CONFIDENTIAL

TASMANIA PRISON SERVICE

INCIDENT INVESTIGATION

Code White – Escape from Custody (RHH)

[redacted]

Royal Hobart Hospital

11th February, 2022

PRESENTED BY: IAN THOMAS
DIRECTOR OF PRISONS

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CAVEAT

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DISCLAIMER

It is acknowledged that the observations, findings and recommendations in this Incident Investigation Report are limited by the information available, or disclosed to the investigator at the time the Investigation was conducted.

INTRODUCTION

The following Incident Investigation has been prepared in accordance with our operating policy of conducting a thorough review of major incidents within the Tasmania Prison System (TPS).

The investigation has examined the incident of 11th February 22, 2022, on which date prisoner [redacted] escaped from custody from the K Block – Level 9 West (Room 14) at the Royal Hobart Hospital.

TERMS OF REFERENCE

The following Terms of Reference have been provided for this Investigation:

1. Establish the circumstances leading up to the incidents on 11th February 22, 2022 at the Royal Hobart Hospital.
2. Detail the incidents and any events or information that may be relevant, or have caused the incidents.
3. Review the incident responses in line with relevant TPS instruments, including incident and crime scene management requirements and provision of medical services.
4. Determine whether parties involved in the incidents performed their duties in line with TPS Instruments.
5. Determine the effectiveness of TPS Instruments relating to the incidents.
6. Establish the root causes of and any risks associated with the incidents and related processes.
7. Make recommendations for consideration by the TPS Senior Management Team (SMT) and associated entities where applicable aimed at improving processes, performance and mitigating risks associated with the incidents.

METHODOLOGY

The Review has involved consideration of relevant Tasmania Prison Service instruments associated with prisoner [redacted] (including their prison file) and the escape from custody at the Royal Hobart Hospital.

Author: [redacted]

Position: [redacted] Ron Barwick Prison

Date: Review commenced – 23/02/2022

INVESTIGATION

1. INCIDENT SUMMARY

1.1 Prisoner [redacted] was received into custody on the 07/02/2022 to the Hobart Reception Prison.

Prisoner [redacted] was reviewed by a partial RIT ([redacted]) at approx. 0900hrs on the 08/02/2022.

Outcome from this RIT was to remain on [redacted], [redacted] on prisoner [redacted] and comments at the conclusion of the RIT relating to [redacted]

At 1515hrs on the 08/02/2022 prisoner [redacted] was transferred to the Royal Hobart Hospital [redacted].

Prisoner [redacted] on the 08/02/2022 [redacted]

- [redacted]
- [redacted]
- [redacted]

It was confirmed by the RHH Surgeon [redacted] The risk of [redacted] was still present, as such a determination was made to keep prisoner [redacted] admitted to the RHH for an additional period of time for monitoring and observation purposes.

On the day of the 11/02/2022, [redacted] was completing a 12-hour day shift at the Royal Hobart Hospital, posted to supervise prisoner [redacted]

At approximately 1440hrs a Doctor from the RHH team entered Room 14 to inform [redacted] and prisoner [redacted] that he was clear for discharge and return back to prison.

At approximately 1450hrs the Doctor from the RHH team returned to Room 14 and advised that scripts and clearance for prisoner [redacted] to consume solids had been finalised, and discharge would follow shortly.

At approximately 1510hrs prisoner [redacted] was permitted access into the toilet of room 14 by [redacted].

At this time [redacted] engaged in conversation with a Nurse regarding prisoner [redacted] discharge and prescriptions that would need to be passed to CPHS.

During this interaction [redacted] was approx. 1m from the allocated room (14)

[redacted] then re-entered the room and knocked on the toilet door. [redacted] did not respond.

[redacted] then proceeded to open the door, and at this time noted that prisoner [redacted] was not in the toilet.

[redacted] then exited the room and informed the nearest nurse to contact RHH Security to inform them that an inmate had escaped from custody.

After delivering this message, [redacted] contacted HRP via the escort mobile phone at 1520hrs, and informed [redacted] of the escape (Code White), as HRP is the closest facility to the RHH. Immediately after making this call, [redacted] contacted the [redacted] and informed her of the escape and current Code White Situation. The following is a timeline of events which occurred immediately from the point of the first phone call made by [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted].

During this time, [redacted] made direct contact with Tasmania Police and advised them of the situation and requested immediate assistance.

[redacted] continued to search the other rooms on K Block Level 9 West with the help of nurses and other hospital staff.

[redacted] were the first to arrive from HRP after [redacted] had deployed staff after activating a Code White.

[redacted] arrived shortly after, and received a brief from [redacted] as a RHH Security officer arrived.

RHH Security informed [redacted] that a person matching [redacted]'s description was sighted on CCTV exiting the hospital on the Campbell Street side.

[redacted] used his radio and informed all responding Correctional Staff to proceed to the Campbell Street exit as this was the most recent confirmed location of prisoner [redacted]

[redacted] then departed the RHH and met with Tasmania Police Officers at the main exit, to provide a further detailed description of the offender and the clothes which he had at the time of escape, before returning to HRP at the instruction of [redacted] as TASPOL had taken over the incident and search (1540hrs approx.)

*During this time it was reported the following areas were searched by Correctional Staff;

- K-Block RHH
- Public Toilets near the exit of RHH
- Street on the entire surrounding block of the RHH (Campbell Street, Liverpool Street, Argyle Street and Collins Street)

At approx. 1615hrs the Code White was stood down, as the immediate area had been searched and the offender was not located.

A de-brief was held at HRP at approx. 1725hrs, which was conducted by [redacted]

2. PROFILES

The following prisoner(s) were involved in the incident:

[redacted]

[redacted] has been involved in the following incidents during their current sentence;

Incident Date	Description
15/02/2022	Escape from Custody - RHH
08/02/2022	[redacted]
08/02/2022	[redacted]

3. PRIOR EPISODE;

Prisoner [redacted] had been received into custody on one previous occasion, where he was received into the Hobart Reception Prison on the 29/10/2021, and was released to Bail on the 04/11/2021.

There is limited information available due to the short sentence length, however the information available does indicate that the prisoner presented with [redacted] Prisoner [redacted] was transported to the Risdon Prison Complex on the 29/10/2021 at 1910hrs where he would be housed in the Crisis Support Unit (CSU).

On the 02/11/2021, prisoner [redacted] was cleared from CSU, and comfortable to live in the Division 6 Unit of the Ron Barwick Minimum Security Prison, until his date of Bail on the 04/11/2021.

1. *TPS CIS Profile –* [redacted]
2. [redacted]
3. *Case Note from* [redacted] *– 29/10/2021 – 2022hrs*

4. INCIDENT DETAILS

4.1 On the 06th February 2022, prisoner [redacted] is received into the Watch House at the Hobart Reception Prison at approx. 1946hrs. (1,4)

4.2 On the 07th February 2022 at approx. 1255hrs prisoner [redacted] was remanded into custody until the 23/02/2022. (1,4)

4.3 SASH Comments on initial Reception – [redacted] – Case Note 07/02/2022 – 1540hrs – [redacted] (8)

4.4 Due to previous [redacted];

[redacted]

1613 - On Call [redacted]

1530 - [redacted]

1530 - [redacted] (6)

4.5 [redacted]

4.6 [redacted] (8)

4.7 RIT Comments – 08/02/2022 – 0905hrs ; [redacted] (11)

4.8 There are no case notes available in the lead up to the Admission to the RHH for prisoner [redacted].

4.9 **CASE Note – 08/02/2022 – 2239hrs –** [redacted]; Received a phone call from [redacted] who is escort officer at RHH for this inmate, [redacted]

[redacted] - 08-Feb-2022 22:39] (10)

4. *TPS CIS Profile –* [redacted]
5. *TPS Watch House Admissions Document*
6. [redacted]
7. *Case Note from* [redacted] *– 29/10/2021 – 2022hrs*
8. *Case note from* [redacted] *– 07/02/2022 – 1540hrs*
9. *Extract from 7A SASH Mandatory Notification and Immediate Support Plan_650244.doc*
10. *Case note from* [redacted] *– 08/02/2022 – 2239hrs*
11. *Extract from* [redacted] *– Risk Treatment Plan_650278.doc*

4.10 **CASE Note – 09/02/2022 – 2015hrs –** [redacted];
Received a phone call from [redacted] who is the escort officer at the RHH. [redacted]

[redacted - 09-Feb-2022 20:15] (12)

4.11 **CASE Note – 08/02/2022 – 2239hrs –** [redacted];
Prisoner [redacted]

- [redacted]
- [redacted]
- [redacted]

It was confirmed by the RHH Surgeon on the 09/02/2022 that [redacted] (13)

4.12 On the day of the 11/02/2022, [redacted] was completing a 12-hour day shift at the Royal Hobart Hospital, posted to supervise prisoner [redacted]. (14)

4.13 At approximately 1440hrs a Doctor from the RHH team entered Room 14 to inform [redacted] and prisoner [redacted] that he was clear for discharge and return back to prison.
At approximately 1450hrs the Doctor from the RHH team returned to Room 14 and advised that scripts and clearance for prisoner [redacted] to consume solids had been finalized, and discharge would follow shortly. (14)

4.14 At approximately 1510hrs prisoner [redacted] entered the toilet in room 14.
At this time [redacted] engaged in conversation with a Nurse who had approached and engaged in conversation in relation to discharge and provided a script that would need to be passed to CPHS. [redacted] then re-entered the room and knocked on the toilet door, and could not hear a response. [redacted] then proceeded to open the door, and at this time noted that prisoner [redacted] was not in the toilet. [redacted] then proceeded to exit the room and informed the nearest nurse to contact RHH Security and informed them that an inmate had escaped from custody. (14)

12. *Case note from [redacted] – 09/02/2022 – 2015hrs*
13. *Case note from [redacted] – 08/02/2022 2239hrs*
14. *Report from [redacted] – 11/02/2022 – 1615hrs – Form ID 1644564794*

4.15 [redacted]. (14)

4.16 [redacted] (15)

4.17 [redacted] (15)

4.18 [redacted]. (16) continued to search the other rooms on K Block Level 9 West with the help of nurses and other hospital staff. [redacted]. (14, 15, 16)

4.19 [redacted] arrived shortly after, and engaged in conversation with [redacted] as a RHH Security officer had just arrived. RHH Security informed [redacted] and [redacted] that a person matching [redacted]'s description was sighted on CCTV exiting the hospital on the Campbell Street side. (18, 19, 20, 17, 16, 14)

4.20 [redacted] used his radio and informed all responding Correctional Staff to proceed to the Campbell Street exit as this was the most recent confirmed location of prisoner [redacted] (14, 16, 17, 18, 19, 20)

15. *Report from [redacted] – 11/02/2022 – 1709hrs – Form ID 1644559571*
16. *Report from [redacted] – 11/02/2022 – 1800hrs – Form ID 1644562856*
17. *Report from [redacted] – 11/02/2022 – 1615hrs – Form ID 1644555633*
18. *Report from [redacted] – 11/02/2022 – 1640hrs – Form ID 1644558149*
19. *Report from [redacted] – 12/02/2022 – 0918hrs – Form ID 1644617809*
20. *Report from [redacted] – 12/02/2022 – 0930hrs – Form ID 1644619218*
21. *Report from [redacted] – 12/02/2022 – 1135hrs – Form ID 1644626216*
22. *Report from [redacted] – 12/02/2022 – 2118hrs – Form ID 1644660879*

4.21 [redacted] then departed the RHH and met with Tasmania Police Officers at the main exit, to provide a further detailed description of the offender and the clothes which he had at the time of escape, before returning to HRP at the instruction of [redacted] as TASPOL had taken over the incident and search (1540hrs approx.)

*During this time it was reported the following areas were searched by Correctional Staff;

- K-Block RHH
- Public Toilets near the exit of RHH
- Street on the entire surrounding block of the RHH (Campbell Street, Liverpool Street, Argyle Street and Collins Street) (14, 16, 17, 18, 19, 20)

4.22 At approx. 1615hrs the Code White was stood down, as the immediate area had been searched and the offender was not located. (14, 16, 17, 18, 19, 20)

4.23 A de-brief was held at HRP at approx. 1725hrs, which was conducted by [redacted]. (14, 16, 17, 18, 19, 20)

4.24 On the 15th February 2022 at approx. 0906hrs prisoner [redacted] was returned to the HRP in the custody of Tasmania Police, who had captured the individual and informed HRP staff that he was required to be housed [redacted]. (1, 23)

23. TPS Watch House Admissions Document – [redacted] 150222

5. FINDINGS

The following issues were identified during the examination of the incident:

5.1 Case notes were limited on the reason for admission for Prisoner [redacted]

[redacted]

6. RECOMMENDATIONS

The following recommendations have been reached from the Findings of this investigation and are proposed for consideration by the Director of Prisons. Endorsed recommendations will be recorded on the Tasmania Prison Service (TPS) Integrated Performance System for action by the responsible managers by the designated due dates.

Recommendation			Endorsement	
A	[redacted]		☐ Approved	☐ Not Approved
	Responsible Manager:	Manager Title (not name)	Due By:	Due Date

B	[redacted]	☐ Approved	☐ Not Approved
	Responsible Manager: Manager Title (not name)	Due By:	Due Date
C	[redacted]	☐ Approved	☐ Not Approved
	Responsible Manager: Manager Title (not name)	Due By:	Due Date
D	[redacted]	☐ Approved	☐ Not Approved
	Responsible Manager: Manager Title (not name)	Due By:	Due Date
E	[redacted]	☐ Approved	☐ Not Approved
	Responsible Manager: Manager Title (not name)	Due By:	Due Date

IAN THOMAS
DIRECTOR OF PRISONS
TASMANIA PRISON SERVICE
DATE

7. APPENDICES

1. *TPS CIS Profile –* [redacted]
2. [redacted]
3. *Case Note from* [redacted] *– 29/10/2021 – 2022hrs*
4. *TPS CIS Profile –* [redacted]
5. *TPS Watch House Admissions Document*
6. [redacted]
7. *Case Note from* [redacted] *– 29/10/2021 – 2022hrs*
8. *Case note from* [redacted] *–07/02/2022 – 1540hrs*
9. *Extract from* [redacted] *_650244.doc*
10. *Case note from* [redacted] *– 0/02/2022 – 2239hrs*
11. *Extract from* [redacted] *.doc*
12. *Case note from* [redacted] *– 09/02/2022 – 2015hrs*
13. *Case note from* [redacted] *– 08/02/2022 2239hrs*
14. *Report from* [redacted] *– 11/02/2022 – 1615hrs – Form ID 1644564794*
15. *Report from* [redacted] *– 11/02/2022 – 1709hrs – Form ID 1644559571*
16. *Report from* [redacted] *– 11/02/2022 – 1800hrs – Form ID 1644562856*
17. *Report from* [redacted] *– 11/02/2022 – 1615hrs – Form ID 1644555633*
18. *Report from* [redacted] *– 11/02/2022 – 1640hrs – Form ID 1644558149*
19. *Report from* [redacted] *– 12/02/2022 – 0918hrs – Form ID 1644617809*
20. *Report from* [redacted] *– 12/02/2022 – 0930hrs – Form ID 1644619218*
21. *Report from* [redacted] *– 12/02/2022 – 1135hrs – Form ID 1644626216*
22. *Report from* [redacted] *– 12/02/2022 – 2118hrs – Form ID 1644660879*
23. *TPS Watch House Admissions Document –* [redacted] *150222*

[redacted]

CONFIDENTIAL

TASMANIA PRISON SERVICE

INVESTIGATION

Royal Hobart Hospital (RHH) Medical Escort Escape of [redacted] on 26 April 2020

PRESENTED BY: IAN THOMAS
DIRECTOR OF PRISONS

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Caveat

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Disclaimer

It is acknowledged that the observations, findings and recommendations in this Incident Investigation are limited by the information available, or provided to the investigator at the time of the composition of this document.

Introduction

A Review of the escape of prisoner [redacted] on the evening of 26 April 2020, was carried out by [redacted].

Investigation Scope

This investigation will focus on the escape as well as broader issues relating to the management of TPS incident response and post-incident response management, as well as the conduct of TPS Staff prior to and during the incident and the systems supporting response processes.

Methodology

This investigation examined documentation relating to the escape, the Custodial Information System (CIS), and records of interviews conducted with TPS Staff involved in these events.

Author: [redacted]

Position: [redacted]
Tasmania Prison Service

Date: 22 July 2020

Investigation

Prisoner Profile

1. The following prisoner was involved in the incident and events preceding the escape from custody at the Royal Hobart Hospital (RHH) on 26 April 2020.

[redacted] – the Escapee

[redacted]	**SURNAME:**
	GIVEN NAME(S):
	OTS:
	DATE OF BIRTH:
	PHYSICAL DESCRIPTION:
	TERMS OF IMPRISONMENT:
	CHARGE(S):
	CURRENT CUSTODIAL SENTENCE:
	RISK RATINGS:

RECEIVED INTO CUSTODY:

ACCOMMODATION UNIT:

2.

3.

Prisoner Classification and Accommodation

4.

5.

6.

7.

8.

9. Prisoner remained at the HRP until his escape from his medical escort at the RHH on 26 April 2020.

Previous Conduct in Custody

10.

11.

12.

13.

14. [redacted]

15. [redacted]

Urinalysis Test (UT) Results

[redacted]

Offence (Disciplinary) Reports

22. [redacted]

Intelligence Reports

23. [redacted]

24. [redacted]

[redacted]

25. [redacted]

26. Following the incident, upon request by myself, [redacted] provided the following information summary from intelligence holdings on 8 May 2020.

[redacted]

Arunta Telephone Call Recordings

27. Prior to his escape from a medical escort on 26 April 2020, prisoner [redacted] made four telephone calls on Friday, 24 April 2020 – two days before the incident. The calls were made to [redacted] and [redacted] A review of these recordings by the author showed no relevance to the investigation and are detailed below.

[redacted]

History of Medical Escort Escapes

28. Of the five most recent escapes and attempted escapes during medical escorts, it should be noted that four of these incidents involved prisoners who were wearing restraints, as detailed in the following table (taken from the TPS Escape Register):

DATE OF ESCAPE	OTS	SURNAME	GIVEN NAMES	ESCAPEE SECURITY RATING	FROM & TIME	DATE OF RECAPTURE/ PERIOD AT LARGE	RESTRAINTS USED (Yes / No) & TYPE
17/04/1992	[redacted]				RHH	17/04/1992	Unreported
04/11/1993	[redacted]				Escort to LGH	07/11/1993	Unreported
31/01/2012	[redacted]				Exit from RHH	31/01/2012	Yes
19/04/2013	[redacted]				RHH Emergency	Attempted	No
07/05/2013	[redacted]				Foot Escort from RHH to HRP	07/05/2013	Yes
04/05/2016	[redacted]				Outside LGH	05/05/2016	Yes
08/01/2019	[redacted]				Outside RHH	Attempted	Yes

Royal Hobart Hospital (RHH)

29. The RHH is a public medical facility situated in the Hobart Central Business District (CBD). Given that it does not have a designated secure area for treating offenders, prisoners attend various sections of the hospital for appointments, during which time they may be in close proximity to community members. This is true of both scheduled appointments and emergency situations. Prisoners may be afforded a waiting room if one is available, where they are separated from the general public, however invariably may need to sit near members of the community.

Memorandum of Understanding (MOU)

30. There is a current MOU between Tasmania Prison Service (TPS) and Royal Hobart Hospital (RHH) dated 3 December 2013, that outlines the relationship and responsibilities between the Tasmania Health Services (THS).

31. **Section 5 - Role and Responsibilities of the Tasmania Prison Service**

5.1 The TPS is responsible under the Corrections Act 1997 for the care, direction, order and control of prisoners.

5.3 The TPS will undertake a Risk Assessment to establish appropriate escort procedures and number of correctional officers, if any, required to supervise a prisoner attending the RHH.

5.6 Prisoner will be supervised in the least restrictive manner possible, consistent with their behavior and security rating.

Section 6 - Role and responsibility of the Royal Hobart Hospital

6.5 RHH staff are not required to perform the role of correctional officers. RHH staff are not expected to give chase to prisoners who are attempting to escape or who have escaped.

Section 8 - Entry into the RHH and Escort of Prisoners

[redacted]

Section 11 – Procedures in the event that a prisoner escapes custody

If a prisoner escapes or attempts to escape custody, the RHH must immediately contact Tasmania Police and then the supervising correctional officer if present.

Directors Standing Orders (DSO) Governing External Escorts

32. There are three DSO's which guide staff escorting prisoners to the RHH:

32.1 DSO 1.20 – External Escorts Section 12 states – [redacted]

32.2 DSO 1.34 – Mechanical Restraints Section 6.2 states – "[redacted]

- [redacted]
- [redacted]
- [redacted]."

Section 11.4.1 states - [redacted]".

32.3 DSO 1.38 – Medical Appointments and Hospital Admissions Section 5.4.1 states – '[redacted]

Incident Summary

33. At approximately 14:15 hours, Prisoner [redacted] was escorted by two correctional staff to the RHH emergency department for assessment for [redacted]

34. Prisoner [redacted] was taken to a treatment room upon arrival and was assessed by a Department of Emergency Management (DEM) doctor. [redacted]

35. At approximately 17:15 hours an RHH Doctor cleared prisoner [redacted] for return to HRP.

36. Prior to restraining prisoner [redacted] he pushed past [redacted] slamming the treatment room door into [redacted] elbow causing him to stumble and hit his face on the doorframe. This caused his significant facial injuries. Prisoner [redacted] then made his escape through the DEM waiting room.

37. Prisoner [redacted] continued to evade capture by Correctional Staff and Tasmania Police (TasPol) for approximately 20 minutes.

38. He was located and recaptured by Tasmania Police members and TPS Correctional Staff whilst hiding behind the Fountainside Hotel.

39. When prisoner [redacted] escaped from escorting officers, he ran through the DEM waiting room where at least four members of the public (3 males and 1 female) and a security guard were in attendance. However, this area can have many more including children. This is common amongst most outpatient areas of the RHH.

40. This may have provided prisoner [redacted] opportunities for hostages to aid and abet an escape should he have chosen to do so.

Incident Details

41. At approximately 12:00 hours on 26 April 2020 prisoner [redacted] attended the Nurses Station on HRP Level 1 and informed the CPHS Nurse that he was experiencing [redacted] The CPHS Nurse issued medication to the prisoner and he subsequently returned to HRP Level 3, where he was accommodated.

42. At approximately 14:00 hours prisoner [redacted] complained to Correctional Officers on Level 3 that he was experiencing [redacted]

43. The on-call Health Services Medical Officer (MO) advised by telephone that the prisoner needed to be assessed at the Royal Hobart Hospital (RHH). It should be noted that the on-call MO did not attend HRP and physically assess the prisoner.

44. Authorisation to escort this prisoner from the HRP to the RHH was given by On-Call [redacted] under section 36(1) of the Corrections Act 1997.

45. [redacted] allegedly completed required documentation, which was subsequently signed by [redacted]

46. At approximately 14:10 hours prisoner [redacted] was escorted from the Hobart Reception Prison by [redacted] to the RHH DEM for medical assessment for [redacted]

47. It should be noted that eight correctional staff were on duty at the HRP at the time of the escort, including:

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

48. [redacted].

49. Prisoner [redacted] was handcuffed and close quarter escorted up the ramp from the HRP Main Sally Port, across Liverpool Street and into the RHH DEM as per standard practice for medical escorts.

50. The prisoner and Escort Officers seated themselves in the Emergency Department waiting area in which community members were also situated whilst awaiting medical triage, assessment or treatment.

51. Prisoner [redacted] was assessed by the Triage Nurse, then seated to await allocation of an assessment room in the Emergency Department.

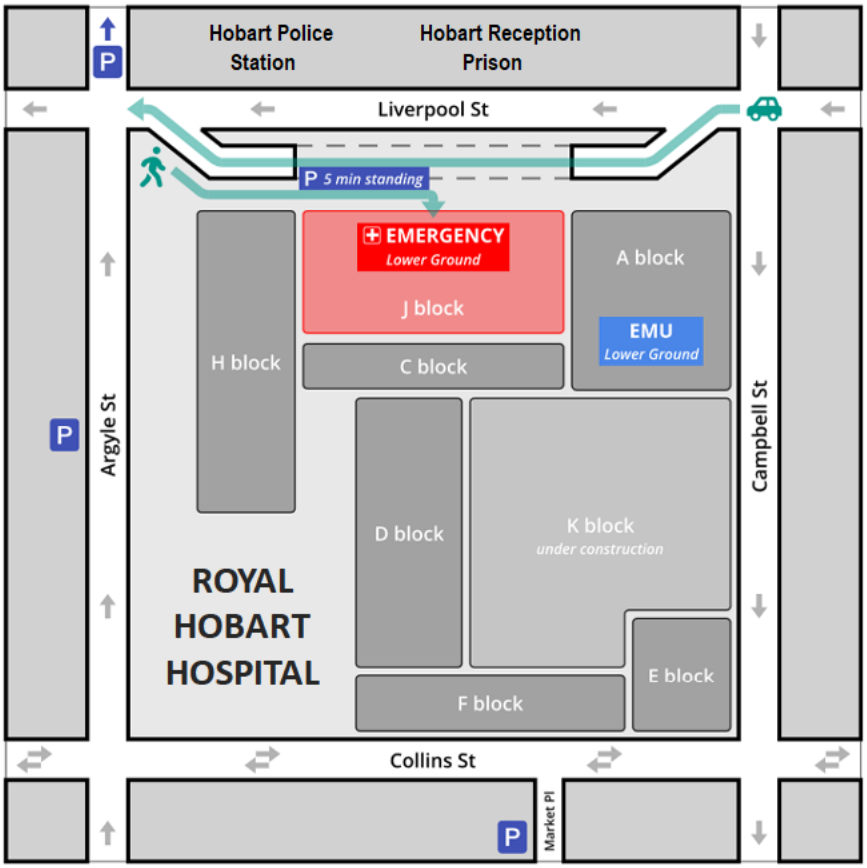


Diagram showing Proximity of HRP to RHH Emergency Medical Department

52. At approximately 14:30 hours, escorting staff decided to remove prisoner [redacted], handcuffs to facilitate medical assessments, including the provision of a [redacted]

53. Correctional Officers noted that the prisoner was seated on a bed in the Emergency Department and was compliant at that time. [redacted] consequently positioned themselves between the prisoner and the exits from the room in which he was receiving treatment as a security precaution given his restraints had been removed.

Emergency Waiting Area Push button exit doors

[redacted]

54. Following the return of medical test results, at approximately 17:15 hours prisoner [redacted] was cleared by RHH Health Services Staff to return to the HRP.

55. [redacted]

[redacted]

57. [redacted] subsequently advised prisoner [redacted] that he needed to be secured with handcuffs before he returned to the HRP.

58. Escort Officers reported that the prisoner failed to cooperate with these instructions and pushed [redacted], exiting the RHH Emergency Department treatment room through the door into the Emergency triage area in which members of the community were seated awaiting assessment, or treatment.

59. As [redacted] attempted to close the door it struck [redacted] elbow and knocked him off balance. The Officer subsequently hit his face against the metal doorframe, falling to the ground.

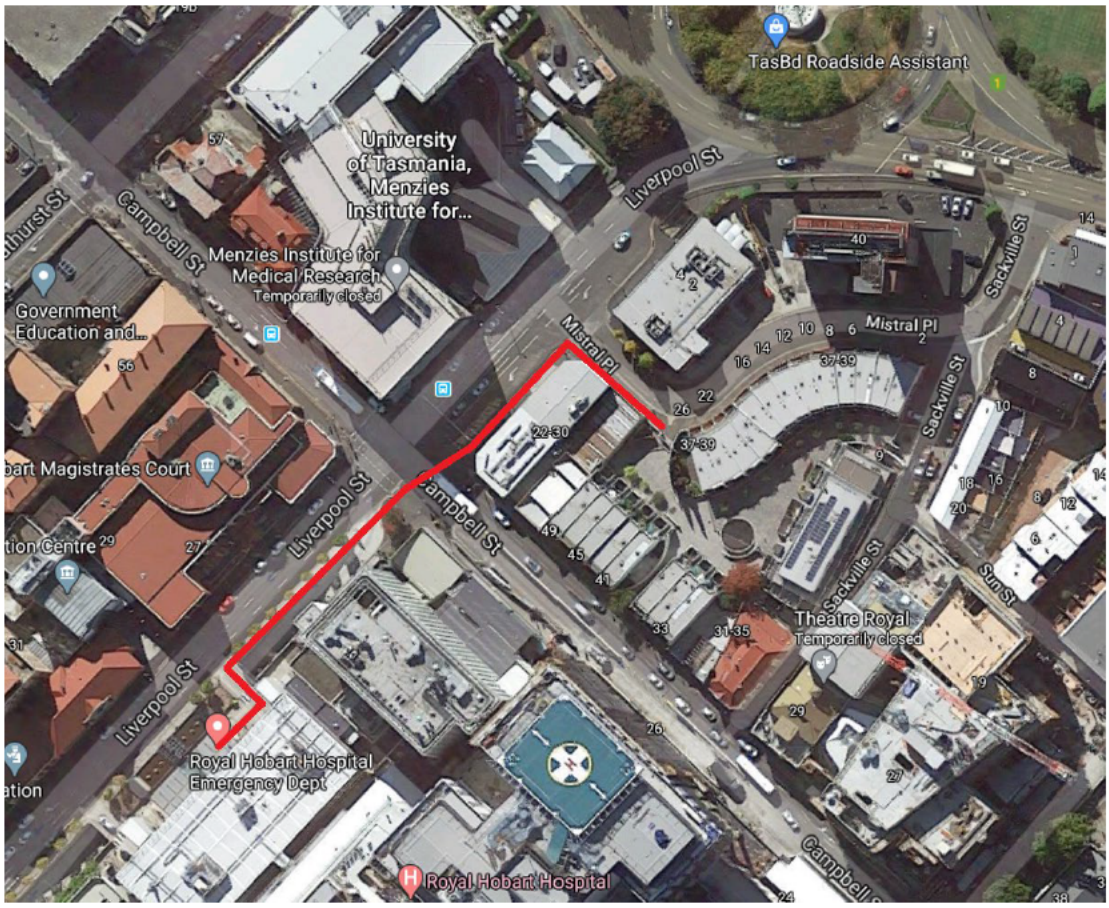
60. [redacted] observed the escape and promptly exited through the push button door into the Emergency Department waiting room to attempt to cut off escapee [redacted] before he left the Hospital.

61. [redacted] observed prisoner [redacted] run through the waiting room and exit through the Liverpool Street main glass sliding door.

62. The Officer continued to pursue the prisoner towards Liverpool Street.

63. When [redacted] had recovered sufficiently from his fall to follow his colleague and chase the escapee, both Officers pursued [redacted] into Liverpool Street.

64. The observed [redacted] turn east and run along Liverpool Street towards the ABC roundabout.



Map showing approximate route of escapee prisoner [redacted] from RHH to Mistral Place

65. [redacted]

66. [redacted]

67. [redacted]

68. [redacted]

69. [redacted]

70. [redacted]

71. [redacted]

72. [redacted]

73. [redacted]

74. [redacted]

75. [redacted]

76. [redacted]

77. [redacted]

78. [redacted]

79. [redacted]

80. [redacted]

81. [redacted]

CCTV Footage Review

RHH CCTV Video Footage

82. [redacted]

83. [redacted]

84. [redacted]

85. [redacted]

86. [redacted]

87. [redacted]

88. [redacted]

89. [redacted]

HRP CCTV Video Footage

90. [redacted]

91. [redacted]

92. [redacted]

93. [redacted].

Capture of Prisoner [redacted]

94. Prisoner [redacted] evaded both [redacted] and [redacted] in the RHH and their pursuit of him in Liverpool Street. He attempted to hide from Police and responding TPS Officers, by kneeling on the ground in a narrow gap between two brick walls near the building site behind Fountainside Hotel in Mistral Place.

95. At approximately 17:25 hours, a police officer standing on a wall spotted a person he believed to be escapee [redacted] and directed responding officers to that area. Approximately 15 minutes after escape, [redacted] was apprehended without issue by TasPol officers with [redacted] and [redacted] providing assistance.

Findings

96. The escape from custody by prisoner [redacted] during a medical escort in the Royal Hobart Hospital on 26 April 2020 appears opportunistic. No evidence identified found during the investigation to indicate the incident was coordinated with other parties.

97. [redacted]

98. [redacted]

99. Information provided to the investigator during an interview involving [redacted] following the incident indicated that prisoner [redacted] said that he made the decision to escape because he was feeling stressed and needed to release the pressure he was experiencing. He also informed correctional staff that he felt remorse for the injury he inflicted on [redacted] which was not intentional.

100. The prisoner was handcuffed for periods of time during the escort.

101. However, Escort Officers removed accoutrements whilst prisoner [redacted] was in a RHH emergency treatment room and they determined he was compliant, in a controlled environment and that the removal of cuffs would assist medical staff during his tests.

102. After removing the accoutrements, Escort Officers did not reapply cuffs to prisoner [redacted] in a timely manner.

103. The investigator notes, however, that the application of restraints (handcuffs) has not prevented medical escort escapes in the past – with four (or 80%) of past five medical escort escapes involving prisoners who were wearing handcuffs when the incidents occurred.

104. [redacted]

Incident Reporting

105. Reports were submitted by persons involved in the incident in line with incident reporting requirements outlines in DSO 1.05 Incident Reporting.

TPS External Escort Risk Assessments

106. Requirements relating to escort preparation and the conduct of risk assessments for external escorts (including medical escorts) in the Tasmania Prison Service are prescribed in Director's Standing Order (DSO) 1.20 – External Escorts.

107. The current version date of this document is 16 April 2013. It is the second version of TPS external escorts procedures and was seven (7) years old at the time of the escape of prisoner [redacted]

108. Specific guidelines relating to the conduct of risk assessments are detailed in Sections 5: Escort Risk Assessment and 6: Risk Controls of DSO 1.20, with specific requirements for medical escorts in Section 11: Medical Escorts.

109. Section 5.1 of DSO 1.20 stipulates that [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]). (*DSO 1.20*, page 6).

110. The use of "any other matter that may affect the safe and secure conduct of the escort" is sufficient in scope to ensure correctional staff conducting a risk assessment take into consideration any potential risk that may relate to, or impact upon the escort.

111. In relation to the incident under investigation, [redacted] explained following the escape that [redacted]. He said that this assessment was not documented.

112. [redacted]

[redacted].

113. [redacted]

114. [redacted]

115. [redacted]

116. [redacted]

117. After considering and assessing these factors [redacted] did not identify a level of risk that required him to take additional precautions, or implement controls beyond routine [redacted] prisoner escort procedures.

118. As such, the [redacted] did not identify anything he deemed "may jeopardize the safe, secure conduct of [the] external [medical] escort" of prisoner [redacted] Consequently, a "formal" risk assessment was not required (Section 5.2 of DSO 1.20).

119. [redacted].

120. Further to this, Section 5.3 of DSO 1.20 prescribes that:

> [redacted]
>
> - [redacted]
> - [redacted]
> - [redacted]"
>
> (*emphasis added*)

121. Given that [redacted] did not meet any of these three criteria requiring the mandatory conduct of a "formal" risk assessment, and the undocumented "risk assessment" by [redacted] did not identify any security or safety risks, a "formal" risk assessment was not compulsory prior to the conduct of the prisoner's medical escort on 26 April 2020.

122. However, the investigator notes that the lack of a documented risk assessment means that the conduct of the "mental risk assessment" by [redacted] cannot be evidenced, assessed for compliance, nor verified.

123. Furthermore, considerations for the risk assessment of the escort of prisoner [redacted] were not discussed with, nor communicated to [redacted] prior to the event.

124. However, [redacted] and [redacted] said they were not aware of the offences for which [redacted] had been placed in custody, which were violent in nature, prior to the conduct of the medical escort.

125. While this information may not have prevented the escape, it may have caused the officers to approach the prisoner with greater caution during the medical escort.

Risk Assessment Controls

126. DSO 1.20 Section 6.1 – [redacted].

127. DSO 1.20 Section 6.2 – [redacted]:

[redacted]

128. DSO 1.20 Section 6.3 – [redacted]

[redacted]

129. [redacted]

130. Typically, risks associated with external escorts are mitigated by an appropriate number of trained correctional officers and appropriate restraints for the prisoners being escorted. [redacted] (DSO 1.20 Section 7.1) and remain appropriately restrained (DSO 1.34 Section 11.1.2

[redacted] unless it is imperative for their removal (for example, during an x-ray or MRI scan). In these cases, alternative methods of restraint should be explored.

131. As previously noted, [redacted] reported that he conducted the risk assessment prior to the departure of the prisoner from the HRP and determined that there were no factors requiring additional controls to be put in place.

Risk Assessment Quality Control Processes

132. DSO 1.20 states that "Compliance with this Standing Order is a standard risk control for all external escorts." (Section 6.1)

133. However, the lack of documented risk assessments for external escorts – including medical escorts – means that evidence to determine the suitability or adequacy of risk assessments and associated controls is not retained by the TPS.

134. Consequently, an evidence-audit trail is not available for most risk assessments that would facilitate a review of risk assessment processes in order to determined compliance and appropriateness to mitigate or eliminate risks.

135. The investigator also notes that the conduct of "formal" risk assessments is at the discretion of correctional staff either coordinating or conducting the escort. As such, differing levels of experience among staff, varying knowledge of prisoners involved in escorts and no standardized checklist prescribing pre-escort preparations, results in potential inconsistency in pre-escort processes and in whether or not "formal" risk assessments are conducted.

Section 36

136. At approximately 12:00 hours on 26 April 2020, prisoner [redacted] complained of [redacted] to the Correctional Primary Health Services (CPHS) Nurse on HRP Level 1. He was medicated, then subsequently returned to his cell at HRP Level 3.

137. At approximately 14:00 hours, following further complaint of [redacted] by [redacted] the CPHS Nurse contacted the On-Call Medical Officer (MO) and was advised to send the prisoner to the RHH for further medical assessment.

138. HRP [redacted] contacted [redacted] to obtain approval for a Section 36 (External Escort) for prisoner [redacted] to the RHH for a medical assessment following advice from the CPHS Nurse.

139. A Section 36 document was completed by HRP [redacted] and signed by authorising [redacted]

140. [redacted].

141. It should be noted that the HRP Level 1 Supervisor is responsible for admissions, discharges and escorts. On the other hand, the HRP Level 2 (Operations) Supervisor is responsible for daily operation of the HRP. Tasks may be shared when busy or if only one is available.

Escort Authorisation Documentation

142. Correction Staff involved in the preparation for and conduct of the escort of prisoner [redacted] on 26 April 2020 said that documentation was completed for the escort according to operational requirements.

143. However, records of the escort were allegedly discarded (thrown out) following the incident and were not available to the investigator to provide evidence that pre-escort processes were adhered to for the escort of prisoner [redacted]

144. Therefore, the HRP failed to comply with records management guidelines outlined in Section 5.12.4 of DSO 1.38 in that they did not retain documentation used as part of operational processes for audit and evidentiary purposes.

145. The investigator found that the HRP did not retain, nor store or upload to Content Manager any documents relating to the conduct of escorts.

146. Instructions were issued to the HRP Superintendent and the investigator is informed that all escort related documents are now routinely retained and will be provided to the Records Department to be archived (uploaded) to Content Manager.

Pre-Escort Briefing

147. As previously mentioned, the pre-escort briefing consisted of the handover of documentation and the escort bag, however did not involve a discussion about the prisoner, his history, offences and risks associated with him, nor with the proposed escort to the RHH.

148. However, the investigator notes that staff resourcing and competing operational priorities may impact on the capacity of the HRP to accommodate escorts – particularly when they are required to supply the staff to facilitate the event.

149. In any case, [redacted] and [redacted] were not regular HRP staff, usually rostered for Court duties. However, their roster had changed during the Covid-19 pandemic response period because of a cessation of physical Court appearances at that time.

150. As such, [redacted] and [redacted] reported that they did not have an intimate knowledge of HRP prisoners and were not familiar with, nor briefed about prisoner [redacted] prior to the escort on 26 Apr 2020.

151. However, [redacted] said that she had been prisoner [redacted] s floor officer on the day of the incident and that she had arranged for him to be assessed by the HRP Nurse prior to the medical escort. She said she spoke to the prisoner about his condition following unlock, to which [redacted] allegedly responded that "the pain was getting worse." "There was nothing that gave me any indication that he was of any concern."

152. She said she had worked on his floor (Level 3) about five times prior to the escort. "He had always been polite and [she] had no issues with him," nor "any reason to pull him up on anything. He hadn't tried to pull any swifties or anything." She also said "he did everything compliantly."

153. [redacted] also reported that he had some interactions with prisoner [redacted] prior to the incident and indicated when interviewed that he believed the prisoner to be respectful toward correctional staff and compliant with instructions.

154. [redacted] said that [redacted] and herself were given the escort bag, as well as a letter of referral to the RHH Emergency from a Health Services Nurse working in the HRP.

155. [redacted] and [redacted] were instructed by [redacted] to escort the prisoner to the RHH and notify the Supervisor when they had an update on his condition.

156. However, they were not informed of the custodial and sentence history of the prisoner, nor briefed on potential risks associated with escorting him to the RHH.

157. The investigation finds that whilst procedures were followed by [redacted] Escort Officers should have received more information about the prisoner in the form of a briefing prior to leaving the HRP.

158. [redacted].

Emergency Management Plan

159. Emergency Operating Procedure (EOP) 08 'Code White' was not completed for this incident, although the roles of Incident Commander and Police Liaison Officer were activated to assist with the incident response.

160. The author found that reduced staffing levels on weekends may have contributed to the failure of the HRP to complete an Emergency Management Plan (EMP) for the escape according to operational requirements.

161. However, copies of EMP checklists were not available to the Control Room Operator at the time of the incident and are not routinely kept in the Control Room in the event of a major incident.

Notifications

162. Emergency Services and the HRP were notified of the escape from custody shortly after the incident.

163. The investigator was not informed of specific information relating to the notification of other operational managers during the conduct of this investigation.

164. [redacted] told the author that she was not informed of the escape of [redacted] through TPS channels. Instead, she became aware of the incident through a Facebook post by 'the vigilante news'.

Crime Scene Management

165. A Crime Scene was not established in the RHH Emergency DEM because the room was required for the treatment of community members following the incident.

166. Consequently, a Crime / Incident Scene Log was not maintained for the escape as a Crime Scene was not established.

167. No photographs were taken to the knowledge of the author of the injuries sustained by [redacted]

Emergency Command Centre (ECC)

168. [redacted].

169. [redacted]

170. [redacted]

Prisoner Count

171. An emergency lockdown count was not conducted when the Code White incident response was activated because the evening meal lockdown count had been completed prior to the incident and all prisoners – expect for [redacted] who was on the medical escort – had been accounted for and secured in their cells.

Escort Staff Training and Development

172. Escort Officers involved in the incident had not received refresher training relating to the conduct of escorts and were overdue for 'control and restraint' and 'mechanical restraint' training at the time of the escape.

173. [redacted] had been trained in conducting escorts during her initial training school on 12 March 2013. TPS training records indicate she was last trained in 'Control and Restraint' and 'Mechanical Restraints' procedures on 5 June 2017 and was due for refresher training on 5 June 2018. The latter refresher training did not occur.

174. Subsequently, [redacted] Control and Restraint and Mechanical Restraint Training was three (3) years overdue when she participated in the medical escort of prisoner [redacted] on 26 Apr 2020.

175. Similarly, [redacted] had been trained in conducting escorts during his initial training school on 11 April 2005. TPS training records indicate he was last trained in 'Control and Restraint' and 'Mechanical Restraints' procedures on 3 July 2017 and was due for refresher training on 3 July 2018. The latter refresher training did not occur.

176. Subsequently, [redacted] Control and Restraint and Mechanical Restraint Training was three (3) years overdue when she participated in the medical escort of prisoner [redacted] on 26 Apr 2020.

177. As such, [redacted] and [redacted] were trained in the conduct of escorts and had been previously instructed in the use of accoutrements and Control and Restraint techniques. However, all refresher training relevant to the conduct of this escort was overdue.

178. The investigator notes that the TPS provides ongoing training to staff for 'Control and Restraint' and 'Mechanical Restraints'. However, once an officer has completed new recruit training, no refresher escort training occurs.

Prisoner Medical Escort

179. [redacted]

180. She also stated that she was informed of her involvement in the escort of prisoner [redacted] by [redacted], who had been directed to conduct the escort by HRP [redacted]

181. The prisoner was hand-cuffed with metal cuffs with [redacted] walking beside him holding the cuffs in a close-quarter escort. [redacted] walked closely behind the prisoner and [redacted].

182. The investigation finds that the staffing level for this escort was appropriate according to the risk posed by a [redacted] prisoner.

183. Escort Staff appeared to have been situationally aware of potential escape routes during the incident and positioned themselves to minimize risks of escape during the escort.

Escort Staff Code White Incident Response

184. Emergency services were notified and a Code White (Escape) incident response callout was made by [redacted] at approximately 5:18 hours following the incident.

185. However, [redacted] indicated that she used her own personal mobile phone to inform Police of the incident, then used the escort mobile phone to contact the HRP. She explained that she was more familiar with the use of her own mobile phone to contact Emergency Services and subsequently used it to make the '000' call. However, the HRP was contacted using the preset number on the escort phone.

186. [redacted]

HRP Code White Incident Response

187. HRP staff responded promptly to the Code White incident response callout and assisted in the search.

188. However, the reduced HRP staffing compliment rostered at the facility on weekends may affect the capacity of the HRP to carry out escorts, or to respond to major incidents.

189. Of the six staff remaining at HRP after [redacted] and [redacted] carried out the medical escort of prisoner [redacted] and [redacted] responded straight away to the 'Code White' call put out via radio by HRP Control.

190. This meant that three staff remained at the HRP to coordinate the incident response from within the HRP and manage the facility and prisoners. This included [redacted] ([redacted]), [redacted] ([redacted]) and [redacted] ([redacted]).

191. [redacted]

192. [redacted]

Notification and Attendance of Emergency Services (Tasmania Police)

193. This investigation finds that whilst the police notification was not coordinated, emergency services were promptly informed about the escape of [redacted]

194. Had escorting staff been trained in the use of the medical escort mobile phone, the notification and attendance of Emergency services may have been quicker.

195. Similarly, the notification process may have been expedited if the Escort Officers had been carrying a prison issue radio to notify the HRP of the escape.

HRP Prison Radio Network

196. [redacted]

[redacted]

Prisoner Offences

197. This investigation finds that DSO 1.23 has no offence category for escape or attempted escape. However, should the prisoner not be charged by Tasmania Police for the escape, the prisoner may be charged for offence 32 – Leaving or attempting to leave the place where a prisoner has been directed to be.

HRP Post-Incident Debrief

198. This investigation finds that while a formal post incident 'Hot debrief' was not conducted as per Emergency Operating Procedure 08 'Code White,' [redacted] and [redacted] were debriefed following the incident by [redacted], who offered support services and assistance.

Recommendations

199. The following recommendations have been determined from the Findings recorded in this Investigation and are proposed for consideration by the Director of Prisons.

200. Recommendations that receive his endorsement will be recorded on the TPS Integrated Performance System (IPS) for action by the Responsible Manager by the designated Due Dates.

Recommendation	Endorsement
201. [redacted]	☐ Approved ☐ Not Approved
Responsible Manager Position:	Due Date:
202. [redacted]	☐ Approved ☐ Not Approved
Responsible Manager Position:	Due Date:
203. [redacted]	☐ Approved ☐ Not Approved
204. [redacted]	

[redacted]

Responsible Manager Position:

Due Date:

205. [redacted]

206. [redacted]

- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]
- [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

207. [redacted] Responsible Manager Position:	☐ Approved ☐ Not Approved Due Date:
208. [redacted] Responsible Manager Position:	☐ Approved ☐ Not Approved Due Date:
209. [redacted] Responsible Manager Position:	☐ Approved ☐ Not Approved Due Date:
210. [redacted] Responsible Manager Position:	☐ Approved ☐ Not Approved Due Date:
211. [redacted] Responsible Manager Position:	☐ Approved ☐ Not Approved Due Date:
212. [redacted] Responsible Manager Position:	☐ Approved ☐ Not Approved Due Date:
214. [redacted] Responsible Manager Position:	☐ Approved ☐ Not Approved Due Date:
215. [redacted] Responsible Manager Position:	☐ Approved ☐ Not Approved Due Date:

216. [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

217. [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

220. [redacted]

- [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

223. [redacted]

☐ Approved ☐ Not Approved

[redacted]

Responsible Manager Position:

Due Date:

225. [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

226. [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

227. [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

228. [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

229. [redacted]

☐ Approved ☐ Not Approved

[redacted]

Responsible Manager Position:

Due Date:

231. [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

232. [redacted]

☐ Approved ☐ Not Approved

Responsible Manager Position:

Due Date:

Tasmania Prison Service Office Use Only:

☐	Investigation and Approved Recommendations recorded on the Integrated Performance System

By Name:		Position:		Date:	