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Outcome of Ombudsman's own initiative investigation into the Department for Correctional Services' handling of a prisoner with type 1 diabetes

The Ombudsman investigated, upon his own initiative, three issues arising from the Department for Correctional Services' (**the department**) handling of a prisoner with type 1 diabetes. The investigation was instigated on the basis of information received from the Office of the Health and Community Services Complaints Commissioner (**HCSCC**).

On 8 February 2017, the prisoner was transferred from Port Lincoln Prison to Port Augusta Prison and shortly after approached South Australian Prison Health Service (**SAPHS**) about high blood sugar levels. On 21 February 2017, SAPHS forwarded a medical instruction to the General Manager of the Port Augusta Prison and requested that he consider the prisoner being managed in a facility where he could have insulin three times a day or, alternatively, give SAPHS staff access to him three times a day. SAPHS continued to raise concerns with prison management about the failure to facilitate doses of insulin three times daily. The Port Augusta Prison did not accommodate the three times daily doses. The prisoner was ultimately transferred to another prison on 28 March 2017.

The department and the Department for Health and Wellbeing have a Joint Systems Protocol (**the Joint Systems Protocol**) which provides guidance on the shared care for prisoners requiring complex case management. The department also has a standard operating procedure (**SOP 001A**) which deals with prisoner admission and case management.

The Ombudsman considered three issues, as summarised below.

1. Whether the department wrongly failed to comply with the Joint Systems Protocol and SOP 001A

The Ombudsman acknowledged that the health of prisoners is primarily the responsibility of SAPHS but commented:

> …the ability of SAPHS staff to provide appropriate health care is dependent on the department supporting them in that function by providing sufficient access to those services. This is particularly important when the timing of access is a significant factor in the management of chronic illnesses, as is the case with type 1 diabetes, and will not generally change from day to day.

The Ombudsman's view was that the department did not comply with the Joint Systems Protocol nor SOP 001A in that it:

- does not appear to have completed the requisite Risk/Needs Assessment forms

- may therefore not have completed associated activities such as ensuring the Prisoner Health Information Sheet and specific placement/management recommendations were forwarded to the department's admissions staff, placed on the prisoner's file and entered into the JIS system
- did not develop a Joint Management Plan for the prisoner
- did not facilitate the prisoner's access to the Health Centre for insulin delivery and Blood Glucose Level (**BGL**) checks three times daily
- did not facilitate SAPHS staff attending to the prisoner's health needs outside of the Health Centre for insulin delivery and BGL checks at the proposed times
- did not ensure the prisoner's safety from risk by facilitating appropriate access to medication and treatment
- did not collaborate with SAPHS to ensure hazards with dosing gaps were addressed
- did not collaborate with SAPHS to ensure the prisoner's health was not adversely affected in his treatment regime due to work/prison routine
- did not escalate the matter in accordance with the dispute management procedures for resolving conflict in instances where the goals of the department and SAPHS are incompatible.

The Ombudsman stated:

> As stated in the Joint Systems Protocol, the proper delivery of a secure and safe environment, accommodation, rehabilitation, and appropriate health and wellbeing services to prisoners requires a joint approach by SAPHS and [the department]. Fundamental to this joint approach is the requirement that the procedures and processes 'acknowledge and accommodate the different roles of the agencies and support the efforts of the staff in ensuring effective cross agency communication and cooperation.' The Joint System Protocol provides for the 'joint and paralleled activity required to achieve this', and for this reason I consider it significant that the department has not complied with the Protocol.

The Ombudsman considered that the department did not provide any compelling reasons for its evident failure to comply with the Joint Systems Protocol and SOP 001A.

The department has already commenced a number of actions to address diabetes management in a broader sense including:

- requesting a review to be undertaken into food options in prison canteens, with reference to recommendations by Diabetes Australia
- seeking advice from SAPHS in relating to timing of meals and provision of snacks to prisoners with medical requirements
- requesting SAPHS to establish a governance framework for its Model of Care
- inviting SAPHS representatives to attend a department General Managers meeting to discuss diabetes management and to present equipment for BGL checks and insulin administration to enable the department to undertake a risk assessment

- developing with SAPHS a Diabetes Management Action Plan and conducting monthly meetings over six months to implement the strategies outlined in that plan
- re-establishing Joint Partnership meetings with SAPHS to improve communication and reinforce expectations in regard to escalation processes
- establishing fortnightly meetings with the Central Adelaide Local Health Network.

The Ombudsman's view is that the department's failure to comply with the Joint Systems Protocol and SOP 001A was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

The Ombudsman recommended that the department provide a further report on the progress of the review of food options and completion of the Diabetes Management Action Plan.

2. Whether the department unreasonably delayed taking action following receipt of a medical instruction from SAPHS regarding the prisoner

While commenting that it was unacceptable that the department was not aware of the prisoner's access requirements sooner, the Ombudsman assessed the department's timeliness from the date that SAPHS issued a medical instruction on 21 February 2017.

The Ombudsman noted with concern that the department did not appear to have a clear understanding of the 'use and effect' of a medical instruction, but also noted that the department has taken steps to consult with SAPHS to clarify the obligations of both parties when a medical instruction is issued.

The Ombudsman considered whether the action taken by the department was reasonable in view of the information known by the prison's management at the relevant time. SAPHS' first request to the prison expressly stated that the prisoner's diabetic control was deteriorating as a result of not receiving insulin three times daily and that this put the prisoner at risk of both hypoglycaemia and hypoglycaemic episodes. The instruction was sufficiently clear that the risk to the prisoner needed to be addressed urgently.

The Ombudsman acknowledged that the department was not solely responsible for the poor management of the prisoner's diabetes, but also expressed the view:

> […] in South Australia we should be aiming to exceed international minimum standards in the humane treatment of prisoners. That is, in this instance, the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

The Ombudsman considered that the prison's delay of 35 days in giving effect to the medical instruction was unreasonable given:

- the clear medical urgency
- the lack of follow up by the General Manager
- the failure of the Assistant Manager to report back

- the lack of compelling reasons as to why the department was not able to facilitate three times daily access
- the lack of compelling reasons as to why the prisoner could not have been transferred immediately.

The department did not accept that transfer to another prison was the most appropriate action in this case but acknowledged that the 'service block' should have been addressed and the Medical Instruction complied with.

The Ombudsman's view is that the department's failure to accommodate three times daily access or otherwise give proper consideration to transferring the prisoner to another prison was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act.

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

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

The department was not able to locate various records pertaining to the prisoner, including a Prisoner Movement Order and various other documents concerning his admission.

The Ombudsman's view is that by failing to retain official records, the department acted in a manner that was contrary to law within the meaning of section 25(1)(a) of the State Records Act.

The Ombudsman has informed the Manager of State Records of this matter.

Noting that the Ombudsman has already made recommendations in relation to retention of records in another matter, and that the department has undertaken to review its record-keeping processes, the Ombudsman did not make any recommendations in relation to this issue.