OmbudsmanSA

Redacted Report

Full investigation - *Ombudsman Act 1972*

Complainant	**[The complainant]**
Department	**Department for Correctional Services (the department)**
Ombudsman reference	**2018/01344**
Department reference	**SEC/18/0051**
Date complaint received	**5 February 2018**
Issues	**1. Whether the level of restraint used on the complainant was at all times reasonable for the duration of his hospitalisation** **2. Whether the use of restraints on the complainant was regularly reviewed in compliance with the department's relevant Standard Operating Procedures**

Jurisdiction

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

On 9 February 2018, the complainant agreed to be identified as the complainant for the purposes of my investigation.

Investigation

My investigation has involved:

- assessing the information provided by the complainant's mother
- assessing the information provided by the complainant
- seeking a response and requesting information from the department
- considering:
  - the Ombudsman Act
  - the *Correctional Services Act 1982*
  - the department's Standard Operating Procedure 013 – Prisoners at Hospital (**SOP 013**)
  - the department's Standard Operating Procedure 032 – Use of Restraint Equipment (**SOP 032**)
  - the department's Deputy Chief Executive Instruction 16-17 re: Hospital Compliance Checks (**DCEI 16-17**)
- providing the department with my provisional report for comment, and considering the department's response
- providing the complainant with a copy of my provisional report at his last known address

Level 5
91 King William Street
Adelaide SA 5000

PO Box 3651
Rundle Mall SA 5000

Telephone 08 8226 8699
Facsimile 08 8226 8602
Toll free 1800 182 150

ombudsman@ombudsman.sa.gov.au
www.ombudsman.sa.gov.au

- 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.[1] It is best summed up in the decision as follows:

> The seriousness of an allegation made, the inherent unlikelihood of an occurrence of a given description, or the gravity of the consequences flowing from a particular finding, are considerations which must affect the answer to the question whether the issue has been proved … .[2]

Response to my provisional report

In response to my provisional report the department responded by letter dated 12 February 2019. The department disagreed with my provisional views and noted that:

- SOP 013 is not under review and was amended and approved by my Office following another investigation
- at no time during the department's custody of the complainant was he unconscious or comatose and there is no evidence that he remained relatively immobile during his hospital stay
- the complainant remained under an Inpatient Treatment Order (**ITO**) until 8 February 2018 (i.e. not only the first week of hospitalisation)
- at the relevant time, compliance checks on restraints had to be done every 24 hours "*(or as close to depending on operational obligations, unforeseen travel time, etc)*" and the department stated that while the delays were not ideal, the department makes every effort to comply with the requirements of SOP 013
- in the current version of SOP 013 the compliance checks have to be done every 12 hours
- on the basis that the complainant was medically fit to leave hospital on 12 January 2018, the department was reasonable to consider that he was a security risk and may self-harm
- contrary to my provisional view, the complainant's individual circumstances were taken into account when the initial restraint review was undertaken, noting that the complainant was recorded by SA Health as a moderate risk of suicide following a high lethality suicide attempt and subject to an ITO and recorded as being alert and orientated
- patients' placement is entirely a matter for SA Health and not the remit of the department; while a patient is subject to an ITO, there is no capacity for the department to manage them in a custodial setting
- the department had no ability to consider the complainant's potential placement until the ITO was lifted on 8 February 2018
- the High Dependency Unit **(HDU)** at Yatala Labour Prison (**YLP**) is not an acute psychiatric unit; it is a 'step down option' for prisoners who have received an appropriate mental health admission and are leaving Psychiatric Intensive Care Units (**PICU**) at hospitals.

---

1 This decision was applied more recently in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* (1992) 110 ALR 449 at pp449-450, per Mason CJ, Brennan, Deane and Gaudron JJ.

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

The department raised various factual issues which I have addressed as necessary in the body of this report. For the reasons discussed in this report, my view remains as set out in my provisional report. I acknowledge the amendments to SOP013, particularly at 3.4 and 3.7 in relation to default restraint regimes and hospital compliance checks. The first two recommendations I foreshadowed in my provisional report have been complied with and I therefore have removed the recommendations from this final report. I commend the department for making these changes.

The complainant was sent a copy of the report on 30 January 2019 and again on 11 February 2019 to his last known address. I did not receive a response from the complainant.

Background

1. At the relevant time, the complainant was a prisoner at Yatala Labour Prison (**YLP**).

2. I was first alerted to the details of the complainant's complaint by his mother, who approached my Office on 5 February 2018. In a meeting with my officers, the complainant's mother explained that:
   - on 8 January 2018, South Australian Police attended the complainant's property to arrest him
   - prior to police arrival at the complainant's home, the complainant inflicted an injury upon himself and was taken by police to the Royal Adelaide Hospital (**the RAH**)
   - at the time of his admission to the RAH on 8 January 2018, the complainant had a serious neck injury and was in a comatose state
   - upon his admission, the complainant was shackled with both a leg and arm restraint, even whilst in a coma, and remained shackled for approximately four weeks with limited movement allowed
   - as a result of his limited mobility whilst restrained, the complainant required regular administering of anticoagulants to prevent his blood from clotting
   - the complainant was expecting to be transferred to James Nash House (**JNH**), but had been advised there would be a delay due to bed shortages at the facility.

3. Following the meeting with the complainant's mother, my officer made enquiries with the department, which confirmed by email dated 6 February 2018 that the complainant:
   - was remanded to the department's custody on 11 January 2018[3]
   - had been subject to restraint since his admission to the RAH on 11 January 2018
   - was initially restrained at three points on the body being 'arm to bed, leg to bed, and leg to leg', but following review by the General Manager (**GM**), the level of restraint was downgraded to two points being 'arm to bed and leg to bed' and he was provided with opportunities to walk around the ward after being assessed as presenting a medium security rating.[4]

4. My officer also contacted JNH by telephone in order to seek an update on the complainant's transfer to JNH. Dr Craig Raeside, Forensic Psychiatrist at JNH returned my officer's call on 6 February 2018 and explained that the complainant's transfer had been delayed due to ongoing pressures caused by legislative changes in November 2017, which had made the task of bed allocation at JNH more difficult.

5. Dr Raeside explained that in addition to prioritising patients based on their clinical needs, recent amendments to the *Criminal Law Consolidation Act 1935* (**the CLC Act**)

[3] The department has since provided a sealed copy of the Warrant of Remand dated 11 January 2018.
[4] A medium security rating is also known as a High 2 security rating and is set out in 3.6 of SOP 031.

have placed an additional burden on JNH, as JNH is now required to manage and give priority to less critical patients subject to various Court Orders made under the CLC Act, as hospitals will often not accept those patients.

6. On 8 February 2018, I telephoned the Chief Executive Officer of the department, Mr David Brown, to discuss the complainant's situation. During that telephone call, Mr Brown stated that:
   - there were issues with bed capacity at JNH
   - more needed to be done by way of placing pressure on the Department of Health and Ageing (**DHA**) to transfer the complainant
   - being shackled for four weeks was excessive
   - he would seek further information as to whether the complainant needed further medical attention, and would contact Ms Vicki Kaminski, former Acting Chief Executive, DHA, to escalate the matter and try to arrange a transfer.

7. An email from the department's Ms Katrina Flannery, Manager Executive Services, dated 8 February 2018 also explained that as a consequence of the bed shortages at JNH, no discharge plan had been put in place for the complainant by that time.

8. Mr Brown then contacted me by telephone on 8 February 2018, and informed me that:
   - he had telephoned the former Acting Chief Executive of the former DHA, Ms Kaminski
   - the complainant's Inpatient Treatment Order (**ITO**) under the *Mental Health Act 2009* had been lifted
   - it had been determined that the complainant could be discharged from the RAH, and he would be transferred to Yatala Labour Prison (**YLP**) later that day.

9. The complainant's mother also contacted my Office by telephone on 8 February 2018. She expressed significant concern that a mental health assessment for her son that had been scheduled to occur had ceased, and that he had instead been transferred to YLP. The complainant's mother felt that these events had occurred as a result of my enquiries with the department. The department advised in response to my provisional report that it was advised that a mental health assessment occurred while the complainant was in hospital through the Psychiatric Consultation Liaison Service, but that the department is not privy to the detail of that assessment.

10. The complainant contacted my Office by telephone on 9 February 2018, and advised my Office that he wished to be treated as the complainant in my investigation.

11. My Office sought a response from the department as to whether it considered the complainant was reasonably restrained, and whether regular reviews of the restraints were conducted during the period of time he was hospitalised.

12. Mr Brown provided a formal response to those enquiries by letter dated 27 March 2018 as follows:

> **Please provide any written records or documents outlining the level of restraints used at various stages during the four-week period [the complainant] was hospitalised, including documentation of any reviews of the restraints that occurred during that time.**
>
> Please refer to the attached Prisoner Movement Order, Prisoner in Hospital Profile and Information Sheet, and Compliance Checklist forms for each day.
>
> I have also attached copies of the log book entries. These show the record of restraint being checked every 30 minutes. The Compliance Officers check these entries as part of their compliance checks.

...

Was [the complainant] in a coma when initially hospitalised? If so, please provide details as to how long he was in a coma and whether this was taken into consideration when assessing the level of restraint required.

Whilst the Department does not have this Health based information, the documentation provided at "Q2" indicates that [the complainant] was "initially intubated and ventilated".

The log sheet from 11 January 2018 indicates that at hand over to the Department [the complainant] was on two points of restraint and that this was "increased to three points as per hospital profile".

As soon as the General Manager became aware of [the complainant's] circumstances and condition, the restraint regime was lowered to two points. Documentation indicates that this was the next day.

Notwithstanding, I acknowledge that the Department should have taken the individual circumstances of [the complainant] into consideration earlier and not increased the restraints given he was intubated at that time.[5]

Was [the complainant] given anticoagulants at any time for the period of 11 January 2018 to 8 February 2018? If so, why were they required?

Whilst this is a Health based question, documentation on file indicates reference to [the complainant] being administered 'blood thinners'.

Please explain whether the department considers the level of restraint used on [the complainant] was at all times appropriate and consistent with:

- **SOP 013- Prisoners at Hospital**
- **SOP 032 – Use of Restraint Equipment**

Upon investigation it appears that the Department was not at all times compliant with the Standard Operating Procedures.

As part of the investigation into this matter, a summary table[6] was developed outlining the hospital compliance checks which shows the dates that were outside of the 24 hour check time period since the previous check.

Table A – Hospital Compliance Checks

Hospital Stay
11/01/2018 to 8/02/2018
Hospital Compliance Check - Hour outside of compliance timeframe (24 hours)

Date	Time	Hours outside 24 hour compliance window
12/01/2018	2037	2.37
14/01/2018	1120	1.65
15/01/2018	1910	7.9
18/01/2018	2020	2.93
22/01/2018	1650	6.95
23/01/2018	1750	1

[5] Records provided by Central Adelaide Local Health Network reflect that the complainant was not intubated at the time he was remanded to the department's custody.

[6] The summary table was provided as a separate attachment. I have inserted it in my report alongside the department's response for ease of reference.

24/01/2018	2040	2.9
25/01/2018	1910	8.1
28/01/2018	1100	0.9
29/01/2018	1635	5.35
30/01/2018	1740	1.05
31/01/2018	1830	0.9
2/02/2018	1905	2.65
5/02/2018	1710	5.85
6/02/2018	1745	0.35

> …It is also apparent that the Department was not compliant with a Deputy Chief Executive Instruction (DCEI) issued in July 2017: *16-17 Hospital Compliance Checks.*
>
> …In response, I have directed that the DCEI be re-issued as a priority to ensure compliance for any future hospital escorts/supervision by DCS.

13. Having considered Mr Brown's response above, it was not clear how the department considered it had not complied with DCEI 16-17, noting that there are several requirements that must be met under DCEI 16-17.

14. My officer therefore sought clarification from the department. The department responded by email dated 15 May 2018, and clarified that the relevant aspect of DCEI 16-17 that was not complied with was limited to the requirement that SOP013 must be adhered to in relation to each of the occasions listed above (i.e. that compliance checks were completed outside of the 24 hour timeframe).

15. Mr Brown also provided the following response to enquiries regarding the appropriateness of the length of the complainant's hospitalisation:

> The documentation provided under 02 indicates that staff followed up on [the complainant's] placement as Health's status updates indicated "awaits mental health bed at JNH" (James Nash House) and "general surgery now happy for discharge from their care, awaits inpatient mental health bed."
>
> Decisions about placements in health facilities and hospital are made by clinical Health staff and not departmental staff.
>
> The documentation is clear that [the complainant] was waiting a secure mental health bed in James Nash House.
>
> Departmental staff also enquired as to whether an alternative psychiatric intensive care unit (PICU) bed was available and suitable for [the complainant]. As you are aware, the only current secure PICU sites are ward 5J at Flinders Medical Centre and James Nash House.
>
> The documentation also clearly indicates from Health that there was a shortage of beds at James Nash House and that this shortage likely contributed to his ongoing accommodation in a general surgery hospital ward bed and unit.
>
> …The lifting of an ITO is a Health decision. Notwithstanding, I have attached documentation on file that indicates that health staff were making enquiries about placement in the Yatala Labour Prison (YLP) High Dependency Unit (HOU) or Health Centre, given Health's assessment that it was highly unlikely that he would be placed in James Nash House, "given the pressures being experienced" (email from Chief Operating Officer Central Adelaide Local Health Network, dated 7 February 2018). The officer noted in that email that that would require the lifting of the ITO.

16. For ease of reference, I have summarised the key events in relation to the complaint as follows:

8 January 2018	- the complainant was admitted to the RAH - at the time of his admission he was intubated and presumably unconscious - surgical repair of the complainant's neck injuries was completed
11 January 2018	- the complainant was remanded to the department's custody, at which time a handover occurred - the complainant was shackled at two points when the department gained custody - the complainant was no longer intubated, and was presumably conscious by this time[7] - an officer from the department sought approval from the General Manager (**GM**) to increase the complainant's level of restraint to three points "as per hospital profile" - bedside hearing held with the Adelaide Magistrates Court
12 January 2018	- an officer from the department sought approval from the GM to reduce the level of restraint to two points, and restraint remained at two points for the duration of the complainant's stay in hospital
14 January 2018	- the complainant was declared medically stable by general surgery, and placed on a waitlist for transfer to JNH
5 February 2018	- the complainant's mother approached my Office
8 February 2018	- I contacted Mr Brown to discuss the complainant's situation - Mr Brown made enquiries with Ms Kaminski, and the complainant was transferred to YLP later that day.

17. It became apparent during the course of my investigation that the issue of transferring the complainant out of hospital related to capacity issues at JNH, and therefore related to the actions of Northern Adelaide Local Health Network (**NALHN**), which has oversight of JNH. Ms Debbie Chin, Interim Chief Executive Officer, NALHN, responded to enquiries by my Office regarding the issue of bed shortages at JNH, including what attempts NALHN had made to address this issue, in addition to what attempts had been made to facilitate the complainant's transfer to JNH, as follows:[8]

> …Our records indicate [the complainant] was arrested on 8 January 2018 and admitted to the RAH after self-harming. Following medical clearance, [the complainant] was placed on the waiting list for a bed at James Nash House on 12 January 2018.
>
> There is a weekly flow meeting at James Nash House to identify and prioritise patients waiting for a bed. Unfortunately, at the time of [the complainant's] [sic] referral in January, there were other more urgent cases requiring priority beds at James Nash House.[The complainant] [sic] was subsequently admitted to Aldgate at James Nash House from 20 February 2018 to 27 February 2018.

---

7 Email dated 6 June 2018 from Mr Adam Spicer, Nurse Consultant, SA Prison Health Services and Intermediate Care Specialties, Central Adelaide Local Health Network.

8 By way of comment, I note that although the issue of bed shortages at JNH has become apparent during the course of my investigation and has been highlighted in recent media reports, this issue has been present for a number of years and was the subject of a report, a *Review of the South Australian Forensic Mental Health Services*, that was submitted to the CEO of NALHN in July 2015.

Despite an increase in the number of forensic beds in recent years (from 40 – 60 beds), there remains a high demand for forensic mental health beds. A number of factors have contributed to the demand:

- an increase in prisoner numbers in general
- a lack of prison based mental health services for prisoners with mental illness who, due to the lack of prison facilities, require forensic mental health beds
- an increase in the number of people being made subject to supervision orders by the Courts and for longer periods
- the inclusion of individuals with intellectual disability and acquired brain injury (ID/ABI) at James Nash House.

[NALHN] and SA Health continue to investigate strategies to address forensic health bed shortages. This includes examining the feasibility of redeveloping James Nash House to provide separate accommodation for women and those with ID/ABU thereby increasing the number of acute beds, and also investigating an increase in the number of step down beds. We are also working with the Attorney General to progress the establishment of court diversion programs and prison in-reach services to reduce the demand for beds in James Nash House.

NALHN also continues to make referrals to the National Disability Insurance Scheme to provide services and/or house people with ID/ABU in more appropriate facilities. Given the complex nature of the referrals however, the NDIS is having difficulties providing care plans with funding attached which is therefore delaying the discharge of come [sic] clients from James Nash House.

18. My Office also made enquiries with Central Adelaide Local Health Network (**CALHN**) in regard to what steps it took in order to attempt to secure the complainant's transfer to an alternative facility. Ms Helen Chalmers, A/Chief Executive Officer, CALHN, responded to those enquiries as follows:

> [The complainant] was regularly reviewed after his surgery at the RAH on the 8th January 2018 (date of admission), per [the complainant's] case notes, by both the Surgical and Mental Health teams.
>
> On the 12th January, [the complainant] was assessed as having a moderate risk of suicide. On this date, his case was continued under the Inpatient Treatment Order (ITO), but the degree of observation was reduced to 15 minute observations. He was placed on a wait list for transfer to JNH on this date by the Mental Health team as this was when he no longer required surgical care.
>
> [The complainant] remained in a surgical ward (5F) for the duration of his stay. The Surgical team continued to closely observe [the complainant's] progress until the 22nd January. His sutures were removed on the 18th January.
>
> …According to [the complainant's] case notes, the Mental Health team actively followed up after each review, by phone, the possibility of transfer to JNH after the majority of patient reviews from the 12th January. A review of the case notes determined that [the complainant] was reviewed by a Psychiatrist or senior Mental Health Nurse, at a minimum, every 2 days.
>
> Triage priority is applied by JNH based on the information at the time of referral and the patient placement is determined by their level of acuity compared to others on the list.
>
> CALHN diligently follows up availability with JNH for all referred patients. JNH has good practices in place, regularly providing referrers with likely transfer time for a given patient. In [the complainant's] case, the only recorded potential transfer date was the 2nd February 2018 which was provided to CALHN on 30th January 2018.
>
> …Consideration of alternative transfer options for [the complainant] commenced on the 15th January. Given [the complainant's] remand status, he could only be transferred to particular mental health facilities. The only other alternative facility from JNH was

> Margaret Tobin Centre (MTC) as [the complainant's] psychiatric diagnosis remained undifferentiated until the end of January. The case notes state that the Psychiatric Registrar regularly followed up with MTC via phone seeking transfer of [the complainant].
>
> [The complainant's] case notes do not reflect consideration of transfer from the RAH to the High Dependency Unit (HDU) at Yatala Labour Prison. Dr Jon Symon has clarified that [the complainant] was not suitable for transfer to the HDU because of initial concern around potential risk of further self harm and then subsequent non-compliance with medication. Dr Symon reviewed [the complainant] on the 8th February 2018 at which time there was adequate insight and willingness to continue treatment with no evidence of acute risk to self. This was the first opportunity that he felt he was safe to leave hospital.

19. On 3 February 2017 in relation to another investigation[9] I made the following relevant recommendations in relation to restraint regimes of prisoners:
    - provide for circumstances where prisoners/patients' restraint regimes are always to be individually reviewed by telephoning a GM when the department assumes custody of the prisoner or patient and not default to a High 2 security rating (recommendation 6)
    - the relevant SOPs be amended to require that an individual review of the restraint regime of any prisoner or patient be conducted by departmental officers upon taking custody of a prisoner or patient (recommendation 10).

    By letter dated 28 April 2017 Mr Brown, Chief Executive of the department agreed these recommendations had not been implemented by amending SOP 013 as above. This has subsequently been rectified by SOP 013 being reviewed and endorsed on 18 May 2018 and again on 4 January 2019.

Relevant law/policies

20. At the relevant time, SOP 013 provided that:

> **3.1 General Managers Responsibilities**
>
> …
>
> 3.1.3 The GM must ensure that the review of restraints process for a hospital escort is in accordance with SOP 031 - Supervised Prisoner Escorts. Initial review of restraints must take place as soon as practicable, but no later than twelve (12) hours after the prisoner arrives at the hospital.
>
> 3.1.4 The twelve (12) hour timeframe for the initial review of restraints commences when the prisoner arrives at the hospital irrespective of when they were admitted EG. if a prisoner is in the emergency department awaiting treatment for twelve (12) hours or waiting for a hospital bed the initial review of the restraints must be conducted.
>
> 3.1.5 If the Compliance Officer is unable to complete the initial review of the restraints within the first twelve (12) hours the GM must ensure that a responsible officer from their site completes the review.
>
> 3.1.6 General Managers must ensure that the compliance checks are conducted every twenty four (24) hours (or as close to depending on operational obligations, unforseen travel time, etc.) including weekends/public holidays, after the initial review of restraints.
>
> …
>
> 3.5.3 On commencement / handover of a hospital watch (including a handover with SAPOL) officers conducting the hospital watch must be updated with the operational orders regarding the prisoner in hospital and ensure that:
>
> … ..
>
> c) if taking over lawful custody from SAPOL, escorting officers must ensure applied restraints are in accordance with a High 2 security rating till such time

[9] Ombudsman's report **February 2017: Department for Correctional Services – Unlawful shackling of a mental health patient in hospital.**

as the Security Assessment is undertaken (Refer to SOP 001) unless the GM has made a determination about the level of restraints;

3.7 Restraint of Prisoners on Medical Escorts / Hospital Watches

3.7.1 Restraints must be used in a hospital where the prisoner has been admitted as a patient and their behaviour or security classification deems that a restraint be used in accordance with the Hospital Profile Sheet.

3.7.2 Where a restraint is used, the officer must:

a) check the restraint routinely but within a [redacted] period to ensure the security and comfort of the prisoner;

b) if it is necessary to rotate the restraints used to the opposite limb 3.7.3 must be adhered to; *and*

c) record in ink, the time of each check and the condition of the prisoner in the Hospital Watch Log Book.

d) if only one restraint is being used, a second restraint must be applied prior to adjusting the primary restraint.

…

3.7.6 Officers must immediately contact the GM if the restraints used need to be altered where a prisoners medical condition changes. In these instances with the approval of the GM, restraints may be reduced prior to receiving the appropriate paperwork or an endorsement from the Compliance Officer. All occurrences are to be recorded in the Hospital Watch Log Book.

21. SOP 032 sets out that:

3.4 Application of Restraint Equipment

…

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; other prisoners; employees; prison property or the community.

22. DCEI 16-17 sets out that:

In accordance with Standard Operating Procedure 013 – Prisoners at Hospital (SOP 13), Compliance Officers must undertake an initial review of a prisoner's restraints as soon as practicable, but no later than 12 hours after the prisoner arrives at hospital.

To ensure adherence to SOP 013, a morning shift compliance team is to be established in addition to the exiting afternoon team.

Following every hospital compliance check, all Compliance Officers must:

- make an entry in the Hospital Watch Log Book;
- if there are no changes recommended contact the Duty Manager by phone;
- if any change is recommended to restraint level, the Compliance Officer must phone the General Manager while at the hospital to seek approval for the change; and
- a Compliance Checklist for Hospital Watches (Hospital Escorts) (FO13/002) must be submitted to the General Manager by 12 noon the next business day, (FO13/002 is the only form approved for the purpose of the compliance checks, no other forms are to be used); and
- the signed Compliance Checklist (FO13/002) must then be forwarded via email to the DL:DCS Hospital Watches and Escorts.

Where rostered Compliance Officer(s) are unable to conduct a Compliance Check, or are unlikely to be able to conduct a Compliance Check within the timeframe set out in SOP 013 for any reason, the Compliance Officer must ensure that the relevant General Manager(s) is notified. The General Manager must then undertake their own enquiry to ensure they are satisfied with the prisoner's level of restraint.

Whether the level of restraint used on the complainant was at all times reasonable for the duration of his hospitalisation

23. The complainant spent 31 days in hospital, from 8 January 2018 to 8 February 2018, but the department only had custody from 11 January 2018 to 8 February 2018, (i.e. a period of 28 days).

24. At the time custody of the complainant was transferred from SAPOL to the department on 11 January 2018, the complainant's restraints were increased from two points to three points.[10] The reason the restraints were increased was stated to be "as per hospital profile". The three points of security consisted of the prisoner being restrained:
    - leg to bed
    - arm to bed
    - leg to leg.[11]

25. The level of restraint was decreased the following day with the General Manager's approval, to two points, with the use of leg to leg restraints removed. The reason for this change was recorded as:

    > Nil behavioural issues
    > Med security rating.

26. The level of restraint used on the complainant remained at two points for the duration of his time in hospital until 8 February 2018. He remained recorded by the department as a medium security risk. The department also stationed a guard outside the complainant's room the entire duration of its custody of the complaint, 24 hours a day. Clinical notes provided to my investigation by the RAH consistently recorded that the complainant did not display any behavioural issues.

27. I have considered whether a three point restraint from 11 January 2018 to 12 January 2018 and/or a two point restraint from 12 January 2018 to 8 February 2018 was reasonable, given the following individual circumstances of the complainant:
    - the complainant was subject to a warrant of remand
    - the hospital was, according to the department's policies, an unsecure location
    - there was a guard stationed outside the complainant's room 24 hours a day
    - the complainant had undergone surgery to his neck after self-harming
    - the complainant was initially unconscious in a comatose state whilst in police custody, and then relatively immobile for most of his hospital stay whilst in the department's custody requiring the use of a wheelchair (although was able to walk around the ward and shower towards the end of his stay in hospital)
    - the complainant was the subject of an Inpatient Treatment Order (**ITO**) as defined under the Mental Health Act until 8 February 2018
    - there were no behavioral issues
    - the complainant was a medium security risk at all times
    - the complainant was not resisting restraints.

28. The hospital watch log records the request for the increase in the level of restraint from two to three points on 11 January 2018 by the department's officer being for the reasons of 'security rating and community safety'. The additional leg to leg restraint was recommended for removal by a different officer from the department on 12 January 2018 for the reasons of 'medium security rating, no behavioural issues.' Both requests were approved by the GM. It is confusing that the medium security rating was given as

---

[10] As reflected in the South Australia Prisoner Movement and In-Court Management (**SAPMIC**) daily watch logs provided by the department.

[11] This was recorded in daily Compliance Checklist for Hospital Watches (Escorts) forms provided by the department.

a reason to both increase and decrease the level of restraint, and perhaps demonstrates confusion by staff as to what level of restraint a medium security rating requires.

29. In accordance with 3.1.6 of SOP 013 GMs must ensure that compliance checks are conducted every 24 hours, "or as close to depending on operational obligations, unforeseen travel time, etc" after the initial review of restraints. The department has already provided a list of dates where this was not complied with, on 15 out of 27 days, and as long as 8.1 hours over the required time. This is completely unacceptable. I note that SOP013 has been amended (newly numbered) 3.1.7 requires compliance checks to be conducted every 12 hours after the initial review of restraints.

30. The clinical notes provided to my investigation by the RAH record the complainant's mobility as being independent from 15 January 2018 (the department assumed custody from SAPOL on 11 January 2018):

Date	Recorded mobility of complainant
8/1/18	admitted to RAH serious self-inflicted neck laceration
9/1/18	sedated and intubated, surgery then extubated
10/1/18	alert, no head control, lying down
11/1/18	bedside court hearing, alert and orientated in bed
12/1/18	lying down, not agitated and compliant
13/1/18	as above
14/1/18	as above
15/1/18	independently showered, mobility independent, resting in bed most of day
16/1/18	mobility independent, guard releases restraints prior to complainant showering
17/1/18	mobility independent
18/1/18	as above
19/1/18	mobilises to toilet and shower independently with guard supervision
20/1/18	as above
21/1/18	as above
22/1/18	as above
23/1/18	walked with guard in corridor
24/1/18	as above
25/1/18	walked short distance on ward with guard
26/1/18	as above
27/1/18	mobilising around bed with guard, calm and reading book, resting in bed most of day
28/1/18	mobility independent
29/1/18	independent mobilising within limitation of guard, sleeping pill anxious about delay to JNH
30/1/18	anxious, upset at delay to JNH
1/2/18	mobility independent
2/2/18	mobilised around ward with guard, interacting more with guard and staff, spoke to father on phone with guard supervision
3/2/18	walking wards with guard
4/2/18	as above
5/2/18	walked several laps of ward with guard
6/2/18	several laps of ward with guard, showered independently
7/2/18	walked wards with guard in morning and afternoon
8/2/18	Discharged to YLP

31. The department has acknowledged 'that the department should have taken the individual circumstances of [the complainant] into consideration earlier and not increased the restraints given he was intubated at that time.' The department later noted that this information was not accurate as [the complainant] was not intubated at the time the department took custody of him. It is clear that a three point restraint was an unnecessary increase on 11 January 2018, noting that the complainant was seriously ill, recovering from surgery and immobile at that time.

32. SOP 032, 3.4.3 sets out that the application of restraint equipment 'must only be applied for as long as it is strictly necessary to maintain the security and/or protection of the prisoner…'. I query whether a two point restraint for 28 days given the individual circumstances of the complainant was strictly necessary to maintain the security and protection of the complainant, particularly given the following:
    - there was a guard stationed outside the complainant's room for 24 hours a day for the entire duration of his stay
    - the complainant was recovering from surgery and could only walk independently from 15 January 2018
    - the behaviour of the complainant was compliant
    - the length of time he was restrained was a month.

33. This Office has a long history of examining the department's use of restraints in hospital settings. My predecessor and I have reiterated that the individual circumstances of the patient/prisoner needs to be taken into account when administering restraints. This, unfortunately is yet another example of where departmental officers appear to have applied a restraint regime in accordance with a default security rating given to the prisoner/patient in accordance with SOP 031 'Supervised Prisoner Escorts' and yet did not comply with 3.4.2 of SOP 013 that requires them to take into account the individual circumstances when undertaking the initial review and not default to a three point restraint regime.

34. I have considered the department's response to my provisional report which, contrary to an earlier response, 'argued' that the complainant's individual circumstances were taken into account, in particular the fact that:
    - the complainant was recorded by SA Health as a moderate risk of suicide following a high lethality suicide attempt
    - the complainant was subject to an ITO and recorded as being alert and orientated it was appropriate to take every care with the complainant to ensure his own safety and security

35. I have considered the department's submission. I do not accept the department's categorisation of the complainant's health. The clinical notes clearly indicate that the complainant was recovering, and though he was increasingly mobile his demeanour was calm, cooperative and his health steadily increasing. In my view:
    - the department has not provided any contemporaneous evidence to support its submission that the complainant's individual circumstances were taken into account by the department at the time that he was in the department's custody
    - the complainant ought not to have been restrained by the department at all from 11 January 2018 to 15 January 2018 whilst he was relatively immobile and there was a guard stationed outside the room 24 hours a day
    - from 15 January 2018 when the complainant became independently mobile to 8 February 2018, two restraints were not strictly necessary to maintain the security and protection of the complainant and one or no restraints should have been trialled.

36. Whilst the clinical notes refer to the complainant being given anti-coagulants, they do not disclose whether this was due to risks associated with the sedentary state caused by the restraints. The notes also refer to the mobility of the complainant under the guard's watch. There is insufficient evidence to conclude that the provision of anti-coagulants was due to the department's restraint of the patient.

37. The fact that the restraint of prisoners and/or patients are still being reported to me is unacceptable and disappointing. The department needs to ensure that its officers on the ground fully understand their responsibilities when determining restraint regimes and not merely rely on a default regime that does not take into account the individual's current circumstances. It is unacceptable that the complainant was restrained for 28 days in any event, let alone when recovering from surgery.

Opinion

In light of the above, I consider that the department acted in a manner that was unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act in regard to the level of restraint used on the complainant for the duration of hospitalisation while subject to departmental custody.

To remedy this error, I make recommendations under section 25(2) of the Ombudsman Act which are set at the conclusion of this report.

Whether the use of restraints on the complainant was regularly reviewed in compliance with the department's relevant Standard Operating Procedures

38. The department has provided my investigation with a summary of when its officers did not comply with 3.1.6 of SOP 013 because it was longer than 24 hours that the complainant's restraints were checked.

39. SOP 013, 3.1.3 also requires an initial review of restraints to take place as soon as practicable but no later than 12 hours after the prisoner arrives at the hospital. Whilst the complainant arrived at the RAH on 8 January 2018, the department did not have custody of the complainant until 11 January 2018. An initial review of restraints took place on 12 January 2018 (where it was increased from two to three points). I therefore consider that the department complied with 3.1.3 of SOP 013 as it was at the time by initially reviewing restraints within 12 hours of having custody of the complainant.

40. The department has stated in correspondence dated 27 March 2018 that the department:
    - was not at all times compliant with 3.1.6 of SOP 013 because compliance checks were not done on restraints inside 24 hours on 15 occasions over 28 days
    - was not compliant with DCEI16-17 which required compliance with SOP 013.

41. In this matter it was also particularly important that the complainant be reviewed regularly because of his medical condition. The complainant was subject to an ITO under the Mental Health Act. An ITO authorises the detention of a person in a treatment centre or hospital and therefore meant that the complainant was required to stay in a treatment centre and receive treatment for his mental illness whilst the subject of an ITO. There were therefore two main transfer options for the complainant being 1) JNH, and 2) secure ward 5J at Flinders Medical Centre's Margaret Tobin Centre (**MTC**). A third option was considered by medical staff after a bed did not become available at either of the first two options, being the High Dependency Unit (**HDU**) in YLP. The complainant's ITO was lifted on 8 February 2018 and he was transferred to the HDU at YLP and removed from the JNH waiting list.

42. Clinical notes suggest that the complainant was medically fit to leave hospital on 12 January 2018 and he was independently mobile from 15 January 2018. There is a question to be asked, I think, about whether the department explored the option of the HDU at YLP at this time rather than wait for the possibility that the complainant would get transferred to JNH (which was unlikely given the current difficulties obtaining a bed in JNH). I query that if the department knew that transfers to JNH were difficult to obtain, whether this would have affected the level of restraint to which the complainant was subject.

43. The department has informed my investigation that:
    - decisions about placements in health facilities and hospital are made by clinical health staff and not departmental staff
    - the documentation clearly shows that the complainant was awaiting a bed in JNH
    - the lifting of an ITO is a health decision
    - there is evidence that health staff were making enquiries about placing the complainant in the HDU of YLP.

44. The complainant was not transferred from hospital until 8 February 2018. I do not hold the department responsible for this delay because it was due to the availability of mental health beds elsewhere. In response to my provisional report, the department emphasised that, while a patient is subject to an ITO, there is no capacity for the department to manage them in a custodial setting. An ITO is a legal order requiring a patient to receive treatment in an inpatient treatment centre and the department had no ability to consider potential placement until the ITO was lifted on 8 February 2018. It is unfortunate though, that because of those delays, the complainant remained restrained for an excessive period of time. As stated earlier, in light of that situation, I query whether a two point restraint should have been given further consideration.

45. It appears from the responses that because the complainant (a) was the subject of an ITO and (b) because of his remand status he could only be transferred to JNH, or MTC and that the possibility of the HDU at YLP was not explored as soon as the complainant became medically stable. The HDU has 38 beds and includes mental health facilities. Whilst the decisions by SA Health in relation to the complainant are not the subject of my report into the department's actions, they are relevant to a broader discussion about systemic issues that will be had outside of this investigation.

46. For the purpose of this report I have formed the view that the complainant's restraints were not reviewed in compliance with 3.1.6 of SOP 013 as it was at the time and that this was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

Opinion

In light of the above, I consider that the department acted in a manner that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act by failing to comply with the requirement of SOP 013 that the complainant's restraints be reviewed every 24 hours.

To remedy this error, I make recommendations under section 25(2) of the Ombudsman Act as set out below.

Summary and Recommendations

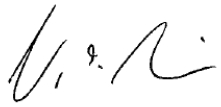
In light of the above, my final view is that the department acted in a manner that was:

1. unreasonable within the meaning of section 25(1)(b) of the Ombudsman Act in regard to the level of restraint used on the complainant for the duration of hospitalisation while subject to departmental custody

2. wrong within the meaning of section 25(1)(g) of the Ombudsman Act by failing to comply with the then requirement of SOP 013 that the complainant's restraints be reviewed every 24 hours.

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

1. remind all staff about the relevant SOPs involving restraint regimes for hospital watches and that the individual circumstances of the prisoner/ patient needs to be taken into account and a default regime is not to be applied automatically
2. provide a letter of apology to my Office to the complainant for the excessive use of restraints while in departmental custody during his hospitalisation in January and February 2018 which I can forward to [the complainant].



Wayne Lines
SA OMBUDSMAN

2 May 2019