OmbudsmanSA

Report

Full investigation - *Ombudsman Act 1972*

Complainant	**Maurice Corcoran (the complainant)**
Agency	**Department for Correctional Services (the department)**
Ombudsman reference	**2015/08306**
Agency reference	**SEC/16/0015**
Date complaint received	**8 October 2015**
Issues	**1. Whether the department acted contrary to law and on the basis of mistake of fact by assuming supervision of the patient on 1 October 2015** **2. Whether the patient was restrained in accordance with the department's policies for unplanned supervision at a non-secure location whilst awaiting a placement in a mental health facility** **3. Whether the restraining of the patient was otherwise unlawful, unreasonable or wrong**

Jurisdiction

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

In order to protect the identity of the person who is the subject of the complaint, I have referred to them as 'the patient'.

Investigation

My investigation has involved:

- assessing the information provided by the complainant
- seeking a response from the department
- seeking more particulars from the complainant
- considering the department's Standard Operating Procedures (**SOPs**):
  - 013 Prisoners at Hospitals
  - 031 Supervised Prisoner Escorts
  - 032 Use of Restraint Equipment
  - 098 Departmental Log Books and Observations
- preparing a provisional report
- providing the provisional report to the department

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- meeting with the Chief Executive (**CE**) Mr David Brown and Deputy Chief Executive (**DCE)** Ms Jacqui Bray from the department to discuss the provisional report
- considering the department's view and response
- preparing a revised provisional report
- providing the department and the complainant with my revised provisional report for comment, and considering their responses
- preparing this final 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]

Response to provisional report

The provisional report was provided only to the department by letter dated 14 July 2016. On 22 August 2016 I met with the Chief Executive of the department Mr David Brown to discuss the provisional report. At that meeting new information was provided to me in relation to this investigation, namely the:

1. Warrant of Remand in Detention (**the warrant**) to which the patient was subject, remitted them into the custody of Forensic Mental Health Services, and not the department. Therefore the department ought not to have taken custody of the patient from 1 to 5 October 2015
2. compliance checks on 2, 3 and 4 October 2015 were telephoned through to the Acting General Manager (**A/GM**) of the Adelaide Women's Prison (**AWP**) in accordance with paragraph 3.10.5 of SOP 013 as it was considered urgent because it was a public holiday weekend. This meant that the department did not have to wait for the compliance checklist to be signed off in hard copy before being actioned as set out in paragraph 3.10.3
3. compliance checklists were considered urgent under paragraph 3.10.5 because it was outside of business hours and urgent due to the public holiday on 6 October 2015
4. eight-hour rule set out in paragraph 3.5.4 of SOP 032 did not apply to the patient because she was compliant with the restraints and non-confrontational as reported by Flinders Medical Centre (**FMC**) treating staff.

I have therefore incorporated this information into the revised provisional report which was sent to the department and the complainant on 30 November 2016.

Response to my revised provisional report

The department responded by letter to my revised provisional report dated 19 December 2016 and provided comment in relation to each of the ten provisional recommendations. I

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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.

summarise the department's response to each recommendation (numbered in accordance with the recommendation). The department stated that it:

1. is currently undertaking a review of bedside admission processes to ensure the correct interpretation of warrants including a project in relation to the 'processing of warrants, administration of prisoner movements and maintenance of accurate records' that will result in the development of a Standard Operating Procedure (**SOP**)
2. does not accept my view as to when a patient should be considered a prisoner because all persons in the department's custody are managed in accordance with SOPs
3. will consider an apology to the patient
4. agreed to the amendment of SOP 32 to clarify its application of the eight hour rule to secure and non-secure locations, and that should staff need to restrain a prisoner over eight hours they need to obtain approval from the Deputy Chief Executive Statewide Operations (**DCESO**). The department did not agree that the eight hour rule applied to the patient because it applied only to at risk or non-confrontational prisoners, and the patient did not present as such
5. explained that the 'widely accepted' meaning of 'escort' within the department includes the entire time that the prisoner is out of the prison environment, including transportation and being admitted to hospital. The department agreed this definition was not reflected in SOP 031
6. is not 'operationally viable to conduct security rating assessments' upon admission particularly in non-secure locations so a default security setting is necessary until a formal assessment can be undertaken. The department stated that restraints are always reviewed when the department assumes custody of a prisoner in a non-secure location; South Australian Police (**SAPOL**) officers remove its restraints and the department officers will then apply its restraints as set out in SOP 013. The department asserted that on this occasion a review of the patient did occur when the department assumed its escort, as evidenced by the addition of hand to hand restraints. The department also stated that the process of review upon custody being assumed by the department is set out explicitly in the revised version of SOP 013, which this Office has not been provided with a copy
7. advised that SOP 013 is currently under review and the draft version no longer contained paragraphs 3.10.3 or 3.10.5, but now 3.1.7 and 3.1.8 which read as follows:

    > 3.1.7 Any hospital compliance checks that recommends a change in the level of restraints must result in a phone call to the General Manager. The General Manager must then consider the appropriateness to change the level of restraint
    >
    > 3.1.8 If any change is authorised by the General Manager on the level of restraints then the Compliance Officer must record and sign the Hospital Watch Log Book authorising the changes and ensure that the changes are implemented immediately unless there is a reason for the delay (EG. Prisoner is receiving medical treatment).

8. is revising SOP 013 as above, which provides for restraint changes to be immediately implemented
9. is also revising SOP 013 to reflect that any proposed change to the level of restraint must result in a phonecall to the General Manager (**GM**) and that it can be changed based on verbal approval from the GM with the compliance officer required to note the approval in the hospital watch log book
10. is expected that restraints are reviewed when the department assumes custody of a prisoner and this occurred in respect of the patient evidenced by the application of the hand to hand restraints.

In summary the department is of the view that it did not act contrary to law in assuming the supervision of the patient because assistance was sought on 1 October 2015 from SA Health and SAPOL, and that legal advice obtained by the department indicated that it may be appropriate for the department to assume responsibility for individuals from time to time even though it does not have legal responsibility for them to minimise the risk to public safety.

Further, the department does not 'entirely accept' the finding that the department acted contrary to law by using excessive force towards the patient, however it does accept that the department erred in not decreasing the patients restraint level on 4 October 2015 and by not retaining a signed copy of the compliance check form.

I will address the department's responses in the relevant parts of the report, and in the final comments at the report's conclusion.

The complainant replied by email dated 16 January 2017. The complainant reiterated that he considered the department breached section 86 of the *Correctional Services Act 1982* (SA) by using excessive force towards the patient because the patient did not 'act aggressively nor was non-compliant and this was confirmed by the specialist mental health nurse, David Hains(sic) – yet they maintained restraints that caused pain, swelling and suffering'. The complainant is of the belief that 'there needs to be consequences for individual officers and those with responsibilities for supervising and overall management of these practices otherwise they will continue to abuse and infringe individuals' rights such as [the patient]'. The complainant believed the CEO and officers should formally apologise for this abuse.

I do not agree with the complainant that individual officers need reprimanding because I consider the cause of the problem relates to the department's approach and policies in relation to prisoners/patients and not particular employees who are following procedure. I agree with the complainant's views in relation to the use of excessive force, and that the department should apologise to the patient. I therefore do not intend to alter my views in that regard.

Background

1. The complainant is the Principal Community Visitor of the South Australia Community Visitor Scheme. The patient made a complaint to the complainant about the treatment received from the department's officers from 1 to 5 October 2015. The patient has given the complainant authority to act for them in making a complaint to my Office.

2. The patient was charged with a series of violent offences and was subject to the warrant issued in accordance with section 269X(1)(b) of the *Criminal Law Consolidation Act 1935* (SA) by the Magistrates Court at Christies Beach on 1 October 2015. The reason for the remand was 'pending investigation of the defendant's Mental Competence or Fitness to Stand Trial'. The warrant stated that the patient should be detained at 'James Nash House or other approved secure treatment centre as defined by section 96 of the Mental Health Act, that location being an appropriate form of custody pursuant to that subsection'. The warrant stated in the last paragraph that the patient was remanded to the custody of the Clinical Director of Forensic Mental Health until 8 October 2015 at 11:30am and directed the Clinical Director in the following terms:

   > To the Clinical Director, Forensic Mental Health Service at James Nash House, you are directed to receive and detain the defendant in an appropriate form of custody pending his/her court appearance in accordance with this warrant and, on the day and at the time specified above, to have the defendant before the Court to which the defendant was remanded to be further dealt with according to law, unless otherwise ordered in the meantime.

3. The warrant directed SAPOL to convey the patient to James Nash House or other approved secure treatment centre. This escort was undertaken on behalf of SAPOL through the Prisoner Movement and In-Court Management Contract. G4S Custodial Services Pty Ltd (**G4S**) (the service provider) conducted the escort on behalf of SAPOL.

4. The department advised that the patient's movements were as follows:[3]

    1. the patient arrived in G4S custody at 4:37pm on 1 October 2015
    2. she appeared before the Christies Beach Magistrates Court at 4:40pm finishing at 5pm
    3. paperwork was produced at 6:10pm
    4. G4S vehicle departed Christies Beach Magistrates Court at 6:25pm
    5. G4S arrived at Flinders Medical Centre (**FMC**) at 6:40pm and departed FMC at 7:25pm
    6. the patient was handed over from G4S staff (on behalf of SAPOL) to FMC staff between 6:40pm and 7:25pm together with the warrant
    7. FMC would appear to have then contacted SAPOL
    8. it is surmised that SAPOL resumed custody at FMC sometime between 7:25pm and 8:54pm
    9. at 8.54pm on 1 October 2015, a fax was sent from SAPOL to DCS Yatala Holding Cells with a copy of the warrant seeking DCS to take over custody of the patient
    10. DCS assumed supervision of the patient from SAPOL, at 11:20pm on 1 October 2015.

5. The department has acknowledged that its officers should not have taken custody of the patient at FMC on 1 October 205 at 11:20pm. The officer at Yalata Labour Prison either did not read, or misunderstood the warrant.

6. The department asserted that it applied procedures in accordance with its SOPs that apply to the circumstance of an unplanned supervision at a non-secure location (such as a hospital). Upon the department's assuming supervision of the patient it was determined, in accordance with SOP 031, that the patient was classified as a High 2 security rating for the following reasons:
    - no previous history with the department (ie had never been in prison)
    - on remand for serious offences
    - there was a lack of admissions assessment usually conducted by the prison which meant that they had not yet been classified.

7. In these circumstances the security classification defaulted to a High 2 pursuant to paragraph 3.3.1 of SOP 031. High 2 is the third highest security rating. There are five security classifications for prisoner escorts. 'High 1 A' which is a 'Prisoner Deemed to Present a Special Risk to National Security,'[4] is the highest security rating. 'Low' is the lowest security rating where the prisoner is accompanied by one escort officer who may be the driver.

8. The patient was considered to be a prisoner for the purpose of SOP 031 (Supervised Prisoner Escorts) and the department has advised that anyone in the custody of the department is managed in accordance with the SOPs regardless of their prisoner/ patient status.

Restraint Regime

9. A restraint regime was applied to the patient in accordance with the defaulted High 2 security rating.

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[3] Provisional Report comments provided by email from Cindy Arthur, 19 August 2016

[4] SOP 031 – Supervised Prisoner Escorts Section 3.4.1

10. The department assumed supervision of the patient at FMC on 1 October 2015 at 11:20pm. The following standard requirement restraint regime was applied to the patient on the basis that section 3.3.2 of SOP 031 was determined to apply:

> Restraints used in Hospital – (Admitted or in Accident/Emergency, etc)
> a. Hand secured to bed frame using closeting chain and,
> b. Legs must be shackled together and,
> c. Leg must be cuffed to the bed frame.

11. The department also advised that departmental officers used their discretion in applying a fourth arm to arm restraint (also known as hand to hand restraint) from when the department assumed supervision on 1 October 2015 at 11:20pm until 3 October 2015 at 12:30pm when these restraints were removed.

Review of restraint regime

12. Section 3.10 of SOP 013 provides that compliance checks on the restraint regime are to be completed every 24 hours to re-assess the regime.

13. The department advised that the patient's restraint regime:
    - was not reviewed on the day of admission to FMC (1 October 2015) because they came into the department's custody at 11:20pm
    - defaulted to a High 2 classification in accordance with SOP 031 which meant they were shackled at three points (as above)
    - was increased at the time the department's officers assumed supervision when officers used their discretion to add an arm to arm restraint
    - was reviewed on 2 October 2015 with no change in the level of restraint
    - was reviewed on 3 October 2015 resulting in the hand to hand restraint being removed
    - was reviewed on 4 October 2015 which resulted in a recommendation that the restraint level be reduced but there was no evidence that this recommendation was reviewed or actioned as the compliance checklist form was misplaced
    - was not reviewed on 5 October 2015 because the patient was transferred to the Margaret Tobin Centre[5] at 2pm therefore the patient was no longer in the department's custody.

14. The department completed compliance checks on the patient's restraint regime on 2, 3 and 4 October 2015, as summarised in the table below:

Date and time regime reviewed	Within 24 hours of last review?	Compliance Officer Recommended	Restraints removed?	Date compliance check form signed
2/10/15 6:05pm	Just under 19 hours after the department assumed supervision of the patient	Restraint level stay the same	No, not recommended	6/10/15. Completed by Trevor Enthoven. Approved by Wayne Gale (AWP).
3/10/15 12:30pm	Just over 18 hours after previous compliance check	Restraint level be decreased because 'no security rating set, no behaviour issues. Authorised removal of arm to arm restraint, OIC[6] AWP notified of	Yes, arm to arm restraint removed	6/10/15. Completed by Trevor Enthoven. Approved by Wayne Gale (AWP).

[5] Margaret Tobin Centre is a mental health inpatient area located within the FMC
[6] Officer in Charge

		restraint level change.'		
4/10/15 4:30pm	28 hours after previous compliance check therefore 4 hours over 24 hour time limit	Restraint level decreased recommended because 'No security rating set, no behaviour issues. Recommended removal of leg to leg restraint.'	No	No signed copy can be located on file by the department. An interview with the Compliance Officer revealed that the leg to leg restraint was not removed.

15. The compliance officer physically reviewed the patient's regime in person on 2, 3 and 4 October 2015. Prison GMs are on call 24 hours. The A/GM actively considered the compliance checks for 2, 3 and 4 October 2015 via telephone and the restraint regime was revised and recorded in the hospital watch log book. The department informed me that, contrary to SOP 3.10.3 compliance check forms do not require a signature for the department to action the recommendation of the compliance officer if it is outside of business hours and the matter is considered urgent pursuant to paragraph 3.10.5 of SOP 013. Therefore the compliance check forms for 2 and 3 October 2015 were actioned following verbal approval and signed by the A/GM on the next available business day Tuesday 6 October 2015 (Monday 5 October was the Labour Day Public Holiday). The department informed my investigation that the compliance check form for 4 October 2015, although completed, was not actioned and a signed copy is unable to be located.

Log Book Entries

16. In accordance with paragraph 3.9.1 of SOP 098, officers are to maintain a department log book whilst conducting a hospital watch (**hospital watch log book**) and follow the guidelines as per paragraph 3.4 when recording entries.

17. The department provided hospital watch log book entries completed by the officers escorting the patient and the department's senior officers at AWP. In relation to the restraint regime the hospital watch log book entries record detail on 2 October 2015 at 9:45pm:

> Prisoner complained of numb fingers and swollen wrists from hand cuffs, medical staff informed, and prisoner attended to by RN.

At 10:30pm and 11:00pm the log book states:

> Restraints checked – wrists & fingers swollen.

At 11:30pm the first watch handed over to the second watch.

At 11:35pm the escorting officer contacted the officer in charge at the AWP to request a change of hand shackled to the bed frame:

> due to bruising and swelling of wrist. Finger discolouring and numbing of fingers.

The AWP authorised the change of hand to be cuffed to the bed and restraints were then checked every half an hour through the night.

18. The complainant was initially contacted on 5 October 2015 by email at 11:14am (prior to the patient leaving the hospital) by David Haines, a Clinical Practice Consultant at FMC. Mr Haines forwarded the complainant a summary compiled by and sent to FMC staff about the treatment the patient had received. My Officer has compiled a table of the relevant information:

Date	Restraint	Additional information
1/10/15 at 11:15pm	'4-point restraint'	Accompanied by 2 prison guards
2/10/15	11pm restraints changed to a larger size	Patient agitated and distressed by restraint
3/10/15		Patient complains of wrist pain
4/10/15		Patient reports difficulty sleeping due to restraints, and noise of guards talking through the night
5/10/15	2 ankles restrained chained together and to the bed. Wrist cuffed to bed.	Patient transferred out.

19. According to the department's records the patient was restrained by its officers at FMC after taking custody of the patient from SAPOL. The patient was initially restrained with a four point restraint (leg to leg, leg to officer/bed, arm to arm, and wrist to officer/bed) and was discharged with a three point restraint, the arm to arm restraints being removed on 3 October 2015 as per compliance check recommendation. The department's records contradict that of the hospital staff which stated that the patient's restraints were changed to a larger size on 2 October 2015. The department's officer's hospital watch log book on 2 October 2015 recorded that the wrist to bed restraint was changed to the other wrist but there is no evidence that the restraint size was changed as the medical staff report.

20. On 13 October 2015 the complainant wrote to the department asking questions in relation to the regime applied to the patient. The complainant wrote:

> [the patient] stated that [the patient] was kept in metal cuffs and shackles the whole time she was in the Flinders ED by DCS guards and this was confirmed by the senior nurse, David Haines who reported this to me.
>
> [the patient] stated that she was not aggressive and was completely compliant with the treating team, this was also confirmed by David Haines. [the patient] felt humiliated and embarrassed by the restraints and has directed me to lodge a formal complaint with the Ombudsman so that this matter can be investigated.

21. On 5 November 2015 the department wrote to the complainant with the outcome of an investigation into the matter. The CEO wrote:

> The regime applied to [the patient] was consistent with the minimum requirements; [the patient] also had an extra restraint applied upon admission which was subsequently removed the following day through the compliance check and review process. […] restraint levels thereafter were consistent with the minimum requirements, as authorised by the Acting General Manager.
>
> Compliance checks are required to be regularly undertaken of those subject to supervision in hospital which include provisions compelling compliance officers to review the level of restraints applied and made recommendations to the general Manager on the appropriateness of the current regime if a change is required. Appropriately, this compliance check process resulted in a recommendation to reduce [the patient's] level of restraints on the 2 October 2015 which was approved and enacted.
>
> Overall, the regime appears to have been based on the profile of [the patient]. Given the serious nature of the charges, the mental health status and complete lack of assessments and lack of background recorded about [the patient].

22. On 10 November 2015 the complainant lodged a formal complaint with my Office to investigate the restraining of the patient. The complainant was concerned that use of four types of restraint represented 'minimum standards', and that the department did

not undertake an individual risk assessment nor consult with the medical treating team about the level of risk posed by the patient.

23. On 18 December 2015 my Officer wrote to the CE of the department asking for further information to assist in assessing the complaint. This response was not provided by the department until 28 March 2016. The CE alleged that the department did not receive the email request for information until 1 February 2016, when my Office re-sent the initial email after it received no response from the department throughout January 2016.

Relevant law/policies/procedures

24. Section 86 of the *Correctional Services Act 1982* (SA) provides:

> **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.

25. Section 269X of the *Criminal Law Consolidation Act 1935* (SA) provides:

> **269X—Power of court to deal with defendant before proceedings completed**
>
> (1) If there is to be an investigation into a defendant's mental competence to commit an offence, or mental fitness to stand trial, or a court conducting a preliminary examination reserves the question whether there should be such an investigation for consideration by the court of trial, the court by which the investigation is to be conducted, or the court reserving the question for consideration, may—
>
> (a) release the defendant on bail to appear later for the purposes of the investigation; or
>
> (b) commit the defendant to an appropriate form of custody (but not a prison unless the court is satisfied that there is, in the circumstances, no practicable alternative) until the conclusion of the investigation.

26. **SOP 013 Prisoners at Hospital**

SOP 013 prescribes the procedures to be adhered to by departmental officers whilst escorting a prisoner to hospital or conducting a hospital watch. The following paragraphs are relevant to this investigation:

> **3.4 Admission to Hospital**
>
> 3.4.1 When a prisoner is admitted to a hospital, escort officials must:
> (a) notify the Institution of the admission and the prisoner's location within the hospital;
> (b) conduct a radio check;
> (c) if the prisoner is to be secured, the prisoner must be secured in the following manner in accordance with the **"Standard Requirements"** SOP 031 Supervised Prisoner Escorts;
>
> **Planned – Restraints used in Hospital –(Admitted or in Accident/ Emergency, etc).**
> ….
>
> **Unplanned – Restraints used in Hospital –(Admitted or in Accident/Emergency, etc).**
> **Secured Custody Prisoners**
> c) Hand secured to bed frame using closeting chain and,
> d) Legs must be shackled together and,

e) Leg must be cuffed to the bedframe.

...

Under no circumstances is the closeting chain to be utilised to extend the length of the leg restraint

(d) take up a position of observation whether they are between the prisoner and any exit point and can observe the prisoner at all times;

3.6 Restraint of Prisoners on Medical Escorts/ Hospital Watches

...

3.6.3 Staff are authorised to remove all restraints when requested by a properly authorised medical officer or similar **only in life threatening circumstances to allow emergency medical treatment** to be administrated. This request and the incident must be immediately communicated to the General Manager of the prison where the prisoner came from and recorded within the hospital watch log book.

...

3.6.10 Officers must immediately contact the General Manager if the restraints used need to be altered where a prisoner's medical condition changes. In these instances with the approval of the General Manager restraints may be reduced prior to receiving the appropriate paperwork. All occurrences to be logged in the Hospital Watch Log Book.

3.10 Requirements for Review of Restraint Levels for all Prisoners in Hospital

3.10.1 Compliance checks are undertaken every twenty four (24) hours and Compliance Officers must complete a Compliance Checklist for Hospital Watches (Hospital Escorts) (F013/002) and forward a copy to the DL:DCS Hospital Watches and Escorts.

3.10.2 Compliance Officers must review the level of restraints applied and make recommendations to the General Manager on the appropriateness of the current restraint regime if a change is required.

3.10.3 General Managers must review these recommendations daily and determine whether to vary the restraint level or not and this decision must be recorded on the Compliance Checklist for Hospital Watches (Hospital Escorts) (F013/002) and endorsed by the General Manager and also recorded in the hospital watch logbook by the Compliance Officer. **Level of restraints must not change until officers receive the signed paperwork unless situation meets paragraph 3.6.3 or 3.6.10 of this SOP. (*my emphasis)***

3.10.4 Compliance Officers are to check the DL:DCS Hospital Watches and Escorts daily for updates on prisoners in Hospital.

3.10.5 Outside of business hours, if the Compliance Officer considers it urgent to vary the level of restraint then they should contact the relevant General Manager directly.

27. SOP 031 Supervised Prisoner Escorts

SOP 031 prescribes the procedures to be followed when escorting prisoners outside the secure perimeter of departmental institutions. The following paragraphs are relevant:

Paragraph 3.3 Unplanned Escorts to Non-Secure Locations

4.3.1 Where a prisoner is required to be escorted to a non-secure location that has not been planned and where the General Manager has not had the opportunity to complete an individual assessment the delegate must ensure that the conditions for the escort are based on the individual prisoner's security classification assessment.

Paragraph 3.6 Prisoner Escort Requirements – High 2

3.6.1 Prisoner is to be transported using a secure escort vehicle except where an alternative vehicle type is approved by the General Manager or Delegate.

3.6.2 Escorts for High 2 security prisoners must have:

(a) a minimum of two (2) escort officers must accompany the prisoner, one (1) of whom may be the driver; and,
(b) the prisoner must be handcuffed in front of their body or handcuffed using the body cuff and handcuffed to an escort officer when outside of a secure location or a secure escort vehicle. **(Refer to 3.2 Planned Escorts and 3.3 Unplanned Escorts "Standard Requirements")**

28. SOP 032 Use of Restraint Equipment

SOP 032 prescribes the procedures for the safe and effective use of restraint equipment. It is a 'how to' practical procedure.

3.5 Restraint of At-Risk or Non-Compliant Prisoners

3.5.1 A risk assessment must include all circumstances for the use of restraint equipment prior to the application

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;
b) When other reasonable methods of control have been exhausted; or
c) Where other reasonable methods of control are not the safest and most reasonable intervention given the situational factors

3.5.3 In the event that a prisoner who is suicidal or self-injurious requires the application of restraint equipment custodial officers 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 Deputy Chief Executive Statewide Operations for approval for continued use of the restraints.

29. SOP 098 Departmental Log Books and Observations

SOP 098 prescribes the records departmental officers are required to keep. The following paragraphs are relevant in relation to hospital watches:

Paragraph 3.9 Hospital Watch Log Book

3.9.1 Officers are to maintain a Departmental Log Book whilst conducting a Hospital watch following the guidelines as per 3.4 when recording entries.

3.9.2 Officers at the commencement and completion of each shift must record in the Departmental Log Book as per 3.4.9 in addition to the following:
(a) Name, Documentation number and Security Rating of prisoner;
(b) Location of hospital, level, ward and room number if applicable; and
(c) Record if prisoner's restraints comply with corresponding paperwork.

3.9.3 Officers must record the names and times of persons entering the room i.e. nurse, doctor, etc

3.9.4 Record of any prisoner movement for treatment, time the institution was contacted, location of treatment, what the treatment entailed i.e. x-ray, physio, etc, time of movement and time of return.

3.9.5 Record times when prisoner restraints are checked – restraints to be checked at the commencement and completion of shift and routinely throughout the shift with a maximum of a thirty (30) minute period to ensure the security and comfort of the prisoner in accordance to SOP 032 Use of Restraint Equipment.

3.9.6 Restraints must not be removed unless the General Manager has granted prior approval. Any changes to the prisoner's restraints must be recorded in the Departmental Log Book and the name of the person who gave the approval and in accordance to SOP 013 Prisoners at Hospital.

3.9.7 If restraints have to be repositioned staff must ensure that the prisoner is restrained at all times during the repositioning and times recorded in the Departmental Log Book and in accordance to SOP 013 Prisoners at Hospital.

Whether the department acted contrary to law and on the basis of mistake of fact by assuming supervision of the patient on 1 October 2015

30. Under the terms of the warrant the patient should have been remitted to the custody of Forensic Mental Health Services.

31. The department has acknowledged that its officers should not have taken custody of the patient at the FMC on 1 October 2015 at 11:20pm.

32. In taking the patient into their custody from 1 to 5 October 2015 the patient was considered to be a prisoner because the patient was taken into the department's custody and therefore the SOPs were applied to the patient.

33. The department advised in correspondence dated 19 December 2016 that whilst it had no legal responsibility to take custody of the patient it was asked to assist by SAPOL and SA Health. In addition it had received legal advice that sometimes it may be appropriate to assist individuals who are kept in a health facility awaiting transfer elsewhere, ie that it would have been irresponsible not to take custody of the patient.

34. Whilst I appreciate the merits of this argument, in these circumstances the department assumed that it had custody of the patient, did not check the terms of the warrant and operated on the assumption that the patient was in the department's lawful custody. The circumstances described by the department would apply if the department was aware that it did not have legal responsibility for a prisoner/ patient but had determined to provide assistance despite this. Here, the department accidentally took custody of the patient in error. I am therefore not convinced of the department's argument.

Opinion

35. In light of the above, my final view is that the department acted in a manner that was contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act and was based wholly on a mistake of fact within the meaning of section 25(1)(f) of the Ombudsman Act.

36. To remedy these errors, I recommend under section 25(2) of the Ombudsman Act that the department:

1. conclude its review of bedside admission processes to ensure correct interpretation of warrants

2. provide clarification in the SOPs about when a patient ought to be considered a prisoner for the purposes of the SOPs

3. apologise to the patient for taking […] into their custody by mistake.

Whether the patient was restrained in accordance with the department's policies for unplanned supervision at a non-secure location whilst awaiting a placement in a mental health facility

37. The patient was admitted to FMC on Thursday 1 October 2015 between 6:40pm and 7:25pm but the department did not assume supervision until approximately 11:20pm. The patient was in the department's custody until 5 October 2015. The dates and times at which compliance checks were undertaken appear earlier in this report.

38. Given that the department's officers were operating on a mistaken basis that the patient was in lawful custody, it is appropriate that the patient was treated in accordance with the department's SOPs.

39. The relevant SOPs are[7]:
    - paragraph 3.10.1 of SOP 013 requires that compliance checks take place every 24 hours and compliance officers must complete a compliance checklist and forward a copy to the relevant department
    - paragraph 3.10.3 of SOP 013 requires the GM to review the compliance check daily and determine whether to vary the restrain level or not and record the decision and that the level of restraint must not change until officers receive the signed paperwork unless the situation meets paragraph 3.6.3 (life threatening circumstance to allow medical treatment) or 3.6.10 (medical condition changes)
    - paragraph 3.10.5 of SOP 013 provides for the compliance officer to contact the relevant GM directly outside of business hours if they consider it urgent to vary the level of restraint. The department has advised me that compliance checks are considered to be urgent on long weekends.

1 October 2015

40. The patient was first restrained by the department when it assumed supervision on 1 October 2015 at 11:20pm. The restraint regime was dictated by the default High 2 security classification pursuant to paragraph 3.3.1 of SOP 031 (three point restraint) and officer discretion (additional fourth restraint).

41. Security classifications are set out in SOP 031 Supervised Prisoner Escorts, paragraphs 3.4 (High 1A classification) to 3.8 (Low classification). As explained by the department, the patient was at no time escorted by them, but SAPOL, yet it is SOP 031 that sets the security classification that was applied to the patient. The department has explained this SOP is applied in circumstances where there is no time to make an individual assessment (it is unplanned) therefore the 'escort' conditions are relied upon to set the security classification, even though there was technically no escorting of the patient by the department, only supervision. The patient was therefore restrained upon hospital admission due to the application of the security classification in SOP 031 which was in relation to escorting prisoners.

42. The department has advised in correspondence dated 19 December 2016 that the term 'escort' included whenever a patient was either transported or supervised outside of prison (including supervision at a hospital) and therefore it was correct in its application of SOP 031. This argument has only recently been raised by the department and is distinct from its first argument as to why SOP 031 was applied to the patient. SOP 031 contains no definition of 'escort' or any indication whether it included supervision or not.

[7] It must be borne in mind that all SOPs are to be read in conjunction with one another

43. I therefore cannot determine whether an administrative error has occurred by the department's application of SOP 031 to the patient. However, I do consider that SOP 031 needs to explicitly state who it does and does not apply to, and whether escort includes supervision of a prisoner or patient outside of prison.

44. The department has advised that paragraph 3.10.5 of SOP 013 provided that GM's of prisons are available 24 hours over the telephone and able to verbally agree compliance checks and restraint regimes.

45. The department has stated that there was no ability for it to make any assessments prior to assuming custody of the patient in hospital, therefore officers used discretion in the application of restraints which they did by adding a fourth form of restraint (hand to hand). The department has explained that it is not operationally viable to conduct security rating assessments as soon as a person is admitted into the department's custody particularly at 11:20pm at a non-secure location. Security ratings are determined following an assessment and after particular information is compiled and considered. I accept this submission from the department, however I maintain the view that even though a formal security assessment may not be able to be done in these circumstances it is always preferable to individually review a restraint regime upon the department taking custody of a prisoner/patient by discussing it with a GM and not relying on officer discretion.

46. In my view I do not consider a High 2 security classification should have been applied to the patient, by default or otherwise, and consider that an individual assessment should have been undertaken by department officers at the time it assumed supervision of the patient by utilising paragraph 3.10.5 and telephoning the A/GM of the AWP as it was outside of business hours and the matter was urgent.

47. In my view, the department erred in failing to consider the patient's level of restraint individually upon taking custody of the patient by utilising paragraph 3.10.5 of SOP 013.

2 October 2015

48. The compliance check for 2 October 2015 was undertaken at 6:05pm, 19 hours after the department assumed supervision of the patient. I therefore consider the department complied with paragraph 3.10.1 of SOP 013 by reviewing the level of restraint within 24 hours.

49. The compliance check recommended no change to the level of restraint; approval was sought verbally over the telephone with the AGM utilising paragraph 3.10.5 of SOP 013. The compliance check was signed on Tuesday 6 October 2015 when the AGM was at work after the public holiday on 5 October 2015.

3 October 2015

50. The compliance check for 3 October 2015 was undertaken at 12:30pm, 18 hours after the previous compliance check. I therefore consider the department complied with paragraph 3.10.1 of SOP 013 as it was within 24 hours.

51. The compliance check recommended the level of restraint be reduced and the arm to arm restraint be removed; approval was sought verbally by telephone to the AGM of the AWP utilising paragraph 3.10.5 of SOP 013. Once approval was given verbally the restraint was removed. The compliance check was signed on Tuesday 6 October 2015, following the public holiday.

52. Paragraph 3.10.3 of SOP 013 stated that the level of restraints must not change until officers receive the signed compliance checklist unless the situation meets paragraph 3.6.3 (life-threatening emergency) or 3.6.10 (change in medical condition) of SOP 013.

I note that the compliance checklists for 2 and 3 October 2015 were not signed until 6 October 2015. The department advised that it actioned the recommendations of the compliance checklists of 2 and 3 October 2015 by its officers telephoning the A/GM of the AWP pursuant to paragraph 3.10.5 of SOP 013 which provided for out of business hours and urgent situations. I consider paragraph 3.10.3 inconsistent with paragraph 3.10.5 because urgency and out of business hours are not included in the reasons listed in paragraph 3.10.3 for varying the restraint levels without a signed checklist.

4 October 2015

53. The compliance check for 4 October 2015 was phoned in at 4:30pm, 28 hours after the previous compliance check. I therefore consider the department did not comply with paragraph 3.10.1 of SOP 013 as it was 4 hours overdue.

54. The compliance check for 4 October 2015 recommended the level of restraint be decreased to remove the leg to leg restraint. A signed copy of this compliance check cannot be located by the department. The compliance officer who completed the form informed the department that the patient's restraints were not removed. It is unknown whether this was because the A/GM of the AWP never received the form; did not consider it; or whether the A/GM made a decision in relation to the recommendation. Had this compliance check been considered and approved by the A/GM the patient would have had the leg to leg shackle removed at least 24 hours before she left FMC on 5 October 2015. It is my view that the department erred in its completion and/or review of the compliance checklist for the patient for Sunday 4 October 2015. The department has accepted that it erred by not decreasing the restraint level on 4 October 2015 and by not retaining a signed copy of the compliance check form.

55. I have reservations about the application of paragraph 3.10.3 of SOP 013 in circumstances where a compliance checklist recommends a decrease in the patient's restraint regime but it has not been signed by the A/GM. This could result in a patient/ prisoner being restrained longer than recommended. I consider that the existence of a public holiday or weekend means that some patients/ prisoners could be subjected to excessive restraint because of a delay in reviewing the compliance checklist. I consider that in this case the compliance checklist should have been reviewed by someone in the department prior to the next business day which in this case was not until Tuesday 6 October 2015. The department has advised me that paragraph 3.10.3 cannot be read in isolation of paragraph 3.10.5 which provides for an exception to the rule that compliance checks must be signed off in writing before a recommendation is actioned. In my view, paragraph 3.10.5 is unclear in that it does not specifically state that long weekends and public holidays classify as urgent.

56. The department has informed me that it is currently reviewing SOP 013, and that the current draft version no longer contains paragraphs 3.10.3 or 3.10.5 and that those paragraphs are replaced by 3.1.7 and 3.1.8 as set out above. 3.1.7 and 3.1.8 appear to clarify that all compliance checks that change a level of restraint need to be approved by a phone call to the GM and if any changes are authorised then the compliance officer must record and sign the hospital watch log book authorising the change and ensure immediate implementation. I am satisfied that 3.1.7 and 3.1.8 resolve the inconsistency between 3.10.3 and 3.10.5, however SOP 013 is only in draft form. I therefore intend to leave recommendation 6 as it appeared in the revised provisional report to ensure the recommendation is implemented, but I commend the department for commencing the changes already.

Restraint for over eight hours

57. Paragraph 3.5.4 of SOP 032 (Use of Restraint Equipment) is relevant in the restraint of at-risk or non-compliant prisoners and states that if the use of restraint equipment exceeded an eight hour period the A/GM should contact the DCESO for approval for

continued use of the restraints. This is known as the eight hour rule. This was not done in relation to the restraint of the patient by the department.

58. The department's view is that paragraph 3.5.4 cannot be read in isolation and sits under the heading 'Restraint of At-Risk or Non-Compliant Prisoners' and that this does not apply to the patient because she was not displaying behaviours indicative of a risk of self-harm or injury to others or non-compliance. The department's evidence for this is the view of the treating medical staff and their own hospital watch log that the patient was non-confrontational.

59. In my view it is inconsistent that a non-confrontational patient or one who is not resisting the restraints is able to be restrained for over 8 hours without approval from a DCE of the department, as opposed to a prisoner or patient who is resisting the restraints. In any event my view is that the patient was an at-risk patient because she had mental health issues, was subject to a warrant of remand for serious violent offences and therefore paragraph 3.5.4 of SOP 032 should have applied to the patient.

Opinion

In light of the above, my final view is that the department failed to adhere to the department's SOPs in the following respects:

- applying the default High 2 security classification that relates to escorting prisoners and patients in circumstances where the department did not escort the patient, SAPOL did;
- failing to individually review the level of restraints upon taking custody to FMC in accordance with paragraph 3.10.5 of SOP 013;
- failing to action a compliance check on 4 October 2015 as required by paragraph 3.10.3 of SOP 013;
- failing to review the compliance check on 4 October 2015 within 24 hours as required by paragraph 3.10.1 of SOP 013;
- restraining the patient in excess of the eight hour period without contacting the DCESO for approval in accordance with paragraph 3.5.4 of SOP 032

and thus acted in a manner that was wrong within the meaning of paragraph 25(1)(g) of the Ombudsman Act.

To remedy these errors, I recommend under section 25(2) of the Ombudsman Act that the department amend SOPs to:

4. consider the application of the eight hour rule to include compliant prisoners and require that paragraph 3.5.4 of SOP 032 (Use of Restraint Equipment) apply to compliant and non-compliant prisoners/patients

5. provide clarity around when to apply SOP 031 Supervised Prisoner Escorts where the department is not escorting a prisoner/patient and include the definition of escort in SOP 031 and whether it includes supervision of a patient or prisoner

6. provide for circumstances where prisoners/patients' restraint regimes are always to be individually reviewed by telephoning a GM when the department assumes custody of the prisoner or patient and not default to a High 2 security rating

7. revise paragraph 3.10.3 of SOP 013 to include the words 'unless situation meets paragraph 3.10.5'

8. revise paragraph 3.10.5 of SOP 013 to include clarification as to what circumstances are considered urgent and include specific insertion that public holidays are considered to fit the urgent criteria.

Whether the restraining of the patient was otherwise unlawful, unreasonable or wrong

60. Section 86 of the Correctional Services Act 1982 (SA) provides that an officer or employee of the department may in the performance of their duties, use force against any person as is reasonably necessary in the circumstances of the particular case.

61. I consider that the requirement of paragraph 3.10.3 of SOP 013 that compliance checklists be signed prior to being actioned could result in unreasonable delay, and result in a person being restrained for longer than necessary. This, in my view is unacceptable, especially in circumstances of public holidays where the next working day deadline could be as much as four days away. The department has informed me that this did not occur in these circumstances because public holidays are not considered to be urgent pursuant to paragraph 3.10.5 of SOP 013. However my view is that all compliance checks should be able to be actioned without waiting for signature approval including non-urgent matters. There is no guidance in the SOPs as to what situations are considered urgent which therefore allows for officers' discretion and can result in a lack of consistency. This difficulty would be alleviated by the proposed amendment to SOP 013 and newly drafted paragraphs 3.1.7 and 3.1.8 because changes to restraints can be made following verbal approval by the GM recorded in the hospital watch log book and implemented immediately.

62. Whilst the patient's level of restraint was reviewed on 2 and 3 October 2015 it was reduced only on 3 October 2015, and then not as recommended on 4 October 2015 due to administrative error. I note that whilst the department maintains that it was not familiar with the patient, hospital staff advised departmental officers that she was non-confrontational.

63. My Office has previously advised that statutory discretion as to the level of restraint should be exercised at the earliest possible time. In this situation the patient was, in my view, incorrectly restrained when the department took custody at 11:20pm on 1 October 2015 because SOP 031 was applied to the patient when it should not have been because it was not a prisoner escort. This error ensured the patient was subjected to a default regime of three types of restraints (with an additional fourth added by the department's officer) which remained unchanged from 11:20pm on 1 October 2015 until 12:30pm on 3 October 2015 when the arm to arm restraints were removed. The patient was therefore subject to the same restraint regime for 37 hours. Particularly given the patient's non-confrontational nature I consider this an excessive use of restraints.

64. Had the below recommendations been implemented officers would be able to telephone the GM upon the patient's admission, review the restraint regime over the telephone and implement the changes immediately. The verbal approval and immediate implementation would have continued throughout the patient's stay in hospital, and would have been preferable to what occurred.

65. I have already expressed the view that approval should have been sought from the DCESO to approve the shackling of the patient for over eight hours in accordance with paragraph 3.5.4 of SOP 032. I consider the department's approach inconsistent in that a patient resisting the shackles could have their restraint regime reviewed more frequently by the DCESO than a compliant and non-confrontational prisoner/ patient.

Opinion

In light of the above, I consider that:

- in not seeking approval from the DCESO to have the patient shackled longer than the eight hour period,

- in not reviewing or signing the compliance checklist for 4 October 2015 that recommended the removal of the leg to leg shackle
- in not individually assessing the patient's restraint regime at the time the department took custody in hospital because it was considered too late at night
- in applying SOP 031 Supervised Prisoner Escorts and default to a High 2 security rating

the department used excessive force and therefore acted in a manner that was contrary to law within the meaning of paragraph 25(1)(a) of the Ombudsman Act.

To remedy these errors, I recommend under section 25(2) of the Ombudsman Act that:

9. SOP 013 be amended to include the requirement that any proposed change to the level of restraint must result in a phone call to the prison's GM and that restraint can be changed based on verbal approval from the GM, with the compliance officer required to note the approval in the hospital watch log book.

10. the relevant SOPs be amended to require that an individual review of the restraint regime of any prisoner/ patient be conducted by departmental officers upon taking custody of a prisoner or patient.

Summary of Recommendations

I recommend under section 25(2) of the Ombudsman Act that the department:

1. conclude its review of bedside admission processes to ensure correct interpretation of warrants

2. provide clarification in the SOPs about when a patient ought to be considered a prisoner for the purposes of the SOPs

3. apologise to the patient for taking the patient into custody by mistake

4. consider the application of the eight hour rule to include compliant prisoners and require that paragraph 3.5.4 of SOP 032 (Use of Restraint Equipment) apply to compliant and non-compliant prisoners/patients

5. provide clarity around when to apply SOP 031 Supervised Prisoner Escorts where the department is not escorting a prisoner/patient and include the definition of escort in SOP 031 and whether it includes supervision of a patient or prisoner

6. provide for circumstances where prisoners/patients' restraint regimes are always to be individually reviewed by telephoning a GM when the department assumes custody of the prisoner or patient and not default to a High 2 security rating

7. revise paragraph 3.10.3 of SOP 013 to include the words 'unless situation meets paragraph 3.10.5'

8. revise paragraph 3.10.5 of SOP 013 to include clarification as to what circumstances are considered urgent and include specific insertion that public holidays are considered to fit the urgent criteria

9. SOP 013 be amended to include the requirement that any proposed change to the level of restraint must result in a phone call to the prison's GM and that restraint can be changed based on verbal approval from the GM, with the compliance officer required to note the approval in the hospital watch log book

10. the relevant SOPs be amended to require that an individual review of the restraint regime of any prisoner/ patient be conducted by departmental officers upon taking custody of a prisoner or patient.

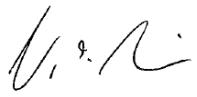
Final comment

I commend the department for taking action in relation to recommendations 1,3,7,8 and 9 already at the revised provisional report stage. However I consider it important that the final report contain the recommendations until each is finalised.

In accordance with section 25(4) of the Ombudsman Act the department should report to the Ombudsman by **13 April 2017** on what steps have been taken to give effect to the recommendations above; including:

- details of the actions that have been commenced or completed
- relevant dates of the actions taken to implement the recommendation.

In the event that no action has been taken, reason(s) for the inaction should be provided to the Ombudsman.



Wayne Lines
SA OMBUDSMAN

3 February 2017