OmbudsmanSA

FINAL REPORT

DEPARTMENT FOR CORRECTIONAL SERVICES

May 2013

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Report

Full investigation - *Ombudsman Act 1972*

Complainant	**Ms Jacqui Davies**
Department	**Department for Correctional Services**
Ombudsman reference	**2012/01161**
Department reference	**CEN/07/0351**
Date complaint received	**22 February 2012**
Issues	**1. Whether it was unlawful or unreasonable to restrain the complainant** **2. Whether other aspects of the complainant's regime were unreasonable or wrong** **3. Whether the department implemented specialist recommendations in a timely manner**

Jurisdiction

The complaint is within the jurisdiction of the Ombudsman under the *Ombudsman Act 1972*.

Section 13(3) of the Ombudsman Act provides that the Ombudsman must not investigate any administrative act where the complainant had a remedy by way of legal proceedings, unless it is not reasonable to expect the complainant to exercise that remedy.

In June 2012 the department advised me that the complainant had also filed a complaint pursuant to the *Australian Human Rights Commission Act 1986* (Cth) alleging unlawful discrimination based on disability. The department expressed the view that section 13(3) of the Ombudsman Act required that I cease my investigation. I formed the view that it was not reasonable in the circumstances to expect that the complainant should resort to an unlawful discrimination claim and, accordingly, I decided to exercise my discretion to continue my investigation. While both complaints may deal with the same factual scenario, in my view they centre on different legal obligations.

In her response to my provisional report, the complainant provided information about her treatment during the two years prior to July 2011 when she was in D Wing of the Adelaide Women's Prison (**AWP**). However, this period of incarceration was not the subject of the original complaint to my office. I did not request and do not have the benefit of any documentary evidence relating to this period.

I have set out in Appendix 1 the complainant's and department's version of relevant events during this period. However, I decline to make any findings of fact about these matters. Further, in light of the fact that I have made findings against the department in relation to similar allegations made about more recent events, in my view, further investigation into the complainant's treatment prior to July 2011 is not necessary or justifiable.

Investigation

My investigation has involved:

- assessing the information provided by the department
- speaking with the complainant
- communicating with the Public Advocate and the Community Visitor
- considering the *Correctional Services Act 1982* and Standard Operating Procedure 32 - 'Use of Restraint Equipment' version 2
- preparing a provisional report
- considering the complainant's and the Public Advocate's responses to my provisional report
- preparing a revised provisional report
- considering the department's and the complainant's responses to my revised provisional report and
- preparing this report.

Standard of proof

The standard of proof I have applied in my investigation and report is on the balance of probabilities. However, in determining whether that standard has been met, in accordance with the High Court's decision in *Briginshaw v Briginshaw* (1938) 60 CLR 336, I have considered the nature of the assertions made and the consequences if they were to be upheld. That decision recognises that greater care is needed in considering the evidence in some cases.[1] It is best summed up in the decision as follows:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue has been proved … .[2]

Responses to my revised provisional report

By letter dated 6 February 2013 I provided the complainant, the department and the Public Advocate, Dr John Brayley, with my provisional views in relation to the complaint. I requested they provide me with comments by 1 March 2013. The department requested, and I granted, an extension to respond by 29 March 2013.

The complainant provided me with a response by letter dated 6 March 2013; and I have incorporated her comments into the body of this report. Dr Brayley provided me with comments by email dated 18 March 2013. Dr Brayley pointed to the rights of mentally ill prisoners in terms of access to mental health care and the fact there is a national quality initiative to reduce and eliminate the use of restraint in mental health situations.[3] In light of Dr Brayley's comments I amended my provisional recommendation about the restraint and management of mentally ill prisoners.

By letter dated 21 March 2013 I provided the complainant, the department and Dr Brayley with my revised provisional views in relation to the complaint. The complainant provided further comments by way of letter dated 1 April 2013. The department's response, by way of letter dated 8 April 2013, comprised some generalised comments and then more specific

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[1] This decision was applied more recently in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 110 ALR 449 at pp449-450, per Mason CJ, Brennan, Deane and Gaudron JJ.

[2] *Briginshaw v Briginshaw* at pp361-362, per Dixon J.

[3] This was identified as a 'Priority Area' in the National Mental Health Working Group (2005) report, *National safety priorities in mental health: a national plan for reducing harm*, Health Priorities and Suicide Prevention Branch, Department of Health and Ageing, Commonwealth of Australia, Canberra, p17.

comments addressing particular paragraphs of my revised provisional report. I have incorporated the latter into the body of this report. In making its generalised comments, the department:

- acknowledged the 'balanced tenor' of revised provisional report and noted that I accept that the primary reason for the restraint of the complainant was to prevent the risk of self-harm and harm to others
- noted that there are limitations on the department's ability to provide a therapeutic environment for the most complex cases in a custodial setting
- noted that the consistent medical advice was that the complainant did not fit the criteria for admittance into a mental health facility such as James Nash House
- stated it remained committed to ensuring the involvement of health professionals and gaining the complainant's admittance into a mental health facility
- explained that the department reviewed logbooks to check the veracity of my provisional view that the complainant was unrestrained for a maximum of two hours per day and advised:

> It is now clear that the evidence contained within these additional log book entries support your position that Ms Davies was unrestrained for a maximum of two hours per day. It is clear that for substantial periods of her management the time in restraint exceeded the requirements documented in her management plans.
>
> Additionally, based on all of the information available to me now, the evidence indicates that Ms Davies was generally unrestrained for medical assessments and appointments but remained restrained in the most part for other professional visits. It is also now evident that Ms Davies [sic] restraint regime was not reduced until March 2012.
>
> I am of the opinion that the staff were not deliberately non-compliant with the implementation and actioning of the management plans. Rather, I consider that staff struggled to implement the terms of the management plan in a way that ensured the safety of Ms Davies and others.

- acknowledged that, while the risk of not restraining the complainant was high, it may have been able to do more to make the custodial environment safer and more therapeutic during her period at the Yatala Labour Prison (**YLP**) Health Centre. The department submitted that it:

> … was focussed on trying to negotiate an inpatient mental health placement and in parallel was progressing modifications to the Adelaide Women's Prison to provide safer and more appropriate accommodation to facilitate her reintegration to the Women's Prison. As acknowledged above and with the benefit of hindsight the Department could have in parallel been considering what modifications could be made to the Yatala Health Centre environment or other facilities to be able to manage Ms Davies in a less restrictive way…

- acknowledged that the complainant experiences significant fear and distress as a result of her seizures. The department submitted that it has actively responded to this through psychological intervention including the engagement of Spectrum Personality Disorder Service for Victoria, Eastern Health (**Spectrum**), and that it has a plan in place to guide staff responses to the seizures.

The department's submission also pointed to a number of changes it is in the process of implementing:

- the construction of a 20 bed cell based accommodation facility at AWP has commenced. These units 'will greatly assist the management of high risk high need females, with complex behavioural and mental health needs'
- a High Dependency Unit, which will provide special accommodation and support services to prisoners with high level care needs due to mental health or age related conditions, is planned for YLP
- a departmental program designed to assist women with Borderline Personality Disorder has recently been implemented at the AWP

- as increasingly more prisoners present complex needs, the department has initiated a review of the case management approach taken by the department in prisons, including the development of alternative management strategies for highly dysfunctional prisoners
- while other agencies were provided the opportunity to participate in the care and treatment of the complainant while she was in YLP, the department has since identified the absence of a formal case escalation protocol with the Forensic Mental Health Service (**FMHS**) and the South Australian Prison Health Service (**SAPHS**). The department has commenced work with FMHS and SAPHS 'in developing this protocol so that any prisoners presenting with multiple and complex needs can be escalated to relevant senior staff in FMHS and SAPHS to ensure collaborative treatment and management approaches are adopted in a timely manner.'
- Dr Sathya Rao (from Spectrum) will be returning to South Australia in April or May 2013 to further review the complainant and to provide advice to her treating team.

Background

1. The complainant was admitted to prison on 3 February 2006 and is currently serving a sentence of 8 years and 11 months with a non parole period of 4 years and 8 months. She has since been sentenced in March 2010 and January 2012 for assaults on AWP staff. Her earliest conditional release date was 29 November 2010 and her current sentence is due to expire on 28 February 2015.

2. This investigation relates to the period from July 2011, when the complainant was moved from the AWP to the YLP, to July 2012. The following table, provided by the department, indicates her movements up to May 2012 and the department's submissions as to why they moved her:

Movement Date	Location moved to	Reason for movement
16 July 2011	YLP, G Division	A number of incidents, including self harm and assault on officer
19 July 2011	AWP	Return to standard placement
22 July 2011	YLP, G Division	Self harm incident
25 July 2011	YLP, Health Centre	Self harm incident requiring hospital escort
26 July 2011	YLP, G Division	Short term placement on return from hospital at night
26 July 2011	YLP, Health Centre	Return from G Division
7 October 2011	YLP, G Division	Self harm and inappropriate behaviour, including cell damage
26 October 2011	YLP, Health Centre	Repairs to cell damage complete
4 January 2012	YLP, G Division	Self harm incident
19 January 2012	YLP, Health Centre	Return from G Division
11 April 2012	James Nash House	Short term therapeutic placement
14 May 2012	AWP	Return to standard placement

3. The complainant was moved to James Nash House in July 2012, and has been accommodated at Port Augusta Prison since 22 October 2012.

4. The department has advised that, since her admission to prison, the complainant has made over 30 attempts of self harm. The most serious attempted suicide occurred on 18 February 2009 when the complainant stabbed / slashed her throat with a piece of broken glass. The complainant subsequently required 'significant ongoing medical treatment' including two hospitalisations in early 2009. I understand many of her subsequent self harm attempts involved re-opening her neck wound, including opening it on 9 April 2009, rubbing faeces into it and causing infection on 26 August 2010, attempting to hang herself on 25 September 2010 and inflicting cuts to her neck and arm on 16 December 2010.

5. As noted above, the complainant was first transferred from AWP to G Division of YLP on 16 July 2011. This followed an incident the previous day in which the complainant assaulted a custodial officer and a self harm incident on 16 July 2011 in which she cut her left wrist. The department has advised that the complainant was separated from all other prisoners in G Division pursuant to section 36(2)(b) of the Correctional Services Act (that is, 'in the interests of the safety or welfare of the prisoner').

6. On 19 July 2011 the complainant was transferred back to AWP. However, she cut her throat while in her cell and required treatment at the Royal Adelaide Hospital. On 21 July 2011 she re-opened her wound and, after receiving treatment, was again transferred to G Division of YLP on 22 July 2011. She was transferred to the YLP Health Centre on 25 July 2011. It was at this time that restraint arrangements became part of the complainant's regime.

7. The department describes the subsequent period (until she was moved to James Nash House in April 2012) as follows:

> Following the successful attempts at re-opening her neck wound, the only way to prevent Ms Davies from doing so, and to allow the wound to heal, was to restrain her to a hospital bed in the YLP Health Centre. As soon as the wound healed her restraint regime was reduced and shortly after she re-opened the wound again. Over an eight month period, commencing in July 2011, a cycle developed between restraining Ms Davies to allow the wound to heal and then removing restraints and her re-opening the wound again.

8. I consider below the extent and manner in which the complainant was restrained during that period but, in brief, it is my view that she was restrained for the majority of the time that she remained at YLP.

9. The department submits that, at YLP, the complainant's self harm attempts included:

   a. 1 August 2011 - Ms Davies pulled stitches out of her neck.
   b. 7 October 2011 - Ms Davies head butted the wall and damaging cell.
   c. 7 October 2011- Ms Davies stabbed herself in the neck with a biro taken from a nurse.
   d. 14 December 2011 - Ms Davies removed stitches in her neck whilst using the shower.
   e. 3 January 2012 - Ms Davies opened her neck wound using a rock.

10. The complainant was referred to the High Risk Assessment Team (HRAT) to monitor her risk of self harm during her placement at YLP, and to provide therapeutic intervention to reduce this risk of harm.[4] In addition, I understand a number of multi-disciplinary case conferences (including staff from the SAPHS and James Nash House) were held to discuss the ongoing management of the complainant during this time. The department has advised it 'actively explored placing Ms Davies in forensic mental health facilities' but that her diagnosis (an Axis 2 diagnosis) does not meet the criteria for admission to James Nash House.

[4] Confidential Psychological Report - Treatment Discharge Summary, by Mr Luke Williams, dated 30 March 2012, p2.

11. The department first sought assistance from Spectrum, a 'specialist Borderline Personality Disorders treatment service from Victoria', in October 2011. The department has advised that treatment recommendations made at that time by Dr Rao were implemented throughout November and December 2011. In particular, a departmental Senior Clinician commenced one on one intervention meetings with the complainant in December 2011 on a weekly basis. The department has advised that Spectrum recommended that the department continue with the existing procedures including the use of restraints.[5]

12. Dr Rao met with the complainant on 23 February 2012, and provided verbal feedback to departmental staff on the same day, including a recommendation that the most appropriate placement for the complainant is within the Forensic Mental Health system. The department's letter dated 20 March 2012 provides that Dr Rao:

> …stated that the forensic system is better equipped to manage her behaviour and implement a treatment plan compared to in the prison system. Dr Rao stated that there was greater flexibility for treatment in the forensic system than in prison…

Dr Rao's subsequent report made a number of recommendations about the complainant's ongoing management and treatment.

13. The department advised my office in March 2012 that the placement options for the complainant within the correctional environment were extremely limited, the only safe accommodation at that time being D Wing in the AWP, G Division in YLP and the YLP Health Centre.[6] The latter was deemed the most appropriate location given it provides 24 hour 7 day a week nursing care, the provision for a constant observation officer, and clear visual coverage of the complainant. In the meantime, infrastructure improvements at AWP were commenced to allow her to return there, and a plan adopted to transition her to AWP via James Nash House. This would allow her to be unrestrained prior to returning the AWP. The department has advised

> It was not until a recommendation was received from an independent expert, that admission of Ms Davies to JNH was considered more favourably, as a short term transitional measure.

14. The complainant was moved to James Nash House on 11 April 2012. Her return to AWP was delayed by industrial action at the site on 30 April 2012. She returned to AWP on 14 May 2012 and remained there until July 2012.

15. The complainant contacted my office on 7 October 2011 and 1 December 2011 complaining that she was being restrained at YLP Health Centre between 16 and 24 hours a day. By letter dated 23 February 2012 I notified the department that I had decided to conduct a preliminary investigation of the complaint. I received a written response dated 20 March 2012 from the then Chief Executive of the department, Mr Peter Severin. There followed a period where it was agreed that it was appropriate for the Office of the Public Advocate, the Health and Community Services Complaints Commissioner and the Community Visitor to consider the matter. In May 2012, I decided to proceed with my preliminary investigation.

16. On 22 May 2012 I wrote to Mr Severin, and requested a response to a number of questions and documents relevant to my investigation. By letter dated 1 August 2012 the department provided a report addressing the issues I had raised and copies of the complainant's Prison file (including relevant plans), Assessment file, Offender file, and portion of her Psychology Services files.

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[5] Letter from Mr David Brown to Ombudsman dated 8 April 2013, p4.
[6] Letter from the Mr Peter Severin, then Chief Executive of the department to Ombudsman dated 20 March 2011.

17. My officers have communicated with the complainant by telephone during this investigation. The complainant has stated that she is only able to remember the last month of her time at YLP (presumably March 2012) and not in great detail. She stated that she was given a television and was let into the yard for an hour a day. She remembers being handcuffed to the bed and a guard saying sorry, with tears in his eyes, as he cuffed her. She recalls that she lay on her back on the bed and that her feet were shackled and her arms were cuffed to the bed. She said officers told her she could not go to the toilet and that she should instead use her incontinence nappy.

18. In response to my provisional report, the complainant provided some additional detail about her treatment at YLP which I have set out in the body of this report. In addition, I note the complainant commented:

> …The closing thoughts I have on my treatment is that I cannot believe that other human beings could of [sic] treated me in this fashion & I want to make sure it never happens to another prisoner ever again. My seizures are not attention seeking or behavioural as suggested by DCS. I have had them since 18 months of age and they were last diagnosed under the name of Adlington at the Queen Elizabeth Hospital, SA by a Neurologist Professor George Rowson as Subconscious Psychological Childhood Trauma. My many suicide attempts were a cry for help with these seizures as I was having them all day, every day at one stage of my imprisonment. My fear factor of these seizures was and is very real to me and my crys for help with them went unrecognised or noticed…

19. Dr Brayley has made enquiries on the complainant's behalf during the period of this investigation; and accordingly I also received some evidence from him.

Whether it was unlawful or unreasonable to restrain the complainant

20. The complainant was accommodated in the YLP Health Centre and YLP's G Division for extended periods between July 2011 and April 2012, and the evidence before me is consistent insofar as she was restrained for significant periods during that time.

21. On 11 April 2012, the complainant was moved to James Nash House, where I understand she was not restrained at any time. Upon her return to the AWP on 14 May 2012, I understand she was subject to an 'intensive operational management plan'[7] which was reviewed and amended on 4 June 2012 and 19 June 2012.[8] The department submits:[9]

> With respect to the use of restraints, the plan effectively provides for Ms Davies to be placed in handcuffs when she is moved from her cell to other facilities in the prison. The principal reason for the application of restraints in these instances is the safety of staff… Currently whilst in her cell, in the recreation area, in the shower room and when at a visit Ms Davies is not restrained.

22. In the absence of evidence to the contrary, I accept that the complainant was restrained in this manner whilst at AWP. Given this regime did not require the complainant to be restrained for long periods, and given the circumstances of the case, I am of the view it was reasonable and does not require investigation.

23. My focus is therefore on the use of restraints by the department on the complainant during her time at YLP.

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[7] Letter from Mr Severin to Ombudsman dated 1 August 2012.
[8] The department provided Ombudsman with copies of the three plans (Appendix D).
[9] Letter from Mr Severin to Ombudsman dated 1 August 2012.

Number of hours the complainant was restrained daily

24. I understand that the complainant was under the constant observation of a correctional officer whilst at YLP. The department has advised[10] that, while her routine varied depending on her 'presenting behaviours, medical needs and operational requirements', the complainant's normal routine for significant periods was as follows:

> 0900-1100 Ms Davies was not restrained. During this period she was encouraged to move around her cell, to shower, to attend to personal grooming and to have her breakfast.
>
> 1100-1300 Ms Davies was restrained to her bed in the manner described [below]
>
> 1300-1600 Ms Davies regime varied dependent upon the activity she was engaged in. See below for more detail.
>
> 1600-0800 Ms Davies was restrained to her bed, except when she needed to use the bathroom.

25. The department has advised that the times out of restraints were deemed 'high risk periods' and were programmed for when additional custodial staff were in the vicinity. The department's submission also points to the following factors as being relevant to whether the complainant was restrained:
    a. whether she wanted to watch television (she was restrained whilst watching television 'to prevent her from attempting to damage the television for the purpose of inflicting self harm')
    b. when she needed to use the bathroom she would be unrestrained
    c. she was generally not restrained when she met with medical and other professional staff (although this was dependent on her behaviour)
    d. she was cuffed when she had access to the outdoor recreation area.

26. A report dated 30 March 2012 authored by Mr Luke Williams, a departmental psychologist, supports this general account of the complainant's regime at YLP:

> Due to the frequent incidences of high lethality self harm behaviour, particularly in regard to tampering with her neck wound, Ms Davies was cuffed to her hospital bed in order to restrict access to this wound. The handcuff regime has been in place from 22/07/2011 to the date of this report. This regime allows her to be un-cuffed for various periods during day shift whilst under constant observation from staff.

27. I note that a minute to the Chief Executive dated 31 July 2012 (**the Finlay Farrin Minute**)[11] states that in the YLP Health Centre, the complainant had:

> … a regime of being unrestrained for 2 hours in the morning and for an hour in the afternoon when she attends the yard outside…

    All of the other evidence before me asserts that the complainant was in fact handcuffed whenever she attended the yard outside.

28. The documents provided to me by the department provide a more specific picture of the amount of time the complainant was restrained on a daily basis whilst at YLP. A Minute to the Minister for Correctional Services from Mr Severin dated 2 August 2011[12] indicates the complainant had been restrained to the bed at YLP Health Centre since 25 July 2011 (following a self harm incident). Mr Severin advised that the department

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[10] Letter from Mr Severin to Ombudsman dated 1 August 2012.
[11] Minute to the Chief Executive entitled 'Ombudsman Investigation - Jacqueline Davies' by Ms Ann Finlay, Director Sentence Management and Ms Jane Farrin, Principal Advisor Offender Services, dated 31 July 2012, p8. (Appendix C provided by the department).
[12] Appendix A4 provided by the department.

had received medical advice that the complainant was not safe in any environment where objects can be used to cause damage to her skin, and:

> Due to the above medical advice, she will remain handcuffed to the bed at this time so that she cannot use her hands to tamper with her wounds or undergo any further self harming actions…

Minutes from a Case Conference on 11 August 2011 confirm that she was cuffed at all times except to go to the toilet and shower and that she was taken out of bed regularly for exercise. The update from the Prison Health Service states 'Due to her wound it is still recommended for her to be restrained, without restraints she could break the wound down again.'

29. It appears this regime had relaxed by September 2011. A memorandum dated 14 September 2011[13] and a Manager's Direction dated September 2011[14] indicate the complainant was to be un-cuffed during the hours of 0800 and 1600 (although I note that both of these documents at some point indicated the period to be 0800 to 1200).

30. Following an incident on 7 October 2011 involving self harm and cell damage, the complainant was moved to G Division. The department has advised, in response to my revised provisional report, that the complainant was not restrained whilst in the G Division cell.

31. I am provided with clearer evidence of the complainant's regime following her return from G Division in October 2011. The complainant's Restraint and Observation Regime dated 25 October 2011 states that she:[15]

> must be handcuffed at all times except during the consumptions of breakfast, lunch, dinner, showering and toileting.
>
> …is permitted one hour yard time throughout the day, but must be handcuffed and observed at all times.

32. On 16 November 2011 the regime was changed to permit the complainant to be un-cuffed from the commencement of breakfast for a period of two hours each morning. It is clear from that and subsequent regime updates issued in December 2011, January 2012, February 2012 and March 2012 that she was to be re-cuffed at the conclusion of the two hours, and that her yard time comprised one hour. She was to remain cuffed whilst in the yard.

33. In other words, the evidence before me establishes that, from October 2011 to 30 March 2012, the complainant was un-cuffed for a maximum of two hours per day.

34. I note that, in response to my revised provisional report, the complainant commented that the 'un-cuffing regime for two hours on the morning and movement in the cell did not take place as far as I am concerned…'

35. An update dated 30 March 2012 indicates a change in regime for the remaining 12 days of her stay at YLP:

> Prisoner Davies is permitted to be uncuffed from the commencement of breakfast until 11.30am…

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[13] A memorandum from Mr Steve Mann, General Manager of YLP, to all staff dated 14 September 2011. Appendix A4 provided by the department.
[14] Appendix A4 provided by the department.
[15] Restraint and Observation Regime for Prisoner J Davies, #70679 - Health Centre, dated 25 October 2011. Appendix A1 provided by the department.

> …Prisoner Davies is then to be uncuffed at 1.00pm and remain uncuffed until 3.30pm.

36. It appears from the evidence before me that the complainant remained cuffed during professional visits at YLP (for example, when visited by Mr Williams and Dr Rao) and during receipt of communion.

37. As noted above, on receiving my provisional report, the department undertook a review of the complainant's log books. As a result, in its response to my revised provisional report, the department supported my conclusions as to the length of time the complainant was restrained (that is, a maximum of two hours a day). The department also acknowledged that the complainant was, at times, restrained for periods longer than was documented in her management plans. The department submitted the complainant was generally unrestrained for medical appointments but remained restrained in the most part for professional visits, and accepted that she was generally restrained with handcuffs while in the outside area. The department asserts that, while it made attempts to allow time unrestrained in the yard, the complainant would internally secrete items from the yard (for example, on 3 January 2012 she secreted a rock which she then used to cause injury to her neck).

38. I note the following submission by the department, in particular its commitment to some reform in work practice.[16]

> …The Department acknowledges that the length of time Ms Davies was in restraints, and the restraint regime implemented on the ground, was not justified for her entire placement at YLP.
>
> The Department is now considering options for ensuring that management plans are adhered to and that compliance checks and audits are undertaken that will be incorporated into the Department's compliance framework and the sites' weekly compliance meetings. More regular case reviews will also be undertaken and this model will form as a feature of the Department's complex case management protocols in order to move forward.

Manner of restraint

39. The manner in which the complainant was restrained is described by the department as:

> …When Ms Davies was not actively attempting to harm herself and/or assault staff the standard restraint arrangement was that her wrists were restrained to the side rail of her hospital bed using a single handcuff on each side. The length between the wrist and the bed rail was sufficient to allow Ms Davies maximum movement possible whilst not being able to reach her throat area…[17]

40. The department also advised:

> …At times during her management at YLP and whilst accessing the outdoor recreation space it was necessary to handcuff Ms Davies at the front of her body with those cuffs being secured to a belt…
>
> …when Ms Davies was actively self-harming and or acting in a violent and aggressive manner towards herself or staff, additional restrain methods were assessed as necessary. These included:
>
> a. Leg restraints;
> b. Body cuff;
> c. Restraint wrap.

[16] Letter from Mr David Brown to Ombudsman dated 8 April 2013, p8.
[17] Letter from Mr Severin to Ombudsman dated 1 August 2012.

41. A memorandum from Mr Steve Mann, General Manager of YLP, to all staff dated 14 September 2011 states that the following restraints are to be applied:

> 1. Left wrist restrained to bed frame with two linked handcuffs;
> 2. Right wrist restrained to bed frame with two linked handcuffs…

42. It appears that a body cuff[18] was used as a matter of course from 19 January 2012 until February 2012. The Restraint and Observation Regime dated 19 January 2012 states:

> …G Division Supervisor will instruct staff in the use of the body cuff restraint system...
>
> …NO FREE MOVEMENT OF BODY CUFF TO BE ALLOWED WITH THE EXCEPTION OF EATING WHEN SHE WILL BE ALLOWED 1 CUFF STRAP TO BE LENGTHENED AND REPOSITIONED AFTER FOOD HAS BEEN CONSUMED…

43. As noted above, the complainant recalls mainly the last month she was in YLP Health Centre, and has stated she remembers that she lay on her back on the bed and that her feet were shackled and her arms were cuffed to the bed.

44. A whistleblower provided the following information to Dr Brayley:

> They were heavy safelock handcuffs - I gather three sets linked in some way connected to the bed. She was unable to roll over in bed. She had pads around her wrists. At one stage she had a staphylococcus infection of her wrist. For 9 months she was in a canvas smock, canvas blankets. She was put in boxing gloves at one stage to stop her picking at her neck.[19]

45. In my view, the evidence establishes that for most of the time the complainant was restrained, each of her hands was cuffed to the bed whilst she lay on her back.

46. I note that the department agrees with the whistleblower's claim that the complainant was put in boxing gloves:

> The use of boxing gloves on Ms Davies was to prevent self harm and to prevent reopening of her wounds. The use of boxing gloves was not endorsed by the Department and they have been directed to be removed from use.[20]

Reasons for use of restraints

47. The department has submitted that the primary reason it restrained the complainant was to protect her from self harm. The department also cites the risk the complainant presented to prison staff. I refer to various passages of Mr Severin's letter to me dated 1 March 2012:

> …Whilst the primary concern has been to try and prevent Ms Davies from successfully committing suicide and further to prevent her from causing irreparable damage to her neck wound, DCS staff have also been challenged by other self harming behaviour and significant assaults on staff. It is probable that if Ms Davies had not been subject to this highly restrictive regime that her suicide / self harm attempts may have been a lot more serious and potentially fatal.
>
> DCS has always been committed to its duty of care to Ms Davies. However DCS is also committed to its duty of care to its staff and other prisons, which adds further complexity to the ongoing management of Ms Davies…

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[18] Para 3.12.2 of SOP 32 provides 'The body cuff is a belt wrapped around a prisoners waist and fastened using seat belt like systems and the hands and ankles are shackled to the belt.'
[19] Email from Dr John Brayley dated 16 June 2012.
[20] Letter from Mr David Brown to Ombudsman dated 8 April 2013, p9.

> …Ms Davies' history of unpredictable assaults on staff also presented a significant risk especially when custodial staff were required to intervene to stop her from self harming…
>
> …In accordance with s 24 of the Correctional Services Act 1982, I have the responsibility for maintaining the custody of prisoners. That responsibility carries with it a duty of care towards all prisoners. Ms Davies presents a very serious suicide risk. She was restrained for her own safety. In my view, it is likely that had she not been restrained, Ms Davies' self harm attempts would have been fatal…
>
> ...The Department is aware of the need to reduce restraints where this is possible without presenting an unacceptable level of risk to either Ms Davies or staff. Not only is this beneficial to Ms Davis' wellbeing, it is also not the practice of DCS to impose restraints such as handcuffs in the absence of demonstrable need. The restraint of Ms Davies, although unusual, has been necessary to meet the extreme risk that she has presented to the safety of herself…
>
> …The Department's principal concern has been to keep Ms Davies alive and to minimise the risk of further assault and injury to our staff…

48. The documentation provided to me by the department (for example, minutes of case management conferences) supports this view; that is, that the decision to restrain the complainant was made because the department considered she presented a very high risk to herself and others.

49. In its response to my revised provisional report, the department asserts that SAPHS made the initial recommendation to restrain the complainant in order to prevent her continuing to self harm and 'there was no alternative strategy (provided by SAPHS) to remove this restraint regime once implemented.'

50. In her response to my provisional report, the complainant submits that the department has asserted that she posed a threat to officers in order to avoid taking responsibility for its actions. Whilst she acknowledges she has been charged with assault of an officer, she states this occurred in the past whilst she was at AWP and when she was psychotic. She notes that she recalls officers at YLP cuffing her and apologising with tears in their eyes.

Effect of restraint regime

51. It is clear that the complainant expressed distress with her restraint regime at the time:

> During her placement at YLP Ms Davies has continually voiced extreme dissatisfaction and distress in relation to her handcuff regime, and has made numerous requests for advocacy from various staff and family members due to the perceived injustice of this.[21]

52. The department's psychologist also reported:

> Ms Davies primarily used the intervention sessions to voice dissatisfaction with her placement at YLP and handcuff regime, and to request advocacy from the writer to influence this.[22]

53. It also clear that the restraints caused physical health issues for the complainant. Minutes from a Case Conference held on 25 November 2011 indicate that SAPHS reported that the complainant was beginning to develop some chronic health problems including pressure sores. Minutes from a Case Conference held on 20 December 2011 indicate that a SAPHS staff member advised that the cuffs were rubbing on her wrists

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[21] Confidential Psychological Report - Treatment Discharge Summary, by Mr Luke Williams, dated 30 March 2012, p2.

[22] Confidential Psychological Report - Treatment Discharge Summary, by Mr Luke Williams, dated 30 March 2012, p3.

and that it was problematic to manage. He put forward an option of a soft foam rubber dressing that could be left on for about a week.[23]

54. Indeed, the SAPHS clearly developed concerns about the use of restraints on the complainant. By letter dated 16 February 2012, Mr Brian Rousseau, the former Chief Executive Officer of the Central Adelaide Local Health Network (SA Health) wrote to Mr Severin:

> The SA Prison Health Service (SAPHS) hold some concerns over the potential adverse impact on the health of Jacqueline Davies; a female prisoner currently held at Yatala Labour Prison.
>
> I am advised by SAPHS that the Department for Correctional Services' (DCS) use of restraints to manage Ms Davies' self harming behaviours is impacting SAPHS' ability to provide adequate health care with potentially long-lasting and severe health issues for the patient.
>
> In light of this, I believe it would be beneficial for us to meet to discuss options that will meet both the security and patient safety needs of this individual. I look forward to hearing from you so that this matter may be resolved as soon as possible.

I note that the department has advised that, in response Mr David Brown (in his then capacity as the Executive Director, Custodial Services) met with Mr Rousseau and that

> Once Mr Rousseau understood the needs, requirements and duty of care of the Department to manage Ms Davies as a prisoner he raised no further issues in regards to the restraint regime.[24]

Action taken by the department

55. In my view, the minutes from the monthly case conferences about the complainant indicate there was an emphasis on exploring how and when the complainant would be able to return to AWP safely. Ultimately a plan was developed involving modifications to AWP's D Wing and the complainant transitioning to AWP via James Nash House. In addition, I acknowledge the department considered the treatment options for the complainant, in particular seeking assistance from Spectrum.

56. Minutes from the case conferences[25] also indicate that the use of soft restraints was investigated as early as August 2011. The December 2011 minutes indicate that soft restraints had been trialled unsuccessfully, partly because they provided very limited movement for the complainant. The department has since confirmed that soft restraints were trialled through November and December 2011 but that none of them were found to be suitable. Staff therefore continued to use the standard restraint 'combined with soft bandages to minimise possible chaffing with Ms Davies'.[26]

57. However, in my view, there is no evidence that the department considered in any detail how, whilst at YLP, the complainant could be managed in a safe manner that did not require her to be restrained for most of a 24 hour period. I accept that the risk of un-restraining her was high, and that the department was primarily concerned to ensure she did not self-harm. The department acknowledged the effect that restraining the complainant was having on her mental health (that it triggered a cycle of self harm). Nevertheless, the evidence before me indicates that options of increasing her time unrestrained were simply not explored. Clearly, it was possible in terms of departmental resources to allow her to be unrestrained for longer periods, as this occurred from 30

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[23] Appendix A3 provided by the department.
[24] Letter from Mr David Brown to Ombudsman dated 8 April 2013, p9.
[25] Part of Appendices A3 and A4 provided by the department.
[26] Letter from Mr David Brown to Ombudsman dated 8 April 2013, p9.

March 2012. Further, there is no evidence that the department turned its mind to whether the restraint regime was acceptable or humane by the national and international standards I consider in detail below.

58. In responding to these conclusions, the department acknowledged that:

> …more could have been progressed to make the YLP Health Centre environment safer and more therapeutic but at that time the focus of the Department's attention was on attempting to stabilise Ms Davies to facilitate her transfer back to a female accommodation area.[27]

Legislative and policy framework

59. Section 24 of the Correctional Services Act provides the Chief Executive with absolute discretion regarding the placement of prisoners and the authority to set and vary regimes. Section 86 of the Correctional Services Act authorises the department to use force against prisoners in certain circumstances:

> **86—Prison officers may use reasonable force in certain cases**
>
> Subject to this Act, an officer or employee of the Department or a police officer employed in a correctional institution may, for the purposes of exercising powers or discharging duties under this Act, use such force against any person as is reasonably necessary in the circumstances of the particular case.

60. The department's Standard Operating Procedure 32 - 'Use of Restraint Equipment' version 2 (**SOP 32**) provides, *inter alia*:

> …DCS acknowledges it is necessary to utilise restraint equipment to manage prisoners that present a risk to themselves or other prisoners…
>
> …3.4.2 Restraint equipment must not be applied as a punishment
>
> 3.4.3 Restraint equipment must only be applied for as long as necessary to maintain the security and/or protection of the prisoner, or for the protection of employees, other prisoners, prison property or the community…
>
> …3.5.2 Following an individual risk assessment, use of restraint equipment may be authorised by the Manager/delegate to assist:
> a) in the prevention of self-mutilation, injury to others or property damage…
>
> …3.5.3 In the event that a prisoner who is suicidal or self-injurious requires the application of restraint equipment a custodial officer must check the prisoner every fifteen (15) minutes and medical staff if available must assess the prisoner every two hours until the equipment is removed.
>
> 3.5.4 If the use of restraint equipment exceeds an 8-hour period for any reason, the Manager/delegate should contact the Executive Director Custodial Services for approval for continued use of restraints…
>
> …4.1 Where handcuffs are applied, they are checked every thirty (30) minutes, and each check is recorded in the appropriate journal.

61. In my view, SOP 32 does not contemplate a situation where a prisoner is restrained almost all of the time for many months. I note that high level approval for the use of

[27] Letter from Mr David Brown to Ombudsman dated 8 April 2013, p10. The department also noted that extensive modifications to D Wing were undertaken to facilitate her return to AWP (following her transition stay at James Nash House). In addition, once it had ensured the engagement of an in-reach Forensic Mental Health Service at Port Augusta Prison, the department commenced infrastructure works at that site to allow for the complainant's safe accommodation there.

restraint equipment beyond an 8 hour period is required, and that, where handcuffs are applied, they are to be checked every thirty minutes and each check is to be recorded. Records indicate this did not occur during the night. Further, while SOP 32 sets out policy in relation to various types of restraints (including handcuffs and body cuffs) I note there is no specific mention of restraining prisoners by handcuffing them to a bed.

62. In her response to my revised provisional report, the complainant stated her restraints were not checked on a half hour basis or overnight. In its response to my revised provisional report, the department advised that log book entries confirm that restraints were not checked and recorded every 30 minutes. The department advised that it intends to require prisons to include the checking and documentation of restraint checks into regular compliance checks.

National and international standards

63. In my 2012 Report in relation to the restraining and shackling of prisoners in hospitals, I set out the established international and Australian standards on the use of restraints (refer to Appendix 1 of this report for the relevant extract) and concluded:

> In summary, the international and national standards and practice acknowledge that there are instances where the restraining of prisoners is necessary to protect the prisoner or the public. However, it is also universally accepted that in these instances prisoners must be restrained for the minimum time necessary, and with the least restrictive type of restraint possible.[28]

64. In addition, I note that there is an emphasis on treating prisoners humanely, and cite Article 10 of the International Covenant on Civil and Political Rights as an example:

> All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

65. Further, the Standard Guidelines for Corrections in Australia[29] make it clear that a balance must be struck between public safety and the proper treatment of the prisoner, and that the management should be 'tailored to address their individual criminogenic needs'.

66. Prisoners with mental health issues add complexity to the issue. The World Health Organisation's guide for the management of prisoners' health called 'Health in Prisons, a WHO Guide to the Essentials in Prison Health'[30] provides:

> **Physical restraint**
>
> In prison, situations of extreme tension can erupt. In such cases, the penitentiary authorities can decide to use physical restraint against one or more detainees for the sole purpose of preventing harm to the prisoner themselves, or to other prisoners and staff. Again, those restraints must only be applied for the shortest time possible to achieve these purposes, and restraints can never be used as a form of punishment. Since the decision to use restraints in situations of violence is not a medical act, the doctor must have no role in the process.

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[28] Report: Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shackling of prisoners in hospitals, July 2012, para 35. http://www.ombudsman.sa.gov.au/publications/Ombudsman%20investigation%20into%20the%20Department%20for%20Correctional%20Services.pdf

[29] Standard Guidelines for Corrections in Australia, Revised 2004. http://www.aic.gov.au/criminal_justice_system/corrections/reform/standards.aspx.

[30] Health in Prisons, A WHO Guide to the Essentials in Prison Health, World Health Organisation, 2007.

> However, there may be instances where some form of restraint must be applied for medical reasons, such as acute mental disturbance in which the patient is at high risk of injuring themselves or others. The decision to use restraints for such purposes must be decided upon by the prison doctor and health staff alone, based purely upon clinical criteria, and without influence from the non-health prison staff.
>
> Medical personnel should never proceed with medical acts on restrained people (this includes people in handcuffs), except for patients suffering from an acute mental illness with potential for immediate serious risk for themselves or others. Doctors should never agree to examine a blindfolded prisoner.

67. The department has advised that the SAPHS made the initial recommendation for the complainant to be restrained and, upon this recommendation being actioned, there was 'no alternative strategy provided by SAPHS to remove this restraint regime…'[31] However, whilst the use of restraints for the complainant appeared to be for medical reasons (occasioned by mental disturbance), the department also submits that it would not be practical for SAPHS to decide on the use of restraints as SAPHS are not often on site to assess and make such a determination. I am nevertheless of the view that the World Health Organisation's recommendation should be given serious consideration and, accordingly, that where restraints are utilised in such circumstances it would be preferable that the decision be made by health professional staff (or at least that the department acts on a formal recommendation by SAPHS).

68. As I stated in my 2012 Report, I am of the following view:

> Particularly for people with mental illness, the minimum standard should be that shackles not be used unless they are absolutely necessary for reasons of safety given the individual circumstances relating to the individual prisoner. People with mental illness should be afforded humane treatment, irrespective of any crime they may have committed or any lack of appropriate facilities for their treatment.[32]

In its response to my revised provisional report, the department concurred with these comments.

Consideration of administrative error

69. I acknowledge that the department's primary concern was to ensure the complainant remained safe from self harm. I note the department's submission that:

> The response (to self harming behaviours) required in a custodial setting is to prevent self harm and suicide attempts, to keep the person safe by reducing risk, and to facilitate access for professional intervention and treatment.

70. I also acknowledge that Dr Rao commended the department:

> …for managing a very complex psychiatric patient such as Ms Davies in the prison system. The fact that Ms Davies is alive is due to the persistent efforts of the staff and clinicians of the prison and forensic system.[33]

71. I agree that the complainant presented with complex needs that are best dealt with outside of a custodial setting, and that a prison is not a therapeutic environment.

72. That said, I am of the view that the department, in addition to keeping the complainant alive, was under an obligation to treat the complainant humanely. For the majority of

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[31] Letter from Mr David Brown to Ombudsman dated 8 April 2013, p11.
[32] Report: Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shackling of prisoners in hospitals, July 2012, para 107.
[33] Letter from Dr Sathya Rao to Ms Jane Farrin of the department of unknown date. (Appendix A2 provided by the department).

the eight months in question, the complainant was cuffed to her bed for around 22 hours a day. Although the department was clearly concerned about her management, in my view it could have done substantially more to explore how her regime could be ameliorated in a safe manner.

73. It is my view that the length of time in a day she was generally restrained, the manner in which she was restrained (lying on her back and the use of hard cuffs) and the length of time this regime lasted, was not in accordance with acceptable national and international standards. I also note that that her self harming behaviour appears to be directly associated with her mental health condition and the fact that she was unable to be cared for in a therapeutic environment. For these reasons, it is my view that the department acted in a manner that was wrong.

74. I note the department's response to my revised provisional report rejecting that the use of restraints constitutes cruel, inhumane or degrading treatment or punishment, and noting that no aspect of the restraint policies and directions can be said to be unlawful on the basis it does not comply with national and international standards. However, the basis of my finding is that the circumstances in which restraints were applied to the complainant was not in accordance with acceptable national and international standards and for that reason it was wrong. I further note that, although the department does not accept it acted in a manner that was wrong, it acknowledges it could have directed greater efforts to make the environment safer 'which may have resulted in the relaxation of restraints rather than focus on alternative accommodation arrangements'.

75. In addition, it is my view that there were occasions during the eight months the complainant was restrained at YLP where it was not reasonably necessary in the circumstances of the particular case to restrain her (as per section 86 of the Correctional Services Act). In particular, I am of the view that it was not reasonably necessary to restrain the complainant during her professional visits and when she received communion. I note that case notes from Mr Williams and Dr Rao indicate for the most part that the complainant was calm during these interviews, and that there appears no evidence that she assaulted staff in similar circumstances.

76. I am of the view that it is likely that there were other circumstances during the period in question where it was not reasonably necessary for the complainant to be restrained. In my view, the requirement in section 86 of restraints being reasonably necessary in the 'circumstances of the particular case', requires an assessment of the circumstances on an ongoing basis. Whilst I acknowledge the complainant's case management was reviewed on a monthly basis, in my view, particularly given the manner in which she was restrained and in light of its ongoing nature, this was not sufficient. For these reasons, it is my view that the department acted in a manner that was contrary to law.

77. The department responded to this aspect of my revised provisional report as follows:

> Whilst the Department accepts there <u>may well</u> have been particular occasions in which is was not reasonably necessary for Ms Davies to be restrained, I do not accept that a positive finding that this occurred can be properly made without detailed consideration of the specific circumstances that pertained on specific occasions. Upon a detailed analysis of any particular occasion on which Ms Davies was restrained it may be that the restraint was, in the circumstances, warranted. For these reasons, I do not consider that finding of unlawfulness can safely be made.

78. I remain satisfied, on basis of the evidence before me, that there were occasions, in particular during her professional visits, when it was not reasonably necessary to restrain the complainant.

Opinion

In light of the above, I consider that, in restraining the complainant for the length of time and in the manner it did, the department acted in a manner that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

I consider also that the department on occasion restrained the complainant in circumstances where it was not reasonably necessary and, in doing so, acted in a manner that was contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.

To remedy these errors, I recommend under section 25(2) of the Ombudsman Act that the department, in consultation with mental health services, develop and implement a policy in relation to the restraint and associated management of mentally ill prisoners. The policy should align to the quality standards that apply to the use of restraints of mentally ill patients in hospital, that aim to minimise the use of restraints for mental health reasons. The policy should include procedures to be taken if a mentally ill prisoner requires restraints to be applied for periods exceeding 24 hours.

I reiterate the recommendation I made in my 2012 Report that when the circumstances justify the use of restraints, a soft form of restraint should be used.

Whether other aspects of the complainant's regime were unreasonable or wrong

79. I now turn to consider other aspects of the complainant's regime. The complainant and Dr Brayley on her behalf have submitted that, in addition to being restrained, the complainant's regime was unduly harsh. It is submitted that she was not permitted to watch television; had very little time outside which led to a Vitamin D and skin deficiency; was not permitted visitors; was fed an unhealthy diet; was not permitted a hair brush or toothbrush; and was allowed very few phone calls. Dr Brayley reported he was provided the following information by a whistleblower[34]:

> At night she was put in nappies. Ostensibly because of her nocturnal seizures with incontinence. However being handcuffed and also in a locked cell, she could not get to the toilet overnight. An OIC (officer in charge) needs to be present when a cell is unlocked but some are too lazy to do this. Nurses cannot unlock a cell by themselves. So she was expected to urinate in her nappy.
>
> She was fed on an unhealthy diet of finger food, because she was not allowed to use cutlery. She did have fruit at her request, but also ate toast, cups of tea, milk. At lunch she would have a roll, hamburger or chiko roll. At dinner when the others were eating she would have a chiko roll or hot dogs. She did not have proper meals.
>
> She was not permitted phone calls and could not call a lawyer. All incoming mail was stopped.

80. In her response to my provisional reports, the complainant made the following additional submissions:
    - that on more than one occasion during the day officers told her 'Just piss yourself, Jacqui. You have an incontinence pad on and we are not getting you up to go to the toilet.'
    - she was not allowed access to the toilet at night time
    - she was very rarely given a shower after urinating in her incontinence pad and bedding all night

[34] Email from Dr John Brayley dated 16 June 2012.

- she was not allowed to brush her hair which was down to her bottom at the time. It got so matted that it was cut off back to her shoulders when she went to James Nash House.
- she did not have regular phone calls with her son and her partner (her next of kin) was not informed of her whereabouts or her declining health
- she was only permitted a television in the last month of her time at YLP Health Centre at night only
- that she was lucky to get half an hour of yard time once a week at YLP, and had no access to fresh air or sunshine at any other time
- she is a smoker and was not permitted to do so
- her teeth deteriorated due to not being allowed to brush them and she lost one due to not being able to clean her teeth for 8 months
- she knocked a tooth out whilst having a seizure
- her diet was never bettered and she was not given fruit when requested
- she disputes that she was given 30 sessions with a psychiatrist, psychologist or doctor
- she is not aware of the soft restraints being implemented
- she did not pose a threat to staff
- she believes she was on medication to cause her to remember little of her time at YLP.

81. The department's letter to me dated 1 August 2012 included the following submissions about the complainant's regime at YLP:

> Recreation and Socialising Opportunities
>
> Ms Davies had access to television each afternoon when her behaviour and risk based management regime permitted. As noted above, during these periods Ms Davies was restrained to prevent physical access to the television.
>
> Ms Davies was also provided access to the outdoor recreation area. As noted above, during these periods Ms Davies was handcuffed to the front and the cuffs were secured to a belt.
>
> Given that YLP accommodates male prisoners and there were no other female prisoners at the institution, Ms Davies could not be permitted to interact with other prisoners. However, Ms Davies was under constant observation by Custodial Officers, which provided a continuous opportunity for interaction. In addition, from December 2011, Ms Davies had regular interaction and support from a departmental Senior Clinician…
>
> …Social and Professional Visits
>
> Ms Davies was permitted to receive visitors, however, during her incarceration at YLP, no domestic visitors booked to see her. Professional visits took place in a room in the Health Centre under constant observation, but with Ms Davies unrestrained. Ms Davies was seen and treated daily by nursing staff and had regular individual contact with Medical Officers, psychologist and psychiatrists. She was generally unrestrained during these visits, unless her behaviour was assessed as presenting an acute risk to herself and/or others….
>
> …Telephone calls
>
> Ms Davies was permitted to have weekly telephone contact with her son, however she was prevented from contacting her ex-partner as this would often lead to an escalation in her behaviour. She also had access to external supports, such as your Office and her lawyer…

82. The complainant's YLP Restraint and Observation Regime forms indicate the following:
    - she was only given finger food during her time at YLP

- she was not allowed access to television from October 2011 until March 2012. I note a Memorandum to all staff from Mr Mann, General Manager of YLP, dated 14 September 2011 permitted her access to television
- she was not permitted books or newspapers from October 2011. The 14 September 2011 memorandum confirmed she was allowed reading material
- she was in a canvas smock until 30 March 2012 when she was allowed prison-issue pyjamas
- phone calls had to be approved by the Manager, General Manager or Acting General Manager from September 2011 to February 2012[35]
- while generally her regime allowed for one hour outside, it appears she did not always go to the yard and, from November 2011, her regime stipulated she MUST attend the yard for at least an hour a day.

83. In its response to my revised provisional report, the department stated that
- it concurs with the complainant's submission that she was not always allowed immediate access to the toilet, and stated that log book entries support that officers told her to urinate in her clothing
- the complainant was given shower access daily, except if her behaviour prevented it, which the log books indicate was rare
- the complainant was given daily access to a hairbrush
- the complainant was given daily access to a toothbrush, however her dental health was poor
- the complainant was permitted a television for 'significant periods during her placement at YLP..'
- smoking is not permitted in the Health Centre. The complainant utilised nicotine replacement therapy at various times
- all food was finger food to prevent self harm from using cutlery
- attempts were made to allow the complainant to regularly access the yard, but this did not always occur due to 'reasons including staffing issues and Ms Davies' behaviour'. It is correct that she did not attend the yard every day as stipulated in her management plan. This was in part due to inconsistent practice of staff in adhering to her management plan and in part due to the complainant refusing to attend the yard.
- the complainant had weekly telephone contact with her son 'with few exceptions, behaviour and placement permitting'. She was prevented from contacting her partner as this would often lead to an escalation in her behaviour. Her mother is listed as her next of kin so she would have been contacted regarding her status
- the complainant often accessed books from the library and had occasional access to magazines, easy readers and a CD player outside her cell. She was given paper and markers to write letters on request
- the complainant was clothed in a smock up until March 2012, apart from a few weeks in January 2012
- log book entries indicate the complainant made numerous telephone calls to her son and the Ombudsman's office. There is no indication these were approved by the General Manager although some entries indicate approval by other senior staff.

84. The parties concur that the complainant was not always allowed access to the toilet and instead was told to soil her nappies. In response to this, the department has advised that its:

> … Intelligence and Investigation Unit has investigated this inappropriate conduct and that a report is currently being finalised[36].

[35] Manager's Direction 09/11 dated 29 September 2011 and the Restraint and Observation Regimes for November 2011 until February 2012.
[36] Letter from Mr David Brown to Ombudsman dated 8 April 2013, p13.

I would be grateful if the department would provide me with a copy of this report upon its completion.

85. It is clear that the complainant was only given finger food during the relevant time period, and I am of the view that this was not unreasonable, for safety reasons. However, the evidence before me also establishes that her diet was not healthy during 2011. It appears this was identified as a contributing problem to her dental health, and that in December 2011 she was provided with healthier food. Minutes from a Case Conference held on 20 December 2011 report that her more varied diet was assisting her teeth and gums.

86. Accounts vary in relation to the complainant's access to telephone calls. I note that file notes made by Mr Williams, departmental psychologist, indicate that the complainant made requests in September and October 2011 to be allowed to contact her son by telephone. The complainant eventually spoke to her son's grandmother in December 2012. It is unclear why this was not arranged sooner, and I note this does not accord with the department's statement that she was 'permitted to have weekly telephone contact with her son'. The department has since advised that the complainant 'requested not to have contact with her son upon her initial placement at YLP' and that regular contact has continued since March 2012. I nevertheless remain concerned that the records indicate she requested telephone contact with her son as early as September 2011, but that that did not occur for some months.

87. I am satisfied on the evidence that the complainant was clothed in a smock for almost all of the relevant time period, and that she had minimal access to an outside area.

88. I also refute the department's claim that the complainant was given paper and markers on request. Restraint and Observation Regimes for November 2011 until February 2012 state that she was not permitted pens, pencils or writing implements 'at any time'.

89. The department asserts that the complainant was given daily access to a toothbrush and a hairbrush during the relevant time period. The complainant's evidence is that she was not, and that her hair was cut when she was moved to James Nash House because it was so matted, and she had dental problems caused by not being able to brush her teeth. The documentary evidence before me establishes that the complainant did indeed have dental problems.[37] Case notes and regime sheets do not mention whether or not she was allowed a hairbrush or toothbrush, although I note that she was not permitted access to other implements like cutlery and pens. In these circumstances, it is difficult to draw a conclusion as to how often, if at all, the complainant was able to brush her hair or teeth whilst at YLP. However, I accept as a minimum that the complainant did not have access to a toothbrush or hairbrush for the first week of her return to AWP from James Nash House in May 2012, and that Dr Brayley advocated on her behalf in relation to this issue; I refer to an email before from Dr Brayley to Ms Russell dated 22 May 2012 asking 'Any outcome yet on Jacqui cleaning her teeth and brushing her teeth?' and a reply from a departmental officer of the same date stating 'Ms Davies is now able to brush her hair.'

90. The Operational Plans for D Wing[38] indicate that from May 2012 the complainant was permitted a television, books, magazine and newspapers, that she was allowed one domestic visit per fortnight as well as professional visits, and that whether or not she had finger food varied as to whether she was on the ICM1 or ICM2 regime. I

[37] For example, minutes of a case conference on 25 November 2011 record that an officer from SAPHS reported the complainant was beginning to develop some chronic health problems which included losing teeth. An email between departmental staff dated 11 April 2011 indicates the complainant had had two dental fillings (see Appendix A6 provided by the department).

[38] Appendix D provided by the department.

understand that on 2 July 2012, works were commenced on the D Wing yard to allow more light in.

91. In addition to the international and national standards referred to above which prescribe that prisoners should be treated with dignity and in an humane way, I refer to the department's own Mission and Value statements:[39]

> *Mission*
> We contribute to public safety through the safe, secure and humane management of offenders and the provision of opportunities for rehabilitation and reintegration
>
> *Values*
> • Integrity
> • Ethical and respectful behaviour
> • Social responsibility
> • Accountability and professionalism
> • Equity, diversity and cultural inclusion
> • Workplace safety

92. It is my view that the complainant's regime at YLP described above, particularly when implemented in the context of the restraint regime, does not amount to the 'humane management' of the complainant and does not comprise 'ethical and respectful behaviour'.

Opinion

In light of the above, I consider that in managing the complainant's regime, the department acted in a manner that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

Whether the department implemented specialist recommendations in a timely manner

93. I understand that approximately 30 psychologist sessions were provided to the complainant between 30 August 2011 and 26 March 2012, but that Mr Williams reported that the complainant's engagement with the intervention offered was poor and, relevantly, was:

> … influenced by a number of factors including her emotional and physical distress. External factors also posed as significant responsivity issues, including her infirmary placement and regime which severely limited the options for a therapeutic environment.

94. In October 2011 the department consulted Spectrum seeking specialist advice as to how to treat and manage the complainant. The department submits that as a result of that the following strategies were put in place:[40]

- Identification of a DCS staff member to work long term with Ms Davies. This was commenced in December 2011.
- Dr Rao attending Adelaide on 23 February 2012. [See below for details]
- Spectrum staff providing training to DCS staff on Borderline Personality Disorders on 1 and 2 March 2012.
- Purchasing 2 different types of soft restraints to trial with Ms Davies. Neither proved successful.
- Regular case conference and action plans with all relevant stakeholders.

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[39] Department for Correctional Services' Strategic Plan 2011-2014.
[40] Minute to the Chief Executive from Ms Ann Finlay and Ms Jane Farrin, dated 31 July 2012 (provided by the department at Appendix C).

- Full neurological assessment.
- Regular psychiatric review, weekly High Risk Assessment Team review and daily nursing contact.

95. In February 2012, Dr Rao met with the complainant and provided verbal feedback to departmental staff. Ms Jane Farrin of the department's summary of his feedback included the following: [41]

> …Dr Rao's first question to the group was 'why is this lady not in a forensic mental health facility?' The response from JNH was that it was a result of a bed shortage for prisoners and a resource issue (only having 40 forensic beds). I think the significance of Dr Rao's comments regarding the forensic system in SA is that in other jurisdictions (specifically Victoria) she would be in the forensic not prison system. The forensic system is better equipped to manage her behaviour and implement a treatment plan compared to the prison system.
>
> He then asked 'would borderline personality disorder come under the forensic system in SA? JNH advised that no, that only axis one diagnoses now come under the forensic system (ie schizophrenia and bipolar disorder) due to lack of resources. They stated that 5-6 years ago they would have placed her at JNH but that is now not possible. In the Victorian forensic system borderline personality disorder (BPD) is considered in the criteria for placement in the forensic mental health system. Dr Rao stated that there was greater flexibility for treatment in the forensic system than in prison. The difficulties in prison was in maintaining consistent staff response and appropriate treatment…
>
> …Dr Rao stated that the cyclic behaviour of gradual escalation and then aggression and self harm was typical of BPD. He said that the use of restraints did produce a 'paradox', by keeping her safe it also makes her worse and her behaviour escalates…
>
> …
> - Currently Ms Davies is being 'managed' not 'treated'.
> - The best option for treating her would be within the forensic system due to greater flexibility and staff trained to work with individuals such as Ms Davies
> - Given that we are advised that due to resource and limited prisoner beds in the forensic system this is not possible, a treatment plan needs to be developed for her management and treatment in the correctional environment.
> - JNH staff will consider medications suggested by Dr Rao.
> - To develop a treatment plan (he will provide a template that is used by Spectrum) that also considers the larger placement and management plan (ie break the cycle of this behaviour and the restraint regime, for a planned placement for 2 weeks to be included to occur at JNH to occur prior to movement back to AWP). A placement at JNH within this broader plan can act as 'a trigger for change' and assist in breaking the cycle.
>
> Dr Rao also advised on specific behaviours appropriate in the management of persons with borderline personality disorder. Relevantly, he also stated that 'it was important not to make too many changes straight away and to do this over a period of time.'

96. I understand the department received Dr Rao's report in late March 2012 and that, following his recommendations for an admission to James Nash House as part of her transition back to AWP, James Nash House agreed to admit her. This did not occur until 11 April 2012 (I gather due to public holidays around Easter and a preference to accept the complainant when they were fully staffed).

97. Upon completion of infrastructure work at AWP, the complainant was returned to AWP on 14 May 2012. The department submits:

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[41] Email from Ms Jane Farrin to various staff members dated 24 February 2012 (provided by the department at Appendix A2).

> JNH advised that they were unable to accommodate Ms Davies longer than this due to the bed shortage in the Forensic Mental Health System and the need to allocate her bed to another individual.[42]

98. In addition to the strategies mentioned above, the department noted at the end of July 2012 that it had done the following in response to the recommendations in Dr Rao's March 2012 report:[43]

> - A one page information sheet regarding the management of Ms Davies psychogenic seizures was developed for use by custodial officers.
> - A comprehensive treatment and care plan was developed in collaboration with all key stake holders (SAPHS and FMHS) and has formally been signed off by all relevant clinical staff. A treatment and care plan has been developed as best possible with the professional staff resources available at AWP. Given that custodial staff members are managing Ms Davies the majority of the time, trying to implement a clinical therapeutic plan with staff that do not have this training, knowledge, or experience, is extremely limited.

99. I have been provided with several drafts of the treatment plan dating from March 2012 and I understand the final version was signed off in June 2012.[44] It is not clear to me when the one page information sheet was implemented, but I note that a new Operational Management Plan took effect from 2 June 2012.[45]

100. In my view, it is clearly preferable that a treatment plan for the complainant be implemented earlier than it was. However, in light of the complexities involved, and the fact that she was in James Nash House for approximately a month, I am inclined to the view that the delay involved was not unreasonable or wrong.

Opinion

In light of the above, I consider that the department did not act in a manner that was unlawful, unreasonable or wrong within the meaning of section 25(1) of the Ombudsman Act.

Final comments

It is clear that both the department and relevant health professionals, including Dr Rao, held the view that the most appropriate place for the complainant was within the Forensic Mental Health System, not a correctional facility. I note Dr Rao's advice that, if she were in Victoria, she would be accommodated in a mental health facility. In my view, it is entirely inappropriate that prisoners requiring mental health care are denied that care, and it is most concerning that it is the result of insufficient mental health beds.

Above, I have made two recommendations following from my findings in relation to this complaint, as follows:

> To remedy these errors, I recommend under section 25(2) of the Ombudsman Act that the department, in consultation with mental health services, develop and implement a policy in relation to the restraint and associated management of mentally ill prisoners. The policy should align to the quality standards that apply to the use of restraints of mentally ill patients in hospital, that aim to minimise the use of restraints for mental health reasons. The policy should include

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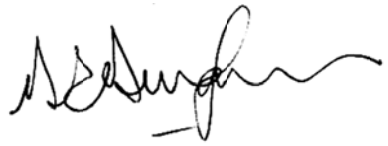
[42] Minute to the Chief Executive from Ms Ann Finlay and Ms Jane Farrin, dated 31 July 2012 (provided by the department at Appendix C).
[43] Minute to the Chief Executive from Ms Ann Finlay and Ms Jane Farrin, dated 31 July 2012 (provided by the department at Appendix C).
[44] Minutes of Case Conference dated 15 May 2012 and copies of Treatment plan (provided by the department at Appendix A3).
[45] Email from Sandra Russell, General Manager of AWP to Dr Brayley dated 7 June 2012.

procedures to be taken if a mentally ill prisoner requires restraints to be applied for periods exceeding 24 hours.

I reiterate the recommendation I made in my 2012 Report that when the circumstances justify the use of restraints, a soft form of restraint should be used.

In accordance with section 25(4) of the Ombudsman Act, I request that the department report to me by **19 July 2013** on what steps have been taken to give effect to these recommendations; and, if no such steps have been taken, the reason(s) for the inaction.



Richard Bingham
SA OMBUDSMAN

24 April 2013

Appendix 1

Subsidiary issue – the complainant's management at AWP prior to July 2011

In her response to my provisional report, the complainant provided information about her treatment during the two years prior to July 2011 when she was in D Wing of the AWP. In particular, the complainant submitted:

- she was left to have seizure after seizure day in and day out on a concrete floor
- she broke toes and ripped off toe nails during these seizures, and suffered bruises all over her body
- she had no contact with other people other than prison staff
- she was not showered regularly
- she was only ever clothed in a canvas smock and given a canvas blanket
- she was fed finger food only
- she was given about half an hour in the yard once a day and was cuffed during that time
- that fellow prisoners recall and would give evidence of the following:
    - one prisoner would be told to clean up the complainant's cell after she had wet herself from fitting and was given tobacco for doing so
    - another prisoner recalls an incident in which the complainant had a seizure whilst being transferred from D Wing. While she was on the ground, officers told her she was faking the seizure and to get up, and 'shoved' her
    - the same prisoner states that she often witnessed officers saying the complainant was faking the seizures and was just attention-seeking
    - that a petition went around D Wing stating she shouldn't be on D Wing.

The department responded to these allegations in its letter dated 8 April 2013, submitting:

- the complainant was involved in 35 'incidents' from July 2009 to July 2011, including critical self harm, self-inflicted injury, threaten self harm, assault on employee, fire in cell.
- 'significant attempts were made to reintegrate Ms Davies into the general prison population but Ms Davies regrettably would frequently breach the regime behaviour requirements and rules resulting in her regime being regressed to a more basic regime…'
- the complainant's seizures occurred frequently and irregularly
- there are no incident reports, other employee reports or records of the complainant having broken her toes or ripped off toenails during seizures nor any evidence that she suffered 'bruises all over her body'
- one senior staff member recalls one instance where the complainant stated she broke a toenail during a seizure and 'she did at times, have an occasional bruise.'
- SAPHS records do not show any incidences of physical injuries as a result of seizures
- ambulances were called on occasion 'but only limited medical treatment recorded [sic] such as 'given an icepack and stat dose of an anti-inflammatory medication and analgesia (6 December 2010)', or 'ambulance called overnight for a suspected seizure… Ms Davies did not require treatment (18 July 2010)''
- the complainant did have contact with other people apart from prison staff. When on Intensive Case Management Regimes (**ICM**) three and two, she was able to associate with other prisoners daily during morning and afternoon recreation periods. She often breached the regime behaviour requirement, attempting to introduce items to D Wing she obtained in association times (such as tobacco and items she could potentially use to self harm). When on ICM one she had limited opportunity to mix with other prisoners.
- the complainant could and did receive professional visits and domestic visits
- the complainant was provided the opportunity to have a daily shower, however she ignored or declined the opportunity from time to time
- the complainant's clothing was in accordance with her approved regime (and when on ICM one this was a canvas smock). Canvas blankets are general issue within D Wing

- the complainant was provided with food according to her regime (and when on ICM one this was finger food)
- the complainant's access to the yard was dependent on her regime, but even on ICM one she was provided at least two hours of recreation in the yard daily. 'It must be acknowledged that these times may have been impacted on a daily basis by her medical and professional appointments and it should be noted that Ms Davies would decline recreation at times.' The complainant was not cuffed during this time.
- the department does not have any evidence to support the complainant's account of fellow prisoners' recall of events
- AWP utilises a professional cleaning service when necessary to clean a cell of bodily fluids or when in a hazardous state
- when on ICM two and three, the complainant would clean her own cell as required, including if she had urinated during a seizure. If on ICM one and her cell was not in a hazardous cell, another prisoner would clean the cell (in a paid employment role).
- the department is not aware of any incident where the complainant was mocked by officers due to her seizures or pushed by an officer
- the General Manager has no evidence, nor received complaints or had expressed to her by prisoners that staff openly expressed scepticism about the complainant's seizures, and is not aware of a petition that was circulated through D Wing regarding the complainant's placement there
- the General Manager was made aware of some verbal complaints made by prisoners to staff when the complainant's self harming caused disruption for other prisoners.

It is evident that the department's account of the complainant's treatment in D Wing does not accord with the complainant's. Nevertheless, the complainant's submissions cause me some concern and, in particular, I note that her period in D Wing ended with her being transferred to YLP. I also understand that the complainant's self-harm risk has greatly reduced since being moved to the different environment of Port Augusta Prison.

However, the complainant's incarceration in D Wing of AWP for the period prior to July 2011 was not the subject of the original complaint. I did not request and do not have the benefit of any documentary evidence relating to this period (which, I note, provided real insight into the circumstances of the complainant's treatment at YLP). I am therefore not inclined to make any findings of fact in relation to these matters. Further, in light of the fact that I have made findings against the department in relation to similar allegations made about more recent events, in my view, further investigation into the complainant's treatment prior to July 2011 is not necessary or justifiable.