

Final Report
Full investigation - *Ombudsman Act 1972*

Complainant	Ombudsman 'own initiative' investigation, section 13(2) <i>Ombudsman Act 1972</i>
Department	Department for Correctional Services
Ombudsman reference	2015/04640
Department reference	CEN/14/1334; CEN 14/1335
Date complaint received	3 December 2014
Issues	<ol style="list-style-type: none">1. Whether Prisoner B was shackled in accordance with departmental policy during a hospital visit2. Whether the department acted contrary to law in failing to exercise the necessary discretion in relation to shackling Prisoner B during a hospital visit3. Whether the management of Prisoner B's custody in hospital was otherwise unlawful, unreasonable or wrong

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 B under the *Mental Health Act 2009 (the Act)*.¹

The Principal Community Visitor reported that he had spoken to nurses in the Emergency Department of the Royal Adelaide Hospital who cared for Prisoner B and were disturbed by the way he was restricted.

The matter was reported prior 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 A, is the subject of a concluded investigation by my Office.

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

¹ For privacy reasons I have designated the prisoner concerned 'Prisoner B' for the purposes of this report.

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

Investigation

My investigation has involved:

- seeking information from the department
- assessing the information provided by the department
- seeking further information from the department
- seeking information from the Mental Health Team and clinicians based in the Emergency Department (ED) at the Royal Adelaide Hospital (RAH)
- 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 13)* and *Standard Operating Procedure 31 - Supervised Prisoner Escorts (SOP 31)*, 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 Principal Community Visitor's and the department's responses to my provisional report
- considering the department's response to recommendations from my final report on the matter of 'Prisoner A'
- 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.² 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 answer³ to the question whether the issue has been proved
... .

Responses to my Provisional Report

By letter dated 22 April 2016, 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 20 May 2016.

The Principal Community Visitor responded by letter dated 19 May 2016. He accepted the findings in my provisional report and made comment and observations as follows:

- the findings made by the Ombudsman regarding SOP 013 and SOP 032 are reasonable and support the documented evidence recorded by DCS personnel making observations of Prisoner B during his stay at the RAH

² 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.

³ *Briginshaw v Briginshaw* at pp361-362, per Dixon J.

- foreshadowed recommendations 1 through 3 which encourage DCS to streamline and improve their Hospital Watch practices and procedures, particularly concerning the review of restraints, are reasonable considering the evidence provided to the Ombudsman
- evidence provided suggests DCS failed to utilise discretion against section 86 of the Correctional Services Act 1972, regarding what is reasonably necessary at the time of admission to the RAH. Therefore, recommendation 4 that the SOP 031 be amended to allow delegated discretion regarding the appropriate level of restraint for a prisoner escorted to hospital admission is reasonable
- one of the most concerning elements identified from this investigation was that Prisoner B was not provided with showering and toileting facilities and forced to wear an adult nappy
- the Principal Community Visitor considers that DCS staff are not qualified to make assessments [about maintaining hygiene] - but the Mental Health nurses and Psychiatrist on the clinical staff of the hospital do have the necessary skills
- it is likely that the restraints used on Prisoner B may have contributed to the deterioration of his mental health
- on the available evidence, the department's treatment of Prisoner B constitutes a violation of his basic human rights, specifically Article 10(1) of the *International Covenant of Civil and Political Rights* which states: 'all persons deprived of their liberty, shall be treated with humanity and with respect for the inherent dignity of the human person'
- recommendations 5 through 9 proposed by the Ombudsman are supported [as they] encourage DCS review and changes in policy to ensure such activities do not happen to other individuals held in custody in future
- the Principal Community Visitor has expressed concerns about the apparent lack of information regarding the medical diagnosis of Prisoner B, his Treatment Plan and an explanation for his apparent deterioration in custody leading to his admission in the RAH.

The department responded to my provisional report by way of letter from the Chief Executive dated 9 May 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
- the department agrees with the foreshadowed recommendation to streamline DCS Hospital Watch procedures to ensure they are operationally achievable and practical
- SOP 013 is currently under review
- the department intends to increase the number of persons undertaking compliance checks to ensure compliance with the 24-hour time period
- 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
- 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 B 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 disagrees with the provisional finding that the act of restraining Prisoner B 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
- the department will consider the foreshadowed recommendation (9) that DCS review the SOP 013 'Standard Requirements' 3-level restraint regime.

Additional submission from the department

As noted above, the case of Prisoner A is the subject of a concluded investigation by my Office. In response to that investigation, the department has, in a letter from the Chief Executive dated 30 June 2016, accepted or partially accepted all eight recommendations made by me in that report.⁴ The eight recommendations are identical to the first eight recommendations made in this report concerning Prisoner B.

The Chief Executive's letter attaches an Action Plan that 'demonstrates [the department's] commitment to progress the recommendations outlined in your report'.

I welcome that development and, as a consequence, note that the eight recommendations included hereunder are a reiteration of those made in the case of Prisoner A.

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. On 7 October 2014 Prisoner B was remanded to the City Watch House. He was charged with unlawful sexual intercourse with a person under 14 years of age. Prisoner B came to Australia from Barundi in East Africa and was 20 years of age at the time of his alleged offence. 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.
2. JIS case notes from 16 October 2014 record that Prisoner B was separated under Section 36(2)(b) of the Correctional Services Act for his own safety 'as he is refusing to communicate with staff and would not follow admissions process.' Mr Paul Saberton from the ARC noted that:

His behaviour has become weird and he may need to be assessed.
3. The department reports that on 17 October 2014 Prisoner B became agitated and stressed, banging on his cell door at the Watch House and talking to himself.⁵ On that date he was transferred to the Adelaide Remand Centre (ARC) and separated under section 36(2)(b) of the *Correctional Services Act 1992*.

⁴ After receipt of the letter dated 30 June 2016, my Office contacted the department to ask if they wished to revise their submission on the Prisoner B Provisional Report. In an email dated 8 July 2016, I was advised that 'the department does not intend to resubmit a response to the Prisoner B Provisional Report as the positions reached in the Prisoner A response supplant the previous positions (s) and apply to aspects of the Prisoner B matter'. As a consequence, I decided to include in this report the summary of the department's original response to my Provisional Report.

⁵ JIS records state that this episode occurred on 16 October 2014 in the afternoon.

4. Prisoner B was seen by an interpreter from ABC International Pty Ltd. (Translating and Interpreting). The interpreter spoke in the language of Prisoner B's homeland. His attendance was arranged by Prison Health Services after Prisoner B had apparently talked 'nonsense' to a correctional officer (who understood him). Prisoner B had also refused to wear clothes. Prison Health had Doctor Hamid a General Practitioner who worked the ARC see Prisoner B and he was subsequently placed in the infirmary at 7.05 pm on 17 October 2014.
5. Prisoner B was then seen by Doctor Craig Raeside who determined that he be detained under the Mental Health Act.
6. DCS reports that footage of Prisoner B's forcible extraction from the Watch House cell has been obtained and reviewed. The Emergency Response Group Commander, Mr Vince Alves, reported that it was necessary to extract Prisoner B from the cell for him to be conveyed to the RAH on the ARC General Manager's instructions. Mr Alves is seen/heard to speak to Prisoner B in English.
7. The footage shows Prisoner B at the cell door facing out. He is asked to turn around on two occasions. Mr Alves is heard to say that the prisoner is semi compliant and will need to be forcibly extracted. On entering the cell Prisoner B is seen to be facing away from the officers and is naked. He is forcibly restrained and, while resisting, is eventually carried from the area.
8. The DCS employee report from Mr S. Berg (completed on 1 February 2015) records that Prisoner B was given a sedative injection 'to control his behaviour' when the ambulance arrived at the ARC to transport him to the RAH. He was then placed on a gurney to which he was handcuffed, described in the report as at '2 points [of contact]: hands together, hands to bed, feet together, feet to bed'.
9. Prisoner B was transported to the RAH and a Hospital Watch Log was commenced at 7.20pm on 17 October 2014.⁶ He was transferred from the RAH and admitted to James Nash House at 2.40 pm on 22 October 2014.
10. The department has provided the following information about the restraints used on Prisoner B during his stay in the RAH:⁷
 - Leg Restraints used between legs;
 - Leg Restraint to bed;
 - Flexi Cuffs to be used when metal restraints prevent medical procedures; and
 - Leg Restraint used when prisoner is out of bed.

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.

Prisoner B's security level was raised from Medium to High 2 while in hospital as a result of self-harming behaviour.

⁶ Records sourced from Health SA show an RAH admission time and date for Prisoner B as 0035 am on 18 October 2014. As yet there is no explanation for the discrepancy in time and date with the DCS record.

⁷ This is apparently an incorrect internal investigation report provided to the DCS Chief Executive and forwarded to me. It omits to note that Prisoner B was restrained by 'one hand cuffed to bed frame' in addition to the leg restraints. The Hospital Watch report from D Zuromski, dated 17/10/2014, confirms: 'one arm secured to the side of the bed to a secure rail with hand cuffs'.

The restraints used were reviewed at the following times:

- 19 October 2014 at 7.00pm;
- 20 October 2014 at 9.30 pm; and
- 21 October 2014 at 8.20 pm.

Psychiatric diagnosis

11. An initial health assessment was conducted on 8 October 2015, at 10.30 am at the City Watch House. The SAMI assessment is a Suicide Assessment Manual for Prisoners. It was conducted by a Social Worker Ms Catriona Hadden from the High Risk Assessment Team. Her notes recorded in the Justice Information System (JIS) on 9 October 2014 state:

[Prisoner B is a young man] who has been in Australia for a year after his mother sponsored his journey here. He engaged well in the process and appeared relaxed. He told me his mother's new husband does not like him and would not let him live with them and this has caused some issues between them. He said he knows his mother loves him, as he does her. He said he has some friends, but not good ones. He said he loves Australia and mostly has a good life. He said he is hopeful for the future. He indicated he has never thought about taking his own life.

When he came into gaol he said he was scared and upset but that he has settled down now. He indicated that he was happy to find someone who could speak his language. I do not believe him to be at risk, but due to his newness in the system, I would suggest him to be further monitored.

12. The department reports that Prisoner B was given a standard stress screen test which resulted in a score of 9. It also states that a Notice of Concern (NOC) was raised 'because of a past history of self-harm'.⁸

The department's investigation

13. 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 B 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'.
14. 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.
15. On 5 March 2015 I received advice from the Chief Executive about Prisoner B'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).
16. 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 B'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

⁸ In the course of a discussion with my Office on 7 July 2015, Prisoner B's sister said she and her family were surprised because they knew nothing about any mental health issues previously experienced by her brother. I did not seek access to SA Health medical records held on Prisoner B. I have no information on the accuracy of the notation of a past history of self-harm.

- 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 EIU investigation
- details of any unmet requests for information from SA Health.

17. The EIU investigation report, dated 9 February 2015, notes irregularities with compliance checks undertaken by DCS staff during the period of Prisoner B'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 still not been received.

18. 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 B's six-day stay in the RAH.

19. One restraint review form completed by Compliance Officer Greg Paine on 19 October 2014 recommended 'a change to Decrease the level of Restraints' and an increase in staffing levels.

20. The recommendation was not approved by the General Manager. Other Compliance Officer checklists provided to my investigation either recommended current levels of security to remain in place or proposed an increase because of 'prisoner self-harming and erratic behaviour'.

Relevant law/policies

21. 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 31 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...⁹

Unplanned - Restraints used in Hospital-(Admitted or in Accident/Emergency, etc).
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.

⁹ DCS advises that SOP 013 *Prisoners at Hospital* does not refer to points of contact when assessing restraints. Rather it refers to restraint levels. Therefore the 'Standard Requirements' for restraints used in hospital equate to three restraint levels, although there are only two points of contact. I note that DCS Hospital Watch reports often conflate the points of contact number with the levels of restraint number.

- 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...
22. 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"

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

23. SOP 032 prescribes procedures to be used by departmental officers delegated with the responsibility of using restraint equipment safely and effectively within DCS. 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 used 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.

24. 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.

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

25. Prisoner B was admitted to the RAH ED and a Hospital Log Watch was commenced at 7.20 pm on Friday 17 October 2014. I am advised by the department that DCS forms (F013/002) for the compliance checks were submitted for the following dates and times:

- 19 October 2014 at 7.00pm submitted by Greg Paine (ARC)
- 20 October 2014 at 9.30pm submitted by Greg Paine (ARC)
- 21 October 2014 at 8.20pm submitted by Greg Paine (ARC)

26. The department's EIU investigation report makes clear the fact that the first compliance check was not undertaken until the evening of 19 October 2014 (Sunday) which is almost 48 hours after the complainant's admission to hospital. Paragraph 3.10.1 of SOP 013 requires that compliance checks take place every 24 hours. It is my final view that the department erred in failing to complete the compliance check on Saturday 18 October 2014.

27. The log also shows that the second compliance check was not undertaken until 26.5 hours after the first check was completed. Paragraph 3.10.1 of SOP 013 requires that compliance checks take place every 24 hours. It is my final view that the department erred in failing to complete the compliance check within time on Monday 20 October 2014.

28. The department's internal investigation of compliance with departmental policy for Hospital Escorts reveals that the required paperwork was not submitted in accordance with SOP 013. It is noted that the Prisoner in Hospital Profile Sheet (F01/001) was not updated in accordance with SOP 013.

29. The department's report to me states (sic):

It seems that the requirement in clause 3.17 of SOP 13, that 'only the General Manager is authorised to reduce or vary the level of restraints use. This must be recorded in writing in the Hospital Watch Log Book' was not followed. On 21 October 2014, at 9.45am, Correctional Officers logged that they had placed an extra closet change on Prisoner B's left arm. This was due to an escalation in the prisoner's behaviour including standing up in bed. At 11.40 am the officers have documented that an extra restraint was placed on the prisoner's left leg, as he was attempting to get out of bed. At 2.03 pm, the Correctional Officers logged that they had removed the left arm closet chain to allow the prisoner to roll on his side to sleep. There is no reference to the Correctional Officers obtaining the required permission for this increase or decrease in restraints in the Hospital Log Book.

30. Whilst I accept that the report from 21 October 2014 represents a technical breach motivated by a desire to allow the prisoner to sleep, I nonetheless conclude that the overall management of the prisoner in accordance with SOP-013 was lax.

31. I turn now to the 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...'
32. I note that the department has, in a related hospital custody matter, contested my consideration of compliance with SOP 032 on the grounds that the Procedure should apply only in a secure custodial setting; i.e. the prison environment. The department has also stated that this situation is that of a prisoner 'on escort' who has been restrained in relation to a number of risk factors.
33. 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'.¹⁰
34. In my review of SOP 032, I can find no requirement that 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.
35. 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.
36. I note that the investigation report from the EIU did not examine this aspect of compliance with SOP 032. I understand this is because departmental officers did not consider the Procedure to apply in a non-prison setting. As such, there was no evidence that that a request was made to the Deputy Chief Executive Statewide Operations to continue the use of restraints with Prisoner B during his stay at the RAH.
37. 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.
38. 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.
39. 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 as soon as possible.

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.

¹⁰ It is at least arguable that the current 3-level 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-level.

The department has acknowledged the above errors and the Chief Executive has advised me that he has asked the Deputy Chief Executive and relevant General Managers to reinforce this requirement to escort staff, supervisors and managers completing compliance checks. He has also asked that consideration be given to additional training in this area.

The department has acknowledged the errors in relation to SOP 013 compliance checks.

Notwithstanding the original response to my Provisional Report, cited above, the department has more recently indicated that it will amend SOP 032 'so that it is clear that it applies regardless of whether the prisoner is being managed in a secure or non-secure location.'¹¹

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 B during a hospital visit

40. 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.
41. 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. In my view, the procedures are therefore *ultra vires*.
42. 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.¹² 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.

¹¹ Letter from the Chief Executive dated 30 June 2016 in response to 'Prisoner A' investigation final report.

¹² 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>.

43. 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.¹³
44. That said, I reiterate my predecessor's view, set out in another report regarding the shackling of a prisoner in hospital in 2014¹⁴, 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).
45. I am not suggesting that the prisoner should be unrestrained in hospital. 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).
46. 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.
47. 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'.¹⁵ 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. In such a situation, restricting movement using a soft restraint at least has the advantage of preventing injury. An alternative may be to remove the hand restraint(s) entirely, or for periods of time.
48. 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.
49. In Prisoner B's case, hand and leg restraints were applied upon admission to hospital as required by SOP 013 and SOP 031. The report completed by Correctional Officer D. Zuromski on 17 October 2014 makes clear what the transport, admission and post-admission restraint arrangements were on 17 October 2014 (sic):

[before transportation] Prisoner B was restrained with handcuffs from behind and escorted to the admissions area of the ARC. Here he remained, secured and supported on the floor by the ERG until a Ambulance arrived. Paramedics assessed Prisoner B and decided it best to sedate and restrain him to the barouche with their full body restraint equipment to supplement our own equipment, which consisted of hands cuffed together and to bed frame, legs shackled together and to bed frame.

¹³ In an email to my Office, dated 12 July 2016, the department summarised Crown Law advice on my ruling that the 'Standard Requirements' procedures used by DCS are *ultra vires*. The email states that 'the procedures have no statutory basis so there is an argument that the procedure itself cannot be said to be *ultra vires*'. Without having seen the Crown Law opinion, I consider that this is a wrong interpretation of the facts. This is because the requirement for departmental officers to assess what force is reasonably necessary in the circumstances emanates from section 86 of the Correctional Services Act.

¹⁴ 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>.

¹⁵ Email from M. Reynolds to Ombudsman SA, 1 April 2016.

Upon arrival at the Royal Adelaide Hospital at approximately 1920 hours, we were greeted with a team from the Hospital Response Group where Prisoner B was assessed by medical staff. Prisoner B was placed onto another bed in which he was restrained in accordance with our escorting and restraint procedures. Both legs shackled together, closing chain from one leg to secure part of bed frame and one arm secured to the side of the bed to a secure rail with hand cuffs.

50. The report identifies that the 'Standard Requirements' restraints were put in place on admission as per 'escort and restraint procedures'. Therefore, it is my final view 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.

Conclusion

In light of the above, my final view is 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 management of Prisoner B's custody in hospital was otherwise unlawful, unreasonable or wrong

51. The department's internal investigation report details the circumstances of the use of DCS restraints during Prisoner B's six-day stay in the RAH. The report also covers questions posed to DCS about the adequacy of toileting and showering arrangements undertaken during his time in hospital. I address these issues below.¹⁶
52. The evidence from the department, which I accept, documents Prisoner B's state soon after his arrival at the RAH. The record shows that, soon after his admission to hospital [2200hrs] on 17 October 2014, Prisoner B removed a cannula from his arm. This required a DCS officer to stem the flow of blood and to call medical staff to attend to the wound and replace the cannula. Prisoner B also reportedly attempted to remove teeth with his fingers and to bite the treating dentist. It was at this point that a sedative was administered and additional restraints placed on Prisoner B to prevent self-harm. Correctional Officer D. Zuromski's report notes that the:

Restraints were upgraded at this point to both arms secured to secure bed rails either side of the bed with handcuffs.

53. On the morning of 19 October 2014 Correctional Officers Williams and Davis advised that Prisoner B still had both arms restrained. At 11.15 am nursing staff requested that they wanted to give Prisoner B a shower. The Officer in Charge (OIC) Darren Hills advised that under no circumstances were the restraints to be removed. Mr Hills was at that time located at Mobilong Prison in Murray Bridge. No shower was given to Prisoner B.

¹⁶ The Principal Community Visitor specifically raised these issues in his complaint to my Office. This was on the basis of a report from a member of the RAH Mental Health Team who had direct contact with Prisoner B.

54. The EIU investigation report to the DCS Chief Executive that was forwarded to me states:

A compliance check was undertaken on 19 October 2014 by Compliance Officer Greg PAINE. He stated that 'Restraint level not clearly understood by both staff on watch and ARC. Officers believed that prisoner was approved to have 4 points of restraint to the bed (Approved by General Manager) matter discussed with ARC GM and restraint level corrected. ARC OIC informed. Prisoner's behaviour is erratic, additional 3^d officer recommended as a result of prisoner behaviour and staff needing to use Hospital security to assist with restraints. Prisoner security level raised to H2 while in hospital. All issues raised with General manager ARC Mr HOSKING at the time of the audit'.

and

On 20 October 2014, the ARC General Manager, Mr HOSKING, did not approve the Compliance Officers review and wrote the following: 'do not wish to decrease restraints and increase staffing. Will keep 4 points of restraint at this time. Manager Security to liaise with Compliance Officers and staff to monitor situation'.

55. As noted above, the department has acknowledged that extra restraints were applied to Prisoner B's left arm and left leg on the morning of 21 October 2014 'due to an escalation in the prisoner's behaviour including standing up in bed'.
56. On the matter of the questions asked by my Office about whether, why and for how long Prisoner B was placed in a nappy, the EIU investigation report states:

On the 18 October 2014, [Prisoner B] was placed in a nappy by hospital staff. Prior to this, four hospital security staff members had been called to assist correctional staff with a change of a urine covered sheet on [Prisoner B's] bed. The prisoner was extremely agitated and his shorts had to be cut off as the removal of restraints at that time was considered to be a risk.

On the 19 October 2014 at 9.45 am [Prisoner B] was trying to get out of the bed and had become restless. He stood up on the bed and the nappy he was wearing fell off. Nursing staff were advised of this. At 11.30 am [Prisoner B] began throwing items around the room including the nappy he was wearing. At 12.10 a nurse entered to put a nappy on [Prisoner B].

On the 21 October the hospital log shows that [Prisoner B] again removed the nappy he was wearing. Shortly after that he was sedated.

The Hospital Log shows that [Prisoner B] was first placed in a nappy on 18 October 2014. His shorts were cut off and disposed of. It would appear that he remained in a nappy whilst at the RAH due to his constant bed wetting and because of his erratic behaviour.

57. The Chief Executive has advised me that he understands that Prisoner B remained in nappies whilst at the RAH because of 'his erratic behaviour and the inability to provide regular access to a toilet due to the risk he posed to himself and staff'. He notes that it is not possible to clarify the situation because 'the [medical] records for the period of his detention at the RAH have not been provided to date'.
58. Be that as it may, the report from EIU on this aspect of Prisoner B's confinement in restraints raises further questions about the accuracy of departmental reports documenting what occurred from time to time. I note, for example, that the EIU investigation report states that on 19 October at 9.45 am Prisoner B 'was trying to get out of bed...he stood up on the bed...' and, at 11.30 am, 'he began throwing items around the room including the nappy he was wearing'.
59. I note that the same report states elsewhere that, at this time, '[Prisoner B] still had both arms restrained', and that:

At 11.15 am nursing staff had requested that they wanted to give [Prisoner B] a shower, the OIC Mobilong Prison Darren HILLS advised that under no circumstances were the restraints to be removed.

The record of the restraint inspection undertaken that day by Compliance Officer Greg Paine is noted above, including his recommendation that the 4-point restraint level (in place on both arms and both legs) be decreased.

60. Whilst I accept that Prisoner B needed an incontinence aid because of his confinement to bed at that time, I find, without further explanation, the evidence about the circumstances of his restraint and his apparently erratic behaviour to be unconvincing. It is difficult to understand, for example, how a man chained and shackled by each of his four limbs could try to 'get out of bed', or '[stand] up on the bed', or indeed, 'throw items around the room'.
61. If this is, in fact, the case, and Prisoner B was able to do these things whilst restrained in hard shackles, it occurs to me that the application of soft hospital restraints [where no movement of the limb is possible] would have been the preferred method of confinement. To date, I have received no explanation of why this alternative was not explored by DCS. I note that the department's response to me, dated 9 May 2016, does not address this point.
62. The EIU report also explains why, on at least one occasion, the attempts by nurses to give Prisoner B a shower were unsuccessful. The report states that the nurses' request, made on that same morning 19 October 2014, was vetoed by OIC Darren Hills with the instruction that 'under no circumstances [are] the restraints to be removed'.
63. The DCS Chief Executive's letter to me, dated 5 March 2015, reports from the EIU investigation on the issue of toilet and shower access for Prisoner B. It says that 'it would have been a difficult operation to move Prisoner B without significant risk to correctional officers, RAH staff and the general public, due to his violent and unpredictable behaviour' [emphasis mine].
64. In my review of Hospital Watch reports completed by DCS officers at the time of their shifts, I can find no explicit reference to violent behaviour. The notes cover the six-day period in the RAH and a record is kept for each shift. The notes are made in chronological order and state (*inter alia*):
- Prisoner awake. Confused. (Not Violent)
 - Prisoner frustrated but not violent
 - Prisoner awake, slightly anxious displaying some odd behaviours, not violent
 - Prisoner eating dinner. OK. Compliant
 - Prisoner awake. Compliant
 - Prisoner standing up - extremely anxious behaviour, becoming agitated...
 - Still agitated, not violent but uncomfortably agitated
 - Spitting, agitated and angry
 - Prisoner restless
 - Prisoner unhappy about restraints, getting restless trying to get out of bed
 - Prisoner agitated...wants cuffs off
 - Prisoner asks for clothes, phone call and for his cuffs to be removed
 - Nursing staff want to give prisoner shower (bad smell)
 - Prisoner received meal - seems happy and calm
 - Prisoner becoming agitated
 - Prisoner becoming noisy again
 - Prisoner stated wants to see my mum and sister - continued to sing to himself
 - Prisoner crying and talking to himself
 - Prisoner singing to himself and becoming agitated
 - Prisoner crying, pleading with staff to let him go

- Prisoner calm and quiet
- Prisoner calm and compliant
- Prisoner ranting very loudly, very agitated
- Prisoner starting to spit and rock bed, very agitated
- Prisoner very restless
- Prisoner removed nappy. Has become extremely agitated, yelling, singing, thrashing. Prisoner restrained
- Prisoner shouting and thrashing about
- Prisoner attempted to break restraints. Unsuccessful
- Very agitated yelling. Given needle by nurse. Depart RAH for James Nash.

65. The Hospital Watch report from officers T. MacGillivray and T. Adair from 18 October 2014 sheds some light onto the situation in the hospital. Describing a difficult shift where Prisoner B was agitated and unsettled and had apparently attempted to get out of the restraints and out of bed, it says, in part:

At no time did we remove or change any restraints as directed by OIC to facilitate toilet or shower or bed cleaning etc. as the risk was too high. A short time later OIC Creaser returned our phone call and replied with saying that the ARC refused to provide assistance and no help or extra staff was coming.

...We also ask the question as to why help and extra staffing assistance was refused when asked?

66. I accept that Prisoner B in his distressed state would have presented considerable management difficulties for DCS officers and RAH medical staff. I also acknowledge the self-harm attempts that he apparently made. However, I doubt that such a heavily sedated and obviously confused young man was exhibiting violent behaviour of a kind that endangered others. If that was, in fact, the case, the decision to refuse the Hospital Watch officers assistance (to facilitate the administration of sedatives and to access toilet, shower and bed cleaning) is inexplicable.

67. The DCS Chief Executive's letter, dated 5 March 2015, is vague in its explanation of the reasons for the unavailability of basic hygiene facilities for Prisoner B:

There remain periods where it is unclear why the opportunity to go to the toilet or shower was not afforded to Prisoner B. DCS is unable to determine, without further advice from Health, what input RAH staff had in relation to the toileting /showering of Prisoner B.

From a procedural perspective, I acknowledge that the Officer in Charge should not be making decisions remotely, as to whether or not a prisoner can go to the bathroom. This is an issue the Department needs to examine in regard to procedures and training.

68. Two issues emerge from this explanation. First, there is clear evidence that RAH nursing staff attempted, on at least one occasion, to get Prisoner B into the shower. It is not helpful for DCS to confuse matters by claiming that 'further advice from Health' is needed to clarify what input RAH staff had in relation to the toileting/showering of Prisoner B. The DCS reports speak for themselves. RAH nursing staff obviously attempted to do their best to provide basic hygienic care to Prisoner B.

69. Second, the department has a duty of care to provide for the safety, health and welfare of all prisoners in its charge. Indeed, DCS has a Mission Statement to this effect and commits itself to the maintenance of safe, secure and humane custodial environments.¹⁷

¹⁷ See also the *Standard Guidelines for Corrections in Australia* (Revised 2012) p.29 at 2.56, which says: 'Prisoners should be encouraged to keep themselves clean and should be provided with ablution facilities that are adequate to meet their health and cleanliness needs'.

70. In this instance, an environment that met the basic hygiene needs of Prisoner B was not provided despite the best efforts of the nursing staff to maintain cleanliness and a level of hygiene. In my view, the department failed to discharge its duty of care responsibilities in this respect. It did this by obstructing the showering and toileting of the prisoner and by failing to find a necessary balance between security and wellbeing.
71. The DCS Chief Executive rightly points to the inappropriateness of an OIC making decisions about the health and cleanliness management of a prisoner from a remote location. As such, he concedes that the departmental procedures that allowed for the OIC to refuse Prisoner B the opportunity to go to the toilet or to shower are wrong and need revision. I concur with this conclusion.
72. In the course of my investigation, clinical and administrative staff from the RAH ED Mental Health Team were interviewed about details of Prisoner B's stay in hospital between 17 October and 22 October 2014.¹⁸
73. A clear statement of the circumstances of Prisoner B's state in the RAH after confinement in shackles for six days was given by Ms Melanie Guiver from the RAH Mental Health Team. Ms Guiver told my investigator:¹⁹

[She] had come on duty on 22 October 2014 on the last day of Prisoner B's confinement in the RAH. She said she found the young man shackled hands and feet. He was screaming; he was in a nappy and the skin around his wrists was broken. He apparently did not speak English. Melanie said she complained about his state to the consulting psychiatrist who took no action. She then reported her situation and concerns to Maurice Corcoran (the Principal Community Visitor). She said he [Prisoner B] was moved to James Nash House about 4 hours later. She said the nurses on duty had done nothing and 'nobody seemed to be bothered'. Asked about who was in control of toileting and showering arrangements Melanie said the nurses were responsible but Prisoner B 'was still in a nappy because they (Corrections Officers) would not let him go to the bathroom'. She presumed this was for security reasons. Melanie said she had not completed an 'SLS Report' (nurses incident report) because she did not have time.

Asked if she had reported the matter to her supervisor she said she had reported to the consulting psychiatrist and she thinks she discussed the matter with her supervisor, the Clinical Service Co-ordinator, after the fact.

74. My investigator also spoke to the consulting psychiatrist on duty at the time. The doctor was less clear in his recollection of the events surrounding Prisoner B's confinement because he did not treat him. His record of interview says:²⁰

..toileting and showers were the responsibility of the general nursing staff and he did not have experience of DCS officers interfering with this. [The doctor] said he hoped they would assist if needed for these activities. He said in his experience a nappy would not normally be used on a patient. He said he had not been aware of [Prisoner B's] distress, but would go through the case notes to check each entry. Asked if he recalled nurse Melanie Guiver reporting [Prisoner B's] distress to him, the doctor said 'she may have reported this to me...but I don't know'. Asked what he would have done if he remembered such a report, he said 'there is a limit to what we can do'. The doctor said he was unfamiliar with the SLS Report procedure.

75. The Clinical Service Co-ordinator of the Mental Health Team did recall Ms Guiver reporting Prisoner B's state to him 'on or about the 22 October'. He reported her as saying to him at the time:²¹

¹⁸ Noting a discrepancy in dates where the official RAH admission incorrectly records 18 October at 12.35am.

¹⁹ Transcript of interview - Ombudsman SA, 19 March 2015

²⁰ Transcript of interview - Ombudsman SA, 14 May 2015

²¹ Transcript of interview - Ombudsman SA, 13 May 2015

'He's in a nappy and its atrocious.'

The co-ordinator could not recall what action he took after hearing her report and can't recall if he asked Ms Guiver to do an SLS incident report. He conceded that there is no report on record, but said 'there should have been'.

Action taken by the department

76. In my view, there is no evidence that the department considered in any detail how, whilst at the RAH, Prisoner B could be managed in a safe manner that did not require him to be restrained for six days. I accept that there was a risk in un-restraining him, and that the department was concerned to ensure he did not self-harm or harm nursing staff. Nevertheless, the evidence before me indicates that options of providing some time un-restrained, lessening the restraints or requesting the use of hospital soft restraints, were simply not explored. As a consequence, Prisoner B left the RAH on 22 October 2014 in a highly agitated state. According to Ms Guiver, he also suffered some injury from the lengthy period in hard shackles.
77. 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.
78. 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.
79. As noted above, the department's SOP 032 - 'Use of Restraint Equipment'²² 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, it has since been confirmed, was not considered. This is relevant because 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

80. 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.²³

²² 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 30 June 2016, a further commitment to review and revise the SOP has now been made.

²³ *Op cit.* Report: Ombudsman investigation July 2012, para 35.

81. In addition, the former Ombudsman 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.

82. Further, the Standard Guidelines for Corrections in Australia²⁴ 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'.
83. 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'²⁵ 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.

84. 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 should be afforded humane treatment, irrespective of any crime they may have committed or any lack of appropriate facilities for their treatment.²⁶

85. In its response to that report, the department concurred with these comments.
86. In a subsequent investigation report dated 24 April 2013,²⁷ 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.

²⁴ *Op cit.* Standard Guidelines for Corrections in Australia.

²⁵ Health in Prisons, A WHO Guide to the Essentials in Prison Health, World Health Organisation, 2007.

²⁶ Report: Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shackling of prisoners in hospitals, July 2012, para 107.

²⁷ Report: Ombudsman Report: Ombudsman investigation into the Department for Correctional Services in relation to the wrongful restraint of a prisoner, 24 April 2013.

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87. 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 B's stay in the RAH.
88. I acknowledge that one of the department's concerns was to ensure Prisoner B remained safe from self-harm. I note also an underlying issue was the lack of an available mental health bed at James Nash House at the time of his admission to the RAH.
89. In these circumstances, it was extremely difficult for DCS to secure a bed 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 unacceptable circumstances of hard shackle restraint in the RAH Emergency Department.²⁸
90. That said, I consider that it was not reasonably necessary to shackle Prisoner B in the manner he was by the department throughout his hospital stay. From the notes and records available to me, it is not unreasonable to conclude that Prisoner B's mental state was aggravated by the conditions of his confinement. I note the Hospital Watch records from DCS officers that repeatedly describe his behaviour as 'confused' 'agitated', 'frustrated' and 'noisy'. These appear to be manifestations of extreme distress rather than threatening conduct.
91. I also note that, with one exception, the exercise of discretion used by DCS staff during stay in the RAH was the decision to increase the restraint regime in place for Prisoner B. It is reasonable to speculate that some attempt to relax or downgrade the restraint regime may have had the effect of calming him. 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.²⁹
92. Further, I am of the view that the department was under an obligation to treat Prisoner B humanely and to respond to his care needs as well as his custody arrangements in the RAH. For the six days in question, Prisoner B was shackled to his bed for 24-hours a day. Although the department was clearly concerned about his management, I consider it could have done substantially more to explore how his restraint regime could be ameliorated in a safe manner. I note the comments made by the Principal Community Visitor in this regard.
93. In my view, the department acted unreasonably in shackling Prisoner B in the manner it did throughout his hospital stay (in particular, the use of hard shackles on both legs and arms). I consider it unreasonable that the department made no efforts to reduce the restraint regime.
94. 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 prisoner escape attempts from hospital. The reaction to these attempts was to significantly elevate the restraint regime from 1-level minimum to a 3-level minimum. It is timely that the 'Standard Requirements' 3-level restraint regime be reviewed by the department to consider an approach that requires an individual assessment of the prisoner's risk(s). I note the department's recent indication of its willingness to consider the recommendation I foreshadowed on this issue.

²⁸ I am hopeful that health authorities will address this issue with the commissioning of the new RAH early in 2017.

²⁹ Despite the restraint regime not being relaxed during Prisoner B's stay in the RAH, I acknowledge the recommendation made to do so by CO Greg Paine on 19 October 2014. The recommendation was not accepted.

Conclusion

In light of the above, my final view is that the manner in which the department managed the custody of Prisoner B 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

and that:

9. DCS review the current SOP-013 'Standard Requirements' 3-level restraint regime for hospital admissions to consider a procedure that requires an individual assessment of the prisoner's risk(s).

Ombudsman Comment

I note that the department has elsewhere indicated agreement with my 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 am gratified to have received confirmation from SA Health, in a letter to me dated 22 June 2016, that a joint DCS and SA Health working group is proposed to address this recommendation.

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.

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.³⁰

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.

In order to obtain the evidence of Prisoner B's circumstances in the RAH during the period he was detained there, I had occasion to request information from the RAH Mental Health Team. I acknowledge the co-operation of the SA Health staff contacted and interviewed.

Summary of Recommendations

I have made nine 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
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

³⁰ Ombudsman SA investigation reports to DCS dated 12 June 2012 and 24 April 2013.

8. when circumstances justify the use of restraints, a soft form of restraint should be used.
9. DCS review the current SOP-013 'Standard Requirements' 3-level restraint regime for hospital admissions to consider a procedure that requires an individual assessment of the prisoner's risk(s).

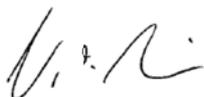
Final comment

I note that recommendations 1 to 8 are already the subject of a DCS Action Plan. I look forward to full implementation of these and recommendation 9 in due course.

In accordance with section 25(4) of the Ombudsman Act the department should report to the Ombudsman by **11 August 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

14 July 2016