

**Final Report**  
**Full investigation - *Ombudsman Act 1972***

<b>Complainant</b>	Ombudsman 'own initiative' investigation, section 13(2) <i>Ombudsman Act 1972</i>
<b>Department</b>	Department for Correctional Services
<b>Ombudsman reference</b>	2014/08834
<b>Department reference</b>	CEN/14/1334; CEN/14/1335
<b>Date complaint received</b>	10 November 2014
<b>Issues</b>	<ol style="list-style-type: none"><li>1. Whether Prisoner A was shackled in accordance with departmental policy during a hospital visit</li><li>2. Whether the department acted contrary to law in failing to exercise the necessary discretion in relation to shackling Prisoner A during a hospital visit</li><li>3. Whether the shackling of Prisoner A was otherwise unlawful, unreasonable or wrong</li></ol>

### **Jurisdiction**

Following an approach from the Principal Community Visitor, the former Acting Ombudsman decided to conduct an own initiative investigation into the administrative acts of the Department for Correctional Services (**the department, DCS**), arising from the detention of Prisoner A under the *Mental Health Act 2009 (the Act)*.<sup>1</sup>

The matter was reported subsequent to a separate complaint from the Principal Community Visitor about the circumstances of another prisoner restrained in custody in the Royal Adelaide Hospital. That matter, designated the case of Prisoner B, is the subject of an ongoing investigation by my Office.

Following receipt of information relevant to Prisoner A's detention, I decided to conduct a full investigation into the matter.

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

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<sup>1</sup> For privacy reasons I have designated the prisoner concerned 'Prisoner A' for the purposes of this report. The prisoner is aware of my investigation and has given informed consent to the use of his medical records for my review.

## Investigation

My investigation has involved:

- seeking information from the department
- assessing the information provided by the department
- communicating with the Principal Community Visitor
- seeking further information from the department
- seeking information from the Mental Health Team based in the Emergency Department (ED) at the Royal Adelaide Hospital (RAH) and Glenside Hospital.
- considering the Department for Health and Ageing Directive Prisoners - Care and Treatment in SA Health Services', the Adelaide Remand Centre - Local Operating Procedure - *DCS Prisoners Housed at the City Watch House (LOP 62)*, the *DCS Standard Operating Procedure 13 - Prisoners at Hospital (SOP 013)*, the *Standard Operating Procedure 31 - Supervised Prisoner Escorts (SOP 031)*, the *Standard Operating Procedure 32 - Use of Restraint Equipment (SOP 032)*, Policy 42 *Management and Restraint of Mentally Unwell Prisoners* and the *Correctional Services Act 1982* and the *Mental Health Act 2009*.
- preparing a provisional report
- considering the department's and the Principal Community Visitor's responses to my provisional report
- considering the department's and the Principal Community Visitor's responses to my revised provisional report, and
- preparing this report.

## Standard of proof

The standard of proof I have applied in my investigation and report is on the balance of probabilities. However, in determining whether that standard has been met, in accordance with the High Court's decision in *Briginshaw v Briginshaw* (1938) 60 CLR 336, I have considered the nature of the assertions made and the consequences if they were to be upheld. That decision recognises that greater care is needed in considering the evidence in some cases.<sup>2</sup> 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  
...<sup>3</sup>

## Responses to my Revised Provisional Report

By letter dated 12 June 2015 I provided the Principal Community Visitor and the department with my provisional views in relation to the own initiative investigation. I requested they provide me with comments by 26 June 2015. The department requested, and I granted, an extension to respond by 10 July 2015. This was further extended by negotiation.

The department provided me with a detailed response to the provisional report by letter dated 8 September 2015. I carefully considered the department's submissions and amended my provisional report accordingly.

By letter dated 28 January 2016 I provided the Principal Community Visitor and the department with my revised provisional views in relation to the investigation. I requested they

<sup>2</sup> 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.

<sup>3</sup> *Briginshaw v Briginshaw* at pp361-362, per Dixon J.

provide me with comments by 29 February 2016. The department requested, and I granted, an extension to respond by 24 March 2016.

The Principal Community Visitor responded to my revised provisional report by email dated 24 February 2016. He accepted the findings and made comment and suggestions as follows:

- hospital clinical staff, inclusive of mental health clinicians working in the emergency departments, have made comment to the Principal Community Visitor about their distress in seeing DCS clients, who are patients within a hospital setting, being treated inhumanely
- [there should be] a means for mental health teams in [hospital] Emergency Departments to be able to escalate their concerns to a senior DCS manager and/or ask for a joint assessment of such patients in the future
- there needs to be a more immediate means of obtaining a review of DCS patients' restraints and one which is willing to consult with the mental health clinicians in the Emergency Department of health unit.

The department responded to my revised provisional report by way of letter from the Chief Executive dated 29 March 2016. A summary of his key comments is as follows:

- whilst the department previously acknowledged the errors in relation to the SOP 013 compliance checks it did not accept the errors associated with SOP 032 in the submission made in response to the provisional report
- the department does not consider that a compliance check undertaken two hours outside of the 24-hour period to be a serious breach of the SOP
- the department agrees with the foreshadowed recommendation to streamline DCS Hospital Watch procedures to ensure they are operationally achievable and practical
- the department intends to increase the number of persons undertaking compliance checks
- the department does not agree that the Deputy Chief Executive (DCE) is the most appropriate person to be reviewing and signing off and intends to maintain current practice whereby the General Manager (GM) will be the compliance authority
- the department will update compliance check procedures with a telephone call arrangement whereby the GM can authorise a decrease or increase in restraints
- on review, the department finds that SOP 032 (use of restraints) is worded ambiguously to imply application to all prisoners and intends to clarify to limit the application of the SOP to a prison setting only
- the safety of staff, the public and the prisoner is the department's paramount consideration when exercising discretion about the use of force [level of restraint] in an unsecure location
- the level of restraint used was commensurate with the fact that Prisoner A was a secure custody prisoner
- the department notes that a prisoner detained under the Mental Health Act remains in the custody of DCS, however the care and control of the prisoner, until the order is revoked, is the responsibility of the Department for Health
- the department states that Prisoner A was not admitted to the RAH as a voluntary patient and notes the Level 1 and Level 2 *Inpatient Treatment Orders* in place
- the department disagrees with the provisional finding that the act of restraining Prisoner A during his hospital admission was contrary to law or wrong
- the department welcomes the foreshadowed recommendation requiring compliance officers to report any apparent injury to the GM and to liaise immediately with the nursing/medical team to ensure any injuries are treated
- the department undertakes to revise the Hospital Compliance Checklist for Hospital Watches to include this requirement
- the department reports that development of a soft form of restraint that is suitable for use in non-secure locations such as hospitals has progressed and is at the point of development of a prototype locking mechanism.

I have carefully considered the Principal Community Visitor's comments and the department's further submissions. I have amended my final report accordingly.

## Background

1. Prisoner A was remanded in custody on 27 October 2014, on charges of Threaten to Kill or Endanger Life. He was initially placed in the City Watch House. On 1 November 2014 Prisoner A was placed in an observation cell due to his confused state. On 3 November 2014, he was placed in a soft cell after 'lunging' at an officer who had attended to investigate why he was banging on his cell. Later that day he was returned to the observation cell and placed on canvas. This means he was placed in a canvas smock and provided with a canvas mattress and canvas blankets only.
2. The department has advised that all Adelaide Remand Centre (**ARC**) operating procedures (LOP 62) were followed during his admission and detention at the City Watch House.
3. On 4 November 2014, Prisoner A was transferred to the ARC Infirmary. On 6 November 2014 he was found to be dancing around his cell, falling down and getting back up. He was found naked and was asked by a nurse and a Correctional Services Officer to get dressed. He placed his underwear on and then curled up in a foetal position on the floor. He was later warned about pushing the television on the floor. The television and other items were subsequently removed from his cell. Due to his strange behaviour, Prisoner A was seen by a doctor, who determined that he be detained under the *Mental Health Act 2009*. He was conveyed to the ED at the RAH and a hospital log commenced at 1.25 pm on 6 November 2014. He was taken from the RAH to Glenside Hospital at 5.40pm on 10 November 2014.
4. The department has provided the following information about the restraints used on Prisoner A during his stay in the RAH:

The initial Prisoner in Hospital (Profile and Information Sheet) indicates the following restraints to be used:

- Leg Restraints used between legs;
- Leg Restraint to bed
- One hand cuffed to bed frame (not rail);
- Flexi Cuffs to be used when metal restraints prevent medical procedures; and
- Leg Restraint used when prisoner is out of bed.

The restraints used were reviewed at the following times:

- 7 November 2014 at 6.30am;
- 7 November 2014 at 6.30 pm;
- 8 November 2014 at 8.35 pm, and
- 9 November 2014 at 9.15 pm.

## *Psychiatric diagnosis*

5. Justice Information System (**JIS**) case notes provided by the department show that Prisoner A was admitted to the City Watch House on 27 October 2014. The officer admitting Prisoner A administered a standard stress screen test which resulted in a high score of 11. A Notification of Concern (**NOC**) was raised.
6. A JIS file entry for 28 October 2014 was made by the High Risk Assessment Team of the SA Prison Health Service (**SAPHS**). It said, in part:

Prisoner A had a somewhat disheveled appearance, also appeared anxious - speaking quickly verbose, good eye contact. Reports medication compliance for mental health issues and was concerned about continuing to receive appropriate medication while imprisoned. Risk factors identified: Psychiatric history: diagnosed with paranoid schizophrenia and drug/alcohol induced psychosis. Reports current mild hallucinations ...He was concerned that he had not had his medications...Previous suicide attempt: 2004 stabbed himself in the stomach in response to paranoid delusion. Recent stressor: has had his son staying with him on home detention, states that he is violent and has been hard to control. Prior to this had also been living alone 12 years. Drug use...sleeping poorly...[Some] protective factors identified.

7. Dr Hamid's medical examination and handover notes from 6 November 2014 are in the RAH admission records. They say:

[Prisoner A] has been observed in prison for the past 3 days with deteriorating mental state and odd behaviour on the background of schizophrenia...

He was previously able to hold a reasonable conversation with prison staff. No intelligible conversation held today. Patient appeared confused and perplexed. He did not answer the questions and there is evidence of tangentially. No insight. Patient willing to go to hospital for further psychiatric assessment.

8. The admission record shows his relevant past medical history, including occurrences of schizophrenia, depression and substance abuse with alcohol. The provisional diagnosis is recorded as 'relapse of schizophrenia'.

### *The department's investigation*

9. By letter dated 3 December 2014 my predecessor wrote to the department advising the Chief Executive of an Ombudsman preliminary investigation into the shackling of Prisoner A at the RAH. The Chief Executive replied to this correspondence on 19 December 2014 advising that the department's Ethics, Intelligence and Investigations Unit (EIIU) was then undertaking a full investigation in relation to this and a related matter 'to assist with the [Ombudsman] investigation'.
10. In February 2015 I was advised that the EIIU investigation had commenced in late January 2015, and that the investigation report would be forwarded to me by 10 March 2015.
11. On 5 March 2015 I received advice from the Chief Executive about Prisoner A's admission to the RAH and the manner and review of his restraint regime whilst in the hospital. The letter also referred to previously provided copies of SOP 013 (Prisoners at Hospitals) and SOP 031 (Supervised Prisoner Escorts).
12. My Office subsequently made enquiries with Mr Bill Kelsey, Director of the EIIU. Mr Kelsey was asked to provide:
- a copy of the EIIU investigation report
  - copies of the Compliance Officer reports for Prisoner A's stay in the RAH
  - copies of the case notes and any incident reports made by the Correctional Officers on duty during his stay in hospital
  - numbers and seniority of Correctional Officers on duty at any given time in the RAH
  - copies of the information provided to date by Health SA to the EIIU investigation
  - details of any unmet requests for information from SA Health.
13. The EIIU investigation report, dated 9 February 2015, notes irregularities with compliance checks undertaken by DCS staff during the period of Prisoner A's stay at the RAH. It states that the report:

is submitted as a preliminary investigation and a number of persons who are currently unavailable will need to be interviewed regarding possible non-compliance with the Standard Operating Procedures. A number of Officer's Reports have not been received.

14. The EIU investigation report attaches JIS Offender Case Notes and a number of completed Compliance Checklist for Hospital Watches forms and DCS Compliance Officer restraint review forms for Prisoner A's four-day stay in the RAH. All restraint review forms recommend 'the levels of security to remain in place at this present time'.

### Relevant law/policies

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

3.1.3 Once a prisoner, on an unplanned escort, has been admitted to a hospital, the General Manager must ensure that the review process for a planned escort in accordance with SOP 031 Supervised Prisoner Escorts is followed. The review must take place as soon as practicable and no later than noon the following business day.

3.1.4 General Managers must review any recommendations by the Compliance Officer on the level of restraints used on a prisoner in hospital on a daily basis and the appropriateness of the current restraint regime and if a change is required....

3.4.1 When a prisoner is admitted to a hospital, escort officers must:

...c) if the prisoner is to be secured, the prisoner must be secured in the following manner in accordance with the "Standard Requirements" SOP 031 Supervised Prisoner Escorts...

<b>Unplanned - Restraints used in Hospital-(Admitted or in Accident/Emergency, etc).</b>
<b>Secured Custody Prisoners</b>
c) Hand secured to bed frame using closeting chain and,
d) Legs must be shackled together and,
e) Leg must be cuffed to the bed frame.
<b>Open Custody Prisoners (CTC, Mulga, PLP Low Security Unit)</b>
f) Leg must be cuffed to the bed

3.6.14 General Managers must use discretion in determining the level of restraints used on a prisoner. General Managers may consider that for medical reasons, a prisoner does not constitute a threat to hospital staff or the community and there is little risk of escape or any action that may cause any liability to the Department or any unnecessary distress to medical staff. As an example, this would apply where a prisoner has suffered severe trauma and is unlikely to recover...

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

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

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

- 3.10.3 General Managers must review these recommendations daily during business hours and determine whether to vary the restraint level or not and this decision must be recorded on the Form F013/002 Compliance Checklist for Hospital Watches (Hospital Escorts) and endorsed by the General Manager and also recorded in the hospital watch logbook by the Compliance Officer. Level of restraints must not change until officers receive the signed paperwork unless situation meets section 3.6.3 or 3.6.10 of this SOP.
- 3.10.4 Compliance Officers are to check the DL: DCS Hospital Watches and Escorts daily for updates on prisoners in Hospital.
- 3.10.5 Outside of business hours, if the Compliance Officer considers it urgent to vary the level of restraint then they should contact the relevant General Manager directly...
16. SOP 031 prescribes procedures to be followed whilst escorting prisoners outside the secure perimeter of departmental institutions. Paragraph 3.3.2 provides:

...For unplanned escorts to non-secure locations (e.g. Hospital, doctors Surgery, etc) the "Standard Requirements" must be adhered to:

**Unplanned Escorts "Standard Requirements"**

...

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

17. SOP 032 prescribes the procedures to be used by departmental officers designated with the responsibility of using restraint equipment. The following paragraphs are relevant to this investigation:

3.4.1 Officers applying restraint equipment must ensure the following:

- a) that the application causes minimum discomfort to the prisoner and the prisoner's blood circulation is not impaired;
- f) officers must be observant of any change in the condition of the prisoner and release weight as soon as any sign of trauma are exhibited; and,
- g) the prisoner must be able, at all times, to relieve the pressure on the body part to which the restraint equipment is applied.

...

3.4.3 Restraint equipment must only be applied for as long as it is strictly necessary to maintain the security and/or protection of the prisoner, or for the protection of employees, other prisoners, prison property or the community.

...

3.5.4 If the use of restraint equipment exceeds an 8-hour period for any reason, the Manager/delegate should contact the Deputy Chief Executive Statewide Operations for approval for continued use of the restraints.

18. Section 86 of the Correctional Services Act provides:

Subject to the Act, an officer or employee of the Department or a police officer employed in a correctional institution may, for the purposes of exercising powers or discharging duties under this Act, use force against any person as is reasonably necessary in the circumstances of the particular case.

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**Whether Prisoner A was shackled in accordance with departmental policy during a hospital visit**

19. Prisoner A was admitted to the RAH and a Hospital Log Watch was commenced at 1.25pm on 6 November 2014. I am advised by the department that DCS forms (F013/002) for the compliance checks were submitted for the following dates and times:
  - 7 November 2014 at 6.30am submitted by Brian Pumfrey (ARC)
  - 7 November 2014 at 6.30pm submitted by Trevor Endhoven (YLP)
  - 8 November 2014 at 8.35pm submitted by Greg Paine (AWP)
  - 9 November 2014 at 9.15pm submitted by Trevor Endhoven (YLP).
20. The department advises me that the two compliance checks submitted by Trevor Endhoven were submitted in accordance with procedures but that: 'the other 2 documents were not'.
21. Paragraph 3.10.1 of SOP 013 prescribes the procedures to be followed for the Review of Restraint Levels for all Prisoners in Hospital. In the case of Compliance Officers Pumfrey and Paine, the forms were not submitted as required. The DCS record shows that the review of restraint levels for 8 and 9 November 2014 were conducted outside the 24-hour timeframe mandated by the SOP.
22. I consider that the department erred in failing to complete the compliance check within the timeframe required under SOP 013 on Saturday 8 November and Sunday 9 November 2014.
23. During the course of my investigation, Compliance Officer Paine advised my Office that he was not aware of the timing of the previous day's restraint review. As a consequence, he said he was unaware that he was outside the 24-hour limit when he conducted his review on 8 November 2014.
24. His point is noteworthy. If there is no previous record accessible to a DCS officer having responsibility for the conduct of restraint reviews, there is an obvious risk that the system check for compliance within the 24-hour rule becomes lax. I consider Compliance Officers should have access to the record of the previous review at all times.
25. DCS have submitted that travel time can be a determining factor for what time officers are able to undertake compliance checks. As a result of this investigation, DCS has stated that it intends to increase the number of persons undertaking compliance checks, which, it says, 'should enable checks to occur within the requisite 24-hour time period'. I welcome that commitment.
26. Whilst I acknowledge the issue raised about transport times between various hospitals, I consider that the logistics of Compliance Officer travel arrangements are a clear responsibility for the department to manage. In my view, the 24-hour rule is not aspirational but mandatory.
27. DCS have also advised me that they will review SOP 013 to determine if changes are necessary to ensure random compliance checks are undertaken once in each 24-hour period. The department says the purpose of the review is to ensure staff and prisoners are unaware of the exact times for the compliance check.
28. The relevance of prisoner knowledge of compliance check timing is unclear to me. Compliance Officers check on the maintenance of required security arrangements by Correctional Officers and review the restraint regime to recommend retaining, decreasing or increasing the levels of restraints to the relevant prison General

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Manager. The issue raised in this report is the fact that Compliance Officers did not know when the previous check had been undertaken. Officer Paine said that is why he did not know he was over the 24-hour limit. In my view, this is also a procedural compliance matter and should be the subject of a mandatory record in the Hospital Watch Log Book or similar. The log has to be accessed by the next Compliance Officer to ensure that their visit is within the 24-hour rule. Currently, the DCS system seems to have none of these controls in place.

29. I consider this to be a more serious matter than a 'technical' breach of a review done a few hours outside the limit. I understand the rationale for paragraph 3.5.4 of SOP 032 is that restraint compliance check rules are to be carefully monitored by senior management.
30. As noted above, paragraph 3.5.4 of SOP 032 requires approval from the Deputy Chief Executive Statewide Operations for continued use of restraints if the use of restraint equipment exceeds an 8-hour period 'for any reason'.
31. In considering my revised provisional report, the department has disagreed that the Deputy Chief Executive Statewide Operations is the most appropriate person to be reviewing and signing off for compliance with Procedures. I have proposed this in every case where DCS restraints are used in a hospital environment.
32. The department states that 'the relevant General Manager would be the most appropriate due to their local site knowledge of the prisoner's behaviour and personal situation'.
33. I do not have any difficulty with initial sign off remaining the responsibility of the prison General Manager. Indeed, I consider it important that prison General Managers are taking active responsibility for compliance with Procedures regarding the use of restraints. However, I consider that an additional check is required at the level of Deputy Chief Executive Statewide Operations for two reasons.
34. First, the proposal is consistent with the requirement at 3.5.4 of SOP 032 where the Deputy is required to approve continued use of restraints for periods longer than 8 hours. As such, the department already considers that the Deputy is the appropriately senior delegate to decide on continued application of restraints after a relatively short period of use. The seniority of the decision maker is a clear signal of the importance of the decision to seek approval for the continued the use of restraints.
35. Second, the inclusion of the Deputy Chief Executive as the authority to sign off the Hospital Watch Log Book in cases where DCS restraints are used in a hospital environment is intended to be a serious quality control check. As this investigation, and previous investigations done by my Office have demonstrated, there have been a number of occurrences where restraints Procedures have not been followed. The department has admitted to errors in this respect. Adding a senior level of departmental scrutiny to the management of restraints used in a hospital environment is not an unreasonable requirement. It is intended to encourage improved compliance and should not be onerous as a retrospective check on the performance of hospital watch practices.
36. I turn now to the direct relevance of SOP 032 in this case. The Procedure is clear in its intent. It states unequivocally that 'restraint equipment must only be applied for as long as it is strictly necessary to maintain the security and/or protection of the prisoner...'

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37. I note that the department has contested my consideration of compliance with SOP 032 on the grounds that the Procedure should apply only in a secure custodial setting. The department also submits that this case relates to a prisoner 'on escort' who has been 'restrained in relation to a number of risk factors'.
  38. I do not accept this interpretation of the Procedure. First, SOP 032 makes a clear reference at 3.9.1 to restraints 'used in a hospital'. This is outside the 'secure custodial setting' cited by DCS. Second, the department contends that SOP 032 does not apply to prisoners 'on escort'. In my view, prisoners held for days on end in a hospital environment cannot be said to be 'on escort'. Rather, the department is effectively creating a *de facto* 'secure facility' by restraining prisoners using the Unplanned Escorts 'Standard Requirements'.
  39. I note that, in response to my revised provisional report, the department now concedes that 'section 3.5 [of SOP 032] can be interpreted to apply to all prisoners, whether in custodial setting or otherwise'. However, the Chief Executive then comments that 'the intention of this section is that it apply only in a prison setting'. He advises 'that SOP 032 will be reviewed and revised to ensure that this is clarified'. In other words, the Chief Executive states his intention to ensure that the higher standards of accountability that he agrees should apply to use of restraint equipment in secure locations, should not apply in non-secure locations. He implies that the risk of escape is the defining factor in this differential approach.<sup>4</sup>
  40. In my review of SOP 032, I can find no requirement which in any way fetters the security level that should apply to a prisoner in a hospital setting. Rather, the emphasis is on prisoner safety and effective use of restraints. The clear intent of the Procedure is to ensure that there are appropriate controls around the use of restraint equipment with prisoners. This is presumably why 3.5.4 mandates the 8-hour review rule. I see no reason why the safeguard 8-hour rule should not apply as an appropriate procedure for the safe use of restraint equipment within the hospital environment. In my view, clause 3.5.4 attempts to regulate a balance between security considerations and the rights, dignity and comfort of the prisoner as a patient in hospital. The safety/security balance should apply wherever the prisoner is held.
  41. I note that the investigation report from the EIU has not examined this aspect of compliance with SOP 032. I assume this is because departmental officers do not consider the Procedure to apply. As such, I have no evidence before me that that any request was made to the Deputy Chief Executive Statewide Operations to continue the use of restraints with Prisoner A during his stay at the RAH.
  42. It is my final view that the department erred in failing to observe the 8-hour restraint approval rule with senior management as required by SOP 032.
  43. As the former Ombudsman has expressed in several previous reports to the department, I consider it important that the Procedures relating to the restraint of prisoners are carefully adhered to.
  44. For this reason, I consider that the current arrangements to ensure compliance need to be tightened up to include a review of procedure after the hospital stay and hospital watch have concluded. If there is any doubt within the department that SOP 032 applies to prisoners secured in a hospital setting, this should be clarified in the affirmative.

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<sup>4</sup> As noted below, it is at least arguable that the current 3-point minimum restraint regime mandated for hospital admissions is an overreaction to a number of escape attempts. I understand that, prior to 2011, the minimum standard restraint regime was 1-point.

## Conclusion

In light of the above, my final view is that the department, in failing to adhere to SOPs 013 and 032 acted in a manner that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

The department has acknowledged the errors in relation to SOP 013 compliance checks. However, it has not accepted the errors associated with SOP 032, arguing instead that the procedure is currently worded poorly and should be revised so as not to apply in non-prison settings. I have explicitly rejected this conclusion as incompatible with the safe and humane management of prisoners.

To remedy the errors identified, I make the following recommendations under section 25(2) of the Ombudsman Act, that:

1. the department streamline DCS Hospital Watch procedures to ensure Watch Officer, Compliance Officer and Senior Management responsibilities meet all requirements, including the 24-hour rule, without exception
2. the Hospital Watch Log Book be reviewed as soon as possible after the prisoner's release from hospital and signed off for compliance by the Deputy Chief Executive Statewide Operations in every case where DCS restraints are used in a hospital environment
3. SOP 032 'Use of Restraint Equipment' be immediately revised to incorporate a clear statement that the procedure applies to hospital watch situations as well as to secure facility situations.

### Whether the department acted contrary to law in failing to exercise the necessary discretion in shackling Prisoner A during a hospital visit

45. Section 86 of the Correctional Services Act provides that an employee of the department, in the performance of their duties, may use force against any person as is reasonably necessary in the circumstances of the particular case. In other words, there is a legislative requirement for departmental officers to assess what force is reasonably necessary in the circumstances of each particular case.
46. SOP 013 and 031 provide that the 'Standard Requirements' for unplanned escorts must be applied and these prescribe a high level of restraint upon admission to hospital in such circumstances. By mandating the shackling of prisoners, the Procedures do not allow for an assessment of what is reasonably necessary in the circumstances of the particular case. In my view, the Procedures are therefore *ultra vires*.
47. In his report dated July 2012 entitled 'Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shackling of prisoners in hospitals', the former Ombudsman found that the Executive Director's Instruction in place at the time was *ultra vires* for the same reason.<sup>5</sup> In response, the department amended SOP 013 and prepared SOP 031. Whilst some positive amendments were made at that time, the Procedures still require prisoners to be shackled for unplanned escorts.

<sup>5</sup> Report: Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shackling of prisoners in hospitals, July 2012, para 59. <http://www.ombudsman.sa.gov.au/publications>.

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48. I note that paragraph 3.6.14 of SOP 013 provides the General Manager with a discretion as to shackling and, as such, it is consistent with section 86 of the Correctional Services Act.
  49. That said, I reiterate my predecessor's view, set out in another report regarding the shackling of a prisoner in hospital in 2014<sup>6</sup>, that, in providing for the mandatory use of restraints prior to the General Manager reviewing a compliance check, the SOPs are *ultra vires*. This may result in an unnecessary and unreasonable use of force on prisoners for some time (approximately 24-hours or, in the case of admittance prior to a weekend, for 2-4 days).
  50. I note that the DCS response to my revised provisional report highlights prisoner security and asserts that the safety of the public is the paramount consideration in the use of restraints. To be clear, I am not suggesting that the prisoner should be unrestrained in hospital.
  51. However, there is a legislative requirement that a discretion is exercised as to what level of restraint is reasonably necessary and, in this case, that discretion was not exercised. Rather, hand and leg restraints were applied upon admission to hospital (as required by SOP 013 and SOP 031).
  52. The department takes the view that its priority is to stop escape from hospital. Whilst this is entirely reasonable and responsible, the current minimum requirement is that hard shackles are applied to one hand and both legs. This militates against the exercise of discretion and discourages an alternative arrangement that may satisfy both security and well-being needs.
  53. The department states that soft restraints are not considered as part of the restraint mix 'because they are designed to immobilise a person to stop a self-harming episode [and the soft restraint] totally restricts movement'.<sup>7</sup> I am of the view that such a mix should be considered, particularly in a situation where the flight risk is low, where there is at least one leg shackle in place secured to the bed frame and where there is clear evidence of injury or potential injury, as in this case. In such a situation, restricting movement using a soft restraint at least has the advantage of preventing further injury. An alternative may be to remove the hand restraint entirely, or for periods of time.
  54. I understand that prison General Managers have, on some occasions, approved a reduction in the level of restraints where this has been warranted - or where hospital clinicians have recommended that a high restraint level was harmful to the prisoner's wellbeing. However, the practice seems not to be consistent or frequent.
  55. I am advised that South Australia has very high restraint levels in place compared to other jurisdictions. This is well known as a consequence of some recent high-profile escape attempts. The reaction to these attempts was to significantly elevate the restraint regime from 1-point minimum to a 3-point minimum. It is timely that the 'standard requirement' 3-point restraint regime be reviewed by the department to consider an approach that requires an individual assessment of the prisoner's risk(s).
  56. In this instance, I remain satisfied that, in failing to exercise any discretion as to what force was 'reasonably necessary' in the circumstances, the department acted contrary to section 86 of the Correctional Services Act.

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<sup>6</sup> Report: Ombudsman investigation into the Department for Correctional Services in relation to the shackling of a prisoner in hospital, 19 May 2014, para 59. <http://www.ombudsman.sa.gov.au/publications>.

<sup>7</sup> Email from M. Reynolds to Ombudsman SA, 1 April 2016.

## Conclusion

In light of the above, I consider that, in failing to exercise any discretion as to what force was 'reasonably necessary' to use on the complainant upon his admittance to hospital, the department acted in a manner that was contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.

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

4. SOP-031 be amended to provide for the exercise of delegated discretion determining what an appropriate level of restraint should be at the time the prisoner escort and hospital admission procedures have been completed.

## Whether the shackling of Prisoner A was otherwise unlawful, unreasonable or wrong

57. In the course of my investigation, clinical and administrative staff from the Mental Health Team RAH ED were interviewed about details of Prisoner A's confinement in hospital between 6 and 10 November 2014. My Office requested case notes and other information held by SA Health relevant to Prisoner A's treatment in hospital.
58. One document that came to light was a SA Health Incident/Event Investigation/ Review Form generally known as a SLS Incident Report (**the SLS report**). The notification was dated 9 November 2014 and had been reported by a Clinical Nurse on duty in ED at that time. The SLS report described the incident as follows:
 

Detained Patient from the Adelaide Remand Centre, Day 4 in the RAH ED. Patient is restrained to his bed by metal shackles, one ankle and one wrist at a time. Skin abrasions to bilateral wrists and bilateral ankles from the shackles. Guards alternating shackles due to damaged skin.
59. The SLS report noted that the patient had been restrained 'greater than 12 hours' and had been 'injured' by the restraints. A photograph of Prisoner A's injured left arm was attached to the SLS report when SA Health managers reviewed the matter at a later date. The photograph was provided to my investigator and is attached to this report as Appendix A.<sup>8</sup>
60. In a section of the completed SLS report marked 'Management' the following comments are recorded:
 

These wounds were not caused by Shackles - they were caused by Metal Handcuffs as the Patient was in Custody. I have asked for direction...as we are unable to control how these devices are managed in the ED. I have yet to see any response. I have attached a photograph of the injuries.
61. Another section of the report is marked 'Reviewer(s)' and contains the following from the Mental Health Team Clinical Coordinator:
 

The consumer was awaiting closed bed allocation, corrections guard had consumer handcuffed as the consumer was in custody. Mental Health staff act as advocates to the consumers within the department, however the Corrections and Forensic team manage their devices independently.

A further entry is made by the Medical Consultant:

<sup>8</sup> The photograph was taken by the Clinical Services Coordinator Eastern Acute Services at Glenside Hospital on 14 November 2014, four days after Prisoner A's discharge from the RAH.

After ED medical assessment, such psychiatric patients should be transferred to more appropriate facilities for their ongoing care. An overcrowded noisy ED with multiple sick medical patients in close proximity is not the right place to care for these patients. In order to keep patients and staff safe, agitated patients need to be chemically and physically restrained. This is to the detriment of the unwell psychiatric patient. Spending 4 days in such an environment is inhumane. Psychiatric patients having prolonged (1-7 days) ED stays is a daily occurrence, so LIKELIHOOD is FREQUENT. I would argue that the CONSEQUENCE is at least MODERATE, but it is difficult to measure the psychological damage that this treatment has caused.

A later entry by the same Medical Consultant is part of an email to colleagues:

Happy to give any one a tour of ED to show you what our psychiatric patients have to experience on a daily basis.

62. RAH case notes from ED general and mental health nursing staff on 8 November 2014 respectively state:

Patient is extremely agitated pulling at shackles...banging handcuffs around...

Prisoner A has had periods of unsettled and agitated behaviour. This is partly due to current mental state and his length of stay in the ED and inability to walk around...

63. The EIU Investigation report from the department notes that on 9 November Corrections Officers MacGillavray and Hackett made a report which indicated that:

one of the RAH nurses had shown concern about skin bruising and some abrasions caused by restraints. The officers advised that the restraints were not tight but injuries had occurred due to a long period of restraint. Nursing staff were more concerned with getting Prisoner A to JNH and advised correctional officers about the availability of hospital restraints, should they be required. The issue was raised with Mr Trevor ENTHOVEN at 9.00 pm (recorded as 9.15 pm by Mr ENTHOVEN) when he conducted his compliance check. Restraints were not altered.

64. Questioned for this investigation about the background to her SLS report made on the same day, the Clinical Nurse stated that:

The Mental Health Team often has concerns about the use of hard shackles for prolonged periods of time by DCS officers and sometimes asked them if patients could move more freely. [She says] DCS officers always said no. [She noted] that hospital shackles were available - a soft form of restraint.

65. Mr Terry Nelson, the investigator for the department's EIU, said that no injury to Prisoner A was reported to his knowledge to either DCS or to medical staff. Any report, he said, should be in the handwritten hospital logs. He said his investigation had found the Corrections Officer logs to be scant in detail. An injury, he said, should have been picked up in the compliance checks.
66. I agree with Mr Nelson's assessment. Prisoner A's injury should have been picked up in the restraint compliance checks. It is apparent to me that despite the commendable report made by Officers MacGillavray and Hackett and the advocacy of nursing staff and the Mental Health Team, Mr Enthoven made the decision not to alter the hard shackle regime for Prisoner A.
67. In his response to questions from my investigator, Mr Enthoven stated that his duties as a Compliance Officer involved staff rules, paperwork and a check on whether the restraints are applied correctly. This involves a 24-hour restraint 'review' which results in completion of the 5-page compliance check document - usually done the next day. The review requires the officer to document any restraint change and the reason for it, if any.

68. Mr Enthoven stated that he does not recall the offer apparently made by medical staff to provide 'hospital cuffs' to ease the restraints on Prisoner A. Asked if he remembered any injury to Prisoner A's arm, Mr Enthoven said: 'no, I don't'. After consulting his notes from the 9 November 2014, he read an entry, which records that, 'the restraints [are] starting to cause bruising and red marks'. He explained that sometimes when this happened the nurses would supply binding for the area underneath the metal cuff to cushion the chafing impact. In response to a question about this length of time in restraints being possibly detrimental to the patient, Mr Enthoven commented that some prisoners are held in restraints for months.
69. An admission case note from Glenside Hospital dated 10 November 2014 (after the restraints were removed) records 'what appear to be marks on wrists, ankles due to cuffs'.
70. One week later, on 17 November 2014 nursing staff made the following case note:

[Prisoner A] remains polite and compliant socialising with other patients appropriately. Removed his [left] wrist dressings. 2-3 areas of red granulating tissue, bleeding present when gently cleaned with medisponge, painful to the touch re-dressed with melolite and crepe bandage and hyperfix.

On 26 November 2014, Glenside staff made a case note that said Prisoner A's 'wrists [are] healing well'.

#### ***Action taken by the department***

71. In my view, there is no evidence that the department considered in any detail how, whilst at the RAH, Prisoner A could be managed in a safe manner that did not require him to be restrained for four days. I accept that the risk of un-restraining him was moderate, and that the department may have been concerned to ensure he did not self-harm. Nevertheless, the evidence before me indicates that options of providing some time un-restrained, lessening the restraints or accepting the hospital offer of soft restraints, were simply not explored. As a consequence, Prisoner A suffered an unnecessary injury.
72. Further, there is no evidence that the department considered whether the restraint regime was compliant with SOP 032 requirements or consistent with the national and international standards recognised by the department and the Government of South Australia.
73. Section 24 of the Correctional Services Act provides the Chief Executive with absolute discretion regarding the placement of prisoners and the authority to set and vary regimes. Section 86 of the Correctional Services Act authorises the department to use force against prisoners in certain circumstances. Balancing that authority, the department sets rules within the parameters of state law, and national and international standards, to regulate the use of force, including restraints.
74. As noted above, the department's SOP 032 - 'Use of Restraint Equipment'<sup>9</sup> requires that restraint equipment must only be applied for as long as necessary to maintain the security and/or protection of the prisoner. If the use of restraints exceeds an 8-hour period for any reason, the Manager/delegate must contact the Executive Director Custodial Services for approval for continued use of the restraints. In this case the SOP was not observed and appears not to have been considered. This is relevant because

<sup>9</sup> SOP 032 Version 2.1 is dated 25/10/2013 and scheduled for review by 25/10/2014. In June 2015 the department advised my Office that the review had not yet been done. As per the Chief Executive's advice to me dated 29 March 2016, a further commitment to review and revise the SOP has now been made.

in my view, SOP 032 does not contemplate a situation where a prisoner is restrained continuously for long periods of time.

### ***National and international standards***

75. In the former Ombudsman's 2012 Report into the restraining and shackling of prisoners in hospitals, he referred to the established international and Australian standards on the use of restraints and concluded:

In summary, the international and national standards and practice acknowledge that there are instances where the restraining of prisoners is necessary to protect the prisoner or the public. However, it is also universally accepted that in these instances prisoners must be restrained for the minimum time necessary, and with the least restrictive type of restraint possible.<sup>10</sup>

76. In addition, Mr Bingham noted that there is an emphasis on treating prisoners humanely. He cited Article 10 of the International Covenant on Civil and Political Rights as an example:

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

77. Further, the Standard Guidelines for Corrections in Australia<sup>11</sup> make it clear that a balance must be struck between public safety and the proper treatment of the prisoner. Guideline 1.28 states a commitment to a prisoner safety regime which: (iv) 'places prisoners in situations which minimises the opportunity for them to be harmed, or for them to harm others'.

78. The former Ombudsman also noted that prisoners with mental health issues add complexity to the issue. The World Health Organisation's guide for the management of prisoners' health called 'Health in Prisons, a WHO Guide to the Essentials in Prison Health'<sup>12</sup> provides:

#### **Physical restraint**

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

However, there may be instances where some form of restraint must be applied for medical reasons, such as acute mental disturbance in which the patient is at high risk of injuring themselves or others. The decision to use restraints for such purposes must be decided upon by the prison doctor and health staff alone, based purely upon clinical criteria, and without influence from the non-health prison staff.

79. I agree with my predecessor's view that:

Particularly for people with mental illness, the minimum standard should be that shackles not be used unless they are absolutely necessary for reasons of safety given the individual circumstances relating to the individual prisoner. People with mental illness

<sup>10</sup> *Op cit.* Report: Ombudsman investigation July 2012, para 35.

<sup>11</sup> Standard Guidelines for Corrections in Australia, Revised 2012, [http://www.aic.gov.au/criminal\\_justice\\_system/corrections/reform/standards.aspx](http://www.aic.gov.au/criminal_justice_system/corrections/reform/standards.aspx).

<sup>12</sup> Health in Prisons, A WHO Guide to the Essentials in Prison Health, World Health Organisation, 2007.

should be afforded humane treatment, irrespective of any crime they may have committed or any lack of appropriate facilities for their treatment.<sup>13</sup>

80. In its response to that report, the department concurred with these comments.
81. In a subsequent investigation report dated 24 April 2013,<sup>14</sup> my predecessor recommended that the department, in consultation with mental health services, develop and implement a policy in relation to the restraint and associated management of mentally ill prisoners. He said the policy should align to the quality standards that apply to the use of restraints of mentally ill patients in hospital that aim to minimise the use of restraints for mental health reasons. The policy should also include procedures to be taken if a mentally ill prisoner requires restraints to be applied for periods exceeding 24-hours.
82. I note that the policy was developed by the department in October 2014 in line with the recommendation made in April 2013, but was not implemented until March 2015. As such, the policy was not officially in place for the period of Prisoner A's stay in the RAH.
83. I acknowledge that one of the department's concerns was to ensure Prisoner A remained safe from self-harm. I note also an underlying issue was the lack of an available mental health bed at James Nash House - or indeed at Glenside Hospital where Prisoner A was eventually admitted on 10 November 2014.
84. The issue of availability of mental health beds in South Australia has historically been a problem of scarce resources. I am advised that, at the time of Mr A's admission to the RAH, James Nash House was full and the situation was not much better at Glenside Hospital. At that time, High Security Inpatient Services (which encompasses James Nash House and the Kenneth O'Brien Rehabilitation Unit) had all 40 high security beds fully occupied.
85. In these circumstances, it was extremely difficult for DCS to secure a bed in either location at short notice. Whilst I understand that additional beds have now been commissioned at James Nash House, referrals to Forensic Mental Health Services can still mean a stay in the RAH. Without a guarantee of placement within, say, 24-hours, there is an ongoing risk of medium term confinement in the 'inhumane' circumstances of hard shackle restraint in the RAH Emergency Department. I am hopeful that health authorities will address this issue with the commissioning of the new RAH later in 2016.
86. That said, I consider that it was not 'reasonably necessary' to shackle Prisoner A in the manner he was by the department throughout his hospital stay. I understand that Prisoner A was admitted to the RAH in a compliant state.<sup>15</sup> The SA Prison Health Service case notes for his psychological assessment at the RAH, dated 6 November 2014, state:
- Not detained as patient cooperative - willing to go to hospital. Alert, compliant.
87. Whilst Prisoner A's behaviour was sometimes described as confused and erratic, there is no record of any attempt to self-harm or to harm others during his confinement at the Watch House, the ARC or the RAH. Indeed, for most of his stay at the RAH Prisoner A was heavily sedated. Whilst I note the report that he apparently attempted to force his

<sup>13</sup> Report: Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shackling of prisoners in hospitals, July 2012, para 107.

<sup>14</sup> Report: Ombudsman Report: Ombudsman investigation into the Department for Correctional Services in relation to the wrongful restraint of a prisoner, 24 April 2013.

<sup>15</sup> DCS has contested my earlier description of Prisoner A as a 'voluntary patient, because of his detention under the Mental Health Act and placement on a *Level 1 Inpatient Treatment Order* (ITO1). I make here the correct distinction between the term 'voluntary patient' (the hospital admission record says 'not detained as patient cooperative') and compliant in demeanour - which is not contested.

- way out of the restraints on 6 November 2014, this resulted in application of a further hand-cuff restraint 'to prevent self-inflicted injury'. The additional restraint was later removed.
88. Evidence from clinical case notes indicates that Prisoner A's demeanour did not deteriorate to the point of 'unsettled and agitated behaviours' until the second day of his detention in ED. In light of Prisoner A's state, it appears he did not constitute a threat to hospital staff or the community and there was little risk of escape.<sup>16</sup>
89. I also note that the only exercise of discretion used by DCS staff during Prisoner A's stay in the RAH was the decision to increase the restraint regime when Prisoner A reacted against the restraints on the first day in hospital. It is reasonable to speculate that some attempt to relax or downgrade the restraint regime may have had the effect of calming Prisoner A. It is also relevant to observe that DCS has an obligation to continuously monitor the prisoner to ensure that [he] is held at a level of security which is commensurate with the level of risk posed.
90. Further, I am of the view that the department was under an obligation to treat Prisoner A humanely and to respond to his care needs as well as his custody arrangements in the RAH. For the four days in question, Prisoner A was shackled to his bed for 24-hours a day. Although the department was clearly concerned about his management, in my view it could have done substantially more to explore how his restraint regime could be ameliorated in a safe manner.
91. I also note that Prisoner A's behaviour in initially attempting to remove the hard cuffs appears to be directly associated with his mental health condition and the fact that he was unable to be cared for in a therapeutic environment.
92. In addition, it is my understanding that there was at least one occasion during Prisoner A's stay at the RAH where medical staff made an attempt to have the hard cuff regime moderated with softer restraints. Given Prisoner A's co-operative demeanour on admission and his heavily sedated state for much of his stay in the RAH, it is reasonable to conclude that the DCS Compliance Officer should have consulted with and sought assistance from relevant medical and mental health staff to assess whether a modified approach to restraint was warranted.
93. I note the DCS comment about the Department for Health and Ageing's Policy Directive in relation to providing medical treatment to prisoners within SA Health.<sup>17</sup> The Policy Directive sets out the process around making a request for restraint removal or modification, and how to escalate that request for action. DCS have submitted that in the case of Prisoner A 'it appears that the Directive was not followed'.
94. I note that the SA Health Policy Directive cites six 'lawful service options available for prisoners to receive mental health treatment'. Option 5 is 'Involuntary inpatient treatment in a Treatment centre with DCS Guard'. This was the treatment option under which Prisoner A was held in the RAH. The Directive states that the treatment will occur in an acute mental health ward in a Treatment Centre [emphasis mine]. Therefore, the Policy does not envisage treatment in an hospital Emergency Department environment.
95. It may be that hospital clinicians generally regard the Policy Directive threshold as too high or restrictive for escalating a genuinely held concern regarding the use of prison restraints in hospitals. For example, one of two options available states that restraints may be removed or modified 'for the purpose of medical treatment'. This may be seen

<sup>16</sup> DCS advised my Office on 10 November 2014 that Prisoner A had been classified as a Medium security prisoner by the GM of the Adelaide Remand Centre.

<sup>17</sup> *Prisoners - Care and Treatment in SA Health Services Policy Directive* - SA Health July 2014.

as a criteria that does not include a request for restraints to be removed or modified for the purposes of calming the patient, providing greater comfort - or indeed preventing an injury. It may be that this was the reason no formal escalation occurred in this case.

96. Whatever the reason, it is clear that no such formal escalation was initiated by hospital staff. However, the evidence shows that Prisoner A sustained an injury and that clinical staff requested, on at least one occasion, consideration of an alternative restraint regime. I consider such a request made by clinical staff to DCS Compliance Officers is sufficient for the restraint review to be reconsidered seriously *in situ*.
97. In my view, the department acted unreasonably in shackling Prisoner A in the manner it did throughout his hospital stay (in particular, the use of hard shackles on both legs and arm). I consider it unreasonable that the department made no efforts to reduce the restraint regime. In particular, I note his status as a mental health patient and the efforts of hospital authorities to ease the restraint regime.

## Conclusion

In light of the above, I consider that the manner in which the department shackled Patient A was unreasonable 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:

5. the department, in consultation with the SA Prison Health Service, Forensic Mental Health Services and the Royal Adelaide Hospital, develop and implement a policy in relation to the transfer of prisoners detained under the *Mental Health Act 2009* for psychiatric assessment and placement in a psychiatric institution. The policy should stipulate, with reasonable exceptions, that no prisoner will be transferred to the RAH or other hospital for a period longer than 24-hours in circumstances where restraints are necessary to prevent escape
6. the department's Hospital Compliance Checklist for Hospital Watches be immediately revised to include a requirement for Compliance Officers to report any apparent injury to the General Manager and to liaise immediately with the nursing/medical team to ensure any injuries are treated
7. the department immediately implement training for DCS Compliance Officers and Corrections Officers charged with Hospital Watch duties in the suite of requirements under SOP 013, SOP 031, SOP 032 and Policy 42 to ensure full compliance with those care, procedural and reporting responsibilities

I also reiterate the recommendation made in my predecessor's 2012 Report, that:

8. when circumstances justify the use of restraints, a soft form of restraint should be used.

## Ombudsman Comment

I note that the department has indicated agreement with my foreshadowed recommendation to develop and implement policy in relation to the transfer of prisoners detailed under the *Mental Health Act 2009*. The department has pointed out that the required consultation with health agencies means that this recommendation is not necessarily within its control. I acknowledge the department's cooperative approach and recognise the complexities of interagency co-operation on such a policy. However, I express my confidence that SAPHS, FMHS and the RAH will cooperate with DCS, as they have in the past, to ensure that my recommendation is seriously considered.

For completeness, I point out that my recommended maximum 24-hour hospital stay is a policy objective. Circumstances may dictate, for a variety of reasons, that the maximum stay rule cannot be implemented in some circumstances. The policy could make provision for reasonable exceptions. I do not expect, for example, that DCS would remove a prisoner from a hospital if they were undergoing medical treatment that requires hospitalisation.

I do expect, however, that the department will be prompted to give serious consideration to the appropriateness of the “Standard Requirements” mandating a 3-point hard shackle regime for hospital admissions. Although I have made no recommendation on this point, I urge the department to review the 3-point minimum, with a view to lowering it; and to consider an approach that requires an individual assessment of the prisoner’s risk(s).

This investigation has brought into sharp focus the ongoing failure of the department to ensure compliance with its Standard Operating Procedures in relation to the shackling of prisoners in hospitals. Whilst I acknowledge the recent progress made, I am concerned that no form of soft restraints has yet been made available to Corrections Officers despite the time elapsed since recommendations made by the former Ombudsman.<sup>18</sup> I am also concerned that there is no application of the SOP 032 rule that departmental executive level approval is required if the use of restraint equipment exceeds an 8-hour period for any reason. I see no well-founded reason for the differential interpretation and application of the rules governing use of restraints in secure, as distinct from non-secure, environments.

As noted, there is systems work to be done in relation to hospital transfers in circumstances where no mental health bed is available after a psychiatric assessment. In my view, no prisoner detained for assessment under the *Mental Health Act 2009* should be moved into the ED environment at the RAH or elsewhere for anything longer than an intended 24-hour stay. If that means the ARC or prison infirmary continues to hold the prisoner until an assessment and mental health bed can be arranged, then so be it. There is ample evidence available from all parties that the current arrangements are not satisfactory, and are, in fact, causing harm.

The evidence from this investigation also indicates that there is scope for SA Health to revisit the *Prisoners - Care and Treatment in SA Health Services Policy Directive*. I note the Principal Community Visitor’s submission to me on the issue of the escalation process. In particular, I consider the range of options available for clinicians to escalate concerns regarding prison restraints should be reconsidered. The aim would be to ensure all reasonable circumstances are covered for the purposes of reducing prisoner agitation and preventing injury.

In order to obtain the evidence of Prisoner A’s injury, which was not reported by the department in the course of their reporting to me, I had occasion to request case notes and other information held by the RAH, Glenside Hospital and by the SA Health administration. I acknowledge the co-operation and goodwill of the SA Health staff contacted and interviewed.

## Summary of Recommendations

I have made recommendations under section 25(2) of the Ombudsman Act that:

1. the department streamline DCS Hospital Watch procedures to ensure Watch Officer, Compliance Officer and Senior Management responsibilities meet all requirements, including the 24-hour rule, without exception
2. the Hospital Watch Log Book be reviewed as soon as possible after the prisoner’s release from hospital and signed off for compliance by the Deputy Chief Executive

<sup>18</sup> Ombudsman SA investigation reports to DCS dated 12 June 2012 and 24 April 2013.

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Statewide Operations in every case where DCS restraints are used in a hospital environment

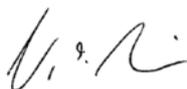
3. SOP 032 'Use of Restraint Equipment' be immediately revised to incorporate a clear statement that the procedure applies to hospital watch situations as well as to secure facility situations
4. SOP-031 be amended to provide for the exercise of delegated discretion determining what an appropriate level of restraint should be at the time the prisoner escort and hospital admission procedures have been completed
5. the department, in consultation with the SA Prison Health Service, Forensic Mental Health Services and the Royal Adelaide Hospital, develop and implement a policy in relation to the transfer of prisoners detained under the *Mental Health Act 2009* for psychiatric assessment and placement in a psychiatric institution. The policy should stipulate, with reasonable exceptions, that no prisoner will be transferred to the RAH or other hospital for a period longer than 24-hours in circumstances where restraints are necessary to prevent escape
6. the department's Hospital Compliance Checklist for Hospital Watches be immediately revised to include a requirement for Compliance Officers to report any apparent injury to the General Manager and to liaise immediately with the nursing/medical team to ensure any injuries are treated
7. the department immediately implement training for DCS Compliance Officers and Corrections Officers charged with Hospital Watch duties in the suite of requirements under SOP 013, SOP 031, SOP 032 and Policy 42 to ensure full compliance with those care, procedural and reporting responsibilities
8. when circumstances justify the use of restraints, a soft form of restraint should be used.

### Final comment

In accordance with section 25(4) of the Ombudsman Act the department should report to the Ombudsman by **13 May 2016** on what steps have been taken to give effect to the recommendations above; including:

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

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



Wayne Lines  
SA OMBUDSMAN

15 April 2016

APPENDIX A

