OmbudsmanSA

Report

Full investigation - *Ombudsman Act 1972*

Complainant	**Ms Rosemary Bowley**
Department	**Department for Correctional Services**
Ombudsman reference	**2014/00069**
Department reference	**CEN/14/0029**
Date complaint received	**3 January 2014**
Issues	**1. Whether the complainant was shackled in accordance with departmental policy during a hospital visit** **2. Whether the department erred in shackling the complainant during a hospital visit**

Jurisdiction

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

Investigation

My investigation has involved:

- assessing the information provided by the complainant
- seeking a response from the department
- considering *Standard Operating Procedure 13 - Prisoners at Hospital* (SOP 13) and *Standard Operating Procedure 31 - Supervised Prisoner Escorts* (SOP 31) and the *Correctional Services Act 1982*.
- providing the department and the complainant with my provisional report for comment, and considering their responses
- 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

[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.

considerations which must affect the answer to the question whether the issue has been proved … .[2]

Response to my provisional report

The complainant responded to my provisional views by letter dated 19 March 2014. In relation to her shackling, she submitted the following additional information:

- the shackles were so heavy on her legs and wrists that she developed bruises
- blood was being taken 3 to 4 times a day from the artery in her shackled wrist and this was very uncomfortable
- when she went back to hospital on 30 January 2014 to be assessed as to whether she still required oxygen, she was advised that lung volumes and diffusing capacity were unable to be performed 'because I was unable to be transferred to the body box – again, this is because I was in restraints'
- she was confined to a wheelchair as she was unable to walk in shackles because of the pain it gave her. She submitted:

> …The wheelchair was wheeled into the toilet cubical by a male officer, I was left shackled to the wheelchair and had to manoeuvre myself off the chair onto the toilet and back again…

The complainant also made the following additional allegations:

- the department did not inform her son or next of kin of her failing health or hospitalisation (another prisoner informed her son she was in hospital). The complainant submits this was of particular concern as, due to her inability to breath properly, she was asked if she wanted 'a DNR if the BIPAP machine did not work'. She submits her son should have been informed immediately so that he could attend hospital and discuss the 'Do Not Resuscitate' options.
- the complainant was not allowed contact with her family during her hospitalisation
- a replacement walking frame was provisionally approved in November 2013 by the Case Management Coordinator but she has still not received it.

By letter dated 31 March 2014 I informed the department of the complainant's submissions and additional allegations.

The department responded to my provisional report by letter dated 24 April. It acknowledged there were delays in undertaking the Compliance Check, the subsequent review of the complainant's restraints, and in forwarding the Compliance Check to the General Manager of the Adelaide Women's Prison (**AWP**). The department therefore agreed with my provisional finding that it acted in a manner that was wrong by failing to adhere to SOP 013.

However, the department does not agree with my provisional finding that it acted unlawfully in shackling the complainant during her hospital visit and in not exercising discretion as to what restraint was reasonably necessary in the circumstances. The department submitted:

- a finding of unlawfulness cannot be made safely as the complainant's escort was unplanned and the General Manager did not have an opportunity to complete an individual assessment of the restraint regime. Hence, in accordance with paragraph 3.3.1 of SOP 31, the delegate made the assessment based on the complainant's security classification assessment
- the subsequent compliance check resulted in the reduction of the level of restraint applied to the complainant
- the Ombudsman, in his report about the shackling and restraining of prisoners in hospital dated July 2012, agreed that the requirement for a medical escort can emerge without notice and therefore, it is appropriate to rely in the first instance on that

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

prisoner's security rating (however that a review of the restraints should occur in a timely manner)
- it does not agree that it was not necessary to restrain the complainant at all during her hospital stay
- it does not agree that in not exercising discretion as to what restraint was reasonably necessary, it acted unlawfully
- draft versions of SOP 13 and SOP 31 were provided to the Ombudsman's office for feedback, and that feedback resulted in changes to the final versions (in particular paragraph 3.6.14 of SOP 13)
- the department will review any recommendation that a further discretion clause or emphasis on discretion be considered and will respond accordingly.

I have considered these submissions, and acknowledge my previous recommendation that, in a practical sense, it is appropriate to rely in the first instance on the prisoner's security rating. That said, I consider that the current policy of requiring the General Manager to review the compliance check by noon the next business day can result (and has resulted in this case) in a situation where a prisoner is shackled for up to two and half days in a manner that is not reasonably necessary in the circumstances. In my view:
- it was not reasonably necessary in the circumstances for the complainant to be restrained by her legs and a hand from Friday evening until Tuesday; in this sense the department acted in a manner that was contrary to law;
- the relevant policies should be amended to ensure this does not happen in the future; for example by shortening the length of time that the General Manager should review the Compliance Check or by allowing for a delegate to exercise the General Manager's discretion.

I have amended the body of my report to reflect this reasoning.

I remain of the view that it was not 'reasonably necessary' to shackle the complainant during her hospital stay. I point to the reasons provided in paragraph 23 below, and note that the department has not provided support for its assertion that restraints were necessary in the circumstances. In my provisional report, I mistakenly referred to this error as 'acting in a manner that was wrong', and note that I have amended my finding below to 'acting in a manner that is contrary to law'.

The department responded to the additional allegations made by the complainant in her letter to me dated 19 March 2014 as follows:

> *Further submissions in relation to the use of restraints*
> The department submitted that South Australian Prisoner Health Service (SAPHS) have confirmed they have no records that detail the complainant having sustained bruising, or details of any other issues as a result of the application of restraints. Similarly, the departmental records do not reflect the complainant raised any concerns about bruising or pain caused by the restraints.
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> I note the complainant's submissions in relation to these matter. However, given I have found the department erred in utilising restraints in this case, I do not consider it necessary to make a finding of fact as to whether the complainant was bruised by them.
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> In relation to the allegation that the complainant was shackled to a wheelchair whilst using the toilet the department submitted:
> - SOP 13 prescribes that the approved levels of restraints are not decreased during a move to use the toilet and that a closeting chain must be used.
> - officers on duty at the time have confirmed the complainant was escorted to the toilet in a wheelchair, the closet chain (approximately 90 cms in length) did not restrict her in any way, and she was allowed to use the toilet in private

- the complainant did not raise concerns with officers at the time.

I accept that the department was adhering to policy in relation to the use of restraints in toilets. However, I remain of the view it was not reasonably necessary to shackle the complainant at all whilst in hospital.

Informing the complainant's next of kin of her condition and hospitalisation and contact with family

The department submitted that it does not contact family members when a prisoner is in hospital, unless there are special circumstances, the prisoner is in a critical condition or in the case of a medical emergency or death in custody. This policy is outlined in SOP 020A and SOP004 and I note the SOPs create a discretion to be exercised by the General Manager. Pursuant to SOP 13, family visits and telephone calls are not permitted for the first 5 days of hospitalisation. I am advised that contact with the complainant's family was facilitated within this 5 day period.

It appears the department acted in accordance with its policies relating to contacting family. I therefore consider that it did not act in a way that is unlawful, unreasonable or wrong within the meaning of the Ombudsman Act, and that further enquiries into this aspect of the complaint are not necessary or justifiable.

The use of the body box

The day escort visit to the RAH actually took place on 29 January 2014 and, as the complainant was required to be connected to an oxygen machine, she was transported in an ambulance. The General Manager of YLP interviewed the correctional officers who were tasked with that escort. They reported that some initial discussions took place in relation to conducting lung measurements on the complainant using a 'body box' device, and departmental staff were asked if she could be transferred to the body box and remain restrained. However, RAH staff determined that the test was not to be performed given the complainant's assessed fragility at the time, and the fact that it was not warranted as a result of a review of the complainant's previous test results and her presentation during the day escort. Department of Health representatives have advised there was no formal request or need for the restraints to be removed to facilitate the use of the body box, and departmental staff have confirmed there was no request to remove the complainant's restraints. Furthermore, there is no evidence that the complainant raised any concerns at the time, and departmental officers recall her as presenting as compliant and cheerful. Finally, there is no record of the restraints interfering with medical treatment during her periods of hospitalisation.

In the absence of further information to the contrary, I accept the department's account of this visit. It appears that the department has not acted in a way that is unlawful, unreasonable or wrong within the meaning of the Ombudsman Act. Accordingly, further enquiries into this aspect of the complaint are not necessary or justifiable.

Replacement walking frame

The department submitted that the walking frame requested by the complainant has been assessed as posing a security risk. I am advised the frame comes apart to enable transformation from walker to wheelchair and that this could allow the hollow metal part to be used to conceal contraband or to be used as a weapon. SAPHS are of the opinion that the walking frame currently being used by the complainant is adequate for her needs and allows her to stop and sit if she becomes breathless, and have recommended she continue light exercise.

In my view, it appears that the department has not acted in a way that is unlawful, unreasonable or wrong within the meaning of the Ombudsman Act. Accordingly, further enquiries into this aspect of the complaint are not necessary or justifiable.

Background

1. The complainant is a 53 year old woman who was admitted to prison on 30 September 2013. I understand this is her first period of imprisonment.

2. The department has provided the following by way of background:

> …Upon admission to prison, Ms Bowley returned a high stress screening score. As a result, a Notice of Concern was raised and she was placed in the management wing of the Adelaide Women's Prison (AWP) and subject to the monitoring of the High Risk Assessment Team (HRAT).
>
> On the following day, Ms Bowley was seen by medical staff and a Departmental psychologist as part of the HRAT process. She advised that she suffered from Chronic Obstructive Pulmonary Disease (COPD) and at times requires a walking frame (for long distances). Ms Bowley also reported that she has diagnosed Post Traumatic Stress Disorder (PTSD) and anxiety (for which she had prescribed medication).
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> On 26 October 2013, Ms Bowley was placed in the Living Skills Unit in cottage type accommodation at the Adelaide Women's Prison (AWP) and case notes indicate she settled well with no issues or concerns raised. Her walking frame was provided to her in accordance with a medical certificate for her to use (as necessary), as the cottages are located a short walk away from the rest of the general prisoner accommodation and other facilities and amenities…

3. The complainant was admitted to the Royal Adelaide Hospital on the 20 December 2013, suffering from breathing difficulties. The transfer to hospital was an unplanned emergency transfer.

4. I understand the complainant was returned to prison on 2 January 2014. She was placed in the Yatala Labour Prison (**YLP**) Health Centre because she required an oxygen machine. SA Prison Health advised she required constant oxygen, a smoke free environment and access to 24 hour medical care (which could not be provided at AWP).

5. The department has advised that the complainant was able to be removed from oxygen support at the end of January 2014 and it was assessed that her condition had improved enough to warrant a transfer back to AWP on 3 February 2014.

6. The complainant's son contacted my office on 3 January 2014 and advised his mother spent 13 days in hospital for respiratory failure, that she was shackled during that time and that she lost a significant amount of weight, weighing only 46kg now. One of my officers then contacted the complainant who advised that, for the first week she was in hospital, she had an arm and leg manacled to the bed; her ankles were shackled; and, during the second week, she had a manacle from one leg to the bed.

7. Ms Emily Strickland of my office subsequently made enquiries with Ms Sandra Russell, the General Manager of AWP. Ms Russell provided my office with copies of SOP 013 and SOP 031 and relevant 'compliance checklists' for the period the complainant was in hospital. The latter indicate that
    - the level of restraint applied upon admittance to hospital was as follows: leg restraint used between legs; leg restraint to bed; one hand cuffed to bed frame; leg restraint used when prisoner is out of bed.
    - the first compliance check, conducted by Mr Brian Pumfrey, is dated 5.30pm, Monday 23 December 2013. This recommended that the complainant's restraints should be decreased to 'leg restraint to bed only'.

- Ms Russell's approval of this recommendation is dated Tuesday 24 December 2013.

8. By letter dated 23 January 2014 I wrote to the department requesting further information regarding the complainant's period in hospital. The department's response to further enquiries indicate that:
    - Ms Russell's recommendation to decrease the complainant's restraints was implemented on Tuesday 24 December 2013.
    - the complainant was shackled 'leg restraint to bed only' until her transfer to the YLP Health Centre 2 January 2014.

Relevant law/policies

9. 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.
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> 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….
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> …
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> 3.4.1 When a prisoner is admitted to a hospital, escort officers must:
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> …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…
>
> …

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.

> …
>
> 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…
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> …
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> **3.10 Requirements for Review of Restraint Levels for all Prisoners in Hospital**
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> 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…

10. 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 closeting chain and,
d) Legs must be shackled together and,
e) Leg must be cuffed to the bed frame.

6. 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 the complainant was shackled in accordance with departmental policy during a hospital visit

11. The complainant was admitted to hospital on Friday 20 December 2013. I am advised by the department that a Compliance Check was not undertaken until the afternoon of 22 December 2013 (Sunday) which is more than 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 view that the department erred in failing to complete the Compliance Check on Saturday 21 December 2013.

12. The department advises me that the Compliance Check was not forwarded to the General Manager of the AWP until the afternoon of the 23 December 2013 (Monday) and it was not reviewed by the General Manager until the morning of the 24 December 2013. The Compliance Check recommended that the level of restraint should be decreased to one leg restraint, and the General Manager approved that on 24 December 2013.

13. Paragraph 3.1.3 of SOP 013 requires the General Manager to review the Compliance Check as soon as practicable and no later than noon the following business day (after the prisoner has been admitted to the hospital). This means that the review should have occurred prior to midday on Monday 23 December 2013. The fact that it did not take place until the following day means that the complainant was shackled by hand and leg for approximately 24 hours more than would otherwise have been the case. It is my view that the department erred in failing to forward the Compliance Check to the General Manager until Monday 23 December 2014 and in failing to undertake the review until Tuesday 24 December 2014.

14. As I have advised in previous reports about the department, I consider it important that the procedures relating to the restraint of prisoners are adhered to.

Opinion

In light of the above, I consider that the department, in failing to adhere to SOP 013, acted in a manner that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

The department has acknowledged the above errors and has advised me that staff have been reminded of the necessity of adhering to processes and timeframes outlined in departmental procedures. I understand the department has also instigated a review of SOP 013 to address inconsistencies within the document. In these circumstances, I do not consider it necessary to make any recommendations pursuant to section 25(2) of the Ombudsman Act.

Whether the department erred in shackling the complainant during a hospital visit

15. 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.

16. In my report dated July 2012 and entitled *Ombudsman investigation into the Department for Correctional Services in relation to the restraining and shacking of prisoners in hospitals* I found the department's previous policy in relation to the restraint of prisoners on medical escorts was ultra vires in that it did not allow for an assessment of what is reasonably necessary in the circumstances. I recommended policy amendment. In doing so, I recognised that the authorisation of restraints should be done by the relevant prison's general manager and that

> …in a practical context the requirement for a medical escort can emerge without notice , and that as such, it is appropriate for the escort to rely in the first instance on a prisoner's security classification. However, the prisoner must be assessed within a very short time to determine the extent to which restraints are required.

17. In response, the department amended SOP 013 and prepared SOP 031, and provided me with draft copies by letter dated 10 April 2013. By letter to the department dated 22 April 2013, I expressed my concern that the draft procedures still required prisoners to be shackled for unplanned escorts. I understand that changes were made to the SOPs prior to being approved in September 2013 and published on 15 October 2013, and that my comments were taken into consideration in drafting the final versions.

18. Paragraph 3.6.14 of SOP 013 provides the General Manager of the prison with a discretion as to the shackling of prisoners on medical escorts; in this way it is consistent with section 86 of the Correctional Services Act.

19. However, where the hospital visit is unplanned, SOP 013 and 031 provide 'Standard Requirements' that must be applied and these prescribe a high level of restraint upon admittance to hospital in such circumstances. The level of restraint is then reviewed by an officer, a copy of the compliance check and recommendation provided to the General Manager, and the General Manager utilises their discretion as to what level of restraint is reasonably necessary in the circumstances. It is the timeframes provided in the policy that, in my view, make this process problematic.

20. Paragraph 3.1.3 of SOP 013 provides that the General Manager must review the Compliance Check as soon as practicable and no later than noon the following business day (after the prisoner has been admitted to the hospital). 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).

21. In the case of the complainant, the fact that the General Manager was not required under SOP 13 to exercise her discretion until noon on the Monday, did lead to an unreasonable use of force being applied for some time; in my view, it was simply not necessary for the complainant to be shackled by both legs and an arm when she was so ill and this occurred over several days. Accordingly, I consider the department, in applying that level of restraint to the complainant, acted contrary to section 86 of the Correctional Services Act.

22. Whilst I recognise that unplanned medical escorts can occur when the General Manager is not available, and whilst I remain of the view that it is therefore practical in the first instance to rely on the prisoner's security rating, the legal requirement that the use of force must be reasonably necessary in the circumstances must be adhered to. Accordingly, I consider that the department's policies should ensure that the application of the statutory discretion is exercised at the earliest possible time. For example, the length of time that the General Manager must review the compliance check could be shortened and / or a delegate could be allowed to exercise the General Manager's discretion. I note the department has advised it will review any recommendation that a further discretion clause or emphasis on discretion be considered and will respond accordingly.

23. It is also my view that it was not 'reasonably necessary' to shackle the complainant at all during her hospital stay. I understand that the complainant was very sick during this time. She had been admitted to hospital after collapsing due to breathing difficulties; she required oxygen during her hospital stay and whilst at YLP Infirmary; she stayed in hospital for 13 days; and I am informed by her son that she relied on a walking frame to walk more than a few steps at a time. In the absence of evidence to the contrary, I accept this was the case. In light of the complainant's condition it appears she did not constitute a threat to hospital staff or the community and there was little risk of escape. I also note that this was the complainant's first period of imprisonment and there had been no issues or concerns raised about her conduct. In these circumstances, it is my view that the department should have exercised a discretion not to shackle the complainant.

Opinion

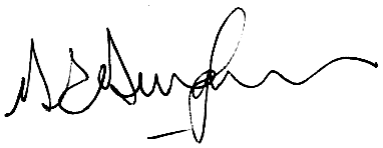
In light of the above, I consider that, in shackling the complainant by both legs and an arm for over two days, the department acted in a manner that was contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.

It is also my view that, in shackling the complainant for the remainder of her hospital visit, 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 the former error, I recommend under section 25(2) of the Ombudsman Act that the department review the SOPs to ensure that the discretion as to what force is reasonably necessary in the circumstances can be exercised almost immediately.

Final comment

In accordance with section 25(4) of the Ombudsman Act, I request that the department report to me by 15 August 2014 on what steps have been taken to give effect to my recommendation/s above; and, if no such steps have been taken, the reason(s) for the inaction.



Richard Bingham
SA OMBUDSMAN

19 May 2014