OFFICE OF THE INSPECTORATE *Te Tari Tirohia*

Terms of Reference

Enhancing the taha hinengaro of those in the care of Ara Poutama Aotearoa – An analysis of apparent suicides and self-harm threat to life incidents in New Zealand prisons 2016-2021

Thematic Review

ARA POUTAMA AOTEAROA
DEPARTMENT OF CORRECTIONS

Our whakataukī

Mā te titiro me te whakarongo ka puta mai te māramatanga
By looking and listening, we will gain insight

July 2021

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This document should not be distributed without the approval of the Chief Inspector or Chief Executive, Department of Corrections.

Background

1. Despite a falling prisoner population, the number of apparent suicides and incidents of self-harm where there was a threat to life, increased sharply during the 2020/21 financial year.
2. There has been a degree of volatility in the apparent suicide figures over several years. While the average annual number of apparent suicides during the period 2010/11 to 2020/21 was six, there were pronounced 'spikes' in 2010/11 (12), 2015/16 (11) and 2020/21 (11). The figures have been relatively stable with the noticeable exception of those three years. Further analysis of these figures suggests no direct correlation between suicides in prison and the total prisoner population.
3. The last substantive research into the characteristics of prisoner suicides in New Zealand was published by the National Health Committee in its 2010 *Health in Justice* report. The last report published by the Department was *Suicide in New Zealand Prisons 2010-2016* back in November 2017. While a number of smaller and more discreet pieces of work have been undertaken in this space since, there remains a lack of clarity around which of the many potential factors contribute most significantly to these stark outcomes.

Purpose

4. Ara Poutama's Hōkai Rangi strategy is guided by the whakataukī: *'Kotahi anō te Kaupapa: ko te oranga o te iwi'* - There is only one purpose to our work: the wellness and wellbeing of the people'. Furthermore, under the banner *'Humanising and healing'*, one of six key strategic areas for change, an explicit long-term outcome is articulated thus: *'People in the care and management of Ara Poutama Aotearoa and their whānau are well...'* including *'ā-hinengaro (mental health)'*. Every effort must be made to better understand the factors that contribute to suicidal ideation in the prison environment, so that the risks can be addressed and mitigated.
5. The purpose of this thematic review is to utilise the insights provided by the rich sources of data, surrounding all incidents involving apparent suicide and self-harm threat to life, to identify causative factors and trends, so that new strategies and approaches can be developed to meet strategic objectives and provide better outcomes for those in care. Specifically, this will involve considering how can we ensure everyone is safe and identifying where we can prevent serious harm occurring to the individual. The review will also consider the experiences of a sample of the staff and others who were involved in some of the incidents considered.

Approach and scope

6. This review will build on the findings of the reports below, and consider all relevant factors in the context of the present-day prison environment, including but not limited to, the substantially increased number of those on remand, the impact of the Covid-19 pandemic and those who have a history of drug use and substance use disorders (SUD).
   - *Suspected Suicide Thematic Review* by Rob Armstrong, Senior Advisor, Mental Health dated 22 September 2020
   - Emma Gardner's work TBC
   - *Suicide in New Zealand Prisons 1 July 2010-30 June 2016* by Robert Jones – November 2017
7. The review will cover the period 1 July 2016 – 30 June 2021 and include all apparent suicides and self-harm threat to life incidents recorded during that time – approximately 24 apparent suicides and 248 incidents of self-harm threat to life.
8. In terms of apparent suicides, and complementing the work previously undertaken by the health team, the review will analyse a range of dynamic and static factors including, but not limited to:

- Circumstances of death
- Demographics
- Prisoner profile
- Social connectedness
- Psychosocial stressors
- General health, including chronic health conditions and pain
- Mental health profile

9. A range of additional specific risk factors will also be considered including, but not limited to:

   - History of drug use and substance abuse disorders (SUD)
   - Having previously attempted suicide
   - Having experienced suicidal distress/thoughts/behaviours
   - Losing a loved one or peer to suicide
   - Age
   - Gender
   - Sexuality
   - Gender identity
   - Ethnicity
   - Family and childhood experiences
   - Relationship breakdowns
   - Losing status/influence
   - The use of the ASIST (alcohol, substance involvement, screening tool) screening of the individual in care and access to relevant rehabilitative programmes
   - The role of pain medications
   - Access to, and responsiveness of, mental health services
   - The impact, if any, of the Covid-19 pandemic since early 2020

10. In terms of incidents of self-harm threat to life, a similar lens will be applied with the addition that opportunities will be identified to talk with, and take testimony from, a cross-section of individuals who have lived experience of the some of the incidents under review. It is acknowledged that behind all of the incidents under review, there are people and their whānau who have been impacted and we have a responsibility to listen and learn.

11. All information gathered will be used to consider causative factors and trends, and the role and efficacy of current systems, practices and processes.

12. Comparisons will be drawn between the experience of apparent suicide and self-harm events in prison with that in the wider community.

13. Care will be taken to apply a cultural lens to the review to identify where Māori and Pasifika may be over-represented in the figures. Any consideration of new or adapted approaches falling out of the findings of the review should be in alignment with the six strategic areas for change that form the core of Hōkai Rangi.

14. Consideration is being given to using the London Protocol (Taylor-Adams and Vincent), or the Yorkshire Contributory Factors Framework as a methodology to inform the analysis of individual incidents within the scope of this review. These methodologies were designed to ensure a comprehensive and thoughtful investigation and analysis of an incident, going beyond the more usual identification of fault and blame.

Work plan

15. There will be a separate workplan developed that all parties will be advised of. However, it is anticipated that a draft report will be provided to the Chief Executive within six months.
16. Any significant findings that may require early remediation will be signalled at the earliest opportunity.

12 July 2021

Janis Adair

Chief Inspector

Office of the Inspectorate

Date

Amended 7 April 2022