



OmbudsmanSA

REPORT

**Ombudsman investigation into the Department for Correctional Services
in relation to the restraining and shackling of prisoners in hospitals**

July 2012

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SUMMARY AND RECOMMENDATIONS

Department	Department for Correctional Services
Complainant	Ombudsman own initiative investigation, section 13(2) of the <i>Ombudsman Act 1972</i>
Allegation	Inappropriate restraint and shackling of prisoners while receiving medical treatment in hospital.

In early 2011, following the escape of three prisoners from hospital escorts in 2010, the Executive Director, Custodial Services, of the Department for Correctional Services (**the department**) ordered a review of the security arrangements for prisoners in non secure locations (such as hospitals), and issued an instruction.

The resulting Executive Director's Instruction (EDI 51-11) (**the EDI**) set new minimum standards for restraint of prisoners. It required that prisoners being held in hospital should be handcuffed to the bed using chain; leg cuffed to the bed; and should have their legs shackled together.¹ This method of restraint is demonstrated in the picture below:



After the introduction of the EDI, I received several complaints from medical professionals who were concerned about the excessive restraining of six prisoners in South Australian hospitals. These complaints related to prisoners who were receiving treatment for significant medical conditions, including end-of-life care and giving birth. Arising from these complaints, I commenced an own initiative investigation into the matter.

My investigation considered the relevant international and national standards. I acknowledge that the international instruments referred to in this report are not incorporated into domestic law in the way required by section 3 of the *Administrative Decisions (Effect of International Instruments) Act 1995* (SA), and hence are not binding on state administrative decisions. However, I consider that the department should meet the standards, which provide guidance on model prison systems and the management of prisoners.

My investigation has concluded that under the international and national standards:

¹ Custodial Services Executive Director's Instruction 51-11, version 2, 18 April 2011.

- shackles should only be used in circumstances where there is a serious flight or security risk
- restraints should only be used as a precaution against escape, harm to self or harm to others. Restraints should never be used as a form of punishment
- when the circumstances justify the use of restraints, a soft form of restraint should be used. Chains should not be used
- when the circumstances justify the use of restraints, the restraints must be used for the minimum time necessary, and a strict time limit must be placed on their use
- pregnant women should never be restrained during labour. Further, they should not be restrained during:
 - transport to hospital
 - pre or post natal appointments
 - pre labour, early labour, or post labour recoveryunless they pose a serious risk to themselves or others, or a substantial risk of escaping, and unless they cannot be restrained by any other means
- all guards escorting pregnant women to hospital or to medical appointments should be female
- guards should not be present when a woman is in labour and giving birth. They should be posted outside the door.

In managing the use of restraints, the rights and dignity of each individual prisoner must be carefully balanced with the public's need for protection. The department should aim for best practice in relation to the treatment and management of prisoners, and its policies and practices should guard against the mistreatment of prisoners.

My investigation has concluded generally that:

- the act of restraining prisoners using force that is not reasonably necessary in the circumstances of the particular case exceeds the power of the department under section 86 of the *Correctional Services Act 1982*
- the current departmental arrangements are not consistent with internationally and nationally accepted standards, and lack necessary flexibility and discretion
- the arrangements do not, and should, require that restraints must be rotated to avoid them causing harm to the prisoner.

The six individual cases I considered revealed that:

- some individual prisoners, including a dying man, a pregnant woman and some low risk prisoners, were unnecessarily restrained; and were not afforded dignity as a consequence
- some prisoners were restrained for unnecessarily long periods of time
- a pregnant woman may have been guarded by male guards while undergoing intimate medical procedures and whilst giving birth
- medical staff were unaware that they may be able to request the alteration or removal of restraints in some circumstances; and they were unable to contact prison management in a timely manner
- there is a lack of adequate communication between guards and prison management in relation to the use of restraints.

My conclusion is that the department's failure to adequately consider the individual circumstances of each prisoner in deciding whether to apply restraints breached section 86 of the Correctional Services Act. That section only authorises the department 'to use such force against any person as is reasonably necessary in the circumstances of the particular case'. It is my opinion that in failing to consider adequately the circumstances of each individual prisoner, and whether restraints were necessary in those circumstances, the department has acted in a way which is contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.

Further, I consider that in dealing with six individual prisoners, the department made further administrative errors, and acted in a way which is wrong within the meaning of section 25(1)(g) of the Ombudsman Act.

On 11 July 2012, the department's Chief Executive (**the CE**) advised me in response to my provisional report that:

Consistent with the legal advice provided by the Crown Solicitor the Department for Correctional Services is committed to ensure that the use of restraints complies with legislative requirements whilst at the same time meeting its obligation to provide for public safety and security. I am confident that the proposed changes to policies, practices and procedures will appropriately address these requirements whilst also maintaining the public confidence into the department ensuring the highest level of community safety for prisoners in non-secure locations.

I make the following recommendations under section 25(2) of the Ombudsman Act.

Recommendation 1

In keeping with the department's obligation under section 86 of the Correctional Services Act to consider the circumstances of each case before using reasonable force, the use of restraints should in each case be appropriately authorised. This should be done by the relevant prison's general manager. I accept 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.

Recommendation 2

Restraints should be applied commensurate with the assessed risk of a prisoner and the individual circumstances relating to the particular environment, the security risks and the individual characteristics and medical condition of a prisoner. The level of restraint used should be determined by what is reasonably necessary for the safety of the prisoner, the medical staff and the public.

Recommendation 3

When the circumstances justify the use of restraints, a soft form of restraint should be used. Chains should not be used.

Recommendation 4

When the circumstances justify the use of restraints, the prisoner must be frequently assessed to determine if the level of restraints used is still appropriate, given that the individual circumstances relating to the particular environment, the security risks and the individual characteristics and medical condition of a prisoner change.

Recommendation 5

Pregnant women should never be restrained during labour. Further, they should not be restrained during:

- transport to hospital
- pre or post natal appointments
- pre labour, early labour, or post labour recovery

unless they pose a serious risk to themselves or others, or a substantial risk of escaping, and unless they cannot be controlled by any other means.

Recommendation 6

The use of restraints should be clearly and accurately recorded. The record should include the type of restraints used, the duration of use, the reasons for use and the names of all people involved. Restraint incident forms containing all restraint information should be kept in accordance with the *State Records Act 1997*, and be readily accessible to review, including by the Ombudsman.

Recommendation 7

Guards should seek immediate advice from the relevant prison's general manager if:

- an at risk prisoner has significant injuries that mean leg or handcuffs cannot be used
- a medical officer advises against the use of restraints
- a prisoner's medical condition renders the use of restraints inappropriate
- the use of restraints is apparently causing harm to the prisoner.

Recommendation 8

At least one guard supervising a prisoner in hospital should be of the same gender as the prisoner. All guards escorting pregnant women to hospital or to medical appointments should be female.

Recommendation 9

Guards should not be present at a prisoner's medical appointment or examination unless the prisoner poses a serious risk to themselves or others, or a substantial risk of escape. In most instances guards should be posted outside the door. Guards should not be within hearing or sight of pregnant women undergoing pre or post natal appointments.

Recommendation 10

Guards should not be present when a woman is in labour and giving birth. They should be posted outside the door.

RESPONSE FROM THE DEPARTMENT FOR CORRECTIONAL SERVICES

By letter dated 11 July 2012, the department's Chief Executive (**the CE**) provided a 25 page submission in response to my provisional report. A summary of his comments is as follows:

- the department does not accept that it is failing to meet its legislative obligations as they relate to maintaining the secure custody of prisoners when on leave of absence from a prison. It is satisfied that conditions placed on the conduct of escorts for individual prisoners are consistent with sections 24 and 27 of the Correctional Services Act
- section 24 of the Correctional Services Act stipulates that the CE has custody of the prisoner whether within or outside the prison within which they are detained. This section also provides the CE with an absolute discretion to place the prisoners in any particular prison and to establish a regime for any individual or class of prisoner
- section 27 of the Correctional Services Act provides for prisoners to be granted a Leave of Absence to attend various external appointments, including escorts for medical appointments and for the purpose of hospital admissions. Sub-section 2 provides the CE with the authority to place specific conditions on an escort as he or she sees fit
- the department did not consider that the application of restraints for the purpose of conducting an escort to a location outside a prison constitutes a 'use of force' pursuant to section 86 of the Correctional Services Act. Rather, it was of the view that the use of restraints whilst escorting a prisoner constitutes a condition stipulated pursuant to section 27 of the Act. However, the department acknowledges and accepts the advice provided by the Crown Solicitor that section 86 applies in these instances. As such, the department will conduct a further review of its policy and procedures to fully assess the implications of this advice
- when conducting external escorts of prisoners, the use of some restraints as a condition of the escort is likely to continue to occur in most instances. The use of restraints as one of the conditions of an escort is fundamental to the maintenance of a prisoner's security
- the department is committed to ensuring that the use of restraints complies with legislative requirements whilst at the same time meeting its obligation to provide for public safety and security
- the strengthening of security arrangements for escorts to non secure locations was precipitated by a number of escapes. In total there were seven escape incidents involving eight prisoners in the period 28 March 2010 to 30 April 2011. The submission states that as a result of these escapes, and subsequent further offending, the safety of the public was placed at significant risk
- since April 2011 the department has considerably tightened its controls with respect to the transfer of prisoners to non secure locations, and this has included the use of additional restraints on all prisoners under escort. It says that this has been in direct response to a heightened level of risk and an increased probability that prisoners will attempt to escape whilst on escort
- since May 2011 there have been no escapes from custody. This is due to the strengthening of the restraint requirements for the escort of prisoners to non-secure locations
- all prisoners admitted to the department's custody are subject to an individual security assessment (Prisoner Classification) and this security assessment is subject to regular review (Classification Review). It is this individual assessment that first and foremost underpins the setting of escort conditions. The department acknowledges that it is clear from the Crown Solicitor's advice that this assessment in and of itself cannot be relied upon when setting conditions for external escorts and that other factors such as risk of escape, risk to the public and the prisoner's medical condition also need to be considered. As such, the department intends to develop a revised policy and procedure to appropriately assess each prisoner when setting escort conditions. This process will consider appropriate individual factors. In addition, where a prisoner is admitted to

hospital, the department will introduce further points of review where a delegate can recommend to the responsible general manager a variation to levels and/or types of restraints applied. The department will also amend procedures to make clear that an escort officer (where discretion is not permitted) can effectively escalate a recommendation to vary restraints based on their own assessment and/or upon request from a medical officer

- the department is required to escort prisoners to hospital at very short notice and at all times of the day. In some instances custody is actually transferred in the hospital. As such, access to relevant information about the prisoners at the point of assessment can be limited and the time in which to complete an assessment can be extremely short. It is vital that the department's officers maintain the security of the prisoner to ensure public safety, the safety of staff and the prisoner. Furthermore, the department needs to provide clear guidance and parameters to the delegate when they are determining escort conditions including the use of restraints. It is appropriate for the escort to rely in the first instance on the prisoner's security classification when determining the level of restraint and other conditions on the escort
- the case studies included in the provisional report do not recognise the actual limitations on the information available to the department at the time of each of those hospital admissions
- there are no appropriate assessment tools that would provide decision makers with an instantaneous overview of the actual risk that a prisoner poses of escape or causing harm to others. Therefore a standard minimum restraint regime will have to continue to apply for standard escorts (subject to modification as medically required). In future, this will be subject to a review within a short period of time to establish the adequacy of the restraints or if the restraint regime can be reasonably relaxed. It is agreed that this assessment and any change to a restraint should be authorised by the relevant general manager
- the department agrees that, in cases where a prisoner is required to remain in hospital, or where the need to be taken to a non-secure facility is known in advance, individual assessments need to be undertaken to establish the appropriate restraints regime prior to their being escorted to a non-secure facility
- the department agrees that soft restraints should be used for prisoners who are hospitalised, and, where suitable, in other cases of prisoner movement in non-secure locations. The department has commenced investigating suitable soft restraints. Until such soft restraints have been identified and procured, the department will continue to use the standard restraints but remains committed to introducing suitable soft restraints in the future
- the department agrees that insufficient consideration was given to Prisoner D's pregnancy when determining conditions for her escort and hospital admission. The department also agrees that EDI 51-11 does not provide direction to staff with respect to assessing the conditions for escorting a pregnant prisoner. As such, the department will modify its procedures to adopt a policy for the future that will apply the following principle:

Where a prisoner is in the last trimester of their pregnancy and is on external escort the prisoner must not be restrained. Where specific risk factors exist that cannot be mitigated through other escort conditions and a level of restraint is considered necessary that approval in these circumstances must be obtained from by [sic] the Executive Director Custodial Services.²

- the department agrees with recommendations 7, 8 and 11 (i.e. renumbered as recommendations 6, 7 and 10 in this report)
- the department agrees in principle with recommendation 9 (recommendation 8 in this report), that at least one guard supervising a prisoner in hospital should be of the same

² The department's response to the provisional report, by letter dated 11 July 2012.

gender as the prisoner, and that all guards escorting pregnant women to hospital or to medical appointments should be female. However, it acknowledges that at times this may not be possible, but it commits to do everything it can to limit these occasions and durations of time

- the department is satisfied that it meets relevant standards and guidelines as they relate to the conduct of escorts and treatment of prisoners during these escorts. The department's view is that 'where appropriate it has taken into account the international standards and agreements but notes that no aspect of the restraint policies and directions can be said to be unlawful on the basis it does not comply with those standards.' The department's response provides discussion of its compliance with each of the international standards referenced
- there are examples where international agreements set a different standard from the Correctional Services Act. In such cases the department must act in accordance with the legislation
- the department rejects that the use of restraints constitutes cruel, inhumane or degrading treatment
- South Australia, unlike a number of other Australian jurisdictions, does not have a secure ward for the accommodation of prisoners admitted to hospital
- the department appreciates and shares the concerns stated in the provisional report with respect to people with mental illness. It notes that it is not the role of the department to determine that a person should face charges, and further, it is not the department's responsibility to determine that they should be remanded in custody
- the department notes that three of the case studies referred to were prisoners detained under the *Mental Health Act 2009*. Whilst people who are detained under the Mental Health Act are mental health patients for the purpose of that Act, they also remain prisoners pursuant to the Correctional Services Act and the Chief Executive must maintain custody of them pursuant to that Act. The department recognises that there is a tension between the working of the two Acts especially where a prisoner is accommodated in an open ward in the general part of a health facility. The department has worked with the Health Department to identify appropriate secure wards where prisoners detained under the Mental Health Act can be safely accommodated to receive treatment for their mental health needs. Unfortunately, it is often the case that these prisoners remain in a general ward for a number of days whilst awaiting a bed in a secure mental health ward. This is not a matter that the department can influence
- the department acknowledges that when a prisoner goes into a public place under restraint they may feel that their dignity is compromised. The department takes reasonable steps to assist the prisoner to preserve their dignity
- department escorts, including those of contracted service provider G4S, do not carry firearms
- instruments of restraint are never used as a punishment
- the department submits that the provisional report was selective in reporting interstate practice. The department provides its understanding of the use of restraint for prisoner escorts to non secure locations in the three largest Australian jurisdictions, as follows:

New South Wales

- New South Wales legislation is silent on the use of restraint on prisoners
- Minimum security prisoners are generally not cuffed, however this is at the discretion of the escorting officer, who can cuff a prisoner if it is necessary
- All other prisoners are cuffed on escorts
- All maximum security prisoners must also be ankle cuffed
- Whilst at hospital, prisoners remain cuffed at all times unless requested by medical staff to remove cuffs for treatment or assessment. In such instances, alternatives [sic] cuffing may occur, such as cuffing to the bed or officer
- Female prisoners are not cuffed during labour. Females over 22 weeks into their pregnancy are not cuffed at all

Victoria

- The Victorian Corrections Act 1986 states that authorised instruments of restraint can be applied to a prisoner to prevent escape or the assault of or injury to any persons
- Cuffing for escorts is dependant on an individual risk assessment, including the prisoner's security classification
- High security prisoners are escorted by the Security and Escort Services Group - they are in a body belt, hand cuffs and leg restraints (handcuffs attached to body belt)
- Cuffing when admitted to hospital depends on which hospital
- St Vincent's hospital has its own purpose built secure ward, with air locks. Prisoners in this ward are not restrained
- When admitted to other hospitals (no secure ward), prisoners are wrist cuffed to the bed. A minimum security prisoner may not be cuffed at all but would be supervised by an escorting officer
- Restraint of a female giving birth is unlikely but depends on the risk assessment. it may be that she is not cuffed and an extra (female) officer is placed in the room while she gives birth

Queensland

- Queensland legislation is silent on the use of restraints on prisoners
 - Some hospitals have secure wards
 - The main hospital used for prisoners in Brisbane is the Princess Alexandra Hospital, which has a secure ward
 - Prisoners admitted to the hospital are accommodated in the secure ward and may be taken on escort to other parts of the hospital for tests, treatment etc
 - Cuffing on escort to/from hospital depends on the location - whether going to/from a secure location, whether there will be walking involved etc
- the department submits that other jurisdictions make use of restrains to prevent escapes in a similar manner to which South Australia does. It submits that the following standards are generally applied:
 - Where a prisoner is being escorted from a secure to non secure location they are generally escorted in restraints. At a minimum that involves the application of handcuffs. In some instances additional restraints are applied including leg shackles and the use of body belts
 - Where a secure custody prisoner is admitted to a Hospital and they are placed in an open ward or room then they are usually restrained
 - Jurisdictions apply additional restraints based on assessed levels of risk and or the specific class of prisoner
 - All three jurisdictions make extensive use of armed (issued firearms) escort officers to oversee the escort of secure custody prisoners. This does at times include placing an armed officer on a prisoner admitted to a non secure part of a hospital
 - All three jurisdictions have high security wards utilised for the general admission of prisoners requiring in-patient care
 - the department submits that it has not failed to adequately consider the individual circumstances of each prisoner in deciding whether to apply restraints. Whilst the department acknowledges that the type of individual assessment could be varied in some instances and that there is a need for subsequent assessments to be carried out whilst a prisoner is in hospital, in the event that there circumstances change, the department submits that it did not act contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.

I have considered the submission from the department, and taken account of it as I consider appropriate in preparing this report. I note in particular that I have deleted recommendation 3, and amended recommendations 1, 2 and 5, from my provisional report.

JURISDICTION

1. This investigation is fully within the jurisdiction of the Ombudsman. It stemmed from several disclosures under the *Whistleblowers Protection Act 1993* about prisoners being unreasonably restrained when they were under the supervision of the department, and were receiving medical treatment in hospitals. In order to protect the identities of the whistleblowers, I commenced an own initiative investigation under section 13(2) of the *Ombudsman Act 1972*. That section provides:
 - (2) The Ombudsman may make such an investigation either on receipt of a complaint or on the Ombudsman's own initiative ...
2. After conducting enquiries into the disclosures, on 14 October 2011 I formally advised the principal officer of the department that I had decided to conduct a preliminary investigation into the use of shackles and other restraints on prisoners who were receiving medical treatment in South Australian hospitals. On 9 February 2012 I advised the principal officer that I was treating the matter as a full investigation.
3. Where I conduct an 'own initiative' investigation, the mandatory steps include:
 - where I make a report affecting an agency, allowing the principal officer a reasonable opportunity to comment (section 18(4))
 - reporting evidence of a breach of duty or misconduct on the part of a member, officer or employee of an department to the department's principal officer (section 18(5))
 - where I consider the administrative act to which the investigation relates has one or more failings described in section 25(1), reporting my opinion and reasons to the principal officer of the agency (section 25(2))
 - sending a copy of any report or recommendation to the responsible Minister (section 25(3)).
4. If I consider it to be in the public interest or in the interests of an agency, I may have a report on an investigation published in such a manner as I think fit (section 26). In this case, I consider it appropriate to publish this report by seeking to have it tabled in the Parliament.
5. Section 13(1) the Ombudsman Act provides:
 - (1) Subject to this Act, the Ombudsman may investigate any administrative act.
6. This investigation is about the administrative acts of the department relating to the restraining of prisoners in South Australian hospitals. It concerns the department's implementation of its policies on the restraint of prisoners in hospitals, and the practices which are purportedly guided by the policies.
7. I do not have jurisdiction to investigate matters of policy and make related findings under section 25 of the Ombudsman Act. However, and in this instance, it is within the proper exercise of my functions to draw attention to the policies of the department in relation to the restraint of prisoners; to the way in which they operate; and how such operation might be unreasonable.³

³ City of *Salisbury v Biganovsky* (1990) 54 SASRJ.

INVESTIGATION

8. My investigation has comprised:
- assessing the information provided by the complainants/whistleblowers
 - seeking a response from the department
 - clarifying the department's response
 - seeking further particulars from the complainants/whistleblowers
 - seeking further information from the department, and clarifying this information
 - seeking medical records from the relevant hospitals
 - seeking information from medical professionals
 - considering the hospital watch journals for two prisoners
 - considering various versions of the Custodial Services Executive Director's Instruction 51-11
 - considering Standard Operating Procedure (SOP) SOP 013 - Prisoners at Hospital, version 01, 12/07/2010
 - considering SOP 031 - Prisoner Escorts and Hospital Watches, version 1.0, approved 23/05/2001
 - considering SOP 32 - Use of Restraint Equipment, version 1.0, modified 17/01/2001
 - considering SOP 001B Custodial - Assessment - Case Management, version 04, 28/10/2011
 - considering the department's Security Classification Assessments in relation to one prisoner
 - speaking with staff at the Royal Adelaide Hospital (**the RAH**)
 - speaking with staff at the Women's and Children's Hospital (**the WCH**)
 - preparing a provisional report
 - providing my provisional report to the department and the Crown Solicitor's Office
 - meeting with the Crown Solicitor and the CE of the department
 - considering the Crown Solicitor's advice, and the response to my provisional report from the department
 - preparing this report.
9. I obtained records and information in relation to six prisoners from the department, the RAH and the WCH. As I do not consider the identity of the prisoners who were restrained to be relevant to my investigation, in my report I refer to these prisoners as Prisoner A, Prisoner B, Prisoner C, Prisoner D, Prisoner E and Prisoner F. I have attempted to contact these prisoners to inform them of my investigation. Where I have determined that it is not appropriate to speak to them directly I have spoken to their next of kin. I have not interviewed any of the prisoners or received any information from them. I have chosen to rely on the records provided to me by the relevant hospitals and the department.

STANDARD OF PROOF

10. The standard of proof applied is on the balance of probabilities. However, in determining whether that has been met, in accordance with the *Briginshaw* principle I have borne in mind the nature of the allegations and the consequences if they were to be upheld. That decision recognises that questions of fact vary greatly in nature, and greater care is needed in scrutinising the evidence in some cases.⁴ It is best summed up in the following statement of Dixon J:

⁴ see *Briginshaw v Briginshaw* (1938) 60 CLR 336. Applied in *Neat Holdings Pty Ltd v Karajan Holdings Pty Ltd* [1992] HCA 66; (1992) 110 ALR 449 at 449-450 per Mason CJ, Brennan, Deane and Gaudron JJ.

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 to the reasonable satisfaction of the tribunal.⁵

BACKGROUND

11. All adult prisoners held on remand and under sentence in South Australia are under the care of the department. Except as noted below, it is responsible for all aspects of their care.
12. The Department for Health and Ageing, through the South Australian Prisoner Health Service (**SAPHS**), provides health services in the nine state prisons.⁶ It provides a range of primary services from nursing staff, salaried medical officers, visiting medical practitioners and a limited range of allied health services.
13. Yatala Labour Prison and the Adelaide Remand Centre have small medical centres capable of managing semi-acute health problems, which are operated by SAPHS. Also, a limited 24-hour nursing service is provided at these sites. On-site psychiatric clinics are provided at these prisons by Forensic Mental Health Services, which also provides a separate inpatient facility at James Nash House.⁷
14. Most secondary and tertiary health care and most allied health services are provided off-site through the public health system.⁸
15. Generally, when prisoners are receiving medical treatment in hospital they are under the supervision of the department. However, this varies with mental health patients. When mental health patients are in an emergency department or an open ward of a hospital, their security is managed by the department. Once a mental health patient is transferred to a secure, locked ward all restraints and guards are removed, and they can be accommodated to receive treatment for their mental health needs.
16. This investigation relates only to the restraint of prisoners who are receiving treatment in the general wards of South Australian public hospitals whilst restrained and under the supervision of the department.
17. In this report, reference to ‘restraints’ means (unless specified otherwise) the physical restraint of prisoners in hospital through the use of three specific limitations on their movement. Under the EDI, the prisoners have one hand cuffed to the bed using chain; they have one leg cuffed to the bed; and their legs are shackled together. This type of restraint is referred to as ‘shackling’. The New Shorter Oxford Dictionary includes in its definition of the word ‘shackle’:

Shackle: A chain or ring enclosing the ankle or wrist... either of a pair connected together by a chain fastened to the floor, wall etc.

⁵ *Briginshaw v Briginshaw* (1938) 60 CLR 336 at 361-362.

⁶ The Adelaide Remand Centre, Yatala Labour Prison, Adelaide Women’s Prison, Cadell Training Centre, Port Lincoln Prison, Mobilong Prison (Murray Bridge), Port Augusta Prison, , Mount Gambier Prison, Adelaide Pre-Release Centre. <http://www.corrections.sa.gov.au/sa-prisons>.

⁷ Belcher J and Al-Yaman F. Prisoner Health in Australia - Contemporary information collection and a way forward, Australian Institute of Health and Welfare, Canberra, 2007, p135.

⁸ Australian Institute of Health and Welfare 2010. The health of Australia’s prisoners 2009, p135.

ESTABLISHED STANDARDS ON THE USE OF RESTRAINTS

International

18. Australia is a signatory to numerous international instruments that protect a range of rights relating to prisoners, notably the International Covenant on Civil and Political Rights (ICCPR). The United Nations Human Rights Committee has made it clear that prisoners enjoy all the rights set out in the ICCPR, subject to 'restrictions that are unavoidable in a closed environment'.⁹
19. Article 10 of the ICCPR states:
 1. All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.¹⁰
20. Australia also is a signatory to the Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).¹¹ Whilst Australia has not yet ratified the protocol, on 28 February 2012 the National Interest Analysis for OPCAT was tabled in the Commonwealth Parliament.¹² The National Interest Analysis proposes that Australia take steps towards ratifying OPCAT.¹³
21. OPCAT reaffirms that 'torture and other cruel, inhuman or degrading treatment or punishment are prohibited'. Article 16 states:

Each State Party shall undertake to prevent in any territory under its jurisdiction other acts of cruel, inhuman or degrading treatment or punishment which do not amount to torture as defined in article 1, when such acts are committed by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. In particular, the obligations contained in articles 10, 11, 12 and 13 shall apply with the substitution for references to torture to other forms of cruel, inhuman or degrading treatment or punishment.¹⁴
22. Whilst these international treaties are not enforceable in Australia, they set out what is generally accepted as being good principle and practice in the management of prisoners.
23. There are also international standards that provide guidance as to the acceptable standards for the treatment of prisoners. These include the three main United Nations standards relating specifically to prisons, namely:
 - the Standard Minimum Rules for the Treatment of Prisoners (**the UN Standard Minimum Rules**)¹⁵

⁹ <http://www.unhchr.ch/tbs/doc.nsf/0/3327552b9511fb98c12563ed004cbe59?Opendocument> General Comment 21.

¹⁰ International Covenant on Civil and Political Rights, opened for signature 16 December 1966, United Nations General Assembly Resolution 2200A [XXI].

¹¹ Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, United Nations, 18 December 2002.

¹² National Interest Analysis [2012] ATNIA 6, Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment. http://www.aph.gov.au/Parliamentary_Business/Committees/House_of_Representatives_Committees?url=/jsct/28february2012/treaties/torture_nia.pdf

¹³ Media release, The Hon Nicola Roxon MP, Attorney-General, The Hon Craig Emerson MP, Minister for Trade, Acting minister for Foreign Affairs, Gillard Government Moves to Ratify OPCAT, 28 February 2012, <http://parlinfo.aph.gov.au/parlInfo/search/display/display.w3p;adv=yes;orderBy=customrank;page=0;query=28%2Bfebruary%2B2012%2Boptional%2Bprotocol%2Bto%2Bthe%2Bconvention%2Bagainst%2Btorture%2Bopcat;rec=0;resCount=Default>

¹⁴ Optional Protocol to the Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment, United Nations, 18 December 2002.

¹⁵ Standard Minimum Rules for the Treatment of Prisoners, United Nations, 13 May 1977.

- the Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment (**the UN Body of Principles**)¹⁶
 - the Basic Principles for the Treatment of Prisoners (**the UN Basic Principles**).¹⁷
24. Whilst the United Nations standards are not legally binding, they seek to describe a model prison system. The Australian Institute of Criminology website states that these standards:
- ... set out what is accepted to be good general principle and practice in the treatment of prisoners. They represent the minimum conditions which are accepted as suitable by the United Nations and, as such, are also intended to guard against mistreatment, particularly in connection with the enforcement of discipline and the use of instruments of restraint in penal institutions.¹⁸
25. Rule 33 of the UN Standard Minimum Rules states that chains shall not be used as restraints. The rule further states that other forms of restraints should only be used in given circumstances. It provides as follows:
- Instruments of restraint**
33. Instruments of restraint, such as handcuffs, chains, irons and strait-jackets, shall never be applied as a punishment. Furthermore, chains or irons shall not be used as restraints. Other instruments of restraint shall not be used except in the following circumstances:
- a. As a precaution against escape during a transfer, provided that they shall be removed when the prisoner appears before a judicial or administrative authority;
 - b. On medical grounds by direction of the medical officer;
 - c. By order of the director, if other methods of control fail, in order to prevent a prisoner from injuring himself or others or from damaging property; in such instances the director shall at once consult the medical officer and report to the higher administrative authority.
26. Rule 34 of the UN Standard Minimum Rules provides that when instruments of restraint must be used, they should not be used for any longer than is absolutely necessary. It states:
34. The patterns and manner of use of instruments of restraint shall be decided by the central prison administration. Such instruments must not be applied for any longer time than is strictly necessary.
27. Both the UN Body of Principles and the UN Basic Principles provide that prisoners should be treated in a humane manner, and with respect for the inherent dignity and value as human beings.¹⁹ The UN Basic Principles state that 'prisoners shall have access to the health services available in the country without discrimination on the grounds of their legal situation.'²⁰
28. The international instruments referred to in this report are not incorporated into domestic law in the way required by section 3 of the *Administrative Decisions (Effect of International Instruments) Act 1995* (SA). This Act provides that international instruments that are binding in international law are binding on state administrative decisions 'only to the extent the instrument has the force of domestic law under an Act

¹⁶ Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment, United Nations, 9 December 1988.

¹⁷ Basic Principles for the Treatment of Prisoners, United Nations, 14 December, 1990.

¹⁸ http://www.aic.gov.au/criminal_justice_system/corrections/reform/standards.aspx

¹⁹ Basic Principles for the Treatment of Prisoners, United Nations, 14 December, 1990, Principle 1.

²⁰ Basic Principles for the Treatment of Prisoners, United Nations, 14 December, 1990, Principle 9.

of the Parliament of the Commonwealth or the State.²¹ Nonetheless, it is my view that in a community such as South Australia, we should be aiming to exceed these minimum international standards in the humane treatment of prisoners.

Australia

29. The Standard Guidelines for Corrections in Australia (**the Standard Guidelines**) were first published in 1978.²² They have been periodically reviewed, revised and updated, with the last revision undertaken in 2004.²³ They are widely accepted as providing appropriate standards for the management of prisoners in Australia.
30. The Standard Guidelines set out ten guiding principles. These stress the importance of balancing the need for public safety with the proper treatment of the prisoner according to their individual security risk. Principle 2 states:

The management of offenders shall seek a proper balance between their needs, rights and responsibilities; those of victims; and those of society for public safety, crime prevention, and reparation.

Principle 5 states:

The management of offenders should be based on an assessment of the security risk they present, their risk of re-offending, and be tailored to address their individual criminogenic needs.

31. In relation the use of restraints, Guideline 1.63 of the Standard Guidelines states:

1.63 Any instruments of restraint are to be used in a timely, appropriate and legal manner for the minimum time necessary. Instruments of restraint should be:

- used only where the restraint of a prisoner is strictly necessary to maintain the security of the prisoner or prevent injury to any person;
- of the least restrictive type appropriate;
- applied for the minimum time necessary to control the prisoner; and
- removed during medical tests and procedures, provided this meets the security and management requirements.²⁴

32. I have undertaken a basic overview of the practices in other states and territories of Australia concerning the use of restraints on prisoners in hospitals. I refer also to the information provided to me by the CE in response to my provisional report. It appears to me that no other state or territory has adopted practices similar to those under the EDI involving the cuffing and shackling of all prisoners in hospitals as a minimum standard.

33. For example, the relevant Victorian regulations state:

Division 3—Restraint

13 Prescription of instruments of restraint and their manner of use

²¹ *Administrative Decisions (Effect of International Instruments) Act 1995* (SA), sub-section 3(1).

²² Standard Guidelines for Corrections in Australia, Revised 2004.

²³ http://www.aic.gov.au/criminal_justice_system/corrections/reform/standards.aspx.

²⁴ *Ibid.*

²⁴ *Ibid.*

- (1) A prison officer or an escort officer may apply an instrument of restraint to a prisoner only if the Governor believes on reasonable grounds that the instrument of restraint is necessary.
- (2) A prisoner must not be kept under restraint longer than is necessary.
- (3) If the immediate safety of a prisoner or the security of the prison is threatened, a prison officer or an escort officer may apply an instrument of restraint to a prisoner if the officer believes on reasonable grounds that it is necessary.
- (4) Subject to this Division, a prison officer or escort officer may restrain a prisoner by using any of the following instruments of restraint–
 - (a) handcuffs;
 - (b) arm restraints;
 - (c) leg restraints;
 - (d) belts which restrain parts of the body.
- (5) An instrument of restraint must be used–
 - (a) as directed by the Governor; and
 - (b) in the manner approved by the Commissioner.

14 Use of restraint for lengthy period

- (1) The Governor must advise the Secretary immediately if an instrument of restraint is applied to a prisoner–
 - (a) for a continuous period of more than 18 hours; or
 - (b) for a cumulative period of 36 hours in any 96 hour period.
- (2) The Secretary may order the removal of the instrument of restraint at any time.

15 Use of restraint during transport

- (1) A prison officer or an escort officer may apply an instrument of restraint to a prisoner for the duration of a transfer of the prisoner under escort from one place to another if the Governor believes on reasonable grounds that the application of the instrument of restraint is necessary to prevent the escape of the prisoner or the assault of, or injury to, any person.
- (2) A prison officer or an escort officer may apply an instrument or an additional instrument of restraint to a prisoner during a transfer of the prisoner under escort from one place to another if the prisoner's conduct during transfer has been such that it is reasonable to believe that the application of the instrument of restraint is necessary to prevent the escape of the prisoner or the assault of, or injury to, any person.
- (3) A transfer of a prisoner from one place to another referred to in subregulations (1) and (2) includes a prisoner moving from one area of a prison to another area of a prison.

16 Report to Governor by prison officer

Except when a prison officer or an escort officer has applied handcuffs to a prisoner under escort as directed by the Governor, the officer must report to the Governor the use of an instrument of restraint on a prisoner as soon as possible after the instrument is applied to the prisoner.²⁵

34. Other states and territories appear to be guided largely by the Standard Guidelines, which make it clear that instruments of restraint should only be used in limited circumstances and for the minimum time necessary.

²⁵ Corrections Regulations, Victoria, Version No. 002, 2009.

35. 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.

MEDICAL ETHICS

36. Whilst national and international standards, principles and guidelines have been established with the aim of protecting the human rights of prisoners, international principles of medical ethics also guide the role of medical professionals in the treatment of prisoners.
37. On 18 December 1982, the UN General Assembly adopted the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman and Degrading Treatment.²⁶ This document includes the following principles:

Principle 1

Health personnel, particularly physicians, charged with the medical care of prisoners and detainees have a duty to provide them with protection of their physical and mental health and treatment of disease of the same quality and standard as is afforded to those who are not imprisoned or detained.

Principle 2

It is a gross contravention of medical ethics, as well as an offence under applicable international instruments, for health personnel, particularly physicians, to engage, actively or passively, in acts which constitute participation in, complicity in, incitement to or attempts to commit torture or other cruel, inhuman or degrading treatment or punishment.

Principle 5

It is a contravention of medical ethics for health personnel, particularly physicians, to participate in any procedure for restraining a prisoner or detainee unless such a procedure is determined in accordance with purely medical criteria as being necessary for the protection of the physical or mental health or the safety of the prisoner or detainee himself, of his fellow prisoners or detainees, or of his guardians, and presents no hazard to his physical or mental health.

38. The World Health Organisation provides a guide for the management of prisoners' health called 'Health in Prisons, a WHO Guide to the Essentials in Prison Health'.²⁷ The guide addresses the internationally acceptable standards relating to the health of prisoners, and includes the following comment in relation to the restraint of prisoners:

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

²⁶ Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman and Degrading Treatment, United Nations, 18 December 1982.

²⁷ Health in Prisons, A WHO Guide to the Essentials in Prison Health, World Health Organisation, 2007.

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.

Medical personnel should never proceed with medical acts on restrained people (this includes people in handcuffs), except for patients suffering from an acute mental illness with potential for immediate serious risk for themselves or others. Doctors should never agree to examine a blindfolded prisoner.

39. In each of the instances of the use of restraints which my investigation considered, none were for medical reasons. In each case, the department required the prisoners to be restrained during medical treatment for security reasons. It is also apparent from my investigation that not all doctors treating the prisoners were aware of their right to request the removal of restraints for the purpose of treating their patients.

THE DEPARTMENT'S POLICIES IN RELATION TO THE RESTRAINING OF PRISONERS

40. Version 1 of the department's SOP 32, 'Use of Restraint Equipment' was created on 7 December 2000. It stated:
- 2.1 The Department for Correctional Services recognises it is necessary to restrain prisoners in certain situations, in order to ensure the safety and security of prisoners, employees and the public.²⁸
41. SOP 32 was modified on 17 January 2001 to create version 1.01, which included the following:
- 8.1 Restraining certain prisoners minimises the potential for escapes and for incidents which may cause harm to both employees and prisoners. In order to minimise the risks, employees for the purpose of exercising their powers on discharging their duties, are authorised under Section 86 of the *Correctional Services Act 1982*, to use such force against any person as is reasonably necessary in the circumstances of the particular case.
- 8.2 Restraint equipment must not be applied as punishment under any circumstances and must only be applied for as long as it is necessary to maintain the security of the prisoner or for the protection of the prisoner, other prisoners, employees, other members of the public or prison property.
- ...
- 12.2.2 Restraints may be applied when a prisoner is an in-patient at a hospital or prison infirmary where his/her security classification or behaviour determines that restraints are to be used.
42. In early 2011, following the escape of three prisoners from hospital escorts in 2010, the Executive Director ordered a review of the security arrangements for prisoners in hospitals and issued an instruction. The EDI effectively replaced SOP 32, and set new minimum standards which required that prisoners in non-secure locations (which includes hospitals and doctors surgeries) must be handcuffed to the bed; leg cuffed to

²⁸ SOP 32 - Use of Restraint Equipment, version 1.0, 7/12/2000.

the bed; and have their legs restrained together, whilst they are admitted to hospital or receiving emergency treatment.²⁹

43. The department has informed me that Version 1 of the EDI was not released, and essentially became Version 2 on release.³⁰ Version 2 was issued on 18 April 2011.
44. On 5 May 2011, Version 3 of the EDI was released. This had only minor differences to Version 2. It included the following:

RE: Minimum Standards: Restraints used for Hospital Watches, Hospital escorts and appointments outside of secure custody sites.

Following the attempted escape of a prisoner from a hospital watch I have ordered a review of security arrangements on all hospital watches and escorts outside of secure facilities. The standards below must be immediately actioned and put in place for all escorts outside of any prison with the exception of the following approved programs:

- MOW Camp
- Work Release
- Approved off centre work gangs
- Education Release
- PREOP and,
- Any other activity approved by the Director Custodial Services³¹

45. A subsequent revision of the EDI (Version 4) was not issued, and essentially became Version 5 on release.³² EDI Version 5 was issued on 29 September 2011. It varied the list of 'approved programs' which were excepted from the operation of the EDI, to read as follows:

RE: Minimum Standards: Restraints used for Hospital Watches, Hospital escorts and appointments outside of secure custody sites.

Following the attempted escape of a prisoner from a hospital watch I have ordered a review of security arrangements on all hospital watches and escorts outside of secure facilities. The standards below must be immediately actioned and put in place for all escorts outside of any prison with the exception of the following approved programs:

- Work Release
- Approved off centre work gangs
- Education Release
- PREOP
- **Prisoners residing at the Adelaide Pre Release Centre or classified as low 2 security** and,
- Any other activity approved by the Director Custodial Services

[my emphasis]

46. Version 5 of the EDI therefore provided an exception for prisoners residing at the Adelaide Pre Release Centre, or classified as low 2 security, whereas version 3 did not have this exception. Accordingly, the restraint standards set out in Version 3 of the EDI applied to prisoners residing at the Adelaide Pre Release Centre or classified as low 2 security until Version 5 of the EDI was issued on 29 September 2011.

²⁹ Custodial Services Executive Director's Instruction 51-11, version 2, 18 April 2011.

³⁰ Email from Mr Jim Freebairn, Senior Advisor Custodial Services, Department for Correctional Services, dated 29 November 2011.

³¹ Note - these standards are the same as in the Version 2 Director's Instruction that was issued on 18 April 2011.

³² Email from Mr Jim Freebairn, Senior Advisor Custodial Services, Department for Correctional Services, dated 29 November 2011.

47. After the commencement of my investigation, the EDI was again amended to create version 6, which was issued on 29 November 2011.³³ EDI version 6 amended the minimum standards only slightly from version 5. It added a requirement that prisoners be leg shackled whilst they are being escorted. Accordingly, version 6 provides the current standards. It provides as follows:³⁴

Minimum standard for Secure Custody Prisoners to Non Secure Locations (e.g. Hospital, Doctors surgery etc):-

- Escort –
 - Prisoner must be handcuffed whilst in vehicle
 - Prisoner must be double cuffed to an officer prior to alighting the vehicle
 - Prisoner leg shackled (unless GM directs otherwise)

General Manager's [sic] may direct that extra restraints (eg Leg shackles, etc) be used based on risk.
- In Hospital – (Admitted or in Accident/Emergency etc)
 - Hand secured to bed frame using closeting chain and
 - Leg cuffed to bed and
 - Legs shackled together

Minimum standard for Open Custody Prisoners (CTC, Mulga, PLP LSU)³⁵ to Non Secure Locations:-

- Escort –
 - Handcuffed
- In Hospital – (Admitted or in Accident/Emergency etc)
 - Leg cuffed to bed

General Manager's [sic] may direct that extra restraints (e.g. Leg shackles, etc) be used based on risk.

Any movement of the prisoner from a ward area to any other part of the hospital must be approved by the General Manager and logged in the hospital watch journal.

Process for adjusting, changing or removal of restraints:

Any non urgent request by medical [staff] for the removal of any restraint equipment must be authorised by the General Manager. In an emergency situation restraints may be removed to allow medical staff to provide emergency treatment. This must be reported to the General Manager immediately.

Prior to adjusting any restraints an inspection of existing restraints must take place to ensure that they are fully secured.

The full staffing compliment assigned to the escort must be present prior to the adjustment or removal of a restraint.

All restraints must be checked on a random basis with a maximum of 30 minute intervals.

When a prisoner is required to leave the bed to use the toilet/shower or for medical procedures, officers must ensure that the prisoner is leg shackled and handcuffed prior to the shackle being unsecured from the bed. Once in the toilet the closeting chain must be

³³ Custodial Services Executive Director's Instruction 51-11, Version 6, issued on 29 November 2011.

³⁴ As at 5 March 2012.

³⁵ CTC - Cadell Training Centre; Mulga - a unit at Port Augusta Prison; PLP - Port Lincoln Prison; LSU - Living Skills Unit at the Adelaide Women's Prison.

secured to a solid fixture and the prisoners [sic] leg or arm. Only then can the handcuffs be removed. The leg shackles must remain in place.

If a prisoner is required to undergo a medical procedure that precludes the use of metal restraints flexi cuffs must be used to restrain the prisoner.

Positioning of staff:

Staff must position themselves so that they can observe the prisoner at all times.

Prior to the adjustment of any restrains the first staff member must be positioned in the door way or closest to the exit point whilst any adjustment of restraints takes place. The second staff member must inspect all restraints prior to making any other adjustments.

48. Prisoner A was hospitalised and restrained during June and July 2011. Therefore version 3 of the EDI was the relevant standard at the time of Prisoner A's hospitalisation.
49. Prisoner B was hospitalised and restrained in February 2011 and September 2011. Therefore SOP 32³⁶ and SOP 013³⁷ were the relevant standards at the time of Prisoner B's first hospitalisation, and version 3 of the EDI was the relevant standard at the time of Prisoner B's second hospitalisation.
50. Prisoner C was hospitalised and restrained during July 2011. Therefore version 3 of the EDI was the relevant standard at the time of Prisoner C's hospitalisation.
51. Prisoner D was hospitalised and restrained during June and July 2011. Therefore version 3 of the EDI was the relevant standard at the time of Prisoner D's hospitalisation.
52. Prisoner E was hospitalised and restrained during 2010 until March 2011. Therefore SOP 32³⁸ and SOP 13³⁹ were the relevant standards at the time of Prisoner E's hospitalisation.
53. Prisoner F was hospitalised and restrained during August 2011. Therefore version 3 of the EDI was the relevant standard at the time of Prisoner F's hospitalisation.
54. The department wrote to me in response to notice of my investigation, by letter dated 31 October 2011. The letter included the following:

...the Department is aware that the use of restraints on prisoners in health settings might attract criticism at times, but is committed to managing the risk to the public, department staff, health staff and the wider community. In this regard, the Department is engaged in ongoing dialogue with senior health staff to ensure individual decisions can be negotiated directly with senior departmental staff when such issues arise.
55. The department informed my investigation that following the issuing of the EDI, the SOP for prisoners in hospital 'is currently under review as it is being updated to reflect the ED instruction.'⁴⁰ In his response to my provisional report, the CE advised me that further changes to the department's policies, practices and procedures are proposed.

³⁶ SOP 32 - Use of Restraint Equipment, version 1.01 modified 17 January 2001.

³⁷ SOP 013 - Prisoners at Hospital, version 01, 12/07/2010.

³⁸ SOP 32 - Use of Restraint Equipment, version 1.01 modified 17 January 2001.

³⁹ SOP 013 - Prisoners at Hospital, version 01, 12/07/2010.

⁴⁰ Email to Ombudsman's office from DCS dated 9 November 2011.

THE AUTHORITY OF THE DEPARTMENT TO RESTRAIN PRISONERS

56. Section 24(1) of the Correctional Services Act provides that the CE has custody of a prisoner whether the prisoner is within, or outside, the precincts of the place in which he or she is being detained, or is to be detained. Section 27 provides that the CE may grant a prisoner leave to be absent from the place in which he or she is being detained for medical or psychiatric examination, assessment or treatment of the prisoner.⁴¹
57. Section 86 of the Correctional Services Act authorises the department to use force against prisoners in certain circumstances:

86—Prison officers may use reasonable force in certain cases

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

58. The policy rationale behind section 86 as it relates to restraints is set out in version 1.01 of SOP 32, which I have quoted above. In summary, it states that restraining certain prisoners minimises the potential for escapes and for incidents which may cause harm to both employees and prisoners, and thus the use of force in certain circumstances is authorised.
59. However, in my view the current terms of the EDI are not supported by section 86, and are therefore ultra vires. The EDI simply sets minimum standards, which require that prisoners in non-secure locations (i.e. hospitals, doctors surgery, the Parole Board etc) be handcuffed to the bed, leg cuffed to the bed and legs restrained together whilst admitted to hospital or attending for an emergency.⁴² In my view, the minimum standards do not consider what is 'reasonably necessary in the circumstances of the particular case' as required by section 86.
60. Accordingly, the act of restraining prisoners using force that is not reasonably necessary in the circumstances of the particular case is beyond the power of the department under the Correctional Services Act.

SECURITY CLASSIFICATION OF PRISONERS

61. Each prisoner admitted into the correctional system undergoes an assessment upon their admission. SOP 001B 'Custodial - Assessment - Case Management' states:
- Assessment is the process by which a prisoner's risk and needs are formally identified through specific assessment instruments, interviews and other sources.⁴³
62. Once assessed, the prisoner is given a security classification. SOP 001B 'Custodial - Assessment - Case Management' provides that a security classification assessment is done 'within twenty-four (24) hours of admission after court - including prisoners' sentences and remanded in custody.'⁴⁴

⁴¹ Correctional Services Act 1982, section 27(1)(a).

⁴² Custodial Services Executive Director's Instruction 51-11, version 2, 18 April 2011.

⁴³ SOP 001B Custodial - Assessment - Case Management, version 04, 28/10/2011, 3.1.2.

⁴⁴ SOP 001B Custodial - Assessment - Case Management, version 04, 28/10/2011, 3.5.1.

63. The department advised me that Case Management Co-ordinators are responsible for ensuring a security classification assessment is administered in the following circumstances:
- a) within twenty-four (24) hours of admission after court - including prisoners sentenced and remanded in custody;
 - b) when reviewing security risk;
 - c) when there is a change in a prisoners circumstances that requires a transfer to higher security custodial facilities such as but not limited to:
 - Additional charges are added
 - Extradition Order
 - Deportation Order
 - Escape risk identified
 - Behaviour or conduct that warrants an increase in security classification⁴⁵
64. The security classification assessment is undertaken using the Security Classification Assessment Form. The assessment form lists eight questions relating to the following headings:
1. Length of sentence
 2. Type of Current Offence
 3. Further Charges/Pending Court Hearings
 4. Severity of Sentence
 5. Escape History
 6. Criminal History
 7. History of Institutional Violence
 8. Parole or Home Detention Status
65. The Case Management Coordinator is required to give a score for each question. The scores are tallied and a scoring key is given as follows:

SCORING KEY:			
55 or Greater - High 2;	54 - 25 Medium;	24 - 15 Low 1;	14 - 0 Low 2

THE GUARDING OF PRISONERS IN HOSPITAL

66. Guards or escorts for prisoners attending hospital are provided by G4S Custodial Services (**G4S**). G4S provide transport, supervision and in court management services of prisoners across South Australia. South Australia Prisoner Movement and In Court Management (**SAPMICM**) is a G4S contract.
67. The job description for G4S Casual Escort Officers includes the following duties:
- Ensure prisoners in his/her custody are treated with care and sensitivity at all times.
...
 - Ensure that prisoners under escort to medical and related appointments are managed in a secure and humane manner.
 - Ensure that prisoners who are the subject of a hospital watch are managed in a secure and humane manner and in accordance with the appropriate hospital procedures.
...⁴⁶

⁴⁵ The department's response to the provisional report, by letter dated 11 July 2012.

⁴⁶ http://www.google.com.au/url?sa=t&rct=j&q=%22sapmicm%22&source=web&cd=2&ved=0CCwQFjAB&url=http%3A%2F%2Fwww.au.g4s.com%2Fcareers%2Fjobdescriptions%2FCE_SA.pdf&ei=vwJST6-4L46fiAfTwtNCw&usq=AFQjCNEpdRyxag9-jr71CGJVf0ntDLgPQ&cad=rja

68. A memo was sent to all casual employees engaged in SAPMICM work on 22 December 2010, as follows:

The risk of escape is particularly high during this period so it is timely that all Escorts take particular care to ensure compliance with Operational Instructions.

In particular, you must ensure that:

- Prisoners are secured to a fixed object or person at all times
- Prisoners may only leave their room for treatment (authorised by MO and Supervisor) or to use the bathroom
- Escorts are to position themselves so that they have a direct line of sight with the prisoner at all times
- Ensure the restraint checks are conducted and properly
- Only authorised visitors are permitted

Any deviations or concerns must be raised with the Supervisor immediately.

D. Amos
General Manager
SAPMICM

69. The Royal Australian College of General Practitioners (**RACGP**) standards for health services in Australian prisons state that patients have the right to confidentiality, unless there are any security or safety risks. The explanation to Standard 5.1 includes the following:

Consultations need to be private and not able to be overheard by others. In cases where a prison officer needs to be within sight and sound of the consultation, attempts should be made to minimise the ability of the prison officer to hear details of the private discussion between a health professional and a patient.⁴⁷

70. Further, criterion 2.1.3 of the RACGP standards says that 'subject to safety and security considerations, the presence of a third party observing or being involved in clinical care during consultation occurs only with the permission of the patient given before the consultation.'⁴⁸ The explanation says that 'the privacy and confidentiality of therapeutic treatment is generally accepted by health professionals as a patient's right and is explicitly supported within these Standards.'⁴⁹ The standards recognise 'that there may be tensions between the need to respect the privacy and confidentiality of a patient and the need to manage any security or safety risks that the patient may pose to health professionals during a consultation.'⁵⁰
71. Medical staff from the RAH and the WCH told my investigation that in their view correctional officers guarding prisoners receiving medical treatment do not know the security classification of the prisoners they are guarding. As such, the officers treat each prisoner as being high risk.
72. Whilst I recognise that the tension between the need to respect the confidentiality of a patient and the need to manage any security risks is real, in my view the minimum standard should be that the officers should remain outside the door whilst a prisoner is receiving treatment. Exceptions can then be exercised in instances where a prisoner poses a high risk of escape or threat to themselves, hospital staff or the general public.

⁴⁷ Royal Australian College of General Practitioners, Standards for Health Services in Australian Prisons, 1st edition, 2011.

⁴⁸ Ibid.

⁴⁹ Ibid.

⁵⁰ Ibid.

Prisoner E

Aged in his late sixties, Prisoner E was admitted to hospital, for palliative care as he was suffering from Motor Neurone Disease. The hospital records indicate that towards the end of his life Prisoner E had difficulty swallowing, breathing and talking and was confined to his bed, unable to sit or walk unassisted. Hospital records show that in December 2010 the department told the hospital that Prisoner E no longer required guarding unless his situation changed. However, Prisoner E remained guarded in hospital for 83 days until he died in hospital.

See Appendix E for further details.

THE TYPE OF RESTRAINTS USED AND THE DURATION OF THEIR USE

73. As I have noted above, the department's minimum standards for the restraint of secure prisoners in hospitals are that they be handcuffed and attached to the hospital bed with a chain; leg cuffed to the hospital bed at the ankle; and that their legs be joined together by chain.
74. In my view, it is only in rare and exceptional cases that low and medium risk prisoners would require restraining at three points. Further, the department's minimum standards provide that all prisoners' legs should be shackled together and the prisoner chained to a solid fixture whilst going to the toilet. In my view, the application of this standard without regard to the security classification and circumstances of the individual prisoner is degrading and wrong.
75. I reiterate that the UN Standard Minimum Rules (as outlined earlier in my report) state that chains should never be used to restrain prisoners,⁵¹ and where restraints of any kind must be used they should not be used for any longer than is absolutely necessary.⁵²
76. My investigation has revealed that it is not uncommon for low risk prisoners to be restrained for many days, with the longest period of restraint I found being 18 days.⁵³
77. Also, I note that the department has no policies or procedures in place regarding the rotating of prisoner's restraints. Medical staff from SAPHS and the RAH told my investigation that it is common for the lack of rotation of the restraints to result in sores where the restraints have rubbed on the skin.
78. The hospital records of one of the prisoners I considered note that the prisoner complained about the pain caused by the restraints and show the department refusing to address this issue. For example, the 9 August 2011 hospital Inpatient Progress Notes for the prisoner record:

.... Complaining about pain at ankles from shackles → cannot put crepe bandages under shackles as per department of corrections.

...
Bruising at ankles bilaterally.⁵⁴

⁵¹ Standard Minimum Rules for the Treatment of Prisoners, United Nations, 13 May 1977, Rule 33.

⁵² Ibid, Rule 34.

⁵³ Prisoner F. See full case study at Appendix F.

⁵⁴ Ibid.

79. The nature of this restraint is demonstrated in the following picture:



80. My investigation was provided with a draft memo, dated 16 August 2011, from Prof Willis Marshall, General Manager, RAH, to Ms Gloria Wallace, Interim Chief Executive, RAH, as follows:

Re: management of patients under the custody of the Department of Correctional Services at the Royal Adelaide Hospital

PURPOSE

To make the Interim CE, CALHN aware of an emerging potential patient safety and media issue.

CRITICAL TIMELINE / DUE DATE

Undetermined

BACKGROUND

- Dr Wareham the RAH Deputy Director Medical Services was approached by Professor Norman James expressing concern on the manner and severity of restraint of prisoners under the management of the Department of Corrections (DCS) at the RAH. His concerns related to his belief that the restraint is often unnecessary, may be provocative and unhelpful to some patients with mental health issues and that it is contradictory and illogical as convicted mental health patients (under Forensic Psychiatry) are less strictly restrained than on convicted patients under DCS. He also noted his request to photograph the nature of the restraint was consented to by the prisoner but refused by the DCS officer and their manager. He contended that this treatment was a breach of the United Nations Covenant on the Medical Treatment of Prisoners.
- Dr James stated he has felt obliged today to raise his objections with Maurice Corcoran (Community Visitor), Margaret Honeyman (Chief Psychiatrist) and John Brayley (Public Advocate).
- Separately Dr Wareham was [sic] also been informed that in another case staff met a refusal by DCS officers to remove shackles in order to put antiembolic stockings on a patient. It has not been fully confirmed at this time but Dr Wareham has been informed that the patient subsequently developed a deep venous thrombosis.
- The [sic] have been a number of other cases of concern most recently when the a [sic] patient for surgery under local anaesthesia had to be sent back to the Women's Prison after officers refused to remove shackles for the procedure and RAH staff felt performing the procedure to be unsafe under the circumstances.

- A preliminary meeting between the RAH and DCS was held on August 3rd and DCS concerning the last issue and at that meeting DCS agreed to review their restraint policy for theatre local anaesthetic cases.

SUMMARY OF ISSUES

- Concern expressed by several RAH staff about the manner and severity of restraint of DCS cases at the RAH.
- Current restraint policy is impeding the ability to provide safe and effective care.
- The matter has been raised by a senior RAH MO as a potential human rights issue.

ATTACHMENTS

None.

ADVICE FROM OTHERS

None.

RECOMMENDATION

- To take note of this briefing.
- To call a high level meeting with the RAH General Manager, Director of Medical Services, Director of Nursing and Professor Norman James to determine with clarity the issues and scope potential solutions.

Yours sincerely

Prof Willis Marshall
General Manager
Royal Adelaide Hospital

81. The department wrote to me in response to my investigation, by letter dated 31 October 2011. The letter included the following statement:

...the Department is currently identifying alternative, softer restraints which will be used instead of metal restraints if and where possible. This will further address concerns in particular as they relate to levels of comfort whilst hospitalised.

Prisoner F

Prisoner F was shackled to the bed by one arm and both his legs for the duration of his 18 days in hospital.

The hospital notes record that after five days of restraining, he had bruising on both his ankles from the cuffs. The notes say that the department refused crepe bandages to be put under the cuffs to protect his ankles.

The hospital notes record that after 11 days of restraining, the patient was suffering from skin tearing due to the cuffs. At this point the department permitted the hospital staff to apply padding under the cuffs.

The patient developed deep vein thrombosis and a pulmonary embolism, which is a type of blood clot in his lungs, due to the restraints on his legs and his lack of mobilisation.

See Appendix F for further details.

THE RESTRAINING AND SHACKLING OF PRISONERS DURING CHILDBIRTH

82. The UN Standard Minimum Rules require that prisons make special accommodation for the care and treatment of pregnant women.⁵⁵ It is widely acknowledged that the restraining of women in pre labour, early labour and immediately after delivery is unacceptable.⁵⁶ Further, it is crucial that a woman be able to walk freely in labour, and in pre and early stages of labour, in order to alleviate pain and reduce the risk of complications during labour.⁵⁷
83. The issue of women being restrained and shackled during pregnancy and labour has gained attention in recent years and its opposition is now widespread.⁵⁸ In 2006 the United Nations Committee Against Torture alerted the US government that shackling during childbirth is a violation of the UN Convention Against Torture. The Committee urged that the US 'adopt all appropriate measures to ensure that women in detention are treated in conformity with international standards.'⁵⁹
84. In 2011 the United States Association of Women's Health, Obstetric & Neonatal Nursing released a position statement on the issue which included the following:
- The Association for Women's Health, Obstetric and Neonatal Nurses (AWHONN) valued patient safety and quality health care for *all* women. As such, AWHONN opposes the practice of shackling incarcerated pregnant women.
- ...
- The ostensible reason for shackling inmates is to prevent them from escaping, from harming correctional officers, and/or harming themselves. However, most incarcerated women are nonviolent offenders and escape attempts by pregnant women who were not shackled have not been reported.
- Pregnant women have unique health care needs and require more regular contact with health care providers than other women. Shackles can put the health and life of the woman and foetus at risk.⁶⁰
85. The American Medical Association has drafted a model anti-shackling proposed law, as follows:
- No restraints of any kind shall be used on a prisoner or detainee during labor, transport to a medical facility, delivery, and postpartum recovery unless there are compelling grounds to believe that the prisoner or detainee presents (1) an immediate and serious threat of harm to herself, staff or others; or (2) a substantial flight risk and cannot be reasonably contained by other means. Under no circumstances shall leg or waist restraints be used on any prisoner or detainee who is in labour or delivery.⁶¹
86. Many states in the United States now prohibit shackling during labour and delivery (except in very rare cases). Some also explicitly prohibit shackling or other restraints

⁵⁵ UN Standard Minimum Rules, Rule 23(1).

⁵⁶ Institute on Women and Criminal Justice, Laws banning shackling during childbirth gaining momentum nationwide, US, http://www.wpaonline.org/pdf/Shackling%20Brief_final.pdf

⁵⁷ Association of Women's Health, Obstetric & Neonatal Nursing, Shackling Incarcerated Pregnant Women, position statement,

⁵⁸ Institute on Women and Criminal Justice, Laws banning shackling during childbirth gaining momentum nationwide, US, http://www.wpaonline.org/pdf/Shackling%20Brief_final.pdf

⁵⁹ Ibid.

⁶⁰ Association of Women's Health, Obstetric & Neonatal Nursing position statement, August 2011.

⁶¹ Institute on Women and Criminal Justice, Laws banning shackling during childbirth gaining momentum nationwide, US, http://www.wpaonline.org/pdf/Shackling%20Brief_final.pdf

- during transport to hospital and during recovery after birth.⁶² Furthermore, a ban exists in federal prisons in the US.⁶³
87. In the United Kingdom pregnant prisoners are not restrained in any way. In 1996, as a result of complaints from the Royal College of Midwives about the restraining of pregnant women, the Secretary of State for the Home Department announced that the practice would be stopped. The Secretary of State said that unless a prisoner presented 'a particularly high risk of escape, and there is no medical objection to restraints being applied' then a pregnant prisoner would not be restrained at any time whilst she was in hospital.⁶⁴
88. In a letter dated 31 October 2011, the CE advised me that:
- Each female prisoner due to give birth whilst in custody has an individual plan developed for the birthing procedure based on risk and individual needs.
- Security procedures and restraint requirements are detailed in each individual plan - these plans always direct that a prisoner in labour will not have restraints fitted.
89. However, my investigation has concluded that in South Australia, pregnant prisoners' arms and legs are usually shackled with metal cuffs during their transportation to hospital. The women are then cuffed directly to their hospital bed by an arm and a leg in the delivery room, with their legs shackled together by a chain. The restraints are only removed during the active stage of labour and are secured again immediately after the birth of the baby.
90. The department's SOP No 31, 'DCS Supervised Prisoner Escorts and Hospital Watches', says:
- Where a female prisoner is admitted to hospital for childbirth, no restraints are to be applied and only female officers are to be used in the escort.⁶⁵
91. However, this SOP was issued prior to the EDI⁶⁶ which updated the minimum standard for securing prisoners in hospital. As outlined earlier in this report, the EDI provides that prisoners are to be restrained with shackles and three point restraints whilst they are in hospital and that any non urgent requests by medical staff for the removal of any restraint equipment must be authorised by the prison's general manager. The EDI makes no mention of any exceptions for pregnant prisoners.
92. Furthermore, my investigation obtained evidence that male officers are frequently used to guard pregnant women in hospital.
93. Section 37(2) of the Correctional Services Act provides that, when a prisoner is to be searched, and the prisoner is naked for the purposes of being searched, those present, except for a medical practitioner, must be of the same sex as the prisoner. In my view, the same protection should apply to women undergoing medical procedures relating to childbirth.

⁶² Ibid.

⁶³ In 2011 sixteen states in the United States of America introduced bills that would restrict the use of restraints on pregnant prisoners during labour and delivery. See - Stop shackling pregnant prisoners, 4 September, 2011, <http://www.thedailybeast.com/articles/2011/09/04/stop-shackling-pregnant-prisoners-new-push-to-ban-controversial-practice.html>

⁶⁴ Hansard, England, Commons Sitting, 18 January 1996, vol 269 cc893-902.

⁶⁵ SOP 31 - Supervised Prisoner Escorts and Hospital Watches, version 1.0, 23/05/2001.

⁶⁶ Custodial Services Executive Director's Instruction 51-11, Version 5, issued on 29 September 2011.

94. I have found no evidence in other Australian jurisdictions of pregnant prisoners being restrained in pre and post childbirth in a similar way to that required by the EDI.
95. Western Australia has a very clear policy opposing the restraint of pregnant prisoners. The relevant policy directive states the following as its purpose:
- To ensure that such escorts and supervision of pregnant or postnatal prisoners are effected in a manner involving the minimal use of mechanical restraints and most privacy wherever possible, consistent with the safety of the public and staff.⁶⁷
96. The WA directive makes it clear that restraints are not to be used on minimum security pregnant prisoners, and are not to be used on medium or maximum security pregnant prisoners unless it is determined that there is a significant risk of escape or a compromise to public safety in the specific case. It specifies that if restraints are to be used then it is 'for the shortest period possible and is to be ceased as soon as level of risk is reduced.' It includes the following:
- This Policy Directive takes into account that pregnant or postnatal prisoners are unlikely to use violence to facilitate an escape, or, having escaped, are unlikely to pose a risk to the public in terms of violent offending.⁶⁸
- ...
- Under NO circumstances are restraints to be applied to a pregnant prisoner undergoing labour, childbirth or termination.**
- While exercising the primary responsibility with regard to security and the continued charge and supervision of the prisoner, the escorting officer shall have due regard in the circumstances to the decency, self-respect and privacy of the prisoner during the course of any appointment and the underlying duty of care to the unborn/newborn child(ren).
97. Further, the WA directive states that 'officers are not to be present within sight or hearing of the prisoner during any appointment - except where there are significant concerns of escape or a compromise to public safety, or if the prisoner or medical staff so requests. When an officer presence is required that officer must be a female.'⁶⁹
98. Medical staff told my investigation of instances where pregnant women have not told medical staff about their drug use because of the presence of guards. This has resulted in newborn babies not receiving adequate treatment for drug withdrawal.
99. Further, my investigation was told by aboriginal women who work in the health system that the presence of male guards and the shackling of aboriginal women is particularly distressing to aboriginal women due to their cultural beliefs and history. Two aboriginal women told my investigation that the experience of seeing aboriginal women shackled was particularly traumatising for them as they felt that they were 're-living history'. They also expressed how culturally inappropriate it is for a male guard to be present at a birth.

⁶⁷ Government of Western Australia Department of Correctional Services, Policy Directive 44, Escorting and Supervision of Pregnant or Postnatal Prisoners

⁶⁸ The Government of Western Australia Department of Correctional Services Policy Directive 44, Escorting and Supervision of Pregnant or Postnatal Prisoners, amended 16 March 2011, effective from 21 March 2011.

⁶⁹ The Government of Western Australia Department of Correctional Services Policy Directive 44, Escorting and Supervision of Pregnant or Postnatal Prisoners, amended 16 March 2011, effective from 21 March 2011.

Prisoner D

Prisoner D was admitted to hospital for an induced labour and remained in hospital for 6 days, during which time she gave birth.

Prisoner D was shackled during her escort to hospital and remained shackled for the duration of stay in hospital, with the shackles being removed for 6.25 hours while she was in active labour.

Prisoner D remained shackled for at least 5 hours after her first contraction.

The shackles were removed 3 hours and 41 minutes before she gave birth.

The shackles were reapplied 2 hours and 34 minutes after she gave birth.

A male and a female officer guarded the prisoner. The male guard remained in the room for duration of the labour, only leaving the room for short periods when the prisoner was being examined and he was asked to by the prisoner's advocate.

See Appendix D for further details.

THE RESTRAINING AND SHACKLING OF PRISONERS WITH MENTAL ILLNESSES

100. It is well recognised that a significantly high proportion of prisoners suffer from mental health disorders. A 2007 study by the Australian Institute of Health and Welfare reported that '[T]he majority of prisoners suffer from psychiatric and substance use disorders'⁷⁰ and that 'almost two-thirds of prisoners will have suffered from a psychiatric disorder in the previous twelve months.'⁷¹ Further, the Australian Institute of Health and Welfare reports that in census week in mid 2009, 37% of prison entrants reported having a mental health disorder at some time.⁷²
101. This raises human rights issues relating to equality and discrimination in the treatment of mentally ill people. As Ms Kerin Leonard of the Victorian Equal Opportunity and Human Rights Commission said at the 2011 Correctional Services Healthcare Summit:

'... people get drawn into the system in different ways - not all prisoners are the same or are being detained for the same reasons and we need to remember to treat individuals as individuals.'⁷³
102. In 1991, the UN adopted the Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care (**the UN mental health principles**), which established minimum human rights standards of practice in the mental health field.⁷⁴ The Australian government was closely involved in the negotiation of the UN mental health principles.⁷⁵
103. Article 11 of the UN mental health principles states:

⁷⁰ Belcher J and Al-Yaman F. Prisoner Health in Australia - Contemporary information collection and a way forward, Australian Institute of Health and Welfare, Canberra, 2007, pviii.

⁷¹ Ibid., p5.

⁷² Royal Australian College of General Practitioners, Standards for Health Services in Australian Prisons, 1st edition, 2011, p3.

⁷³ The Correctional Services healthcare Summit, Kerin Leonard, Victorian Equal Opportunity and Human Rights Commission, 18 October 2011, p8.

⁷⁴ Principles for the Protection of Persons with Mental Illness and the Improvement of Mental Health Care, United Nations, 17 December, 1991.

⁷⁵ http://www.hreoc.gov.au/disability_rights/speeches/2005/mental09.htm

Physical restraint or involuntary seclusion of a patient shall not be employed except in accordance with the officially approved procedures of the mental health facility and only when it is the only means available to prevent immediate or imminent harm to the patient or others. It shall not be prolonged beyond the period which is strictly necessary for this purpose. All instances of physical restraint or involuntary seclusion, the reasons for them and their nature and extent shall be recorded in the patient's medical record. A patient who is restrained or secluded shall be kept under humane conditions and be under the care and close and regular supervision of qualified members of the staff. A personal representative, if any and if relevant, shall be given prompt notice of any physical restraint or involuntary seclusion of the patient.

104. In 2002 my predecessor undertook an investigation into 'the treatment of mental health patients: shackling and other forms of restraint.' The investigation was conducted into the administrative acts involving the use of shackles or any other form of restraint on any patients, including patients who are treated as mental health patients. The inquiry was into the practices relating to shackling and other forms of restraint which may have been used by the relevant health agencies in the case of mental health patients.
105. My predecessor proposed the following model for treatment of mental health patients who might be subjected to restraint:
1. All restraints must involve clinical assessment as soon as practicable but not later than one hour after initial restraint. Should these conditions not be met sufficient reasons shall be provided and these reasons documented in patient case-notes. Patients should only be restrained without clinical assessment where the circumstances properly require such an action in order to prevent harm to any person which may be caused by the conduct of the patient.
 2. When a mechanical device ("shackles") are applied there must be a strict time limit on its application; and the time should never exceed the time taken for sedatives or other pharmacological form of restraint to be safely applied in lieu of the temporary physical/mechanical restraint. Suitably qualified medical practitioners should determine whether it is appropriate to apply physical or mechanical restraint for a fixed period during which a person may be seriously affected by drugs or alcohol. If shackling is required then the department should preferably apply a type of shackle appropriate to the circumstances at the time and in all possible cases a "soft form" of shackling should be applied. This should apply to treatment given in all sections of the hospital.
- ...
- 6 All forms of restraint shall be clearly and accurately recorded, providing reasons and times involved and names of all relevant personnel involved in effecting and supervising the restraint. Regard shall be had at all times for the human and legal rights of the patient. A Restraint Incident report form containing all restraint information/data shall be retained in the patient's personal medical file. A separate, true copy of the restraint Incident Report form should be kept separately and shall be readily accessible to a review process, including the Ombudsman.
106. In my view the model proposed by my predecessor's investigation and report remains appropriate. My investigation was advised by medical staff from the RAH that several mentally ill prisoners have been unreasonably restrained by the department for unnecessary periods of time. I consider that the department should adopt and apply the model outlined by my predecessor ten years ago.
107. 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.

108. In his response to my provisional report, the CE recognised the need to safely accommodate mentally ill prisoners in appropriate secure wards where they can receive treatment for their mental health needs. He noted that beds are not always available in these wards.
109. The CE also queried the relevance of my reference to both the UN mental health principles, and the previous investigation by my predecessor, given that these both relate to mental health patients, and not to prisoners. The CE pointed out that the prisoners I refer to in this report who were detained under the Mental Health Act were remanded in custody by a magistrate on criminal charges, and as such, the department is obliged by law to manage them as prisoners pursuant to the Correctional Services Act. The CE noted that it is not the department 'that determines that a person should face charges and further it is not the department's responsibility to determine that they should be remanded in custody.'⁷⁶ I accept this statement, and I acknowledge that the management of prisoners with complex mental health needs presents a constant challenge for the department.
110. I observe that several prisoners of whom I became aware during the course of my investigation were taken into custody and restrained unnecessarily in circumstances where their behaviour appeared to me to be directly associated with their mental health condition and lack of adequate psychiatric treatment. I acknowledge that this identifies a serious and complex issue that, in my view, needs to be addressed in a broader context. I have described these instances in the appendices to this report.

Prisoner B

Prisoner B is a man in his late twenties. He has a history of mental illness, having suffered from schizophrenia and bipolar disorder since he was 16 years old.

On 14 February 2011 Prisoner B presented at the RAH Emergency Department suffering from a psychotic episode and requesting treatment and hospitalisation. He was told to go home and to talk with the community health staff at Port Adelaide Community Care Team.

Three days later Prisoner B was arrested for endangering life, being unlawfully on premises and disorderly behaviour. He was taken from Yatala Prison to the RAH where he was admitted and handcuffed and ankle cuffed to the bed in a prison uniform.

Prisoner B remained restrained in hospital for five days before he was transferred to James Nash House. Prisoner B remained in custody for a further 27 days.

Once released from custody Prisoner B presented at the RAH on two more occasions in the following four months, and on both occasions he was admitted suffering from psychosis. He was not restrained in hospital on these occasions.

35 days after his last release from hospital Prisoner B was again taken into custody. He was assessed as suffering from a psychosis and was transferred to the RAH again. He was restrained in hospital for three days before being transferred to James Nash House where he remained for a further ten days before being released.

See Appendix B for further details.

⁷⁶ The department's response to the provisional report, by letter dated 11 July 2012.

WHETHER THE DEPARTMENT SHOULD EXERCISE DISCRETION TO ADJUST, CHANGE OR REMOVE RESTRAINTS

111. I accept that in some situations, for the safety of the public and of hospital staff, prisoners may have to be restrained when in a hospital environment for reasons of security. However, where the use of restraints is required, I am concerned about:
- the method of restraint used by the department, and
 - the duration of time for which prisoners are restrained.
112. Prior to the issuing of the EDI relating to the restraint of prisoners, SOP 13 applied.⁷⁷ SOP 13 included the following discretion:
- Leg 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.
- ...
- General Managers may use discretion in the restraint of 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.
113. The department's current EDI includes a discretion which enables a prisoner's restraints to be adjusted, changed or removed at the request of medical staff:
- Process for adjusting, changing or removal of restraints:**
- Any non urgent request by medical [staff] for the removal of any restraint equipment must be authorised by the General Manager. ...⁷⁸
114. My investigation found that the minimum standards are often rigidly enforced and the discretion to adjust, change or remove restraints is rarely exercised. In part this appears to be because medical staff are not aware that such requests can be made. However, in some cases where medical staff have requested that restraints should be removed or altered, it has taken too long for the discretion to be exercised. Prisoners have been unnecessarily restrained and shackled for long periods of time, and at great discomfort.
115. Further, it appears that decisions about whether or not to exercise any discretion about the adjusting, changing or removal of restraints are often made by outside (contract) security staff who are guided by the EDI and who are unqualified to make such decisions.
116. For example, the hospital notes received for Prisoner F record that the patient had developed bruising from cuffs that had rubbed on his skin for five days. The notes say that the medical staff were told by the guards that padding must not be used to protect the patient's skin.⁷⁹
117. The hospital notes for several of the prisoners also show that requests made to the prison guards for removal or alteration of restraints on some occasions did not reach the prison's general manager. Further, directions from management do not always reach hospital staff in a timely manner, if at all.

⁷⁷ SOP 013 - Prisoners at Hospital, version 01, 12/07/2010.

⁷⁸ Custodial Services Executive Director's Instruction 51-11, Version 5, issued on 29 September 2011. Note that this discretion was also included in previous EDI versions, and has therefore been in place since version 2 was issued on 18 April 2011.

⁷⁹ See Appendix F.

118. I have been told that SAPHS often advocates on behalf of prisoners who are unnecessarily restrained, and that a great deal of advocacy is required in each individual case.
119. Given that I consider that the department's minimum standards of restraint for prisoners in hospitals are below international and national standards, in my view exceptions to these standards should be exercised, and exercised expeditiously, wherever required. In each case, the rights and dignity of the prisoner must be carefully balanced with the need for security.

Prisoner C

Prisoner C is a man in his mid thirties. He has schizophrenia and bipolar disorder.

Suffering from psychosis, Prisoner C left his home interstate to travel to Perth. He claimed that his parents were abusive and that he needed to deliver evidence he had collected to professionals in Perth. He had taken his father's car without permission.

When Prisoner C reached Ceduna he stole some foodstuffs and petrol and was subsequently arrested. He was charged with making off without payment, dishonestly taking property and disorderly behaviour. He was taken to prison where he was 'found to be erratic in his behaviour'.⁸⁰ Three days later he was transferred to the RAH where he was assessed as exhibiting delusions, mania and paranoia. He was cuffed to the bed and shackled with chains.

On the day of Prisoner C's admission to the RAH the treating doctor contacted the General Manager at Yatala expressing concern at the patient's unreasonable restraint.⁸¹

Prisoner C remained restrained for three days, before being transferred to James Nash House.

Prisoner C had never been imprisoned before.

See Appendix C for further details.

Prisoner E

When Prisoner E was admitted to hospital for palliative care the hospital records note that that upon his admission he was handcuffed to the bed, but that hospital staff requested that he be leg cuffed instead. The hospital records note that this request had been approved but that the guards did not report the approval for three days.⁸²

See Appendix E for further details.

⁸⁰ Royal Adelaide Hospital, Inpatient Progress Notes, 22 July 2011, 1400 hours.

⁸¹ Royal Adelaide Hospital Inpatient Progress Notes, 22 July 2011.

⁸² Royal Adelaide Hospital Doctor Notes, 13 August 2010.

PROVISION OF DEPARTMENTAL INFORMATION TO MY INVESTIGATION

120. On a number of occasions, the department was unable to provide clear information in response to my questions about the duration of restraining and shackling of prisoners in hospitals. It appeared to me that the department was reticent about providing this information, and my office often had to ask for the same information several times. For example, my office made several requests of the department for Prisoner D's birth plan before it was provided.
121. Further, on some occasions the department gave incomplete information to my investigation. I will provide four examples. First, the department informed my investigation of only one occasion where Prisoner B, Prisoner D and Prisoner E had been restrained and shackled in hospital. Hospital records show that they were each hospitalised and restrained on two separate admissions to hospital.
122. Second, when my investigation requested 'Prisoner in Hospital' profile sheets from the department, my office was provided with one for Prisoner D but not for four other prisoners, as had been requested. On following this up, my investigation was told⁸³ that the department does not keep these profile sheets. The officer stated that the profile sheets are provided to hospital staff when prisoners are admitted to hospital; that they are not retained on prisoner's departmental files; and that therefore the department does not have copies of them. However, my office had previously been provided with a profile sheet for one prisoner by another officer of the department.
123. Third, my office requested information, including profile sheets, for Prisoner F via letter dated 9 February 2012. The department's response included the following:

It is noted that there was not a Prisoner Information Sheet with [Prisoner F] at the hospital.

124. However, the Compliance Checklist for Hospital Watch (Hospital Escorts) that was provided to my office records that a profile sheet was in fact delivered, although a Prisoner ID sheet was not present.
125. Fourth, on 28 November 2011 my office requested a copy of the hospital watch logs relating to five prisoners. These were provided to my office on 8 December 2011 for Prisoners A, D and E. My office was informed that such records were either not recorded, or not found, for the other prisoners. My office was instead provided with an email from the Director Custodial Services, to departmental staff dated 5 December 2011 as follows:

Hi all,

We are following up information for the Ombudsman's office over prisoners detained under the Mental Health Act and taken to hospital by DCS staff waiting for a bed in a secure ward.

We have attempted to get hospital watch logs from a number of sites but it appears that none were made at one location as the prisoner was not admitted but held in emergency awaiting a bed.

It appears that the two prisoners in question were in hospital for 3 days and 5 days respectively.

Please confirm by return email:

That your prison does complete hospital watch logs in these instances.

⁸³ Telephone conversation with an officer of the department, 17 November 2011

If your site does not keep logs in this type of hospital escort please confirm that they will on all future watches of this type.

Please report by COB Wednesday 7 December 2011 ...

It is imperative that we keep accurate records of prisoners being guarded in hospital. These records protect both the staff and the department from criticism and ensure that the directions of the GM such as the placement and checking of restraints are maintained.

Regards
Mike Reynolds
Director Custodial Services

126. In his response to my provisional report, dated 11 July 2012, the CE provided me with further information in relation to each of the case studies. This included information that was inconsistent with what I had been provided during the course of the investigation. I have now considered the additional information and attempted to reconcile the facts that were available to me throughout the investigation with this new evidence. I note that I have not included all of the information available to me in relation to the case studies in order to protect the identity of the individuals. Further, I have not included all of the information available to me as I do not consider it to be relevant to this investigation.
127. Finally, I note that it was difficult for my office to determine the movement of the prisoners between prison and hospitals. My office requested from the department prisoner movement sheets in relation to the six prisoners. The department informed my investigation that these sheets had been destroyed, but that it will be issuing an instruction directing that in the future they should be retained.

CONCLUSIONS

128. In drawing my conclusions, I reiterate Article 10 of the ICCPR:

All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person.⁸⁴

129. My investigation found that the department has failed to comply with acceptable national and international standards regarding the restraining of prisoners in hospital. I acknowledge that EDI 51-11 is not unlawful on the basis that it does not comply with article 10 of the ICCPR, or with any of the other international instruments or standards I have referred to in this report. However, in my view, it is appropriate for the department to take into account these international standards and agreements when formulating its policies about the restraint of prisoners.
130. In my view the humanity and dignity of prisoners should be maintained, no matter what crime they have committed. This principle is clearly contemplated by the requirement in section 86 of the Correctional Services Act to have regard to the individual circumstances of each case in deciding whether to use force.
131. I accept that there is need to balance security needs and the interests of prisoner patients. However, in my view not all prisoners will be potentially dangerous; likely to escape; or likely to inflict self harm or harm to others. Plainly, a prisoner would be highly unlikely to do so whilst in the terminal stages of an illness, or in the late stages of pregnancy.

⁸⁴ International Covenant on Civil and Political Rights, opened for signature 16 December 1966, United Nations General Assembly Resolution 2200A [XXI].

132. The level of risk in relation to each individual prisoner should be assessed, and prison staff and medical staff should make a joint decision about whether the use of appropriate restraints is warranted in each case.
133. It was reported to my investigation by a member of staff at SAPHS that, as a result of the department's current minimum standards for use of restraints, it is common for prisoners to refuse medical treatment. This is because the prisoners (particularly low risk prisoners) do not wish to face the humiliation and shame of attending medical facilities amongst the general public in prison clothing and shackles.

OPINION

134. I have noted above that in my view the department's failure to adequately consider the individual circumstances of each prisoner in deciding whether to apply restraints is a breach of section 86 of the Correctional Services Act, because that section only authorises the department 'to use such force against any person as is reasonably necessary in the circumstances of the particular case'. It is my opinion that in failing to consider the circumstances of each individual prisoner, and whether restraints are necessary in those circumstances, the department has acted in a way which is contrary to law within the meaning of section 25(1)(a) of the Ombudsman Act.
135. I acknowledge that the department did not have all the information that I had in relation to each of the prisoners in the case studies at the time that they were hospitalised. The CE in his response to my provisional report, stated that during the admission interview process, an initial classification assessment would have been completed and a Prisoner Stress Screening Interview would have also been completed for the prisoners. He stated that the individual assessments would have relied on information that was available about each of the prisoners, such as whether the offence they committed was violent, their security classification, the nature of their offending, the length of their sentence etc. However, this does not change my view that the department failed to adequately consider the individual circumstances of each prisoner in deciding whether to apply restraints.
136. I consider also that in dealing with six individual prisoners, the department has made further administrative errors. My opinions about these cases are as follows.

Prisoner A

137. Prisoner A was hospitalised for mental health reasons during July of 2011. She was restrained at four points. Her hands were secured to the bed with cuffs and chains, and her legs were attached to the bed with cuffs and chains and shackled together. She was restrained in this manner for approximately 27 hours.
138. It is my opinion that in restraining Prisoner A for approximately 27 hours, the department acted in way that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.
139. Factual details relating to this case appear in Appendix A.

Prisoner B

140. Prisoner B was hospitalised for mental health reasons in February 2011 (**first admission**) and in September 2011 (**second admission**). On his first admission, Prisoner B was restrained at two points for one day - one hand was secured to the bed with cuffs and a chain, and one leg was cuffed to the bed. He was then restrained at three points for the

next four days. That is, both hands and one leg were attached to the bed with cuffs and chains, and his legs were shackled together. On his second admission, Prisoner B was restrained to the bed at three points for three days. He was restrained for five days on his first admission and for three days on his second admission.

141. It is my opinion that in restraining Prisoner B on two occasions, for five days and for three days, the department acted in way that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.
142. Factual details relating to this case appear in Appendix B.

Prisoner C

143. Prisoner C was hospitalised for mental health reasons in July 2011. He was restrained at four points. His hands were secured to the bed with cuffs and chains, and his legs were attached to the bed with cuffs and chains and shackled together. He was restrained in this manner for 3 days.
144. It is my opinion that in restraining Prisoner C for 3 days, the department acted in way that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.
145. Factual details relating to this case appear in Appendix C.

Prisoner D

146. Prisoner D was hospitalised for in June 2011 and July 2011. She was restrained at three points on her first admission to hospital, for five days whilst in late pregnancy. She was restrained at three points for six days on her second admission to hospital. That is, both hands and one leg were attached to the bed with cuffs and chains, and her legs were shackled together. The restraints were removed for 6.25 hours while she was in active labour. The prisoner remained shackled for at least 5 hours after the commencement of her contractions. The shackles were removed 3 hours and 41 minutes before the prisoner gave birth. They were reapplied 2 hours and 34 minutes after she gave birth.
147. In my view, compelling evidence is needed to justify the shackling of any woman in any stage of labour or recovery. My investigation has found no such evidence in the case of Prisoner D.
148. Further, it is my understanding that male guards were present at the birth of Prisoner D's baby, as well as during a vaginal examination. This allegation was put to my investigation, and has not been denied by the department. This is notwithstanding that Prisoner D's birth plan says that the escort officer was to be placed outside the room during the birth.
149. It is my opinion that in restraining Prisoner D for five days and for six days, the department acted in way that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.
150. It is my opinion that in having male guards present during Prisoner D's internal medical examination and the birth, the department acted in way that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.
151. Factual details relating to this case appear in Appendix D.

Prisoner E

152. Prisoner E was hospitalised and restrained during 2010 until March 2011. Prisoner E was restrained at one point on his first admission to hospital suffering from motor neurone disease, a terminal illness. He was cuffed and secured to the bed with a chain by one point. He was restrained in this manner for 14 days. During this time the hospital notes record him as having limited mobility in his arms and difficulty walking.
153. Prisoner E was again hospitalised, this time for palliative care on 13 December 2010. Prisoner E was again restrained by cuffing him and securing him to the bed by one point with a chain. He was restrained in this manner for two days.
154. Prisoner E remained under guard in hospital for 83 days until he died on 5 March 2011. The hospital notes record that, from late December 2010 Prisoner E suffered from decreased ability to swallow, breathe, speak and move. He required full assistance. By February the notes record him as being completely immobile.
155. It is my opinion that in restraining Prisoner E for 14 days and for 2 days, the department acted in way that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.
156. Factual details relating to this case appear in Appendix E.

Prisoner F

157. Prisoner F was hospitalised for respiratory distress / shortness of breath in August 2011. He was restrained at three points. Both hands and one leg were attached to the bed with cuffs and chains, and his legs were shackled together. He was restrained in this manner for 18 days. Prisoner F developed deep vein thrombosis and a pulmonary embolism due to the restraints on his legs and his lack of mobilisation.
158. It is my opinion that in restraining Prisoner F for 18 days, the department acted in way that was wrong within the meaning of section 25(1)(g) of the Ombudsman Act.
159. Further details of this case appear in Appendix F.

RECOMMENDATIONS

I make the following recommendations under section 25(2) of the Ombudsman Act.

Recommendation 1

In keeping with the department's obligation under section 86 of the Correctional Services Act to consider the circumstances of each case before using reasonable force, the use of restraints should in each case be appropriately authorised. This should be done by the relevant prison's general manager. I accept 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.

Recommendation 2

Restraints should be applied commensurate with the assessed risk of a prisoner and the individual circumstances relating to the particular environment, the security risks and the individual characteristics and medical condition of a prisoner. The level of restraint used should be determined by what is reasonably necessary for the safety of the prisoner, the medical staff and the public.

Recommendation 3

When the circumstances justify the use of restraints, a soft form of restraint should be used. Chains should not be used.

Recommendation 4

When the circumstances justify the use of restraints, the prisoner must be frequently assessed to determine if the level of restraints used is still appropriate, given that the individual circumstances relating to the particular environment, the security risks and the individual characteristics and medical condition of a prisoner change.

Recommendation 5

Pregnant women should never be restrained during labour. Further, they should not be restrained during:

- transport to hospital
- pre or post natal appointments
- pre labour, early labour, or post labour recovery

unless they pose a serious risk to themselves or others, or a substantial risk of escaping, and unless they cannot be controlled by any other means.

Recommendation 6

The use of restraints should be clearly and accurately recorded. The record should include the type of restraints used, the duration of use, the reasons for use and the names of all people involved. Restraint incident forms containing all restraint information should be kept in accordance with the *State Records Act 1997*, and be readily accessible to review, including by the Ombudsman.

Recommendation 7

Guards should seek immediate advice from the relevant prison's general manager if:

- an at risk prisoner has significant injuries that mean leg or handcuffs cannot be used
- a medical officer advises against the use of restraints
- a prisoner's medical condition renders the use of restraints inappropriate
- the use of restraints is apparently causing harm to the prisoner.

Recommendation 8

At least one guard supervising a prisoner in hospital should be of the same gender as the prisoner. All guards escorting pregnant women to hospital or to medical appointments should be female.

Recommendation 9

Guards should not be present at a prisoner's medical appointment or examination unless the prisoner poses a serious risk to themselves or others, or a substantial risk of escape. In most instances guards should be posted outside the door. Guards should not be within hearing or sight of pregnant women undergoing pre or post natal appointments.

Recommendation 10

Guards should not be present when a woman is in labour and giving birth. They should be posted outside the door.

APPENDIX A – Prisoner A

Prisoner A is a woman in her twenties who has schizophrenia and anti-social personality disorder.

On 28 June 2011 Prisoner A absconded from a rural Victorian hospital and travelled to Adelaide.

On 1 July 2011 Prisoner A went to an Adelaide hairdressing salon and had her hair cut. She was charged \$270 for the haircut. She did not have enough money and tried to pay only half the amount. The salon owner contacted the police. The police discovered that there was an arrest warrant out for her in Victoria and that she was subject to an involuntary treatment order. Prisoner A was arrested and taken to the City Watch House. She was transferred to the RAH for psychiatric assessment.

On 1 July 2011 Prisoner A reported to a doctor at the RAH that she had not taken her medication for two days.

A bedside hearing of the Magistrates Court was held via telephone on 4 July 2011. Prisoner A was charged with making off without payment, robbery, carrying an offensive weapon and failure to comply with bail agreement. Bail was refused and she was remanded into the custody of the department and detained under the *Mental Health Act 2009* by order of the court.

Upon being taken into the custody of the department on 4 July 2011, Prisoner A was restrained and shackled.

The department's Hospital Watch Daily Log (**the daily log**) reports that Prisoner A was secured to the bed at 18:50 on 4 July 2011. She was double shackled. That is, both her hands and both her feet were cuffed and attached to the bed with chains and her legs were shackled together with chains. Her restraints included the use of standard double handcuffs which forced her wrists to remain together at all times, whilst at the same time being chained to the bed.

Prisoner A was detained and transferred to ward 5J at the Flinders Medical Centre (**FMC**) on 5 July 2011. This is a secure, locked ward. Upon being transferred to this ward the management of security for the patient was transferred from DCS to Health and her restraints were removed.

The department told my investigation that Prisoner A was restrained for less than 24 hours between her remand at bedside on 4 July 2011, and her transfer to FMC on 5 July 2011.

Hospital Records and the daily log record that the ambulance arrived at 21:45 on 5 July 2011 to take the patient to the FMC secure ward (when her restraints would have been removed). Therefore, Prisoner A was shackled for approximately 27 hours.

The department says that Prisoner A was transferred to Adelaide Women's Prison on 8 August 2011; was transferred to James Nash House on 30 September 2011; and was still there as of 28 November 2011.

Prisoner A has a long history of mental illness.

The department informed me that no violence or other behavioural issues have been recorded on Prisoner A's prison records. It also informed me that no history of escape has been recorded on Prisoner A's prison records, but that she has a history of absconding. I had assumed that this referred to her absconding from the rural hospital where she was under a treatment order. However, in his response to my provisional report the CE informed me that at the time of her admission the department was not aware that she had absconded from a rural hospital.

Prisoner A's most serious previous offence was making off without payment and disorderly behaviour in 2010. In the information it provided to my investigation on 17 November 2011, the department informed me that the security classification of Prisoner A at the time of her being restrained was High 2. The department was unable to inform me why she was given a High 2 security classification, as it has been unable to locate her Security Classification Assessment. However, in his response to my provisional report, dated 11 July 2012, the CE informed me that the security classification of Prisoner A at the time of her being restrained was medium.

Further, in its response to my provisional report the department informed me that its Justice Information System recorded a warning for the High Risk Assessment Team in relation to Prisoner A.

The doctor at the RAH reported in the hospital notes on 1 July 2011 as follows:

[Prisoner A] is pleasant and reactive, She is well dressed in black slacks and black silk top. Not fidgety. Sitting comfortably. Slower rate of conversation however appropriate contact. Maintains eye contact. Did not appear to be reacting to internal or external stimuli. Good insight. Good rapport established.

A RAH Assessment Mental Health Risk Hospital Based Services form was completed by a doctor on 3 July 2011. On the form, the doctor circled the following:

(2) RISK OF HARM TO OTHERS

None

(e.g. no thoughts or action of harming others, judgement intact)

...

(6) ATTITUDE TO AND ENGAGEMENT WITH TREATMENT

No problem / very Constructive

(e.g. accepts illness and agrees with treatment)

Prisoner A remained cooperative and calm when she was unrestrained in the hospital. The hospital progress notes for 3 July 2011 at 10:15am state:

Cooperative, pleasant.

On the same day at 7:10pm, the progress notes say:

Nil management problems.

However, when the shackles and restraints were applied on 4 July 2011 the patient became greatly distressed. The progress notes for 5 July 2011 at 10:30am say:

Nursing note: settled in the morning til after breakfast wanted to go to the toilet and unable to go as she had to be double shackled. Her behaviour escalated, yelling, becoming abusive, and threatening to throw herself out of bed. Given her more medication ...(unknown) to help her settle down with some effect. ...

...She is double shackled to the bed...

At 7:15pm on the same day the progress notes state:

[Prisoner A] became more agitated this morning and started threatened to throw herself (and potentially) injure herself as she is shackled.

Her behaviour has escalated since she was restrained. She was reasonably cooperative and settled before this occurred.

We are told she has to be double cuffed / shackled, which severely restricts her movements and even the most basic needs such as using the toilet.

We have discussed the situation and believe she should be moved up the list as a priority patient considering the patient has very special needs and is likely to become increasingly distressed and potentially harm herself here by agitation / restraints which would be highly distressing to her and other patients.

APPENDIX B – Prisoner B

Prisoner B is a man in his late twenties who has schizophrenia and bipolar disorder. He suffered from his first psychotic episode at the age of 16.⁸⁵

At 08:30am on 14 February 2011 Prisoner B presented at the RAH Emergency Department suffering from a psychotic episode and requesting to be put in Glenside Hospital. He was told to go home and to talk with the community health staff at Port Adelaide Community Care Team. He was discharged and given a taxi voucher to get to Port Adelaide.⁸⁶

On 18 February 2011 Prisoner B presented at the RAH Emergency Department again. This time he was under the control of the department, having been taken into custody on 17 February 2011. Prisoner B was charged with 'endanger life', 'unlawfully on premises' and 'disorderly behaviour'. In his response to my provisional report the CE informed me that Prisoner B had breached conditions of his bail.

The relevant hospital notes say:

From Yatala, with 2 prison guards. Went there → admitted only last night. Sent in for psychosis, "suicidal ideation". Auditory hallucinations, threatening with lighter at petrol station.

The hospital nursing notes for 18 February 2011 record as follows:

11:30 - Patient is co-operative, rambling monologue, occasional outburst. Remains handcuffed and leg cuffed to barouche with 2 Yatala guards. Awaiting a closed bed, admitted.⁸⁷

11:45 - Patient is co-operative, rambling monologue, occasional outburst. Remains handcuffed and leg cuffed to barouche with 2 Yatala guards. Awaiting a closed bed, admitted.⁸⁸

The hospital doctor's notes for 18 February 2011 at 15:00 say:

Handcuffed and ankle cuffed to bed in prisoners uniform.⁸⁹

All doctor notes say he had a drug-induced psychotic episode.

The hospital mental health nurse notes for 19 February 2011 record:

07:50 - [Prisoner B] under prison guard and leg cuffed to bed. [Prisoner B] tearful and remorseful for being arrested. [Prisoner B] was advised not to think too much about that now and discuss these feelings when he gets to psych ward.⁹⁰

15:40 - [Prisoner B] could be heard yelling and screaming from short stay. [Prisoner B] now with three cuffs x1 Right hand, x1 Left hand, x1 right leg. [Prisoner B] desperately wanting cuffs removed, swearing abuse and threats to prison guards and general nurses. Good rapport with MHCN (Mental Health Community Nurse), given meds orally as charted. Apparently mental health team was not aware in [sic] change in behaviour and need for increased handcuffs. Prison guards records show increase in aggressive outburst and given opportunity for no increase in hand cuffs. [Prisoner B] superficially settled after [unknown] and given food... [unknown].⁹¹

⁸⁵ Royal Adelaide Hospital, Progress Notes, 18 February 2011, 15:00.

⁸⁶ Royal Adelaide Hospital, Progress Notes, 14 February 2011, 10:00.

⁸⁷ Royal Adelaide Hospital, Nursing Observation Chart, 18 February 2011, 11:30.

⁸⁸ Ibid.

⁸⁹ Royal Adelaide Hospital, Progress Notes, 18 February 2011, 15:00.

⁹⁰ Royal Adelaide Hospital, Progress Notes, 19 February 2011, 07:50.

⁹¹ Royal Adelaide Hospital, Progress Notes, 19 February 2011, 15:40.

Prisoner B was restrained whilst at the RAH for 5 days. He was then transferred to James Nash House on 23 February 2011. He was released from custody on 22 March 2011.

Subsequently, Prisoner B was admitted to hospital on 6 May 2011 for two days suffering from psychosis. He was not in custody at this time. The hospital records record him as being at moderate risk of harm to himself and to others at this time but makes no reference to any need to physically restrain him in any way.

Prisoner B was again admitted to hospital for mental health reasons on 17 and 18 July 2011. He was not in custody at this time.

Prisoner B was again taken into custody on 22 August 2011. He was reviewed by the forensic psychiatrist whilst in remand, who was of the opinion that he was 'suffering from a manic psychosis and required inpatient treatment.'⁹² Prisoner B was transferred to hospital on 9 September 2011.

On his transfer to hospital on 9 September 2011, Prisoner B reported to a doctor at the RAH that he had been taking his prescribed medication. The doctor at the RAH reported in the hospital notes as follows:

Young Caucasian man, dressed in prison clothes, shackled with handcuffs.
Lying on barouche.
Cooperative, friendly, good EC, psychometric agitation.
Speech - rapid, pressured, though disordered. Themes: religious and grandiose
Affect - elevated, restricted no suicidal ideation.
Percept - multiple voices commenting on his surroundings. Appears to make him laugh.
Cogn - oriented to TPP, grossly intact
Judg - impaired by thought disorder
Insight - moderate, accepting of treatment and medication, accepts illness.

Prisoner B was restrained whilst at the RAH for three days. The department's daily log for 9 September 2011 at 16:30, records that he was restrained as follows:

Prisoner secured to bed by leg, arm to bed and hand cuffs.

The daily log for the same day at 17:30 records that Prisoner B was given a bottle so that he could urinate whilst restrained.

The daily log records that Prisoner B remained restrained until 23:50 on 12 September 2011.

The hospital records say that Prisoner B was transferred to James Nash House, whereas the department's daily log records that he was transferred to Flinders Hospital. In any event, Prisoner B was released from custody on 22 September 2011.

Prisoner B was further remanded in custody on 17 January 2012 and remains in custody on remand for the following offences:

- engage in sexual intercourse with a person without consent and
- breach bail.

Prisoner B has a long history of mental illness. He has had multiple hospital admissions for mental health. The hospital notes say that he 'is well known to mental health services.'⁹³

⁹² Prisoner B, Royal Adelaide Hospital, Inpatient Progress Notes, 9 September 2011.

⁹³ Royal Adelaide Hospital, Progress Notes, 14 February 2011, 10:00.

In the information it provided to my investigation on 17 November 2011, the department informed me that the security classification of Prisoner B at the time of his being restrained was High 2. The department was unable to inform my investigation of why Prisoner B was given a High 2 security classification, stating that it was unable to locate the Security Classification Assessment. However, in his response to my provisional report, dated 11 July 2012, the CE informed me that the security classification of Prisoner B at the time of his being restrained was medium.

The department informed my investigation that no escape history has been recorded on Prisoner B's prison records. There were no SAPOL warnings concerning him. The department said that there are 'high self harm issues noted on [his] case notes.' It told me that the most serious previous offence of Prisoner B was 'endanger life'. In his response to my provisional report on 11 July 2012 the CE further informed me that the department's Justice information System case notes during the time of Prisoner B being restrained 'indicate that he was failing to report as required by his bail conditions and was using illicit drugs during the period.'

APPENDIX C – Prisoner C

Prisoner C is a man in his mid thirties who has schizophrenia and bipolar disorder. He lives with his parents interstate.

Prisoner C was attempting to drive to Perth, claiming that his parents were abusive and he had collected evidence that needed to be delivered to professionals in Perth. He took his father's car without permission to make the trip. On the way he stole petrol and food in Ceduna and was subsequently arrested.

Prisoner C was arrested in Ceduna on 19 July 2011 and charged with making off without payment, dishonestly taking property and disorderly behaviour. He was taken to Port Augusta Prison. According to hospital records he was 'found to be erratic in his behaviour while in the prison.'⁹⁴ He was then transferred to the medical centre at Yatala.

Prisoner C was transferred to the RAH on 22 July 2011. The doctor's hospital notes for that day state:

Patient arrested 3 days ago in Ceduna for stealing his father's car. Transferred to Yatala Prison. As per court order, for medical and [unknown] assessment prior. Also, prison psychologist alerted to exacerbation of sx [symptoms].

On arrival, manic sx were apparent, with flight of ideas, grandiosity (wealth, spending and power), and themes of God and heaven. Also exhibited paranoia - against the security guards. Denies self harm / suicidal ideas.

...

Patient handcuffed to barouche, lying comfortably. No obvious distress. Not agitate. Polite and cooperative.

Prisoner C was restrained whilst at the RAH for three days. The doctor's notes on 22 July 2011 say:

Physically chained with steel cuffs.

...

Shackled with metal cuffs and steel chain. Tied to the bed.

The Community Visitor reported to my office that he visited the patient on this day, and:

...upon arrival observed [Prisoner C] being escorted by two prison guards (one either side) back to his bed, he had both hands cuffed and both ankles joined by a chain (described as shackles). I was brief [sic] by [doctor] who indicated that [Prisoner C] was compliant with all treatment and that I would be safe to visit him.

When I approached the room and introduced myself, the security guards informed me that I was not able to visit and if I wanted to discuss with anyone, I needed to talk to Steve Mann, General Manager at Yatala. I rang and spoke to Mr Mann who when I introduced myself and my role alerted me to the fact that he was unaware of my role and that of the CVs.

He was initially resistant to me undertaking the visit and was concerned that I was intending to take photos of the patient which I said I was not. I got to the stage where I suggested to Mr Mann that it would be wise for him to inform his Minister that he was not allowing me to visit a patient at the patient's request which was part of my statutory role as I would be briefing my Minister. It was at that point that he agreed to the visit on a commitment from me that I would not take any photos.

I awaited sufficient time for Mr Mann to contact his staff and then entered the room to speak with [Prisoner C] who was very great-ful [sic] of the visit. When I asked him about his restraints and

⁹⁴ Royal Adelaide Hospital, Inpatient Progress Notes, 22 July 2011, 14:00 hours.

how he felt about them, he became emotional and said that he felt they were treating him like he was the 'mad axe murderer'. When I asked whether he had ever experienced this in the past in NSW, he said "No, never." He was relieved to hear that he was being transferred to Cedars PICU, a secure Unit where he no longer would need handcuffs and leg shackles.⁹⁵

Prisoner C was transferred to James Nash House on 25 July 2011. His restraints were removed (James Nash is a secure facility), and he was released from custody on 19 August 2011.

Prisoner C has a long history of mental illness, with records of multiple hospital admissions in NSW, WA and SA over the past ten years. The department provided my office with information saying 'Case notes - Poor Mental Health'. Doctors' notes also confirm this.

The offence he committed related to his condition. My investigation has no evidence that he posed any significant threat to himself or others.

Prisoner C had never been imprisoned before.

The department's security classification of Prisoner C at the time of his being restrained was Medium. The department was unable to inform my investigation of why Prisoner C was given a 'Medium' security classification, claiming that they had been unable to locate the Security Classification Assessment.

The department informed my investigation that no violence or other behavioural issues had been recorded on Prisoner C's prison records. Furthermore, there were no South Australian Police warnings concerning him.

In information provided to me on 17 November 2011, the department told my investigation that the most serious previous offence of Prisoner C was 'possessing controlled substance'. In its 11 July 2012 response to my provisional report the department informed me that prisoner C has no previous offences. The department further stated that 'it is noted that the prisoner had no recorded contact with the adult justice system in South Australia this [sic] is not to say that the prisoner did not have interstate criminal history.'

A doctor treating Prisoner C at the RAH was concerned about the restraints used on him. Hospital notes dated 22 July 2011 say:

Correctional Officers refused to allow patient to be photographed. They contacted their Chief at Yatala, ... who spoke to me on the telephone stating that I could not photograph the patient this was against regulations. I told him that this was contrary to UN Protocols on the management of prisoners. He insisted that the patient remain under his jurisdiction...⁹⁶

In his response to my provisional report the CE noted:

It would appear that based on the medical assessments completed by South Australian Prison Health staff and his subsequent detention under the Mental Health Act that Prisoner C was acutely unwell. This category of prisoner presents the Department for Correctional Services with particular challenges. This includes that a mentally unwell person is remanded in custody and further that following detention under the Mental Health Act the prisoner needs to be accommodated in a general ward of a hospital until an acute Mental Health bed becomes available.

⁹⁵ Email from Community Visitor to Ombudsman Office dated 16 September 2011.

⁹⁶ Royal Adelaide Hospital Inpatient Progress Notes, 22 July 2011.

APPENDIX D – Prisoner D

Prisoner D, a woman in her thirties, was taken into custody on 28 June 2011. She was approximately 32 weeks pregnant. She was sentenced to 6 months for dishonestly dealing with property without the owner's consent. She had a history of breaching bail: her birthing plan notes she had 'multiple breaches for failing to comply with bail agreement'.⁹⁷ She also had a history of violent offences.

Prisoner D was first admitted to WCH on 29 June 2011 with alcohol and drug withdrawal symptoms (**the first admission**). The progress notes on that day state:

[Prisoner D] was very agitated 2 leg shackles however she was responsive and settled once made more comfortable → padding applied to ankles.

...

[Prisoner D] was frustrated in the room as 2 guards was [sic] talking to each other constant and loud [sic].

...

Guards x 2 have been in the room throughout shift and remains shackled to bed.

Over subsequent days, the progress notes state:

1 July 2011 - [Prisoner D] has combine dressings around ankles to protect them from shackles. One guard on duty tonight - sitting outside the room.

3 July 2011 - [Prisoner D] agitated with need to be shackled to bed, restless at times but cooperative with staff.

4 July 2011 - [Prisoner D] calm, happy and interactive until 12.30. Quickly became agitated, upset, yelling, screaming and verbally abusive. Wanted to go 'home' to jail. Felt she was 'going out of her head' being chained to the bed. ...

Prisoner D was transferred back to prison on 4 July 2011.

On 16 July 2011 Prisoner D was taken by ambulance to the RAH, which transferred her to the WCH where she was admitted (**the second admission**). Hospital notes say that two guards were present, and the patient was handcuffed and shackled to the bed. On the date of her admission, the progress notes state:

Requests to go for a shower [illegible] but according to guards is unable to do so without permission from the coordinator. Have stated that this request needs to attended [sic] to as [Prisoner D] will need to shower daily due to [illegible].

Subsequently, the progress notes state:

17 July 2011 - [Prisoner D] has slept poorly overnight. Request made to guards again regarding [Prisoner D] having a shower. Pressure area care attended to ankles and wrist where shackles / chains are insitu.

18 July 2011 - Didn't get much sleep.
Uncomfortable.
2° shackles.

The department's daily log for 18 July 2011 at 09:00 says that two guards were present and:

⁹⁷ Adelaide Women's Prison, Birthing Plan, dated 19 July 2011.

Doctor to assess prisoner.

Midwife requested additional pjs and undies and requested we remain outside door in corridor. We stated that we must remain within sight of prisoner. Comms with AWP. Complaint from midwife that prisoner was not allowed to shower on admission to room on Friday.

The following entries also appear in the daily log for 18 July 2011:

13.08 - Prisoner complaining about "being fucking shackled like a dog". "You fucking dogs don't give a shit" "only been able to walk 3 steps" etc.

13.38 - Prisoner becoming frustrated with being secured called officers "fucking dog" "fucking old dog" "you fucking doped up jail dogs" "cruel fucking cruel cunts" Communicated with OPS3 Whatley about prisoner [illegible] frustration.

14.10 - Communication with OPS3 Whatley. Restraints to remain on.

14.45 - General Manager AWP and Mr Goode AWP attended [Prisoner D], tubular bandage placed between cuffs and ankles and wrist and cuffs.

The hospital progress notes for 18 July 2011 note the following:

14.55 - [Prisoner D] agitated and upset for most of shift. States that she has "had enough" of being shackled, is unable to get comfortable. Yelling loudly at times. Threw water jug and other items on floor after pads under her cuffs removed by guards. Is shackled x3, one arm and both legs.

On 19 July 2011 the prisoner was referred to a physiotherapist. The referral document gives the reason for the referral as follows:

Hands and feet cuffed to bedside. Limited movement. Shoulder and back pain +++

On the same day, the progress notes included the following:

10.15 - Agitated about shackles.

...

Ankles and wrists 2° shackles.

16.10 - (Physiotherapy note) In police custody, shackled to bed hands and feet. Restrained to bed rest, up for toilet privileges only. Reports [unknown] low back pain ...worse since lying in bed.

20.30 - (Physiotherapy note) 3 guards in attendance at all times.

According to the department, labour commenced in the early hours of 20 July 2011. A hospital record made at 02:30 on 20 July 2011 confirms that contractions had commenced and were two to three minutes apart.

The hospital notes state that Prisoner D became aggressive about being uncovered for a procedure (an internal examination) at 04:45. Guards were present in the room.

Hospital staff present have informed my investigation that Prisoner D was extremely uncomfortable. Numerous requests were made for her to be able to get out of the bed and walk around the room. These were denied. There is no evidence that the general manager of the prison was contacted to seek approval of this request.

The department's daily log for 20 July 2011 notes the following at 03:35:

Restraints off at nurses request for examination. Control alerted.

The restraints were reapplied immediately after the examination.

At 05:00 an epidural was administered. Hospital staff requested that the prisoner's restraints be removed as she was now unable to walk and therefore posed no risk of escaping. These requests were refused.

The prisoner's restraints were removed during labour at 07.30am on 20 July 2011, but my investigation has been told that the restraints were only removed after much advocacy by hospital staff present. The hospital notes confirm that the guards were still in the room at 08:00 on that day.

Prisoner D delivered the baby at 11:11am on 20 July 2011, and the baby was transferred to the nursery at 11:55.

The hospital's progress notes for 20 July 2011 at 12:35 recorded the following:

I have explained to [Prisoner D] that she should not attempt to stand out of bed and that we need to make sure that her limbs have no numb patches on them (hand cuffed / leg cuffed to be returned once mobile).

The department informed my investigation that the prisoner's restraints were reapplied at 13:45 on 20 July 2011.

At 16:00 and 22:00, Prisoner D was taken to the nursery to breastfeed her baby, with guards present.⁹⁸

The progress notes at 23:00 on 20 July 2011 say that [Prisoner D] was to express breast milk three times overnight, but she was reluctant to do so. The notes further say that two guards were present and that the shift changed during this time. The notes indicate that the prisoner eventually did hand express and use a breast pump.

Prisoner D was discharged from hospital on 22 July 2011 and returned to the Adelaide Women's Prison.

In summary, Prisoner D was shackled for the duration of her first admission, which amounted to five days whilst she was in late pregnancy. She was shackled for the duration of her second admission (six days), with the shackles being removed for 6.25 hours while she was in active labour.

In his response to my provisional report the CE stated that 'it is the Department's clear understanding that in the lead up to, whilst giving birth and after giving birth, Prisoner D was not restrained.' However, it appears to me (from the hospital progress notes and information provided to my investigation from the department) that:

- Prisoner D remained shackled for at least five hours after the commencement of her contractions
- the shackles were removed three hours and 41 minutes before Prisoner D gave birth, and
- the shackles were reapplied two hours and 34 minutes after Prisoner D gave birth.

In the information provided to my investigation on 17 November 2011, the department informed me that the security classification of Prisoner D at the time of her being restrained was High 2. The department also told my investigation that there was a risk that she may try to escape, and that Prisoner D was 'verbally abusive and aggressive in prison and on Hospital Watch.'

⁹⁸ WCH, Progress Notes, 20 July 2011, 16:30 and 22:40.

However, the Security Classification Assessment Forms relating to Prisoner D, given to my office on 8 December 2011, indicate that on 30 June 2011 Prisoner D was given a security classification of medium. This security classification status was confirmed in the CE's response to my provisional report.

Further, in his response to my provisional report the CE informed me that Prisoner D:

- has an extensive criminal history including for offences of violence, with the most serious offence being armed robbery, and
- has an extensive substance abuse history.

Prisoner's D birth plan⁹⁹ says that she has no escape history. It states:

- The prisoner as per SOP31 will be restrained EXCEPT during childbirth and immediate recovery.
- Escort officer assigned to supervise be placed outside the room during childbirth and immediate recovery.

⁹⁹ Adelaide Women's Prison, Birthing Plan, dated 19 July 2011.

APPENDIX E – Prisoner E

Prisoner E was taken into custody on 17 May 2006 aged in his mid sixties.

Prisoner E was admitted to the RAH on 2 August 2010 for investigation of muscular weakness (**the first admission**). He remained restrained in hospital for 14 days. The department has told my investigation that Prisoner E was assessed and it was determined that he required a single point of restraint.¹⁰⁰

Prisoner E was initially handcuffed to the bed. The hospital progress notes for 2 August 2010, (a nursing note) state:

Guard present. Patient handcuffed to bed.

...

Normally needs some help with feeding due to [unknown] mobility in arms.

The progress notes for 6 August 2010 at 16:30 state:

Had a fall at 15:45hr. He said when he was trying to get his clothes from his locker he lost his balance and fell over. Found him lying on his back. He managed to get up from floor with some assistance. ...

A lung function test undertaken at the RAH on 10 August 2011 indicated that the prisoner may have had motor neurone disease. Staff Specialists in Neurology wrote that the 'results are consistent with a chronic denervating process affecting multiple myotomes in the upper and lower limbs.'

A physiotherapy note in the progress notes for 11 August 2010 described Prisoner E as having 'difficulty walking.' An occupational therapy note for the same day describes him as needing 'near full assistance with washing and dressing' and with feeding and notes that 'his functional level will likely decline and needs will continue to increase.'

The doctor's notes for 12 August 2010 record the following:

Caucasian man in gown, chained to bed, guard in-sitn. Bearded. Good EC, engages well. Cooperative.

The hospital requested that he be cuffed to the bed by his ankle rather than his wrist. The doctor's notes for 13 August 2010 record the following:

S/w Stevan Janosevic, GM @ Yatala.
- he had oked leg restraints 3 days ago!
- not reported by guards.

A nursing note for 13 August 2010 records the following:

... assisted in hygiene this am and some of his ADLs [Activity of Daily Living] as has got handcuff on one of his wrist! ... Prison authority guard to move/transfer cuff from wrist to ankle as per request of patient and supported by team...

Prisoner E was discharged from the RAH on 16 August 2010.

Prisoner E was cuffed to the bed for the duration of his first admission (14 days in hospital). I note that this restraining occurred prior to the issuing of the EDI setting the minimum standards for restraining prisoners in hospital. Accordingly, Prisoner E was not restrained by three points but was cuffed to the bed by one point.

¹⁰⁰ The CE's response to my provisional report, by letter dated 11 July 2012.

I note also that initially the department did not inform my investigation about Prisoner E's first admission, and did not provide me with its daily logs for this period.

In the RAH Discharge 'Final v1 Separation Summary' dated 16 August 2010, Dr Thomas Kimber wrote:

[Prisoner E] is a 69 year old man, who is currently incarcerated at the Port Lincoln Prison with a 9 week history of progressive limb weakness, initially affecting the upper limbs on the right side more than the left. He first notices left weakness approximately 4 months ago. Over the last few months, the weakness had progressed significantly. He was having difficulty feeding himself because he was unable to lift his arms, difficulty standing up off the toilet bowl and was using significant compensatory mechanisms in order to shower. Despite these issues, his symptoms were relatively under-recognised by the Prison and he was not receiving any functional support.

...

Given his clinical findings, it was likely [Prisoner E] had motor neurone disease.

The RAH 16 August 2010 discharge letter says:

Mobility: (level of assistance, aids, endurance, balance)

[unknown], waddling gait, unaided

↓ arm swing R) arm

↓ BOS at times but fluctuates. Able to ↑ with cues. Tends to speed up and lose control with fatigue.

Managed 760m.

Additional Comments:

Given the nature of MND, [Prisoner E] is likely to progressively and rapidly deteriorate.

Dr Janakan Ravindram, RAH specialist in neurology, wrote a letter to Dr Alan Moskwa of Yatala Labour Prison, dated 25 August 2010. The letter included the following:

I reviewed [Prisoner E] today in the company with the nurse from the Health Centre at Yatala.

[Prisoner E] had felt there was improvement in his left leg strength, such that he was able to lift the leg off the bed a little bit higher than previously. Otherwise, there had been no functional change with the course of IVIg.

Again, I noted the 12 month history of progressive weakness initially in the shoulders but now also in the legs, and the upper limbs especially in the shoulder girdle but also in the hip girdle with associated wasting and fasciculation. I noted these fasciculations were also around the thoracic region.

...

However, I note that he has had a visit from the Motor Neurone Disease Society and it would be important to obtain from the Palliative Care Services with regards to end of life issues, such as PEG feeding and ventilation.

Hospital records show that in November 2010 Prisoner E was using a walker, and on 13 November 2010 he was taken to the RAH emergency department after a fall. The nursing observation chart notes:

Fall - unwitnessed - walker hit bump, pt fell and hit head.

Prisoner E was transferred to palliative care at the RAH on 13 December 2010 suffering from Motor Neurone Disease (**the second admission**). The department's daily log notes at 23:00 that 'restraints (were) applied.'

On the same day, 13 December 2010, the daily log further notes that the patient had to have the assistance of two people to get in and out of bed in order to shower.

The doctor's notes on 13 December 2010 include the following comment:

Walks with frame but 5 x falls recently.

The nursing notes for 14 December 2010 observe:

Pt managed to stand transfer from bed to chair reasonably well with stand-by assistance x 2. Pt showered with full assistance x1, is unable to wash any areas independently. BWO today. Pt voiding using bottle in bed, pt requires assistance with this as can't hold the bottle. Pt is tolerating diet and fluids, does require feeding. ... Pt has remained guarded by x1 guard and is handcuffed whilst in bed.

On 14 December 2010 Dr Rowena Newcombe, a palliative care registrar at the RAH, wrote a letter which was faxed to Yatala. The letter included the following comments:

[Prisoner E] has been referred to our care at the Palliative services unit, Royal Adelaide Hospital, with worsening motor neurone disease, involving severe arm and leg weakness. He currently has great difficulty moving on his own and requires a high level of care. He is likely to require increased care in future. His diagnosis has been confirmed by a neurologist, Dr Ravindran.

The palliative care unit, and the Director of Palliative Care services, Dr Michael Briffa, are concerned that his handcuffing is greatly impairing his care and comfort. At current, [Prisoner E] is unable to move from his bed and his condition is likely to worsen, as he has a terminal illness. We therefore feel that it would not prove a security risk to remove his handcuffs.

If possible, we request that he please be allowed to move without handcuffing, based on compassionate grounds. This would allow him much greater comfort in what is already a very difficult time for him.

The palliative care doctor's notes for 14 December 2010 state:

Have sent a letter of request to Yatala that pt be allowed free movement without handcuffing. General Manager unavailable to discuss but will speak with Dr Briffa if needed. Likely that handcuffs will be removed.

The daily log for 15 December 2010 at 13:00 records that:

EO [escorting officer] received phone call from the depot confirming that P is no longer to be secured with restraints as authorised by the General Manager at Yatala. Forthwith EO [escorting officer] has removed restraints.

However, at 23:00 on the same day the daily log notes:

P + restraints checked.

It therefore appears to me that even once the general manager's decision to dispense with restraints was made, there was some delay in implementing it.

In his response to my provisional report the CE submitted that Prisoner E's restraints were removed on 15 December 2010, and that he was not restrained until he passed away on 5 March 2011.

The evidence suggests that Prisoner E's restraints were removed either after 23:00 on 15 December 2010 or on 16 December 2010. It seems to me more likely that the restraints were removed on 16 December 2010.

The hospital palliative care nursing notes for 16 December 2010 noted the following at 14:00:

Patient given full assistance with shower and shampoo this morning. Pt now unshackled but guard remains in situ. ...

My investigation spoke to Dr Michael Briffa, the RAH Director of palliative care services at the time of Prisoner E's hospitalisations. Dr Briffa said that he remembered that it was a 'rigmarole' to get the approval from the department have the restraints removed, but that they were eventually removed. Dr Briffa said that Prisoner E was so weak that he could not turn in bed due to the weight of the chains. Dr Briffa recalled that Prisoner E was guarded until his death. He said that Prisoner E had no mobility and clearly did not need to be guarded. Dr Briffa said that the guards were inside the room most of the time, but that they did leave the room when he asked them to so that he could treat the patient in private. Dr Briffa further commented that, in his view, the department does not accommodate care for terminal patients at all well.

The Braden Scale for predicting pressure ulcer risk, which assesses a patient's risk of developing a pressure ulcer by examining six criteria, records him as being 'chairfast' and having very limited mobility on 17 December 2010, 21 December 2010 and 5 January 2010. The scale defines 'very limited mobility' as 'makes occasional slight changes in body or extremity position but unable to make frequent or significant changes independently.' Defines 'chairfast' as 'ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.'

Prisoner E remained under guard until 31 December 2010. The palliative care nursing notes for 31 December 2010 note the following:

CSC called. [Prisoner E] is to no longer be guarded unless his situation changes. Any problems contact CS immediately.

However, the hospital records say that Prisoner E was still being guarded right up until his death. This is confirmed by the department's daily log. The CE, in his response to my provisional report wrote:

Whilst the department acknowledged his very poor health and his frailty when determining not to apply restraints, the very serious nature of the prisoner's offending history and victim concerns warranted the prisoner remaining under the supervision of a single escort officer.

On 10 January 2010 the RAH weekly nursing summary recorded that Prisoner E required full assistance for toileting, hygiene, grooming, bed mobility, transferring, and sitting; and that he can walk only on a frame with two people assisting for very short distances.

Subsequent records show that Prisoner E's health continued to deteriorate. He suffered from decreased ability to swallow, breathe and speak and decreased mobility. He required full assistance for everything (eating, drinking, moving). He required lap belt support to enable him to sit in a chair. He suffered from pressure sores from being unable to move in bed.

The Braden Scale recorded him as being confined to bed and completely immobile on 16 February 2011 and 23 February 2011. According to the Braden Scale, 'completely immobile' means 'does not make even slight changes in body or extremity position without assistance.'

Prisoner E died in custody in the RAH's palliative care ward on 5 March 2011. The Medical Practitioner's Deposition prepared for the death report to the Coroner notes that advanced Motor Neurone Disease was the cause of death. It states the symptoms on presentation to hospital and admission diagnosis as follows:

Increasing weakness and muscle atrophy requiring increasing care.

The department says that:

[Prisoner E] was hospitalised from December 2010 and had the progressive neurodegenerative condition, Motor Neurone Disease.

[Prisoner E] subsequently passed away in March 2011.

Whilst hospitalised, [Prisoner E] was not restrained from 15 December 2010, due to his health condition, until he passed away.

The department told my investigation that Prisoner E was 'under G4S guard for 83 days' and that 'restraints (were) used for 2 days until authority to remove these by GM rec'd.'

My investigation spoke to a social worker at the RAH who was involved in Prisoner E's palliative care. The social worker confirmed that at the time that Prisoner E was restrained, 'pain was an issue', saying that 'he couldn't move to a position to relieve that pain.' The social worker further stated that 'no one felt that he was a risk to anyone. He was unable to walk if he had been able to get out of bed.' The social worker recalls that it took a considerable amount of time to go through the bureaucracy to arrange to have the restraints removed. Further, the social worker confirmed that Prisoner E was guarded the entire time he was in palliative care, until he died.

Prisoner E gave an Anticipatory Direction under the *Consent to Medical Treatment and Palliative Care Act 1995* on 21 September 2010. This included the direction that if, at some future time, he was in the terminal phase of a terminal illness that he be nursed and kept in a dignified manner.

The *Consent to Medical Treatment and Palliative Care Act 1995* defines palliative care as 'means measures directed at maintaining or improving the comfort of a patient who is, or would otherwise be, in pain or distress'.

The guide for health professionals 'An explanation for the key provisions of the *Consent to Medical Treatment and Palliative Care Act 1995*' defines palliative care as follows:

palliative care is the active total care of people with a progressive life limiting illness, whose disease is not responsive to curative treatment. In palliative care, optimal management of pain and other physical symptoms, and attention to psychological, social, spiritual and bereavement needs, is paramount. The goal of palliative care is achieving the best possible quality of life for patients and their families. Palliative care may include the withholding or withdrawal of active treatment, in accordance with section 17(2) of the *Consent to Medical Treatment and Palliative Care Act 1995*.

The department informed me that a decision was made to remove the prisoner's restraints towards the end of his life. However, he remained under guard until his death, and my investigation was told that the restraints were only removed at the end of his life due to prolonged advocacy by SAPHS and the numerous representations that it made to the department. In response to these comments in my provisional report the CE said:

The evidence presented in the provisional report and the evidence available to the department does not support this claim. I submit the following:

- The prisoner's classification was reduced to Low Security by the department prior to the prisoner's first admission to hospital. This reduced the security conditions required for an external escort;
- During the first admission only one restraint was used;
- On the second admission to hospital only one restraint was used;
- This single restraint was removed two days after the admission following a request from the Director of Palliative Care;
- The prisoner remained un-restrained for some 80 days.¹⁰¹

¹⁰¹ The CE's response to the provisional report, by letter dated 11 July 2012.

Prisoner E was serving a significant period of imprisonment for a serious offence. The department's security classification of Prisoner E at the time of him being restrained was Low 1. He was reduced from a Medium security to a Low security rating following an individual classification review approved by a member of Executive on 1 August 2010. The CE told my investigation that the reduction in classification from medium to low security would have considered a range of factors including:

- length of sentence
- serious nature of offending
- his physical health.¹⁰²

In response to my provisional report the CE said:

During his first hospital admission the General Manager conducted an individual assessment and determined that the prisoner required a single point of restraint. In the subsequent admission and following input from health a further assessment was completed. As a result of this assessment restraints were removed. The prisoner remained under the supervision of an escort officer as a condition of his leave of absence.

¹⁰² Ibid.

APPENDIX F – Prisoner F

Prisoner F is a man in his late fifties. He has a history of mental illness. Prisoner F was taken into custody on 28 July 2011 charged twice with failing to comply with bail conditions.

Prisoner F was taken to the RAH emergency department on 3 August 2011 for respiratory distress / shortness of breath. The diagnosis was chronic obstructive airways disease.¹⁰³ He was admitted with the admission diagnosis given (on the Admission Details form) as empysema exac.

The hospital's progress notes for 3 August 2011 note the following at 07:00:

Leg shackles in place at all times. No flexi-cuffs supplied.

The department's daily log for 3 August 2011 at 13:00, says:

Restraint status to remain as is, as per D Hosking (DCS).

Subsequent entries are as follows:

6 August 2011 18:30 - Doc wishes P [prisoner] to stand and walk periodically in relation to lung issue.

7 August 2011 19:21 - P unsecured at ankle in order to walk in room as per D's orders.

7 August 2011 19:34 - P secured to bed by wrist and ankle.

8 August 2011 16:35 - R leg to bed removed so P could stand and walk - leg and closing chain still attached.

8 August 2011 16:50 - R leg to bed secured.

8 August 2011 17:42 - Panicking and covering head with blanket, hearing voices.

8 August 2011 20:00 - P still having panic attack. did not check R [restraints] as P has covered himself entirely with blanket and is shacking. will check once P is calm again.

The hospital's progress notes for 8 August 2011 note the following:

Pt has been compliant. Chained to bed and guarded ...

Pt has bruising to legs where cuffs have been. Security told him that he mustn't have any padding to protect...

The progress notes for 9 August 2011 note the following at 09:55:

Complaining about pain at ankles from shackles → cannot put crepe bandages under shackles as per department of corrections.

...

Bruising at ankles bilaterally.

The department's daily log for 9 August 2011 at 09:30 says:

P complaining about R [restraints]. D [doctor] will contact DCS re some kind of padding for leg R [restraints].

The hospital notes record that the patient often used a walking stick to walk longer distances. On 10 August 2011 the patient requested a walking stick. The physiotherapist wanted him to be

¹⁰³ Letter from RAH Emergency Department Registrar to Yatala Prison dated 3 August 2011.

more mobile and requested from the guards that he be allowed a stick. The guards stated that no clearance had been given for him to have a stick. Clearance was given for the patient to have a walking stick on 11 August 2011.

The daily log for 10 August 2011, 11:32, says

11:32 - Wanting to issue P with a walking stick and also walk P along the corridor. 11:38 phone to control advising of above. Call will be made by Supervisor to gain permission.

19:05 - P unsecured at ankle in order to walk in room, per D orders.

19:10 - P back to bed resecured at ankle to bed.

For 11 August 2011, the daily log records:

11:20 - Rang control to get permission for P to walk in corridor with physio - secured to EO [escorting officer]. 11:27 - P back in bed - resecured.

13:30 - Spoke to [control] re P [prisoner] ID sheet and the incorrect information. P has asthma, psych cond. (ie schizophrenia un-medicated) self harm, diabetes and previous cardiac - all of which were indicated NO!

16:38 - P requests to empty his bowels - EO rang control to get permission from YLP operations manager - control informs me P is to remain secured to me whilst he empties his bowels.

16:45 - P to toilet - secured to EO [escorting officer] through the closed door.

18:39 - P crying saying he just wanted to die.

For 12 August 2011, the daily log records:

19:00 - EO [escorting officer] asks permission for P to have leg restraint removed and P to be able to stand out of bed to help with circulation occasionally. T. Richards gives permission.

20:55 - EO [escorting officer] uncuffs leg restraints for P to stand up - 21:00 P back in bed - R [restraints] checked.

The next day, 13 August 2011, the daily log records:

14:43 - Physio in to talk to P. We walked in passage (secured to me) for a short time. Returned to bed secured at 14:50.

The hospital's progress notes for 14 August 2010 (nursing note) state:

Leg has skin tear due to leg cuffs
Dressing to be applied. Guard aware. Unable to remove leg cuffs at present.

For 15 August 2010, the nursing notes state at 12:00:

Face washers used to pad around shackles. Shackles on wrist causing some irritation but pt refusing to wear dressing at this time.

A bail hearing was held on 15 August 2011 and bail was approved. The guards and restraints were removed.

The RAH Final Separation Summary, dated 16 August 2011, includes the following:

Clinical Synopsis

[...] yo man who was an inmate at Yatala Labour Prison on admission.

Presented with 1 day of progressive dyspnoea and productive cough. He had been in custody and stated that he had not received his regular medications for the proceeding 10 days.

Examination revealed an anxious man with poor air entry throughout and generalised expiratory wheeze. He was using all his accessory muscles and was clearly in respiratory distress. pO₂ 51mmHg. CXR showed changes of COPD.

He was treated with high dose Prednisolone and IV, followed by oral, antibiotics and showed marked improvement. Viral PCR, sputum AFB and atypical serology returned negative. He was osteoporotic on a bone scan from 2007, and given ongoing prednisolone usage, he was given a Zoledronic acid infusion during admission and commenced on Calcium supplements.

Throughout admission he was shackled to the bed by both of his legs with minimal mobilisation. Despite DVT [deep vein thrombosis] prophylaxis, he became increasingly SOB with chest pain and worsening hypoxia at 1 week into the admission with CTPA confirming a R) pulmonary embolism. He was treated with therapeutic Enoxaparin and was commenced on Warfarin. His legs were badly bruised from the shackles. Concerns over this have been brought up with Hospital Administration and they will be looking into this event.

Prisoner F was discharged from the department's custody on 15 August 2011. He had been restrained and shackled in hospital for 18 days. He was discharged from hospital on 16 August 2011.

On 15 August 2011, Dr Matthew Hauser, Intern RAH, wrote the following letter to the CE:

Dear Mr Severin,

I am writing to you regarding a prisoner in custody who has been an inpatient under my care in the Royal Adelaide Hospital for the last two weeks. During this period he has been shackled to the bed by one arm and both his legs. This treatment is not appropriate in a hospital setting and has severely limited our capacity to adequately care for him and has also resulted in the development of further medical complications and injuries to his ankles.

The shackles impeded investigations, such as electrocardiograms, and hindered our ability to diagnose and treat his condition. Further to this we were not allowed to put therapeutic devices on his legs underneath the shackles. These devices may have helped to prevent the resulting pulmonary embolism, which is a type of blood clot in the lungs.

I understand that prisoners need to be guarded and shackled, but shackling their legs puts them at risk of developing blood clots in their legs and hence a clot in their lungs, which are potentially life threatening. There has to be some understanding from the Department of Corrections that while in hospital a prisoner must be able to mobilise to prevent blood clots and pneumonia developing.

I would be happy to discuss this matter with you further.

Kind Regards,

Matthew Hauser
Intern; Royal Adelaide Hospital

My investigation spoke to Dr Hauser. Dr Hauser said that he remembered Prisoner F well and thought that the department was unreasonable. He said that he had asked for the patient's shackles to be removed telling them that the patient was at risk of developing deep vein thrombosis and/or pulmonary embolism. The department refused. The department also refused his request to have pressure bandages put on the patient. Doctor Hauser said that he was told

by staff of the department that it was up to him to negotiate with the department to try and get the prisoner's restraints removed or altered. Dr Hauser said that this was very difficult for him to do, particularly given that he was very busy and the process took a considerable amount of time.

My investigation requested information about Prisoner F from the department by letter dated 9 February 2012. In response, I was not provided with any security assessment information regarding Prisoner F. In his response to my provisional report the CE informed me that the prisoner's security classification was High 2, as follows:

During the admission interview process an initial classification assessment would have been completed and a Prisoner Stress Screening Interview would have also been completed. The prisoner's classification was High 2. I am advised that the department had limited information with respect to the prisoners [sic] antecedents.

This individual assessment is completed based on the information available. Critical to that assessment would have been that:

- the prisoner was remanded in custody by a magistrate
- the prisoner was on remand for a violent offence

It is noted that the prisoner had recorded contact with the adult justice system in South Australia which included an offence of aid and abet carnal knowledge and stealing related offences. At the time of admission the department was not able to determine if the prisoner had an interstate criminal history.¹⁰⁴

¹⁰⁴ The CE's response to the provisional report, by letter dated 11 July 2012.