



DEPARTMENT OF JUSTICE AND ATTORNEY-GENERAL
BRIEF FOR APPROVAL/NOTING

TO: [REDACTED] Acting Commissioner, Queensland Corrective Services
FROM: Samay Zhound, Chief Inspector of Prisons
SUBJECT: Self-harm – Prisoner [REDACTED] Wolston Correctional Centre
DATE: 25 September 2017

PURPOSE

- To inform you of the findings and possible practice improvements identified by the Office of the Chief Inspector (OCI) as a result of the review of the treatment of prisoner [REDACTED] at Wolston Correctional Centre (**Attachment 1**).

BACKGROUND

- Prisoner [REDACTED] is an inmate of Wolston Correctional Centre, and has a history of self-harm.
- Over an approximately 20 hour period on [REDACTED] and [REDACTED] July 2017 prisoner [REDACTED] self-harmed on a number of occasions and required two episodes of escort to and treatment at the PAHSU;
- Officers restrained the prisoner at various times and to varying degrees throughout the course of the 20 hour period.
- Due to his self-harming and non-cooperation the prisoner presented significant problems for attending correctional officers over that extended period of time;
- at one stage no medical treatment was available at the Centre due to the lateness of the hour and the fact that QH did not provide medical assistance to the Centre at that hour.
- Prisoner [REDACTED] requested that his treatment be reviewed.

ISSUES

The Office of the Chief Inspector (OCI) has reviewed lengthy CCTV footage of most of the interaction between the prisoner and correctional officers relevant to this matter, and a summary of the facts as revealed by that footage is contained in **Attachment 1** to this memorandum. Unfortunately that footage did not contain audio.

Issues raised by the incident/s reviewed in the footage include –

1. Use of restraint/s

Briefing Officer	[REDACTED]	Approved by	Samay Zhouand Chief Inspector
	Inspector		Queensland Corrective Services
	Office of the Chief Inspector	Date	25 September 2017
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Throughout some parts of the incidents it was obvious that the prisoner was being resistant and was actively self-harming and attempting to spurt blood on to QCS and QAS staff. The use of the restraints and the way they were used in these instances appeared appropriate.

The footage shows that handcuffs, leg irons, bed cuffs and a body belt were all used in varying combinations at different times during the incident both in the ambulance, vehicle bay and DU cell. However at no time were all limbs restrained together from behind.

At times the prisoner was double handcuffed; however from the footage this appeared procedurally correct and not harsh or excessive e.g. when the body belt was being applied. Bed cuffs were applied to his ankle, no doubt in consideration of the injuries to his forearms.

However, despite a lack of audio to enable the conclusive determination of the issue, there were periods during the events where it appeared that it might have been more appropriate to loosen or remove (or at least endeavor to loosen or remove) the restraints earlier, for example at 2344 when the prisoner appeared to have settled, rather than 2 hours later.

2. Escort of prisoner

Due to his leg irons the prisoner couldn't walk to his cell upon return to the Centre and he was carried by officers. Again, the lack of audio makes it difficult to assess whether the prisoner was making threats or comments that led officers to determine that the only safe way to escort the prisoner was the manner in which they did (four officers, one limb each, prisoner face up). However, subject to that, a wheelchair or medical trolley may have been a more dignified or respectful way of conveying the obviously disturbed prisoner to his cell.

3. Access to water

The prisoner claimed that he requested water but was given none. In the absence of audio recordings it is difficult to ascertain whether or not he was offered or requested water at any time.

4. Medical attention after hours

QH do not staff WCC on a night shift. While the officers' decision not to escort the prisoner to PAHSU for a third time appears to have been vindicated, had the situation rapidly deteriorated more immediate attention than an escort to PAHSU may have been required.

5. Cleaning of cell

After the prisoner left the cell for the first escort to the PAHSU significant amounts of blood were on the floor, wall, bed and mattress of his cell. When the prisoner returned to his cell it was still covered in blood. There were obvious health and hygiene issues with this, but also psychologically this was potentially damaging given that the prisoner was an acutely suicidal and emotionally vulnerable/volatile individual. Shortly after the officers exited the cell

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and left the prisoner alone in the dirty cell he began to self-harm again.

SUMMARY

While officers undoubtedly faced a difficult and protracted situation, and on the evidence available it is not possible to say they acted inappropriately, the approach adopted in this case arguably reflects that observed in other similar cases elsewhere in relation to prisoners who are suicidal and/or self-harming.

The approach tends to be more punitive than therapeutic or recovery focused. Perhaps the pressures of overcrowding and a prison population with higher risks and needs due to increased incidence in mental health and drug use etc has meant that staff are more compassion fatigued and therefore are struggling to recognise that suicide attempts and self-harming behaviour are indications of psychological and emotional instability as opposed to manipulative and deliberately negative behavioural choices.

Some professional development with staff about these issues and how to manage compassion fatigue could potentially be beneficial.

PRACTICE IMPROVEMENT OPPORTUNITIES

The following practice improvement suggestions could assist the continued professional development of relevant officers involved in the incident and perhaps all centres –

1. **Body worn cameras:** In the absence of audio on fixed cameras within Centres, and given the potential for serious injury or fatality in self-harming cases, there be greater use of body worn cameras with both visual and audio recording in cases of self-harm so as to ensure that interactions between self-harming prisoners and officers can be clearly documented and reviewed
2. **Review of restraints:** Wherever possible restraints on self-harming prisoners be reviewed at regular intervals, and if appropriate loosened or removed when prisoners become compliant
3. **Conveyance of prisoners:** Wherever possible, self-harming prisoners restrained for their own protection and thus unable to walk be transported or conveyed within a Centre by wheelchair or medical trolley rather than manually by officers
4. **Food, water, toilet:** Officers ensure that self-harming prisoners are offered food, water and toilet access at all reasonable times
5. **After hours medical attention:** QCS review the MOU with QH to assess the adequacy of the current service delivery in light of this incident
6. **Cleaning of cells:** Cells be cleaned as soon as possible after a self-harming incident and self-harming prisoners not be returned to an uncleaned cell

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7. **Review of incident:** Officers involved undertake a reflective practice exercise/use of force review involving a review of footage and discussion of what was done well and what improvements could be made to identify strategies for the physical handling of resistant prisoners engaging in self-harm in the future
8. **Professional development:** Officers generally undertake professional development to deal with compassion fatigue and to take where possible a therapeutic and recovery-focussed approach to self-harming prisoners.

Samay Zhouand
 Chief Inspector
 Office of the Chief Inspector
 Date: / /

☒ Noted ☐ Approved ☐ Not Approved

Signed: [REDACTED]

A/Commissioner

Date:

4.10.17

A/D. Commissioner.

This memo is not ~~over~~ critical of staff generally however does make some valuable observations.

Can you please read.

I think one of the very relevant pieces is the reference to 'compassion fatigue'. Maybe worth giving that some thought.

4.10.17

Briefing Officer

[REDACTED]
 Inspector
 Office of the Chief Inspector

Approved
 by

Samay Zhouand
 Chief Inspector
 Queensland Corrective Services
 25 September 2017

Telephone

Date