OmbudsmanSA

Redacted Report

Full investigation - *Ombudsman Act 1972*

Complainant	**Ombudsman 'own initiative' investigation, section 13(2) *Ombudsman Act 1972***
Department	**Department for Correctional Services**
Ombudsman reference	**2017/03387**
Department reference	**SCE/17/0085**
Date complaint received	**27 March 2017**
Issues	**1. Whether the department wrongly failed to comply with the Joint System Protocol and Standard Operating Procedure 001A** **2. Whether the department unreasonably delayed taking action following receipt of a medical instruction from the South Australian Prison Health Service regarding a prisoner** **3. Whether the department's failure to maintain records in accordance with the *State Records Act 1997* was contrary to law.**

Jurisdiction

In this matter I have conducted an 'own initiative' investigation, under section 13(2) of the Ombudsman Act, on the basis of information received from the Office of the Health and Community Services Complaints Commissioner (**HCSCC**) relating to the administrative acts of the Department for Correctional Services (**the department**, **DCS**).

The investigation concerns the department's management of a prisoner and is within the jurisdiction of the Ombudsman under the *Ombudsman Act 1972*.

Nature of the complaint

On 27 March 2017, the Deputy Commissioner of the HCSCC provided my Office with information it had obtained as part of an investigation into a complaint made by a prisoner.[1]

[X] has type 1 diabetes and his complaint to the HCSCC concerned the South Australian Prison Health Service's (**SAPHS**) management of his diabetes. As part of that investigation, it

[1] The information was provided to my Office, pursuant to section 86A of the *Health and Community Services Complaints Act 2004*

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became apparent that the ability of SAPHS to provide [X] with adequate health care was being restricted by the department's failure to accommodate sufficient access to SAPHS.

More specifically, SAPHS had indicated to the HCSCC that [X] had been transferred to Port Augusta Prison on 8 February 2018 and that, since that time, Port Augusta Prison management had not been facilitating [X's] access to SAPHS three times daily for the purposes of insulin delivery and blood glucose level checks (**BGLs**). SAPHS stated that, despite its requests, the department was only facilitating [X's] access to SAPHS twice daily and, therefore, he was not receiving Novo Rapid insulin three times daily to coincide with meals, as was prescribed and is the usual treatment for patients with type 1 diabetes.[2]

Investigation

My investigation has involved:

- considering information provided by the HCSCC
- seeking information from the department
- assessing the information provided by the department dated 21 June 2017
- seeking further information from the department
- assessing information provided by the department dated 5 February 2018
- seeking information from SAPHS
- assessing information provided by SAPHS
- seeking further information from the department
- assessing information provided by the department dated 16 May 2018
- seeking further information from the department
- assessing information provided by the department in e-mails dated 25 June 2018, 2 July 2018, 12 July 2018, 16 July 2018
- considering:
    - the *Correctional Services Act 1982*
    - the *Administrative Decisions (Effect of International Instruments) Act 1995*
    - the *State Records Act 1997*
    - the following policies:
        - Standard Operating Procedure*, SOP 001A Custodial – Admission – Case Management* (**SOP 001A**)
        - Standard Operating Procedure, *SOP 001C Custodial – Planning – Case Management* (**SOP 001C**)
        - *Department for Correctional Services and Department of Health (Central Northern Adelaide Health Services, South Australian Prison Health Service, Forensic Mental Health Service & South Australian Dental Service) Joint Systems Protocol*, approved May 2010 (**the Joint Systems Protocol**)
        - *A Memorandum of Understanding Between the Central Northern Adelaide Health Service and the Department for Correctional Services Regarding the Provision of Prisoner Health Care Services*, November 2007 (**the MOU**)
- preparing a provisional report and providing it to the parties for comment
- 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

[2] *Confidential Expert Review for HCSCC, Re Complaint lodged by [X]*, Ms Jayne Lehman report, undated.

upheld. That decision recognises that greater care is needed in considering the evidence in some cases.[3] 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 … .[4]

Response to my provisional report

The department's response to my provisional report

In response to my provisional report, the department responded to the three issues considered as follows.

The department accepted my provisional view in relation to the first issue (i.e. the failure to comply with the Joint System Protocol and Standard Operating Procedure 001A). The department advised that it has commenced the following actions to address matters identified in my report:

- A review into the food options available in prison canteens with reference to recommendations by Diabetes Australia

  The Department for Correctional Services (DCS) is finalising a Public Health Partnership initiative with SA Health. This is nearing completion and the next step is to implement a review of food options, overseen by the Chief Dietician.

- Seeking further advice form SA Prison Health Service (SAPHS) in relation to timing of meals and the provision of appropriate snacks to prisoners who have a medical requirement.

  DCS and SAPHS have been meeting regularly to complete the Diabetes Action Plan. Part of this process includes planning around ensuring DCS provide access to meals at the appropriate times and ensure [sic] there is immediate escalation if any concerns, by either service, are noted.

- The request to SAPHS to establish a governance framework for their Model of Care (MOC) to ensure continued progress of oversight in relation to providing community-equivalent health care practices within the prison system.

  DCS have discussed this recommendation with SAPHS and, as a result, monthly Central Adelaide Local Health Network (CALHN)/DCS meetings and joint Partnership meetings (as the governance/oversight committee) have been initiated.

- The invitation to SAPHS representatives to attend the General Manager's (GM) meeting on 29 June 2017 to discuss diabetes management and equipment to enable the Department to undertake a risk assessment.

  Since the commencement of the Diabetes Action Plan, the plan has again been formally discussed at the DCS General Managers meeting held in August 2018. Discussion included key aspects of the Diabetes Action Plan including the importance of DCS ensuring prisoners have access to appropriate meal times and nursing intervention.

- Development of a Diabetes Management Action Plan by end June 2017 and the conduct of monthly meetings over 6 months to implement the strategies that are outlined in the plan.

  A Diabetes Management Action Plan was developed in March 2017 and will be completed once the dietician review is finalised. The Department has also undertaken a number of

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[3] 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.

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

actions to work towards ensuring that there is an increased awareness of diabetes and chronic illnesses across the prison system through the establishment of a joint DCS/SAPHS Diabetes Working Group. This Working Group has worked through a number of actions including:

- Arranging for healthy diabetic snacks to be included on prisoner canteen lists;
- Provision of canteen lists to SAPHS in order to identify when diabetic prisoners are purchasing unhealthy items;
- Identification of means of encouraging more exercise for those with chronic health conditions such as type 1 and type 2 diabetes;
- The development of strategies for low, medium and high security locations in relation to blood sugar levels (BSL) and insulin;
- SAPHS providing GM's with a demonstration of diabetes related products including BSL monitoring devices;
- Review of the management of prisoners with type 1 diabetes during transfer/escort; and
- Review the process regarding SAPHS advising DCS when a prisoner is non-compliant with their diabetes management/medication.

- Re-establishment of Joint Partnership Meetings with SAPHS to improve communication and reinforce expectations in regards to escalation processes.

  DCS and SA Health have, in the last twelve months, taken active steps to re-invigorate the joint agency governance and oversight meetings. This includes the following meetings:
  - Site DCS/SAPHS Joint Prison Interface Meeting (frequency varies weekly monthly;
  - DCS/CAHLN (Corporate) Operational meeting (monthly);
  - Joint Partnership Meeting DCS and SA Health (Chaired by CE DCS) (quarterly);
  - FMHS Operational and Strategic Partnership Committee (quarterly); and
  - Oversight Committee Meeting Forensic Patients in DCS Custody.

- Establishment of a fortnightly meeting with CAHLN to proactively work through the suite of current issues raised by DCS.

  As described above, the Department has implemented fortnightly meetings with CALHN. These have now been adjusted to occur monthly. The meetings focus on interface, communication, escalation and medical/mental health placement in the hospital settings. Key points that the meeting works through includes diabetes, Aboriginal MOC, information sharing, handover, provision for direct admission to hospital to avoid emergency departments, shared training opportunities, My Health record opt out process and procedure implementation between services.

In relation to the second issue (i.e. the unreasonable delay taking action in response to a medical instruction), the department responded that it did not accept that a transfer to another prison was the most appropriate action, but that, instead, in this case the service block should have been addressed and the Medical Instruction complied with. The department indicated that it accepted that a procedural change is required to ensure that medical instructions provide appropriate indication of medical requirements.

In relation to my foreshadowed recommendation that the department amend the procedure for medical instructions, the department advised:

> A Deputy Chief Executive Instruction (DCEI) will be developed to address the procedural gap in the interim. In the medium term SAPHS has been asked to develop a formal procedure outlining the issuance and obligations of a Medical Instruction. Once this has been finalised DCS will make any necessary amendments to ensure appropriate guidance is provided to staff and reissue the DCEI. The interim DCEI will outline the purpose and use of the Medical Instruction Form (PHS106) and the responsibilities of each party. It also includes the requirements outlined in your provisional recommendation:
> - An indication as to the level of urgency/seriousness of an instruction
> - A timeframe for compliance

- A requirement that the Department provide reasoning if a medical instruction cannot be complied with, including a timeframe for responses in this regard.

The department noted that I did not foreshadow making specific recommendations in relation to issue three (i.e the failure to maintain records) as the department had recently provided my Office advice on a review of its records management systems. The department stated:

> On 4 January 2018, I issued a Direction to the Department's Executive Director People and Business Services that the Department's records management processes were to be reviewed and strengthened. This Direction was issued in response to recommendations made by you in relation to an unrelated complaint lodged with your office. The requirements of the *State Records Act 1997* was to be the focus of the review. I can advise that a draft report on the external review of the Department's records management processes has been received and is currently under consideration. The final report is scheduled for tabling at Executive in late August 2018. Standard Operating Procedure 99 Records Management will be reviewed to incorporate the recommendations of that report. Finally I can advise that Policy 31 Records Management has been reviewed and re-published as Policy 47 Information Management.

Other responses to my provisional report

The Chief Executive Officer of the Central Adelaide Local Health Network responded to my provisional report as follows:

> I have been informed by Mr Alan Scarborough, Director of Prison Health Services that the SA Prison Health Service (SAPHS) does not wish to make a submission. However I have been informed that a revision of the Medical Instruction document, noted in your provisional report, is being prepared by SAPHS to include a timeframe for the instruction and clinical consequences should the instruction not be facilitated. This will further enhance communication between SA Prison Health Services and the Department for Correctional Services in the provision of shared care of prisoner/patients.

The complainant responded by letter:

- clarifying one factual issue
- expressing his general satisfaction with the report
- querying whether there were going to be changes to how diabetic prisoners get their insulin when required
- commenting that 'all South Australian Prison Health Services should be able to access prisoners at all times.'

The HCSCC did not provide a response to my provisional report.

Having considered the parties' responses, my view remains as set out in my provisional report.

Background

1. [X] was diagnosed with type 1 diabetes sometime between 2010 and 2011 during a period of imprisonment.[5]

2. Since diagnosis, [X] has been incarcerated a number of times.

3. The most recent period of imprisonment commenced on 31 December 2013.

4. During this period of imprisonment [X] spent time in the Adelaide Remand Centre, Mobilong Prison, Yatala Labour Prison, Port Augusta Prison, Port Lincoln Prison and Mount Gambier Prison.

[5] While information provided to my investigation suggested that [X] was incarcerated at Cadell Training Prison at the relevant time, [X] recalls that the diagnosis occurred while he was at Yatala Labour Prison. As nothing turns on this discrepancy for the purposes of this report, I have not made further enquiries in that regard.

5. On 8 February 2017 [X] was transferred from Port Lincoln Prison (**PLP**) to Port Augusta Prison (**PAP**).

6. A Diabetic Nursing Record provided by SAPHS (capturing the period 13 August 2016 to 1 April 2017) indicated that prior to the transfer, and throughout his imprisonment at PAP, [X] had had been receiving insulin, on average, only twice daily.

7. It appears that Lantus (long acting) insulin was delivered in the mornings at approximately 9:00am along with Novo Rapid (fast acting) insulin. A second dose of Novo Rapid was delivered in the afternoon at approximately 4:00pm. [X's] BGLs were checked at these times also.

8. On 14 February 2017 [X] submitted a Patient Health Request, stating the reason as:

> To see the doctor - about diabetes and insulin due to high sugar levels all the time.

9. On 21 February 2017 [X] was seen by Dr James Moran. The handover notice completed by Dr Moran indicated that [X] was '*requesting lunchtime dose of insulin*' and made the following recommendations

Nursing Follow-Ups	Speak to managers about transfer
MO Recommendations	Change to Novorapid sliding scale Medical instruction re: changes to facility that accommodates [three times daily] insulin or facilitate [three times daily] access here.

10. Accordingly, on 21 February 2017, Nursing Unit Manager of Port Augusta Prison Health Services, Ms Melissa Allen, sent the following email (**the first request**) to the PAP General Manager, Mr Brenton Williams, the former PAP Assistant General Manager, Mr Damian Prentis, and copied in a number of SAPHS staff:

> Please see attached medical instruction from MO today regarding patient who is insulin dependant [sic] diabetic. Could consideration please be given to this patient being managed in a facility where he will be able to have his insulin 3 times per day or alternatively can nursing staff at PAP please have access to him at 0830, 1200 and 1700 daily to administer his insulin please?

11. The Medical instruction attached to the email stated:

> Patient's BSLs (blood sugar) / diabetic control deteriorating due [sic] not having access to three times a day Novo Rapid insulin. Puts patient at risk of [high] blood sugars and of hypoglycaemic episodes due to difficult twice daily dosing.

12. Later that day Ms Allen sent a further e-mail to Mr Williams and Mr Prentis which included an email she had received from Nursing Director, Mr Andrew Wiley, in response to her earlier e-mail. Ms Allen stated:

> Further to the email I forwarded you earlier i.e. medical instruction seeking greater access to above patient to administer insulin – there is some further context to this case as per below email from nursing Director Andrew Wiley.
>
> Nursing staff would be happy to work with DCS to come up with a process to facilitate – 'patient to self-administer his insulin with his insulin held in the Officers station along with a Blood Glucose Monitor or he holds in his cell and we exchange sharps on a one for one basis.
>
> What are your thoughts regarding this please?

13. Mr Wiley's email stated:

> FYI the Health Complaints Commissioner undertook a formal investigation in relation to complaints raised by [X] previously around the management of his diabetes, his case was reviewed by a Credentialed Diabetes Educator on behalf of HCSCC who produces a 33 page report with 34 recommendations that we need to respond to in the next couple of weeks.
>
> Agree, we (DCS and SAPHS) need to find a way to facilitate insulin 3 times a day, either SAPHS having access or he self-administers his insulin with his insulin held in the Officers station along with a Blood Glucose Monitor or he holds in his cell and we exchange sharps on a one for one basis.

14. On 22 February 2017, the SAPHS Medical Head of Unit, Dr Michael Findlay, and SAPHS Director of Nursing Intermediate/Primary Health Care, Mr Alan Scarborough, sent further e-mails to Mr Williams and Mr Prentis indicating that [X's] situation was being investigated by HCSCC and reiterating his need for insulin three times daily.

15. I understand that [X's] access to SAPHS did not change and, on 27 February 2017, he submitted a further Patient Health Request to see a doctor about 'diabetes due to high sugar levels constantly'.

16. The department advises that following the first request, Mr Williams requested that Mr Prentis meet with SAPHS to 'work through the access service block' and determine 'what parameters were needed in order to arrange nursing staff to have additional access to [X] over the lunch period'.

17. As part of my investigation, my Office sought copies of any records relating to communications, meetings or discussions that occurred in relation to access times or the possibility of transferring [X]. The department advised that it was unable to locate any such records but that "multiple" discussions and meetings took place in relation to the required medical service delivery to [X].

18. As a result, I have only been able to rely on documentation provided by SAPHS to ascertain what action occurred following the first request. Below I have set out relevant extracts from a series of e-mail communications that SAPHS provided to my Office as part of my investigation. These extracts have informed my decision in this matter.

19. At 7:52am on 9 March 2017, Ms Allen sent an e-mail to Ms Elizabeth Sloggett, Nurse Management Facilitator, stating 'FYI – no response from GM yet' in relation to her email of 21 February 2017.

20. At 8:28am on 9 March 2017, Ms Allen e-mailed two SAPHS staff stating:

> …Remains on NovoRapid sliding scale [three times daily] with meals however we cannot access him for lunchtime hence [twice daily] novorapid. Patient is participating in [twice daily] BGL's and has been since transfer to us.'
>
> …
>
> I am having a meeting with Damian Prentis A/GM this morning at 10am to discuss medical instructions in general. I will use opportunity to push for further feedback as to the previous 2 emails I have sent GM seeking access to patient [three times daily] to provide BGL/insulin or officer or patient hold sharps and insulin and officers allow patient access to self manage his BGLs and insulin in unit.

21. Following the meeting, at 3:54pm Ms Allen e-mailed a number of SAPHS staff as well as Mr Prentis, and included the following summary of their discussion (my emphasis):

> I have spoken with A/GM Damian Prentis today about stretching patient's meals to at least 5-6 hours between breakfast, lunch and dinner. This would effectively mean there would need to be consensus & permission within DCS for patient to have his meal in his cell to eat at approx. 12.30 instead of current time approx. 11am (which is very close to breakfast at 0900) and also evening meal at approx. 1800. I have also asked Damian if we could please then also access patient at his trap (as will not unmast cell on lockdown) after the 12:30 & 1800 meal to get patient to self administer BGL and also self administer sliding scale insulin. This would be done through trap meaning no requirement to unmast cell during lockdown, with nurses able to visualise through viewing panel. Of the options available Damian felt this one would have highest likelihood of support. More likelihood then officers holding the insulin and glucose meters or than patient being permitted to hold all of above in cell himself. Again this option needs to be approved and discussed further by Damian with GM and Accommodation Manager in first instance and then also more broadly DCS officers.
>
> I will await advicsloe (sic) from Damian as to the actions he has committed to explore further for us on behalf of patient.

22. On the information available to me, it appears that this meeting was the first discussion in relation to the request made by Ms Allen on 21 February 2017.

23. In response to enquiries by my Office, the department advised that the times initially proposed by SAPHS were not suitable because PAP would have been required to roster an additional three staff on a daily basis to escort [X] from his cell to SAPHS due to the unit being in lockdown. Alternatively, SAPHS staff would have been required to dose [X] via the cells trap, which the department states was not an accepted practice by SAPHS.

24. This appears to conflict with the e-mail of Ms Allen, above at paragraph 21, and later e-mails, cited below, which indicate that SAPHS were willing to access [X] via the cells trap but that this option had been refused by the Accommodation Manager, Ms Maria Mafrici.

25. The department also advised that Mr Prentis had proposed alternatives, including adjusted meal times, or that lunchtime access occur at 11:00am or 1:30pm. The department advises that these times were considered unsuitable by SAPHS because effective diabetes management required a six to eight hour gap between meals.

26. At 10:17am on 14 March 2017, Ms Allen provided an e-mailed response to Ms Sloggett, who had requested an update. Ms Allen's response stated (my emphasis):

> There is not really anything further to tell you other than the emails I have previously forwarded you.
>
> I spoke to Damian Prentis re [three times daily] access last week on Thursday as follow up to the many emails I have sent him and [Brenton Williams] - summary in the e-mail I sent you previously.
>
> Maria Mafrici the Manager of Banksia Unit where patient resides, came to speak to me on Friday last week whilst Andrew was present.
>
> Maria advised Damian Prentis not happy to really go with the option he and I had previously discussed. Neither was Maria. Reason given was due to the spiralling industrial issues they felt this would cause if patient was allowed to hold/have his meal in his cell and then for us to access afterwards to do BGL and give insulin through trap. Her advice was officers reaction would be 'where would this end'?
> I suggested to Maria that if we had no success [three times daily] access then could DCS please consider moving him to 24 health site. Maria stated she could see if that was option too but first needed to check he wasn't SOC client and check his sentence management plan. I specifically asked Maria if transferring him was going to be an option could we wait until after the 16th March as I had arranged for Dietician to review

> him at prison on 16th. This was/is planned as first visit by her with follow-up later to involve her working with DCS to custom design a diet for patient that included as far as possible his choices, dietician recommendations from what the DCS PAP kitchen was able to offer.
>
> …
>
> Currently patient on long acting mane [sic] insulin dose then [three times daily] short acting sliding scale with the lunchtime dose being unachievable currently due to access issues.

27. I note, this appears to be the second time that Ms Allen suggested that [X] be considered for transfer to another prison facility. Whilst it appears from the above e-mail that Ms Mafrici had indicated that she could check whether transferring [X] was possible, it does not appear that she reported back to Ms Allen on this option.

28. At 3:06pm on 17 March 2017, Ms Allen e-mailed a number of SAPHS staff stating:

> Also, I think we may have had a win today.
> I have just spent 30 minutes with Banksia Accommodation Manager – Maria Mafrici to draft a communique to officers in banksia unit regarding patient eating breakfast, lunch and dinner in his cell and nurses taking his BGL 1 hour after and facilitating patient to self administer insulin via trap at same time. This will be [three times daily] i.e. sliding scale insulin will now hopefully be [three times daily].
> Maria has advised the communique needs to go back to A.GM Damian Prentis for final approval and then out to officers.
> Maria will send copy to me once approved and I will forward to you for your records.
>
> At this point breakfast will be at 0700/0730, lunch will be 1230 and dinner will be 1900. It is proposed by Maria we will visit/be provided access at 0800/0830, 1330 and 2000 to facilitate through trap, patient to do his BGL and self administer insulin. We will take and bring back all equipment each time.
> We have at request of Maria been asked to avail ourselves of any questions at anytime that officers may have regarding the process, which I have agreed to.

29. Whilst I note that there was no reference to the option of transferring [X], Ms Mafrici may not have further considered, or reported back on, this option on the basis that a potential solution had been reached.

30. However, at 4:41pm that day Ms Allen wrote a further e-mail stating (my emphasis):

> It is disappointing to now hear we may not be able to follow process of [three times daily] access to patient for meals and BGL's/insulin as per our earlier discussion today i.e. approx. 0800, 1330 and 2000.
>
> As per our discussion the proposed [three times daily] access times of 0830, 1330 and then 1530/1630 for meals/BGL's and insulin this close together – in longer term the risks/comorbidities associated with doing this for a type 1 insulin dependent young man are as follows:
> - Neuropathy
> - Kidney/renal problems
> - Visual problems
> - Hypertension
> - overweight
>
> All of these above co-morbidities will significantly impact patients [sic] functional abilities to live and also his life expectancy and quality of life.
>
> As per below I have pasted one of the recommendations from the recent independent report by credentialed diabetes educator – commissioned by the HCSCC which

> outlines amongst other things the frequency time frames for taking Blood glucose levels.
>
> As you can see the proposal SAPHS suggested in first instance – [three times daily] – is far less than the recommended normal practices advised of patients with [X's] condition.
>
> Given that we cannot stretch [X's] meals to at least 6 hours between breakfast, lunch and dinner (with overnight snacks) and subsequently test his blood glucose levels and administer insulin after these times may I please suggest/request:
>
> **[X] is moved to HDU in YLP where the below may be more reasonably/precisely achieved please?**

31. I note this appears to be the third time that Ms Allen suggested that [X] be considered for transfer to another prison facility.

32. On the evidence available to me, it does not appear that proper consideration was given to transferring [X] despite Ms Allen's repeated requests in this regard and the obvious difficulties the agencies were having with reaching agreement on access logistics at PAP. It also does not appear that PAP management made any further proposals or otherwise attempted to give effect to the first request which had still not been complied with.

33. By this stage, PAP management had been aware of [X's] need to access SAPHS for administration of insulin three times daily, for 24 days. Despite this, and the known effect this was having on [X's] health, [X] continued to receive access only twice daily.

34. Accordingly, on 23 March 2018, Ms Allen emailed Mr Williams, Mr Prentis and Ms Mafrici, and copied in a number of SAPHS staff (**the second request**), stating:

> The patient has now been 45 days since transfer to PAP from PLP and 45 days without his prescribed three times per day insulin/BGL checks – due to the ongoing access issues. There are now further HCSCC complaint matters to respond to regarding this issue.
>
> If we are unable to achieve this at PAP could he please be considered for transfer back to YLP ASAP? As I note from reading his medical records he was able to achieve three times per day insulin administration and BGL checks at YLP.

35. Although this is the second request that Ms Allen forwarded to Mr Williams, I note that this appears to be the fourth time that she suggested that [X] be considered for transfer to another prison facility.

36. While it is evident that both agencies had been attempting to reach agreement with regards to the logistics of thrice daily access, I note that there was an initial delay to those negotiations commencing. I also note that no temporary measures were put in place by the department to ensure [X] was receiving greater access to SAPHS in the interim. For example, rostering on additional officers to transport [X] to the health centre at the proposed times or enabling SAPHS staff to access [X] via the traps as it had suggested.

37. Following the second request I understand that the department placed [X] on the next available escort to Yatala Labour Prison which was Tuesday, 28 March 2017.

38. I am informed that following his transfer on 28 March 2017 [X's] BGL control returned to being within therapeutic parameters.

Relevant law and policies

Correctional Services Act 1982

39. Section 22(2) of the Correctional Services Act provides:

> **22 – Assignment of prisoners to particular correctional institutions**
>
> (2) Subject to this section, a person who is sentenced to imprisonment or committed to prison will be imprisoned in such correctional institution as the CE may determine.

40. Section 23 (3) of the Correctional Services Act provides:

> **23—Initial and periodic assessment of prisoners**
>
> (3) In carrying out an assessment under this section, the CE must have regard to—
>
> (a) the age, gender, gender identity, sexuality or sexual identity, and the social, medical, psychological and vocational background and history, of the prisoner; and
>
> (b) the needs of the prisoner in respect of education or training or medical or psychiatric treatment […]

41. Section 24(1) of the Correctional Services Act provides:

> **24—CE has custody of prisoners**
>
> (1) The CE has the custody of a prisoner, whether the prisoner is within, or outside, the precincts of the place in which he or she is being detained, or is to be detained.

42. Section 25 of the Correctional Services Act provides:

> **25—Transfer of prisoners**
>
> (1) The CE may, by written order, direct that a prisoner be transferred from the place in which he or she is being detained to any other correctional institution.
>
> (2) An order given by the CE under subsection (1) is sufficient authority for the transfer of the prisoner in accordance with the order and the detention of the prisoner in the correctional institution to which he or she is transferred.

Policies

43. The MOU provides:[6]

> …
>
> The MoU is an agreement by the parties to work in cooperation to promote a safe and coordinated system of health care delivery to meet the needs of prisoners under the care and control of DCS.
>
> Signatory parties acknowledge:-
> - The right of prisoners to receive culturally appropriate health care services as close as possible to those which are available in the general community.

[6] A Memorandum of Understanding Between the Central Northern Adelaide Health Service and the Department for Correctional Services Regarding the Provision of Prisoner Health Care Services, November 2007, p 3.

44. The Joint Systems Protocol provides:[7]

> In South Australia, the Department for Correctional Services (DCS) has core responsibility for the provision of a secure and safe environment, accommodation and rehabilitation of prisoners … The Department of Health [including SAPHS] … is responsible for ensuring that people in prisons have access to an appropriate range of health and wellbeing services …
>
> Ensuring the proper delivery of the above services to people in prison requires a joint approach between all relevant Departments. The comprehensive management of this joint approach requires procedures and processes between DCS and SAPHS … that acknowledge and accommodate the different roles of the agencies and supports the efforts of the staff in ensuring effective cross agency communication and cooperation.

45. Part 2 'Health Centres' of the Joint Systems Protocol provides:[8]

> …
>
> Outpatients
> (Prisoners receive health services in the Health Centre and leave upon completion)
>
> DCS
> - Ensure, where practicable, prisoners are taken to the Health Centre for appointments.
> - Notify SAPHS as early as possible when prisoners cannot be taken to the Health Centre.
>
> …
>
> Outreach Patients
> (Prisoners are attended to outside of the health Centre by SAPHS/FMHS staff).
>
> DCS
> Where appropriate, DCS will facilitate SAPHS attending to prisoner's health needs outside of Health Centres (e.g. within their cells/units) and provide appropriate security during this period.
>
> SAPHS
> - Provide services to prisoners within their cells/units where required (e.g. medication).
> - Where possible, provide notice of requirement to attend to specific prisoner needs outside of the health Centre.

46. Part 3 'Shared Care for Prisoners Requiring Complex Case Management' of the Joint Systems Protocol provides:[9]

> DCS and SAPHS
> - DCS and SAPHS jointly assess and develop Joint Management Plans for prisoners identified as being at very high-risk of attempted suicide and prisoners with complex needs (e.g. unstable mental illness, intellectual or physical disabilities, elderly prisoner, complex health needs, complex or disruptive).
> - Prisoners requiring shared care may be identified by DSC[sic], SAPHS and FMHS staff.

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7 Department for Correctional Services and Department of Health (Central Northern Adelaide Health Services, South Australian Prison Health Service, Forensic Mental Health Service & South Australian Dental Service) Joint Systems Protocol, approved May 2010, 1

8 Department for Correctional Services and Department of Health (Central Northern Adelaide Health Services, South Australian Prison Health Service, Forensic Mental Health Service & South Australian Dental Service) Joint Systems Protocol, approved May 2010, 7-8.

9 Department for Correctional Services and Department of Health (Central Northern Adelaide Health Services, South Australian Prison Health Service, Forensic Mental Health Service & South Australian Dental Service) Joint Systems Protocol, approved May 2010, 8.

- Joint Management Plans will be negotiated through:
  - …
  - Behaviour Management teams, or their equivalent, for prisoners with other complex needs.

47. Part 4 'Information Sharing' of the Joint Systems Protocol provides:[10]

> Medical Advice Notifications
>
> DCS and SAPHS
> - SAPHS utilises MEDICAL ADVICE notifications to inform DCS of prisoner's specific health needs.
> - MEDICAL ADVICE notifications are advice only, not INSTRUCTIONS. DCS management determines the response. (**my emphasis**)
>
> …

48. Part 7 'Escorts/Transfers' of the Joint Systems Protocol provides:[11]

> Prison to Prison Transfer
>
> DCS
> - DCS State Movement Coordinator organises and arranges transport for prison to prison transfers
> - A Movement Order (form number 134, part 1) is sent to the Health Centre to notify of the transfer
> - Where possible, 24 hours notice is required to enable SAPHS staff to organise medications and adequately prepare transfer documentation
> - DCS staff are to organise the medical file with other transferring documents.
> - DCS are to make note on the Movement Order of any instructions/notes provided by SAPHS (**my emphasis**)
> - If transferred, the medical file is to be delivered to the relevant Health Centre
>
> …
>
> SAPHS
> …
> - Provide relevant instructions/notes to DCS for the escorting officers.

49. Part 9 'Prisoner Medication' of the Joint Systems Protocol provides:[12]

> DCS
>
> …
> - Liaise with SAPHS at a local level to coordinate the delivery of medications on set medication rounds
> - Custodial Staff are to ensure prisoners safety from injury and risk by facilitating appropriate access to medication and treatment
>
> …
>
> DCS and SAPHS
> …
> - Custodial staff and SAPHS collaborate to ensure hazards with dosing gaps are addressed and prisoners have access to essential health services and quality use of medicines.

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[10] Department for Correctional Services and Department of Health (Central Northern Adelaide Health Services, South Australian Prison Health Service, Forensic Mental Health Service & South Australian Dental Service) Joint Systems Protocol, approved May 2010, 9.

[11] Department for Correctional Services and Department of Health (Central Northern Adelaide Health Services, South Australian Prison Health Service, Forensic Mental Health Service & South Australian Dental Service) Joint Systems Protocol, approved May 2010, 17-18.

[12] Department for Correctional Services and Department of Health (Central Northern Adelaide Health Services, South Australian Prison Health Service, Forensic Mental Health Service & South Australian Dental Service) Joint Systems Protocol, approved May 2010, 20 - 21.

- Custodial staff and SAPHS collaborate to ensure prisoners are not adversely affected in their treatment regimes through acts or omission occurring in connection with the work/prison routine.

50. Part 13 'Dispute Management' of the Joint Systems Protocol provides:[13]

> Purpose: To define the means of resolving an ad hoc interagency conflict in instances where the goals of the Health and Correctional Services are incompatible.
>
> DCS and SAPHS
> Identification that a conflict exists between DCS and SAPHS requirements, in relation to prisoner management, or an inability to provide appropriate services that is not considered within current interagency protocols.
>
> DCS
> - The senior DCS officer typically the Prison General Manager/Manager Operations) will discuss the issues with the most senior available SAPHS staff member taking advice on the nature of the health need and its priority
> - DCS will record the advice and decision in the prisoner's DCS case file and refer the matter to the local DCS/SAPHS committee for post event discussion and/or referral to the DH/DCS Oversight Committee
>
> SAPHS
> - The senior SAPHS staff member available will assess and identify the health requirements and provide an opinion regarding the prisoner's health needs (including timeframe, priority and site) and any relevant health information
> - Record the event and outcome in the prisoner's medical file.

51. The department's Standard Operating Procedure *001A Custodial – Admission – Case Management* (SOP 001A) establishes the procedures to be followed in relation to admission such as the creation of prisoner case files, initial interviews and assessments, prisoner induction process, transfer of prisoners from prison to prison.[14]

52. Clause 3.6 of SOP 001A, relating to the 'Transfer of Prisoners Between Prisons', provides:

> 3.6.1 The Sending Prison
>
> Prior to the transfer of a prisoner the operational supervisor must ensure:
>
> …
>
> c) The Prisoner Movement Order is valid, the information is correct and the order had been signed by a delegate authorised pursuant to the Correctional Services Act 1982
>
> d) The prisoner's warrants, dossier, case file, medical notes and medication supply have been prepared by the relevant areas and are ready to be taken by the escorting officers.
>
> …
>
> i) The prisoner is not transferred out of the prison until all of the above factors have been completed, checked and confirmed as being correct
>
> 3.6.2 The Receiving Prison

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[13] Department for Correctional Services and Department of Health (Central Northern Adelaide Health Services, South Australian Prison Health Service, Forensic Mental Health Service & South Australian Dental Service) Joint Systems Protocol, approved May 2010, 24.

[14] Standard Operating Procedure, *SOP 001A Custodial – Admission – Case Management* (Approved: 25 June 2014), 5-8.

Upon arrival of a prisoner from another DCS prison, the operational supervisor must ensure:

…

c) The Prisoner Movement Order is valid, the information is correct and that it has been signed by a delegate authorised pursuant to the Correctional Services Act 1982

d) The prisoner's warrants, dossier, case file, medical notes and medication supply are handed to admissions staff by escorting officers.

…

f) The prisoner is not accepted into the prison until all of the above factors has been completed, checked and confirmed as being correct

…

k) the prisoner is seen by the SAPHS prior to being placed in an accommodation unit/wing as per section 3.8 of this procedure,

53. Clause 3.7 of SOP 001A, relating to the 'Risk/Needs Assessments', provides:

3.7.1 The operational supervisor must ensure that an admission interview is conducted with each prisoner regardless of status and having regard to SOP 090 – Management of Prisoners at Risk of Suicide or Self Harm. The following forms are to be completed and placed in the admission section of the Prisoner Case File, with relevant information then entered onto the JIS prior to the prisoner being place into an accommodation unit/wing:

a) Admission Checklist (F001/001)
b) Specific Needs Assessment (F001/002)
c) […] Prisoner Stress Screening Form – On Transfer (f001/003b)
d) Prisoner Interview Form (F001/004)
…
f) Prisoner Health Information Form (F001/006). Must also be completed for those prisoners transferring I from Community Corrections or another South Australian prison).

54. Clause 3.8 of SOP 001A, relating to the 'Initial Health Assessments', provides:

3.8.3 The Joint Systems Protocols detail specific responsibilities for DCS and SAPHS relating to the Intake process. These responsibilities are:

a) SAPHS must conduct an initial health assessment and complete a Prisoner Health Information Sheet and make specific placement/management recommendation where necessary for each prisoner that is admitted into a prison.

…

d) SAPHS staff must forward the completed Prisoner Health Information Sheet and any specific placement/management recommendations to DCS admissions staff.

e) the operational supervisor must ensure that the Prisoner Health Information Sheet is placed in the prisoner's Case File and a case note recorded on the JIS under the "Medical" heading listing any issues that have been identified.

55. Clause 3.14 of SOP 001A, relating to the 'JIS Case Noting', provides:

3.14.1 Upon completion of the admission process, a case note must be entered on JIS for each prisoner, outlining their admission/transfer Prisoner Stress Screening score, accommodation placement, and that they have been seen by the SAPHS and any issues. This must be done within twenty-four (24) hours.

3.14.2 Case notes must be entered on JIS throughout the admission and induction processes detailing any issues that are identified that could have an impact on the health and welfare of a prisoner.

3.14.3 Issues that may have an impact on a prisoner's health and welfare could include but are not limited to:

[…]

g) Personal health issues.

International Instruments

56. Australia has signed and ratified a number of international instruments which aim to protect prisoners from human rights abuses:
    - International Covenant on Civil and Political Rights (**ICCPR**)[15]
    - International Covenant on Economic, Social and Cultural Rights (**ICESCR**).[16]

57. Article 10 of the ICCPR provides:[17]

> ***Article 10***
>
> 1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.

58. Article 12 of the ICESCR provides:[18]

> ***Article 12***
>
> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> …
>
> (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

59. An international instrument to which Australia is a party does not form a part of Australian law unless the relevant provisions have been given legislative effect.[19] Section 3(2) of the *Administrative Decisions (Effect of International Instruments) Act 1995* establishes that an international instrument that does not have the force of domestic law cannot give rise to a legitimate expectation that an administrative decision in South Australia will conform to that instrument. However, section 3(3) of this Act does permit a decision-maker to have regard to such an international instrument 'if the instrument is relevant to the decision.'

60. The international instruments referred to in this report have not been relevantly incorporated into domestic law in the manner required by section 3 of the

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15 International Covenant on Civil and Political Rights, adopted and opened for signature, ratification and accession 16 December 1966 (entry into force 23 March 1976).
16 International Covenant on Economic, Social and Cultural Rights, adopted and opened for signature, ratification and accession 16 December 1966 (entry into force 3 January 1976).
17 *ICCPR*, above n 18.
18 *ICESCR*, above n 20.
19 Minister of State for Immigration & Ethnic Affairs v Ah Hin Teoh (1995) 183 CLR 273 at [22] per Mason CJ and Deane J.

Administrative Decisions (Effect of International Instruments) Act. That said, I am of the view that in a community such as South Australia, we should be aiming to exceed these international minimum standards in the humane treatment of prisoners.

State Records Act

61. Section 13 of the State Records Act 1997 provides:

> **13—Maintenance of official records**
>
> Subject to this Act, every agency must ensure that the official records in its custody are maintained in good order and condition.

62. Section 23(1) of the State Records Act provides:

> **23—Disposal of official records by agency**
>
> (1) An agency must not dispose of official records except in accordance with a determination made by the Manager with the approval of the Council.

Whether the department wrongly failed to comply with the Joint System Protocol and Standard Operating Procedure 001A

63. As part of my investigation, I sought to understand what knowledge PAP had of [X's] diabetes at the time of his arrival, and in particular his SAPHS access requirements.

64. When attempting to ascertain what knowledge PAP had of [X's] access requirements I considered the Joint Systems Protocol and Standard Operating Procedure 001A Custodial – Admission – Case Management (**SOP 001A**) to understand what actions should have been taken by both agencies during the transfer of [X], including what documents should exist and might indicate what knowledge PAP had in this regard.

65. I note that the Joint Systems Protocol provides guidance on the shared care for prisoners requiring complex case management. More specifically, DCS and SAPHS are to jointly assess and develop a Joint Management Plan for prisoners identified as being at very high-risk of attempted suicide and prisoners with complex needs. The department has advised that type 1 diabetes is a complex chronic and lifetime condition.

66. The Joint Systems Protocol also states that during 'Prison to Prison Transfers' DCS are to send a Prisoner Movement Order (**PMO**) to the SAPHS Health Centre to notify them of the transfer so that SAPHS can organise the prisoner's medications and adequately prepare transfer documentation. The Health Centre is to complete the PMO, send the medical files in sealed envelopes to the admissions area on the day of the transfer and provide any relevant instructions or notes to DCS.

67. SOP 001A provides that when a prisoner is transferred between prisons, the Operational Supervisors at the sending and receiving prison must ensure that the prisoner's forms, including the PMO are valid, the information correct and the order is signed by a delegate authorised pursuant to the Correctional Services Act. They must also check that the prisoner's warrants, dossier, case file, medical notes and medication supply have been prepared by the relevant areas and are ready to be taken by escorting officers at the sending prison. The receiving prison's Operational Supervisor is to do the same on receipt of this information and must not accept that prisoner until this is completed.

68. While the PMO is a DCS Form, 'Section 9 – Medical/Mental Health Needs' states that it is to be completed by SAPHS. This section contains the following questions (my emphasis):
    - Does the prisoner have any known physical injury/disability/medical needs?
    - If yes, what must be done?
    - Does the prisoner need any prescribed medication during movement and management?
    - If yes, what is the medication
    - When must the medication be taken
    - Can the prisoner retain the medication?

69. Given the type of information to be included on a PMO, on 16 January 2018 I wrote to the department seeking, amongst other things, confirmation as to whether [X's] PMO or other transfer documents indicated that he required insulin doses and BGL checks two or three times daily and, if so, whether this was accommodated from the time of his transfer. I also requested copies of any other relevant documents in this regard given that SOP 001A provides that a "Risk/Needs Assessment" is to be completed when a prisoner is transferred, which includes completion of the following forms:
    - Admission checklist
    - Specific needs assessment
    - Prisoner Stress Screening Form – On Transfer
    - Prisoner interview form
    - Compatibility to Share Accommodation
    - Prisoner Health Information Form
    - PTS – Prisoner Declaration Access and use Conditions.

70. On 5 February 2018, the department responded stating:

> The Prisoner Movement Order for [X] to move from PLP to PAP on 8 February 2017 cannot be located on [X's] dossier (prison file), nor in electronic files.

71. The department did not provide or refer to any other record that would indicate what knowledge PAP management had of [X's] needs at the time of his arrival at PAP.

72. I understand that SAPHS are responsible for completing the Prisoner Health Information Sheet and making specific placement/management recommendations. The Prisoner Health Information Sheet is forwarded to DCS admissions staff and the Operational Supervisor is to ensure it is placed in the prisoner's case file and a case note recorded on the JIS under the "medical" heading listing any identified issues.

73. My Office later requested copies of PMOs relating to other transfers of [X] throughout 2017. The department provided seven PMO's all of which contained minimal detail regarding [X's] medical requirements and I therefore consider it unlikely that the PMO relative to [X's] transfer to PAP on 8 February 2017 included [X's] required SAPHS access times.

74. On 23 March 2018, I wrote to the department seeking, amongst other things:
    - When did DCS become aware that the Health Centre required access to [X] three times per day? Please include copies of all documentation indicating [X's] requisite daily attendances at the Health Centre throughout the period of imprisonment, as distinct from his actual attendances. For example, daily lists for patient attendance requirements, medical instructions, medical notes, medical advices or any other communications between SAPHS and DCS staff regarding the management of [X's] diabetes

    - Whether type 1 diabetes is considered a 'complex health need' such that DCS and SAPHS were required to jointly assess and develop a Joint Management Plan

(**JMP**) for [X] as per Part 3 of the Joint Systems Protocol between the department and the Department of Health. If so, whether a JMP was developed for [X]?
- Copies of all relevant communications, notes, and documentation concerning the management of [X's] type 1 diabetes and its impact on decisions made in relation to his imprisonment.

75. On 16 May 2018 the department responded stating:

> PAP management first became aware of the need for access three times per day on receipt of an email and attached medical instruction from the Nurse Unit Manager on 21 February 2017.
>
> Documentation held by the Department relating to the management of [X's] diabetes is located at Attachments 2 – 8A. This includes email advice between SAPHS DCS, copies of Medical Instructions, a patient summary email from SAPHS and Dietitians Reports from Port Augusta Hospital.
>
> …
>
> The Director SA prison health Service has advised that the service does not keep a list of those attending for medication. This is recorded as part of the medication chart which is signed when the patient receives medication. This includes insulin. This chart forms part of the medical record as the primary document.
>
> When a prisoner attends the Port Augusta Prison health Centre the Custodial officer records their attendance in the Log Book, the officer does not include the reason for the attendance as they are not normally privy to this information. A sample of log book entries is attached for your information (Attachment 9).
>
> I am advised that the prison health service holds approximately eight volumes of medical records pertaining to [X]. This record exists in hard copy form only. SAPHS advised that it would not be able to provide copies of [X's] medical notes to the Department.
>
> …
>
> Enquiries were conducted with the SAPHS in response to [whether type 1 diabetes is considered a 'complex health need']. Advice received from the Nurse Manager, Clinical Risk was that whilst Type 1 Diabetes is a complex chronic and lifetime condition, it is not an unmanageable condition.
>
> The department and SAPHS recognise that in the absence of a self-management model for a prisoner with Type 1 Diabetes that the agencies need to coordinate access to enable blood glucose monitoring and the administration of insulin. There is also the role of diet and exercise to assist in controlling blood glucose levels.
>
> In the case of [X] a Joint Management Plan was not in place. Given the issuance of the Medical Instructions I am satisfied that it was reasonable [sic] open to both the NUM and the AGM to develop a Joint Management Plan for [X]. Such a plan could have formed the basis of the necessary actions of both agencies to give effect to the Medical Instructions issued with respect to [X].
>
> …
>
> Please refer to Attachments 2 – 8a for documentation held by the Department in relation to this question.

76. While the department provided copies of an Individual Development Plan (dated 31 May 2016), email correspondence between SAPHS and DCS, copies of two medical instructions (dated 21 February 2017 and 9 March 2017), logbook entries for PAP Health Centre (dated 8 February 2017 – 23 February 2017, 1 March 2017, 3 March 2017, 14 March 2017, 16 March 2017 and 28 March 2017), a patient summary e-mail from SAPHS and a Dietitians Report from Port Augusta Hospital (dated 17 March

2017), none of these documents (which totalled 36 pages) indicated what [X's] access requirements were at the time of his arrival at PAP on 8 February 2017.

77. On 27 June 2018, my Legal Officer wrote to the department's Principal Advisor of Offender Services, Mr John Strachan, seeking clarification as to how DCS is generally informed of a prisoner's SAPHS access requirements when admitted to a prison facility either for the first time or following transfer from another prison.

78. On 2 July 2018, Mr Strachan responded advising:

> whilst there is an opportunity for SA Prison Health Services to reference some health advice on the Prisoner Movement Order, more detailed information (such as appointment times/frequency) would instead be found within the prisoner medical file (that follows the prisoner across sites) and managed via the SA Prison Health Services handover process between prison sites health centres/clinics.

79. When asked how the *prison* is advised of access requirements (i.e. frequency and/or times) rather than how this information is relayed between health centres, Mr Strachan responded advising the process varies slightly from prison to prison but that at each site SAPHS provide a daily list of appointments to the prison staff to ensure DCS supports appropriate access to health appointments. Mr Strachan also indicated that the SAPHS team at receiving prison sites can also provide a Medical Instruction to DCS for admission, transfer in, doctor's review, nurse review or when other health information becomes available.

80. I note that no medical instruction appears to have been provided in relation to [X's] transfer to PAP on 8 February 2017.

81. I also note that neither the department nor SAPHS have been able to provide copies of the daily list of appointments for the relevant period. Presumably SAPHS were listing [X] as requiring three appointments daily but prison staff were not supporting access to those health appointments. This at least appears to be the case from copies of e-mails provided to my Office by SAPHS which indicate that [X] was prescribed three times daily doses of insulin to coincide with breakfast, lunch and dinner, but that SAPHS staff had not been supported in accessing [X] for the midday dose.

82. In any event, it is evident that there is no single source document that provides this information to DCS.

83. It is worth commenting here that I find it unacceptable that neither the department nor SAPHS appear to have a clear and consistent method of conveying and retaining information concerning a prisoner's SAPHS access requirements in circumstances where a prisoner requires SAPHS to administer medication at routine intervals on an ongoing basis. I do not consider the daily health centre attendance list to be a sufficient sole source of such information.

84. I also comment that responses from the department on this issue has at times given the impression that it seeks to excuse these evidently deficient processes by pointing out that SAPHS is responsible for prisoner health, that departmental staff do not have medical knowledge and so should not be expected to pass on health information, and that prison officers are not generally privy to medical information. I consider these points to be irrelevant to the present situation.

85. I acknowledge that the health of prisoners is primarily the responsibility of SAPHS; however, the ability of SAPHS staff to provide appropriate health care is dependent on the department supporting them in that function by providing sufficient access to those services. This is particularly important when the timing of access is a significant factor

in the management of chronic illnesses, as is the case with type 1 diabetes, and will not generally change from day to day.

86. Additionally, I do not consider it unreasonable to expect DCS staff to be capable of relaying information concerning a prisoner's access requirements during a prisoner's transfer from prison to prison. I do not consider this to require any medical knowledge as all it requires is that DCS staff relay information that prisoner 'X' has been attending the Health Centre at times a, b and c, and will continue to require such access until advised otherwise. If the department is hesitant to accept such information from its own employees for fear that a prisoner will incorrectly be escorted to the health centre, it would at least prompt communication regarding access times.

87. If it is nevertheless argued this would require a degree of medical knowledge beyond that which can be expected of DCS staff, this simply adds weight to the contention that there should be a single document in place to relay such information.

88. Further, I do not consider a prisoner's SAPHS access requirement to be medical information of the sort that should be kept confidential. It is simply unavoidable that prison officers responsible for escorting prisoners to prison health centres will become aware that the prisoner is attending for some medical reason.

89. On 4 July 2018 my Office requested copies of all documentation relative to [X's] induction and admission on 8 February 2017 (including admission checklist, specific needs assessment, prisoner interview form and prisoner health information form).

90. On 12 July 2018 I was provided with a copy of [X's] 'Prisoner Stress Screening Form' and was advised that this was the only document located on [X's] dossier file relating to his admission at PAP on 8 February 2017.

91. This indicates that the department has either not retained, or did not complete, the following required forms in relation to [X's] transfer to PAP:
    - Admission checklist
    - Specific needs assessment
    - Prisoner interview form
    - Compatibility to Share Accommodation
    - Prisoner Health Information Form
    - PTS – Prisoner Declaration Access and use Conditions
    - Prisoner Movement Order
    - Prisoner Health Information Sheet.

92. In view of the above, it is apparent that the department has not complied with the Standard Operating Procedure 001A Custodial – Admission – Case Management nor the Joint Systems Protocol, given it:
    - does not appear to have completed the requisite Risk/Needs Assessment forms
    - may therefore not have completed associated activities such as ensuring the Prisoner Health Information Sheet and specific placement/management recommendations were forwarded to DCS admissions staff, placed on the prisoners file and entered into the JIS system
    - did not develop a Joint Management Plan for [X].

93. The first two conclusions above have been made on the basis that the department was unable to provide copies of documents evidencing completion of the requisite forms and associated activities. I acknowledge the possibility that these actions may have been completed at the time but the forms have since been lost by the department, as appears to be the case with the PMO (I will address the issue of failing to retain records later in my reasons).

94. However, in my view it is reasonable to conclude that these actions did not happen given the lacking evidence and the department's submission that it first became aware of [X's] need for thrice daily access on 21 February 2017 despite emails of SAPHS which suggests otherwise.[20]

95. As stated in the Joint Systems Protocol, the proper delivery of a secure and safe environment, accommodation, rehabilitation, and appropriate health and wellbeing services to prisoners requires a joint approach by SAPHS and DCS. Fundamental to this joint approach is the requirement that the procedures and processes 'acknowledge and accommodate the different roles of the agencies and support the efforts of the staff in ensuring effective cross agency communication and cooperation'. The Joint System Protocol provides for the 'joint and paralleled activity required to achieve this', and for this reason I consider it significant that the department has not complied with the Protocol. In particular, I draw attention to the following extracts which appear relevant to this matter:
    - Where appropriate, DCS will facilitate SAPHS attending to prisoner's health needs outside of Health Centres (e.g. within their cells/units) and provide appropriate security during this period.
    - Liaise with SAPHS at a local level to coordinate the delivery of medications on set medication rounds
    - Custodial Staff are to ensure prisoners' safety from injury and risk by facilitating appropriate access to medication and treatment
    - Custodial staff and SAPHS collaborate to ensure hazards with dosing gaps are addressed and prisoners have access to essential health services and quality use of medicines.
    - Custodial staff and SAPHS collaborate to ensure prisoners are not adversely affected in their treatment regimes through acts or omission occurring in connection with the work/prison routine
    - DCS and SAPHS jointly assess and develop Joint Management Plans for prisoners identified as being at very high-risk of attempted suicide and prisoners with complex needs (e.g. unstable mental illness, intellectual or physical disabilities, elderly prisoner, complex health needs, complex or disruptive)
    - Prisoners requiring shared care may be identified by DSC[sic], SAPHS and FMHS staff.

96. As will be elaborated on later in these reasons, the department also appears to have not complied with the Standard Operating Procedure 001A Custodial – Admission – Case Management nor the Joint Systems Protocol, given it:
    - did not facilitate [X's] access to the Health Centre for insulin delivery and BGL checks three times daily
    - did not facilitate SAPHS staff attending to [X's] health needs outside of the Health Centre for insulin delivery and BGL checks at the proposed times
    - did not ensure [X's] safety from risk by facilitating appropriate access to medication and treatment
    - did not collaborate with SAPHS to ensure hazards with dosing gaps were addressed
    - did not collaborate with SAPHS to ensure [X's] health was not adversely affected in his treatment regime due to work/prison routine
    - did not escalate the matter in accordance with the dispute management procedures for resolving conflict in instances where the goals of DCS and SAPHS are incompatible.

97. The department has not provided any compelling reasons for its evident failure to comply with the Joint Systems Protocol and Standard Operating Procedure 001A Custodial – Admission – Case Management. It appears that the failure to comply with the relevant policies in this instance has contributed to the department's inability to reach agreement with SAPHS and to ultimate delays in providing [X] with adequate access to SAPHS.

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[20] Referred to above at paragraph 81.

Opinion

In light of the above, my final view is that the department failed to comply with the Joint System Protocol and Standard Operating Procedure 001A Custodial – Admission – Case Management, and that this was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

I note that the department has advised that it has commenced a number of actions to address diabetes management in a broader sense and it appears that some of these may address the department's failure to comply with the Joint Systems Protocol and SOP001A.

Specifically, the A/Deputy Chief Executive of the department has:

- requested a review be undertaken into the food options available in prison canteens with reference to recommendations by Diabetes Australia
- sought further advice from SAPHS in relation to timing of meals and the provision of appropriate snacks to prisoners who have a medical requirement to ensure these are available
- requested SAPHS establish a governance framework for their Model of Care to ensure continued progress of oversight in relation to providing community-equivalent health care practices within the prison system
- invited SAPHS Corporate representatives to attend the department's General Managers Meeting on 29 June 2017 to discuss diabetes management and to present equipment for BGL checks and insulin administration to enable the department to undertake a risk assessment
- requested that the department and SAPHS develop a Diabetes Management Action Plan by the end of June 2017 and conduct monthly meetings over six months to implement the strategies that are outlined in the Plan.

The department also advises that it has re-established Joint Partnership meetings with SAPHS to improve communication and reinforce expectations in regards to escalation processes. I am informed that these meetings are jointly chaired by the Chief Executive of DCS and the Chief Executive of Central Adelaide Local Health Network and includes senior officers from both DCS and SAPHS. I am informed that the meeting acts as a systems based escalation point for issues between DCS and SAPHS involving aspects of prisoner health and mental health.

I am also informed that DCS has established a fortnightly meeting with CALHN to proactively work through a suite of current issues that DCS has raised with SA Health. This is attended by the Deputy Chief Executive and Principal Advisor Offender Services from DCS, and the Chief Operating Officer and Director of Nursing from SAPHS.

In my provisional report, I foreshadowed recommending that the department report to me on the progress of all of the above actions. The department has provided a report on current progress in response to my provisional report, as set out earlier in this report. That said, a number of actions are yet to be completed.

In light of that, I recommend that the department:

1. provide a further report on the progress of the following actions:
    - the review of food options available in prisons with reference to recommendations by Diabetes Australia
    - completion of the Diabetes Action Management Plan being formulated by the department and SAPHS.

Whether the department unreasonably delayed taking action following receipt of a medical instruction from the South Australian Prison Health Service regarding a prisoner

98. As outlined above, as part of my investigation, I sought to understand what knowledge PAP had of [X's] SAPHS access requirements, and his diabetes more generally, at the time of his arrival. However, my requests for information from the department and SAPHS, indicated that a number of [X's] documents were either not completed, or not retained.

99. I turn to consider whether other material provided to my Office might be indicative of what knowledge PAP management had of [X's] access requirements.

100. I note the following comments made by Credentialed Diabetes Educator, Ms Jayne Lehmann, in her report prepared for the HCSCC's investigation of [X's] complaint:

> It appears from the documentation that [X] was admitted to the prison service this incarceration on Lantus daily before breakfast, with a sliding scale of rapid acting Novo Rapid insulin ordered for administration before breakfast and before dinner. The usual treatment for people with type 1 diabetes using multiple daily injections would be for the Lantus to be injected once a day (usually pre-bed but breakfast time is also acceptable) and then rapid acting insulin administered three times a day before each of the main meals (breakfast, lunch and dinner).

101. Later in her report she states (my emphasis):

> On 8/9/2016 it is noted by the Port Lincoln Prison medical officer that "instruction as per ENDO. From Notes (all sic)" started on Lantus 40units mane and 8 units of **Novo Rapid before each of the three meals**...

102. This appears consistent with copies of e-mails of SAPHS staff that were provided to my Office as part of my investigation, and referred to above at paragraph 81. These e-mails suggest that [X] was prescribed three times daily doses of insulin to coincide with breakfast, lunch and dinner, but that SAPHS staff had not been supported in accessing [X] for the midday dose. As already stated, given I have not been provided copies of the daily list of appointments I cannot be certain as to whether SAPHS were listing [X] as requiring three times daily access.

103. Despite the above, I have been unable to conclude with certainty what knowledge PAP management had of [X's] access requirements at the time of his arrival. In view of this, I accept the department's submission that it first became aware of his need for access three times daily on receipt of the first request, and the attached medical instruction, on 21 February 2017.

104. Although I consider it unacceptable that the department was apparently not aware of [X's] access requirements sooner, my assessment of the timeliness of the department's actions has commenced from this date.

105. As part of my investigation, I also sought to understand what obligation a 'medical instruction' imposed on the department. I reviewed the Joint Systems Protocol and the MOU and noted that neither joint policy indicated what effect a 'medical instruction' was intended to have.

106. The only reference to medical instructions appears in the Joint Systems Protocol which draws a distinction between medical advices and medical instructions, without going on to explain the purpose of medical instructions or the obligations they impose on SAPHS or DCS.

107. The Protocol states (my emphasis):

> Medical Advice Notifications
> DCS and SAPHS
> SAPHS utilises MEDICAL ADVICE notifications to inform DCS of prisoner's specific health needs.
> MEDICAL ADVICE notifications are advice only, not INSTRUCTIONS. DCS management determines the response.

108. As the above suggests that a medical instruction has more force than medical advice, I requested that the department advise on this.

109. The department sought a response from SAPHS which advised that medical instructions are used for a variety of reasons to communicate prisoner health information to DCS, including:
    - diabetic information
    - specific intolerances
    - allergies, and/or sensitivities
    - health conditions
    - client observations
    - sick certificates
    - declined medical treatment
    - infectious conditions.

110. Given the type of information to be recorded on a medical instruction it is of concern that medical instructions have not been included in any joint policy for DCS and SAPHS, and that the department did not appear to have a clear understanding of its use and effect.

111. The department has advised that this matter has identified a procedural gap in relation to medical instructions. As a result, I am informed that the department has commenced consultation with SAPHS to develop a procedural change to make clear the obligations of both agencies when it comes to the issuance of a medical instruction.

112. Given there was no policy or guideline in relation to medical instructions at the time, I have turned my mind to whether the action taken by the department was reasonable in view of what was known to PAP management. This includes, the content of the first request, the content of the medical instruction, and the emails of Ms Allen which summarised her interactions with PAP management.

113. The first request and the medical instruction expressly stated that [X's] diabetic control was deteriorating as a result of not receiving Novo Rapid insulin three times per day. It also stated that this put [X] at risk of both 'high blood sugars' (hyperglycaemia) and hypoglycaemic episodes.

114. To highlight the seriousness of the situation, the nature of the disease and the importance of good blood glucose management, I provide the following extracts from the Diabetes Australia website:

> Diabetes is a serious complex condition which can affect the entire body. Diabetes requires daily self-care and **if complications develop, diabetes can have a significant impact on quality of life and can reduce life expectancy.**
>
> In type 1 diabetes, the pancreas […] stops making insulin […]. **Without insulin, the body's cells cannot turn glucose (sugar), into energy**.
>
> People with type 1 diabetes depend on insulin every day of their lives to replace the insulin the body cannot produce. **They must test their blood glucose levels several times throughout the day.**
>
> …

Type 1 diabetes is managed with insulin injections several times a day or the use of an insulin pump.

…

Type 1 diabetes is a life threatening condition which needs to be **closely managed with daily care.**

The aim of diabetes management is to keep blood glucose levels as close to the target range as possible, **between 4 to 6 mmol/L (fasting).** However, the ranges will vary depending on the individual and an individual's circumstances.

…

Keeping your blood glucose level at the optimum range is a careful balance between what food is eaten, physical activity and medication. **Blood glucose levels which are too high, could result in hyperglycaemia or ketoacidosis**. **Blood glucose levels which are too low, could result in hypoglycaemia. […]**

Keeping your blood glucose levels on target will help prevent both short-term and long-term complications.

Hypoglycaemia, is a condition that occurs when a person's BGL has dropped too low, **below 4mmol/L.** It is important to treat a hypo quickly to stop the BGL from falling even lower and the person becoming seriously unwell.

Symptoms of hypoglycaemia vary from person to person. Early signs and symptoms may include:

- Shaking, trembling or weakness
- Sweating
- Paleness
- Hunger
- Light headedness
- Headache
- Dizziness
- Pins and needles around mouth
- Mood change

Later signs and symptoms of hypoglycaemia may include:

- Lack of concentration/ behaviour change
- Confusion
- Slurred speech
- Not able to treat own hypo
- Not able to drink or swallow
- Not able to follow instructions
- Loss of consciousness
- Fitting/seizures

Hypoglycaemia can be classified as mild or severe. A mild hypo occurs when a person can treat their own hypo. A severe hypo occurs when a person needs help from someone else to treat their hypo.

Hyperglycaemia means high blood sugar level. This can develop over many hours or days.

Symptoms

- **Feeling excessively thirsty**
- **Frequently passing large volumes of urine**
- **Feeling tired**
- **Blurred vision**
- **Infections (e.g. thrush, cystitis, wound infections)**

- **Weight loss.**

In type 1 diabetes, high blood glucose levels can progress to a serious condition called Ketoacidosis.

Ketoacidosis is related to hyperglycaemia, it is a serious condition associated with illness or very high blood glucose levels in **type 1 diabetes**. It develops gradually over hours or days. **It is a sign of insufficient insulin**. Most cases of ketoacidosis occur in people with type 1, it very rarely occurs in people with type 2.

Without enough insulin, the body's cells cannot use glucose for energy. To make up for this, the body begins to burn fat for energy instead. This leads to accumulation of dangerous chemical substances in the blood called ketones, which also appear in the urine.

Symptoms
High blood glucose levels and moderate to heavy ketones in the urine with:

- Rapid breathing
- Flushed cheeks
- Abdominal pain
- Sweet acetone (similar to paint thinner or nail polish remover) smell on the breath
- Vomiting
- Dehydration.

This is a serious medical emergency and can be life threatening if not treated properly.[21]

115. I also note from Ms Lehmann's report that the long term complications associated with poorly managed diabetes include eye disease, potential blindness, foot/leg amputation, coma, heart attack, stroke, kidney disease and death.

116. Whilst I am willing to acknowledge that DCS staff may not necessarily have understood the medical significance of terms such as "hypoglycaemic episodes", or the importance of good diabetic control, I expect that most people do understand the risks of high and low blood sugar in diabetics, and hence the need for good diabetic control. Regardless, in my view, the instruction was sufficiently clear that the risk to [X] needed to be addressed urgently.

117. Having regard to the above information relating to type 1 diabetes, in combination with [X's] requests to see doctors about his high BGLs, SAPHS' concern regarding his prescribed doses, and the BGLs recorded on the Diabetic Nursing Record, it is, in my view, safe to assume that [X] was experiencing the impacts of receiving insufficient insulin; particularly those symptoms associated with hyperglycaemia.

118. On the information available to me, it is evident that DCS is not solely responsible for the poor management of [X's] diabetes. It is clear from the report of Ms Lehmann that a number of issues were identified with SAPHS's practises in regards to diabetes management. I also note comments made by the department that [X] had at times failed to comply with dietary requirements, missed meals, refused recommended 'sugarine' tablets, and purchased unsuitable items from the prisoner canteen, all of which would conceivably have made management of his diabetes difficult.

119. That said, I concur with the following comments made by Ms Slogget in an e-mail to Mr Williams, Mr Prentis, Ms Mafrici and a number of SAPHS staff, on 23 March 2017:

> Prisoners should be afforded the same access rights as those in health facilities and the general community. There is a difference between an individual's non-compliance with the

[21] Diabetes Australia website <www. www.diabetesaustralia.com.au> accessed on 24 May 2018.

> resultant consequences however when one is not afforded access to clinical management there will be medico-legal consequences and the increasing health burden of the individual.

120. As noted above at paragraph 60, it is my view that in South Australia we should be aiming to exceed international minimum standards in the humane treatment of prisoners. That is, in this instance, the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

121. It should be noted that the department has not suggested that it was not possible to provide [X] with access to SAPHS three times daily at PAP or any other prison. Rather, the department stated that the service block at PAP should have been addressed and the medical instruction complied with.

122. The issue here is therefore the failure to treat the instruction with sufficient urgency and thus the failure to take timely action following receipt of the instruction, given [X's] health was being compromised.

123. On the information available to me, it appears that as at 9 March 2017 the General Manager had not responded to the first request. There is no evidence to suggest that Mr Prentis had responded either and it seems that the first discussion between the agencies took place on 9 March 2017.

124. Given the content of the first request, I consider this 16 day delay before commencing discussions to be very concerning.

125. From 9 March 2017 onwards it appears that both SAPHS and DCS attempted to reach agreement on access times and the method of access.

126. Whilst I acknowledge that this would involve a degree of back and forth between the agencies to assess the proposals and reach agreement, I do not get the impression from Ms Allen's e-mails that the matter was being treated by DCS with priority and it is evident that no temporary measures were put in place while long term arrangements were negotiated.

127. In my view, this impression of apathy has also been evident from the responses provided by the department to enquiries made by my Office. For instance, I note the following comment in the department's letter of 21 June 2017, as follows:

> Whilst [X] could have been seen by SAPHS at 11:00am or alternatively at 1:30pm (for a lunchtime check), I am advised that these times were not suitable. All further adjustments proposed, including delaying meal times for [X] were subsequently rejected by SAPHS.
>
> It is my view that it is open to PAP SAPHS to be more flexible, noting that [X's] insulin and BSL are currently administered at Yatala Labour Prison (YLP) by SAPHS at 7:30am, 3:30pm and 7:00pm.

128. In my view, the information that SAPHS appears to have been communicating to PAP management made it clear that the timing of [X's] meals and insulin delivery were significant factors in ensuring sufficient management of his diabetes. Therefore, SAPHS was somewhat restricted in how flexible it could be. In my view, it does not appear that Mr Prentis or Ms Mafrici appreciated this.

129. I also note the comments of Ms Allen in her e-mail of 17 March 2017 in which she advises the department that the proposals suggested by SAPHS were far less than the recommended normal practices for people with type 1 diabetes.

130. On 16 January 2018, I requested an explanation from the department as to why it was unable to accommodate the access times of 8:30am, 12:00pm and 5:00pm daily as suggested in the first request.

131. In its letter dated 5 February 2018, the department stated:

> The early discussions between SAPHS and DCS in relation to access times, identified issues by both agencies. For SAPHS to access [X] at the requested times, SAPHS would be required to dose [X] via the cells trap which is not an accepted practice by SAPHS. Alternatively DCS would have had to roster an additional three staff on a daily basis to escort [X] from his cell to the Health Centre due to the unit being in lockdown.

132. As noted above at paragraph 24 this conflicts with the information provided by SAPHS which indicates they were willing to access [X] via the cells trap. It also conflicts with Part 3 of the Joint System's Protocol which states, under 'Outreach Patients', that DCS will facilitate SAPHS attending to prisoner's health needs outside of Health Centres where appropriate.

133. On the information available to me, it appears that the department was not willing to accommodate the suggestions proposed by SAPHS owing to operational restrictions, yet it did not give consideration to transferring [X] either.

134. On 16 January 2018, I requested an explanation from the department as to why [X] was not transferred following the failed attempts to reach agreement on access times. In its letter dated 5 February 2018, the department stated:

> The first request, on 21 February 2017, to transfer [X] was not actioned, as PAP management was under the impression that [X] was being provided with his required level of medical care, three times per day, and his health was not being compromised. It was not until PAP management received the second request for transfer that they realised [X] was only seeing SAPHS twice per day, at which time the request was actioned immediately.
>
> The second request for [X] to transfer to YLP was made on Thursday, 23 March 2017, to the GM from the NUM. [X] was placed on the next available escort to YLP, which was on Tuesday, 28 March 2017.

135. On 23 March 2018, I sought, amongst other things, an explanation from the department as to why PAP management was under the impression that [X] was being provided with his required level of medical care and his health was not being compromised given the content of the first request.

136. On 16 May 2018 the department responded:

> The General Manager has advised that he understood arrangements had been put in place following the 21 February 2017 instruction to provide thrice daily access to the prisoner for BSL and insulin administration. **It is apparent that the General Manager did not follow this matter up with the AGM or NUM to confirm that appropriate arrangements had been put in place. Further it would appear that the AGM has not reported back to the GM to advise that the service block had been resolved or not.** Finally it would appear that prior to the further email of 23 March 2017, that the NUM did not raise an ongoing concern with the GM.
>
> By way of example, on 9 March 2018, the NUM emailed the GM and AGM with a further medical instruction concerning [X]. At this time it would appear that the NUM did not take the opportunity to advise that the instruction of 21 February 2017 had not been addressed to the satisfaction of SAPHS. It was only after a further 14 days, on 23 March 2017, that the NUM again raised the Medical Instruction of 21 February 2017.

> It was incumbent upon the NUM and AGM to escalate the fact that they were not in a position to satisfy the request made in the Medical Instruction of 21 February 2017. The Joint System Protocol provides both staff with clear escalation protocols.

137. Later in its response the department stated:

> Further, I am of the view that the NUM and AGM should have been able to make the necessary arrangements for this to occur. Given the two senior managers appear not to have been able to ensure thrice daily access this service block should have immediately been brought to the attention of more senior officers (of both agencies) and in accordance with the agreed escalation protocols.
>
> The General Manager has advised that he understood that following receipt of the above instruction that the AGM and NUM had made the necessary arrangements to provide thrice daily access. Clearly this was not the case. Based on the evidence available to me there is insufficient evidence to demonstrate follow up and report back to the General Manager.
>
> As such I do not accept that a transfer to another prison was the most appropriate action in this case the service block should have been addressed and the Medical Instruction complied with.

138. The department states that on receipt of the second request, [X] was placed on the next available escort to Yatala Labour Prison, which was on Tuesday, 28 March 2017. I am informed that escorts from PAP to Adelaide occur on Tuesdays and Thursdays; however, the timing of the second request meant that [X] missed the escort on that day; hence a further five day delay before his transfer.

139. In view of the above, I consider that PAP management's delay in giving effect to the medical instruction for 35 days was unreasonable given:
    - the clear medical urgency
    - the lack of follow up by the General Manager
    - the failure of the Assistant General Manager to report back
    - the fact that there are no compelling reasons as to why the department was not able to accommodate three times daily access
    - the fact that there are no compelling reasons as to why [X] could not have been transferred immediately; noting that this was the action taken following receipt of the second request.

140. The department has acknowledged that it was not reasonable or acceptable that [X] was not receiving his prescribed insulin doses or BGL checks in a manner that was consistent with the medical instruction.

Opinion

In light of the above, my final view is that the department acted in a manner that was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act given it failed to accommodate three times daily access in a timely fashion or otherwise give proper consideration to transferring [X] to another prison facility.

I am informed that the department has commenced consultation with SAPHS to develop a procedural change to make clear the obligations of both agencies when it comes to the issuance of a medical instructions. Specifically, the department has asked SAPHS to develop a formal procedure outlining the issuance and obligations of a Medical Instruction with the department proposing to make necessary amendments before reissuing the DCEI. The department has stated that an interim DCEI will be issued that addresses the requirements of my foreshadowed recommendation.

In those circumstances, given that the process is not yet complete, I still consider it necessary to make the recommendation as foreshadowed.

In regard to the medical instruction, I recommend that the department:

2. amend its procedure regarding medical instructions to include:
   - an indication as to the level of urgency/seriousness of an instruction
   - a timeframe for compliance
   - a requirement that the department provide reasoning if a medical instruction cannot be complied with, including a timeframe for responses in this regard.

Whether the department's failure to maintain records in accordance with the *State Records Act 1997* was contrary to law

141. As indicated above, in conducting this investigation, I sought to understand at what point DCS became aware that [X] required access to SAPHS three times daily for insulin administration and BGL checks.

142. In doing so, I requested confirmation from DCS as to whether [X's] PMO or other transfer documents indicated that he required three times daily access to SAPHS.

143. On 5 February 2018 the department advised that the PMO for [X's] transfer from PLP to PAP on 8 February 2017 could not be located on his dossier, nor in electronic files.

144. I sought an explanation from the department in this regard and was advised that the department was unable to determine why [X's] PMO had not been retained.

145. Following subsequent requests for documentation from the agency, it also appeared that the department had either not completed or not retained other forms associated with admission and prison to prison transfers.

146. The *State Records Act 1997* provides that every agency must ensure that 'official records' in its custody are maintained in good order and condition, and are only destroyed in certain circumstances. In particular the State Records Act provides:
   - an official record is a record made or received by an agency in the conduct of its business[22]
   - agencies are required to keep official records in their custody in good order and condition[23]
   - agencies must ensure that official records are only disposed of in accordance with the Act and under relevant disposal schedules[24]
   - to *dispose* of an official record includes to carry out an act or process as a result of which it is no longer possible or reasonably practicable to reproduce the whole or a part of the information contained in the record[25]
   - Section 16 of the Act provides that if the record keeping practices of an agency are brought to the attention of the Manager of State Records as being inadequate, then the Manager is required to report this to the Minister.

147. Section 23(1) of the State Records Act requires that an agency must not dispose of official records except in accordance with a determination made by the Manager of State Records, with the approval of the State Records Council. As I understand it, the following disposal schedules authorise arrangements for the retention and destruction of DCS records in accordance with section 23 of the State Records Act:

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22 State Records Act 1997, s 3(1).
23 State Records Act 1997, s 13.
24 State Records Act 1997, s 23.
25 State Records Act 1997, s 3.

- General Disposal Schedule No.30 - State Government Agencies in South Australia[26] (**the GDS**)
- Operational Records Disposal Schedule - Department for Correctional Services (DCS) (and predecessor agencies) (**the RDS**).

148. The Adequate Records Management Standard (**the Standard**), issued by State Records provides a practical records management framework to support agencies to satisfy their obligation to maintain records in good order and condition and assists State Records in determining whether a matter must be reported to the Minister under section 16 of the State Records Act. Outcome 5 of the Standard provides that agencies must ensure official records are protected from unauthorised or unlawful access and that 'measures are in place to prevent 'loss, damage and destruction' of records'.[27]

149. It appears that the failure by DCS to locate the PMO, Admission checklist, Specific needs assessment, Prisoner interview form, Compatibility to Share Accommodation, Prisoner Health Information Form, PTS – Prisoner Declaration Access and use Conditions and Prisoner Health Information Sheet may amount to a breach of the State Records Act.

150. Therefore, I consider that the apparent loss of these records is contrary to law within the meaning of the Ombudsman Act. I will inform the Manager of State Records of this matter.

Opinion

In light of the above, my final view is that, in failing to retain official records, the department has acted in a manner that was contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.

The department has advised that the PAP General Manager, Mr Williams, has reiterated to staff the processes in place regarding document management responsibilities and that:

> With regard to document management processes more broadly, the department has already commenced action to improve its performance in this area. On 4 January 2018, I issued a Direction to the Department's Executive Director People and Business Services that the Department's records management processes were to be reviewed and strengthened. This Direction was issued in response to recommendations made by you in relation to an unrelated complaint lodged with your office, concerning the retention of documents.

As noted, I have recently made recommendations in relation to the retention of records and therefore will not make further recommendations here given this investigation relates to events that preceded those recommendations.

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[26] State Records of South Australia, *General Disposal Schedule No. 30, State Government Agencies in South Australia*, Disposal Schedule (Effective from 1 January 2016 to 30 June 2026) Version 1.1.

[27] State Records of South Australia, *Adequate Records Management Standard,* December 2013, Version 3.0, p 8.

Summary and Recommendations

In light of the above, my final view is that:

- by failing to comply with the Joint System Protocol and Standard Operating Procedure 001A Custodial- Admission-Case Management, the department acted in a manner that was wrong for the purposes of section 25(1)(g) of the Ombudsman Act
- by failing to accommodate three times daily access in a timely fashion or otherwise give proper consideration to transferring [X] to another prison facility, the department acted in a manner that was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act
- by failing to retain official records, the department has 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:

1. provide a further report on the progress of the following actions:
    - the review of food options available in prisons with reference to recommendations by Diabetes Australia
    - completion of the Diabetes Action Management Plan being formulated by the department and SAPHS.
2. amend its procedure regarding medical instructions to include:
    - an indication as to the level of urgency/seriousness of an instruction
    - a timeframe for compliance
    - a requirement that the department provide reasoning if a medical instruction cannot be complied with, including a timeframe for responses in this regard.

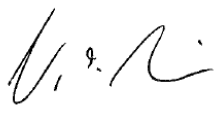
Final comment

In accordance with section 25(4) of the Ombudsman Act the department should report to the Ombudsman by **7 December 2018** 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.

I have also sent a copy of my report to the Minister for Correctional Services as required by section 25(3) of the Ombudsman Act.



Wayne Lines
SA OMBUDSMAN

6 September 2018