Summary of Corrections Inspectorate case review of the management of a prisoner at Auckland Prison's maximum security unit and the use of a tie-down bed

Overview

On 27 April 2016 the Chief Ombudsman via the COTA team raised some areas of concern with the Deputy Chief Executive, Corporate Services in relation to a prisoner's treatment and that their overall view was that; '*The use of the tie-down bed in the particular case of the prisoner was inhumane, dehumanising and could amount to torture under the Crimes of Torture Act.'*

As a result the Chief Executive determined that the management of the prisoner should be fully investigated by the Chief Inspector of Corrections. The Investigation into the management of the prisoner during the period 27 February 2016 to 3 May 2016 was carried out by Louise MacDonald, Inspector of Corrections on behalf of Andrew Fitzharris, Chief Inspector, under terms of reference approved by the Chief Executive.

The tie-down bed (TDB) restraints (consisting of a tie-down bed, wrist bed restraints and torso restraints) are a legal authorised form of mechanical restraints in accordance with Sections 87 and 88, Corrections Act 2004, regulations 124-129, and Schedule 5 Corrections Regulations 2005.

The Investigation methodology involved a review of all records relating to the prisoner's management during the period 28 January 2016 to 3 May 2016; the prisoner's electronic file, At Risk management file and management plans; prisoner's electronic Health (including medical notes) file (Medtech) and Treatment Plan; the prisoner's Department of Corrections psychological involvement and case file, and the prisoner's Department of Corrections case management involvement and Offender Plan. The Investigation reviewed all relevant legislation, Departmental policy and procedures, including Memorandum of Understandings and Service Level Agreements. Further, the Investigation completed an interview with the prisoner, relevant Departmental staff and external agency personnel involved in the professional decisions relating to the prisoner's management (Mason Clinic Psychiatrist and Mason Clinic Manager).

In February 2016 a prisoner was mechanically restrained via the TDB from 1600 hours to 0830 hours in response to an escalated risk of self-harm and infection following three incidents of self-harm (deep cut to abdomen and wound tampering) during February 2016. There were also subsequent incidents of self-harm in March 2016.

The TDB continued to be used during 1600 hours to 0830 hours daily as part of the prisoner's management plan which was aimed at reinforcing positive behaviours by reducing time restrained on the TDB.

The use of the TDB was discontinued in April 2016 by staff following joint agreement by the multi-disciplinary team; being Mason Clinic staff, psychological services, regional office staff, and Auckland Prison health and custodial management staff.

The prisoner concerned is reported to have severe borderline personality disorder and substance abuse (drug seeking) issues. His personal records document a person who intentionally selects the timing of his self-harm to coincide with low staffing levels on site (custodial and health) to facilitate external medical treatment in the hope of facilitating specific drugs (pain-relief opiates).

The prisoner had regular involvement with Mental Health Services throughout his terms of imprisonment. Since being transferred to Auckland Prison in July 2015 he was admitted to the Mason Clinic following a series of self-harm incidents which resulted in the use of the tie-down bed consecutively for approximately 41 hours until being transferred to Mason Clinic, and then returning to Auckland Prison in September 2015.

The prisoner was transferred to the Mason Clinic (June 2016) following further self-harm attempts. The prisoner was reportedly kept in isolation with the use of mechanical restraints under supervision of three staff whilst at Mason Clinic.

There are still serious concerns within Corrections Services as to the prisoner's ongoing management and the risk of him seriously self–harming to the point that he will take his own life. This is a heavy burden for the individual staff involved and the Department as a whole.

Key Findings

The Investigation is of the opinion that the decision to place the prisoner on the TDB in February 2016 was justified given his recent escalated self-harm behaviours and that the prison regimes and resources were not the cause of the prisoner's placement on the TDB (from 1600 hours to 0830 hours) but rather a consideration given his historical self-harm occurred during these hours so as to facilitate hospital treatment in order to meet his drug seeking behaviours.

It is acknowledged, with hindsight, that there was a subsequent change in focus regarding the management of the prisoner and that he should have been removed from the TDB sooner.

The Investigation is of the view that due to:

- A lack of legislative detail and comprehensive guidelines for use of the TDB restraints; and
- The involvement of numerous staff from various disciplines throughout the prisoner's time on the TDB; and
- A lack of training of all Departmental staff (custodial, health, psychological services) in the purpose and restrictions in the use of the TDB restraints; and
- A lack of sharing professional information (albeit acknowledging professional privacy restraints) and assumptions of how the prisoner was being managed on the TDB; and
- A lack of a lead role overseeing the prisoner's overall management

The use of the TDB crept from being used as a last-option resource to assist in reducing his immediate risk of self-harm, to a tool for managing his health, and complex behaviours. The complexity of each risk however being inter-related and as such blurring the overall purpose of the TDB use.

Although there were procedural shortfalls and non-compliance with regulations and policies, overall the intentions were to maintain the prisoner's wellbeing. The Chief Inspector noted that, to the extent to which I am qualified to judge, I do not believe the Department's actions amount to torture.

Specific Findings
It is acknowledged that the decision to keep the prisoner on the TDB was a joint decision by those involved in the Multi-disciplinary Team (which included the Mason Clinic Prison Forensic team).

The Prison Director, who ultimately has responsibility for the prisoner's safety and well-being, and is the decision maker on whether the prisoner would be placed on/off the TDB, is unlikely to go against professional advice received. (GP/psychiatrist & psychologist).

The Investigation found that the relevant legislation, delegations, national policy, procedures and instructions, and local site policy for the use of mechanical restraints (specifically the TDB) lacks alignment and robust guidance, and has contradicting requirements.

That the lack of review regarding the national TDB policy and procedures following the amendments to the Corrections Act 2004 & Corrections Act 2005 in June 2013 contributed to the confusion as to the correct application of the mechanical restraints process and the legal roles authorising use of the TDB mechanical restraints.

General Findings
The lack of timely reporting to the Regional Office caused a delay in identifying the authorisation breaches.

Though there were multiple people involved with the prisoner's management during the initial period there was no one role overseeing and collating the whole process to ensure compliance.

That the Auckland Prison staff (custodial & health) working in an extremely volatile and stressful situation managed a complex, difficult prisoner to the best of their abilities and that the gaps in their knowledge and the policies and processes has opened staff up for criticism.

The Investigation found there was confusion specifically in relation to the medical and health practitioners' responsibilities in accordance with the legislation and delegations, and how that translated to the national policies and procedures regarding the application of the TDB mechanical restraints.

The Investigation concurs with the findings regarding this matter as identified in the At Risk prisoners Review completed by the Northern Region in May 2016 which states that;

- *'There does not currently appear to be any current departmental clinical practice guidelines to enable the Medical Officer to reach a considered decision regarding the use of mechanical restraint.*

- *There is also lack of clarity around what decision the Medical Officer is being asked to make in relation to the use of mechanical restraint and whether processes to make such decisions are reflective of safe clinical practice that supports a medical practitioner's professional accountability.*
- *In addition, there does not appear to be any current support or mechanism for the Medical Officer to peer review these decisions.'*

The Investigation found that there were varying degrees of compliance with the relevant national policies and procedures as per the Prison Operations Manual (POM), Custodial Practice Manual (CPM) and local policy for use of the TDB.

The Investigation found there were no specific current national guidelines for use of the TDB. However Auckland Prison had a local outdated policy containing instructions and guidance on using the TDB. The Investigation found that the site did not comply with this local policy in that:

- Restraints were applied to the ankles without specified medical advice
- Limbs were not exercised
- Recording of fluids & foods was not completed to an acceptable standard.

The Investigation found that the local policy requirement regarding placing a urinal bottle between a prisoner's legs during general lockup in the Investigations' view is degrading and should immediately be removed from the local policy.

The Investigation found that the circumstances in which the prisoner was placed on directed segregation for Medical Oversight pursuant to section 60(1)(a) in January 2016 and Section 60(1)(b) in February 2016 were appropriate and reasonable; authorised by the delegated authority on the Health Centre Manager's recommendation with the required authorisation form completed.

The Investigation is of the view that the use of the TDB for the prisoner was a last resort for prison management who believed he would be admitted to the Mason Clinic as had occurred in similar circumstances five months earlier. However when he was assessed as "not mentally ill" by the Mason Clinic psychiatrist, the pressure was placed back on custodial & health staff to manage his self-harm risk behaviours.

The Investigation is of the view a more strategic consideration of the staff placement in the At Risk Unit needs to be a focus moving forward which includes robust training and supervision.

The Investigation found that there is a Human Resource guide developed to assist managers involved in making staff placement decisions into units defined as high risk and to assist staff in understanding how these decisions are made and what they need to do to contribute in these environments.

The Investigation acknowledges the contribution the COTA Inspectors' have played in the process of identifying the shortfalls within the Department's TDB policy and also the involvement of Northern Regional Office staff in dealing with these shortfalls when identified.

The Investigation is of the view that a single management role was required to ensure all levels of involvement in the prisoner's management was collated and processes complied with appropriately.

The Investigation is of the view that the Prison Director who is legally responsible for any prisoner while imprisoned at his/her site should have access to all relevant information/documentation pertaining to that prisoner which includes general Health, psychological & psychiatric information to enable an informed decision.

External Agencies Involvement

The Prison Director contacted the Visiting Justice (VJ) on 9 March 2016 given his oversight following the required notification process relating to the use of mechanical restraints (TDB) in accordance with the national policy form (POM IR.05.form 2 – Notice of the use of mechanical restraints) as sanctioned under Section 87 of the Corrections Act 2004.

The VJ made arrangements to visit the At Risk Unit and speak with the prisoner and relevant staff in accordance with the VJ assigned powers under Section 19 (4)(b) Corrections Act 2004. The VJ had concerns for the lengthy period in which a prisoner had been restrained on the TDB.

Following the visit, the VJ emailed Mason Clinic Team Leader and prison forensic psychiatrist with a comprehensive report on his findings of the prison staff managing the prisoner and the prisoner himself. He stated that:

'*I believe [the prisoner] should be immediately removed from Auckland Prison and be detained in the Mason Centre (or a similar centre) for reassessment*.'

The Mason centre was unable to accommodate the prisoner but offered support to corrections staff.

The VJ continued to raise concerns about the prolonged use of TDB with the prisoner and contacted the Prison Director, Ministry of Health, including the Director Mental Health (MOH). The Director of Mental Health referred the email correspondence to the Department of Corrections, Health Director and National Commissioner.

Following on-going concerns raised by the VJ, the Director of Mental Health, MOH contacted the Department's Health Director, copy to National Commissioner raising some concerns, which the National Commissioner discussed directly with the Assistant Regional Commissioner, Northern on the same day.

The Chief Inspector of the Office of the Ombudsman COTA team emailed the Prison Director at Auckland Prison on 2 March 2016 requesting information concerning the use of TDB with the prisoner between 26 February 2016 and 2 March 2016, the long term plan for management of the prisoner and relevant health notes including details of the involvement of Mental Health Services.

On 15 March 2016, the Regional Senior Advisor made arrangements with the COTA Inspector for a phone conference to discuss the prisoner's management which was arranged for later that day with the inclusion of the inspectors and the COTA Chief

Inspector from the office of the Ombudsman and the Prison Director. The Ombudsman requested documentation and other electronic data which was provided by the Prison Director.

On 11 April 2016, the COTA Inspectors conducted a site visit which included the At Risk Unit (ARU) and interviews with the prisoner (and another prisoner), discussions with ARU staff and management, Prison Director, Prison Forensic Psychiatrist and Chaplain.

On 10 March 2016, the Acting Principal Corrections Officer (APCO) of the ARU forwarded a copy of the Multi-disciplinary Team (MDT) management plan for the prisoner to the regional Inspector. The regional Inspector responded advising that the plan is comprehensive and covers the use of the TDB; however there was no reference to the frequency of observations while the prisoner is on the TDB. The APCO responded advising that the observations are continuous and that the prisoner is on directed segregation under Section 60 for medical oversight.

On 17 March 2016 the Office of the Ombudsman Prison Investigator contacted the Chief Inspector, Inspectorate Office. He asked whether the Inspectorate Office were monitoring the management of the prisoner and if all the approvals had been sought as per the policy.

The Chief Inspector, Inspectorate Office referred the matter to the regional Inspector for Auckland Prison to follow up. On the same day the regional Inspector advised the Chief Inspector that he had been monitoring the situation and had visited the ARU during the previous week during a routine site visit where he spoke to the staff and viewed the prisoner's management plan.

The regional Inspector advised that the prisoner was being managed by a MDT who met weekly to review the prisoner's management plan and that he is also subject to a Section 60 medical oversight segregation order due his risk of self-harm. The MDT progressed to have daily meetings concerning the prisoner.

In the course of the investigation the Inspector identified some inappropriate behaviours exhibited by staff. These consisted of a hand written post-it note attached to the practice guide on securing a prisoner to the tie down bed. This is referenced in the Ombudsman's report. And an incident which involved a staff member assaulting the prisoner whilst restrained.

Recommendations

That the Chief Executive should:

- Commission a review to ensure alignment of the Department's current legislation, delegations, policies and procedures in relation to TDB restraints as defined under clause 3 (f-j) of Schedule 5, Corrections Regulations 2005 and to ensure a robust and prescriptive guideline and high level reporting structures are developed and communicated across the prison estate.
- Provide the Chief Ombudsman with a copy of this report in response to the concerns raised via the briefing notes in April 2016 and May 2016.
- Ensure that there is specific and comprehensive staff training for those custodial staff and managers assigned to High Risk Units managing high complex prisoners, specifically with mental and/or extreme personality disorders.

- Ensure that the management team of the current Auckland Prison PPP are made aware of this report and its findings to assist in their considerations in planning the operational needs of high complex prisoners in a more therapeutic & multi-discipline environment.
- The Department should review the current Memorandum of Understanding with Ministry of Health and Service Level Agreements with local DHB's to ensure a greater collaborative approach and practical assistance when dealing with highly complex prisoners.