and from the OPD via a vehicle. For most people, the distance between MSPC 1 and LBH 2 is an easy walk of approximately 10 minutes. However, the vehicle escort was considered necessary for inmates with maximum security classifications and MSPC 1 is a maximum security area, although we note not all MSPC 1 inmates have a maximum security classification and the security level of the escort should reflect the classification of the individual, not the correctional centre where they are held. Patients from MSPC 2 and MSPC 3 with minimum security classifications were escorted by correctional officers by foot. Staff told us that any minimum security classified patients requiring a wheelchair would be assisted by an inmate hygiene worker.

A number of patients will choose to decline specialist appointments either when first offered to them or when it is time to be transferred to Sydney to attend the appointment. This appears to be due to a reluctance to leave their correctional centre of classification, which may offer close proximity to family or employment opportunities, and a fear they may struggle to return. Escort journeys from regional locations to Sydney can be a disincentive due to their length and conditions. Men with minimum security classifications also do not like being held in maximum security facilities like MSPC 1 or LBH 2. During this inspection staff reported observing an increasing number of cancelled appointments. They believed this was due to the amount of time people in MSPC 1 were waiting to be escorted to the OPD and back, in old yard areas.

118 Information provided by the Justice Health and Forensic Mental Health Network, 1 December 2023.

Expanding regional specialist outpatient services across NSW has significant benefits for patients, creating greater stability and more timely access to health services. A regional model of specialist outpatient service delivery has commenced in the Hunter region, where patients from the Cessnock Correctional Complex and St Heliers Correctional Centre can attend specialist outpatient appointments virtually or in-person at John Hunter Hospital. CSNSW established a regional MEU to transport and escort patients to specialist appointments. CSNSW should consider establishing additional MEUs for regional areas.

In addition, during the inspection JH&FMNHN advised that it was their aim to increase the use of myVirtualCare for specialist appointments which would also aid in reducing the need for patients to be transferred to Sydney to access specialist services. We commend JH&FMHN for their commitment to expanding the virtual specialist service program.

2 Metropolitan Special Programs Centre

2.1 Metropolitan Special Programs Centre profile

2.1.1 Inspection history

We previously inspected the Metropolitan Special Programs Centre (MSPC), as part of the following thematic inspections:

- *Full House: The Growth of the Inmate Population in NSW*. The inspection took place from late September to early October 2014 and the report was published in April 2015.
- *Old and Inside: Managing Aged Offenders in Custody*. The inspection took place in May 2015 and the report was published in September 2015.
- *Health Services in NSW*. The inspection took place in July 2018 and the report was published in March 2021.
- *Programs, Employment and Education*. The inspection took place in September 2018 and the report was published in February 2020.

2.1.2 Function and capacity

MSPC is a maximum and minimum security correctional centre. It is not a reception location for people newly entering custody, meaning all inmates at MSPC have been transferred from another correctional centre. On 8 May 2024, MSPC had an approved operational capacity of 826 inmates and a population of 612 inmates.[119] MSPC consists of three areas – MSPC 1 (Table 11), MSPC 2 (Table 12) and MSPC 3 (Table 13).

Table 11: MSPC 1 (maximum security)[120]

Wing	Capacity	Population and function
7-wing	82	Mainstream remand and sentenced inmates. In addition to its 82 beds, 7-wing has eight camera cells used for people at risk of self-harm or suicide.
9-wing	80	Not operational at the time of the inspection. Held remand and sentenced protection inmates prior to its temporary closure.
10-wing	82	Sentenced and remand protection inmates.
11- & 31-wings: Violent Offender Therapeutic Program (VOTP)	74	11-wing can hold up to 54 mainstream inmates participating in VOTP. 31-wing holds up to 20 protection inmates participating in VOTP.
30-wing: Acute Crisis Management Unit (ACMU)	10	Not operational at the time of the inspection. The unit held inmates at risk of self-harm and suicide and included eight camera cells.
32-wing: Kevin Waller Unit (KWU)	26	Not operational at the time of the inspection but reopened in July 2024. The KWU holds aged and frail inmates.

119 Metropolitan Special Programs Centre, *Metropolitan Special Programs Centre Overview* (8 May 2024).
120 Metropolitan Special Programs Centre, *Metropolitan Special Programs Centre Overview* (8 May 2024).

Table 12: MSPC 2 (maximum and minimum security)[121]

Wing	Capacity	Population and function
1-wing: Sex offender programs	40	Sentenced protection inmates with a minimum security classification participating in sex offender programs.
3-wing: Mental health step-down unit	67	A mental health step-down unit for mainstream inmates with a minimum security classification.
4-wing: Aged and frail unit	72	Protection inmates with a minimum security classification who are aged and frail or participating in sex offender programs.
5-wing: Additional Support Unit (ASU)	22	An ASU for inmates with an intellectual disability or cognitive impairment managed by Statewide Disability Services (SDS). This is a maximum security unit but may hold people with a lower security classification.
6-wing: ASU	21	An ASU for inmates with an intellectual disability or cognitive impairment managed by SDS. This is a maximum security unit but may hold people with a lower security classification.
Integrated Support Unit (ISU)	14	A maximum security unit used for inmates who are difficult to place elsewhere. In addition to its 14 beds there are three camera cells for people at risk of self-harm or suicide.
Segregated Housing Unit (SHU)	10	A maximum security unit used to hold inmates with segregation orders. All 10 cells have cameras.

Table 13: MSPC 3 (minimum security)[122]

Wing	Capacity	Population and function
14-wing	84	Sentenced protection inmates.
15-wing	84	Sentenced protection inmates.
16-wing	84	Sentenced protection inmates.
17-wing	78	Sentenced protection inmates.
18-wing: ASU	16	An ASU for inmates with an intellectual disability or cognitive impairment managed by SDS. 18-wing also has a camera cell.

During the inspection, MSPC 1 was used to hold people on remand or outpatients with specialist health appointments or scheduled medical treatment in Long Bay Hospital (LBH) or at a hospital in the community.

In January 2024, Corrective Services NSW (CSNSW) announced that it would be temporarily closing 9-wing and the Kevin Waller Unit (KWU) in MSPC 1 from February 2024. This was part of a broader bed consolidation project. The aged and frail inmates held in KWU were moved to a unit in the Metropolitan Remand and Reception Centre (MRRC) (see chapter 4). KWU later reopened in July 2024. At the time of writing, 9-wing remained closed.

The ACMU was closed in June 2023, shortly after being refurbished. We understand the closure related to an industrial dispute regarding staffing levels. At the time of writing, it remained closed.

121 Metropolitan Special Programs Centre, *Metropolitan Special Programs Centre Overview* (8 May 2024).
122 Metropolitan Special Programs Centre, *Metropolitan Special Programs Centre Overview* (8 May 2024).

2.1.3 Inmate profile

Most inmates in MSPC were sentenced, had a minimum security classification and were in protective custody. On 31 August 2023, there were 746 inmates at MSPC. Of these:

- Most were sentenced (563 or 75.5%). There were 163 inmates (21.8%) on remand and 20 (2.7%) were appealing.
- A significant proportion of people were aged 65 years and over (146 or 19.6%) and more than half were over the age of 45 years (390 or 52.3%).[123] The age profile is depicted in Figure 5.
- Most had a minimum security classification[124] (498 or 66.8%) (see Figure 7).
- Most were held in a Special Management Area Placement (SMAP)/on protection (608 or 81.5%). There were no Protection Non-Association Area (PRNA) inmates.
- A significant proportion were managed by the Serious Offenders Review Council (SORC)[125] (75 or 10.1%) and the Pre-Release Leave Committee (PRLC) (261 or 35%).[126]
- There were 167 inmates (22.4%) who were Aboriginal people.
- Most inmates were born in Australia (571 or 76.5%) and most spoke English at home (675 or 90.5%). Nine inmates required an interpreter.[127]

Data obtained for the following year showed a decrease in the inmate population consistent with the closure of 9-wing but little change in the demographic profile. On 31 August 2024, there were 673 inmates at MSPC. Of these:

- Most were sentenced (506 or 75.2%). There were 149 inmates (22.1%) on remand and 18 (2.7%) were appealing.
- A significant proportion of people were aged 65 years and over (116 or 17.2%) and just under half were aged 45 years and over (327 or 48.6%) (see Figure 6).
- Most had a minimum security classification (469 or 69.7%) (see Figure 8).
- Most were SMAP/protection inmates (527 or 78.3%). There were two PRNA inmates.
- A significant proportion were managed by the SORC (55 or 8.2%) and the PRLC (270 or 40.1%).
- There were 159 inmates (23.6%) who were Aboriginal people.
- Most inmates were born in Australia (518 or 77%) and most spoke English at home (592 or 88%). Nine inmates required an interpreter.[128]

123 As at March 2025, the average age of male inmates in NSW was 38.8 years: See Bureau of Crime Statistics and Research, *New South Wales Statistics Quarterly Update March 2025* (Report, 21 May 2025) 25.
124 *Crimes (Administration of Sentences) Regulation 2014* cl 12.
125 SORC provides advice, recommendations and reports regarding the management of serious offenders: *Crimes (Administration of Sentences) Act 1999* s 3 (definition of 'serious offenders') and pt 9.
126 The PRLC is a sub-committee of SORC that reviews and makes recommendations regarding applications by public interest inmates: Corrective Services NSW, *Inmate Classification and Placement: Serious Offenders Review Council (SORC) and Subcommittee Managed Inmates* (version 2.6, 8 April 2022) 17–22.
127 Information provided by Corrective Services NSW, 17 November 2023.
128 Information provided by Corrective Services NSW, 17 January 2025.

Figure 5: Inmate age profile, 31 August 2023[129]

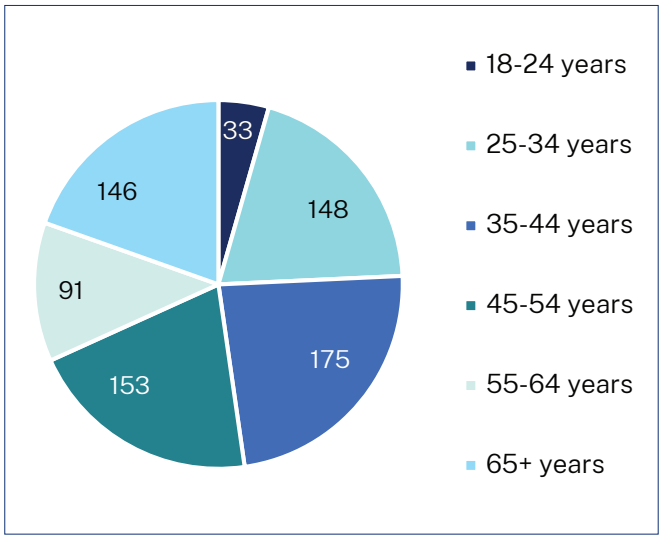


Figure 6: Inmate age profile, 31 August 2024[130]

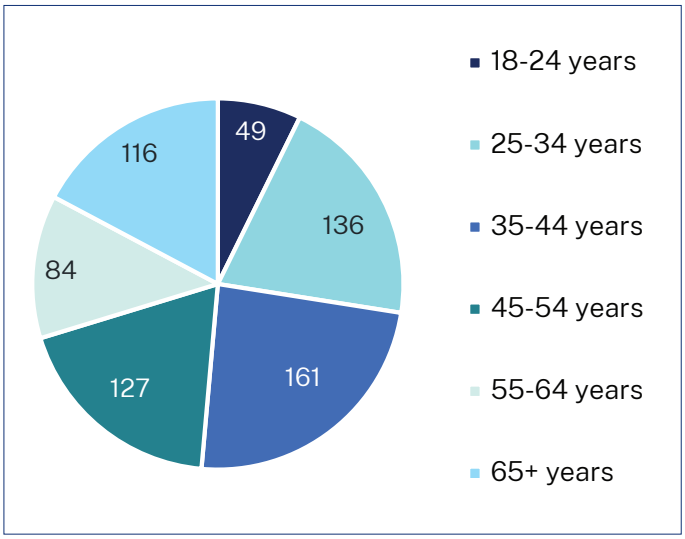


Figure 7: Security classifications of inmates at MSPC on 31 August 2023[131]

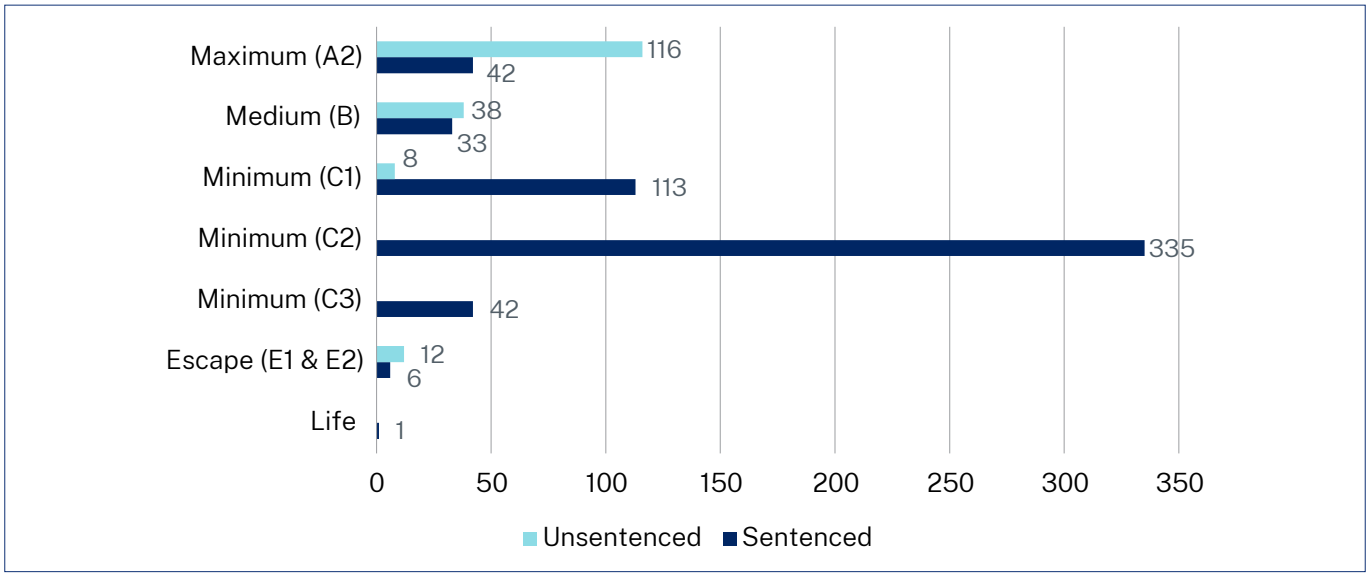
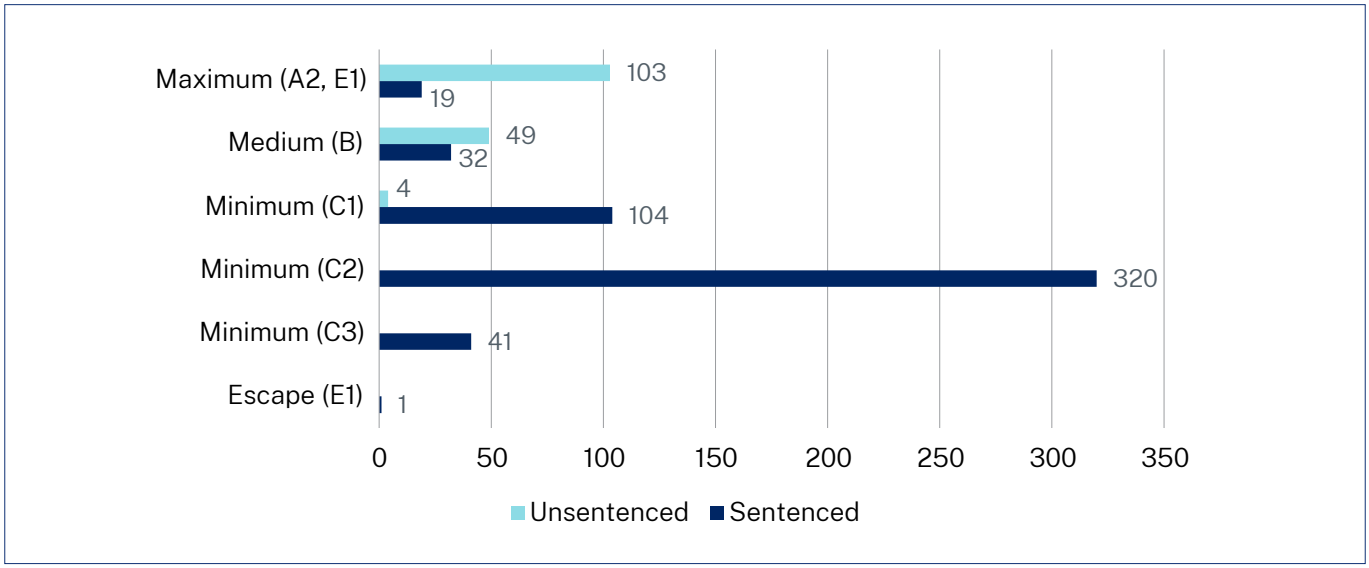


Figure 8: Security classifications of inmates at MSPC on 31 August 2024[132]



129 Information provided by Corrective Services NSW, 17 November 2023.
130 Information provided by Corrective Services NSW, 17 January 2025.
131 Information provided by Corrective Services NSW, 17 November 2023.
132 Information provided by Corrective Services NSW, 17 January 2025.

2.2 Physical environment

2.2.1 Layout

MSPC has two gates, one in MSPC 1 and one in MSPC 2. The reception and audiovisual link (AVL) areas are used by inmates from all areas. The AVL area is located in MSPC 1 and the reception area borders MSPC 1 and MSPC 2. Otherwise, the three areas of MSPC are largely self-contained and operate independently.

MSPC 1 consists of a gate area, main health centre and a satellite health centre, an oval, a programs and education area, a demountable building used as a visits area (for inmates in maximum security wings), the AVL area, staff offices and accommodation wings. The accommodation wings are arranged in a radial design around a courtyard. Each accommodation wing adjoins a concreted yard area. The laundry is located in MSPC 1 but is staffed by MSPC 3 inmates.

MSPC 2 has a separate gate area, a main health centre and a satellite health centre, staff offices and accommodation wings. The buildings are arranged around a large courtyard. The two largest wings, 3-wing and 4-wing, have adjoining concreted yard areas and inmates have scheduled access to the main courtyard area. The other wings are more enclosed, fenced off from each other, each with their own cells, common areas and outdoor spaces.

MSPC 3 contains a main health centre, programs and education building that includes a library, a visits area (for inmates in minimum security wings), staff offices, and accommodation wings. Each wing has an adjoining concreted yard area, except 18-wing which is separated by a fence from the rest of MSPC 3. A courtyard with a garden sits at the centre of the MSPC 3. It is also where most Corrective Services Industries (CSI) staff and workshops are located. Some industries (Technology, Print, Textiles and the Bakery) are situated at the border of the three areas but are staffed by MSPC 3 inmates. MSPC 3 has a gate, but this is only used for inmate visitors during scheduled weekend visit times. Staff and professional visitors access MSPC 3 via the MSPC 2 gate.

MSPC 1 gate, May 2024

MSPC 1, 10-wing exterior, May 2024

MSPC 2 grounds, August 2023

MSPC 3 courtyard, August 2023

2.2.2 Living conditions

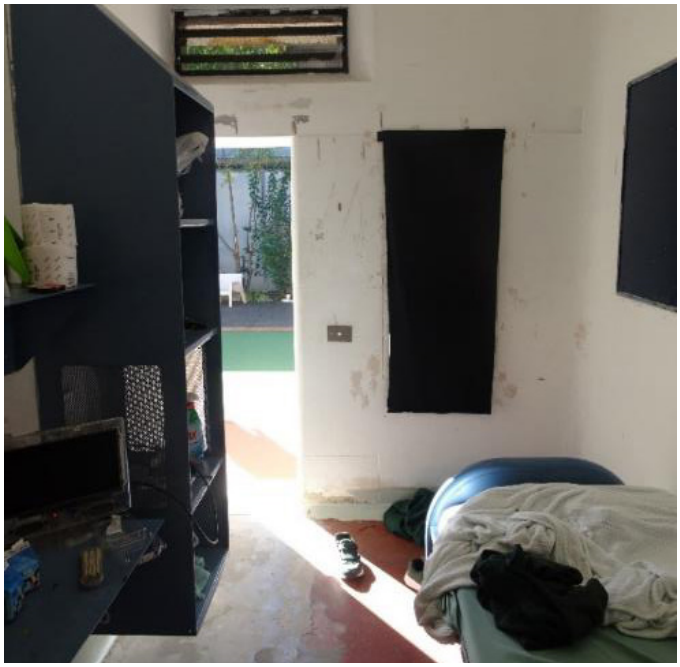
In all three areas of MSPC, most cells contain a bunk bed, toilet, sink and shelving. Most cells do not contain a shower and inmates use shared shower areas. Only cells in 1-wing, 5-wing, 6-wing, the SHU and the ISU, and one part of the KWU, have showers.

We observed ligature points in cells across MSPC. Consistent with their age (see section 2.2.3), cells were rundown and small, with little natural light or ventilation. The accommodation wings were susceptible to weather conditions and extreme temperatures. We observed mouldy walls, rusted furniture and evidence of vermin. The dimensions and doorways of most cells were too small to accommodate some mobility aids, meaning people relying on walking frames or wheelchairs had to leave these outside their cells and make do without them while they were secured in their cells.

MSPC 1, 7-wing cell, February 2024

MSPC 1, 11 wing (VOTP) cell, May 2024

MSPC 2, ISU camera cell, May 2024



MSPC 3, 15-wing cell, May 2024

MSPC 1, 7-wing yard, May 2024

MSPC 1, 10-wing yard, May 2024

MSPC 2, 3- and 4-wing yards, May 2024

MSPC 3, 16-wing yard, February 2024

Shower blocks across all areas were unsafe and in poor condition. In the MSPC 1 wings, the showers had no privacy barriers. The drainage was ineffective, causing flooding. Wet tiles were slippery and the floor mats had no grip, increasing rather than reducing the slip hazard. The MSPC 1 showers had no hot water for at least two days during our week-long inspection in May 2024. There were also damaged and broken tiles. This was particularly concerning in 7-wing as these showers were used by inmates placed in camera cells.

MSPC 1, 7-wing showers with broken tiles and slip hazards, May 2024

MSPC 1, 10-wing showers, February 2024

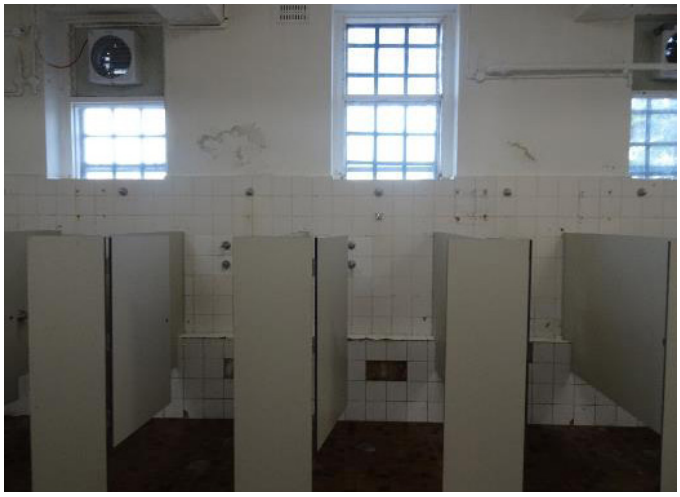
MSPC 1, 11-wing (VOTP) showers, May 2024

The shower blocks in MSPC 2 and MSPC 3 had privacy barriers but were otherwise poorly maintained, with broken and damaged tiles, uneven flooring, rust, mould, and general disrepair.

MSPC 2, 4-wing showers, May 2024

MSPC 2, ISU outdoor shower, February 2024

MSPC 3, 14-wing showers, May 2024



Condition of closed wings

During the inspection in May 2024, we observed the closed wings in MSPC. At that time the wings had been empty for several months, from February 2024. These wings were described as 'mothballed' and CSNSW instructed MSPC to leave them in a state that would allow for them to be reopened at short notice. Consequently, inmate clothing, mattresses, pillows, and linen were stored in cells and appliances and other common use objects were left in the wings.

Neither KWU nor 9-wing were in a fit state to be reopened without significant work. Despite having only been closed for just over three months, we found both wings to be filthy. There was evidence of one or more stray cats residing in KWU, including faeces and fur on the furniture. In both wings we observed dead cockroaches and rubbish. Perishable food was abandoned to rot in staff fridges. A toilet in a staff area had been urinated in and left unflushed, presumably for the period of the closure, creating a foul smell.

Some of the clothing and bedding stored in empty cells was damaged by the damp and dirty storage conditions. It was difficult to understand the decision to store so many high demand essentials in unsanitary conditions when they could have been used and may have helped mitigate shortages in other parts of MSPC. There was stock of other items including cleaning products, books and kettles that could have been put to good use, improving the living conditions of MSPC inmates.

Hard copy inmate records were abandoned in staff offices, including accommodation journals, identification cards, and movement orders. In the ACMU, this information included inmate behaviour management guidelines. Documents with inmate information that needed to be retained should have been accounted for and securely stored. Anything else should have been securely destroyed. Nothing should have been deserted in unused office space.

While we were on site in May 2024, a group of inmates was moved into the upper landing of 4-wing. This landing had been vacant for some time and was in a similarly poor condition to 9-wing and KWU. The cells and furniture were dirty and mouldy. Nothing was cleaned prior to the arrival of this group of inmates, which included aged and frail men who were unable to clean their cells themselves.

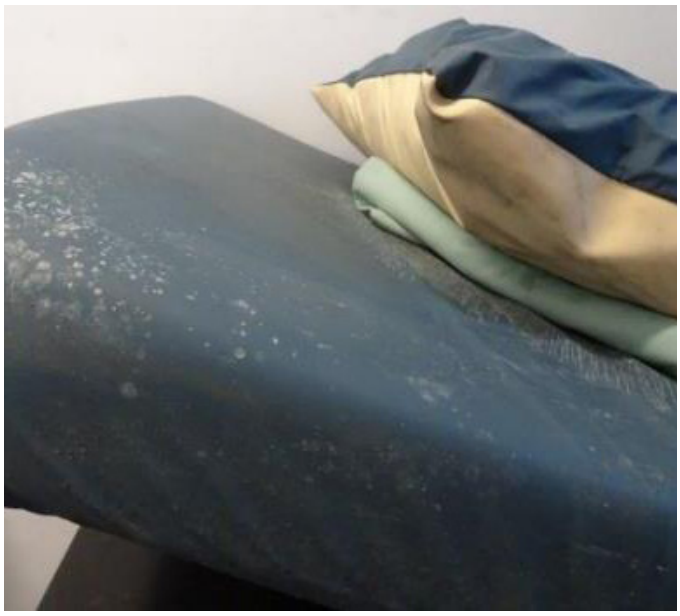
Given what occurred in 4-wing, we raised our concerns about the conditions of the closed wings with the governor of MSPC and emphasised that, should either 9-wing or KWU be reopened, they needed to be thoroughly cleaned. We were relieved that this feedback was actioned prior to the reopening of KWU in July 2024. During subsequent visits we found this unit to be very clean and tidy and noted that the hygiene issues we previously observed had been remedied.

Evidence of stray cats in the KWU, May 2024

9-wing cell, May 2024

9-wing storage, May 2024

Dirty, dilapidated cells on 4-wing upper landing on the day new inmates arrived, May 2024



2.2.3 Age of the MSPC infrastructure

We found the physical environment of MSPC to be cruel and degrading. The inability or failure to make modifications make it a particularly undignified and unsafe environment for aged and frail inmates, inmates with disability and inmates with serious health concerns. Due to the supports offered at MSPC and its proximity to Justice Health and Forensic Mental Health Network (JH&FMHN) services, LBH and Prince of Wales Hospital, it held a number of inmates who found the environment extremely challenging and unsuitable for their needs.

The facility now known as MSPC opened in 1909. Its age is evident in almost every inmate and staff area. The living conditions were substandard (see section 2.2.2) and aspects of the built environment created safety risks for inmates and staff (see section 2.4). This is a significant barrier for implementing a routine that supports inmate rehabilitation and reintegration, which requires decent living conditions and opportunities for purposeful activity like work, education, programs and exercise. Good initiatives will never fulfill their potential in a harsh and unsafe physical environment that lacks fit for purpose spaces for staff and inmates.

We consider the continued reliance on MSPC a reflection of a profound failure in estate planning. MSPC is an unsuitable location for intensive criminogenic programs and inmates with high needs due to disability, illness or age and frailty.

As highlighted in our previous reports, the 2016–17 NSW Budget included an investment of $3.8 billion over four years to create around 7,000 new beds in NSW correctional centres.[133] This included the construction of Clarence, Hunter and Macquarie correctional centres and additional maximum and minimum security accommodation for male inmates. We cannot understand why more of this funding was not utilised with the specific goal of decommissioning old and unfit infrastructure.

At MSPC there has been some investment in discrete projects. The SHU is an entirely new unit that opened in May 2018, at a cost of $2,837,172.20. The ACMU was refurbished, completed in March 2023 at a cost of $1,050,000 (excluding GST).[134] It is hard to understand this investment in the context of an otherwise derelict correctional centre.

Recommendation: CSNSW cease the practice of 'mothballing' 1800s and early 1900s infrastructure and commit to permanently closing MSPC.

133 NSW Government, 'NSW Budget: New Prisoner Beds, Record Corrections Funding' (Media Release, 16 June 2016).
134 Information provided by Corrective Services NSW, 27 February 2025.

2.3 Staffing

The staff profile for MSPC is outlined in Table 14.

Table 14: CSNSW staffing profile at MSPC[135]

Area	Position	Approved FTE
Custodial	Governor	1
	Manager of security (MOS)	1
	Functional managers (FM)	11
	Senior correctional officers (SCO)	51
	Correctional officers	196
CSI	Operations manager	1
	Manager of industries	2
	Manager of business unit	2
	Senior overseer	19
	Overseer	15
	Education services coordinator	2 (Complex-wide)
	Assessment and planning officer	4 (Complex-wide)
Offender Services and Programs (OS&P)	Senior services integration manager	1
	Manager of offender services and programs (MOSP)	1
	Services and programs team leader (SAPTL)	2
	Services and programs officer (SAPO)	9
	Senior psychologist	7
	Psychologist	32
Classification	Senior classification & placement officer	1
	Classification & placement officer (CAPO)	2
Case Management Unit (CMU)	Senior case management officer (senior CMO)	2
	Case management officer (CMO)	10
Administration	Business manager	1
	Finance and administration manager	1
	Senior finance manager	1
	Centre liaison officer	1
	Rosters clerk grade 3/4	4
	Clerk 3/4	2
	Clerk 1/2	7
	General scale clerks	5
Total		**394**

135 Information provided by Corrective Services NSW, 15 November 2024.

In early 2024, a redesign of Services and Programs was implemented across NSW correctional centres. This impacted psychologists and staff working in programs, classification and placement, and case management. Following the redesign:

- Staff are now embedded in either the community or custody, not working across both.
- Governors and standalone MOS' are accountable for inmate attendance to services and programs, including psychologist interventions and activities outlined in an inmate's case plan.
- Staffing structures vary depending on the size of the correctional centre. Psychology, case management, classification and placement and services and programs staff all report to a newly appointed senior service integration manager, service integration manager, or service integration team leader. These positions report to the governor or standalone MOS. Some MOSP positions have been deleted. At MSPC, a senior service integration manager was appointed.
- The FM case management continues to sit on local classification committees and maintains a relationship with the case management team.
- Clinical supervision of senior psychologists is provided by the chief psychologist.[136]

On 27 May 2024, MSPC had a total of 44 staff absences including 20 staff on short term sick leave, three staff on long term sick leave, 15 staff absent on worker's compensation and six staff were suspended. We were informed that, where possible, absences are filled with casual staff or overtime shifts. However, if these options are not available, lockdowns are implemented.

We reviewed two sets of Incident Reporting Modules (IRMs) from April to July 2023 and 2024. They included 34 restricted movement (lockdown) IRMs for the 2023 period and 56 for 2024, concerning single, multiple, or all the wings in MSPC. Short staffing significantly contributed to these numbers. On 10 occasions in the 2023 period and nine occasions in 2024, there were insufficient custodial staff to fill every custodial position. On six occasions in the 2023 period and 15 in 2024 staff redeployment to facilitate unscheduled medical escorts resulted in short staffing. Staff training, events and meetings also necessitated lockdowns to enable staff attendance.[137] Time out of cell and lockdowns are discussed in more detail in section 2.6.1

2.3.1 Workplace culture

We found MSPC staff to be respectful and facilitative of the inspection. However, we have concerns about the staff culture at MSPC, specifically in relation to staff attitudes towards inmates and standards of professionalism.

During the multiple periods we were on site in this inspection, we heard widespread reports of inmates being threatened, intimidated, and assaulted by custodial staff. Although we did not receive allegations of misconduct specific enough to refer for investigation, we heard consistent accounts that the Immediate Action Team questioned inmates in rooms with no CCTV coverage, with their body cameras turned off. While being questioned, staff allegedly threatened to spread rumours that the inmate was an informant. Some reports included allegations of inmates being assaulted by staff. We received these reports from different inmates in different areas of MSPC. Strikingly similar reports were made during separate conversations with different members of our inspection team.

In addition to this, we were told by inmates that correctional officers threaten them with negative case notes, that cells searches can be destructive and appear retributive, and that some staff use rude and unprofessional language towards inmates, such as 'putrids'. Similarly, staff reported that some correctional officers treat inmates poorly, including with name calling and threats. With respect to an inmate who was scheduled to be transferred to a different correctional centre, we heard a correctional officer comment 'Hopefully he tries to escape so they can shoot him'.

International human rights law and related instruments, including the ICS' *Inspection Standards for*

136 Information provided by Corrective Services NSW, 23 April 2024; Joint Deputy Commissioner's Memorandum, Security and Custody (2024/35) and Strategy and Governance (2024/05), *Functional Manager Role Change* (22 August 2024).
137 Information provided by Corrective Services NSW, 11 November 2023 and 15 November 2024.

Adult Custodial Services in New South Wales consistently affirm that inmates must be treated with respect and dignity.[138] This is also reflected in the *Crimes (Administration of Sentences) Regulation* (CAS Regulation) which provides that staff must not use insulting or abusive language to other staff, any inmates or any visitors to a correctional centre.[139] The relevant code of conduct for CSNSW staff further provides that employees 'demonstrate respect and courtesy towards inmates, offenders and detainees, even in difficult and challenging circumstances' and that 'intimidation, harassment, insults or abuse' are a breach of the code of conduct and may result in misconduct action.[140] Some of the conduct and language we observed and heard about during this inspection fell well below these requirements.

It is difficult to know with certainty what factors have helped develop and sustain these attitudes. We note that a number of staff at MSPC have worked in that location for most, if not all, of their careers. In these circumstances, unprofessional behaviour can become normalised, particularly when people have not experienced a different workplace.[141] Limited training offerings may have also impacted staff development. From 1 September 2022 to 31 August 2023, some staff undertook training in relation to batons and different firearms. In addition, 180 staff undertook Five Minute Interventions training, a course that aims to help staff have positive interactions with inmates.[142]

CSNSW has advised that the governor of MSPC emailed staff 'reminding them of the importance in [sic] respectful and professional interactions with all staff and inmates, and to refer to the CSNSW Code of Ethics and Conduct'.[143]

It should be noted that specific allegations made to the Inspector are referred to the appropriate body for assessment or investigation. As at 30 June 2024, Professional Standards and Investigation were investigating 30 MSPC staff in relation to 32 matters. There were 86 staff under assessment in relation to 80 matters. One staff member was on special leave and two were suspended from duty.[144]

2.3.2 Hybrid shift model

At the time of the inspection, MSPC was operating with a roster of 8-hour and 12-hour shifts. Different shift lengths were assigned to different posts. For example, custodial staff rostered to the MSPC 1 accommodation units worked 8-hour shifts and those placed in the MSPC 2 and 3 accommodation units worked 12-hour shifts.

MSPC staff told us that the hybrid shift model was not working. Most concerns centred around 12-hour shifts. Due to the length of time between working periods, managers had limited overlap with staff working 12-hour shift cycles creating barriers for training, proper handover, and incident-related follow-up. There were also concerns about fatigue due to the longer working days combined with lengthy commutes. For some posts, there was little benefit to having a 12-hour shift and there was not corresponding productivity for the additional working time.

Consequently, at the time of our week on site in May 2024, MSPC were in the process of developing a roster of 8-hour shifts. The draft roster had four fewer posts but more staff on duty during out of cell hours. Staff expressed mixed views about this draft roster due to different preferred working patterns.

We acknowledge that the hybrid shift model can create challenges for managers and the operations of correctional centres. However, we do not agree that 12-hours shifts are inherently problematic. Rather, we see the issue as relating to the introduction of 12-hour shifts via a hybrid rostering model. It appears CSNSW has directed correctional centres to adopt this approach but there has been

138 *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976) art 10; *United Nations Standard Minimum Rules for the Treatment of Prisoners*, GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016, adopted on 17 December 2015) rule 1; Inspector of Custodial Services, *Inspection Standards for Adult Custodial Services in New South Wales* (May 2020) standard 67.
139 *Crimes (Administration of Sentences) Regulation 2014* cl 249(1).
140 Department of Communities and Justice, *Code of Ethical Conduct* (version 1.0, 19 April 2021) 9.
141 *Special Commission of Inquiry into Offending by Former Corrections Officer Wayne Astill at Dillwynia Correctional Centre* (Final Report, February 2024) 391–5.
142 Information provided by Corrective Services NSW, 11 November 2023.
143 Information provided by Corrective Services NSW, 23 September 2025.
144 Information provided by Corrective Services NSW, 17 January 2025.

limited guidance on its overarching aims and implementation.

We consider that reverting to a roster of 8-hour shifts is not the solution. It is difficult to see how this would not impact the length of the purposeful day, the time available for service delivery and time out of cell, particularly in MSPC 2 and MSPC 3 which have more posts on 12-hour shifts than 8-hour shifts. In the 2022–23 financial year, NSW figures for time out of cell were among the lowest in Australia.[145] It seems unlikely this can improve with the widespread use of 8-hour shifts. We discuss time out of cell further in section 2.6.1.

Implementing 12-hour shifts across all custodial posts removes the challenges created by a hybrid shift model and supports prisoner rehabilitation by increasing opportunities for purposeful activity and minimising the detrimental impact of long periods locked in cells. In our report on Shortland Correctional Centre, we recommended that CSNSW implement standard 12-hour shifts for custodial staff. We reiterate that recommendation in this report.

Recommendation: CSNSW implement a 12-hour shift model for custodial staff.

2.4 Custody

2.4.1 Gate security

We found the gate security at MSPC to be extremely lax. Strong gate security is crucial for preventing the introduction of contraband or other unauthorised items into correctional centres and ensuring all staff and visitors are accurately identified and authorised to be on site.

The main points of entry into MSPC for staff and professional visitors are two separate gates in MSPC 1 and MSPC 2.[146] Gates for maximum security areas typically require staff and visitors to go through a metal detector and have their belongings scanned by an x-ray machine (similar to the checks conducted at an airport). Staff and visitors are identified before entry using a biometric scan of their eyes or fingerprints. The person's eyes or fingerprints are also scanned when they leave the correctional centre, creating a digital record of who is behind the secure perimeter and the period for which they were present.

The gates in MSPC 1 and MSPC 2 did not have a walk-through metal detector, x-ray machine or access to the biometric system. Instead, gate staff used a handheld metal detector (known as a wand) to check staff and visitors for metal objects. Visitors were also required to sign in and out of a paper-based logbook. No checks were conducted of the bags people were taking behind the secure perimeter.

Gates are not required to have a walk-through metal detector, x-ray machine or access to the biometric system. The policy makes provision for alternative procedures, respectively the use of a handheld metal detector, visual inspections of bags and belongings, and the maintenance of manual records of persons entering and exiting the correctional centre.[147] However, these alternatives are less effective and lack the precision and documentation offered by the technological systems available elsewhere. We were concerned that manual procedures were not being undertaken with the rigour required to consistently prevent the introduction of contraband. It was no surprise that the introduction of contraband was a significant issue at MSPC (see section 2.4.4).

During the health services inspection of MSPC, the correctional centre was locked down for around two hours due to a missing set of keys. It was later confirmed that a staff member had accidentally taken the keys home. CSNSW policy provides that correctional officers 'must not leave the correctional centre until all security keys have been accounted for and permission to cease duty

145 Productivity Commission, *Report on Government Services 2024: Justice (part C)* (29 January 2024) data table 8A.13. In 2022–23 in NSW, time out of cell was 9.4 hour per day for open custody and 7.0 hours per day for secure custody. In each category, these were the lowest figures in Australia. The total time out of cell was 7.6 hours per day, ahead of only Tasmania which recorded a total of 7.3 hours per day.

146 People attending in-person social visits with inmates at MSPC access the visits areas via different entry areas, not the gatehouses. This is discussed in section 2.6.9.

147 Corrective Services NSW, *Custodial Operations Policy and Procedures: 16.1 Correctional Centre Gates* (version 1.7, 17 July 2025) 8, 10.

has been granted' by the MOS or delegated officer. Keys must be accounted for before correctional officers cease duty. This is the responsibility of the gate keeper.[148]

Unusually for a correctional centre, staff were able to take food and drink from the Long Bay Café behind the secure perimeter of MSPC. Although the café is located on the Long Bay Correctional Complex it is not inside a correctional centre, meaning it is regarded as external. This is prohibited by the *Custodial Operations Policy and Procedures* (COPP) which provides that only drinks contained in sealed cans or bottles are permitted past the gate area and coffee or tea purchased from an external café (including a café on a correctional complex) should be regarded as opened and unsealed, and as such should not be permitted past the gate area.[149]

There does not appear to be a reason to exempt MSPC staff from these rules. Such poor compliance with the policy struck us as particularly high risk in the context of MSPC's antiquated gate security.

Recommendation: CSNSW review gate security at MSPC.

2.4.2 Strip searching

Legislation and policy on strip searching

The CAS Regulation provides that a correctional officer may search an inmate, the inmate's cell and the inmate's property.[150] Searches of an inmate or their cell 'must be conducted with due regard to dignity and self-respect and in as seemly a way as is consistent with the conduct of an effective search'.[151]

Inmates may be searched by way of a strip search or an electronic or x-ray scanning device.[152] A strip search may include:

- requiring the person to remove their clothes, and
- 'an examination of the person's body (but not of the person's body cavities) and of the clothes'.[153]

The COPP outlines the procedure correctional officers should follow when conducting a strip search. A strip search must be conducted by at least two correctional officers.[154] In summary, the correctional officers should:

- ensure the search area provides sufficient privacy and space for the search
- identify themselves, inform the inmate that they will be performing a strip search, provide the inmate with an opportunity to surrender any contraband or unauthorised property, and explain how the search will be conducted
- visually inspect the inmate's mouth, dentures (if applicable), ears and nostrils and search the inmate's hair
- instruct the inmate to empty their pockets and remove their shoes and socks and each item of clothing (one item at a time) and inspect each item and the soles of the inmate's feet.[155]

While the inmate is undressed, the correctional officers should:

> Instruct the inmate to:
>
> - stand with feet shoulder width apart
> - place their hands (palms down) out front with their fingers spread, and then turn the palms

148 Corrective Services NSW, *Custodial Operations Policy and Procedures: 16.1 Correctional Centre Gates* (version 1.7, 17July 2025) 15.
149 Corrective Services NSW, *Custodial Operations Policy and Procedures: 16.1 Correctional Centre Gates* (version 1.7, 17 July 2025) 10.
150 *Crimes (Administration of Sentences) Regulation 2014* cl 46(1).
151 *Crimes (Administration of Sentences) Regulation 2014* cl 46(3).
152 *Crimes (Administration of Sentences) Regulation 2014* cl 46(1)(a).
153 *Crimes (Administration of Sentences) Regulation 2014* cl 46(5).
154 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 11.
155 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 11–13.

> of their hands upwards to allow for a visual inspection of their hands
>
> - raise their arms up above their head to allow for visual inspection of their underarms
>
> **Conduct a visual inspection of the buttocks and pubic regions. Instruct the inmate to:**
>
> - **lift their penis then the scrotum and**
> - **abdomen or skin folds, if applicable.**
>
> **An officer may only instruct an inmate to bend over, squat or part their buttocks as part of a search, if there is reasonable suspicion at the time of the search that the inmate has something secreted in that part of their body.**
>
> If this occurs, a report to the Governor must be submitted detailing the reason why this type of search was conducted and the results of the search ...[156]

Strip searches at MSPC were particularly invasive

Inmates at MSPC were being instructed by correctional officers to pull back their foreskins during strip searches. We heard multiple complaints about this practice during the inspection by inmates, across all areas of MSPC. It had also been raised by inmate delegates in Inmate Development Committee (IDC) meetings. Staff acknowledged to us that this practice was occurring. We were informed that staff had been directed to cease this practice. However, it was unclear if staff were following this direction. We also heard complaints about other invasive strip search practices, including correctional officers instructing inmates to 'squat and cough' and using a torch to visually examine the anus/between their buttock cheeks while they were spreading their buttock cheeks.

We condemn the practice of directing inmates to pull back their foreskins or 'squat and cough' during strip searches in the strongest possible terms. Such searches breach the legislation and policy. These practices are offensive and degrading.

Strip searching should be conducted in strict compliance with the processes outlined in the legislation and policy. It should never be more invasive than what is explicitly permitted.

CSNSW acknowledge staff directing inmates to pull back their foreskins during strip searches is not appropriate and that it does not support this practice.[157] Following this inspection, CSNSW included an explicit prohibition in relevant chapters of the COPP, which now state that an inmate 'must never be asked to roll back their foreskin as part of a strip-search'.[158] Where contraband is suspected to be concealed under the foreskin, this should be treated as an internal concealment of contraband and inmates referred to health staff for clinical assessment.[159] We welcome these updates to the COPP.

These issues speak to broader deficiencies with the legislation and policy for strip searching inmates. The legislation does not define the terms 'examination' or 'body cavity'. The policy does not refer to the legislative definition of a strip search or, aside from the most recent update, outline prohibited practices. It provides no indication of what circumstances may give rise to a 'reasonable suspicion' that a person is hiding contraband between their buttock cheeks. It offers multiple options for searching this part of the body but no guidance on choosing the most appropriate for the circumstances. In our view, this lack of precision allows too much scope for interpretation by CSNSW and individual staff.

From May to August 2024, six reports of searches where inmates were required to 'bend over, squat or part their buttocks' were provided to the governor of MSPC.[160] The circumstances described in these reports were vague, referring to unspecified intelligence or possibility, which in our view does

156 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 13 (emphasis added).
157 Information provided by Corrective Services NSW, 23 September 2025.
158 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 13; Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.4 Internal Concealment of Contraband* (version 1.3, 17 July 2025) 4.
159 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 13–14.
160 Information provided by Corrective Services NSW, 18 November 2024.

not meet the threshold of a reasonable suspicion. This strongly suggests there is a need for greater guidance. Our review of IRMs from this period identified three instances of contraband suspected or found either between the buttocks or internally concealed with no corresponding report to the governor.[161] This suggests that the reporting requirement is performed inconsistently and this type of search may be more prevalent than indicated by reports submitted to the governor.

Some of the descriptions of searches in IRMs where inmates appeared to have internally concealed contraband (not outside the body between the buttocks) suggested CSNSW policy and procedure was not always followed, placing inmates at risk. In one instance, an inmate was directed by searching officers to remove an internally concealed item. The policy clearly states that inmates suspected of internally concealing contraband should be 'clinically assessed to determine possible threats to their health'.[162] Greater internal oversight of searching practices is needed.

CSNSW should record the reasons for strip searches

Beyond IRMs and reports to the governor, there is no record or register of strip searches. IRMs do not provide a complete record of the number of routine and targeted strip searches undertaken in a correctional centre and across the NSW custodial system.

The Mandela Rules provide that:

> For the purpose of accountability, the prison administration shall keep appropriate records of searches, in particular strip and body cavity searches and searches of cells, as well as the reasons for the searches, the identities of those who conducted them and any results of the searches.[163]

The lack of a strip search register makes monitoring compliance with the legislation and policy concerning strip searching extremely difficult. In previous reports, we have recommended that reasons for strip searches be recorded.[164] CSNSW have claimed that this would place an administrative burden on staff.[165] We do not accept this explanation.

The need for strip searching should have greatly reduced following the introduction of body scanners across NSW custodial settings, although we note that they were not in use for a period in 2024 due to an industrial dispute. Typically, a strip search should only be necessary where 'body scanning is unavailable or impractical, or when the body scan indicates the presence of contraband'.[166] Strip searches are intrusive and can be misused to harass and intimidate people in custody. There should be a record that enables review to ensure that they are only undertaken when strictly necessary and in accordance with legislation and policy. Transparency and accountability with respect to fundamental rights should be regarded as a priority, not a burden.

Recommendation: CSNSW review the legislation and policy regarding strip searching and ensure strip search practices comply with legislation.

Recommendation: CSNSW implement effective accountability and monitoring processes in relation to strip searching, including maintaining a record of reasons for strip searches.

2.4.3 Assaults and fights

Data and information we obtained in relation to assaults and fights in MSPC suggest that MSPC 1 is a particular safety and security concern. It also suggests that the closure of 9-wing and the reduction of the size of the MSPC 1 population has not improved safety and security within MSPC 1.

161 Information provided by Corrective Services NSW, 15 November 2024.
162 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.04 Internal Concealment of Contraband* (version 1.3, 17 July 2025) 4.
163 *United Nations Standard Minimum Rules for the Treatment of Prisoners*, GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016, adopted on 17 December 2015) rule 51.
164 Inspector of Custodial Services, *Inspection of Wellington Correctional Centre 2022* (Report, May 2024) recommendation 15; Inspector of Custodial Services, *Inspection of Shortland Correctional Centre and Cessnock Correctional Centre* (Report, June 2024) recommendation 10.
165 Inspector of Custodial Services, *Inspection of Shortland Correctional Centre and Cessnock Correctional Centre* (Report, June 2024) 31.
166 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 4; Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.5 Body Scanning* (version 1.9, 17 July 2025) 5.

In the 12 months from 1 September 2022 to 31 August 2023, there were three assaults on staff and 86 assaults on inmates (in which the victim was injured).[167] In the subsequent 12-month period from 1 September 2023 to 31 August 2024, there were nine assaults on staff and 86 assaults on inmates.[168]

A sample of IRMs obtained from MSPC for the four months from 1 April to 31 July 2023 included 19 assaults on inmates. Of these:

- Most of the reported assaults occurred in MSPC 1 (11).
- Most assaults came to the attention of staff after the incident (at least 11 of the 19 reports).
- Assaults frequently occurred in the yards (eight in total, seven of which were in the MSPC 1 yards) or in cells (six in total).
- Three assaults resulted in a hospital escort.[169]

A corresponding sample of IRMs from 1 April to 31 July 2024 also included 19 assaults on inmates. Of these:

- Most of the reported assaults occurred in MSPC 1 (14).
- Most were observed by staff at the time of the incident (at least 10 of the 19 reports).
- Assaults frequently occurred in the yards (five in total, at least four of which occurred in MSPC 1) or shower areas (five in total, all in MSPC 1).
- Five assaults resulted in a hospital escort.[170]

The 2023 sample also included 15 IRMs of fights among inmates, nine of which occurred in MSPC 1. Almost half of the reported fights occurred in the MSPC 1 yards (seven in total). Three fights resulted in a hospital escort.[171] Similarly, the 2024 sample included 14 IRMs of fights among inmates, seven of which occurred in the MSPC 1 yards. Two fights resulted in a hospital escort.[172]

Consistent with the number of fights and assaults occurring in MSPC 1, the IRMs we reviewed suggested there were a significant number of gaol-made weapons in this area. This suggests inmates are arming themselves as they do not feel safe. Of the 50 reports in the 2023 sample related to contraband finds (some of which included multiple items or types of contraband), there were 14 IRMs concerning weapons, usually gaol-made knives (11 of the 14 reports). Most weapons were found in MSPC 1 (nine reports).[173] Similarly, in the 2024 sample, 18 of 88 contraband IRMs related to weapons. Most weapons were gaol-made knives (16 of the 18 reports, with a total of 23 gaol-made knives located) and were found in MSPC 1 (13 of the 18 reports, with a total of 17 gaol-made knives located).[174]

CSNSW has advised that staff 'make every effort to prevent contraband being introduced to the centre', including daily cell searches, targeted searches, searching inmates returning from work, use of body scanners and assistance from the Security Operations Group.[175]

2.4.4 Drugs and other contraband

Drugs and drug paraphernalia

In the 12 months from 1 September 2022 to 31 August 2023, there were 78 random (9% positive), 57 targeted (47.4% positive) and 362 program-related (3.9% positive) urinalysis tests conducted at MSPC. The most common drug detected was buprenorphine. This is consistent with drug-related contraband finds. During this period buprenorphine was the most frequently found drug (28 of 56

167 Information provided by Corrective Services NSW, 17 November 2023.
168 Information provided by Corrective Services NSW, 17 January 2025.
169 Information provided by Corrective Services NSW, 11 November 2023.
170 Information provided by Corrective Services NSW, 15 November 2024.
171 Information provided by Corrective Services NSW, 11 November 2023.
172 Information provided by Corrective Services NSW, 15 November 2024.
173 Information provided by Corrective Services NSW, 11 November 2023.
174 Information provided by Corrective Services NSW, 15 November 2024.
175 Information provided by Corrective Services NSW, 23 September 2025.

drug-related contraband finds). Other drugs found included prescription medication (8) and tobacco/cigarettes (10 in total).[176]

Drug-testing notably increased in the 12-months from 1 September 2023 to 31 August 2024. During this period MSPC conducted 96 random (4.2% positive), 126 targeted (34.9% positive) and 388 program-related (7% positive) urinalysis tests. Again, the most common drug detected was buprenorphine. This was consistent with drug-related contraband finds, with buprenorphine being the most frequently found drug (58 of 155 drug-related contraband finds). Other drugs found included tobacco (23), prescription medication (18) and cigarettes (15).[177]

The sample of IRMs for the four-month period from 1 April to 31 July 2023 included 50 reports related to contraband finds (some of which included multiple types and items of contraband). Of these, 17 IRMs concerned drugs and 12 concerned drug paraphernalia. Of the 17 IRMs related to drugs, nine concerned buprenorphine strips, four concerned brown vegetable matter/tobacco and six concerned medication that had been hoarded or prescribed for a different person. The most frequently located type of drug paraphernalia was gaol-made syringes (eight of 12 IRMs).[178]

The sample of IRMs from 1 April to 31 July 2024 detailed an increase in search activity, including coordinated search operations. This was reflected in the volume of contraband-related IRMs. In this period there were 88 IRMs related to contraband finds (some of which included multiple types and items of contraband). Of these, 30 concerned drugs and 27 concerned drug paraphernalia. Of the 30 IRMs related to drugs, 10 concerned the location of buprenorphine strips, nine concerned brown vegetable matter/tobacco, and eight concerned medication that had been hoarded or prescribed for a different person. The most frequently located types of drug paraphernalia were gaol-made syringes (10 of 27 IRMs), smoking implements (nine IRMs) and medical syringes (eight IRMs).[179]

There were notable trends in the types of drug-related contraband across the different areas of MSPC. The drugs and drug paraphernalia found in MSPC 3 more frequently concerned tobacco/brown vegetable matter and smoking-related items. Buprenorphine and syringes were more commonly located in MSPC 1 in both the 2023 and 2024 samples:

- Of the 17 IRMs detailing drug contraband finds in 2023, 11 occurred in MSPC 1, including eight related to buprenorphine. Of the 30 IRMs detailing drug contraband finds in 2024, 13 occurred in MSPC 1, including nine related to buprenorphine.
- Of the 12 IRMs concerning drug paraphernalia contraband finds in 2023, eight occurred in MSPC 1, including seven related to gaol-made syringes. Of the 27 IRMs concerning drug paraphernalia contraband finds in 2024, 12 occurred in MSPC 1, including seven related to gaol-made syringes.[180]

Other contraband

In both the 2023 and 2024 samples, after drugs and drug paraphernalia, the most common item of contraband located at MSPC was weapons, with 14 IRMs in 2023 and 18 IRMs in 2024 (see section 2.4.3). Tattoo equipment including gaol-made tattoo guns and stencils and alcohol (gaol-made brew) were also regularly located.[181]

We were alarmed at some of the other items located when we reviewed contraband IRMs. In March 2023, a CSNSW issued 911 tool was located hidden in an inmate's cell. These tools have a curved, metal blade and are used by officers to cut material that may be harming an inmate, such as a hanging ligature. In its original form it cannot be used to slash or stab. However, it is not unusual in correctional environments for seemingly innocuous items to be fashioned into weapons or used in ways that can create a safety and security risk. Metal items can be particularly dangerous if used in a way that was not intended.

176 Information provided by Corrective Services NSW, 17 November 2023.
177 Information provided by Corrective Services NSW, 17 January 2025.
178 Information provided by Corrective Services NSW, 11 November 2023.
179 Information provided by Corrective Services NSW, 15 November 2024.
180 Information provided by Corrective Services NSW, 11 November 2023 and 15 November 2024.
181 Information provided by Corrective Services NSW, 11 November 2023 and 15 November 2024.

CSNSW policy requires that all correctional officers whose duties involve contact with inmates must carry a 911 tool for the duration of their shift. Additional tools should be stored in places accessible to correctional officers in inmate accommodation areas. Each correctional centre is required to implement a local operating procedure assigning responsibilities for the issue and return of 911 tools to relevant correctional officers.[182]

From April 2025, in response to coronial inquests into unnatural deaths in custody, correctional centres began providing each custodial staff member in contact with inmates with a personally issued 911 tool.[183] This will hopefully ensure that all relevant custodial staff have access to a 911 tool if needed and the timely identification of any lost or misplaced 911 tools. CSNSW has confirmed that MSPC staff have been issued with their own 911 tools.[184]

In July 2023, several cell searches located drawings of children, described in the IRMs as appearing to be 'child pornography'.[185] It was unclear from the IRMs if these items were reported to the NSW Police. In the 2024 sample, three IRMs detailed the location of pornographic material, although this was apparently not child sex abuse material.[186] As at 31 August 2024, the most serious alleged or proven offence for more than half the inmates at MSPC (358 of 673) was sexual assault and related offences.[187] In this context, the creation and distribution of pornographic material needs to be closely monitored.

CSNSW has advised that MSPC ensures close monitoring of inmates though daily cell searches and examining inmate mail. If found, contraband will be removed and the inmate will be charged accordingly.[188]

In the 2024 sample, 10 IRMs related to electronic items including tablet and tablet chargers. There were also four IRMs concerning tools, including screwdrivers and a paint scraper.[189] This suggests a need for improved accountability measures for these items. Inmate tablets are expensive and hoarding can result in some inmates missing out. Tools have obvious potential to be used as weapons. There need to be systems in place to ensure that missing items of this nature are identified without delay, not when they are discovered during cell searches.

2.4.5 Use of force

The sample of IRMs from 1 April to 31 July 2023 included 28 incidents in which force was used. Of these, 15 occurred in MSPC 2, including seven in the ISU and four in the SHU, and 11 occurred in MSPC 1. Two involved the use of chemical munitions.[190] For the same period in 2024, there were 24 use of force IRMs. Of these 16 occurred in MSPC 1 and six occurred in MSPC 2. One involved the use of chemical munitions.[191]

We were pleased to observe improvements in the standard of reporting across the two samples. The 2024 IRMs provided more clarity on any action required following the use of force such as referral to the Use of Force Review Committee or local remedial action where there was scope for learning and improvement.

However, we have concerns about the effective use of body-worn cameras by MSPC custodial staff. There was no body-worn camera footage recorded for three of the 28 IRMs that we reviewed from the 2023 period or for six of the 24 IRMs from the 2024 period.[192] In some reports it was noted that, although there was some body-worn camera footage, some staff had failed to activate their body-

182 Corrective Services NSW, *Custodial Operations Policy and Procedures: 5.3 Musters, Let-go and Lock-in* (version 1.3, 18 August 2023) 9–10.
183 Deputy Commissioner Security and Custody, *Deputy Commissioner's Memorandum: Order 911 Rescue Tool (911 RT) for Personal Issue of Custodial Staff* (2025/09, 2 April 2025).
184 Information provided by Corrective Services NSW, 23 September 2025.
185 Information provided by Corrective Services NSW, 11 November 2023.
186 Information provided by Corrective Services NSW, 15 November 2024.
187 Information provided by Corrective Services NSW, 17 January 2025.
188 Information provided by Corrective Services NSW, 23 September 2025.
189 Information provided by Corrective Services NSW, 15 November 2024.
190 Information provided by Corrective Services NSW, 11 November 2023.
191 Information provided by Corrective Services NSW, 15 November 2024.
192 Information provided by Corrective Services NSW, 11 November 2023 and 15 November 2024.

worn cameras. Where a reason was provided, the lack of footage was explained as being due to human error or the spontaneity of the incident.

We reviewed a sample of use of force packages, including footage. In each instance there was either no body-worn camera footage at all or no body-worn camera footage of the actual incident as the cameras were not activated until after the initial use of force. CCTV footage of the incidents did not provide conclusive support of the version of events provided in the incident reports. This is highly problematic when inmates contest the justification for the use of force and makes it impossible to verify if force was properly used.

In some of the instances we reviewed, force was used as a result of interactions that took place during pat searches of inmates in MSPC 1. Due to the prevalence of contraband in MSPC 1, a random sample of inmates were being pat searched during 'let-go'. It is unsurprising that incidents may arise in these circumstances. Routinely activating body-worn cameras during pat searches would ensure that footage and audio of the entirety of any incidents are captured for review.

During our time on site at MSPC, we observed staff wearing body-worn cameras attached to their belts, rather than the chest area. We have serious concerns about the quality of footage and audio captured from this angle. Staff should be directed to wear their body-worn cameras on their chest area to ensure footage and audio are properly recorded. This was raised immediately with the governor.

Recommendation: CSNSW instruct custodial staff on the use of body-worn cameras, including that they must be worn on the chest area and must be turned on during searches and incidents.

2.4.6 Inmate discipline

The *Crimes (Administration of Sentences) Act 1999* (CAS Act) and CAS Regulation provide the framework for correctional centre discipline and penalties for disciplinary breaches.[193] The top five institutional offences from 1 September 2022 to 31 August 2023 are detailed in Figure 9 and from 1 September 2023 to 31 August 2024 in Figure 10, showing a significant increase in drug charges.

Figure 9: Institutional offences, 2022–23[194]

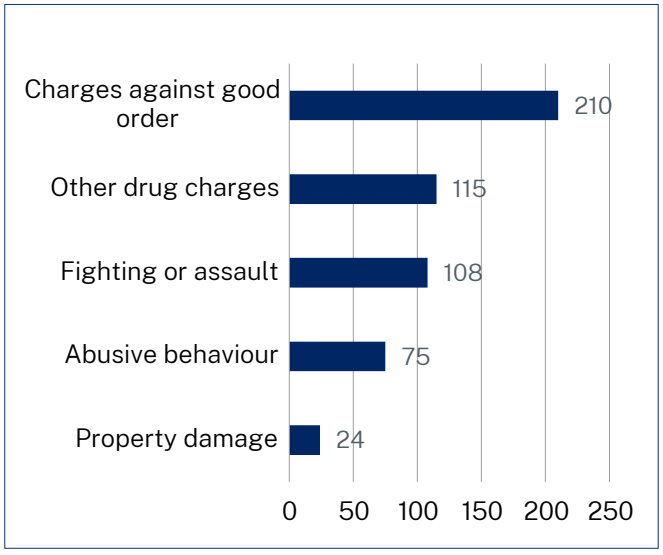
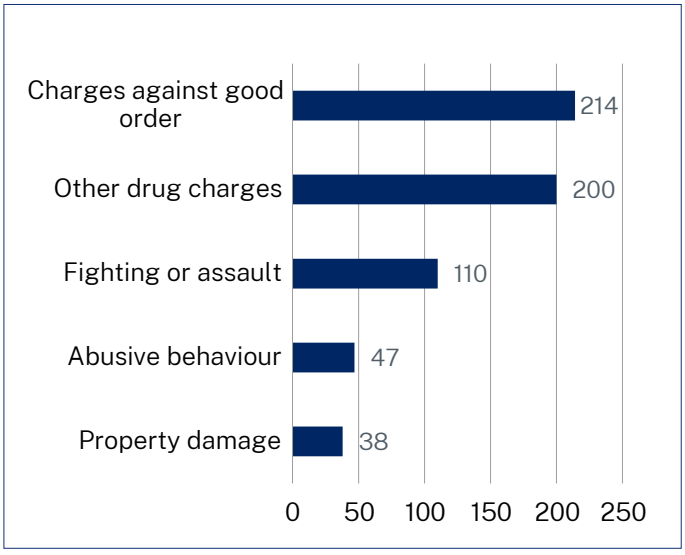


Figure 10: Institutional offences, 2023–24[195]



We reviewed a sample of adjudication paperwork relating to alleged breaches of correctional centre regulations at MSPC from April to July 2024. This sample included 109 adjudications for 120 alleged offences. The most common alleged offence was fighting/physical combat (18 charges), followed by refuse/fail to supply drug test sample (14 charges), intimidation (12), phone breaches (9), possession of drugs (9) or drug implements (8) and assault (7).[196]

193 *Crimes (Administration of Sentences) Act 1999* pt 2, div 6; *Crimes (Administration of Sentences) Regulation 2014* pt 6.
194 Information provided by Corrective Services NSW, 17 November 2023.
195 Information provided by Corrective Services NSW, 17 January 2025.
196 Information provided by Corrective Services NSW, 18 November 2024.

In all cases, inmates were found guilty, although we note there were two cases where the outcome was unclear due to incomplete paperwork. In eight cases, a guilty plea was entered despite recorded comments from inmates suggesting they disputed the charge. In a further six cases, the inmate pleaded not guilty. The basis for finding these inmates guilty beyond a reasonable doubt, as required by the CAS Act,[197] was unclear in all but one of these cases (where the offending was captured on CCTV).[198]

Figure 11 provides the penalties imposed for the top five institutional offences from 1 September 2022 to 31 August 2023 and Figure 12 provides this information from 1 September 2023 to 31 August 2024.

Figure 11: Penalties, 2022–23[199]

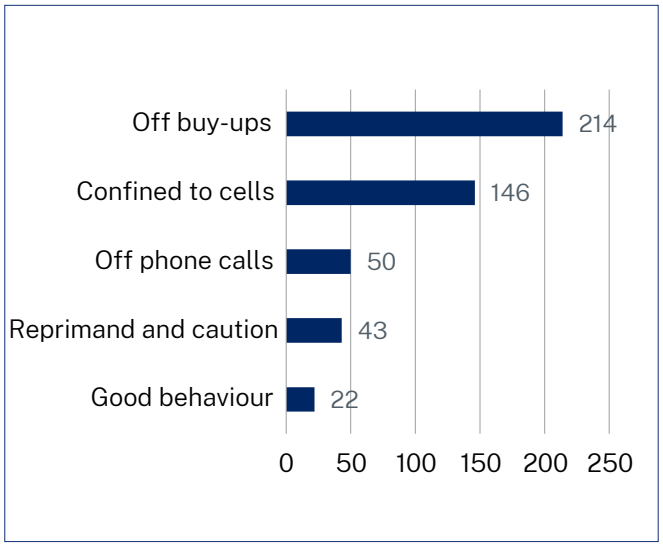
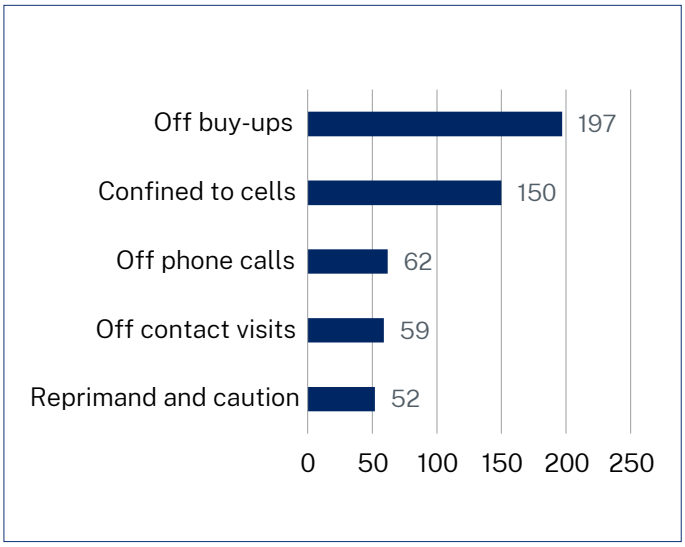


Figure 12: Penalties, 2023–24[200]



In the sample of adjudication paperwork we reviewed, 119 penalties were imposed for institutional offences. The most frequently used penalty was the withdrawal of access to buy-up purchases (off buy-ups) which was imposed on 45 occasions, followed by confinement to cell[201] (22), withdrawal of access to contact visits (20), reprimand and caution[202] (17), and withdrawal of phone access (off phone calls) (9).[203]

We have concerns about the imposition of penalties for correctional centre offences at MSPC. CSNSW policy provides that the inmate discipline checklist must be completed before an inmate is confined to cell as a penalty for a correctional centre offence. This checklist helps ensure staff identify any vulnerabilities that must be considered when determining if cell confinement is an appropriate penalty.[204] In the sample we reviewed, the inmate discipline checklist had only been completed for six of the 22 occasions this penalty was imposed.[205]

The sample we reviewed also included examples of inmates being charged with multiple correctional centre offences and receiving multiple penalties for a single breach. We acknowledge that this occurred in a small number of instances. The CAS Act provides that 'one (but not more than one)' penalty may be imposed where an inmate is guilty of a correctional centre offence.[206] The NSW Ombudsman has highlighted that the practice of charging an inmate with multiple offences for

197 *Crimes (Administration of Sentences) Act 1999* s 53(1).
198 Information provided by Corrective Services NSW, 18 November 2024.
199 Information provided by Corrective Services NSW, 17 November 2023.
200 Information provided by Corrective Services NSW, 17 January 2025.
201 *Crimes (Administration of Sentences) Act 1999* s 53(1)(c).
202 *Crimes (Administration of Sentences) Act 1999* s 53(1)(a).
203 The *Crimes (Administration of Sentences) Act 1999* s 53(1)(b) permits the removal of 'withdrawable privileges' as a penalty for a correctional centre offence. Withdrawable privileges are defined in the *Crimes (Administration of Sentences) Regulation 2014* cl 163 and include the ability to purchase goods, participation in contact visits and use of the telephone (except calls to legal practitioners and exempt bodies).
204 Corrective Services NSW, *Custodial Operations Policy and Procedures: 14.1 Inmate Discipline* (version 1.2, 9 August 2024) 12, 16.
205 Information provided by Corrective Services NSW, 18 November 2024.
206 *Crimes (Administration of Sentences) Act 1999* s 53(1).

the same conduct enables staff to circumvent this limitation.[207] To address these concerns, the NSW Ombudsman recommended that CSNSW develop a tool to assist delegates with selecting correct offences and develop guidelines and criteria for applying penalties.[208] We support these recommendations.

We also noted the number of times access to phone calls and contact visits were withdrawn both in the sample we reviewed and in the 12 months of data from 1 September 2023 to 31 August 2024 (see Figure 12). CSNSW policy provides that contact visits and telephone call privileges should 'only be withdrawn as a last resort'.[209] However, there is no other guidance on when these 'last resort' penalties would or would not be justified. In its response to the NSW Ombudsman's investigation into inmate discipline, CSNSW conceded that it is likely more staff training is needed on this issue.[210] Implementing the NSW Ombudsman's recommendation on the development of guidelines and criteria for applying penalties would also assist.

CSNSW has advised that, following the NSW Ombudsman's investigation, it is:

> committed to reforming inmate discipline systems. Initial reform will focus on improving compliance with currently applicable legislation and policy and, in due course, a comprehensive review of the policy and legislative framework will consider more substantial system-level reform.[211]

2.4.7 Segregated Housing Unit

SHU, May 2024

SHU cell, August 2023

PRNA inmates and those subject to segregation orders are placed in the SHU. At the time of the inspection, inmates subject to 'separation orders' under section 78A of the CAS Act were also placed in the SHU. However, staff have since been advised that section 78A does not provide a power to separate inmates and cannot be used for this purpose. Protective custody or segregation orders should be considered for inmates requiring separation from the rest of the inmate population for 'care, control or management'.[212] CSNSW has advised that it is reviewing the implementation of the communication provided to staff to ensure it is compliant with legislative requirements.[213]

The SHU consists of 10 single cells, including one accessible cell, each of which contains a bed, shower, toilet, desk and have a secure rear yard for time out of cell. All cells contain CCTV cameras.

207 NSW Ombudsman, *Investigation into Inmate Discipline in NSW Correctional Centres: A Special Report under Section 31 of the Ombudsman Act 1974* (Report, 21 August 2024) 49.
208 NSW Ombudsman, *Investigation into Inmate Discipline in NSW Correctional Centres: A Special Report under Section 31 of the Ombudsman Act 1974* (Report, 21 August 2024) recommendations 5 and 13.
209 Corrective Services NSW, *Custodial Operations Policy and Procedures: 14.1 Inmate Discipline* (version 1.2, 9 August 2024) 15.
210 NSW Ombudsman, *Investigation into Inmate Discipline in NSW Correctional Centres: A Special Report under Section 31 of the Ombudsman Act 1974* (Report, 21 August 2024) 34.
211 Information provided by Corrective Services NSW, 23 September 2025.
212 Deputy Commissioner Security and Custody, *Deputy Commissioner's Memorandum: Changes to Separation of Inmates for Safety or Protection* (2024/52, 19 December 2024).
213 Information provided by Corrective Services NSW, 23 September 2025.

Inmates in the SHU are managed by way of a weekly, multidisciplinary review meeting. We observed the meeting during our week on site in May 2024. The meeting was attended by the governor, MOS, relevant FMs and SCOs, a senior CAPO, the MSPC 2 health centre nursing unit manager (NUM), a SAPTL, psychologist and the regional Aboriginal pathways officer (RAPO). The meeting reviewed seven inmates.

We were concerned that one inmate was in the SHU without a relevant order. He had been subject to a segregation order that had expired several days prior to the meeting. He apparently remained in the SHU without an order because he was scheduled to be transferred to a different correctional centre on the day of the meeting, however this transfer was delayed. During the meeting the governor directed that the inmate be placed on a section 78A separation order until the transfer took place.

Nobody should be subject to a restricted regime like that in the SHU for any period, even a few days, without a valid order. The CAS Act and CSNSW policy provide mechanisms for oversight of inmates on segregation and protective custody orders. If the order is not in place, this monitoring will not occur and records of the length of a person's separation from the general population will be inaccurate. All staff must be aware, and regularly reminded, of the importance of maintaining proper orders and records.

2.5 JH&FMHN services

Compared with other male correctional centres, MSPC has larger numbers of complex patient cohorts, including higher acuity mental health patients, aged and frail patients, patients with intellectual disability and patients on medical hold because they have complex and/or serious health issues requiring ongoing access to specialist outpatient services. We found there was a fairly high demand for health services and it was evident MSPC health staff were effective and committed to managing these complex patients.

2.5.1 Health centre infrastructure

Each area of MSPC has a health centre. MSPC 1 and MSPC 2 have additional smaller satellite health centres. The health facilities available at MSPC are detailed in Table 15.

Table 15: MSPC health facilities[214]

Area	Capacity[215]	Facilities
MSPC 1 main health centre	5 inmates	1 consultation room 2 treatment rooms 1 observation cell with a camera
MSPC 1 satellite health centre	2 inmates	1 treatment room
MSPC 2 main health centre	3 inmates	2 consultation rooms 1 treatment room
MSPC 2 satellite health centre (ASU)	2 inmates	1 consultation room 1 treatment room
MSPC 2 satellite health centre (SHU)	1 inmate	1 consultation room
MSPC 3 health centre	4 inmates	1 consultation room 3 treatment rooms 1 dental suite

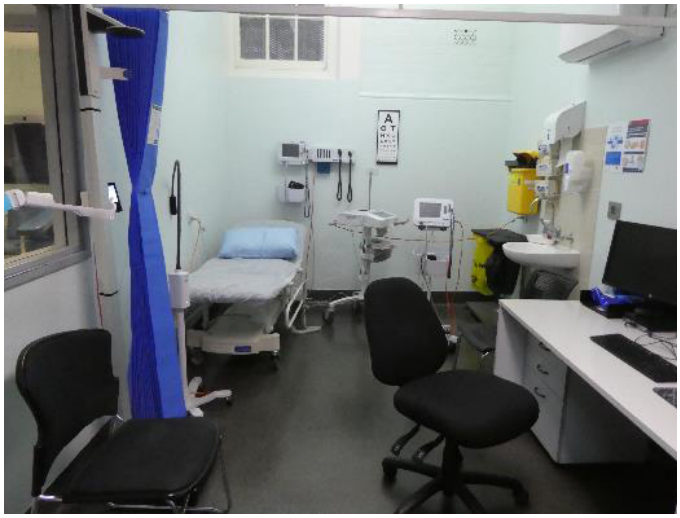
214 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.
215 The maximum number of inmates that can be present in a health centre at a time is subject to a centre-level agreement with CSNSW: Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.

All treatment and consultation rooms in the MSPC health centres have myVirtualCare facilities, a videoconferencing platform for secure virtual consultations between patients and health professionals.[216]

Generally, the health centres were sufficiently equipped to meet patient demand for health services, although staff across areas agreed that they would easily make use of additional consultation or treatment rooms if they were available.

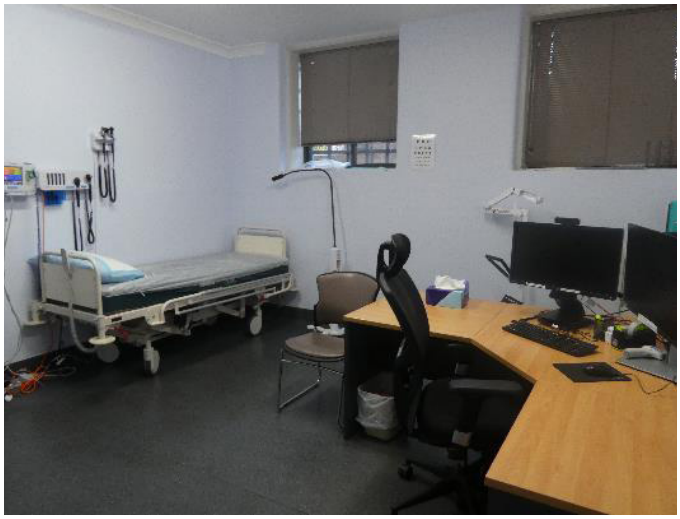
We found the health centres at MSPC to be in good condition. The main health centres were clean and well-maintained. The satellite health centres in MSPC 2 were also in good condition. However, the satellite health centre in MSPC 1 was dirty and untidy and had not been cleaned for several months. This area had been managed by LBH as part of the KWU. Following the closure of the KWU, there was no clear line of responsibility for its maintenance, even though it was still used for medication and OAT administration to some MSPC 1 patients. The reopening of the KWU has likely addressed this gap.

MSPC 1 health centre, April 2024



MSPC 2 health centre, April 2024

MSPC 3 health centre, May 2024



216 'myVirtualCare', *eHealth NSW* (Web Page, undated) <https://www.ehealth.nsw.gov.au/solutions/virtual-care/consultations/myvirtualcare>.

2.5.2 Staffing and operations

Staffing establishment

The staffing establishment of each MSPC health centre is detailed in Table 16. The operating hours and rostering arrangements are shown in Table 17.

Table 16: MSPC health centre staffing establishments[217]

Position	MSPC 1	MSPC 2	MSPC 3
NUM	1.0 FTE	1.0 FTE	1.0 FTE
Registered nurse (RN)	10.7 FTE	8.4 FTE	7.2 FTE
Enrolled nurse (EN)	Nil	Nil	1.2 FTE
Health centre clerk (HCC)	1.0 FTE	1.0 FTE	1.0 FTE
Clinical support officer (CSO)	0.5 FTE	Nil	0.5 FTE

Each health centre appeared to have adequate staffing levels for the services provided. However, staff turnover had impacted the mix of skills and experience in the MSPC 2 and MSPC 3 health centres, creating some rostering challenges. We observed each team working efficiently and professionally.

Hours of operation

Table 17: Health centre operating hours and roster[218]

Area	Hours	Nursing shifts	Custodial shifts
MSPC 1	24 hours per day, 7 days	7am to 3.30pm: 4 RNs (7 days) 7am to 3.30pm: 1 RN (Mon to Weds) 12pm to 8.30pm: 1 RN (7 days) 1.30pm to 10pm: 1 RN (7 days) 9.30pm to 7.30am: 2 RNs (7 days) 8am to 4.30pm: NUM & HCC (weekdays) 8am to 4.30pm: CSO (Mon to Weds)	7am to 3pm: 5 correctional officers (weekdays) 7am to 3pm: 4 correctional officers (weekends)
MSPC 2	7am to 10pm, 7 days	7am to 3.30pm: 4 RNs (7 days) 12pm to 8.30pm: 1 RN (7 days) 1.30pm to 10pm: 1 RN (7 days) 8am to 4.30pm: NUM & HCC (weekdays)	6am to 6pm: 1 correctional officer (7 days) 7am to 3pm: 1 correctional officer (weekdays)
MSPC 3	7am to 10pm, 7 days	8am to 4.30pm: NUM (weekdays) 7am to 3.30pm: HCC (weekdays) 7am to 3.30pm: CSO (Mon & Tues) 7am to 3.30pm: 3 RNs & 1 EN/RN (7 days) 12pm to 8.30pm: 1 EN/RN (7 days) 1.30pm to 10pm: 1 RN (7 days)	6am to 6pm: 1 correctional officer (7 days) 8am to 4pm: 1 correctional officer (weekdays)

Unlike most correctional centres, MSPC has 24-hour medical coverage, with two nursing staff located in MSPC 1 overnight (from 9.30pm to 7.30am). We were informed that JH&FMHN had recently increased night shift staffing from one to two nurses, which was welcomed by MSPC 1 health staff.

217 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.
218 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023; Information provided by Corrective Services NSW, 11 November 2023.

Access to patients

The layout of MSPC 2 and MSPC 3 and the location of their health centres helped facilitate access to health services. The health centres were a short walk from the accommodation areas and due to the operational routine, most patients could make their way unhindered to and from the health centres as needed. In MSPC 2, patients could attend the health centre for primary health nurse and specialist appointments from 8.30am to 3pm, equating to around six-and-a-half hours of patient access per day. In MSPC 3, there were around seven hours of patient access per day, from 8am to 3pm. Patients could also attend the health centres for ad hoc appointments until they were locked into their cells at 6pm during daylight savings time or 5pm in other months.

Access to patients was more challenging in MSPC 1 due to the routine and shorter purposeful day. Patients could attend the MSPC 1 health centre for primary health nurse and specialist appointments from 8.30am to 11am and 12.30pm to 2.30pm, with the last patient at 2pm. This equated to only four hours of patient access per day. Part of the reason for this was the earlier 'lock-in' of patients in MSPC 1 at around 2.30pm. Another contributing factor was the cessation of health centre operations from 11am to 12.30pm for the lunch break of correctional officers. Staggering the lunch break of the five correctional officers assigned to work in the MSPC 1 health centre was proposed as a solution to this problem.

Although there was limited access to the health centre, we were impressed by the number of patients seen in the primary health nurse clinic on the day of the inspection. JHFMHN staff reported they worked closely with custodial staff to facilitate efficient patient flow to the health centre.

We were advised by health staff that health care delivered afterhours or during lockdowns is not routinely undertaken through closed cell doors. If nursing staff need to review a patient in their cell and/or administer medication, correctional officers will usually unlock the cell door. We were informed that if there are any issues with accessing a patient in a cell, the matter is escalated to a senior officer and access is facilitated.

Although there are always nurses on site at MSPC, the distance and secure gates between the three areas could delay the response of the night duty nurses to a health-related emergency in MSPC 2 or MSPC 3. Health staff undertake mandatory emergency management training, including CPR refresher training. The clinical nurse educator for the Long Bay Correctional Complex had commenced scenario training with nursing staff in the management of health-related emergencies.

We were advised no interagency health-related emergency management exercises were currently conducted in MSPC. We consider that there would be benefit in CSNSW and JH&FMHN staff undertaking joint scenario training exercises for health-related emergencies at MSPC. Custodial staff are often first responders in health-related emergencies and it is important they can respond confidently. This would also help ensure that custodial and health staff work well together in an emergency.

Recommendation: JH&FMHN and CSNSW consider undertaking joint scenario training on the management of health-related emergencies in MSPC.

2.5.3 Health service provision

Each health centre provides routine clinics for access to primary health, population health, drug and alcohol, mental health, dental and general practitioner (GP) services (see Table 18 for more detail). Patients are placed on a clinic list for the relevant service. The clinic list is developed from the wait list for the service, according to the patient's priority category. Patients may request health services by completing a hard copy self-referral form or calling the JH&FMHN Patient Enquiry and Self-Referral Service. To ensure patient confidentiality, hard copy forms should either be provided directly to health staff or placed in a locked box that can only be accessed by health staff. The Patient Enquiry and Self-Referral Service allows inmates to request appointments for health services and follow-up previous enquiries by phone. This is a free phone call available Monday to Friday from 8am to 4pm.

Daily primary health nurse clinics are conducted in each health centre; one per day in MSPC 1, three per day in MSPC 2, including one in the MSPC 2 satellite health centre (ASU), and two per day in MSPC 3. In addition to seeing patients for primary health related matters, nursing staff also assist the specialty streams in the provision of services to their patients, including Buvidal injections, mental health depot injections, vaccinations, and completing the Early Detection Program for blood borne viruses and sexually transmitted infections. A population health nurse worked across all three areas. A GP attended each health centre for one day per week in MSPC 1 and MSPC 2 and two days a week in MSPC 3.

Almost all health services are delivered to patients by health providers attending MSPC in person. JH&FMHN has implemented the myVirtualCare platform in all NSW correctional centres, a significant achievement that should increase the accessibility of custodial health services, particularly specialist appointments. At MSPC myVirutalCare was being used for specialist appointments including cardiology, haematology, renal, neurology and gastroenterology.

However, we heard that the requirement for a nursing staff member to be present with a patient during a myVirutalCare appointment was a barrier to increasing the use of this platform. This means a health centre resource is being diverted from their usual work. Given nursing staff are not present during in-person appointments in the Outpatient Department (OPD) in LBH 2 or external hospitals, it was unclear why this was necessary for virtual appointments. There are many benefits to the use of myVirutalCare for specialist appointments. If the use of this platform is to expand, JH&FMHN needs to review the patient supervision requirements to ensure there is minimal impact on the provision of other health services.

JH&FMHN advised us that they support a review of patient-end supervision requirements for virtual care appointments, noting that the appointment type and purpose, and patient status and support needs, are key factors to be considered in determining the level of supervision that may be necessary.[219]

Recommendation: JH&FMHN review the supervision requirements for telehealth specialist appointments undertaken within a health centre.

Data provided by JH&FMHN indicates that most scheduled clinic hours were delivered in all three health centres between March and August 2023.[220] During the same period, clinic hours were delivered for all of the services scheduled as required in the MSPC 1 and MSPC 2 health centres.[221] Scheduled clinic hours are detailed in Table 18.

There is an Aboriginal health worker position allocated to the Long Bay Correctional Complex and services are provided as required. From 1 July 2023 to 30 June 2024, Aboriginal identified services and roles delivered 236 appointments across MSPC. This included appointments with an Aboriginal Chronic Care Program nurse, Aboriginal health worker, drug and alcohol (D&A) Aboriginal health worker and palliative care Aboriginal health worker.[222]

CSNSW and JH&FMHN facilitated Close the Gap day activities in MSPC 1 and MSPC 3 in 2024. Men in MSPC 2 were able to attend the MSPC 3 event. We were informed that local primary health nurses, the Long Bay Aboriginal health worker, Aboriginal Chronic Care Program nurse, staff from speciality streams and members of the JH&FMHN Suicide Prevention Outreach Team (SPOT) attended those events, providing men with health checks, support and advice, and health promotion materials. Staff from the Redfern Aboriginal Medical Service also attended. Any patients with health issues identified during the health checks were reviewed during primary health nurse clinics.

219 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.
220 During this period, the mental health nurse was scheduled to provide 12 clinic hours per week in MSPC 2 and delivered 8 clinic hours per week. This was the only instance of scheduled clinic hours not being delivered: Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.
221 From around May to November 2023, the MSPC 1 health centre delivered 16 hours per month of oral health, 2 hours per month of optometry, 8 hours per month of the primary care nurse practitioner and 8 hours per month of physiotherapy. For the same period the MSPC 2 health centre delivered 22 hours per month of oral health and 2 hours per month of optometry: Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.
222 Information provided by the Justice Health and Forensic Mental Health Network, 5 July 2024.

Table 18: Scheduled clinic hours and delivery format, March to August 2023[223]

Clinic	MSPC 1	MSPC 2	MSPC 3
Primary health nurse	7 days per week (in person)	7 days per week (in person)	7 days per week (in person)
Primary care nurse practitioner	As required (in person)	Nil	Nil
Population health nurse	16 hours per week (in person)	8 hours per fortnight (in person)	4 hours per week (in person)
GP	16 hours per week (in person)	16 hours per week (in person)	16 hours per week (in person)
Mental health nurse	24 hours per week (in person)	12 hours per week (in person)	16 hours per week (in person)
Mental health consultation liaison nurse	8 hours per month (in person)	8 hours per month (in person & virtual)	8 hours per month (in person)
Psychiatrist	4 hours per week (in person & virtual)	16 hours per week (in person)	8 hours per week (in person)
D&A doctor/nurse practitioner	6 hours per week (in person)	4 hours per week (in person)	4 hours per week (in person)
D&A nurse	12 hours per week (in person)	4 hours per week (in person)	4 hours per week (in person)
Oral health	As required (in person)	As required (in person)	16 hours per week (in person)
Optometry	As required (in person)	As required (in person)	6 hours per month (in person)
Physiotherapy	As required (in person)	8 hours per month (in person)	8 hours per month (in person)
Integrated care	Nil	Nil	2 hours per week (in person)
Connections	Nil	Nil	2 hours per week (in person)
Wound care nurse	Nil	Nil	2 hours per month (in person)
Diabetic nurse	Nil	Nil	2 hours per month (in person)

223 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.

Table 19: MSPC 1 health centre – care provided within and outside the recommended wait time by triage category, from 1 September 2022 to 31 August 2023[224]

Clinical priority[225]	Total arrived appointments	Seen on time	Seen outside recommended time
P1 (urgent)	13	5 (38%)	8 (62%)
P2 (semi-urgent)	348	245 (70%)	103 (30%)
P3 (non-urgent)	759	673 (89%)	86 (11%)
P4 (routine)	1,259	1,259 (100%)	0
P5 (follow-up)	180	No timeframe	No timeframe
Total	**2,559**	**2,362 (92%)**	**197 (8%)**

Table 20: MSPC 2 health centre – care provided within and outside the recommended wait time by triage category, from 1 September 2022 to 31 August 2023[226]

Clinical priority	Total arrived appointments	Seen on time	Seen outside recommended time
P1 (urgent)	43	38 (88%)	5 (12%)
P2 (semi-urgent)	232	173 (75%)	59 (25%)
P3 (non-urgent)	642	572 (89%)	70 (11%)
P4 (routine)	2,165	2,165 (100%)	0
P5 (follow-up)	264	No timeframe	No timeframe
Total	**3,346**	**3,212 (96%)**	**134 (4%)**

Table 21: MSPC 3 health centre – care provided within and outside the recommended wait time by triage category, from 1 September 2022 to 31 August 2023[227]

Clinical priority	Total arrived appointments	Seen on time	Seen outside recommended time
P1 (urgent)	16	15 (94%)	1 (6%)
P2 (semi-urgent)	300	191 (64%)	109 (36%)
P3 (non-urgent)	1,399	1,191 (85%)	208 (15%)
P4 (routine)	1,274	1,274 (100%)	0
P5 (follow-up)	473	No timeframe	No timeframe
Total	**3,462**	**3,144 (91%)**	**318 (9%)**

Table 19 (MSPC 1), Table 20 (MSPC 2) and Table 21 (MSPC 3) show that for the 12-month period from 1 September 2022 to 31 August 2023, over 90% of all patients across the three health centres were seen on time. Of some concern was the number of patients with a clinical priority of P1 (urgent) or P2 (semi-urgent) who were seen outside the recommended timeframes for those categories (one to three days for P1 patients and three to 14 days for P2 patients). However, it should be noted that for the data time period, all accommodation wings in MSPC 1 were operational and more restrictive COVID-19 management protocols were in place, impacting timely access to health services.

224 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023. This table does not include data for oral health waiting times and patients seen without being waitlisted.
225 The following timeframes apply for each clinical priority: P1 = 1 to 3 days, P2 = 3 to 14 days, P3 = 14 days to 3 months, P4 = 3 to 12 months, P5 = no timeframe.
226 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023. This table does not include data for oral health waiting times and patients seen without being waitlisted.
227 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023. This table does not include data for oral health waiting times and patients seen without being waitlisted.

2.5.4 Chronic disease management

In October 2023, JH&FMHN separated the screening of patients at risk of developing chronic conditions from the assessment and management of patients with chronic conditions, implementing new procedures for each category of patient. This was to eliminate duplicate and redundant appointments and screening, so as to streamline the care experience for patients and staff.[228]

When a patient is identified as having a chronic condition, through either the health screening process when they enter custody or subsequent diagnosis, health staff will complete a Chronic Condition Assessment to assist in determining the patient's ongoing care needs. Ongoing review and care are guided by condition-specific clinical pathways. Patients are reviewed every 12 months, or more frequently depending on the patient's health needs and clinical pathway, and updated care arrangements are documented in the patient's health record.[229]

Preventive health screening for those at risk of developing a chronic condition commences 12 months after the patient enters custody. It targets non-Aboriginal patients aged 55 years and over and all Aboriginal patients. Thereafter, screening is completed annually for Aboriginal patients and every two years for non-Aboriginal patients aged 55 years and over. This procedure should enable early detection of chronic conditions and opportunities for health staff to provide health information to patients and address behaviours to decrease risk.[230]

JH&FMHN advised us that the new procedures and assessments were developed with clinicians and have been communicated to all staff. Staff orientation was supported by an education package, including training sessions, information sheets and a recorded training presentation. Over 100 staff were trained in the new procedures, with 84% of surveyed participants reporting the changes were a positive improvement. All education and procedure resources are available to staff on the JH&FMHN intranet.

This is a great initiative by JH&FMHN. Given the rates of chronic disease within the patient population, it is essential to have a straightforward and efficient screening, assessment and management process. This will help ensure patients at risk of chronic conditions are identified and monitored and those with a chronic condition/s have robust management plans.

However, during the health services inspection, it was evident that some health staff at MSPC were unaware that JH&FMHN's review of chronic condition management processes had been completed and new procedures had been implemented. As a result, assessments were not being completed for some patients while staff waited for the outcome of the review they believed was ongoing. In the interim, primary health nurses were monitoring and undertaking comprehensive observations on patients with chronic conditions. JH&FMHN may need to undertake some additional work to ensure that all staff are aware of these changes.

Recommendation: JH&FMHN ensure all health staff are aware of its new preventive health screening and chronic disease assessment and management processes.

2.5.5 Mental health services

The model of mental health care in JH&FMHN provides for two categories of mental health patient:

- Level A: patients with anxiety disorders and depression on low dose antidepressants who are managed by primary care GPs and the Mental Health Liaison Service, consisting of mental health nurses working in consultation with the clinical director, primary health.
- Level B: patients with a diagnosed serious mental illness, who are on antipsychotics and are managed by psychiatrists/psychiatric registrars and mental health nurses.

Mental health services include the commencement and/or review of medication, continuation of treatment and monitoring patients with serious mental illness; sleep hygiene clinics and referral to

228 Information provided by the Justice Health and Forensic Mental Health Network, 5 July 2024.
229 Information provided by the Justice Health and Forensic Mental Health Network, 5 July 2024.
230 Information provided by the Justice Health and Forensic Mental Health Network, 5 July 2024.

other services, such as psychology services as considered clinically indicated.

MSPC had one mental health nurse position who worked across the three areas. The mental health nurse provided services to patients two days per week in MSPC 1, one day per week in MSPC 2, and two to three days per week in MSPC 3. A psychiatrist attended MSPC 1 for half a day every fortnight and MSPC 2 and MSPC 3 one day per week each. Health staff reported there was a demand in MSPC 1 to increase the psychiatrist clinic to one full day a fortnight.

When a mental health patient requires a higher level of observation and intervention, they are transferred to either the Mental Health Screening Unit (MHSU) at MRRC or to the Mental Health Unit (MHU) at LBH. We were informed that patients waited around 14 days to one month to be transferred to the MHSU or MHU. Patients will often be placed in a camera cell while waiting for transfer. The mental health nurse participates in the weekly Mental Health Bed Demand Committee meeting and will advise the committee of any patients who are clinically deteriorating.

Patients in the mental health step-down unit in MSPC 2 (3-wing) are managed more intensively by JH&FMHN's Custodial Mental Health Service. The patients in 3-wing are reviewed weekly as part of the Mental Health Bed Demand Committee process that determines the most suitable placement for the management of their mental illness. They are monitored and managed by a mental health nurse and a psychiatrist.

During the health services inspection, JH&FMHN staff highlighted the SPOT project. The SPOT trial commenced in February 2023. SPOT comprises a statewide team of three clinicians who provide in-person and online support to people in custody experiencing suicidal thoughts and behaviours. The service aims to empower patients to identify their own warning signs and use coping strategies to stay safe when their thoughts are overwhelming. Patients can access the service directly through the Mental Health Helpline or by referral from a clinician or CSNSW staff. The project also aims to build organisational capability, including through staff education, enhancing governance and monitoring, and improving policy, procedures and data collection. This initiative has great potential and we will continue to monitor its development.[231]

2.5.6 Drug and alcohol services

A D&A nurse and D&A doctor conduct clinics in each area of MSPC. The D&A nurse undertakes clinics on their own and also attends the D&A doctor clinics. In both MSPC 1 and MSPC 2, the D&A nurse clinic and D&A doctor clinic each occur one day per week. In MSPC 3, the D&A nurse undertakes a clinic one day per week and the D&A doctor clinic takes place for half a day per week.

Patients who come into custody on an opioid agonist treatment (OAT) maintain their treatment during their incarceration. Patients who seek OAT after entering custody are assessed by a D&A nurse and D&A doctor or D&A nurse practitioner and if considered suitable go on a waiting list to commence treatment.

The preferred OAT in correctional centres is Buvidal, which is an injectable depot (long acting) version of Buprenorphine, rather than methadone which needs to be administered daily. D&A staff undertake the initial assessment of a patient for Buvidal and ongoing monitoring.[232] Primary care nurses undertake the initiation of and ongoing administration of the Buvidal depot injections at MSPC.

At MSPC, most OAT patients were receiving Buvidal rather than methadone. At the time of the health services inspection in late April and early May 2024, in MSPC 1 there were 60 patients on Buvidal and four on methadone, in MSPC 2 there were 18 patients on Buvidal and four on methadone, and in MSPC 3 there were 41 patients on Buvidal and five on methadone. The number of people receiving OAT at the time of the inspection was broadly similar to figures provided by JH&FMHN for 31 August 2023. These showed that there were 62 patients in MSPC 1 receiving OAT, 21 in MSPC 2, and 43 in

231 Information provided by the Justice Health and Forensic Mental Health Network, 5 July 2024.
232 Justice Health and Forensic Mental Health Network, *OAT NO. 1 Assessment and Commencement for Opioid Agonist Treatment (OAT)* (March 2021).

MSPC 3.[233] On 31 August 2023, the numbers of people waiting to be assessed for OAT were relatively small (16 in MSPC 1, five in MSPC 2, and three in MSPC 3).[234]

2.5.7 Oral health services

Patients can request oral health services by calling the JH&FMHN Oral Health line. This is a free call available Monday to Friday from 8am to 4pm. Patients answer a questionnaire and staff triage and place the patient on the dental services wait list based on their clinical presentation. Health centre staff will escalate any patients of concern to the JH&FMHN Oral Health service.

Dental clinics were conducted in each area of MSPC: three times per month for MSPC 1 patients, one day per week for MSPC 2 patients and two days per week for MSPC 3 patients. MSPC 1 and MSPC 2 do not have a dental suite and patients with maximum and medium security classifications requiring dental treatment must be escorted to the OPD in LBH 2. There is a dental suite in the MSPC 3 health centre that is used for patients with minimum security classifications.

Health staff reported that the number of patients presenting to the health centres with dental abscesses was small. However, we heard that the number of patients grinding their teeth has increased, which is believed to be a result of methamphetamine use.

Data provided for 25 October 2023 suggested that MSPC 1 had a backlog of patients waiting for oral health assessment, with 49 patients on the assessment waiting list, 32 (65.3%) of which had not been assessed within the timeframe for their clinical priority. All of these patients were in the two highest priority groups and 12 patients should have been assessed within a week and 20 within a month.[235] There were 67 patients on the treatment waiting list, 14 of which had exceeded the recommended wait time for their clinical priority, although it should be noted that all these patients were in the lowest priority categories.[236] At this time, all the wings in MSPC 1 were open and COVID-19 significantly impacted waiting lists for oral health due to limitations on the provision of dental services during periods of heightened pandemic restrictions. Feedback from health staff suggests that the provision of oral health services had improved at the time of the health services inspection and were adequate for patient demand.

On 25 October 2023, around one third of patients on the oral health assessment waiting lists in MSPC 2 (three of nine) and MSPC 3 (14 of 44) had not been assessed within the timeframe for their clinical priority. Like MSPC 1, all of these patients were in the two highest priority groups. In MSPC 2 there were 39 patients on the treatment waiting list, none of which had exceeded the recommended timeframe for their clinical priority. In MSPC 3, four of 113 patients on the treatment waiting list had exceeded the recommended wait time for their clinical priority and all were in the two lowest priority categories.[237] Given the impact of COVID-19 and considering the feedback we received from health staff, it appeared that the oral health services in MSPC 2 and MSPC 3 were also adequate to meet patient demand.

At the time of inspection, due to the high proportion of aged people at MSPC, the Oral Health service was conducting a series of denture clinics in the MPSC 3 health centre. Patients had also been transferred from across NSW to be fitted for dentures.

2.5.8 Medication management

Some medications are required to be taken by patients under the supervision of nursing staff. Other medication can be self-administered, and patients will be given sufficient supply for a day or a month via:

- Imprest stock: where nursing staff prepare patient medications in the health centre's pharmacy

233 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.
234 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.
235 The following timeframes apply to each clinical priority: 3a = 1 week, 3b = 1 month, 3c = 3 months, 4 = 6 months, 5 = 12 months and 6 = 24 months.
236 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.
237 Information provided by the Justice Health and Forensic Mental Health Network, 17 November 2023.

room, placing them in a sealed bag with the patient's name and MIN.

- Dose administration aids (DAAs) or sachets: where medications are prepared by the JH&FMHN Pharmacy Service using an automated medication dispensing system.
- The self-medication program: where patients receive a month's supply of medication prepared by the JH&FMHN Pharmacy Service, depending on a risk assessment of the patient and the nature of their medications.

At the time of the health services inspection, half of the medications for patients in MSPC 1 were prepared by imprest stock, a much higher proportion than in MSPC 2 (no patients) and MSPC 3 (16%), reflective of the inmate profiles of each area. In MSPC 2, most inmates on prescribed medication had medications provided in DAAs (63%). In MSPC 3, nearly half of patients on prescribed medications were on the self-medication program (47%) and over a third (37%) had medications provided in DAAs.

During the health services inspection, we observed medication preparation and administration in all three health centres. Medications were signed in e-Meds prior to administration, which is compliant with JH&FMHN Medication Guidelines. DAAs and the self-medication program are great initiatives by JH&FMHN. The self-medication program is an excellent model for medication provision as it encourages patients to be more involved in their medication management and assists them to be better prepared to manage their medication when they are released from custody. Nursing staff also provided positive feedback about the provision of DAAs as it saved nursing time preparing the medications and provided patients with clearly labelled medications which included a description of the medication and when it was to be administered.

All three health centres commence the day by seeing patients requiring insulin and blood glucose monitoring. This is followed by supervised and non-supervised medication and methadone administration, for which patients present to either a main or satellite health centre to collect and/or consume their medication. Supervised medications are also provided to patients in the evenings at around 6pm to 6.30pm. This is an appropriate time for patients to receive evening medications, supporting their efficacy and therapeutic benefits.

Nursing staff attend the SHU at around 9am to administer supervised and non-supervised medications and methadone. During this time, they also undertake daily welfare checks for SHU patients and provide any other treatments they may require, such as wound dressings, blood glucose monitoring, or Buvidal or mental health depot medications.

We observed the administration of supervised medication and methadone in all three health centres. On all observed occasions, supervised medication was administered correctly, with one health staff member, either a RN or EN, administering the supervised medication after identifying patients using their identification cards. Nursing staff observed patients swallowing the medication and checked the patient's mouth.

On all observed occasions, methadone was administered correctly, with two health staff including a RN, identifying patients using their identification cards, dispensing the methadone using a medication pump measuring system, checking the dose against the medication chart, observing the patient swallow the dose, and signing the medication chart and drug register at the completion of the methadone administration. The chain of custody of this schedule 8 medication was maintained by the two nursing staff throughout the process.

We observed custodial staff ensuring patients removed their hats (to facilitate their identification) and remain next to patients during the administration of methadone. However, we did not observe custodial staff check the patient's mouth after administration, as required by the COPP. The COPP provides that custodial staff are required to visually check the patients mouth after the administration of OAT to ensure it has been digested (methadone) or dissolved (Suboxone or Buprenorphine strips).[238] CSNSW should remind custodial staff of this requirement.

Recommendation: CSNSW remind custodial staff of their responsibilities, as outlined in the COPP, in relation to OAT administration.

238 Corrective Services NSW, *Custodial Operations Policy and Procedures: 6.4 Opioid Substitution Treatment* (version 1.2, 18 August 2023) 6.

Nursing staff may need to transport medications out of the main health centre for administration in a satellite health centre or to patients locked in their cells. These medications were carried in a plastic bag that was not secured. Medications should be kept secure at all times. We consider that it would be safer for medications to be transported in a lockable carry container/box. This also decreases the risk of a small bag of medications being accidently dropped or lost as staff walk between locations.

JH&FMHN advised us that it purchased secure medication containers in June 2025 and provided these to those locations where needed, following an audit of all sites.[239]

2.5.9 Patient dignity and privacy

During the health services inspection we observed numerous occasions across all three health centres where custodial staff were physically in the room during the provision of health care to patients. This included routine activities such as the administration of insulin, Buvidal and depot injections and pathology collection for patients. None of those patients were agitated or distressed. Most had a minimum security classification.

This practice is unusual. In similar circumstances in other correctional centres, custodial staff usually stand at the doorway of the room or in the corridor. They will only be present in the room with a patient if they are agitated or considered a safety or security risk.

Patients have a right to privacy and for information about their health to be confidential. Unless there is a known or perceived risk to the safety and security of staff or patients, custodial staff should not be in the room when health care is being provided to a patient.

Recommendation: CSNSW, in consultation with the JH&FMHN, review the presence of custodial staff in treatment and consultation rooms when health care is being provided to patients, with a view to maintaining patient privacy and the confidentiality of patient health information. This review should capture all applicable care areas, including the main health centres and satellite health centres in all areas of MSPC.

During the health services inspection of MSPC, we observed health staff refer to patients using only their surnames. This practice was highlighted in our previous inspections of Silverwater Women's, Dillwynia, Shortland and Cessnock correctional centres.[240]

Addressing a patient using only their surname is inappropriate. Patients should at all times be afforded respect and dignity in health care settings, including correctional centres. If their full name is not known, courtesy titles such as Mr or Ms should be used. At no time should a patient be referred to by their last name or identification number. Full patient names should also be used on white boards.

That being said, in all three areas, health staff appeared to be polite and pleasant in their interactions with patients. Health staff also appeared to be genuinely committed to providing the optimal level of care to patients.

Recommendation: JH&FMHN formally remind health staff of the requirement to refer to patients by their full name or a title followed by their last name and not by their last name and/or identification number.

239 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.
240 Inspector of Custodial Services, *Inspection of Silverwater Women's and Dillwynia Correctional Centres 2022* (Report, November 2023) 52; Inspector of Custodial Services, *Inspection of Shortland Correctional Centre and Cessnock Correctional Centre 2023* (Report, June 2024) 64.

2.6 Daily life and support

2.6.1 Routine and time out of cell

The routine for inmates differed significantly in each area of MSPC:

- **MSPC 1**: The purposeful day routine for MSPC 1 inmates provides they should be let out of their cells each morning from 7.15am and locked in their cells from 2pm.
- **MSPC 2**: Minimum security areas (1-wing, 3-wing and 4-wing) should be let out of their cells at 6.15am and locked in their cells from 5pm. Maximum security areas (ISU, SHU, 5-wing, and 6-wing) should be let out of their cells from 7.15am, locked in their cells for lunch from around 11am to 12pm and locked in their cells for the night from 2.15pm.
- **MSPC 3**: Inmates working in some industries are let out of their cells at 5.30am and all other inmates at 6.30am. Inmates are locked in their cells from 5.15pm, except for 14-wing which is locked in at 7.30pm from Monday to Thursday. Inmates in 18-wing are locked in their cells from 10am to 11am and again from 2pm to 3pm before being locked in their cells for the night from 5.15pm.

No concerns arose from our observation of the 'let-go' and 'lock-in' of the minimum security wings in MSPC 2 and MSPC 3.[241] However, the 'let-go' process for MSPC 1 significantly decreased time out of cell for these inmates. We reviewed the times when 'let-go' and 'lock-in' commenced and finished over a week in May 2024. The earliest 'let-go' commenced was 7.40am and the earliest it was completed was 8.07am. The 'lock-in' process was more efficient and consistently concluded by around 2.35pm. This was consistent with our observations during the inspection.

For the 2022–23 financial year, the average time out of cells at MSPC was 6.36 hours per day for inmates in secure custody and 11.02 hours per day for inmates in open custody.[242] NSW-wide, inmates in secure custody had 7 hours of time out of cell per day and inmates in open custody had 9.4 hours of time out of cell per day. In the 2022–23 financial year, the NSW figures for time out of cell were among the lowest in Australia.[243]

From 1 September 2022 to 31 August 2023, there were six full day lockdowns (where the whole correctional centre was locked down for the whole day) and 124 partial lockdowns.[244] There was an increase in lockdowns in the subsequent 12-month period from 1 September 2023 to 31 August 2024, with five full day lockdowns and 144 partial lockdowns.[245]

As described in section 2.3, we reviewed samples of restricted movement (lockdown) IRMs from April to July 2023 and April to July 2024. The 2023 sample consisted of 34 IRMs and the 2024 sample comprised 56 IRMs. The IRMs detailed the lockdown of a single wing, multiple wings, one or more areas or the whole correctional centre.[246]

Across these two samples, we made the following observations:

- Wings in MSPC 3 were rarely locked down. MSPC 3 holds most of MSPC's inmate workers, so if a lockdown is implemented these inmates may not be impacted as they are at work and supervised by industries overseers. The exception to rarely being locked down was the 18-wing ASU.

241 'Let-go' refers to the process of letting inmates out of their cells, usually in the morning. 'Lock-in' refers to the process of securing inmates in their cells, usually at the end of the day.
242 Information provided by Corrective Services NSW, 17 January 2025. Secure custody refers to facilities where the regime for managing prisoners requires them to be confined by a secure perimeter physical barrier. Open custody refers to facilities where the regime for managing prisoners does not require them to be confined by a secure perimeter (irrespective of whether such a barrier exists): See the explanatory material of the Productivity Commission, *Report on Government Services 2025: Justice (part C)* (4 February 2025).
243 Productivity Commission, *Report on Government Services 2024: Justice (part C)* (29 January 2024) data table 8A.13. In 2022–23 in NSW, time out of cell was 9.4 hour per day for open custody and 7.0 hours per day for secure custody. In each category, these were the lowest figures in Australia. The total time out of cell was 7.6 hours per day, ahead of only Tasmania which recorded a total of 7.3 hours per day.
244 Information provided by Corrective Services NSW, 17 November 2023.
245 Information provided by Corrective Services NSW, 17 January 2025.
246 Information provided by Corrective Services NSW, 11 November 2023 and 15 November 2024.

- The three ASUs experienced significant disruptions due to lockdowns:
  - 5-wing was impacted by four lockdowns in the 2023 sample and nine in the 2024 sample.
  - 6-wing was impacted by eight lockdowns in the 2023 sample and eight in the 2024 sample.
  - 18-wing was impacted by seven lockdowns in the 2023 sample and 11 in the 2024 sample.
- MSPC 1 was regularly impacted by lockdowns, with 15 IRMs involving one or more wings in MSPC 1 (including eight reports indicating all MSPC 1 wings were locked down) in the 2023 sample and 25 IRMs in the 2024 sample (including 14 reports indicating that all MSPC 1 wings were locked down).
- The number of lockdowns impacting MSPC 2 increased across the two samples. In the 2023 sample, there were 12 IRMs involving one or more wings of MSPC 2 (often the ASUs). This doubled to 24 IRMs in the 2024 sample.
- As discussed in section 2.3, staff-related reasons (including staff events, training, industrial action and shortages) caused a large number of lockdowns (18 out of 34 IRMs in the 2023 sample and 26 out of 56 IRMs in the 2024 sample). A number were also caused by unscheduled medical escorts (six IRMs in the 2023 sample and 15 IRMs in the 2024 sample).[247]

2.6.2 Psychology services

At the time of the inspection, MSPC had seven general psychologist positions, including a senior psychologist, providing general psychology services across all areas. There were also psychologists working in the intensive programs (see section 2.7.3).

In February 2024 the cluster model of service delivery (where MSPC psychologists split their time between community-based locations and MSPC) ceased. MSPC psychologists now only provide services to MSPC inmates. The senior psychologist reports to the senior service integration manager for all non-clinical/administrative work and to the chief psychologist for clinical matters.

Psychology services were provided Monday to Friday during business hours. All referrals were received via the electronic referral system in the Offender Integrated Management System (OIMS). Referrals may be made by OS&P and JH&FMHN staff or custodial officers and are triaged according to priority level (PSYCH1 being the highest and PSYCH3 the lowest).[248]

From 1 March to 31 August 2023 there were 2,012 psychology sessions at MSPC. These included 1,091 mental health impairment sessions (PSYCH2). This was the service line with the greatest demand, followed by transition and coping (318 sessions) and criminogenic needs (286 sessions). Information provided indicated there had been a decrease in sessions related to suicide/self-harm referrals and an increase in sessions related to cognitive impairment and challenging behaviour referrals.[249]

During the inspection we were informed that there were four vacant psychologist positions and another psychologist would be moving to a new position in July 2024. Recruitment to fill these positions was close to being finalised. However, the recruitment and retention of psychology staff was reported to be an ongoing issue due to lower salaries than those paid to other public sector psychologists.[250] This issue was also observed in relation to sex offender programs (see section 2.7.3).

247 Information provided by Corrective Services NSW, 11 November 2023 and 15 November 2024.
248 Information provided by Corrective Services NSW, 11 November 2023.
249 Information provided by Corrective Services NSW, 11 November 2023.
250 '"Under paid, overworked and leaving in droves": Significant Improvements Needed for Public Service Psychologists', *Public Service Association* (Web Page, 2 April 2025) <https://psa.asn.au/under-paid-overworked-and-leaving-in-droves-significant-improvements-needed-for-public-service-psychologists/>; Inspector of Custodial Services, *Inspection of Mid North Coast Correctional Centre 2023* (Report, December 2024) 99.

2.6.3 Management of inmates at risk of self-harm

MSPC held a significant number of inmates with histories of mental illness or at risk of self-harm. As at 31 August 2024, there were 55 inmates (8.2%) at MSPC with a history of mental illness and 111 inmates (16.5%) who had been managed by a Risk Intervention Team (RIT).[251]

We reviewed a sample of IRMs of people who had threatened self-harm or had been assessed as at risk of self-harm and those who had self-harmed. From 1 April to 31 July 2023, there were 27 IRMs of actual self-harm. These figures reflected several inmates self-harming on multiple occasions and over half of the 27 IRMs concerned repeat incidents, including one inmate who was the subject of eight reports. There were also 41 IRMs concerning people reporting thoughts of self-harm or who were assessed as being at-risk.[252]

There was a reduction in self-harm IRMs the following year. In the subsequent period from 1 April to 31 July 2024, there were seven IRMs of actual self-harm and 35 IRMs concerning people reporting thoughts of self-harm or who were assessed as being at-risk. In this sample, only one inmate self-harmed on multiple occasions, accounting for two of the seven IRMs.[253]

When an inmate is identified as being at risk of suicide or self-harm, the first responding officer must take any action required to ensure the safety of the inmate and notify the officer in charge. The officer in charge must complete a mandatory notification form and develop an immediate support plan which reflects the level of risk and considers the principle of least restrictive care.[254] Depending on the level of risk, the inmate may be placed in a normal cell, in a cell with another suitable inmate, or a camera/assessment cell where they can be more closely monitored.[255]

A RIT will be convened following a mandatory notification and creation of an immediate support plan. A RIT consists of the RIT coordinator, a JH&FMHN staff member and an OS&P staff member. To be a member of a RIT, CSNSW staff must complete the 'Awareness of Managing At-Risk Offenders' on-line e-learning module and RIT coordinators must also complete the 'Managing At-Risk Offenders' two-day training course. The RIT is responsible for the ongoing assessment and management of an inmate's risk of suicide or self-harm.[256]

Our biggest concern in relation to the management of inmates at risk of self-harm at MSPC related to cell placements for people managed by a RIT. The placement options for inmates requiring close monitoring were:

- Four camera cells in 7-wing in MSPC 1. Each cell is equipped with two CCTV cameras, a bed and a toilet/sink but no shower and no electrical outlets, so TVs and fans cannot be used. As these cells do not contain showers, RIT managed inmates use the common showers used by other 7-wing inmates. Although RIT inmates use the showers at a different time of day, there is a risk they may find sharp objects.
- Two camera cells and three 'step-down' cells in the ISU in MSPC 2. These cells are equipped with showers and TVs.

251 Information provided by Corrective Services NSW, 17 January 2025.
252 Information provided by Corrective Services NSW, 11 November 2023.
253 Information provided by Corrective Services NSW, 15 November 2024.
254 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.7 Management of Inmates at Risk of Self-harm or Suicide* (version 1.10, 21 May 2024) 8–9.
255 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.7 Management of Inmates at Risk of Self-harm or Suicide* (version 1.10, 21 May 2024) 11–12.
256 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.7 Management of Inmates at Risk of Self-harm or Suicide* (version 1.10, 21 May 2024) 19–20.

MSPC 1, 7-wing camera cells, May 2024

MSPC 2, ISU camera cell, May 2024

In all cases, inmates in a camera cell had minimal time out of cell and little access to natural light or diversional activities. Multiple staff members expressed significant concern about the conditions experienced by inmates at-risk, particularly those in 7-wing. One described the 7-wing cells as 'medieval'. The physical environment was widely thought to contribute to the distress of inmates at-risk, rather than support improved mental health. Many could not understand why money was spent on refurbishing the ACMU only for it to be closed soon after that refurbishment. According to evidence provided to the Coroners Court of NSW, this closure is permanent.[257] CSNSW has since advised us that consultation is underway to reopen the ACMU.[258]

The camera cells in MSPC were frequently occupied. In addition to those managed by the RIT, these cells were used for inmates requiring monitoring due to physical health concerns. At the time of the

257 *Inquest into the Death of Alfonso Ceniccola* (Coroners Court of New South Wales, Deputy State Coroner Elizabeth Ryan, 24 February 2025) 7.

258 Information provided by Corrective Services NSW, 23 September 2025.

inspection, one of the 7-wing camera cells was occupied by someone who was not at risk of self-harm but could not be accommodated in a cell that met his needs. Consequently, he was placed in a camera cell for additional monitoring overnight.

This further highlights the inadequacy of MSPC's infrastructure in providing a modern and safe correctional environment. We refer to the recommendation in section 2.2 that MSPC should be closed.

2.6.4 Support for Aboriginal inmates

As at 31 August 2023, 22.4% of inmates at MSPC were Aboriginal people.[259] By 31 August 2024, the proportion of Aboriginal people had increased to 23.6%.[260] In December 2024, across NSW 32.3% of adults in custody were Aboriginal people.[261] Some effort has been made at MSPC to improve cultural safety for Aboriginal inmates. While this is encouraging, more work is needed.

Cultural support for Aboriginal inmates at MSPC was primarily provided by two Aboriginal SAPOs (in identified positions). There were also Aboriginal staff in positions in other staffing groups, although these were not identified positions.

The Aboriginal SAPOs provided support to Aboriginal men in all areas of MSPC, including family liaison, funeral applications and funeral attendance. From 1 September 2022 to 31 August 2023, there were 21 applications to attend funerals from Aboriginal inmates and 19 from non-Aboriginal inmates. Of those submitted by Aboriginal inmates, one was declined as it was submitted on the day of the funeral and one inmate was approved to attend in person. The remaining applications were approved for remote attendance (via audiovisual link (AVL) or online) or the outcome could not be determined. However, some of those approved to attend remotely were still unable to attend as this could not be facilitated by the family or funeral home.[262] This highlights that despite the increased availability of virtual options, opportunities to attend funerals in-person remain important.

The Aboriginal SAPOs were also facilitating a First Nations Creative Group for Aboriginal men in MSPC 1. At the time of the inspection, the group was meeting twice a week, providing one session per week each for men in 7-wing and 10-wing. Pleasingly, the group was resourced with sufficient art supplies. This seemed to be a great local initiative, offering Aboriginal men with some support, cultural connection and meaningful activity.

CSNSW employs six regional Aboriginal pathways officers (RAPOs). The RAPOs provide culturally specific expert advice to correctional centre management and staff and mentoring and support for Aboriginal inmates. Each RAPO services correctional centres in a specified region of NSW, with the Long Bay Correctional Complex falling within the Inner-Metro region. We were informed that the RAPO regularly visited MSPC and was particularly involved with Aboriginal men placed in the SHU. At the time of the inspection, four of the nine people in the SHU were Aboriginal people. We were told that the responsible FM notified the RAPO when an Aboriginal person was placed in the SHU and that the RAPO usually visited the SHU once a week. The RAPO also attended segregation review meetings and would speak with affected inmates following the meeting.

Aboriginal delegates who attend IDC meetings are also a source of support for Aboriginal people in custody. This is a paid position. At the time of the inspection, the MSPC 1 and MSPC 2/3 IDCs had Aboriginal delegates.

MSPC has four Yarning Circles, one in each ASU and one in MSPC 3. These are easily accessible for inmates in 5-wing and MSPC 3 and are in good condition. However, it appeared they were rarely used outside of NAIDOC celebrations and plans for a cultural program in the MSPC 3 Yarning Circle were cancelled due to cost. Some of the staff we spoke with highlighted that there was demand for more cultural teaching and connection and that a program similar to Budbudda Dreaming[263] at Cessnock

259 Information provided by Corrective Services NSW, 17 November 2023.
260 Information provided by Corrective Services NSW, 17 January 2025.
261 Bureau of Crime Statistics and Research, *NSW Closing the Gap Quarterly Update December 2024* (April 2025).
262 Information provided by Corrective Services NSW, 11 January 2024.
263 Budbudda Dreaming is a six week cultural strengthening program for Aboriginal men: Inspector of Custodial Services, *Inspection of Cessnock Correctional Centre and Shortland Correctional Centre* (Report, June 2024) 113.

and St Heliers correctional centres would be welcomed by inmates.

Other initiatives for Aboriginal inmates at MSPC included Literacy for Life, an education program targeting Aboriginal inmates delivered by local Aboriginal mentors.[264] Non-Aboriginal inmates could also participate in this program. Materials were also provided to facilitate inmate participation in the annual NAIDOC art competition. The Mini Dads at a Distance program included a targeted program for Aboriginal inmates at MSPC. There were also plans to re-establish a project with IndigiGrow at MSPC, after it ceased with the closure of LBH 2.[265]

MSPC 3 Yarning Circle

2.6.5 Chaplaincy and spiritual support

At the time of the inspection, MSPC had five men and women of Buddhist, Catholic, Christian and Muslim denominations providing chaplaincy and spiritual support to inmates. Inmates did not report any concerns regarding access to chaplaincy services and spiritual support to the inspection team.

Chaplaincy services also provided sponsorships to inmates seeking to undertake external leave to participate in community projects. During the inspection, at the invitation of organisers, we attended an Eid al-Fitr celebration which involved a barbeque lunch for Muslim inmates and concluded with group prayer led by the Muslim chaplain. The inmates seemed to enjoy the celebration.

2.6.6 Inmate advocacy and complaints mechanisms

Inmates can make enquiries or raise complaints and concerns by:

- Talking with a custodial officer or manager.
- Using the inmate application or request systems, which require inmates to complete an

264 See *Literacy for Life Foundation* (Web Page, undated) <https://www.lflf.org.au/>.

265 IndigiGrow is a First Hand Solutions Aboriginal Corporation social enterprise that propagates native plants, including bush foods and endangered varieties, and operates a native plant nursery. The IndigiGrow project that ran at LBH involved IndigiGrow staff teaching inmates how to grow and care for native plants: Information provided by Corrective Services NSW, 24 August 2023. See also *IndigiGrow* (Web Page, undated) <https://indigigrow.com.au/>.

application form (for significant issues) or request form (for minor issues).[266]

- Making a free phone call to the Corrective Services Support Line (CSSL), a telephone support service for inmates in all NSW correctional centres.[267]
- Speaking in-person with an Official Visitor who visits the centre fortnightly and will help resolve inmate complaints and concerns.[268]
- Contacting the NSW Ombudsman by making a free call, in writing or in-person to a NSW Ombudsman staff member during a visit to a correctional centre.[269]
- For centre specific issues, referral to the monthly IDC meeting.[270]

Despite these avenues, inmates from all areas told us they were reluctant to seek help for fear of being punished or transferred to a different correctional centre (also see section 3.4.3). These concerns are reminiscent of evidence presented by inmates at the *Special Commission of Inquiry into Offending by Former Corrections Officer Wayne Astill at Dillwynia Correctional Centre,* where it was recognised by Commissioner McClellan AM KC that fear of reprisal can make it difficult for inmates to trust the 'system'.[271] It is difficult to know the extent to which this perception is a consequence of rumour and speculation or actual threats and intimidation or both. However, it was clear that the fear was genuine and work is required to create an environment where people feel safe to make complaints and raise concerns. We also noted very few posters about complaint avenues on display in the centre. We raised this with the governor at the time of the inspection.

IDCs are required to operate in all correctional centres and meetings must be held monthly. These meetings provide a forum for inmates to meet with management and raise issues relating to services, programs and activities. They consist of inmate delegates approved by the governor, generally representing each accommodation area. Aboriginal inmates and inmates from culturally and linguistically diverse backgrounds should be represented, including the appointed Aboriginal inmate delegate. The governor, FMs and other custodial and non-custodial staff should attend the meetings.[272]

MSPC had two IDCs – one for inmates in MSPC 1 and a combined IDC for MSPC 2 and MSPC 3. Meetings for both appeared to be occurring monthly. However, we found the combined MSPC 2 and MSPC 3 IDC perplexing given the diversity of cohorts and needs across these areas. The mixture of SMAP and mainstream inmates from those areas is not ideal and requires careful selection of the inmate delegates. MSPC should review this arrangement and consider if two separate IDCs would be more appropriate and efficient.

Our review of MSPC IDC minutes from several meetings in 2024 showed there was representation of Aboriginal and LGBTIQA+ inmates at IDC meetings. We heard that sometimes delegates working in industries were not called to meetings. CSNSW policy provides that the governor must ensure IDC delegates are not impeded in carrying out their responsibilities.[273] CSI staff must be informed of this and that attendance at the IDC meeting is considered attendance at work.[274] It seemed greater effort was needed to facilitate the participation of all inmate delegates.

Conversations with inmates across MSPC revealed that IDC meetings were viewed as ineffective. There was a widespread sense that staff were reluctant to progress and resolve matters. The exception to this was when the governor attended the meeting. MSPC management staff need to ensure that action items are reviewed and progressed between meetings.

266 Corrective Services NSW, *Custodial Operations Policy and Procedures: 9.1 Inmate Applications and Requests* (version 1.7, 17 July 2025) 4–10.
267 Corrective Services NSW, *Custodial Operations Policy and Procedures: 9.7 Corrective Services Support Line* (version 1.2, 14 January 2025).
268 Official Visitors are appointed by the Minister for Corrections and are managed by the Inspector of Custodial Services. For information on the Official Visitor Program see 'Official Visitor Program', *Inspector of Custodial Services* (Web Page, 1 November 2023) <https://inspectorcustodial.nsw.gov.au/official-visitor-program.html>.
269 Corrective Services NSW, *Custodial Operations Policy and Procedures: 9.6 Inmate Complaints to the Ombudsman* (version 1.1, 12 March 2020).
270 Corrective Services NSW, *Custodial Operations Policy and Procedures: 9.8 Inmate Development Committees* (version 1.2, 12 March 2020).
271 *Special Commission of Inquiry into Offending by Former Corrections Officer Wayne Astill at Dillwynia Correctional Centre* (Final Report, February 2024) 31.
272 Corrective Services NSW, *Custodial Operations Policy and Procedures: 9.8 Inmate Development Committees* (version 1.2, 12 March 2020) 4–5.
273 Corrective Services NSW, *Custodial Operations Policy and Procedures: 9.8 Inmate Development Committees* (version 1.2, 12 March 2020) 7.
274 Corrective Services NSW, *Custodial Operations Policy and Procedures: 9.8 Inmate Development Committees* (version 1.2, 12 March 2020) 8.

CSNSW has advised that the governor and MOS both attend every IDC meeting. It further noted 'security checks are undertaken in consideration of mixing inmates for these meetings' and MSPC has found a combined meeting for MSPC 2 and MSPC 3 inmates to be the most effective approach.[275]

2.6.7 Food, clothing, and bedding

All inmates receive pre-packaged meals provided by CSI. Therapeutic diets are provided for inmates with medical approval from JH&FMHN. Inmates at MSPC regarded meal portions as small and of poor quality. We were also told that bread portions had recently been reduced to address wastage. Inmates reported being hungry and having to supplement meals through weekly buy-ups. While employed inmates used their wage for this, inmates who could not work, particularly in MSPC 1 where there were few work opportunities, relied on money from family to enable them to purchase additional food items.

CSNSW is required to provide inmates with a diet that is varied, provides adequate amounts of essential nutrients and ensures 'optimal nutritional health'.[276] The situation is not specific to MSPC and affects inmates statewide. CSI Food Services manages the nutritional needs and dietary requirements of inmates through a Menu Control Plan that aims to deliver varied and healthy meals within Australian Dietary Guidelines. While this appears to demonstrate sound practice, it does not reflect the information we receive from inmates and what we have observed during this and other inspections.

JH&FMHN informed us that they currently have two dieticians for the adult custodial population, which requires them to prioritise assessments and recommendations regarding the most urgent and complex patients.[277] The April 2025 report of the *Special Commission of Inquiry into Healthcare Funding* recommended that JH&FMHN should set the minimum nutritional requirements for the NSW custodial population, to be followed by CSNSW and private operators, and receive any additional funding it requires to perform this function. The recommendation also stated that any legislative amendments needed for this transfer of responsibility should be made within six months of the date of the report.[278] We support this recommendation and reiterate that responsibility for inmate dietary requirements should be transferred to JH&FMHN.

Recommendation: CSNSW should transfer responsibility and requisite funding for inmate dietary needs and meal menus to JH&FMHN.

Inmate clothing and linen allocations are prescribed in policy.[279] While inmates at MSPC received all clothing items, the number of underwear items were less than the minimum level required to be maintained throughout their sentence. Inmates are issued one pillowcase, two sheets and two blankets. Additional bed linen can be provided at the discretion of the governor but is generally related to requests around climate and inmate health. However, throughout the inspection, several inmates reported not having a pillow and having insufficient clothing. This needs attention.

2.6.8 Access to phone calls

Inmates can access phone calls via in-cell tablets or phones in yards or units. Both are important as inmates may not have access to tablets during the day while they charge and cannot access phones in units or yards after being locked in their cells in the afternoon. Having both options readily available ensures inmates can contact lawyers and other professionals during business hours and family or friends after they have finished work or school.

We observed sufficient phones on all accommodation units and received no complaints regarding their availability or functionality. Inmates did express concerns around call costs. The Offender Telephone System includes a Common Auto Dial List (CADL) that allows inmates to make free

275 Information provided by Corrective Services NSW, 23 September 2025.
276 *Crimes (Administration of Sentences) Regulation 2014* cl 50.
277 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.
278 *Special Commission of Inquiry into Healthcare Funding* (Final Report, April 2025) 401–3, 407, recommendation 13.
279 Corrective Services NSW, *Custodial Operations Policy and Procedures: 1.5 Issuing Correctional Centre Clothing and Linen* (version 1.4, 22 June 2023) 5.

calls to over 30 service providers including Legal Aid NSW, the Aboriginal Legal Service NSW, the Commonwealth and NSW Ombudsmen, and Services Australia.[280] Phone calls to and from exempt bodies and persons are confidential and are not recorded or monitored.[281] In addition to calls to CADL numbers, CSNSW policy provides that CSNSW will meet the cost of:

- all legal phone calls for unsentenced inmates or sentenced inmates with outstanding charges
- three personal local calls per week for all unsentenced inmates
- one personal local call per week for all sentenced inmates.[282]

Inmates are required to meet the cost of calls to all other approved contacts (up to 10 personal numbers).[283] Inmates reported finding phone calls expensive. This was particularly challenging for inmates with no options for work who relied on family or friends for money. The financial burden was significant for those with family residing overseas.

We have previously reported that the cost of a 10-minute call to a local fixed line was $0.25, to a national fixed line was $1.80, and to a mobile phone was $2.60. International call rates vary according to the country called and a 10-minture call can cost between $4.45 to $30.35. These rates are the same for in-cell tablets and phones located in common areas.[284] Prior to June 2023, many inmates were managing call costs by using third party call management services[285] which allowed calls at cheaper local rates, irrespective of the call destination. However, this option was deactivated by CSNSW due to security concerns arising from some inmates making unauthorised calls, in some cases breaching Apprehended Violence Orders (AVOs).[286]

Following this decision, we have observed an increase in inmate complaints about phone call costs and have raised this issue in previous reports. We have recommended that CSNSW review the cost of phone calls and explore if there are measures to mitigate the security risks of third party call management services.[287] Consequently, we will not be making a further recommendation in this report. However, we reiterate the importance of CSNSW looking at ways to make phone calls more affordable for inmates.

CSNSW has advised that in the 2024–25 financial year it met the cost of 946,114 calls made by inmates.[288] CSNSW has re-negotiated its contract with Telstra, resulting in reduced call costs for inmates. From September 2025, the following charges will apply:

- an inmate's first call of the week to a mobile number will be free and there will be a small reduction in the costs of subsequent mobile calls
- calls to a national fixed line will decrease from $1.80 to $0.25, the same as the cost of a local fixed line call
- the flag fall cost for international calls will be reduced and the cost for international calls of up to 10 minutes will be a flat rate, depending on the country being called.[289]

There will be no change to the scope of calls paid for by CSNSW.[290] We commend CSNSW for actioning the concerns raised by stakeholders regarding call costs, enabling inmates to better maintain contact with their families and friends.

280 Corrective Services NSW, *Custodial Operations Policy and Procedures: 8.2 Inmate Telephones* (version 1.12, 18 July 2024) 9–10.
281 *Crimes (Administration of Sentences) Regulation 2014* cl 119B; Corrective Services NSW, *Custodial Operations Policy and Procedures: 8.2 Inmate Telephones* (version 1.12, 18 July 2024) 12.
282 Corrective Services NSW, *Custodial Operations Policy and Procedures: 8.2 Inmate Telephones* (version 1.12, 18 July 2024) 8.
283 Corrective Services NSW, *Custodial Operations Policy and Procedures: 8.2 Inmate Telephones* (version 1.12, 18 July 2024) 5.
284 Inspector of Custodial Services, *Inspection of Cessnock Correctional Centre and Shortland Correctional Centre* (Report, June 2024) 48–9; Inspector of Custodial Services, *Inspection of Mid North Coast Correctional Centre 2023* (Report, December 2024) 52–3.
285 For example, engine numbers or voice over internet protocol (VOIP) services such as Skype.
286 Inspector of Custodial Services, *Inspection of John Morony Correctional Centre 2023* (Report, March 2024) 44–5; Deputy Commissioner's Memorandum, Security and Custody, *Blocking of VOIP or Engine Phone Numbers* (2023/18, 17 May 2023).
287 Inspector of Custodial Services, *Inspection of John Morony Correctional Centre 2023* (Report, March 2024) 45; Inspector of Custodial Services, *Inspection of Cessnock Correctional Centre and Shortland Correctional Centre* (Report, June 2024) 49; Inspector of Custodial Services, *Inspection of Mid North Coast Correctional Centre 2023* (Report, December 2024) 53.
288 Information provided by Corrective Services NSW, 23 September 2025.
289 Information provided by Corrective Services NSW, 23 September 2025.
290 Information provided by Corrective Services NSW, 23 September 2025.

2.6.9 Visits

Inmates at MSPC have access to in-person and virtual visits on weekends. During the inspection, virtual visits were on Saturdays and in-person visits were on Sundays.

MSPC has two areas for visits – a demountable block in MSPC 1 for maximum security inmates and a sheltered, outdoor area in MSPC 3 for minimum security inmates. Maximum security inmates access virtual visits via the AVL facilities in MSPC 1. Minimum security inmates use tablets set up in the MSPC 3 visits area. MSPC 2 does not have a visits area and MSPC 2 inmates attend visits in the area appropriate for their security classification. Our inspection included observation of in-person visit sessions in MSPC 1 and MSPC 3.

For in-person visits in MSPC, visitors convene at the main entrance gate of the Long Bay Correctional Complex (known as the boom gate) where their identification and visit booking are verified by security staff. Visitors then walk from the boom gate to the relevant visits area. The walk to either area is approximately 600 metres and includes a short but steep hill. It is difficult for people with limited mobility to negotiate this walk, especially in poor weather conditions.

Visitors with mobility issues may obtain approval from the governor to use car parking within the complex (of which there is ample availability on weekends). However, we heard there is a lack of clarity around the steps required for people to obtain this approval and information from staff could vary.

The COPP includes a 'request for disabled parking' form for people who already have accessible parking permits. This request must be completed and submitted by the inmate but consists of information and supporting documentation that can only be provided by the visitor, including a medical certificate, issuing doctors details and mobility parking permit number.[291] As there is no policy guidance on this issue, it is entirely unclear why visitors cannot make this request to the governor directly. This seems to us to be an unnecessary barrier for visitors with disability or who are aged and frail, particularly those visiting inmates with low literacy or intellectual or cognitive disability who may struggle with the requirements of this form.

Parking on site at MSPC is not an option for people travelling by public transport. We observed a visitor with a walking frame struggling to walk from the boom gate to a visits area. We were told that in years past, a community-run courtesy bus operated that would drive visitors to the different visiting areas. It would help visitors to have this service restored.

We note that these issues also impact visitors to LBH. Consequently, we consider that CSNSW should review the accessibility of visits areas for inmates and their visitors at MSPC and LBH. This should include creating a clear process for visitors to apply for permission to use car parking within the complex and strategies for assisting people with the walk between the boom gate and visits areas.

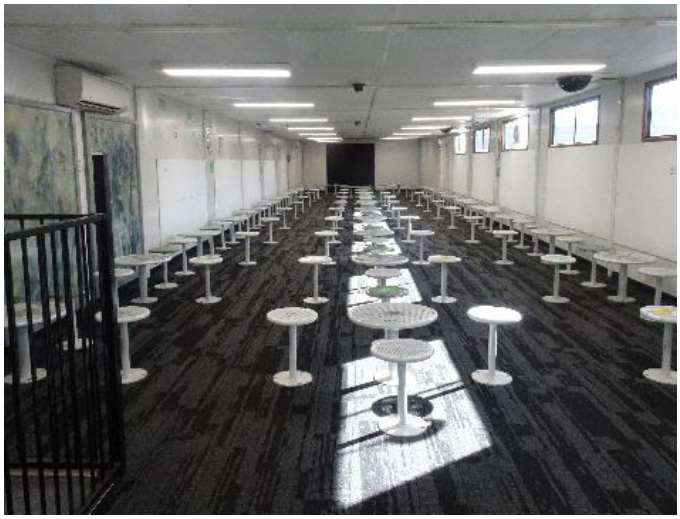
The infrastructure of both visits areas also have significant accessibility issues for people with disability, injury or other physical mobility issues. These are discussed further below.

Recommendation: CSNSW review the accessibility of visits areas on the Long Bay Correctional Complex.

291 Corrective Services NSW, *Request for Disabled Parking* (version 1.1, 20 January 2020).

In-person maximum security visits

MSPC 1 visits room, June 2024



MSPC 1 non-contact visits, June 2024

The MSPC 1 visits area consists of a single visits room and three non-contact visits suites. It is located in a demountable building that was described to us as a temporary visits area that had been in place for around 20 years. The visits room is small, basic and dilapidated. Of particular concern, we observed the fire exits were secured shut and could not be opened in an emergency. Although there is a ramp leading to the visitor's entrance of the building, bumps, sharp corners and narrow corridors make parts of the entrance and exit difficult to navigate for people with mobility aids. The inmate entrance has stairs and is inaccessible for people using a wheelchair or other mobility aid. Inmates who cannot use this entrance go through a sterile zone area to access the ramp. This is a longish walk and is not ideal from a security perspective.

Unlike visits areas at modern correctional centres, there are no family rooms or an outdoor area. Child visitors have no access to toys or an activities area, although we note the efforts of staff to provide children with colouring packs from Shine for Kids. We observed that the room became quite noisy when visits sessions approached capacity. The non-contact visits suites are side-by-side and are not self-contained, making it difficult for visitors and inmates to communicate due to noise.

Unlike other maximum security correctional centres, visitors are processed manually as there is no biometric identification device, which allows for faster processing and accountability checks in an emergency. They are then body scanned.[292] We heard the process of body scanning visitors was generally efficient unless a new profile was required or there was a full visits session.

Before entering the visits building, visitors wait in an area surrounding the body scanner. We observed that the bathrooms in the waiting area were closed. The only available bathroom for visitors was in a different building, around a 10 minute walk away. There were no vending machines and no access to drinking water. We observed a large pack of bottled water but bottles were not offered to visitors. One person was provided a bottle on request but was later required to throw it in the bin during the visit. CSNSW has advised that MSPC has confirmed that the visitor's toilets are functioning and visitors are supplied with bottles of water.[293]

Inmates receiving visitors wait in the AVL holding cells (see section 2.6.10). Prior to the visit, in a room adjoining the visits area, inmates change into a pair of overalls and place their clothing and any other items in a locker. At the end of the visit, inmates remain seated as visitors leave the area. Inmates are then strip searched. All maximum and medium security inmates must be body scanned or strip searched following a visit.[294]

292 The *Crimes (Administration of Sentences) Regulation 2014* cl 93(2A) permits authorised officers to require a visitor to submit to scanning by means of an X-ray scanning device. CSNSW policy provides that all visitors 'undergo body scanning on entry to a correctional centre where a body scanner is available': Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.5 Body Scanning* (version 1.0, 17 July 2025) 15.

293 Information provided by Corrective Services NSW, 23 September 2025.

294 Corrective Services NSW, *Custodial Operations Policy and Procedures: 10.1 Visits to Inmates by Family and Friends* (version 1.10, 24 May 2023) 4; Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 15.

We observed that the inmate processing area did not have any privacy barriers and we were told that two inmates would be searched at a time. Some inmates unable to change into overalls may be permitted to wear standard prison clothing. Staff informed us that those inmates may still be searched. Although there is a body scanner for inmates in the visits area, this was not being used at the time of our inspection due to an industrial dispute. The body scanning of inmates recommenced in September 2024,[295] which should have largely removed requirements for overalls and strip searches.[296]

CSNSW contends that the back of the MSPC visits area has cubicles and partitions for privacy during searches. It noted that consultation was underway with relevant unions regarding staff training for operating body scanners.[297]

At the time of the inspection, visit sessions in MSPC 1 were one hour in length. There were different visit sessions for different inmate cohorts – VOTP inmates (all mainstream); VOTP and 10-wing inmates (all protection); ISU and ASU inmates (5-wing and 6-wing); and 7-wing inmates (all mainstream).

We were concerned about the mixing of 10-wing inmates from different landings in the same visit session. Although they were from the same wing, they typically did not come into contact with each other. This provided additional protection for inmates considered more vulnerable due to their age/frailty or the nature of their charges/offending. Staff were trying to manage this issue by placing inmates from different 10-wing groups at opposite ends of the visits room. We consider this approach still presents a security risk and MSPC should consider offering separate visit sessions for these groups.

CSNSW has advised that MSPC ensures all alerts and restrictions are checked prior to inmates attending visits and that separating these inmate groups would impact the number of visits able to occur.[298]

In-person minimum security visits

The MSPC 3 visits area is in a large, outdoor courtyard with sheltered tables and chairs. Consequently, it is partially exposed to the weather and very cold in winter. There is no play area for child visitors. This is old infrastructure that, like other parts of MSPC, poses safety concerns for people with disability or limited mobility. There is a set of three stairs leading to the door to the visitor's entrance/exit. During the inspection, we observed one visitor with a mobility aid and another who was vision impaired navigating these stairs as they entered and exited the visit area. Visitors in wheelchairs entered and exited through the transport vehicle gate. There was broken and uneven concrete flooring and no high contrast markers on stairs or around hazard areas. We observed staff doing their best to assist visitors requiring help. However, the facilities remain inadequate.

295 Deputy Commissioner's Memorandum, Security and Custody, *Resumption of X-ray Body Scanning in Correctional Centres* (2024/39, 18 September 2024).
296 Corrective Services NSW, *Custodial Operations Policy and Procedures: 10.1 Visits to Inmates by Family and Friends* (version 1.10, 24 May 2023) 11.
297 Information provided by Corrective Services NSW, 23 September 2025.
298 Information provided by Corrective Services NSW, 23 September 2025.

MSPC 3 visits area, May 2024

Visitors arriving at MSPC 3 visits may have to wait outside before entering the waiting area. There is seating but no shelter from poor weather. There is no body scanner for visitors in MSPC 3 and the walk through metal detector reportedly broke around four months prior to the inspection, so visitors were subject to a wand search with a handheld metal detector. CSNSW has confirmed that this metal detector has been replaced.[299] Positively, we observed staff providing bottled water to visitors. Like MSPC 1, there are no vending machines with which to purchase food and drink to share with inmates. Visitors are processed manually as there is no biometric identification device.

Inmates receiving visitors are held in a caged yard attached to the visits area. Inmates from MSPC 2 are placed on one side of the visits area and inmates from MSPC 3 on the other. As these inmates have minimum security classifications, they can undertake visits in their prison clothing (not overalls). At the end of the visit, inmates remain seated while visitors exit the area. They are then called to the inmate processing area to be searched.

CSNSW policy provides that minimum security inmates may be randomly body scanned or strip searched after visits.[300] As there is no body scanner for inmates in MSPC 3, inmates are strip searched. Staff informed us that strip searches were random. Inmates reported they were all strip searched following a visit. As there is no strip search register, there is no way to verify the number of searches conducted (see section 2.4.2).

At the time of the inspection, visit sessions in MSPC 3 were one hour long. This is short for a minimum security population, who would have access to longer visits at other correctional centres.[301] The shorter visits sessions may be attributable to the need to balance different cohorts and provide tablet visits on Saturdays. There were five in-person visit sessions for MSPC 3:

- one session for 3-wing inmates (mental health step-down)

299 Information provided by Corrective Services NSW, 23 September 2025.
300 Corrective Services NSW, *Custodial Operations Policy and Procedures: 10.1 Visits to Inmates by Family and Friends* (version 1.10, 24 May 2023) 4.
301 See Inspector of Custodial Services, *Inspection of Mannus Correctional Centre and Glen Innes Correctional Centre 2022* (Report, February 2024) 16, 33; Inspector of Custodial Services, *Inspection of Bathurst Correctional Centre 2023* (Report, February 2025) 78–9.

- three sessions for inmates from 1-, 4-, 14-, 15-, 16-, 17- and 18-wings *with* child protection alerts
- one session for inmates from 1-, 4-, 14-, 15-, 16-, 17- and 18-wings with *no* child protection alerts (meaning inmates present could receive child visitors).

Given there is only one visit session available for inmates with children, MSPC should consider extending the length of this session or providing an additional session (depending on demand).

Virtual visits

AVL and tablets provide an additional means for inmates to have a face-to-face visit with family and friends unable to travel to a correctional centre for an in-person visit. This is particularly helpful for inmates with family who live in remote regions. Unfortunately, we heard many complaints that the tablets located in MSPC 3 were not fully charging and batteries were running out during visits. Portable battery banks provided a temporary solution, but the tablets needed replacing. Inmates were told several months prior that new tablets had been purchased by CSNSW and would be distributed. At the time of inspection, the tablets had not arrived. CSNSW has since confirmed that these tablets have been replaced and the new tablets are operational.[302]

Visit booking process

We heard from visits staff that AVOs are not consistently captured by Just Connect (the visit booking system) and recorded in the visit booking schedule. This was reportedly due to a communication issue between OIMS and Just Connect. This has significant consequences for visits around ensuring compliance with AVOs.

Prior to the scheduled visit, visits staff check the OIMS record of all inmates scheduled to be visited. Details of any AVOs are cross-checked with the visits schedule to ensure compliance with any relevant order. While this process is time consuming, it is important. If an inmate has an AVO 1 status they may receive a supervised visit, but inmates with an AVO 2 status cannot receive visits from a person the order identifies as someone they cannot be in contact with. Visits staff reported there have been instances an AVO 2 alert was missed and not recorded on the visits schedule until these additional checks were undertaken. We commend the commitment of visits staff to ensure the safety of visitors.

2.6.10 Access to courts and legal representatives

We were concerned that MSPC's AVL facilities were insufficient to meet demand due to their age and condition. Although MSPC has a small remand population compared with other similar sized correctional centres (around 18% in May 2024), AVL facilities were used to facilitate inmate attendance before courts, SORC, the State Parole Authority (SPA) and meetings with lawyers and other professional visitors.

MSPC's only AVL area is located in MSPC 1. It has six AVL suites for court appearances and professional visits (including with legal representatives). There are also two rooms for phone calls with legal representatives and two interview rooms for in-person professional meetings. There are two AVL suites in the SHU, only used by SHU inmates when needed.

The AVL area has six holding cells where inmates wait for their court appearance or professional appointment. Inmates are brought to AVL around 9am and may spend lengthy periods waiting for court, which in many cases can take all day. We observed the holding cells to be substandard, with only some having a toilet and washbasin, and others exposed to the climate. The limited bathroom amenities require inmates to be shuffled between holding cells and, when managing various inmate cohorts, this can place inmates and officers at risk of harm.

For inmates with mobility issues, the AVL area presents many challenges. A removable ramp allows for inmates in wheelchairs and walkers to enter the area. The space is tight and has narrow doorways to AVL suites, making it difficult for people with mobility aids to manoeuvre. The AVL area is unsafe,

302 Information provided by Corrective Services NSW, 23 September 2025.

unfit for purpose and does not meet the expectations of a modern correctional environment.

As mentioned in section 2.6.6, inmates can also make free calls to Legal Aid NSW and the Aboriginal Legal Service NSW from the phones in the yards and units or using in-cell tablets. CSNSW also covers the cost of all legal calls for unsentenced (remand) inmates and for sentenced inmates facing further charges.[303] However, these phone calls have a 10-minute time limit at most correctional centres, including MSPC.[304]

AVL holding cell, May 2024

AVL holding cell, August 2023

2.6.11 Mail

CSNSW commenced the practice of photocopying inmate mail in 2020 to prevent contraband from entering correctional centres via inmate mail. At that time COVID-19 restrictions on in-person visits were in place and there were concerns that inmate mail was increasingly being used to spread contraband, particularly drugs.[305]

CSNSW policy provides inmates should be provided with a colour photocopy of their mail, including the letter, front and back of the envelope and any attachments. Mail may be photocopied in black and white where colour is temporarily unavailable but the capacity for colour photocopies should be restored as soon as possible. Photographs may be issued to an inmate if they have not been tampered with and are not prohibited, inappropriate in relation to the relevant inmate, or larger than a standard photograph size (10 x 15 cm). Mail may also be scanned and delivered via an inmate tablet.[306]

Photocopying requirements do not apply to privileged mail from exempt persons and bodies, as defined by the CAS Regulation.[307] The CAS Regulation provides that mail from an exempt body or person must be provided to inmates 'as soon as practicable' and 'without opening, inspecting or reading it'. Mail from an inmate addressed to an exempt body or person should be posted 'as soon as practicable' and 'without opening, inspecting or reading it'.[308]

Privileged mail must be contained in an envelope or package addressed to the governor with an explanatory note stating the letter or parcel is to be delivered to the inmate without being opened, inspected or read by any person other than the inmate. If the correspondence is not sent in this manner but appears to be privileged, staff must return the mail to the sender with a factsheet on sending privileged correspondence.[309]

303 Corrective Services NSW, *Custodial Operations Policy and Procedures: 8.2 Inmate Telephones* (version 1.12, 18 July 2024) 8.
304 Corrective Services NSW, *Custodial Operations Policy and Procedures: 8.2 Inmate Telephones* (version 1.12, 18 July 2024) 9.
305 Inspector of Custodial Services, *Review of the Response to COVID-19 in NSW Custody* (Report, November 2023) 86.
306 Corrective Services NSW, *Custodial Operations Policy and Procedures: 8.1 Inmate Mail* (version 1.13, 17 July 2025) 5.
307 *Crimes (Administration of Sentences) Regulation 2014* cls 3, 113.
308 *Crimes (Administration of Sentences) Regulation 2014* cls 113(1)–(2).
309 Corrective Services NSW, *Custodial Operations Policy and Procedures: 8.1 Inmate Mail* (version 1.13, 17 July2025) 11.

During this inspection we received many complaints from inmates around mail. This is consistent with our other inspections following the implementation of this approach.[310] Complaints included lengthy delays in receiving mail, lost mail, and photos copied in black and white. Inmates spoke of inconsistent and careless practices in the handling of personal and legal mail by staff. There were reports of inmates receiving opened legal mail and having difficulty sending legal correspondence. Legal practitioners are exempt persons under the CAS Regulation,[311] so inmates should not be receiving opened legal mail. If sent in the specified manner, legal mail should be given to the inmate unopened or, if not, it should be returned to the sender. Inmates receiving opened legal mail suggests it was opened in error.

In our report, *Review of the Response to COVID-19 in NSW Custody*, we reflected on the poor implementation of policy and procedures to copy, and then destroy, inmate mail.[312] With respect to privileged mail to and from exempt bodies and persons, we consider it is now clear that accountability measures are required to ensure compliance with the legislation. This could be achieved with a register of privileged mail that records incoming and outgoing correspondence and when it was received/posted, including inmate verification that privileged mail received was unopened.

Recommendation: CSNSW implement a privileged mail register.

2.6.12 Access to recreation

All accommodation units in MSPC have an outdoor area, which in most cases consists of a concrete yard with a makeshift exercise area. The gym equipment we observed varied but generally included chin up bars, weight bags or makeshift weight bars. Some units in MSPC 2 (1-, 5-and 6-wings) and MSPC 3 (17-and 18-wings) have an indoor gym space or equipment for other recreational activities such as ping pong. MSPC 1 has an oval, however, we heard that access was sporadic and that in the six months prior to the May 2024 inspection, inmates had used the space three times. MSPC 2 and MSPC 3 has large, outdoor courtyards which most inmates in these areas can access at some time during the day.

We saw little evidence of inmates engaged in structured recreational activity. While programs and work occupied most inmates' days at MSPC there were many inmates who were unemployed and aged and frail with little to do. Those inmates generally had only cards and television to occupy their time. This is not enough, and inmates are bored. Boredom often contributes to anti-social behaviour. More attention must be given to this cohort to deliver a structured and meaningful day.

310 Inspector of Custodial Services, *Review of the Response to COVID-19 in NSW Custody* (Report, November 2023) 86–8; Inspector of Custodial Services, *Inspection of Silverwater Women's and Dillwynia Correctional Centres 2022* (Report, November 2023) 85–6; Inspector of Custodial Services, *Inspection of the Metropolitan Remand and Reception Centre* (Report, February 2024) 61; Inspector of Custodial Services, *Inspection of Wellington Correctional Centre 2022* (Report, May 2024) 34–5; Inspector of Custodial Services, *Inspection of Geoffrey Pearce Correctional Centre* (Report, December 2024) 32; Inspector of Custodial Services, *Inspection of Bathurst Correctional Centre 2023* (Report, February 2025) 81.

311 *Crimes (Administration of Sentences) Regulation 2014* cl 3.

312 Inspector of Custodial Services, *Review of the Response to COVID-19 in NSW Custody* (Report, November 2023) 86.

MSPC 3 oval and gym area, May 2024

Makeshift exercise equipment in MSPC 2, 4-wing, May 2024

2.7 Rehabilitation and release preparation

2.7.1 Classification and placement

The case management reform in 2017 led to the separation of case management, and inmate classification and placement responsibilities. The reform resulted in the creation of CMUs, which undertake case planning and management (see section 2.7.2).[313] Under this model, the FM case management was responsible for all classification and placement duties and had oversight of the CMU.

The Services and Programs redesign in 2024 moved the reporting line of CAPOs from the FM case management to the senior service integration manager. The FM case management continues to form part of local Classification and Placement Teams (CPT).[314] Classification and placement staff at MSPC were positive about these changes, although noted they had not long been implemented.

The classification process consists of determining an inmate's security classification in accordance with the CAS Regulation and identifying the most appropriate correctional centre in which they should be placed. In the first instance, classification assessments are undertaken by the CPT, consisting of the FM case management, who convenes and chairs the CPT meetings, and a senior CAPO or CAPO. The CPT makes a recommendation on an inmates' classification and placement, which is reviewed by the governor or MOS. The manager or deputy manager classification and placement will approve, vary, or decline this recommendation. A classification consultative group[315] will be convened where further discussion is required or a recommendation is not supported.[316]

There are three types of classification assessment undertaken by the CPT:

- **Initial classification and placement**, which is conducted when the inmate first enters custody and, if they enter custody on remand, when they are sentenced.[317]
- **Review of classification and placement**, which must occur at least once every 12 months as required by the CAS Regulation. Reviews may be scheduled (12 months from the previous assessment) or unscheduled (outside the planned review date). Reasons for an unscheduled review include additional court matters, involvement in an incident and behavioural issues.[318]
- **Change of placement**, which only considers the correctional centre where an inmate is held, not their security classification.[319] Reasons for a change of placement include program participation or completion, inmate request, or because their current location is no longer suitable due to association issues.[320]

At the time of the inspection, classification and placement staffing consisted of a senior CAPO and two CAPOs. There was also a FM case management. There were no vacant positions.

MSPC 1 is not a gaol of classification. It holds people on remand, VOTP participants, and people with a medical hold due to health appointments scheduled at LBH or a Sydney hospital. Classification and placement work in MSPC 1 consists of initial classification and placement recommendations when inmates are sentenced or change of placements following an incident or when a medical hold has been lifted.

Staff reported that there can be impediments to transferring inmates who had been on a medical

313 Corrective Services NSW, *Inmate Classification and Placement: Policy for Inmate Classification and Placement* (version 2.1, 29 October 2021) 5.
314 Joint Deputy Commissioner's Memorandum, Security and Custody (2024/35) and Strategy and Governance (2024/05), *Functional Manager Role Change* (22 August 2024).
315 A classification consultative group consists of the manager or deputy manager of classification and placement, as the chair, and the MOS: Corrective Services NSW, *Inmate Classification and Placement: Policy for Inmate Classification and Placement* (version 2.1, 29 October 2021) 19.
316 Corrective Services NSW, *Inmate Classification and Placement: Policy for Inmate Classification and Placement* (version 2.1, 29 October 2021) 17–20.
317 Corrective Services NSW, *Inmate Classification and Placement: Initial Classification and Placement* (version 2.3, 30 June 2022).
318 Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement Reviews* (version 2.2, 18 October 2021).
319 Corrective Services NSW, *Policy for Inmate Classification and Placement* (version 2.1, 29 October 2021) 13.
320 Corrective Services NSW, *Inmate Classification and Placement: Placement of Inmates* (version 1.0, 24 May 2025) 7–9.

hold back to their gaol of classification if the gaol of classification no longer has an available place or if there is a lack of special transport availability. They may also become 'stuck' at MSPC 1 if they are too unwell for transfer. The different information systems used by JH&FMHN and CSNSW can mean that medical appointment information is not up to date, making timely decision making challenging. Inmates with all security classifications are held in MSPC 1, although it is a maximum security location. Consequently, inmates with minimum security classifications and a medical hold may be held in MSPC 1 for an extended period. This is not ideal.

Generally, MSPC 2 and MSPC 3 are gaols of classification for protection inmates with a minimum security classification, although many wings have additional placement criteria that align with their specific function, namely the ASUs, SHU, ISU, aged and frail unit (4-wing), mental health step-down unit (3-wing) and sex offender programs unit (1-wing). Classification and placement work in MSPC 2 and MSPC 3 largely consists of scheduled and unscheduled reviews.

A lack of placement options in the Sydney metropolitan area for minimum security inmates on protection was described by staff as an ongoing issue. Another issue was competition between correctional centres across NSW for minimum security inmates who can work. Classification and placement staff reported actively looking for inmates who meet this profile who may wish to be located at MSPC.

We observed a tension between these demands with respect to the placement of aged and frail inmates at MSPC (many of whom are on protection and have a minimum security classification) with limited or no capacity to work. Staff across different disciplines considered staffing inmate work locations to be the priority and expressed frustration at being unable to transfer aged and frail inmates elsewhere. Classification and placement staff would regularly review the list of inmates medically unfit for work to identify those who may be suitable for a change of placement. However, as unsuitable as MSPC's physical infrastructure is for aged and frail inmates, there is not currently another location in the Sydney metropolitan area that meets their needs. Until this is resolved, their placement should be the priority.

2.7.2 Case planning and management

CMUs are responsible for case planning and management. This involves conducting assessments, developing individualised case plans that include programs and activities to be undertaken by the inmate during their time in custody, and ongoing casework with inmates. Unsentenced inmates, and inmates with a sentence of less than three months are not eligible for a case plan. These inmates have a service plan based on the Intake Screening Questionnaire undertaken when they enter custody.[321]

Case plans are based on analysis of the inmate's pre-sentence reports, applicable assessment tools, criminal history, and any other relevant information. The development of case plans should also involve active engagement with the inmate. Case plans should be approved within 42 days of sentencing and reviewed and updated at regular intervals, the duration of which depend on the inmate's needs and sentence length.[322]

At the time of the inspection, the CMU consisted of two senior case management officers and 10 case management officers (CMO). Three CMO positions were vacant. Each CMO had a case load of around 50 inmates. Staff reported that a case load of around 30 inmates per CMO would be more optimal.

Staff estimated that there were around 20 eligible inmates who did not have a case plan. As at 31 August 2024, 490 inmates (72.8%) at MSPC had a current, up to date case plan. The remaining 183 inmates (27.2%) were ineligible. There were no eligible inmates who did not have a current case plan.[323]

321 Corrective Services NSW, *Procedures for Case Planning with Inmates in CSNSW* (version 3.2, 1 April 2025) 8–10.
322 Corrective Services NSW, *Procedures for Case Planning with Inmates in CSNSW* (version 3.2, 1 April 2025) 10–11, 13.
323 Information provided by Corrective Services NSW, 17 January 2025.

2.7.3 Programs

Determining program eligibility and suitability

All people who receive a custodial sentence are automatically assessed for program eligibility via an automated process called the Criminogenic Program Eligibility Overview (CPEO). The CPEO considers the person's current offence, sentence length, time remaining on sentence, and risk assessment score[324] to identify what, if any, programs they may be eligible for. A CMO then completes the Most Appropriate Program Pathway (MAPP) for the identified program(s) to determine the inmate's eligibility.[325] If eligible, they will be placed on the waitlist.[326]

Program suitability is determined at the time a person is being considered for treatment. Factors considered include the person's current mental health, any security and placement issues (non-associations, alerts, affiliations), any further/outstanding court matters, recent offences in custody for violent behaviour, and security classification. For the VOTP and sex offender programs, the suitability check and waitlist management are completed by subject matter experts either within the intensive program teams or the Offender Transformation team. Special management committees, including SORC and the High Security Inmate Management Committee, may also make recommendations about program participation.[327]

In addition to general program offerings, MSPC has two units that accommodate inmates identified as eligible and suitable for VOTP or a sex offender program. Inmates must consent to participate in these programs, although it should be noted that participation is considered by SPA in decisions to release a person to parole. Only sentenced inmates can participate in these programs.

General programs

At the time of the inspection, the MSPC OS&P team consisted of a MOSP, two SAPTLs and 11 SAPOs, including two identified positions for Aboriginal SAPOs. There were no vacant positions. The SAPTLs and SAPOs were split into two groups, one providing services to MSPC 1 and the other to MSPC 2 and MSPC 3. The Aboriginal SAPOs worked across all areas. The MOSP reported to the senior service integration manager.

In MSPC 1, OS&P staff facilitated remand-focused programs (Remand Addictions and Remand Domestic Violence, Mini Dads at a Distance) and coordinated Narcotics Anonymous and Alcoholics Anonymous sessions. There was also a First Nations Creative Group facilitated by Aboriginal SAPOs to Aboriginal men in 7- and 10-wings (see section 2.6.4).

In MSPC 3, OS&P staff delivered programs to sentenced inmates including the EQUIPS suite, RUSH and CONNECT.

The OS&P team were also responsible for facilitating a number of supports for inmates. These included:

- arranging for a community legal centre to assist aged inmates with estate planning (wills, power of attorney, and enduring guardianship arrangements)
- assisting survivors of institutional child sexual abuse with Redress Scheme applications
- facilitating the provision of Homeless Not Nameless packs for inmates at risk of homelessness on release[328]
- helping prepare inmates for release by facilitating contact with Services Australia and other community-based services

324 According to the Custody Triage Risk Assessment Scale (TRAS).
325 There are eight MAPPs in total. Each program has a specific MAPP and there is a MAPP for education: Corrective Services NSW, *Procedure for the Use of Intervention Pathways Supporting Tools* (version 1.1, 23 February 2022).
326 Information provided by Corrective Services NSW, 23 April 2024.
327 Information provided by Corrective Services NSW, 23 April 2024.
328 *Homeless Not Nameless* (Web Page, undated) <https://www.homelessnotnameless.com.au/home>.

- starting a pilot program with psychology staff called Seeking Safety, to help inmates address the impacts of trauma.

Sex offender programs

Sex offender programs are located in MSPC 2 in 1-wing. Some program participants and recent graduates are located in 4-wing. Sex offender programs include several treatment programs that aim to reduce the likelihood of continued sexual offending behaviour by an inmate upon their return to the community:

- **High Intensity Sex Offender Program (HISOP)**: approximately 10 months duration (300 hours). For offenders identified as 'well above average risk' or 'above average risk' of reoffending.
- **Moderate Intensity Sex Offender Program (MISOP)**: approximately 6 months duration (130 hours). For offenders identified as 'above average risk' of reoffending and ineligible for HISOP.
- **Self-Regulation Program: Sexual Offenders (SRP:SO)**: approximately 18 months duration (up to 300 hours). For offenders with an intellectual disability or cognitive impairment identified as 'well above average risk' or 'above average risk' of reoffending.
- **Deniers Program**: approximately 6 months duration (130 hours). For offenders who deny the sexual offences of which they have been convicted, also identified as 'well above average risk' or 'above average risk' of reoffending.[329]

As at 2 April 2024, there were 60 inmates on the waitlist for HISOP (two past their earliest possible release date), 54 inmates on the waitlist for MISOP (one past their earliest possible release date), three inmates on the waitlist for SRP:SO (one past their earliest possible release date) and 12 inmates on the waitlist for the Deniers Program (none past their earliest possible release date).[330]

Data on the number of inmates who have completed sex offender programs from 2021 to 2023 is in Table 22. The information provided by CSNSW noted that the SRP:SO is run bi-annually and as of April 2024, the most recent SRP:SO program had commenced in mid-2023. The Deniers Program is run around every 18 months, subject to demand and sufficient participant numbers. Consequently, there will not be data for these programs every year. MSPC is the primary location for sex offender programs. In 2021 and 2022 'satellite programs' were delivered at Kirkconnell and South Coast correctional centres, under the supervision of the sex offender programs team at MSPC.[331]

Table 22: Sex offender program completions, 2021 to 2023[332]

Year	Program	Total (all CCs)	At MSPC
2021	HISOP	19	19
	MISOP	6	0
	SRP:SO	8	8
2022	HISOP	28	18
	MISOP	39	31
2023	HISOP	30	30
	MISOP	35	35
Total		**165**	**141**

The sex offender programs team has a staffing profile of three senior psychologists, 12 psychologists and one administration officer.[333] Similar to psychologists providing mainstream services, the sex offender programs team reports to the senior service integration manager for all non-clinical/

329 Corrective Services NSW, *Compendium of Offender Behaviour Change Programs* (October 2023) 93–106.
330 Information provided by Corrective Services NSW, 23 April 2024.
331 Information provided by Corrective Services NSW, 23 April 2024.
332 Information provided by Corrective Services NSW, 23 April 2024.
333 Information provided by Corrective Services NSW, 23 April 2024.

administrative work and the chief psychologist for clinical matters. The most significant issue impacting the capacity of sex offender programs was short staffing. At the time of the May 2024 inspection, there were six vacant psychologist positions. This was expected to increase to seven vacancies as one psychologist had recently resigned.

Short staffing reduced service provision capacity and increased the workload for the sex offender programs team. Psychology staff we spoke to across areas reported that CSNSW and the Department of Communities and Justice are not competitive employers for psychologists. Put simply, psychologists can receive higher salaries in other positions requiring comparable experience, in both the public and private sectors. This is partly why CSNSW struggles with the recruitment and retention of psychologists. Recruitment timeframes are also an issue as it can take months for security checks to be completed. We were told of a recruitment that had commenced in November 2023 and had not been finalised by our inspection in May 2024. This can lead to the loss of successful candidates who accept other opportunities with earlier commencement dates.

Capacity limitations due to vacant psychologist positions were compounded by the end of contracts between CSNSW and LSC Psychology for the completion of sex offender risk assessments and the delivery of MISOP and the Deniers Program. Whether the sex offender programs team would be able to deliver MISOP or the Deniers Program depended on their staffing profile. There were no plans to run either program in the foreseeable future, creating concern about the impact on waitlists.

At the time of the inspection, the sex offender programs team was delivering HISOP and SRP:SO. HISOP had a total of 15 participants, split evenly across three groups, each with one facilitator. SRP:SO had four participants with one facilitator. Short staffing meant that the sex offender programs team could not have two facilitators for each group, which would allow for more participants. A larger group with two facilitators was the preferred model for delivering sex offender programs.

This has not improved since our previous inspection of sex offender programs. That inspection found that vacant psychology positions were negatively impacting the capacity of CSNSW to deliver intensive programs and recommended CSNSW explore innovative recruitment initiatives to fill vacancies. In response to that inspection, CSNSW reported engaging with the Department of Communities and Justice Strategic Human Resources team and conducting significant recruitment activity for psychology positions.[334] We acknowledge CSNSW's efforts to address this issue but unfortunately, they do not appear to have had a lasting impact on staffing levels for the sex offender programs team.

Improving recruitment and retention of psychologists in the sex offender programs team is essential for the delivery of programs for sex offenders before they are released from custody, in line with the expectations of SPA and the community. We have since made several recommendations in other inspections concerning the recruitment and retention of psychology staff. In our report on the inspection of South Coast Correctional Centre we recommend that CSNSW review pay scales for psychologists to assist with recruitment and retention.[335] We reiterate this recommendation in this report. In addition to reviewing pay scales, CSNSW should also consider security clearance processes and look at pathways for graduates and student placements and greater flexibility in relation to part time work and secondary employment.

Recommendation: CSNSW review pay scales for psychologists to assist with attraction and retention of those staff.

334 Inspector of Custodial Services, *Programs, Employment and Education Inspection* (Report, February 2020) 47.
335 Inspector of Custodial Services, *Inspection of South Coast Correctional Centre 2023* (Report, November 2025).

Violent Offender Therapeutic Program

VOTP is located in MSPC 1 in 11-wing (mainstream inmates) and 31-wing (protection inmates). It is a high intensity group treatment program for inmates with a history of violent behaviour that aims to change the thinking, attitudes and feelings that led to an inmate's violent offending. It takes approximately 10 months (300 hours).[336] Self-Regulation Program: Violent Offenders (SRP:VO) adapts VOTP for those with intellectual disability or cognitive impairment. It takes approximately 18 months (300 hours).[337]

As at 12 March 2024, there were 78 inmates on the waitlist for VOTP (10 past their earliest possible release date) and eight on the waitlist for SRP:VO (two past their earliest possible release date). Completion figures are in the Table 23. Around 71% of VOTP completions and all SRP:VO completions occur at MSPC.[338]

Table 23: VOTP completions, 2021 to 2023[339]

Year	Program	Total (all CCs)	At MSPC
2021	VOTP	39	29
	SRP:VO	1	1
2022	VOTP	22	12
	SRP:VO	2	2
2023	VOTP	46	33
	SRP:VO	5	5
Total		**115**	**82**

The VOTP team at MSPC had a staffing profile of two senior psychologists, 14 psychologists and one administration officer. As at 1 March 2024, there were four vacant psychologist positions – two substantive vacancies and two temporary vacancies.[340] Similar to psychologists providing mainstream services, the VOTP team reports to the senior service integration manager for all non-clinical/administrative work and the chief psychologist for clinical matters. The changes in reporting lines had only been in place for a few months but staff seemed to view it positively and did not report any concerns about the new model.

Program delivery was operationally challenging for the VOTP team due to the inmate cohort and the location of the unit in MSPC 1. As highlighted in section 2.6.1, MSPC 1 has less time out of cell and is more frequently impacted by lockdowns than other areas of MSPC. VOTP participants were also locked into their cells from 10.30am to 11.45am each day. Together, this limited the available time for program delivery and disrupted the facilitation of VOTP group sessions.

Therapeutic communities for intensive programs

In our *Programs, Employment and Education Inspection* report, we highlighted the importance of creating a therapeutic community for intensive program participants. Although challenging in a correctional environment, adhering to this principle as much as possible maximises the effectiveness of intensive programs. Key among our concerns during that inspection was the physical infrastructure of the wings at MSPC that accommodated participants in the sex offender and VOTP programs and the attitudes of some custodial staff.[341] Unfortunately, these issues remained of concern in this inspection.

We heard that some custodial staff interact positively with program participants and work collaboratively with psychology staff. Having more regular custodial staff can support the

336 Corrective Services NSW, *Compendium of Offender Behaviour Change Programs* (October 2023) 74–6.
337 Corrective Services NSW, *Compendium of Offender Behaviour Change Programs* (October 2023) 77–9.
338 Information provided by Corrective Services NSW, 23 April 2024.
339 Information provided by Corrective Services NSW, 23 April 2024.
340 Information provided by Corrective Services NSW, 23 April 2024.
341 Inspector of Custodial Services, *Programs, Employment and Education Inspection* (Report, February 2020) 48–9.

development of professional relationships with both psychology staff and program participants. Psychology staff also reported that the management team in place at the time of the inspection, particularly the governor, were communicative and inclusive.

However, some custodial staff continue to display a poor attitude to program participants and non-custodial staff. This not only frustrates the aims of these programs but can create safety concerns for psychology staff. Name calling, threats or other poor treatment can make participants unsettled and volatile. A failure to model appropriate treatment reinforces the negative and anti-social behaviour the programs are trying to challenge and weakens the impact of program messaging.

In our previous inspection we recommended that CSNSW provide relevant training for custodial staff posted in intensive program areas. In response, CSNSW reported that it was creating a training package for custodial staff working in intensive therapeutic programs. We understand that this has been rolled out.

During the inspection, it was suggested to us that joint training with psychologists and custodial staff might be beneficial and we agree. This could help strengthen professional relationships, collaboration and a sense of shared purpose. CSNSW should consider opportunities for this to occur. It was also observed that working in intensive programs areas can be more challenging than other areas and incentives that recognise this might increase the engagement of custodial staff.

CSNSW has advised that its Staff Support, Culture and Wellbeing team are in the early stages of implementing the Culture and Wellbeing Framework across CSNSW locations. This includes workshops focusing on respectful relationships and team cohesion and collaboration. The workshops aim to develop understanding of how interpersonal interactions can impact and facilitate attitudinal change among inmates and colleagues.[342]

Positively, the cell capacity in the sex offender programs wing had been reduced from double to single occupancy. Otherwise, the built environment of the sex offender programs and VOTP wings has not improved since our last inspection.[343] The cells in both areas remain cramped and dilapidated and unfit for purpose. In the VOTP area, the units for mainstream and protection inmates are in close proximity and inmates can see and hear each other, providing opportunities for harassment or inciting incidents. VOTP participants have limited access to green space. It was reported that the VOTP wing has mice, mould in the group rooms and had previously flooded with sewage.

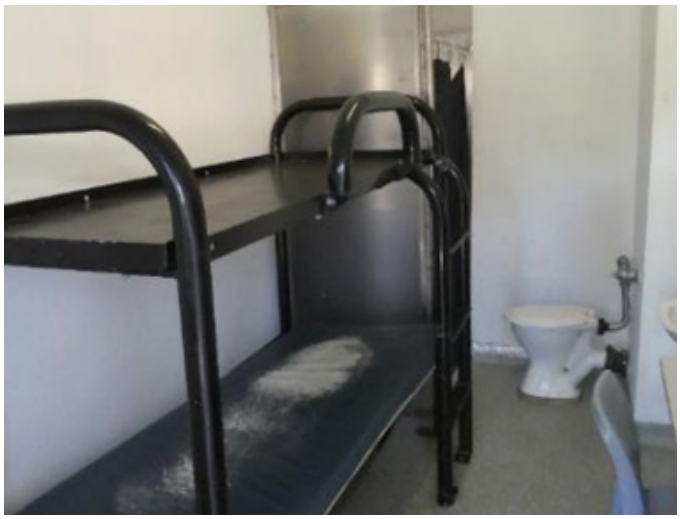
In our previous inspection, we recommended that CSNSW review the accommodation and placement of intensive programs. In response, CSNSW agreed to conduct a review.[344] However, participants in these programs remain in an unfit environment with no plans to relocate them. We acknowledge that this may be challenging given a Sydney metropolitan base would be ideal to attract sufficient psychology staff. However, this is not a new problem and delaying the development of an alternative will not make resolving the challenges any easier.

342 Information provided by Corrective Services NSW, 23 September 2025.
343 Inspector of Custodial Services, *Programs, Employment and Education Inspection* (Report, February 2020) 48–9.
344 Inspector of Custodial Services, *Programs, Employment and Education Inspection* (Report, February 2020) 49.

31-wing (SMAP VOTP) cell, May 2024

VOTP group room, May 2024

1-wing cell, May 2024



1-wing outdoor area, August 2023

2.7.4 Employment and education

At the time of this inspection, there were a number of CSI business units and service industries operating at MSPC, providing a total of 458 inmate jobs. These workplaces make goods and deliver services to correctional centres, government agencies and the private sector. Service industries also include inmates undertaking programs. Employment areas, the number of jobs available to inmates, a description of the work and the location where inmate workers are housed are detailed in Table 24 and Table 25.

Table 24: CSI business units, job numbers, hours of operation and worker location[345]

Business unit	Jobs	Description	Worker location
Laundry	30	Provides laundry services to MSPC, LBH, some army barracks and NSW Police cells.	MSPC 3
Bakery (Reg Boys)	45	Makes bread and other baked goods for inmates in correctional centres in the Sydney metropolitan region, South Coast and Goulburn.	MSPC 3
Technology & assembly	15	Refurbishing airline headsets and electrical goods and assembling items such as laundry tubs and toilet seats.	MSPC 3
Technology & assembly	32	Refurbishing airline headsets and inmate hygiene packs.	ASUs
Textiles	45	Making textiles including sheets, curtains and robes for private contractors and certain items of prison clothing.	MSPC 3
Print	30	Digital and screen printing work including stickers, t-shirts and pens.	MSPC 3
Food services	40	Preparing sandwich lunches and retherming evening meals for MSPC.	MSPC 3
Facilities management	51	Includes work such as painting, plumbing, electrical, and general repair work.	All areas
Total	**288**		

Table 25: CSI service industry, job numbers, hours of employment and worker location [346]

Service industry	Jobs	Description	Worker location
Café	15	Inmates make and serve food in the Long Bay café.	MSPC 3
Community projects	10	Inmates undertake maintenance work in the community, including mowing lawns in a cemetery.	MSPC 3
Service industries	135	Includes program participants, Aboriginal IDC delegates, hygiene workers, barbers and ground maintenance workers.	All areas
Warehouse stores	10	Management of the storage warehouse.	MSPC 3
Total	**170**		

345 Information provided by Corrective Services NSW, 11 November 2023.
346 Information provided by Corrective Services NSW, 11 November 2023.

Textiles workshop, May 2024

Reg Boys Bakery, May 2024

Hiring and dismissal processes

The manager of industries interviews and assesses each inmates' suitability for employment, after they have submitted an application for work. This application details their education and work history and allows inmates to express a workplace preference, although workplace needs will be prioritised over inmate preference. Inmates who are unable to work are paid an unemployment wage of $16.20 per week.[347] Sentenced inmates who refuse to work are not paid.[348]

Dismissal from work is also managed by the manager of industries. Sentenced inmates dismissed from work are managed in accordance with CSI policy and do not receive any wages for two weeks. If they refuse to work after this period, they will not be paid an unemployment wage.[349] They may also be charged with a correctional centre offence if this was the reason for their dismissal from work. Prior to dismissal, inmates who are performing poorly at work are placed on a behaviour management plan that identifies their performance issues and how these should be addressed. Inmates are required to acknowledge that they will be at risk of being moved to a different correctional centre if they do not 'adhere to the procedures and policies of CSI employment'.[350] The plan is then reviewed in one to two months.

The number of dismissed workers at MSPC was considered small. Staff reported workers were most commonly dismissed for possession of contraband, stealing, fighting, or damaging products. Dismissal was considered a last resort as there were insufficient inmates to fill the employment profile of the business units. Sometimes, rather than dismissal from work, inmates would be moved to work in a different industry.

Number of inmate workers

Most jobs were only available to inmates in MSPC 3. Inmates in MSPC 1 and MSPC 2 (except those in the ASUs) could only be employed in facilities management or service industries positions. On 17 May 2024, of the 178 inmates in MSPC 1, 135 (75.8%) were unemployed, the rest were employed or in a program and one was medically unfit. Of the 320 inmates in MSPC 3, six (1.9%) were unemployed, 287 (89.7%) were employed or in a program and 27 (8.4%) were medically unfit. The work figures for MSPC 2 were more complex as the mental health step-down unit (3-wing) and aged and frail unit were categorised as programs, meaning these inmates were paid at a higher rate than unemployed inmates. Consequently, of 120 inmates in MSPC 2, 17 (14.2%) were unemployed, 102 (85%) were employed or in a program and one was medically unfit. In total, 29 inmates at MSPC were medically unfit for work.[351]

347 Corrective Services NSW, *CSI Policy and Procedures: 8.2 Inmate Incentive Allowance Framework* (21 January 2025) 9, 11.
348 Corrective Services NSW, *CSI Policy and Procedures: 8.2 Inmate Incentive Allowance Framework* (21 January 2025) 4.
349 Corrective Services NSW, *CSI Policy and Procedures: 8.2 Inmate Incentive Allowance Framework* (21 January 2025) 4.
350 Information provided by Corrective Services NSW, 27 May 2024.
351 Information provided by Corrective Services NSW, 27 May 2024.

Despite support from program staff, inmates enrolled in the VOTP and sex offender programs could not concurrently work and participate in their program. Although program participation is itself considered a job for which inmates are paid a wage, program staff felt that further job opportunities could support the goals of these programs, especially in sex offender programs where inmates have longer out of cell hours. Inmates may also earn more money in business unit jobs, depending on their wage level and the availability of bonus payments.

As described in section 2.7.1, MSPC staff reported there were insufficient inmate workers to operate MSPC's industries. This was largely attributed to the number of aged and frail inmates and inmates on medical holds placed in MSPC, particularly in MSPC 3, who were unable to work or had limited capacity to work. These concerns were reflected in MSPC's 2024 Strategic Review of Correctional Industries and Education. This meeting determined that JH&FMHN would conduct a review of current inmates on medical holds to identify who could work and at what capacity and to notify classification and placement staff to prioritise the ratification of classification and placement decisions relating to 'suitable inmates to maintain worker numbers'.[352]

We acknowledge the importance of inmates having access to work. Inmate jobs can alleviate boredom and anti-social behaviour and provide inmates with a sense of purpose, money for additional food and hygiene items, and skills that may help them secure work after release. We support the efforts of CSNSW and MSPC to ensure that industries are operating and inmates can access jobs. However, we consider that CSNSW places too high a priority on staffing industries with inmate workers and that this consideration needs to be better balanced with other concerns, including program participation, literacy and numeracy education, and proximity to health services.

Workplace conditions

Workplace induction and training for inmate workers is provided by business unit overseers, who are custodial officers with industry relevant qualifications and experience. Workplace signage and hazard control seemed adequate.

CSI convenes quarterly workplace health and safety meetings for MSPC industries. We reviewed minutes from several of these meetings which showed that ventilation and 'extremely hot' temperatures in the laundry during summer months were regularly raised. We attended the laundry during the inspection in May 2024. While it was a cool day, it was significantly warmer in the laundry with washing machines, an industrial iron and one dryer operating. It was clear that, in full operation on a warm day, the temperature in the laundry would be much hotter. We were told that several requests for fans and ventilation have been made to BGIS (responsible for facilities management) but, at the time of the inspection, a response had not been received.

Education and vocational training

CSI is also responsible for inmate education, including literacy courses, traineeships, and vocational training (VTP) and workplace training (WTP) programs. The Long Bay Correctional Complex had two full-time education services officers and four assessment and planning officers responsible for assessing inmate needs, facilitating distance education and course delivery by third party providers and supporting inmates where needed.

When people enter custody, they undertake a core skills assessment (a computer-based literacy and numeracy assessment that helps identify any learning needs) and an education and employment plan (which includes past education and work experience and future goals). These are used in the case planning process and help determine any education or vocational training opportunity the inmate may undertake during their imprisonment. When an inmate is released to the community, they receive a Statement of Employment and Training outlining the work and training undertaken.[353]

Education and vocational training programs are delivered by external providers, such as BSI Learning and TAFE. Literacy courses, also called Foundation Skills Programs (FSP), consist of various levels of digital literacy courses and language, literacy and numeracy (LLN) courses. Vocational and

352 Information provided by Corrective Services NSW, 15 November 2024.
353 Information provided by Corrective Services NSW, 11 November 2023.

workplace training courses are generally related to inmate employment. Inmates can gain certificate qualifications, with formal instruction and assessment provided in most cases by TAFE NSW.

Table 26 details the education and training offered at MSPC from 1 September 2022 to 31 August 2023 and from 1 September 2023 to 31 August 2024 and related enrolment figures.

Although we spoke with inmates engaged in vocational training, we did not observe or hear about any vocational training taking place at the time of the May 2024 inspection and the data provided did not include completion information for most courses.

MSPC's 2024 Strategic Review of Correctional Industries and Education highlighted that short staffing often resulted in the custodial post for supervising education services being left vacant. Despite this, targets for assessment and planning, and education and training delivery were achieved at MSPC.[354]

Table 26: Inmate enrolment numbers for education and vocational training[355]

Course	2022–23 enrolment	2023–24 enrolment
FSP Pre-certificate – LLN	72	18
FSP Level 1 – LLN	52	60
FSP Level 2 – LLN	2	4
FSP Level 1 – Digital Literacy	44	4
FSP – Digital Literacy Advanced	28	42
FSP – Digital Literacy Basic	92	126
Distance Education – Certificate I-IV (secondary)	4	1
Distance Education – Higher Education	3	3
Business Diploma	Not offered	1
Traineeship/Apprenticeship	35	46
VTP – Aboriginal Cultural Programs	7	Not offered
VTP – Cleaning Operations	31	7
VTP – Clothing and Production	18	12
VTP – Community Services	19	23
VTP – Construction	10	10
VTP – Hospitality	Not offered	8
VTP – Kitchen Operations	7	7
VTP – Logistics	10	Not offered
VTP – Warehousing Operations	Not offered	10
WPT – First Aid	17	20
WPT – Food Safety	6	13
WPT – Forklift	40	22
WPT – Test and Tag	Not offered	19

354 Information provided by Corrective Services NSW, 15 November 2024.
355 Information provided by Corrective Services NSW, 17 November 2023 and 17 January 2025.

2.7.5 External leave programs

External leave allows inmates to leave a correctional centre for the purpose of undertaking activities that will support throughcare and their reintegration into the community when they are released from custody. They include day or weekend leave, work release, leave for participation in community-based education, vocational training or life skills programs such as Alcoholics Anonymous. Male inmates must have a C2 security classification to participate in an escorted external leave program or a C3 security classification to participate in an unescorted leave program. Unescorted and escorted external leave programs also require a leave permit issued pursuant to section 6(2) or section 26 of the CAS Act.[356]

Day and weekend leave is important for preparing people who have served long sentences of imprisonment for release and may be influential in the SPA decision making. A sponsor is required for inmates to participate in unescorted day or weekend leave. During the inspection, we were told that one of the biggest challenges for inmates was a lack of sponsors. Some inmates do not have family or friends in the community who are willing or suitable to act as sponsors. MSPC was trying to address this by arranging for chaplains to sponsor day or weekend leave for people with no other option.

356 Corrective Services NSW, *Inmate Classification and Placement: Progression to C3/Category 1 and External Leave Programs (ELP)* (version 2.5, 4 August 2023).

3 Treatment of people with disability in custody

3.1 Introduction

People with disability are overrepresented in all stages of the criminal justice system, including in adult correctional centres.[357] In particular, the *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Royal Commission) described the proportion of Aboriginal and Torres Strait Islander people with cognitive disability in custody as a 'national crisis'.[358]

International human rights instruments outline the rights of people in custody with disability, highlighting the importance of non-discrimination and an accessible custodial environment. The *Convention on the Rights of Persons with Disabilities* provides:

> States Parties shall ensure that if persons with disabilities are deprived of their liberty through any process, they are, on an equal basis with others, entitled to guarantees in accordance with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation.[359]

The Committee on the Rights of Persons with Disabilities has expressed concern for the living conditions experienced by people with disability in prisons and has recommended that 'places of detention are accessible and provide humane living conditions'.[360] Further it has stated that States Parties:

> must take all relevant measures to ensure that persons with disabilities who are detained can live independently and participate fully in all aspects of daily life in their place of detention, including ensuring their access, on an equal basis with others, to the various areas and services, such as bathrooms, yards, libraries, study areas, workshops and medical, psychological, social and legal services.[361]

The Mandela Rules further provide that:

> Prison administrations shall make all reasonable accommodation and adjustments to ensure that prisoners with physical, mental or other disabilities have full and effective access to prison life on an equitable basis.[362]

These rights are reflected in our inspection standards, which highlight the need to consider disability, and different types of disability, in building design, inmate complaints and disciplinary processes, routine, transport, the provision of health services and assistive equipment.[363]

Our inspection of the Long Bay Correctional Complex gave considerable attention to the conditions and treatment experienced by people in custody with disability, particularly the Additional Support Units (ASUs) at the Metropolitan Special Programs Centre (MSPC). We also visited the Metropolitan Remand and Reception Centre (MRRC) in June 2024 to better understand the reception and screening process and its role in identifying people with disability at the outset of their incarceration, particularly those with intellectual or cognitive disability. We address our observations in this chapter.

357 *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 8, 36.
358 *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 8, 33.
359 *Convention on the Rights of Persons with Disabilities*, opened for signature 30 March 2007, 2515 UNTS 3 (entered into force 3 May 2008) art 14(2).
360 *Report of the Committee on the Rights of Persons with Disabilities*, UN Doc A/72/55 (11 May 2017) annex ('*Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities*') para 17.
361 *Report of the Committee on the Rights of Persons with Disabilities*, UN Doc A/72/55 (11 May 2017) annex ('*Guidelines on Article 14 of the Convention on the Rights of Persons with Disabilities: The Right to Liberty and Security of Persons with Disabilities*') para 18.
362 *United Nations Standard Minimum Rules for the Treatment of Prisoners*, GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016, adopted on 17 December 2015) rule 5(2).
363 Inspector of Custodial Services, *Inspection Standard for Adult Custodial Services in NSW* (May 2020).

3.2 Disability in NSW custody

As at 30 June 2024, there were 2,206 people in NSW custody with one or more disabilities. This equates to 17% of the 12,946 people in custody on this date. Of these, 198 inmates with disability were placed in MSPC. This was 9% of all inmates with disability and 31% of the 638 inmates at MSPC on this date. Noting that people may have one or more disabilities, there were 290 disabilities recorded for the 198 people with disability at MSPC. The most common disabilities were intellectual disability or low cognitive function (91), mobility or physical access (51), psycho-social (35) and acquired brain injury (33).[364] Table 27 shows the number of people in NSW custody and at MSPC with a disability over a five-year period from 2020 to 2024. Table 28 shows the number of disabilities recorded for inmates across NSW over a five-year period from 2020 to 2024.

Table 27: Number of inmates with a disability across NSW and at MSPC from 2020 to 2024[365]

Date	NSW custody	MSPC
30 June 2020	2,338	316
30 June 2021	2,305	231
30 June 2022	2,211	264
30 June 2023	2,211	259
30 June 2024	2,206	198

Table 28: Number of recorded disabilities among inmates in NSW from 2020 to 2024[366]

Disability or impairment	30-Jun-20	30-Jun-21	30-Jun-22	30-Jun-23	30-Jun-24
Autism/Autism spectrum	94	97	111	118	150
Acquired brain injury	565	598	556	551	541
Aged and frail	54	59	62	76	74
Blind or vision impaired	101	106	113	122	128
Communication or speech difficulties	6	8	9	17	17
Dementia	32	24	25	28	32
Deaf or hearing impaired	190	210	211	215	202
Intellectual disability or low cognitive function	1,097	1,038	1,020	986	992
Mobility or physical access	342	338	334	349	328
Psycho-social	501	465	419	372	400
Total disabilities	**2,982**	**2,943**	**2,860**	**2,834**	**2,864**

364 Information provided by Corrective Services NSW, 17 June 2025.
365 Information provided by Corrective Services NSW, 17 June 2025.
366 Information provided by Corrective Services NSW, 17 June 2025.

3.3 Statewide Disability Services

3.3.1 Staffing profile and structure

SDS is a specialist unit of Corrective Services NSW (CSNSW), situated on the Long Bay Correctional Complex. SDS provides statewide support to inmates with disability through a multidisciplinary team of psychologists, service and programs officers (SAPOs), administration, training and community engagement staff. The staffing profile of SDS is detailed in Table 29.

Table 29: SDS staffing profile at 29 February 2024[367]

Position	Number
Statewide manager specific needs	1
Senior neuropsychologist	1
Senior psychologist	3
Psychologist	9
Neuropsychologist	1
Manager	1
Services and programs team leader (SAPTL)	1
Services and programs officer (SAPO)	7
Service linkage officer	1
Project officer systems and administration	1
Policy, project and training officer	1
Records and administration officer	1
Total	**28**

Inmates are eligible for assistance from SDS if they have one or more of the following disabilities:

- intellectual disability or low cognitive functioning
- acquired brain injury (including traumatic brain injury and alcohol/drug related brain injury)
- sensory disability (hearing or vision impairment)
- physical disability
- dementia
- autism spectrum
- aged and frail offenders with disability.[368]

SDS delivers its services to both people in custody and offenders in the community managed by CSNSW. Those services include:

- Conducting assessments of disability in relation to sensory and physical disability, intellectual disability, acquired brain injury and dementia.
- Oversight of the three ASUs at MSPC that accommodate inmates who, because of their cognitive or intellectual disability, cannot be safely managed in a mainstream correctional centre environment.
- Referral of inmates with disability to the National Disability Insurance Scheme (NDIS).

367 Information provided by Corrective Services NSW, 12 April 2024.
368 Information provided by Corrective Services NSW, 12 April 2024.

- Arranging assistive devices for inmates with physical or sensory disability.
- Helping CSNSW custodial and non-custodial staff statewide to support inmates with disability.
- Designing and facilitating training for CSNSW staff on working with people with disability.[369]

The SDS was reviewed prior to this inspection and from October 2023 a new business model commenced aligning its services to reflect the custodial pathway of incarcerated people. The model is based around three multi-disciplinary teams, each focusing on one of the following inmate groups:

1. remand inmates and early intervention
2. sentenced inmates, and
3. ASU inmates.

The model places emphasis on identifying the needs of inmates and providing the support they require while in custody. The SDS remand and sentenced teams provide a tertiary service to correctional centre SAPOs, psychologists, and Case Management Units across NSW custodial centres, giving direction and support around the care and management of inmates with disability. The ASU team engage directly with ASU inmates at MSPC and provide general case management and support services to that cohort. The co-location of the SDS team and the ASUs on the Long Bay Correctional Complex facilitates this support.

3.3.2 Referrals to Statewide Disability Services

Generally, inmates with disability are identified through the reception screening process, which includes the completion of questionnaires administered by SAPOs and Justice Health and Forensic Mental Health Network (JH&FMHN) staff. However, referrals to the SDS can be made at any time an inmate is in custody, by custodial and non-custodial staff (via the disability screen on the Offender Integrated Management System (OIMS)), JH&FMHN staff and external sources including family members, friends, legal representatives, advocates, and service providers. In addition to internal referrals, SDS reviews the daily synopsis of incidents. This allows SDS staff to identify inmates who may be eligible for SDS services but have not been referred to SDS and to monitor the behaviour of inmates with disability. This is a time-consuming exercise, but SDS staff considered it to be important as inmates can be masking a disability (for example, while detoxing from drugs or alcohol) or their disability may be related to their behaviour. We were impressed by the efforts of SDS to identify people requiring more support.

SDS considers that the referral process is working well. However, we consider that frontline reception processes should be reviewed to ensure all inmates with disability who may require referral to SDS, or who may have an undiagnosed disability, are identified when they enter custody. This should include information sharing regarding inmates with disability already identified at police and court cells.[370] JH&FMHN were supportive of such a review and noted that there should be defined procedures for CSNSW to share information about disability with JH&FMHN.[371]

At MRRC we observed the general reception screening and admission of a first-time remand inmate with multiple disabilities. The inmate was deaf (had hearing aids and was able to lip read) and had speech and cognitive impairments. Reception staff were unprepared for this and struggled to communicate with the inmate. We observed staff adopt few communication adjustments that may have assisted, such as increasing speech volume, using plain English, not using acronyms, slowing their speech, checking understanding, rephrasing, or explaining the context of questions. The screening interview was held in a very noisy room in the reception area and the level of background noise likely impacted the inmate's ability to communicate. We were told an Auslan interpreter would be arranged for the following day. However, we were perplexed by MRRC's lack of preparedness and awareness of how to promptly provide for this inmate's needs. This meant the inmate spent their first

369 Information provided by Corrective Services NSW, 12 April 2024.
370 Corrective Services NSW, *Custodial Operations Policy and Procedures: 6.9 Inmates with Disabilities* (version 1.4, 18 August 2023) 6.
371 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.

night in custody with little understanding of where he was, the screening process, how correctional centres operate and unable to contact his family.

During this inspection we also observed occasions of custodial staff struggling to navigate the OIMS disability screen, including identifying if a person has a disability, has previously been referred to SDS and, if not, initiating the referral. We note that using the disability screen in OIMS is addressed in detail in the *Custodial Operations Policy and Procedures* (COPP).[372]

In 2023, 1,068 referrals were made to SDS via the OIMS disability screen. Of these, most referrals were made via the screening process (27.5%), SDS (20.1%), psychologists (15.4%), case management staff (14.8%) and Offender Services and Programs staff (12%). Only two referrals were made by correctional officers.[373] A similar pattern was evident with referrals for inmates at MSPC (see Table 30). We found this surprising given the higher level of day-to-day interaction between correctional officers and inmates.

Table 30: Number of SDS referrals in 2023 and the source of the referral[374]

Position	NSW custody	MSPC
Case management officer	146 (13.7%)	20 (17.9%)
Classification staff	14 (1.3%)	1 (0.9%)
Community corrections	21 (2%)	2 (1.8%)
Correctional officer	2 (0.2%)	-
External notification	14 (1.3%)	1 (0.9%)
Functional manager case management	14 (1.3%)	-
Intellectual Disability Rights Service	10 (0.9%)	-
JH&FMHN	30 (2.8%)	3 (2.7%)
Mental Health Review Tribunal/SPA/SORC	1 (0.1%)	-
Offender Services and Programs staff	128 (12%)	9 (8%)
Office of the Public Guardian	1 (0.1%)	-
Psychologist	164 (15.4%)	20 (17.9%)
Risk assessment intervention team	2 (0.2%)	1 (0.9%)
Screening	294 (27.5%)	10 (8.9%)
Senior case management officer	12 (1.1%)	1 (0.9%)
Statewide Disability Services	215 (20.1%)	44 (39.3%)
Total	**1,068**	**112**

When SDS receives a referral, the referral is placed in the relevant programs and services line on OIMS for action. The referral is then triaged according to the prioritisation model for that programs and services line and must be actioned within the applicable timeframes.[375]

Questionnaires and screening tools are fundamental to determining ASU placement and inmate management. SDS use the following questionnaires and screening tools to assess cognitive and intellectual disability, acquired brain injury, sensory and physical disability, and dementia:

- Acquired Brain Injury Questionnaire (ABIQ)
- Sensory and Physical Screening Questionnaire (SPSQ)

372 Corrective Services NSW, *Custodial Operations Policy and Procedures: 6.9 Inmates with Disabilities* (version 1.4, 18 August 2023) 5.
373 Information provided by Corrective Services NSW, 12 April 2024.
374 Information provided by Corrective Services NSW, 12 April 2024.
375 Information provided by Corrective Services NSW, 12 April 2024.

- Dementia Screening Questionnaire (DSQ)
- Wechsler Abbreviated Scale of Intelligence-2 (WASI-II).[376]

Questionnaires are largely administered by correctional centre based SAPOs, with the help of SDS SAPOs if needed. SDS SAPOs administer questionnaires for MSPC inmates. The WASI-II and neuropsychological assessments are administered by correctional centre based and SDS psychologists.[377]

During the inspection we were informed that critical demands are making it difficult for psychologists at MRRC to conduct timely assessments of cognitive and intellectual disability and neuropsychological disorders on new admissions. Decisions by SDS around ASU placements (see section 3.4.2) and supports for inmates cannot occur without proper assessments. While we accept that service demand on psychologists in remand centres is high, processes need review and the reasons for delay addressed.

3.4 Additional Support Units

Some inmates with intellectual or cognitive disability can be managed with supports in a mainstream custodial environment. Those who do not cope well in a mainstream custodial environment may benefit from the additional services and supports available in the ASUs.

There are three ASUs at MSPC. Two are maximum security units placed in MSPC's original early 1900s infrastructure (5-and 6-wings) in MSPC 2. The third is a minimum security unit located in more modern infrastructure (18-wing), within MSPC 3 but separated from other wings by a fence. Each ASU has a small population of inmates – 5-wing has capacity for 22 men, 6-wing has capacity for 19 men, and 18-wing has capacity for 16 men. The three ASUs provide options for progression, with the aim of inmates reaching 18-wing as they near the end of their sentence.

3.4.1 Physical environment

We consider the older units (5-and 6-wings) to be unsafe environments for people with disability and not conducive to rehabilitation. Both have a two-level design and include a combined kitchen and communal space, an outdoor area and Yarning Circle. Some of the inmates we met had mobility issues. Those with mobility issues lived (in a single cell) in ground floor accommodation. However, like other cells in MSPC, the cell dimensions do not allow access for walking aids and wheelchairs. When inmates are locked in cell, mobility aids are left outside. Without this, inmates must negotiate the toilet and shower without any support, non-slip mats or grab rails, increasing the risk of falls and injury. It is also degrading for inmates being compelled to sleep on mattresses on the floor and crawl around their cell on the floor.

376 Information provided by Corrective Services NSW, 12 April 2024.
377 Neuropsychological assessments include Autism Diagnostic Observation Schedule ADOS-2 and Ritvo Autism Asperger Diagnostic Scale – Revised (RAADS-R).

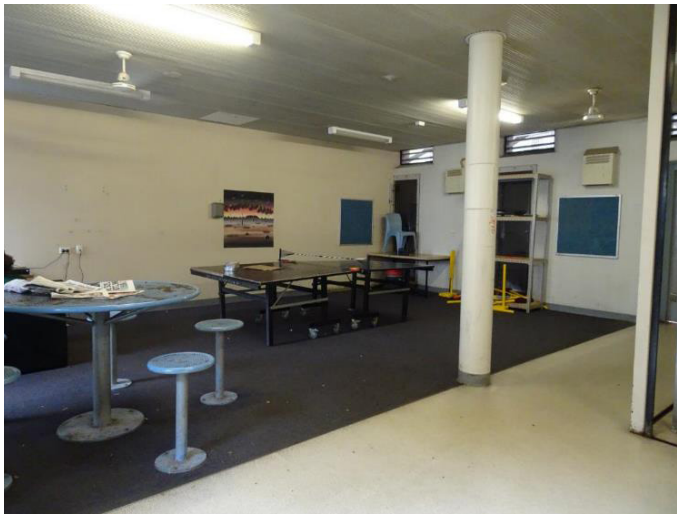
Mouldy and damaged cell ceilings in 5-wing, May 2024

Cells in 5-wing, May 2024

Bird faeces in 6-wing, May 2024

6-wing cell, May 2024

6-wing common room, February 2024



We observed both 5-and 6-wings had many areas that were inaccessible and in need of repair. Inmates would benefit from grab rails, ramps, and tactile and high contrast markers on steps, pathways and ramps. The inaccessible environment means inmates with physical disability rely on mobility, access, and personal care support from peers. Hearing and sight impaired inmates found it difficult to negotiate call buttons, watch television and use tablets and, in some cases, relied on other inmates to help with buy-up forms and calls to family and friends. With their independence removed these inmates are placed in a vulnerable position and may be at risk of manipulation and standover. We observed mould on the walls and ceilings of many cells and peeling paint. There were also windows with significant build-up of bird faeces which presented a health risk.

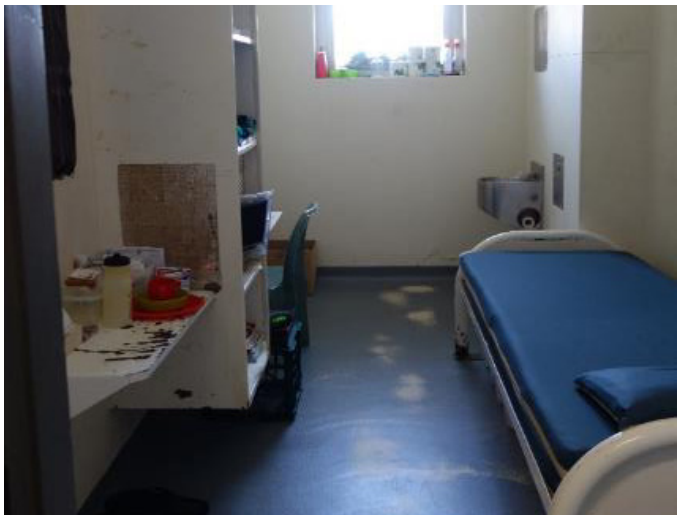
The accessibility shortcomings observed in the ASUs were also observed throughout MSPC. Understanding disability and associated needs is paramount when determining accommodation and facilities for those inmates. CSNSW can no longer rely on a one size fits all approach to accommodation and must provide spaces that are accessible for inmates with disability.

Recommendation: CSNSW review the use of 5-wing and 6-wing at MSPC as ASUs to identify and address accessibility and safety concerns for inmates with disability or find an alternative location.

In contrast 18-wing provided a more accessible environment. The inmates we spoke with liked living in 18-wing. It is a single level building with 16 single rooms and one double room (a camera cell). The unit has a large communal space with a kitchen, lounge and games area. The outdoor area is also generous with well-kept gardens, a Yarning Circle and vegetable garden. Being a more modern building, it was in better condition than 5- and 6-wings and provided easy access to indoor and outdoor common areas. Bathrooms however were in poor repair.

18-wing common area, August 2023

18-wing single cell, August 2023



18-wing double cell, May 2024

18-wing showers, May 2024

3.4.2 Placement

SDS convenes weekly meetings of the ASU Bed Placement Committee (the Committee) to determine inmate placements in the ASUs. Inmates must have an IQ below 80 and be suitable for placement in an ASU based on their:

- ability to participate in specialised programs offered in the ASU
- assessment needs, specialised case management or pre-release planning
- placement in mainstream correctional centres being problematic, resulting in repeated transfers between correctional centres
- vulnerability within the custodial environment, including a history of assaults or standover, which indicates a current or future risk to safety
- inability to cope in mainstream prison due to a lack of support, including difficulty with social adjustment and peer relationships.[378]

The Committee considers referrals to the ASUs and oversees the ongoing custodial management of all ASU inmates. Questionnaires and screening tools are fundamental to determining ASU placement and ongoing management of the inmate. The assessment process can take up to 12 weeks and delays are regularly noted and monitored by the Committee.

SDS informed us that not all inmates assessed as suitable for placement in an ASU will be placed in an ASU, as they may cope well within a mainstream environment. They may also decline placement or be precluded for placement by other factors such as risk to self and others or acute mental illness.

Another ongoing concern for the Committee is the placement of inmates in Multipurpose Units (MPUs) while waiting for an ASU bed. The periods these inmates spend largely isolated from others can be lengthy. While MPUs provide little opportunity for inmates to mix and therefore should lessen the risk of physical harm, lengthy periods of isolation can result in psychological harm for inmates with intellectual and cognitive disability.[379] The practice of CSNSW placing inmates with disability approved for ASU placement in MPUs for an extended period until they are transferred needs attention.

378 Information provided by Corrective Services NSW, 12 April 2024.
379 *Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability* (Final Report, September 2023) vol 8, 66.

3.4.3 Custodial operations

Daily routine

We heard from both inmates and staff that the ASUs experience regular lockdowns. Inmates in 5- and 6-wings were locked in their cells daily for lunch, which did not occur in other parts of MSPC. Custodial staff from the ASU wings were also regularly deployed to other areas of MSPC to backfill custodial officer vacancies resulting from unscheduled leave and unscheduled medical escorts.

This was confirmed by data we received from CSNSW. As highlighted in section 2.6.1, two samples of restricted movement (lockdown) Incident Reporting Modules (IRMs) from April to July 2023 and April to July 2024 showed the three ASUs experienced significant disruptions due to lockdowns:

- 5-wing was impacted by four lockdowns in the 2023 sample and nine in the 2024 sample.
- 6-wing was impacted by eight lockdowns in the 2023 sample and eight in the 2024 sample.
- 18-wing was impacted by seven lockdowns in the 2023 sample and 11 in the 2024 sample.[380]

We acknowledge MSPC's attempts to minimise the impact of staffing gaps. However, this approach means that impact is being disproportionately felt by a small group of inmates with disability for whom time out of cell and engagement with support staff and activities is particularly important. We suggest lockdown practices are reviewed at MSPC with the intention of operating a fair and equitable model that does not effectively discriminate on the grounds of disability.

Custodial staff – disability awareness, training and inmate support

Disability awareness among custodial staff is inadequate and needs attention. We observed at MSPC (and MRRC) a profound lack of disability confidence and awareness across staffing groups but particularly among custodial staff. Consequently, staff lacked initiative in relation to identifying and implementing reasonable adjustments for inmates with disability. Examples of this included staff being unaware of when and how to make a referral to SDS, and how to engage with inmates who are neurodiverse or have an intellectual or cognitive disability.

We observed little interaction between custodial staff and ASU inmates, or inmates with disability more broadly. Although inmates with disability described some officers as approachable, they also reported custodial staff using derogatory and abusive language, becoming impatient and not understanding their disability and associated support and reasonable adjustment needs. They also expressed reluctance to make complaints about poor staff conduct to the NSW Ombudsman due to past threats and fears of reprisal, such as false institutional charges. This was disappointing to hear, particularly following the findings of the Astill Inquiry[381] and the vulnerability of some of the inmates we spoke to during this inspection. All staff must be reminded of their duty of care to inmates and the duty to report their colleagues who engage in discrimination and unprofessional conduct.

The IDRS's Justice Advocacy Service (JAS) provides independent disability advocacy and support to people with intellectual or cognitive disability who are involved with the criminal justice system.[382] This includes inmates with disability in NSW correctional centres. Inmates can access JAS through the Common Auto Dial List.

Positive behaviour support plans were developed for inmates with cognitive disability by SDS psychologists. These were uploaded to OIMS, printed out and placed on the wing but custodial staff were not trained on the implementation of the individual plans. The approach of custodial staff to perceived misconduct – which often arose from communication barriers or inmates not understanding what was expected of them – was in direct conflict with a positive behaviour support approach.

Some senior custodial staff were supportive of a model for ASUs involving consistent staffing of carefully selected custodial officers with the skills to respond appropriately to the behaviours and

380 Information provided by Corrective Services NSW, 11 November 2023 and 15 November 2024.
381 *Special Commission of Inquiry into Offending by Former Corrections Officer Wayne Astill at Dillwynia Correctional Centre* (Final Report, February 2024) 31.
382 'Justice Advocacy Service (JAS)', *IDRS* (Web Page, undated) <https://idrs.org.au/jas/>.

support needs of ASU inmates. It was thought these officers should have disability awareness training and be able to support inmates by, for example, participating in functional assessments, implementing reasonable adjustments and accessible communication, making assessment and support referrals, and implementing de-escalation and positive behaviour support strategies.

SDS has a staff member who provides training to new custodial officers and CSNSW staff (on request). We accept the importance of training for new custodial staff but there would be benefit in providing training for all custodial and non-custodial staff (with refresher options). This would help staff to identify disability and better understand the behaviour of some inmates, increasing their confidence to make referrals and manage their interactions with those inmates.

However, we also emphasise the importance of cultural and attitudinal change regarding how the needs of people with disability are understood and prioritised. This cannot be achieved by staff training alone and requires leadership and commitment from CSNSW's executive staff and local management teams.

Recommendation: CSNSW deliver compulsory disability awareness training (including refresher training) to all custodial staff and consider more intensive training options for selected staff working with inmates with disability.

We observed hygiene workers and peers providing essential support, without formal training, to inmates with disability in ASUs. Inmates with disability described this as invaluable help that enabled them to cope in the ASU environment. The assistance included personal care, mobility, communication, participation in activities, and literacy support. We were reminded of the important aged care support role hygiene workers perform in the Kevin Waller Unit and encourage CSNSW to consider applying a similar model of disability support in ASUs and other areas holding inmates with disability who require more support.

A reverse integration approach of accommodating non-disabled inmates in ASUs would also lessen stigma arising from separation on the basis of disability. This reasonable adjustment could assist inmates with disability integrate in mainstream programs, work and recreation. Appropriate hygiene workers carefully selected to perform these disability support roles, as well as being renumerated for their work, could be given access to training and qualifications in Certificate III in Individual Support (Disability) that would be valuable post release. This inmate peer disability support program could be implemented and supervised by SDS.

Recommendation: CSNSW formalise and expand inmate peer to peer disability support in the ASUs, with access to training and qualifications.

Inmate discipline

The Mandela Rules provide that:

> Before imposing disciplinary sanctions, prison administrations shall consider whether and how a prisoner's mental illness or developmental disability may have contributed to his or her conduct and the commission of the offence or act underlying the disciplinary charge. Prison administrations shall not sanction any conduct of a prisoner that is considered to be the direct result of his or her mental illness or intellectual disability.[383]

In relation to the inquiry to be conducted when an inmate has been charged with an institutional offence, the *Crimes (Administration of Sentences) Act 1999* (CAS Act) provides that the governor must allow a person (other than an Australian legal practitioner) to represent or assist the inmate if satisfied that an inmate does not sufficiently understand the nature of the inquiry or is unable to properly represent themselves during the inquiry.[384]

During the charging process for alleged institutional offences, the COPP requires the governor or

383 *United Nations Standard Minimum Rules for the Treatment of Prisoners*, GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016, adopted on 17 December 2015) rule 39(3).
384 *Crimes (Administration of Sentences) Act 1999* s 52(2)(e).

delegated officer to check OIMS to ascertain if the person has an intellectual disability or cognitive impairment.[385] The COPP doesn't provide any guidance on what the governor or delegated officer should do with this information, only that SDS must be informed for the purpose of providing the inmate with assistance.[386] The support person's role is to help the inmate understand proceedings, facilitate communications, answer any questions about the proceedings, and help them understand questions asked of them.

During this inspection we reviewed a sample of adjudication paperwork relating to institutional charges (see section 2.4.6). We also observed a disciplinary hearing concerning an ASU inmate. Although an ASU SAPO was present at this hearing, as required by the CAS Act and the COPP, there was no evidence of this in the paperwork. We consider that CSNSW should amend its adjudication template to include the undertaking of checks regarding disability and the presence of a support person during a hearing. This will help ensure relevant action is taken and related information is recorded.

The disciplinary hearing we observed raised a number of concerns around process and the inmate's participation. The proceedings were not adjusted to make them accessible to the inmate, who had hearing and cognitive impairments. Despite help from the SAPO, the inmate appeared confused about their charge (refuse or fail to comply with a direction to supply a drug test sample[387]) and plea. We noted that relevant information was provided concerning the inability of the inmate to provide a sample but this was given little or no consideration by the determining officer, which made us question whether the legislative standard of proof, of beyond reasonable doubt, was met.[388]

The NSW Ombudsman, in their investigation into inmate discipline in NSW correctional centres, found legislation and policy compliance to be a systemic failure of CSNSW. In response, CSNSW has committed to reviewing disciplinary breach practices and delivering associated training.[389] This review presents an opportune time for CSNSW to ensure that policies and procedures governing inmate disciplinary processes are accessible and inclusive for those with disability.

Recommendation: CSNSW review policies and procedures concerning inmate discipline to ensure they are inclusive of inmates with disability.

3.4.4 SDS support services

ASU SAPOs have regular interaction with ASU inmates, made possible by the locality of SDS on the Long Bay campus. Being close allows SAPOs to support inmates in a timely manner which is helpful when an inmate is experiencing difficulties or demonstrating challenging behaviours. Their work includes delivering programs, assisting with inmate welfare needs and arranging NDIS applications and support services. They are also support persons for inmates in the context of misconduct hearings, police interviews, drug and alcohol testing, RIT reviews, classification and placement hearings, and parole.

Prior to the SDS restructure ASU inmates were supported by five SAPOs. This was reduced to two SAPOs. The work was demanding and an additional SAPO was considered necessary to meet the service demands of ASU inmates and have capacity to cover the workload of other SAPOs during periods of illness or leave. Involving occupational therapists, speech pathologists and recreational staff was considered necessary in ASUs and would help the work of SAPOs. Despite their demanding role, inmates described the SAPOs as being accessible and supportive.

Two psychologists are assigned to ASU inmates and shared a maximum caseload of 56 inmates (being the capacity of the three ASUs). Their responsibilities include the daily triage of referrals from the ASUs. The frequency of consultations is determined by the inmate's clinical needs. At the time of inspection there were four inmates under mental health review appearing regularly before

385 Corrective Services NSW, *Custodial Operations Policy and Procedures: 14.1 Inmate Discipline* (version 1.2, 9 August 2024) 9.
386 Corrective Services NSW, *Custodial Operations Policy and Procedures: 14.1 Inmate Discipline* (version 1.2, 9 August 2024) 11.
387 *Crimes (Administration of Sentences) Regulation 2014* cl 159.
388 *Crimes (Administration of Sentences) Act 1999* s 57(2).
389 Evidence to Portfolio Committee No. 8 – Customer Service, Parliament of NSW, Sydney, 10 September 2024, 28–9 (Anoulack Chanthivong, NSW Corrections Minister).

the Mental Health Review Tribunal (MHRT). This created considerable work for the psychologists, including the preparation of reports and attendance at MHRT hearings. Psychologists reported prioritising MHRT work which left little time for client intervention. Psychologists also help SAPOs deliver CONNECT, a 10-week Dialectical Behaviour Therapy (DBT) program.

ASU psychologists have experienced increasing requests for help from psychologists statewide. Their responsibilities extend to female inmates with an intellectual disability or cognitive impairment in the Mum Shirl Unit at Silverwater Women's Correctional Centre. ASU psychologists perform an oversight role conducting regular reviews of the women's files and engaging with Silverwater Women's psychologists and chief psychiatrist.

We were impressed with the SDS team and their dedication to their work. However, the workload of the SAPOs and psychologists is extraordinary and should be reviewed. The work performed by both disciplines is important and must be adequately resourced to meet service demands. Consideration should be given to increasing SDS staffing levels to ensure that the needs of ASU inmates and inmates with disability across NSW are being met. We also noted that SDS has no Aboriginal identified positions, despite the significant population of Aboriginal inmates with disability. We would encourage CSNSW to consider creating an identified SAPO position to work with Aboriginal inmates with disability.

Preparing ASU inmates for release can be complex. ASU inmates are directly supported by the ASU multidisciplinary team. SDS staff work with custodial staff, community corrections officers, the NDIS and external agencies to create and implement a pre-release framework that provides a safe and supported transition for the inmate to the community. SDS is supported by the DCJ Community Safety Program (previously the Community Justice Program) which helps inmates navigate release by working with the NDIS services assigned to support the inmate. However, we were told that low staffing levels and high work demands can, at times, make it challenging for SDS staff to have sufficient time for pre-release planning and engagement with inmates.

The resourcing of SDS is discussed further in section 3.5.

3.4.5 Programs, work and recreation

Programs

SDS has two full-time SAPOs assigned to the ASUs who delivered EQUIPS criminogenic programs to inmates in those units. The EQUIPS programs are not modified for inmates with intellectual disability and low cognitive functioning. Rather, SAPOs provide time and individual attention to ASU inmates to keep them engaged and ensure they understand the program content. We heard that with general service needs increasing in ASUs, the SAPOs were finding it difficult to meet the demands of running those programs. Uncompleted programs may impact the ability of some inmates to meet their case management goals and parole requirements. We were also told that regular lockdowns of the ASUs were impacting program delivery.

Cultural support for Aboriginal inmates in the ASUs appeared to be minimal with inmates reporting involvement in Close the Gap Day and NAIDOC events. Inmates reported Elder visits at NAIDOC celebrations, and we observed Yarning Circles in all ASUs, although our conversations with inmates led us to believe that they were rarely used.

Narcotic Anonymous (NA) sessions were occurring weekly and were appreciated by ASU inmates.

Employment and vocational training

Employment options for ASU inmates were limited and involved repackaging airline headsets (5- and 6-wing inmates) and preparing inmate hygiene and travel packs (18-wing inmates) in a technology and assembly workshop.

Inmates told us that they were unhappy with the highly repetitive and limited work opportunities and would like to be considered for employment in other industries at MSPC. SDS supported this. We were told by SDS staff that many ASU inmates were skilled workers and could be employed in other

workplaces. In past years ASU inmates completed skills training courses in forklift, test and tag and first aid and worked in other industries, including the Long Bay café.

We visited ASU workplaces and spent time with 18-wing inmates in their workplace. 18-wing inmates worked six hours per day, Monday to Friday assembling reception packs and travel packs, distributed statewide to correctional centres, police and court cells, youth justice centres and ACT custodial services.

We observed the inmates at work and noted unsafe work practices including trip hazards and inmates mouth siphoning detergent into containers. Workplace signage was inadequate for workers with an intellectual disability or low cognitive functioning.

Signage and makeshift floor mats in 18-wing industries, May 2024

We viewed induction and safety checklists, and employment contracts, which appeared to be standard Corrective Services Industries (CSI) documentation and, again, not modified for people with low cognitive functioning and intellectual disability. Induction and workplace safety information is important and should be presented in a way that is easily understood. Consequently, we were concerned the induction process was ineffective. The 18-wing workplace and safe work practices require review.

A dedicated education space was available in the 18-wing work area. BSI Learning delivered literacy and numeracy support to ASU inmates. However, there was no evidence of work-related training and education occurring for ASU inmates and no inmate reported having received such training. We heard that TAFE had been providing skills training and certificates in forklift, test and tag and first aid but this was no longer occurring.

CSI is responsible for all business and service units in correctional centres and the employment and education of inmates. Work and education are central to CSI objectives with policies that support safe work for inmates, pathways to achieving vocational qualifications and developing marketable vocational skills that will help with post release employment.[390] CSI policies do not refer to employment and education, and associated reasonable adjustments, for inmates with disability, particularly relevant for inmates with intellectual disability and low cognitive functioning given ASU inmates have a dedicated workplace. Their needs differ from mainstream inmates and should be captured in policies to ensure equitable access to employment and education.

ASU inmates expressed concern about their rates of pay and believed they were paid less than inmates in other industries. Unlike inmate hygiene workers employed in correctional centres statewide, ASU hygiene workers were not paid for their work but were given extra milk. ASU industry workers were required to meet a weekly output target to receive a $5.00 bonus payment and were at times required to work longer hours and through lunch to attain that goal. CSI must set equitable work standards and ensure ASU inmates have access to the same pay rates, bonuses, work and

390 Corrective Services NSW, *CSI Policy and Procedures*: *1.3 Vocational Education and Training* (May 2007).

vocational training opportunities available to other inmates. This overt discrimination against inmates with disability must cease and was raised immediately during the inspection.

Recommendation: CSNSW review:

a. **CSI policies around disability inclusion and equitable access to employment and education**

b. **the operation and work practices of technology and assembly workshops at MSPC with particular attention to safe work environments, induction and inmate wages.**

Recreation

Few recreational offerings existed for ASU inmates. Gym equipment was provided for inmates in ASUs but resources differed across units. 5-wing had an outside exercise space with new sandbag weights. 6-wing had a dedicated indoor gymnasium with various gym and weight machines. However, instructions on how to use gym equipment were written and not accessible for many inmates and should be converted to Easy Read formats. 18-wing had no defined gym area and little exercise equipment. Inmates reported enjoying opportunities for exercise. We were told by SDS staff that ASU inmates would benefit from more activities, sensory spaces and aids.

A library was available to inmates in each of the ASUs. 5-and 6-wings had an assigned library room, while 18-wing had a small collection of books available in the common area. We observed the library resources were appropriate for the inmate cohort but would benefit from updated resources. We were told that SDS had sought funding for audio books and text to speech programs to be loaded on inmate tablets. We support SDS's application for funding which would provide increased opportunities for learning and recreation.

5-wing exercise yard, May 2024

6-wing gym, May 2024

5-wing library, May 2024

18-wing outdoor area and Yarning Circle, May 2024

3.5 Future directions

CSNSW has for many years focused on inmates with disability and much has been achieved through SDS and their work with the DCJ Community Safety Program.[391] We commend CSNSW for their efforts, but our inspection shows there is more to be done.

As previously highlighted in this chapter, work is required to improve inclusion for inmates with disability, including the revision of CSI work and education policy and procedures, improved disability awareness and cultural change among staff and addressing barriers in the physical environment. While we were impressed by SDS and the dedication of this team to their work, it was evident their workload was considerable and needed to be addressed. We observed that limited resources and high demand required SDS to prioritise its work and respond to critical issues and inmates with very high needs, primarily those with intellectual disability. This limited their capacity to take a cross-disability approach and meet the fundamental needs of all inmates with disability including inmates who were undiagnosed, neurodiverse or with sensory, physical, psychosocial and neurological disability. Increasing SDS' capacity is essential to meet the need for services for inmates with disability.

CSNSW is developing a Disability Framework that aims to provide a consistent approach to disability across CSNSW, outline current strategies and future aims for enhancing inclusion via targeted initiatives, and ensure a disability perspective is evident more broadly.[392] We believe the creation of a disability access and inclusion plan and reviewing current policies and procedures would help ensure the goals of this framework are realised. At the time of writing, the document was waiting agency approval. The framework we viewed included a review at two years from the approval date, which will be crucial to CSNSW delivering a continued commitment to inmates with disability in their care and ensuring service provision keeps pace with demand.

Recommendation: CSNSW review the resourcing of SDS to ensure it is adequate to deliver statewide cross-disability services.

Recommendation: CSNSW ratify a Disability Framework and review and amend existing policy, procedures and practice to align with its key principles.

Recommendation: CSNSW develop a disability access and inclusion plan.

391 CSNSW established Statewide Disability Services in 2001.
392 Information provided by Corrective Services NSW, 26 November 2024.

4 Treatment of aged and frail people in custody

4.1 Background

4.1.1 The ageing prison population

Corrective Services NSW (CSNSW) policy provides that an inmate is considered to be aged and frail if they have:

- difficulty with daily living activities such as showering, following instructions or completing programs due to physical or sensory disabilities, or deteriorating mental faculties
- mobility issues that restrict access or create a falls risk
- a need for assistive devices to manage sensory or physical disabilities
- a need for alternate accommodation options, including transfer to a specialised unit, or access to adjustments in a mainstream correctional centre, such as access to a ramp or bottom bunk.

Finally, one or more of the above issues must be caused by deteriorating health issues and age (45 years or older for Aboriginal inmates, or 55 years or older for non-Aboriginal inmates).[393]

Table 31: Number of aged inmates in NSW from 2014 to 2024[394]

Year	Non-Aboriginal (55+ years)	Aboriginal (45+ years)	Total aged inmates	Total inmates	Aged inmates as % of total
2014	761	260	1,021	10,565	9.7%
2015	830	302	1,132	11,797	9.6%
2016	904	350	1,254	12,629	9.9%
2017	996	403	1,399	13,149	10.6%
2018	1,049	495	1,544	13,740	11.2%
2019	1,130	462	1,592	13,458	11.8%
2020	1,123	456	1,579	12,730	12.4%
2021	1,189	523	1,712	13,126	13.0%
2022	1,182	527	1,709	12,372	13.8%
2023	1,231	549	1,780	12,316	14.5%
2024	1,262	665	1,927	12,946	14.9%

The growing number of aged and frail people in custody has been of concern for nearly two decades.[395] Between 2000 and 2010, the number of people aged 50 years and over in Australian

393 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.10 Aged and Frail Inmates* (version 1.1, 12 March 2020) 4.
394 'Prisoners in Australia', *Australian Bureau of Statistics* (Web Page, undated), <https://www.abs.gov.au/statistics/people/crime-and-justice/prisoners-australia>. For 2014 to 2016, refer to data table 20. For 2017 to 2024, refer to data table 21. Data as at 30 June of each year.
395 See Select Committee on the Increase in Prisoner Population, Parliament of NSW, *Inquiry on the Increase in Prisoner Population* (Final Report, November 2001); Susan Baidawi et al, 'Older Prisoners – A Challenge for Australian Corrections' (Trends and Issues in Crime and Criminal Justice No 426, Australian Institute of Criminology, August 2011); Natasha Ginnivan, Tony Butler, and Adrienne Withall. 'The Rising Health, Social and Economic Costs of Australia's Ageing Prisoner Population' (2018) 209(10) *The Medical Journal of Australia* 422.

prisons increased by 84%.[396] As Table 31 shows, the number and proportion of aged inmates[397] in NSW correctional centres steadily increased between 2014 and 2024, despite fluctuations in the total inmate population.

Aged inmates' health needs, including diminished mobility and cognition, can be more complex due to premature, or accelerated ageing, meaning people in custody age earlier than the general population.[398] The earlier onset of age-related conditions compared with the general population means that prisoners are considered 'older' from the ages of 45 years for Aboriginal inmates and 55 years for non-Indigenous inmates, around 10 years younger than people in the community.[399] This effect is more pronounced among First Nations people in custody.[400] The accelerated ageing of people in custody is driven by the greater likelihood this cohort have experienced poverty, housing instability, lower levels of education, and lack of employment.[401]

These health concerns are exacerbated by the limited accommodation meeting the needs of aged and frail inmates in custody. Many are housed in less suitable accommodation within the general inmate population.[402] Aged inmates are at risk of deteriorating when they do not have age-appropriate accommodation or reasonably structured daily activities.[403]

Aged inmates in custody should receive the same standard of health and aged care that is provided to older persons in the community. While there is currently no specific international instrument addressing the human rights of older persons, they are entitled to the same rights as other persons under international human rights law.[404] Aged inmates are at risk of age discrimination and can face a heightened risk of abuse and violence at all stages of incarceration.[405] Ageism can manifest as mistreatment of older persons and when services are not designed in a way that are accessible.[406]

4.1.2 Old and Inside report

We previously considered the ageing prison population in NSW in our *Old and Inside* report, published in 2015. That report highlighted:

- the accessibility challenges of mainstream correctional environments
- the limited capacity of units more tailored to the needs of aged and frail inmates
- the need for comprehensive and resourced programs and activities that are varied to respond to the particular needs of ageing inmates
- the use of inmate hygiene workers as 'pseudo carers' for inmates requiring support with laundry, cleaning and personal care
- the challenges of discharge planning for inmates requiring aged care following their release into the community.[407]

396 Susan Baidawi et al, 'Older Prisoners – A Challenge for Australian Corrections' (Trends and Issues in Crime and Criminal Justice No 426, Australian Institute of Criminology, August 2011) 2.
397 Aboriginal inmates aged 45 years and over and non-Indigenous inmates aged 55 years and over. This is consistent with the definition used by CSNSW and JH&FMHN. See Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.10 Aged and Frail Inmates* (version 1.1, 12 March 2020) 4.
398 Brie Williams, Cyrus Ahalt, and Robert Greifinger, 'The Older Prisoner and Complex Chronic Medical Care' in Stefan Enggist et al (eds) *Prisons and Health* (World Health Organization, 2014) 165, 166.
399 Natasha Ginnivan, Tony Butler, and Adrienne Withall. 'The Rising Health, Social and Economic Costs of Australia's Ageing Prisoner Population' (2018) 209(10) *The Medical Journal of Australia* 422; Australian Institute of Health and Welfare, *Health and Ageing of Australia's Prisoners 2018* (Report, July 2020) 1.
400 Susan Baidawi et al, 'Older Prisoners – A Challenge for Australian Corrections' (Trends and Issues in Crime and Criminal Justice No 426, Australian Institute of Criminology, August 2011) 3.
401 Australian Institute of Health and Welfare, *Health and Ageing of Australia's Prisoners 2018* (Report, July 2020) 2.
402 Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015) 27–32.
403 Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015).
404 Including those outlined in the *United Nations Standard Minimum Rules for the Treatment of Prisoners*, GA Res 70/175, UN Doc A/RES/70/175 (8 January 2016, adopted on 17 December 2015) and the *International Covenant on Civil and Political Rights*, opened for signature 16 December 1966, 999 UNTS 171 (entered into force 23 March 1976).
405 Claudia Mahler, *Older Persons Deprived of Liberty*, 51st sess, 12th mtg, Agenda Item 3, UN Doc A/HRC/51/27 (9 August 2022) 10.
406 Attorney-General's Department (Cth), *Draft National Plan to End the Abuse and Mistreatment of Older People 2024–2034* (Consultation Draft, December 2024) 22.
407 Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015).

We recommended that CSNSW revisit previous internal proposals to ensure that long-term estate planning meets the needs of an ageing population. We also recommended that CSNSW, with the Justice Health and Forensic Mental Health Network (JH&FMHN), create accommodation for aged and infirm inmates in the metropolitan area through a new CSNSW facility, or the acquisition of an existing aged care facility in the community.[408] These two recommendations have not been implemented and accommodating a growing aged inmate population in suitable facilities remains a considerable challenge.

4.2 Accommodation for aged inmates/patients

A large proportion of aged and frail inmates face significant challenges with their mobility and cognition.[409] They may have functional difficulties navigating the prison environment and there are limited specialist units to meet their needs.[410] Specialist units for people identified as requiring additional supports include the Aged Care Rehabilitation Unit (ACRU) in Long Bay Hospital (LBH) and the Kevin Waller Unit (KWU) in the Metropolitan Special Programs Centre (MSPC). However, due to the growing ageing population, many aged inmates are housed in areas within the general population where the physical environment is not appropriate.

But for a short period from February to July 2024, which coincided with our inspection, when the KWU was closed and aged inmates were transferred to the Metropolitan Remand and Reception Centre (MRRC) (see section 4.4), we found conditions unchanged since our *Old and Inside* report. We visited each of the areas described in this section as part of this inspection.

4.2.1 Aged Care Rehabilitation Unit

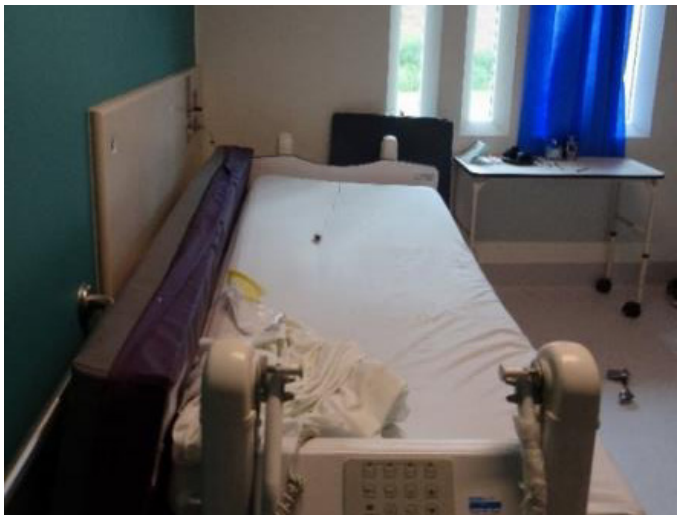
The ACRU in LBH 1 is a 15-bed unit and is currently the only dedicated facility for aged and frail inmates with very high needs. The JH&FMHN aged care team that manages the ACRU also manages the care of patients in KWU. Patients can be admitted to the ACRU for baseline assessment and determination of their ongoing health and care requirements related to ageing and/or cognitive decline. Patients may also have been 'ageing in place'[411] in a correctional centre and a determination has been made that, due to deteriorating health, they require long term placement in the ACRU. Due to the proximity and management arrangements of the ACRU and KWU, some patients will be moved from the ACRU to KWU for a 'test' placement. This allows the same health staff to provide support and monitor patients for deterioration. Others will require a long term placement in the ACRU.

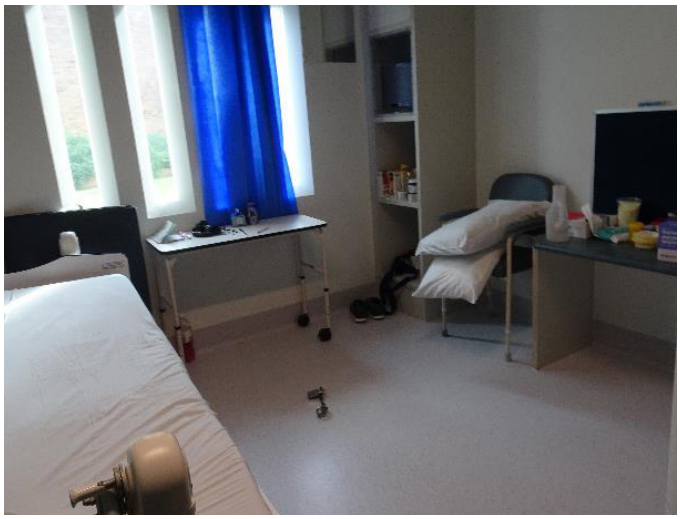
The ACRU contains single occupancy cells equipped with a hospital-style bed and an accessible bathroom with a shower, toilet and sink. The intercom system in each cell is connected to a buzzer (like those commonly found in hospitals) to make it more accessible. It also contains indoor and outdoor recreation areas, a common dining area, and treatment/consultation rooms for the provision of health services.

As we noted in the *Old and Inside* report, the ACRU is designed primarily as a hospital ward, not an aged care facility. Aspects of the layout are suitable for aged inmates, including wider corridors with handrails and cells that can accommodate patient lifting hoists, wheelchairs and walking frames. The unit is situated across a single level with no stairs and easy access to the outdoor area. Although the single occupancy cells allow for some privacy, they can make it difficult to supervise patients with dementia or who may otherwise lack the capacity to use the buzzer/intercom systems. Observations from the *Old and Inside* report including a lack of contrasting colours to aid navigation and high impact and slippery flooring also remain relevant.[412]

408 Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015) 46.
409 Inspector of Custodial Services, *Health Services in NSW Correctional Facilities* (Report, March 2021) 40–1.
410 Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015).
411 The term 'ageing in place' refers to approaches enabling people to remain as independent as possible in a familiar place with appropriate activities, services, mobility, and safety supports. See Victoria Government, 'Ageing in Place' *Ageing Well Action Plan* (Web Page, 28 June 2022) <https://www.vic.gov.au/ageing-well-action-plan/victorias-seniors/ageing-place>.
412 Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015) 42–3.

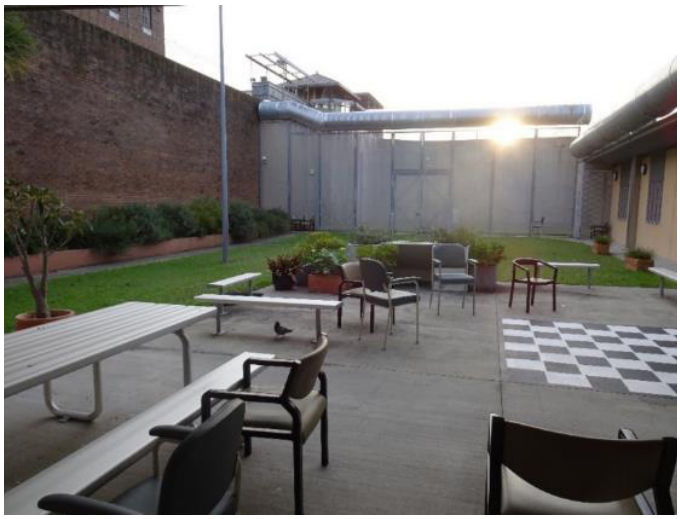
ACRU cell, May 2024





ACRU cell bathroom, May 2024

ACRU outdoor area, May 2024



ACRU common area, May 2024

4.2.2 Kevin Waller Unit

The KWU in MSPC 1 operates in conjunction with the ACRU and provides a supported living environment for aged and frail inmates with medium to high needs. It is a 26-bed unit split across two buildings. It also has its own satellite health centre, indoor and outdoor recreation spaces, and a shared kitchen and dining area. KWU has a mix of single and double occupancy cells, all containing single beds (no bunk beds). All cells contain a toilet, television, and shelving. Some also contain a shower but most do not. Those in a cell without a shower must use a common shower area with no privacy barriers.

KWU is dated and forms part of the original MSPC infrastructure which opened in the early 1900s. It requires continual maintenance such as fixing leaks, bathroom refurbishments for more appropriate grip-paint flooring, and roof repairs. Although it has been fitted with grab rails and ramps, a number of accessibility limitations remain. Cells are too small for wheelchairs and walking frames, which must be left outside the cells when inmates are locked in. The bathroom taps are specifically designed to prevent any ligature points however, they are difficult to operate for inmates with arthritis. In the main building, inmates must navigate a small step to access the outdoor common area.

KWU main building, July 2024

KWU main building corridor with mobility aids outside cells while inmates were locked in their cells, July 2024

KWU main building shower area, July 2024

KWU outdoor area, July 2024

KWU rear building, July 2024

4.2.3 Metropolitan Special Programs Centre

Many inmates who meet the definition of being aged and frail are housed in mainstream correctional centres, often in units for protection inmates. Some units with higher concentrations of aged and frail inmates have become known as quasi aged and frail units, although they do not offer the additional supports of the KWU and ACRU. At the time of the inspection, such units included 4-wing in MSPC 2 and 17-wing in MSPC 3.

Both 4-wing and 17-wing have ground and upper landings. Most cells are double occupancy, containing a toilet and bunk beds. No cells contain showers and inmates use a common shower area. The showers in both units have cracked and broken tiles, mould and water damage.

The age and design of these units create many challenges for safely accommodating aged inmates. Some cells and bathrooms had been retrofitted with grab rails and assistive equipment such as shower or toilet chairs were available. We also observed that ramps had been installed in some locations. However, these modifications cannot rectify the accessibility limitations inherent to a correctional centre constructed in the early 1900s, including:

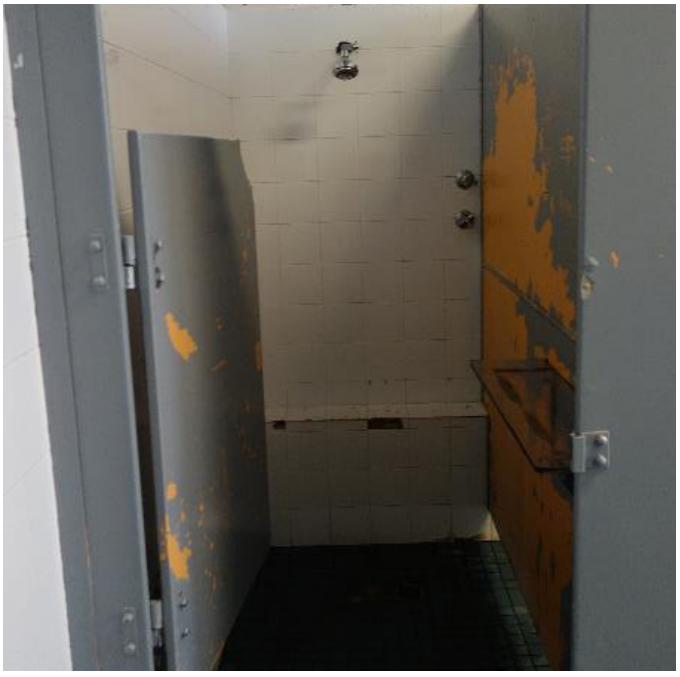
- doorways that are too narrow for mobility aids such as wheelchairs and walking frames
- cells that are too small for mobility aids or two single beds (that are not bunk beds)
- stairs, a lack of ramps and walking distances between areas, and
- a lack of accessible/modified bathrooms.

4-wing yard, May 2024

4-wing cell, May 2024

4-wing shower, February 2024

17-wing shower, August 2023



4.2.4 The Hamden Aged Care POD

The Hamden unit in MRRC consists of four accommodation wings (15-wing, 16-wing, 17-wing and 18-wing). At the time of this inspection, Hamden 18-wing was designated for aged and frail inmates and was known as the Hamden Aged Care POD. The lower landing of Hamden 15-wing was used as an 'overflow' unit for aged and frail inmates who could not be accommodated in Hamden 18-wing.

Hamden 18-wing can hold up to 70 inmates. However, the accessibility limitations of its upper landing and use of bunk beds in most cells reduced its effective capacity for an aged and frail population. A lift was being installed but this had not been completed by March 2024 when the first group of inmates was moved from KWU to MRRC (see section 4.4.2). On 22 March 2024, Hamden 18-wing held 14 inmates.

Hamden 18-wing has a mix of single and double occupancy cells. Although most cells contain bunk beds some have two single beds placed side-by-side. Cells also contain a shower, toilet, sink, shelving/desk with a stool, and a television. The unit also has an indoor common area with a kitchenette and a concreted outdoor yard.

At the time we visited in March 2024 modifications had been made to Hamden 18-wing to make it more suitable for aged and frail inmates, including reducing the height of the shower hobs and refitting shower curtains, and installing a large television in the common area. As noted, a lift was being installed. There were also plans to purchase furniture more appropriate for an aged and frail population. However, we observed many aspects of the infrastructure remained unsuitable, some of which would be difficult to remedy, including:

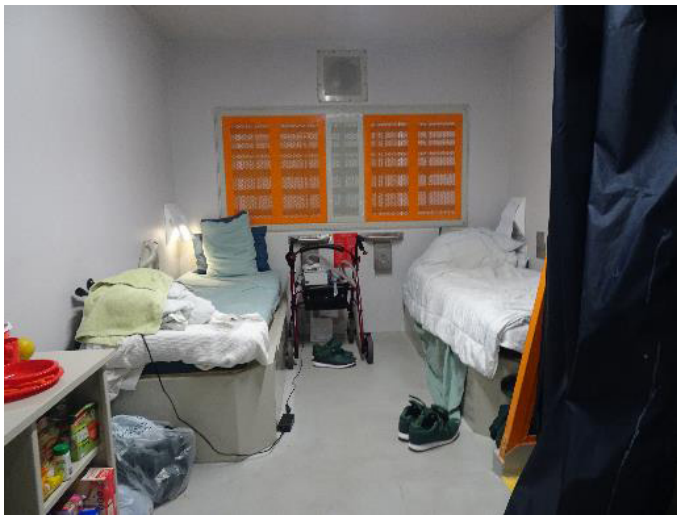
- the low height of toilets, beds, and shelving in the cells
- the lower shower hobs created uneven flooring that was poorly demarcated and did not contain water from the showers, both of which are a fall hazard
- solid grab rails that are difficult to hold and were poorly situated
- cell dimensions that could accommodate only one walking frame.

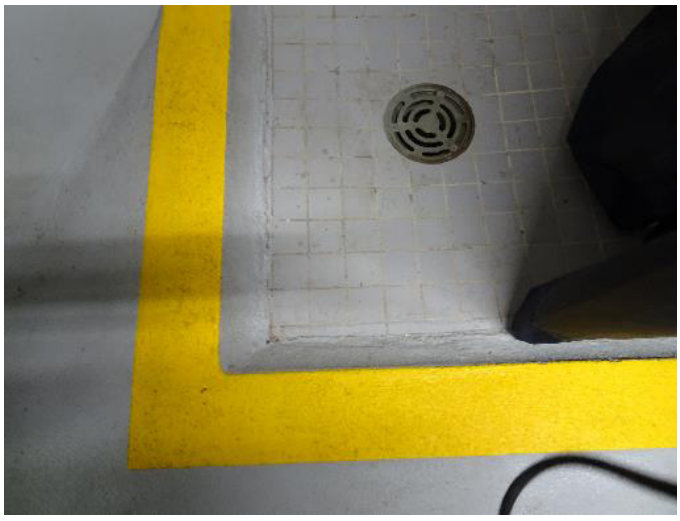
We raised our concerns about the suitability of the Hamden unit for aged and frail inmates with CSNSW after our visits in March 2024.

Hamden Aged Care POD cell, March 2024

Hamden Aged Care POD yard, March 2024

Hamden Aged Care POD double occupancy cell and shower recess, March 2024





Overall, there are insufficient purpose-designed beds for aged and frail inmates with higher needs and few suitable beds for the ageing prison population. This shows a profound failure of CSNSW to plan for the growing aged and frail population by ensuring there is sufficient appropriate accommodation. This is not a new issue and it requires urgent attention.

JH&FMHN advised us that it strongly supports CSNSW review accommodation for aged and frail inmates to ensure long term estate planning meets the needs of an ageing inmate population. It highlighted that there is a:

> dire need for non-inpatient supported accommodation, along with a combination of appropriately trained inmate workers (sweepers) and possibly NDIS funded support workers to provide support in daily living tasks.[413]

This is discussed further in section 4.6.

Recommendation: CSNSW urgently provide fit for purpose facilities for aged and frail inmates that have capacity for the projected growth of this cohort.

Recommendation: Future decisions about the accommodation of aged and frail inmates should be made jointly by CSNSW and JH&FMHN.

413 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.

4.3 Placement of aged and frail inmates

While not all older inmates coming into custody necessarily require mobility aids or other assistive equipment, SDS support, or medium-to-high level care, there is a growing number of inmates presenting with age-related health conditions that can make correctional centre placement more complex. The challenges for placement are exacerbated by a shortage of appropriate accommodation.

4.3.1 Assessment and referral

JH&FMHN staff complete a routine Reception Screening Assessment (RSA) for all inmates when they enter custody. JH&FMHN staff must advise custodial staff of any risks identified during the RSA that will affect an inmate's management in custody, including whether they are aged and frail. Any clinical recommendations concerning the patient's cell placement or management are communicated to CSNSW via a Health Problem Notification Form (HPNF).[414]

CSNSW and JH&FMHN staff who believe a person may be aged and frail should refer that person to SDS or the Aged Care Bed Demand Committee (ACBD Committee) for aged care support. All referrals to the ACBD Committee should be discussed with the relevant nursing unit manager and must be accompanied by completed Basic Aged Care Assessment Tool (BACAT)[415] and Falls Risk Assessment (FRA). The BACAT can be completed by any CSNSW employee, while the FRA must be completed by JH&FMHN staff.[416]

4.3.2 Aged Care Bed Demand Committee

The ACBD Committee is a multidisciplinary forum consisting of representatives from CSNSW and JH&FMHN including the clinical director, Aged Care, older persons nurse practitioner, older persons psychiatrist, Older People's Mental Health Service clinical nurse consultant (OPMHS CNC), relevant nurse managers and nursing unit managers and the manager of SDS.[417] It meets weekly to review referrals and recommend appropriate further assessment and suitable placement options. The ACBD Committee is also responsible for planning and managing the care of referred patients' during their time in custody.

Placement recommendations that may be made by the ACBD Committee include:

- ACRU
- KWU
- 4-wing in MSPC 2
- Hamden 18-wing (remand inmates only).

Other placement recommendations may include the Medical Unit (MU) in LBH 1, the inmate's gaol of classification (with additional equipment and support or further medical assessment and a follow-up review or no change to their current management), or a different correctional centre for assessment and monitoring.[418] Recommended transfers are facilitated by CSNSW.

There are no designated aged care beds within women's correctional centres or units. Most women who require closer monitoring and greater support due to age and frailty are transferred to Dillwynia Correctional Centre and live in an accommodation unit. Here older women are provided assistance and support by other women in custody. Their health and care needs are provided by local health centre staff, an aged care nurse practitioner, an OPMHS CNC and palliative and aged care allied

414 Corrective Services NSW, *Custodial Operations Policy and Procedures: 5.2 Inmate Accommodation* (version 1.7, 3 September 2024) 6; Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.
415 The BACAT measures health factors regarding frailty, mobility, falls risk and aspects of age-related functional decline.
416 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.10 Aged and Frail Inmates* (version 1.1, 12 March 2020) 4–5.
417 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.
418 Corrective Services NSW, *Placement and Management of Aged and Frail Inmates (Joint Policy with Justice Health & Forensic Mental Health Network (JH&FMHN))* (version 1.1, 15 November 2016) 6–7; Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.

health services. There are occasions where a woman will be admitted to the ACRU however, they usually do not remain as a long term placement.

During the inspection, we observed an ACBD Committee meeting. We found its members to be knowledgeable of their patients and the aged care bed management flow processes. Patients awaiting Aged Care Assessment Team, NDIS and Guardianship assessment were discussed as were patient flow requirements of the case managed older patient population. We found the ACBD Committee to be a highly functional interagency committee that closely monitors complex older patients to ensure their safety, suitable placement, close monitoring and provision of age-appropriate care and health services. We commend JH&FMHN and CSNSW for establishing this intensive case management approach to the management of complex older people who are vulnerable and have high needs.

4.3.3 Information sharing between CSNSW and JH&FMHN

HPNFs are created by JH&FMHN staff to communicate advice and recommendations regarding a person's clinical status to CSNSW. They may concern recommendations regarding cell placement, cell access during the day, access to health-related equipment, risks or features that should be noted by custodial staff and related actions should these be observed.[419]

CSNSW policy requires custodial staff to implement recommendations provided by JH&FMHN unless there are overriding security reasons. The reasons for any decision to override JH&FMHN recommendations must be recorded. Such a decision may only be made by a governor, manager of security or a functional manager.[420]

The original HPNF is signed by CSNSW staff and placed in the patient's health record. Two copies are then provided to custodial staff – one for the patient's case management file and one for the officer in charge of the accommodation unit where the patient will be held.[421] These are paper documents.

Due to mobility limitations, a number of aged and frail inmates will have a HPNF specifying they require placement on a bottom bunk and in a cell on a ground floor landing. A recurring issue throughout this inspection was a lack of bottom bunk, ground floor cell placement options. We observed people placed in camera cells because they required a shared cell for medical reasons and a bottom bunk in a ground floor cell and there was no suitable placement. This issue was exacerbated by the temporary closure of KWU. We heard of instances where inmates with bottom bunk, ground floor landing placement requirements were transferred to MSPC, or came very close to being transferred, despite there not being an available, suitable bed. It needs to be clear to all relevant staff if a suitable bed is available in the designated location, ideally at the time transfer decisions are made.

Recommendation: CSNSW and JH&FHMN improve systems for sharing information relevant to the placement of aged and frail inmates in a correctional centre or particular cell.

4.4 Closure and reopening of the Kevin Waller Unit

4.4.1 Decision to close the Kevin Waller Unit

In January 2024, CSNSW announced that the KWU would be closed. A dedicated location for aged and frail inmates was to be established in Hamden 18-wing at MRRC. Typically, moving people out of KWU occurs only at the recommendation of the ACBD Committee, but this did not occur as part of the transfer of inmates from KWU to MRRC. By February 2024, most KWU inmates had been assessed by JH&FMHN nurses and were in the process of being transferred to either Hamden 18-wing or elsewhere. JH&FMHN advised that as part of the review process, six inmates were identified as needing to remain on the Long Bay Correctional Complex to facilitate regular hospital treatment

419 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.
420 Corrective Services NSW, *Custodial Operations Policy and Procedures: 5.2 Inmate Accommodation* (version 1.7, 3 September 2024) 6.
421 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.

and end-of-life or palliative care needs.[422]

As previously noted, when aged and frail patients are located at the KWU, they have the co-located specialty services of LBH next door, including a geriatrician, older person nursing and allied health. The temporary closure of KWU resulted in significant operational issues and meant that the trial discharges from the ACRU to KWU were no longer possible. This impacted the efficient flow of patients to and from designated statewide correctional centre aged care beds. In addition, JH&FMHN considered that the transfer of aged and frail patients to MRRC increased wait times for beds, either in the ACRU, MSPC, Hamden 18-wing or elsewhere.

Health staff create a 'medical hold' to ensure patients are not transferred when they are unfit to travel due to a medical condition or need to be in a location for specialist medical appointments or treatment.[423] We were informed by JH&FMHN staff that, to facilitate the closure of KWU, CSNSW transferred patients on medical hold from MSPC to other correctional centres across the state without consultation with health staff. This resulted in JH&FMHN staff having to arrange with CSNSW to transfer the patients back to MSPC again.

Although there had been some consultation and planning about the establishment of an Aged Care POD in MRRC, there appeared to be little input from JH&FMHN on the closure of KWU and the risks and consequences of this decision. In addition, prior to the initiation of inmate transfers, there was insufficient opportunity for JH&FMHN to make recommendations about alternative placements for KWU inmates or for CSNSW to make previously recommended modifications to Hamden 18-wing. This created a challenging operational environment for JH&FMHN and CSNSW staff and significant distress for impacted inmates. Given the very complex health needs of some aged and frail inmates, all decisions about dedicated accommodation options and the implementation of new arrangements should be made collaboratively.

4.4.2 Transfer to the Hamden Unit Aged Care POD

We visited Hamden 15-wing and 18-wing on two occasions in March 2024. We observed that CSNSW appeared to be wholly unprepared for managing this frailer cohort of inmates.

CSNSW and JH&FMHN had previously considered the suitability of Hamden 18-wing for aged and frail inmates. In 2023, the JH&FMHN Aged Care Specialty team advised CSNSW that the Hamden unit accommodation would not be suitable for any frail patients with mobility, cognition, or visual issues. JH&FMHN provided a plan to CSNSW detailing the necessary modifications to ensure patient safety and wellbeing.[424]

Despite this earlier advice, CSNSW decided to transfer aged and frail inmates from the KWU to the Hamden 18-wing between February to March 2024 with minimal modifications made to cells. JH&FMHN attempted to address the risks as best they could and again advised CSNSW that the MRRC Aged Care POD did not fully address the design requirements of an aged care setting.[425]

The JH&FMHN advice to CSNSW suggested modifications including grinding floors flat around shower hobs, painting any floor height discrepancies with high visibility paint and installing grab rails in key positions.[426] Although some of these were implemented, the facility remained unfit for the needs of this cohort.

As noted in section 4.2.4, the size of the cells limited available space for mobility aids (wheelchairs and walking frames). Over toilet aids could not be used due to the position of the in-cell toilets. Despite CSNSW having the shower hobs ground down, the uneven shower recess remained a trip hazard. In some ways the shower hob alteration increased the falls risks because it created uneven, often wet flooring in a very confined space. In addition, there was a lack of functional grab rails. The position of grab rails installed near toilets was assessed as being unhelpful for assisting a person to

422 Information provided by the Justice Health and Forensic Mental Health Network, 9 May 2024.
423 Inspector of Custodial Services, *Health Services in NSW Correctional Facilities* (Report, March 2021) 133.
424 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.
425 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.
426 Information provided by the Justice Health and Forensic Mental Health Network, 3 April 2024.

sit and stand. The poor temperature control was of concern as the accommodation was very hot in summer which could lead to dehydration or falls. The cells were likely to be poorly heated in winter.[427]

We observed frail inmates with impaired mobility struggling to get up and down from their bed. Grab rails were placed in unhelpful positions and were filled in, making them difficult to grip. There was limited access to mobility aids due to the physical layout and size of the cells, so if both cell mates required a walker, one would be left outside. Inmates told us that the toilet was too low for them to feel secure when sitting and standing and that its position near the open door of the cell meant that there was no privacy. They also said that it was a difficult area to navigate with their walker. Older inmates also said that they needed to sleep with their jackets on to keep warm due to the breeze from the windows at the head of their beds.

Due to insufficient ground floor cells in Hamden 18-wing, some aged and frail inmates were housed in another area, Hamden 15-wing, referred to as the as the 'overflow unit'. This area also housed Protection Non-Association Area inmates, so aged and frail inmates were moved to Hamden 18-wing with the other aged inmates during the day. This meant, unlike the inmates housed in Hamden 18-wing, the 'overflow' inmates were unable to retreat to their cell or have access to their personal belongings. Given the lack of both cell access and seating in the common area, there were concerns that this prolonged period during the day would negatively impact this group.

Following the transfer of inmates from KWU to MRRC, eight were identified by MRRC JH&FMHN staff as 'high risk'. Consequently, a three-person multidisciplinary team, consisting of two physiotherapists and an occupational therapist, conducted a further assessment of whether the care and safety needs of these inmates could be provided at MRRC. In early March 2024, following review by the ACBD Committee, two of these patients were transferred to the MU.[428] A further two patients at MRRC were also transferred to the MU following the recommendation of the ACBD Committee (see section 1.4.2).[429]

Policy on aged and frail inmate placement states that CSNSW and JH&FMHN staff should work together to ensure that the physical, cognitive, security and medical needs of the inmate are met through the development of comprehensive case plans.[430] Indeed, best practice indicates the need for multidisciplinary care planning involving both health and custodial staff.[431] However, during the inspection it was apparent there was very little planning for the joint management of inmates being transferred to the Hamden 18-wing.

4.4.3 Reopening of the Kevin Waller Unit

In May 2024 we inspected the units at MSPC that were temporarily closed, including KWU, and found them to be dirty and unhygienic (see section 2.2.2). We observed dead cockroaches and animal faeces and animal hair on furniture, apparently from one or more feral cats accessing the unit. Cells were littered with rubbish and pillows were left on dirty floors at risk of contamination from rodents and feral cats.

In June 2024 the decision was made to re-open the KWU. JH&FMHN advised that the reasons for this decision included the lack of clinical oversight at MRRC for aged patients with more complex health needs and the need to improve the proximity of patients to the JH&FMHN pharmacy and the Prince of Wales Hospital. JH&FMHN staff were given four weeks to prepare for the transfer of aged and frail patients back to the KWU. By mid July 2024, the first patients were being assessed by JH&FMHN for transfer.

Not all those originally transferred from KWU to MRRC were transferred back again. The main criteria for those being transferred to the KWU when it was reopened was that they were sentenced, may require palliative care, were at risk of falls, had deteriorating health or were struggling with

427 Information provided by the Justice Health and Forensic Mental Health Network, 3 April and 9 May 2024.
428 Information provided by the Justice Health and Forensic Mental Health Network, 9 May 2024.
429 Information provided by the Justice Health and Forensic Mental Health Network, 9 May 2024.
430 Corrective Services NSW, *Placement and Management of Aged and Frail Inmates (Joint Policy with Justice Health & Forensic Mental Health Network (JH&FMHN))* (version 1.1, 15 November 2016) 4.
431 Gary Forrest et al, 'Previously Unrecognised Issues: Managing the Health of an Ageing Prison and Homeless Population' in Marree Bernoth and Denise Winkler (eds) *Health Ageing and Aged Care* (Oxford University Press, 1st ed, 2017) 225.

activities of daily living (ADL). The most 'high risk' patients were identified for transfer to the KWU from mid July 2024. By 30 July 2024, there were 20 inmates in KWU.

In late July 2024, we conducted two visits to observe the environment and how inmates were adjusting to the KWU. Following our inspection in May 2024, we advised the governor that significant work was required for KWU (and other closed units) to be fit for use should CSNSW decide to reopen it. Pleasingly, we observed that this advice was actioned. We found KWU to be very clean and tidy and there were no signs of rodents, stray cats, or other mess.

We spoke with an inmate who had originally been transferred from the KWU to MRRC, and back again to the KWU. He reported that he had more opportunity to consult with nurses when he was accommodated at the KWU because of the satellite health centre. He also said that he was able to access a computer and treadmill to exercise in the KWU, whereas the Hamden 18-wing had no such facilities.

The KWU has many limitations as a location for housing aged and frail inmates. Despite this, it has become a key part of the framework for managing aged and frail people in custody. The experience of closing and reopening the KWU within a six-month period highlights the significant level of planning required to change accommodation for aged and frail inmates. It is essential that future alternate placement for this cohort considers their health, care, and accommodation needs and ensures the facility meets these needs *prior* to their transfer. In addition, JH&FMHN needs to ensure the health staff at the alternate facility have been suitably briefed about the patients and receive the appropriate additional training to provide health care for an aged, complex and high needs population. Custodial staff should also be provided with training on how to manage older inmates, highlighting their health, care or cognitive limitations.

4.5 Adaptive ageing and ageing in place

Adaptive ageing is a concept that not only views ageing as a process of personal adjustments, compensation, and modifications as people age, but also requires those engaging and interacting with older persons to be 'adaptive' in order to best suit their individual needs.[432]

JH&FMHN advise that they are moving towards an adaptive ageing approach in their management and care of aged patients. A draft model of care and procedure have been created to support this approach, the aim of which is to shift focus away from chronological age to the individual age-related needs of Aboriginal patients aged 45 years and over and non-Indigenous patients aged 55 years and over. This involves assigning patients to an ageing-related service group based on the outcomes of screening[433] for chronic conditions, disabilities or reduced activities of daily living ADL function and follow up assessment. Those identified with ageing-related needs are provided with care and support according to their service group.[434] Ageing-related service groups and related care and support are detailed in Table 32.

The draft procedure acknowledges that collaboration with external organisations, including CSNSW, will be required to implement this approach. This includes information sharing, to the extent permitted by patient consent, regarding the person's current community services and supports, release information, the provision of services and programs in custody, and the coordination of services prior to release. CSNSW and JH&FMHN need to continue to work together to develop a strategy for managing older people in custody.[435]

The adaptive ageing approach recognises the wide ranging and diverse needs of ageing inmates and that an individualised enablement approach helps maintain patients' health to age in place (see Figure 13). Adaptive ageing also aligns with the shift to approaches underpinned by wellness and

432 Australian Association of Gerontology, *Moving from Successful or Positive Ageing to Adaptive Ageing* (Position Paper, 23 December 2021).
433 This may occur during the Reception Screening Assessment following the person's entry into custody, during routine preventive health screening or during other contacts between health staff and patients.
434 Information provided by the Justice Health and Forensic Mental Health Network, 16 September 2024.
435 Information provided by the Justice Health and Forensic Mental Health Network, 16 September 2024.

reablement in the Commonwealth Government's aged care program.[436] This is an approach that we endorse and can see the value of promoting amongst JH&FMHN and CSNSW staff.

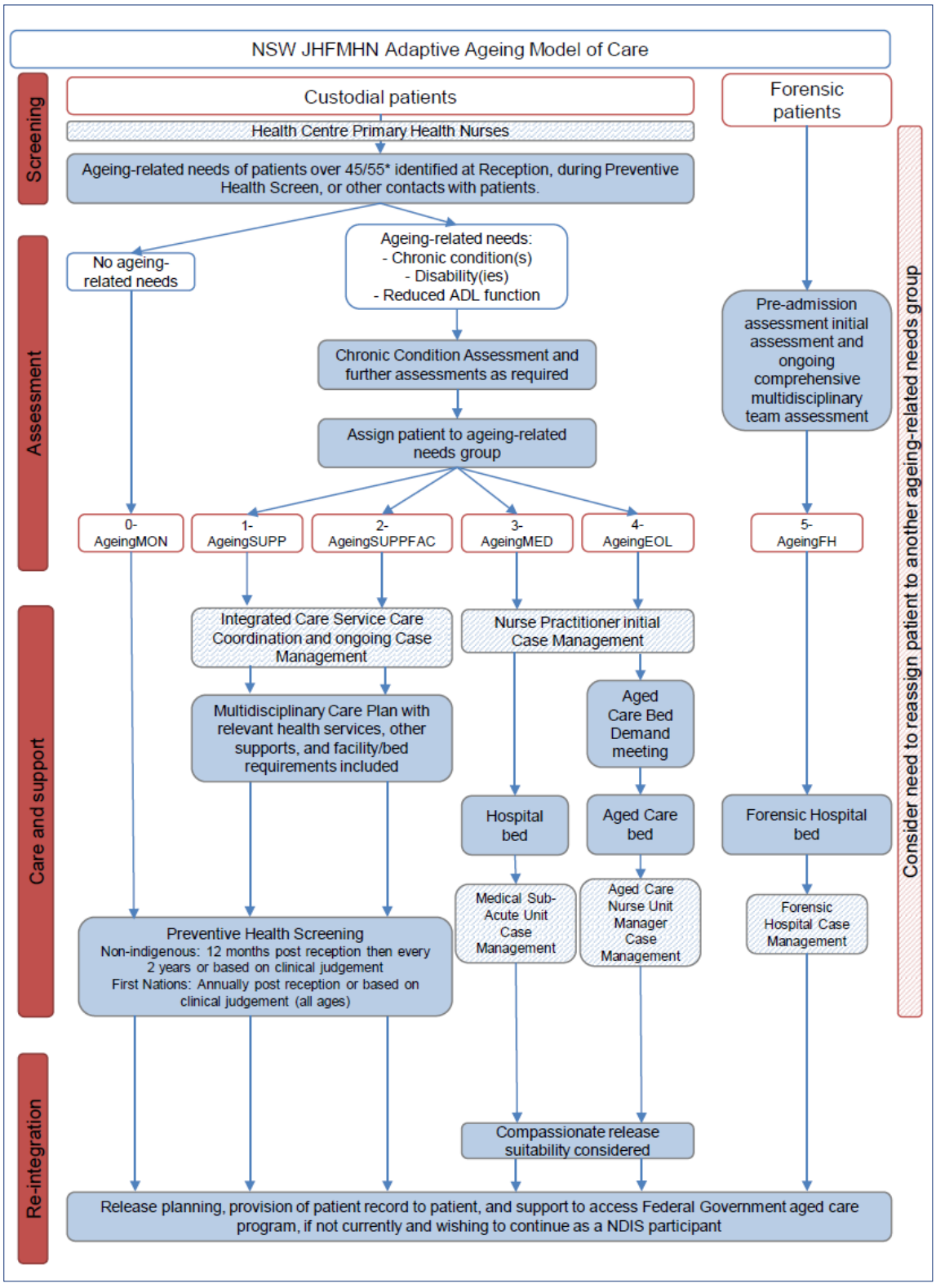
In 2024, JH&FMHN and CSNSW formed a joint working group to finalise the Adaptive Ageing model of care and a new 2025–30 Aged Care Strategy.[437]

Recommendation: CSNSW support the implementation of the JH&FMHN Adaptive Ageing model of care.

436 Australian Government, 'Wellness and Reablement Resources', *Department of Health, Disability and Ageing* (Web Page, 6 August 2025) <https://www.health.gov.au/resources/collections/wellness-and-reablement-resources?language=en>.

437 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.

Figure 13: JH&FMHN Adaptive Ageing Model of Care[438]



438 Information provided by the Justice Health and Forensic Mental Health Network, 16 September 2024.

Table 32: Ageing-related groups needs and services to promote Adaptive Ageing[439]

Ageing-related group	Level of need	Required services
0 – AgeingMON	Patients with no chronic conditions, disabilities, or reduced function for ADL whose ageing-related needs must be monitored.	Monitor for ageing-related needs through preventive health screening.
1 – AgeingSUPP	Patients can self-manage ageing-related needs in any NSW correctional facility with the provision of supports.	Patients can self-manage with aids and equipment, or clinical services as outlined in a Multidisciplinary Care Plan. Refer to Integrated Care Service for care coordination and/or case management.
2 – AgeingSUPPFAC	Patients can self-manage ageing-related needs with the provision of supports and allocation to a facility/bed with specific physical, social or service access.	A Multidisciplinary Care Plan through Integrated Care Service. Receive case management, allocation to a facility/bed and reasonable adjustments together with CSNSW.
3 – AgeingMED	Patients cannot live in the general population even with supports. They require medical care in hospital to stabilise and rehabilitate.	Patients receive initial case management from the aged care nurse practitioner for placement in an appropriate MU hospital bed. Primary care will be undertaken by the relevant MU admission team.
4 – AgeingEOL	Patients cannot live in the general population even with supports and are suspected to be within the last three years of their life.	Patients are initially to be referred to the aged care nurse practitioner. They will be referred to the ACBD Committee meeting and may be assigned to a lower level group, ageing-related services group, receive care in ACRU or KWU or be eligible for end-of-life care.
5 – AgeingFH	All forensic patients are allocated to this group.	Support and services in line with the Care Coordination, Risk Assessment, Management, Planning and Review Forensic Hospital policy.

4.6 Activities of daily living support

The term 'activities of daily living' refers to those tasks we all must perform to maintain our health and wellbeing. They include showering, grooming and personal hygiene, using the toilet, food preparation and eating, dressing, and mobility. Age is a risk factor for reduced function across activities of daily living and aged people may require support to undertake these tasks.

In the ACRU, ADL assistance was provided by JH&FMHN nursing staff (registered nurses and assistants in nursing). The level of assistance for patients ranged from prompting patients to perform tasks (such as showering, going to the toilet or eating meals) to providing full care of patients regarding their hygiene and nutrition.

439 Information provided by the Justice Health and Forensic Mental Health Network, 16 September 2024.

Following the reopening of KWU, JH&FMHN advised that nursing support was increased to enable higher level clinical supervision and support in line with patient need. This created greater capacity for nursing staff to support patients with higher care needs through clinical monitoring, wound and dressing care and full showering assistance. Inmate hygiene workers also provide assistance with cleaning, social support and basic ADLs.[440]

In other areas with higher concentrations of aged inmates, ADL assistance is managed in an ad hoc manner. For example, either staff or other inmates may provide support where possible. The *Custodial Operations Policy and Procedures* (COPP) states that 'peer-support trained inmates' or inmates with previous experience in aged health care may also be able to provide assistance to aged and frail inmates.[441] However, there is a lack of clarity or guidelines regarding who is responsible to provide this support and we found it was often provided informally by other inmates.

CSNSW needs to ensure that inmate hygiene workers providing assistance to aged and frail inmates (or inmates with disability) are appropriately trained, supervised, and compensated for this type of work. We have met many inmates who work hard and do their best to support those who need it. However, a failure to put in place appropriate structures creates a risk of neglect, exploitation, and elder abuse. Roles and responsibilities need to be formalised. And where inmates are providing assistance, they must have relevant training and adequate supervision by CSNSW staff.

Other states have explored programs that include existing and potential prisoner caregiving programs. For example, a review conducted by Catholic Social Services Victoria considered an official model of care with governance structures, development of a training manual for officers and certification for inmates undertaking prison service work to provide ADL support for aged and frail patients.[442] CSNSW and JH&FMHN may benefit from exploring such caregiving models as the aged inmate population continues to grow.

4.7 The role of custodial staff

There is often the assumption that support for aged inmates is purely a healthcare function. While we observed some supportive CSNSW staff, it was evident that others were ill-equipped to manage aged and frail inmates.

During this inspection we observed a poor understanding of the needs of aged inmates among some custodial staff. This sometimes manifested as resentment or frustration about the provision of supports and adjustments. For example, some custodial staff expressed to us that JH&FMHN too readily issue HPNFs with cell and bed placement specifications or medical holds. We note that no examples were provided of improperly issued HPNFs or medical holds.

We also observed a widespread view among staff at MSPC that the number of aged and frail inmates at MSPC was slowing down the industries workflow. This was because these inmates were unable to work, or only able to do certain types of work, and were therefore occupying a bed that could have been occupied by a 'working' inmate. Consequently, the industries at MSPC were not fully staffed with inmate workers (see section 2.7.4). There was a general lack of understanding of the need for these inmates to be close to medical specialists for appointments or treatment and of the want of other placement options.

Health and custodial staff also highlighted the importance of custodial staff receiving de-escalation training that addresses techniques for people with dementia or who are presenting with delirium and confusion. This group were described as potentially unpredictable. As we highlighted in the *Old and Inside* report, there is a risk that an inability to understand instructions is misinterpreted as resistance or a refusal to comply.[443] While this group may not always be aged and frail, with young people experiencing early onset dementia or confusion for another reason, we note, during this inspection,

440 Information provided by the Justice Health and Forensic Mental Health Network, 16 September 2024.
441 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.10 Aged and Frail Inmates* (version 1.1, 12 March 2020) 6.
442 Ruth Webber and Alicia Evans, *Prisoner-Caregiving Programs: Supporting Older Prisoners* (Catholic Social Services Victoria, November 2020).
443 Inspector of Custodial Services, *Old and Inside: Managing Aged Offenders in Custody* (Report, September 2015) 48.

we reviewed Incident Reporting Modules (IRMs) documenting uses of force in the ACRU. There is nothing indicating these uses of force were unjustified or excessive and we are not suggesting force was used improperly. However, this does highlight the need for custodial staff, particularly those in Immediate Action Teams, to be properly equipped with the skills to respond safely and appropriately to aged and frail people experiencing cognitive decline.

Recommendation: CSNSW provides custodial staff working in aged and frail units and LBH 1 with appropriate training in the management of delirious, confused or disoriented people in custody.

4.8 Transportation

People in custody may be transported in secure vehicles for a range of different reasons including transfer to a different correctional centre, for court appearances or for medical appointments and treatment. CSNSW has vehicles that can be used for aged and frail inmates or inmates with disability, including wheelchair users.

Where JH&FMHN staff assess that a person requires particular transport arrangements, they may issue a special transport certificate. This certificate notes the appropriate form of transport for the inmate. The certificate is emailed to the Court Escort Security Unit (CESU) and a relevant alert is created on the Offender Integrated Management System (OIMS).[444] CSNSW policy further provides that special transport certificates may be provided to aged and frail inmates for the duration of their sentence, where required.[445]

During the inspection of LBH, we were advised by health staff that most of their patients were able to attend appointments via a special transport vehicle. However, we heard the high needs of some men in the ACRU made transportation challenging. Some patients are hesitant to being transported in vans due to their frailty or confusion and find being in a closed-in style van distressing. Some aged and frail patients are unable to walk long distances from the parked van to the appointment location and health staff have noted that when they recommend the use of a wheelchair some custodial officers are reluctant to push it. These challenges were echoed by aged and frail inmates who reported having difficulty getting in and out of vehicles and finding journeys physically demanding.

Given these challenges, health staff considered there may be benefit in CSNSW adding one or more sedan vehicles to its special transport fleet for some of the older and more frail patients. There were also concerns about the wheelchair accessible vehicle, used for those who remain in their wheelchair during transport. Although the wheelchair is secured there is still movement when the vehicle is in motion. However, there is nothing for the person to hold onto as the vehicle does not contain grab rails. This is because a grab rail would be a ligature point. We acknowledge this risk however, it should be balanced against the needs of people who use wheelchairs and other mitigation strategies, including assessments of a person's self-harm risk and staff supervision.

The use of restraints on aged and frail people was another area of concern for health staff and inmates. Many aged and frail people have delicate skin, and it is not uncommon for friction abrasions from ankle cuffs and handcuffs to cause skin tears. Restraints can further constrain their already limited mobility, creating a risk of falls. For those who rely on mobility aids, restraints can be impractical and largely pointless. Health staff reported that sometimes their patients are reluctant to go to medical appointments because of the distress caused by being transported and restrained.

CSNSW policy includes detailed procedures for the use of restraints, according to the risk associated with the inmate and type of escort. These are summarised in Table 33.

444 Corrective Services NSW, *Custodial Operations Policy and Procedures: 19.1 General Escort Procedures* (version 1.11, 5 July 2024) 11.
445 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.10 Aged and Frail Inmates* (version 1.1, 12 March 2020) 8; Corrective Services NSW, *Placement and Management of Aged and Frail Inmates (Joint Policy with Justice Health & Forensic Mental Health Network (JH&FMHN))* (version 1.1, 15 November 2016) 11.

Table 33: CSNSW policy provisions on the use of restraints during escorts

Escort	Restraints used	Exceptions
General escorts[446]	Handcuffs for men with maximum (AA, A1, A2), medium (B) or escape-risk (E1, E2) security classifications. Handcuffs for women with Category 4 or 5 security classifications. Handcuffs are not required for men or women with minimum security classifications unless an exception applies, including that they are being escorted in a vehicle with inmates requiring handcuffs.	Handcuffs are not mandatory: • when the inmate has an injury and handcuffs cannot be secured • when the inmate is entering court (unless a court direction is in place) • if the governor is satisfied, based on a risk assessment, that handcuffs are unnecessary • during secure vehicle escorts of female inmates conducted by the CESU, and • for inmates who are pregnant.
Medical escorts[447]	Handcuffs and ankle cuffs for: • all inmates with an extreme high risk restricted or extreme high security designation[448] • men with maximum (AA, A1, A2), medium (B) or escape-risk (E1, E2) security classifications • women with Category 3, 4 or 5 security classifications who are physically capable of an escape (one form of restraint must be in place at all times). Handcuffs only for all C1 inmates. Restraint belts must also be used for inmates with certain security classifications and designations or who are assessed as an escape risk (not applicable for pregnant inmates). Inmates may be handcuffed to the base of a hospital bed to facilitate medical treatment.	Approved restraints should not be applied if: • an inmate patient has an injury and handcuffs or ankle cuffs would cause further injury or cannot be secured due to the injury • a medical officer specifically advises against their use for medical reasons (such as the use of handcuffs during an MRI scan) or • the inmate patient's general medical condition renders the use of handcuffs and ankle cuffs inappropriate (aged and frail inmates who rely on walking aids). Following relevant approvals, consultation with medical staff and an ongoing risk assessment indicates the: • use of handcuffs (or ankle cuffs) may be unnecessary • type of restraint may be changed in accordance with this revised level of risk. Restraints may be removed without approval in emergency or life-threatening circumstances.

During our inspection of LBH, we were informed that discussions between relevant CSNSW and JH&FHMN staff had resulted in acknowledgement of the need for discretion when using restraints for aged and frail inmates on escort. However, we are concerned that escorting staff are not

446 Corrective Services NSW, *Custodial Operations Policy and Procedures: 19.1 General Escort Procedures* (version 1.11, 5 July 2024) 18.
447 Corrective Services NSW, *Custodial Operations Policy and Procedures: 19.6 Medical Escorts* (version 1.17, 15 July 2024) 9–11.
448 *Crimes (Administration of Sentences) Regulation 2014* cl 15.

consistently considering whether restraints are appropriate for aged and frail inmates on medical escort. We engaged with multiple aged and frail inmates who reported being hand cuffed and ankle cuffed on medical escorts. One man with Parkinson's disease who experienced chronic tremors told us he was handcuffed for the trip to a medical appointment but not the return journey. We heard from staff and inmates of instances where inmates relying on walking frames and walking sticks have been handcuffed and ankle cuffed. The handcuffing of people to beds was a particular concern for health staff, who expressed that soft restraints would be more appropriate.

We consider that the policy and procedure in this area requires review and amendment to support better decision making. Given medical escorts involve transporting inmates to a community setting, it is understandable that a higher level of restraint may be required. However, it is less clear why the exceptions vary depending on the type of escort. In particular, we note that:

- the general medical condition exception does not apply across all types of escorts
- the procedures for escorting aged and frail inmates do not include consideration of whether restraints are appropriate
- the procedures for aged and frail inmates and inmates with disability vary despite the potential overlap between these cohorts.

We are also concerned that restraints may be applied according to the security classification of the correctional centre rather than the individual inmate as the ACRU, KWU and Hamden 18-wing are all maximum security units.

Recommendation: CSNSW review policies and procedures for inmates on escort to ensure they are fit for purpose for aged and frail inmates and the adequacy of special transport vehicles.

4.9 Release planning

Aged care homes may be reluctant to accept ex-inmates, particularly those convicted or charged with serious offences. Significant work has been undertaken by JH&FMHN staff to build relationships with aged care providers. However, they fear increasing demand for aged care beds will result in a placement crisis.

A significant amount of work must be completed when patients are being considered for placement in an aged care facility following their release and JH&FMHN staff reported finding this burdensome. Staff felt there could be better delineation of responsibilities between relevant CSNSW and JH&FMHN staff for completing the required liaison and assessment, particularly the My Aged Care and Centrelink requirements. The My Aged Care processes require specific knowledge that JH&FMHN staff may be better placed to provide and the Centrelink income assessment requirements are best dealt with by CSNSW services and programs officers.

The lack of role delineation, the volume of administrative work, and a deficit of knowledge and understanding of aged care requirements were reported to cause delays in patients being released into the community. CSNSW and JH&FMHN need to review this process and develop procedures that clearly allocates the workload and expectations and ensure there is adequate resourcing to complete the process within a reasonable timeframe.

Discharge planning was identified as a priority issue in the JH&FMHN 2021–25 Aged Care Strategy and JH&FMHN have advised us that this will be retained for action in the 2025–30 Aged Care Strategy. Any procedures developed regarding the discharge of aged and frail patients will need to align with the JH&FMHN Adaptive Ageing model of care.[449]

Recommendation: CSNSW and JH&FMHN jointly develop procedures which delineate each agency's responsibilities for the discharge of aged and frail patients to residential aged care facilities and resource this process accordingly.

449 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.

5 Treatment of LGBTIQA+ people in custody

During this inspection, we engaged with a number of LGBTIQA+ inmates held at the Metropolitan Special Programs Centre (MSPC), particularly transgender women. In this chapter, we reflect on their experiences in custody and the broader management, safety and wellbeing challenges faced by this cohort.

The following terminology is used throughout this chapter. We acknowledge that language is always evolving and the following definitions are not exhaustive, but are included here as a guide:

- LGBTIQA+ (lesbian, gay, bisexual, trans and gender diverse, intersex, queer and asexual) is an inclusive abbreviation of diverse sexualities, genders and sex characteristics.
- Gender is part of a person's personal, cultural and social identity and refers to their identity, expression and experience as a woman, man or gender diverse person.
- Gender diverse refers to a range of different genders including people who identify as non-binary (neither exclusively male nor female) or whose gender is fluid.
- Trans or transgender refers to someone whose gender does not exclusively align with their sex assigned at birth.
- Sex assigned at birth refers to the sex (male, female or intersex) used to describe a person at birth, based on their external anatomy.
- Intersex or variations of sex characteristics refers to people born with variations to physical or biological sex characteristics, including chromosomes, hormones or anatomy, that are different from medical and conventional expectations of female and male bodies.[450]

We requested data concerning the number of trans and intersex inmates in NSW custody. However, Corrective Services NSW (CSNSW) advised that it 'does not report data' on these groups.[451] A subsequent media report stated there are 50 transgender inmates in NSW custody.[452]

5.1 CSNSW's policy framework for trans and intersex inmates

This section describes the policy framework in place at the time of this inspection. At the time of writing, this was under review and may change after this report is published. The *Custodial Operations Policy and Procedures* (COPP) included a dedicated chapter on the management of transgender and intersex people in custody.[453] CSNSW's inmate classification and placement policy and procedures also included a chapter on the classification and placement of transgender and intersex inmates.[454] We note these were removed from CSNSW's internal policy libraries and its website while under review. It is unclear what policy and procedures are being followed or could be accessed by staff during the review period.

The policy and procedures distinguished between transgender people who have been able to change the sex on their identification documents and those who have not. They used the term 'recognised transgender person', which refers to a person the record of whose sex has been altered under

450 Victorian Government, *LGBTIQA+ Inclusive Language Guide* (2023); NSW Department of Communities and Justice, *LGBTIQA+ Glossary* (2025); 'LGBTIQ+ Language and Terminology', *NSW Health* (Web Page, 25 February 2025) <https://www.health.nsw.gov.au/lgbtiq-health/Pages/language-and-terminology.aspx>; Australian Human Rights Commission, *Resilient Individuals: Sexual Orientation, Gender Identity and Intersex Rights* (Consultation Report, 2015) 5.

451 Information provided by Corrective Services NSW, 17 January 2025.

452 Jake McCallum, 'Killer's Trans Jail Bid to be Rejected, Will Stay in Male Prison', *Daily Telegraph* (online, 10 July 2025) <https://www.dailytelegraph.com.au/truecrimeaustralia/police-courts-nsw/double-murderer-terry-donais-bid-to-be-sent-to-a-womens-prison-nixed-after-18month-review/news-story/b4f2dc3049abf5ee64f2ff2d5bcb1d12>.

453 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023).

454 Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021).

the *Births, Deaths and Marriages Registration Act 1995*[455] or corresponding legislation in another Australian jurisdiction. This is the terminology and definition contained in the *Anti-Discrimination Act 1977*.[456] The policy and procedures used the term 'transgender' for people who have not altered their sex on their identity documents.

Both documents provided that a person received into custody 'must be managed as the gender with which they identify at the time of their incarceration'.[457] They further provided that recognised transgender, transgender, and intersex inmates:

> are to be managed according to their identified gender in all stages of incarceration to provide best practice, non-discriminatory, safe and secure management. This includes the form of address, escorts, placement assessment, searching and urinalysis, clothing and buy-ups, medication and health services, rehabilitation and integration, and access to information.[458]

The COPP stated that a recognised transgender person must be treated as a member of the sex recorded on their identity documents. Transgender and intersex inmates 'are to be managed according to their identified gender'.[459]

Positively, a 2024 review of correctional policies for the management of trans people in Australian jurisdictions noted that NSW policies:

> appear to have had input by advisors knowledgeable about trans issues, showing a depth of understanding about issues such as prosthetics, black-market hormone use, and diverse identities which indicate a commitment to improvement.[460]

However, we considered the policy framework concerning transgender and intersex people in custody in place during the inspection required more work. It was largely concerned with people entering custody and their initial placement and provided only minimal guidance regarding their ongoing management and safety considerations. It did not contemplate a person coming out during their time in custody or provide guidance on how correctional centres should act to ensure their safety and dignity. It was also largely silent on gender diverse people and future policy should provide staff with guidance on how to ensure these cohorts are treated with dignity.

In our view, a single policy framework for transgender and intersex people is fundamentally flawed and creates confusion. Some people have variations of sex characteristics and are trans (i.e. their gender does not align with their sex assigned at birth), but this is not always the case. The policy did not clearly articulate this. It focused on transgender people in custody and inconsistently provided for intersex people, who may not be trans. The consequence is that, in policy and practice, intersex people are assumed to be transgender. This creates the risk that their needs and vulnerabilities will be misunderstood and overlooked and needs to be addressed.

Recommendation: CSNSW review and revise all policy and procedures concerning transgender, gender diverse and intersex people in custody.

455 *Births, Deaths and Marriages Registration Act 1995* pt 5A.
456 *Anti-Discrimination Act 1977* s 4(1).
457 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 4; Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021) 3.
458 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 1; Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021) 3.
459 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 4.
460 Charlie Winter, 'Correctional Policies for the Management of Trans People in Australian Prisons' (2024) 25(2) *International Journal of Transgender Health* 130, 144.

5.2 Admission to custody and placement for trans and intersex inmates

CSNSW policy in place at the time of the inspection provided that when a recognised transgender person enters custody and has identification 'showing that they are a recognised transgender person', they are to be 'sent to a correctional facility of their recognised sex'. Transgender people who do not have such identification and have a previous arrest/custody record as a different sex, must be sent to the Metropolitan Remand and Reception Centre (MRRC) for assessment and determination of placement. This also applies for gender diverse people.[461] The COPP did not identify Silverwater Women's Correctional Centre (SWCC) as a reception option, although this was included in the inmate classification and placement policy.[462]

As part of this inspection, we observed the reception screening process for transgender people in custody at MRRC in June 2024. We observed staff repeatedly refer to a transgender woman using male pronouns and she was not provided with a copy of the *Fact sheet: transgender and intersex persons in custody* as required by the COPP.[463]

During our March 2022 inspection of MRRC, we observed unprofessional behaviour in relation to the reception of a transgender person entering custody. We recommended that staff at MRRC receive training in the management of LGBTIQA+ people.[464] We were subsequently informed that CSNSW was reviewing their policy in relation to the management of transgender inmates and exploring staff training options.[465] We were disappointed to be told during our June 2024 visit that no policy change or staff training had yet occurred. We note that since this visit, CSNSW's 2025 *Placement Practice Guide* was published providing that staff 'assessing and determining placement must participate in Transgender and Gender Diverse training facilitated by the Brush Farm Academy'.[466] However, we emphasise the importance of CSNSW ensuring that all staff at MRRC and SWCC are equipped with the skills needed to perform their duties in relation to trans people entering custody.

CSNSW policy further provided that trans and intersex inmates 'will have the same classification and placement options as all other inmates in the correctional centre where they are housed'.[467] We take this to mean that transgender and intersex inmates can be placed in any area of any correctional centre in NSW and placement decisions are made on a case-by-case basis. In practice, we observed that trans and intersex inmates are often placed in a Special Management Area Placement (SMAP)/ protection area, such as those in MSPC 2 and MSPC 3. CSNSW senior executive staff are the sole decision-makers for placement decisions for transgender and gender diverse inmates whose placement has been discussed at an interagency meeting with the Justice Health and Forensic Mental Health Network (JH&FMHN).[468]

In theory, the policy and procedures enabled a transgender person to be placed in a correctional centre of their gender identity. However, the relevant policies allowed decision makers discretion to place an inmate in a correctional centre of their 'biological sex'. Relevant considerations included:

- the nature of their current offence and criminal history, for example violent or sex offences against women or children
- custodial history, including any management problems during previous periods in custody

461 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 5.
462 Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021) 5.
463 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 8.
464 Inspector of Custodial Services, *Inspection of the Metropolitan Remand and Reception Centre* (Report, February 2024) 22.
465 Inspector of Custodial Services, *Inspection of the Metropolitan Remand and Reception Centre* (Report, February 2024) 22.
466 Corrective Services NSW, *Placement Practice Guide* (version 1.1, 21 July 2025) 30.
467 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 4; Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021) 5.
468 Corrective Services NSW, *Placement Practice Guide* (version 1.1, 21 July 2025) 34.

- perceived risks to the safety of the inmate.[469]

Although this appeared to also apply to intersex inmates, this made no sense in this context. The reference to 'biological sex' was confusing as intersex people have innate sex characteristics that don't conform with traditional medical definitions and social norms of male and female bodies. Elsewhere, the policies unhelpfully used the terms 'female-to-male' and 'male-to-female'.[470] This effectively conflated intersex people with transgender people, erasing their unique needs and leaving a notable policy gap.

Almost all the trans women and intersex people we spoke with at MSPC and MRRC said they would prefer to be in a female correctional centre but were told that was not possible. Data provided by CSNSW for this inspection showed there was one person at MSPC who was recognised (and entered in the Offender Integrated Management System (OIMS)) as female but nonetheless remained at MSPC. This suggests most inmates did not have identification documents to support a request for transfer. Most were accommodated in single occupancy cells, which helped to address their safety concerns. However, most reported being victims of violence, harassment, and abuse while incarcerated.

For some transgender people, flexibility regarding placement decisions can create uncertainty. We are aware of one case where an application for transfer to a female correctional centre had progressed to the Commissioner of CSNSW for determination. This decision remained outstanding for around two years until July 2025. At times this inmate has been held in isolated and restrictive, and allegedly unsafe, conditions. Such a prolonged decision making process is unjustifiable. CSNSW need to do more to ensure that this never happens again.

Recommendation: CSNSW create timelines and an accountability framework for senior executive decisions concerning the placement of transgender and gender diverse inmates.

The Equality Legislation Amendment (LGBTIQA+) Bill 2024 was passed by both houses of the NSW Parliament on 17 October 2024 amending the *Births, Deaths and Marriages Registration Act 1995* to allow people who have not had gender affirming surgery to alter records of sex with affirming documentation.[471] However, people in custody must have the approval of CSNSW to make such an application. CSNSW must be satisfied that the change of sex is necessary and reasonable[472] and must not approve the making of an application if satisfied:

> a. the change of sex would, if registered, be reasonably likely to:
>
> i. adversely affect the security, discipline or good order of premises or a facility at which the restricted person is held or accommodated, or
>
> ii. jeopardise the restricted person's or another person's health or safety, or
>
> iii. be used to further an unlawful activity or purpose, or
>
> iv. be used to evade or hinder the supervision of the restricted person, or
>
> b. the proposed change of sex would be reasonably likely to be regarded as offensive by a victim of crime or an appreciable sector of the community.[473]

Consequently, the legislation is likely to have no impact on the current arrangements for the placement of transgender inmates and inmates who transition while in custody. With such a broad scope for refusal, it will be difficult for transgender inmates to meet the legislative requirements for approval. At the time of writing, it was not yet clear how CSNSW would approach the management and placement of transgender people entering custody who had previously altered their records

469 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 5–6; Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021) 4–5.
470 Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021) 5.
471 New South Wales, *Parliamentary Debates*, Legislative Assembly, 24 August 2023, 9146–7 (Alex Greenwich).
472 *Births, Deaths and Marriages Registration Act 1995* s 32GC(1).
473 *Births, Deaths and Marriages Registration Act 1995* s 32GC(2)(a)-(b).

of sex pursuant to the amendments made by the Equality Legislation Amendment (LGBTIQA+) Bill 2024.

5.3 Strip searching trans and intersex inmates

Legislation provides that inmates must not be strip-searched by or in the presence of a person of the opposite sex.[474] CSNSW policy provides that, except in an emergency:

- a recognised transgender inmate must be strip or pat searched by an officer of the same sex
- a transgender and intersex inmate must be asked their preference regarding the gender of the officer conducting a strip or pat search and it should be conducted by an officer of the preferred gender.[475]

If an officer is uncomfortable performing a pat or strip search, another officer of the recognised sex or preferred gender should be assigned the task.[476] We are troubled by this exception. It is not clear to us why an officer, conducting their duties professionally, would find strip or pat searching some inmates more offensive than others. In our view, this supports discriminatory values and attitudes towards trans inmates and should not be supported by CSNSW policy.

The strip searching practices described to us by staff and inmates during this inspection did not comply with the policy and procedures. A top/bottom strip-searching practice was imposed on trans women, involving a male officer observing the unclothed lower portion of the inmate's body and a female officer observing the unclothed upper portion.

Comments from transgender and intersex inmates around strip search practices were varied. However, most reported being uncomfortable with the bottom half/top half search arrangements. It seemed that trans and intersex inmates adopted a strategy of least resistance to avoid the possibility of an incident or retribution. This can mean, at times, that they do not object to non-compliant search practices. One trans person told us they choose not to have in-person visits with their family to avoid being strip searched. This would not be happening if searches were conducted as prescribed by policy.

Body scanning machines are in most custodial centres, largely replacing the need to strip search inmates. We note that at the time of this inspection, body scanners were not being used for inmates (see section 2.4.2) and the recommencement of body scanning may help address this issue. However, this is contingent on the availability of body scanners and there was no body scanner in the MSPC 3 visits area. CSNSW policy provides that inmates should be body scanned after visits where practicable. In the absence of a body scanner, minimum security inmates will be randomly strip searched.[477] As highlighted in section 2.6.9, we heard that all minimum security inmates were strip searched after visits. Transgender inmates in MSPC were predominantly located in MSPC 3.

Despite the availability of body scanning, it remains important to ensure that strip searching is conducted according to legislation and policy and with respect for the dignity of the person being searched. CSNSW should immediately remind custodial staff of their obligations and this should be monitored closely by local management. CSNSW should also consider installing body scanners in minimum security locations housing vulnerable inmates, including trans people. In section 2.4.2, we recommended that CSNSW ensure that strip search processes comply with legislation and policy. We reiterate that recommendation in this context.

Recommendation: CSNSW remind custodial staff of their obligations regarding the strip and pat searching of trans and gender diverse inmates and ensure practices are closely monitored by local management teams.

474 *Crimes (Administration of Sentences) Regulation 2014* cl 46(2).
475 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 6.
476 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 6.
477 Corrective Services NSW, *Custodial Operations Policy and Procedures: 17.1 Searching Inmates* (version 1.14, 17 July 2025) 15–16.

5.4 Health and wellbeing

5.4.1 Clothing and personal items for trans inmates

CSNSW policy in place at the time of this inspection allowed for recognised transgender inmates to wear clothing appropriate to their recognised sex. Transgender inmates 'have the right to dress at all times in clothing appropriate to their gender of identification, including those inmates housed in correctional centres of their biological sex'. This also applied to intersex inmates, although as we noted previously the reference to 'biological sex' makes little sense in this context. Gender diverse inmates were to be provided with clothing of their preference. This also applied to personal care and other items purchased through the buy-ups system.[478]

Most trans inmates we spoke with were wearing female clothing. However, some trans inmates reported having to wait several months for female underwear and shirts which they had purchased through monthly buy-ups. We heard of similar problems at MRRC which resulted in the governor arranging for underwear to be sought from SWCC. We applaud this sensible approach. Providing clothing that aligns with a person's gender should be standard practice when managing trans inmates and clothing should be provided without delay.

Recommendation: CSNSW include clothing that aligns with a person's gender identity in their standard clothing allocation.

5.4.2 Support and awareness

Information, connection and support from within a correctional centre and the community is essential for LGBTIQA+ inmates broadly, and particularly for transgender and intersex inmates who feel isolated and unsafe in a custodial environment.

CSNSW policy provided that recognised transgender, transgender and intersex inmates are to be 'provided with the same access to services and programs as other inmates' and 'access to services specific to their needs such as peak community services and groups' such as the Gender Centre and specialised legal services.[479] Other examples could include QLife, ACON, InterAction for Health and Human Rights, and Twenty10.

We received no complaints from inmates at MSPC concerning access to external agencies and services and most confirmed this was happening without incident or obstruction from staff. The Women's Justice Network, which is a trans inclusive service, was highly regarded by inmates and described as generous in their support to trans inmates. It was pleasing to hear that inmates have been able to communicate with them via AVL.

While inmates connect with community agencies largely by mail, the ability to communicate by other means, such as a free phone call, is limited. Enabling tablets to allow LGBTIQA+ inmates to connect with services specific to their needs and to access materials published by external agencies (such as the Gender Centre), should be given consideration. We see merit in utilising tablets for such purposes and encourage CSNSW to pursue that capability for inmate tablets.

For a period, the Inmate Development Committee (IDC) for MSPC 2 and 3 had an inmate from the LGBTIQA+ community attending meetings. They were not an official delegate representing all LGBTIQA+ inmates but were able to provide support and raise issues relevant to that cohort. LGBTIQA+ inmates were pleased that their concerns could be presented at monthly IDC meetings. LGBTIQA+ inmates highlighted the importance of this representation for recognition, awareness and inclusivity. We commend management at MSPC for supporting this initiative. We noted the reported success and benefits to LGBTIQA+ inmates and consider having an identified LGBTIQA+ inmate delegate role should continue.

478 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 7.
479 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 8.

The LGBTIQA+ inmates we spoke with also highlighted the importance of awareness-raising events and days, such as IDAHOBIT (International Day Against Homophobia, Biphobia, Interphobia or Intersexism and Transphobia), Wear it Purple day and Pride month. These events are regularly commemorated by staff, but not inmates. Unfortunately, staff events often result in inmates being locked in their cells to enable staff attendance.[480] We were informed of one exception where inmates were permitted to hold an informal celebration during the Sydney World Pride festival. Although it was a small gathering, LGBTIQA+ inmates were thankful of the support of the governor and staff. We would like to see greater awareness and inclusion of LGBTIQA+ inmates in correctional centres across NSW and for CSNSW to support inmates and staff celebrating days of significance.

Recommendation: CSNSW support LGBTIQA+ inmates and staff to recognise days of significance for the LGBTIQA+ community and explore ways to enhance the LGBTIQA+ inmates' access to services specific to their needs.

5.4.3 Access to gender-affirming health care

Reports from LGBTIQA+ inmates around health services were generally favourable. Several inmates reported coming out as gay, bisexual or trans while at MSPC and seeking information and support while incarcerated. Some of those inmates described having little access to information about sexuality, gender identity, and safer sex.

At the time of this inspection, both JH&FMHN and CSNSW had policies concerning access to gender-affirming health care for trans inmates. The policies of both agencies provided that trans people prescribed gender-affirming hormone therapy before entering custody are to continue receiving this treatment during their incarceration. This requires JH&FMHN to obtain the patients' health information from their community prescriber. Care plans are developed by a multidisciplinary team including JH&FMHN and CSNSW staff.[481] The plan should include 'clear management guidelines including ongoing risk assessments for the inmate and others within the centre as well as determining appropriate psychosocial support'.[482]

Patients may request gender affirming hormone treatment while in custody. In these circumstances, the patient will be assessed by health staff for confirmation of gender incongruence or dysphoria and may be referred to a psychiatrist:

> if the patient has complex mental health, or legal requirements or cognitive impairment, which may impact the ability to provide informed consent or if there is a psychiatric diagnosis that could complicate their gender-affirmation journey.[483]

A care plan should be developed for these inmates by a multidisciplinary team including JH&FMHN and CSNSW staff.[484]

JH&FMHN advised us that it is updating its policy and guidelines to align with the informed consent standards developed by the Australian Professional Association for Trans Health (AusPATH),[485] which do not require a diagnosis of gender incongruence or dysphoria.[486] As noted previously, CSNSW policy was under review at the time of writing.

Inmates raised concern around access to gender-affirming hormone therapy and the delays with JH&FMHN accessing the medical history of those inmates who had commenced gender-affirming hormone therapy in the community. Obtaining required information can be a barrier for continuity of care in relation to prescribed medications.

480 Information provided by Corrective Services NSW, 17 November 2023 and 15 November 2024.
481 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 7; Information provided by the Justice Health and Forensic Mental Health Network, 11 February 2025.
482 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 7.
483 Information provided by the Justice Health and Forensic Mental Health Network, 11 February 2025.
484 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 7.
485 AusPATH, *Australian Informed Consent Standards of Care for Gender Affirming Hormone Therapy* (2024).
486 Information provided by the Justice Health and Forensic Mental Health Network, 21 July 2025.

JH&FMHN policy provides surgical gender affirmation will generally not be arranged for trans and gender diverse people in custody and may only be recommended by JH&FMHN staff 'under exceptional circumstances'.[487] CSNSW policy further provided such treatment would be provided at the inmate's own expense.[488]

5.5 Treatment of LGBTIQA+ inmates by custodial staff

Reports around inmate and staff interaction were varied. LGBTIQA+ inmates shared stories of positive engagement with staff but there were also many stories of inappropriate and unprofessional behaviour from custodial staff, which we found troubling.

CSNSW policy provided that:

> Recognised transgender inmates are to be addressed by name and according to their recognised sex.
>
> Transgender and intersex inmates are to be addressed by their chosen name and according to their identified gender.[489]

Inmates told us that this does not always happen and that on occasions cell identification cards do not reflect their identified status. At times they have needed to remind officers of how they should be addressed and noted this was generally well received, with some officers apologising. It was reassuring to hear this and to be told that some officers are considered 'LGBTIQA+ friendly' and approachable when LGBTIQA+ inmates require assistance.

In some instances, misgendering may be inadvertent. Male/female gender markers in OIMS generally reflect a person's records of sex, as stated on their identification documents. The preferred pronouns and names for trans and gender diverse inmates who have not altered identification documents are recorded in OIMS in a case note.[490] OIMS case notes are submitted on a range of matters related to a person's time in custody. A large volume of case notes can make those concerning gender identity difficult to locate. A better system is needed to ensure that this information is communicated to staff. Such initiatives could be developed and implemented locally by the correctional centres where trans and gender diverse inmates are placed.

However, we also heard about many instances of intentional misgendering and cruel treatment. This included name calling, such as 'Priscilla', 'princess', 'precious', 'freak', 'it', and 'tranny' by officers and inmates. Trans women spoke about staff deliberately using their 'deadname', the male name given to them at birth, rather than their current female name. It was concerning to hear of staff engaging in such behaviour. This language is designed to demean, intimidate, and humiliate its targets. Although the instances reported to us largely concerned trans women, this conduct enables and permits the abuse of LGBTIQA+ inmates more broadly. It creates the impression that staff will not act to protect LGBTIQA+ inmates, making inmates reluctant to report threats to their safety and tacitly approving bullying and intimidation by other inmates.

487 Information provided by the Justice Health and Forensic Mental Health Network, 11 February 2025.
488 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 7.
489 Corrective Services NSW, *Inmate Classification and Placement: Classification and Placement of Transgender and Intersex Inmates* (version 2.0, 2 February 2021) 4.
490 Corrective Services NSW, *Custodial Operations Policy and Procedures: 3.8 Transgender and Intersex Inmates* (version 1.2, 16 August 2023) 4.

During the inspection we observed a poster on an inmate communal kitchen fridge in a wing of MSPC 3, titled 'Department of Corrective Services Hurt Feelings Report'. Aside from being vulgar and juvenile, it included misogynistic, homophobic and transphobic language, including the statements:

> 2) I am a pussy
>
> 3) I have confused hormones
>
> 4) My man rod is not as firm as it should be
> (More commonly referred to as softcockitis)
>
> 5) My sexuality has been questioned ...

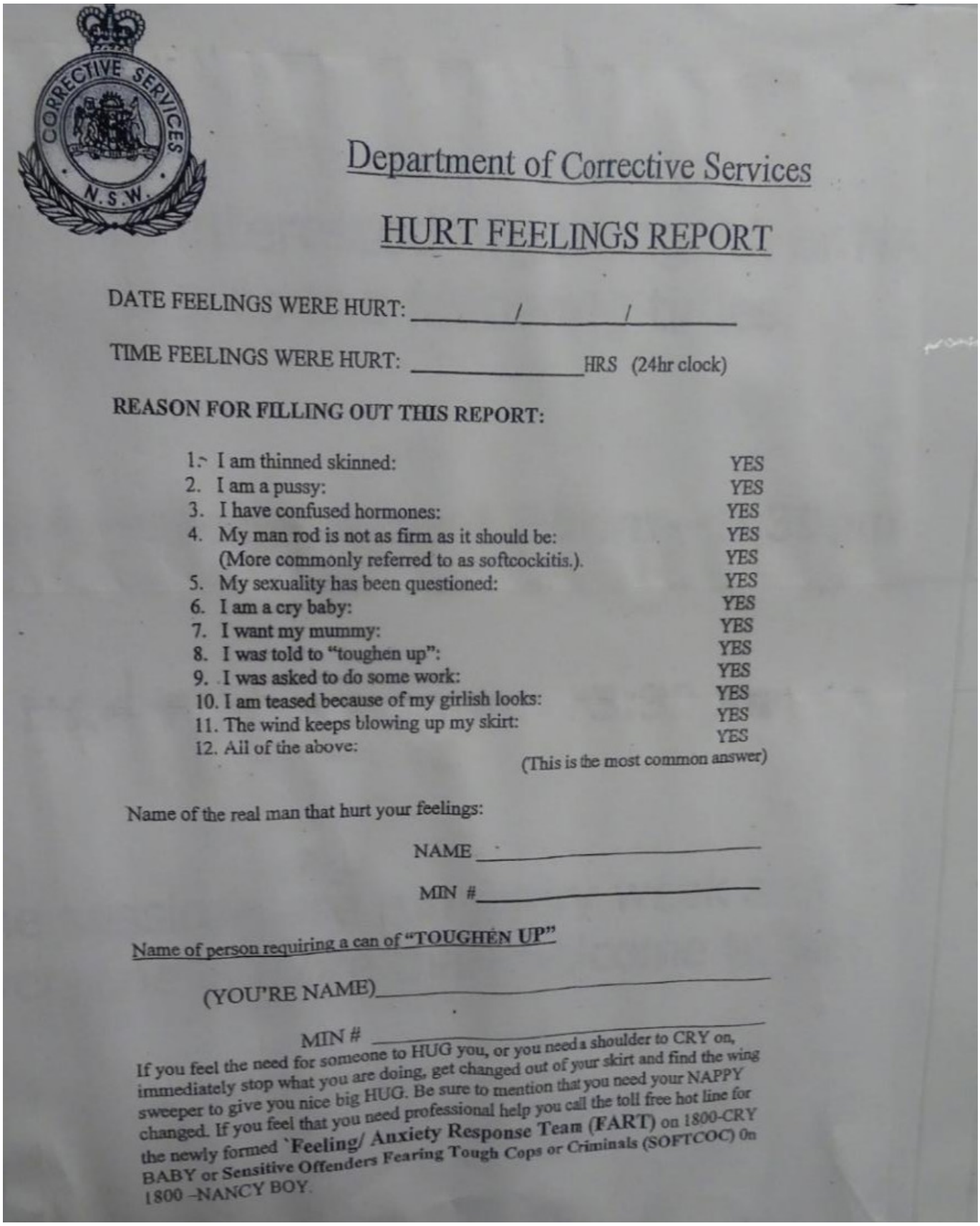
Given inmates' lack of access to computer and printing facilities, this poster was almost certainly created by staff. This conclusion is supported by the bureaucratic tone and style of the poster and the inclusion of the CSNSW logo. The poster can be seen in full in the photograph. Following the inspection, we informed the governor of MSPC of its presence and that it needed to be removed immediately.

The seriousness of this poster and related conduct and attitudes should not be minimised. It is not only immature and offensive, but also likely a breach of the codes of ethics and conduct applicable to NSW government sector employees. The NSW Code of Ethics and Conduct for NSW Government Sector Employees provides that '[b]ullying, unlawful discrimination, and all forms of harassment (including sexual harassment) are not acceptable under any circumstances and not tolerated in our workplaces'.[491] Behaviour contrary to the Code may constitute misconduct under the *Government Sector Employment Act 2013*.[492] The Department of Communities and Justice Code of Conduct more specifically provides:

> Discrimination, bullying or harassment and/or other inappropriate behaviour will not be tolerated by the department in any form, and may constitute misconduct. Inmates, offenders and detainees are clients of the Department. Employees must remain fair and impartial at all times and must demonstrate respect and courtesy towards inmates, offenders and detainees, even in difficult and challenging circumstances. Acts of intimidation, harassment, insults or abuse towards any Departmental client is a serious breach of this Code which may result in misconduct action.[493]

491 NSW Public Service Commission, *Code of Ethics and Conduct for NSW Government Sector Employees* (13 May 2024) 8.
492 Public Service Commission, *Code of Ethics and Conduct for NSW Government Sector Employees* (13 May 2024) 15.
493 Department of Communities and Justice, *Code of Ethical Conduct* (version 1.0, 14 April 2021) 9.

Poster on a fridge in an inmate common area in MSPC 3, May 2024



Department of Corrective Services

HURT FEELINGS REPORT

DATE FEELINGS WERE HURT: _____/_____/_____

TIME FEELINGS WERE HURT: _____HRS (24hr clock)

REASON FOR FILLING OUT THIS REPORT:

1. I am thinned skinned: YES
2. I am a pussy: YES
3. I have confused hormones: YES
4. My man rod is not as firm as it should be: YES
   (More commonly referred to as softcockitis.). YES
5. My sexuality has been questioned: YES
6. I am a cry baby: YES
7. I want my mummy: YES
8. I was told to "toughen up": YES
9. I was asked to do some work: YES
10. I am teased because of my girlish looks: YES
11. The wind keeps blowing up my skirt: YES
12. All of the above: YES

(This is the most common answer)

Name of the real man that hurt your feelings:

NAME _____

MIN #_____

Name of person requiring a can of "TOUGHEN UP"

(YOU'RE NAME)_____

MIN # _____

If you feel the need for someone to HUG you, or you need a shoulder to CRY on, immediately stop what you are doing, get changed out of your skirt and find the wing sweeper to give you nice big HUG. Be sure to mention that you need your NAPPY changed. If you feel that you need professional help you call the toll free hot line for the newly formed `**Feeling/ Anxiety Response Team (FART)** on 1800-CRY BABY or **Sensitive Offenders Fearing Tough Cops or Criminals (SOFTCOC)** On 1800 –NANCY BOY.

Trans inmates told us that at times they feel unsafe and have to mask who they really are to survive and prevent physical and sexual assault. Communal showers were described as unpleasant and unsafe places and to be avoided on certain days and times. Shower blocks with low shower stall partitions make it difficult for inmates to have privacy. Some inmates have been successful in negotiating with other inmates to leave the next cubicle free as they shower. Leaving it to transgender and intersex inmates to negotiate potential risks to their safety is unacceptable. Shower routines need immediate attention. MSPC should consult with transgender and intersex inmates to identify a solution that would address these concerns.

Cultural change is essential to reduce the risk of physical, sexual and psychosocial harm, not only for transgender inmates but for all LGBTIQA+ inmates. Inmates spoke to us about the importance of custodial staff modelling good conduct and language to stop inmates repeating and amplifying unacceptable behaviour. We noted the requirement for training for staff involved in placement decisions above (see section 5.2). However, it was clear to us that more is required to build the capacity and capability of all staff regarding the management, treatment and safety of transgender and intersex inmates. This should include LGBTIQA+ awareness training that helps staff understand relevant legislative and policy requirements and the needs of LGBTIQA+ inmates. We have reviewed the slide deck of the JH&FMHN Trans-Affirming Practice eLearning module and consider this provides a good model for developing staff understanding of different concepts and the experiences of trans people in healthcare and custodial settings. Something similar that applies to the LGBTIQA+ community would be beneficial.

As noted above, inmates told us there were LGBTIQA+ friendly staff at MSPC. Inmates also suggested that staff who are members of and/or supportive of the LGBTIQA+ community wear a pride pin or similar on their uniform to help LGBTIQA+ inmates identify staff who may better understand their concerns. This would help encourage disclosures of mistreatment, improving inmate safety, and promote awareness and inclusivity. Inmates reported having LGBTIQA+ inmate delegates at IDC meetings at MSPC had helped increase recognition of the needs of LGBTIQA+ inmates.

Cultural change alone cannot ensure the safety of LGBTIQA+ inmates. There were overwhelming calls from inmates for an LGBTIQA+ friendly accommodation wing, focused on providing a safe environment for LGBTIQA+ inmates. We consider there would be merit in CSNSW conducting a statewide LGBTIQA+ safety audit and action plan to address risks for LGBTIQA+ inmates. This should include strategies for preventing physical violence but also harassment and abusive language. We suggest such an audit include consultation with staff and LGBTIQA+ inmates

Recommendation: CSNSW take action to address the violence, harassment and abuse directed at LGBTIQA+ inmates.

Recommendation: CSNSW provide staff training on LGBTIQA+ awareness and associated legislative and policy obligations.

Inspector of
Custodial Services

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