Recording and reporting of self-harm and attempted suicides in custody

April 2024

The Office of the Inspector of Custodial Services acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of this country, and their continuing connection to land, waters, and community throughout Australia. We pay our respects to them and their cultures, and to Elders, be they past or present.

Reviews undertaken as part of the Office of the Inspector of Custodial Services' *Snapshot Series* are designed to provide a brief summary of an issue or trend impacting the Western Australian custodial environment. This review examines the accuracy of recording and reporting for self-harm and attempted suicide incidents within adult and youth custodial facilities.

The information examined for this *Snapshot Series* was obtained from the Department of Justice. The Department has reviewed this report and provided feedback which has been taken into consideration.

Recording and reporting of self-harm and attempted suicides in custody

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Reader advice

The following review contains discussions on self-harming and suicide. Reader discretion is advised as some people may find the content of this report distressing.

If you or someone you know is having thoughts of suicide or is distressed, please seek help.

Help is available:	
Mental Health Emergency Response Line (MHERL)	Metro – 1300 555 788 Peel – 1800 676 822
Rurallink	1800 552 002
Lifeline	13 11 14 www.lifelinewa.org.au
Kids Helpline	1800 551 800 www.kidshelpline.com
13 YARN – Aboriginal & Torres Strait Islander Crisis Support	13 92 76 www.13yarn.org.au
Mensline	1300 789 978 www.mensline.org.au
Suicide Call Back Service	1300 659 467 www.suicidecallbackservice.org.au
Samaritans	13 52 47 www.thesamaritans.org.au
Open Arms – 24 hour helpline for Veterans and Families	1800 011 046 www.openarms.gov.au
In an emergency, call an Ambulance on 000	

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Inspector's Overview

Accurate and reliable data is the key to system level analysis and decision making

This Snapshot Review was undertaken to look at how the Department of Justice records and reports on incidents of self-harm and attempted suicide by people in custody. It was prompted by our ongoing monitoring of custodial data for trends and emerging issues, from which we undertook a more in-depth review to better interrogate the available data on this subject.

The Review was not intended to be an examination of individual cases or the causes of self-harm or attempted suicide in custody, such a review would require far more detailed research, analysis, and exploration of issues. Similarly, the Review was not an examination of the response to specific incidents, nor a review of the adequacy of clinical or custodial care in each instance.

The focus was on the recording and reporting of relevant data. The rationale for this focus is that good decision making necessarily relies on having accurate and reliable data. As the Department acknowledged in its response to the draft of this report, accurate reporting and recording of incidents is essential to the challenges of prevention and incident reduction. Having a clear picture of the nature and extent of problems and the drivers behind them allows for more informed decision making and targeted response, including resource allocation.

We also agree with the Department that clear definitions allow for accurate data and classification of incidents. With this in mind, we made three recommendations, only one of which was supported by the Department.

Recommendation 1 was to review the Department's current definition of 'attempted suicide' with a view to better aligning it with the Mental Health Commission's definition used in their suicide preventions strategy for Western Australia. Essentially, this is a simpler definition that does not include consideration of the 'intention' of the individual involved - research has shown that determining intention can prove to be problematic (Mendoza and Rosenberg 2010). Although the Department did not undertake a review as recommended, they did provide a plausible rationale for the use and retention of the current definition, particularly how it links to the Gatekeeper Suicide Prevention Program which is their preferred suicide prevention training package for staff.

Recommendation 2 related to having a process of clinical review of self-harm and attempted suicide incidents to ensure the chosen incident classification was accurate. While we understand the Department's stated difficulty in recruiting clinical staff and preference for having them focus on service provision and clinical intervention, this overlooks the overall system benefits to be gained from having a formal mechanism of clinical coding to ensure the highest level of reliability and confidence in this critical data source.

Recommendation 3 was accepted by the Department, noting that they had already implemented an additional category of 'suicide threat' which meets the intention of the recommendation.

As noted from the outset, this review was always focussed on the quality and reliability of system level data. Our approach in undertaking a desktop analysis of how the Department records and reports incidents remains, in my view, an appropriate mechanism to be used in the circumstances.

Our findings and recommendations all focussed on the potential for improvement to the definitions used and the quality of data classification and categories. We did not identify any evidence of an intention to downplay the numbers or under-record serious incidents.

One of the positives to come from this snapshot review is, in my opinion, an increased awareness of possible gaps in data recording and the importance of improving data quality and integrity to facilitate system level analysis, decision making and reporting. Given the subject matter involved, nothing less should be accepted.

ACKNOWLEDGEMENTS

It is important to acknowledge the contribution and assistance we received in undertaking this review from key personnel at the Department of Justice and at Serco, the private operator of Acacia Prison.

I acknowledge the contribution and hard work of the team in our office who were involved in undertaking this review. I would particularly acknowledge and thank Ryan Quinn for his work in leading this snapshot review and as principal analyst and drafter of this report.

Eamon Ryan
Inspector of Custodial Services

24 April 2024

Executive Summary

Key Findings

Policy framework establishes expectation for accurate incident reporting

The Department has a clear policy and procedural framework requiring custodial staff to report all incidents involving threats of self-harm, acts of self-harm and actual attempts of suicide. The definition of self-harm and attempted suicide used by the Department generally align with mental health agencies. However, the Department's definition of an attempted suicide requires a confirmation of the intent of the person in addition to an act to end life. Identifying suicidal intent can be difficult. We take the position that the Department should consider using the Mental Health Commission's definition, which focusses less on intent and more broadly on non-fatal suicidal behaviours.

Some self-harm and attempted suicide occurrences are not recorded correctly

Analysis of departmental data found not all self-harm and attempted suicide incidents were being recorded correctly. Over a nine-month period, we identified at least 18 attempted suicide incidents that had been misclassified as a self-harm. An additional 20 incidents were identified that appeared to include an act to end life but did not record any suicidal intent. We also identified over 300 incidents that included suicidal behaviours but were listed as acts or threats of self-harm in lieu of a suicidal behaviour category. By introducing this category and a clinical review process, the Department will have a clearer understanding of the prevalence of self-harm and attempted suicides across the estate.

List of Recommendations

Recommendation	Page	DOJ Response
Recommendation 1 Review the definition of 'attempted suicide' in *COPP 13.1 Incident Notifications, Reporting and Communications* and in the *At Risk Management System (ARMS) Manual* and align with the Mental Health Commission of Western Australia.	2	Not Supported
Recommendation 2 Introduce a clinical review process of all self-harm and attempted suicide incidents to ensure the classification applied is accurate, enabling the Department to have accurate and informative oversight.	4	Not Supported
Recommendation 3 Introduce a 'suicidal behaviour' occurrence type for incident reports to accurately report incidents of prisoners or detainees thinking, planning or threatening suicide.	5	Supported – Current Practice/Project

1 Policy framework establishes expectation for accurate incident reporting

1.1 Threats or actual acts of harm are recorded as incidents

Staff in adult and youth custodial facilities are required to report incidents involving threats of self-harm, acts of self-harm and actual attempts of suicide (DOJ, 2020).

Actual self-harm incidents are later classified as either 'minor' or 'serious' using algorithms that consider information provided during the incident reporting process. Typically, a serious self-harm incident will involve an actual occurrence of self-harm that results in ongoing medical treatment or overnight hospitalisation. Minor self-harm incidents are occurrences of actual self-harm, but without the need for external medical treatment or overnight hospitalisation.

Attempted suicides are reported as critical incidents and are not affected by the abovementioned classification process.

Threats of self-harm include threats to commit acts of self-injury such as self-laceration, self-battering or deliberate recklessness, all without suicidal intentions.

The Department does not have a requirement to report threats of suicide and no incident type exists for a person displaying suicidal ideation or making threats of suicide (DOJ, 2020). However, we find these are typically reported as threats of self-harm.

1.2 Definitions of self-harm and attempted suicides generally consistent with mental health profession

The Department defines self-harm as an act of self-injury by a prisoner or detainee without suicidal intention, including 'self-laceration, self-battering or deliberate recklessness' (DOJ, 2020, p. 31). This generally aligns with definitions of non-suicidal self-injury and non-suicidal self-harm used by mental health agencies (MHC, 2020; National Suicide Prevention Project Reference Group, 2020).

The Department's definition of an attempted suicide focuses on the 'act' and the 'intent' of the person. It states an attempted suicide is:

> An act performed by a prisoner/detainee where the circumstances indicate there was an intent of the act to take their own life through:
>
> - self-inflicted injury; or
> - self-asphyxiation or hanging; or
> - intentional self-poisoning (including drug overdose); or
> - other intentional acts intended to take one's own life (DOJ, 2020, p. 29).

Similarly, the Department's *At Risk Management System (ARMS) Manual* defines a suicide attempt (with or without injury) as an action 'where there is evidence (implicit or explicit) that the injury was self-inflicted and that the person intended at some level to kill him/herself' (DOJ, 2016, p. 5).

These definitions are generally consistent with the mental health profession (APA, 2023). However, Mendoza and Rosenberg (2010) note that understanding 'intent' can be challenging. Some people express a clear intention to end their own life, while others may be driven by a desire to cause hurt or pain rather than death. Where intent is unclear, the severity of the act may infer that no other intent was likely (Gordon & Melvin, 2014).

The Mental Health Commission's (MHC) suicide prevention strategy for Western Australia defines an attempted suicide more simply as 'any non-fatal suicidal behaviour' (MHC, 2020, p. 52). This definition has less focus on intent, noting that it can be difficult to determine if a person intended for their actions to result in death. Rather, it focusses on suicidal *behaviour*. This includes any 'actions that have the potential to lead to suicide' from 'role-playing an intended suicide to making an attempt' (MHC, 2020, p. 53).

Custodial staff, responsible for recording self-harm and attempted suicide incidents, would benefit from this simpler definition. In any case, the Department should align its definitions with the MHC's suicide prevention strategy.

Recommendation 1
Review the definition of 'attempted suicide' in *COPP 13.1 Incident Notifications, Reporting and Communications* and in the *At Risk Management System (ARMS) Manual* and align with the Mental Health Commission of Western Australia.

2 Some self-harm and attempted suicide occurrences are not recorded correctly

Our review of departmental data found not all attempted suicides were being recorded correctly. The Department reported 1069 self-harm occurrences across 1039 unique incidents between 1 January and 30 September 2023. Following our review, we found at least 18 attempted suicides which had been, in our view, recorded incorrectly as a self-harm.

Our review also identified at least 318 incidents where the person in custody displayed suicidal behaviours such as making threats or admitting to suicidal thoughts. The Department does not have a suicide threat or suicidal behaviour occurrence type, which means these are typically recorded as threats of self-harm. This means suicidal behaviours, other than attempted suicides, are not tracked in any meaningful way.

A summary of our review can be found in Appendix A.

2.1 Some attempted suicides were misclassified as self-harm

Using key-word searches and a random sample review we identified 18 attempted suicides that, in our view, had been recorded incorrectly. Most (15) had been recorded as a 'self-harm – actual' and later classified as 'self-harm – minor' (14) and 'self-harm – serious' (1). The remaining three did not appear in the Department's self-harm report as they had been recorded as a threat of harm, rather than an actual occurrence of self-harm.

We reviewed the incident reports for these 18 occurrences and found that the people involved had verbalised their intent to end their life and had acted in a way to fulfill that intent. Most frequently this involved acts of self-strangulation but also included other acts of harm such as ingesting foreign objects.

The 18 occurrences involved 15 unique individuals, including:

- Nine males and six females
- Ten Aboriginal people and five non-Aboriginal people
- Five young people in youth detention involved in eight distinct incidents

In one incident, a young person located in the Unit 18 Juvenile Security facility swallowed pieces of metal before placing a ligature around their neck, attached it to a ligature point, and commenced tightening the ligature. A code red was called, and custodial staff used a hoffman knife to remove the ligature and place him into the recovery position. He was then placed in hand and leg restraints after stating that he would continue to try and kill himself.

We were initially advised of this incident through the critical incident notifications process. At this time, it was listed as an attempted suicide with the young person verbalising their suicidal ideation. Post-incident the report was merged with a separate incident report involving a use of force and a staff assault. The attempted suicide was then re-classified as a self-harm.

2.2 Incident reports often do not discuss intent

During our key-word search we identified an additional 20 occurrences that, on face value, appeared to be an act to end life. However, the incident reports did not include any verbalised intent by the prisoner or detainee, or any other evidence to suggest there was a clear intent. All had been classified as acts of self-harm.

In some cases, the acts of harm appeared to be of such severity that without intervention the risk of death would be high.

As intent was not verbalised or demonstrated in some way, it appears a decision was made to record these incidents as self-harm rather than attempted suicides. This is technically correct, as per the definition of attempted suicide that the Department prescribes to. They were also not classified as a serious self-harm because they did not involve an overnight hospital stay.

Where intent has not been made explicitly clear, it would be inappropriate for custodial staff to make assumptions. Incident reports are required to be factually correct (DOJ, 2020). This means some occurrences of attempted suicides may be misclassified as self-harm or unreported as there was insufficient evidence at the time of reporting. Broadening the definition of attempted suicides to encompass any actions that have the potential to lead to death would better capture these incidents.

The Department should also consider introducing a method of review by clinical staff following a self-harm incident to determine if there was suicidal intent and whether the occurrence classification is accurate. This could be performed by local Prisoner Risk Assessment Group (PRAG) committees who monitor at-risk prisoners.

Recommendation 2
Introduce a clinical review process of all self-harm and attempted suicide incidents to ensure the classification applied is accurate, enabling the Department to have accurate and informative oversight.

2.3 Suicidal behaviours are not distinguished from threats of self-harm

The Department's reporting system does not distinguish between threats of non-suicidal self-injury and suicidal behaviours such as thinking, planning or threatening suicide. These suicidal behaviours are considered a significant risk factor for someone taking suicidal actions (AIHW, 2023). Currently, thoughts or threats of suicide appear to only be recorded by the Department under the occurrence type 'self-harm – threat'. This limits the Department's ability to monitor the prevalence of suicidal ideation across the custodial estate.

Between 1 January and 30 September 2023 there were 2199 self-harm threat occurrences. Using key-word searches we identified 238 occurrences (10%) where the high-level description stated the person in custody was having suicidal thoughts or making threats of suicide.

Most (73%) of the remaining occurrences described threats of self-harm in very general terms. Often the detail in the incident description prevented us from distinguishing whether these were threats of non-suicidal self-injury or if they included suicidal threats or ideation. The remaining occurrences (16%) did not mention self-harm or suicide at all in their high-level description.

We reviewed a random sample of these remaining occurrences to assess whether they were suicidal threats or threats of non-suicidal self-injury. To do this we reviewed the officer reports from each incident. From the 50 occurrences we reviewed, 19 included suicidal behaviours such as talk of suicide or use of ligatures. These results suggest a high proportion of occurrences labelled as self-harm threats would be more appropriately labelled as suicidal behaviour or threats of suicide.

As we continued our work, we identified further occurrences of suicidal ideation or threats, bringing the total to at least 318 (14.4%) for the period 1 January to 30 September 2023. This is without conducting a review of each individual incident.

By not distinguishing between suicidal and self-injury threats, the Department lacks awareness of the prevalence of suicidal behaviours across the custodial estate. Limited oversight prevents the Department from providing the resources necessary to support the health and wellbeing of people held under their care.

Recommendation 3

Introduce a 'suicidal behaviour' occurrence type for incident reports to accurately report incidents of prisoners or detainees thinking, planning or threatening suicide.

2.4 Most ligature incidents recorded at Banksia Hill and Unit 18

Using a key-word search we identified 85 self-harm incidents that involved the use of a ligature. Most (71%) of these occurred either at Banksia Hill Detention Centre (32) or the Unit 18 Juvenile Security facility at Casuarina Prison (29). Twenty-three young people were involved in the 61 incidents.

We reviewed these incidents and found four involved a young person using the ligature to self-asphyxiate while verbally expressing an intention to end their life. On one occasion the young person was unconscious when the ligature was removed. In a separate incident staff were required to use a hoffman knife to remove eight ligatures that the young person had tied around their neck. All four incidents were listed as actual self-harm, rather than attempted suicides.

The remaining 57 incidents included suicidal behaviour such as the creation of ligatures, the placement of ligatures around ligature points, or the placement of ligatures around their necks. In some cases, the young person involved was observed talking or threatening suicide, they prepared ligatures, but then did not use them. In other cases, young people placed the ligatures around their neck and tightened them before it was removed by staff or themselves.

Most (56) of these incidents were recorded as actual self-harm and one was recorded as a threat of self-harm. Recording these incidents as suicidal behaviour increases transparency around the prevalence of suicidal thinking, planning and actions in the youth custodial estate.

We also conducted key-word search of incidents involving ligatures that were not categorised as self-harm and found an additional two at Banksia Hill and four at Unit 18. These generally related to staff finding and removing ligatures that young people had made, rather than attempted or actual use of the ligatures.

Given the prevalence of ligature use in the youth custodial estate, it is likely that the actual number of ligature incidents was significantly higher than what we could identify through key-word searches.

2.5 Unrecorded incidents and poor data hampered our analysis

Unrecorded self-harm and attempted suicides, or incident reports that are inaccurate or lacking detail, are limitations we could not avoid during this review. Potential for staff apathy towards self-harm or suicidal behaviours, and perceptions of using self-harm as a tool for manipulation, increase the likelihood of incidents being unrecorded or recorded incorrectly. This will result in the Department's reporting not reflecting actual rates of self-harm or suicidality and may also result in people not receiving the monitoring and supports needed following a self-harm incident.

Inaccuracies or insufficient detail also hampered our analysis. Many incidents were described in overly simplistic ways such as 'self harm threat' or 'self harm'. To obtain the detail, we were required to manually review individual officer reports because these are not extractable for bulk analysis. This prevents us, and the Department, from performing systemic analyses. In some cases, even the individual officer's reports lacked detail or were inconsistent with other officer's reports, making analysis more difficult.

As a result, the quality of our analysis was limited by the quality of the data recorded. This means that it is likely that there are more instances of self-harm or attempted suicides than what we have identified and what is reported by the Department.

The issue of data quality impeding the Department's oversight has been raised in several of our previous reports, in different contexts.

Appendix A Summary of reported self-harm and attempted suicide incidents

Table 1: Self-harm incidents reported by the Department of Justice (1 January - 30 September 2023) and summary of OICS review identifying misclassified attempted suicides and suicide threats.

Facility	Occurrences Recorded by DOJ				OICS Review	
	Attempted Suicide	Self-harm - Serious	Self-harm - Minor	Self-harm - Threat	Attempted Suicides	Suicidal Behaviours
Acacia Prison	3	5	68	95	4 (+1)	26
Albany Regional Prison	4	0	15	21	4 (-)	2
Bandyup Women's Prison	1	2	88	178	4 (+3)	45
Boronia Pre-Release Centre	0	0	0	1	0 (-)	0
Broome Regional Prison	0	0	1	8	0 (-)	0
Bunbury Regional Prison	4	0	11	41	4 (-)	7
Casuarina Prison	6	6	69	179	7 (+1)	31
E. Goldfields Regional Prison	0	0	31	48	0 (-)	5
Greenough Regional Prison	2	0	7	10	2 (-)	0
Hakea Prison	7	5	130	577	10 (+3)	84
Karnet Prison Farm	0	0	0	1	0 (-)	0
Melaleuca Women's Prison	5	1	121	169	7 (+2)	25
Pardelup Prison Farm	0	0	0	0	0 (-)	0
Roebourne Regional Prison	0	0	4	23	0 (-)	5
Wandoo Rehab. Prison	0	0	0	0	0 (-)	0
W. Kimberley Regional Prison	0	0	3	32	0 (-)	5
Wooroloo Prison Farm	0	0	0	2	0 (-)	0
Banksia Hill Detention Centre	13	2	235	424	17 (+4)	51
Unit 18 Juvenile Security	4	7	210	393	8 (+4)	32
Total	*49*	*28*	*993*	*2199*	*68 (+18)*	*318*

Appendix B Definitions of self-harm occurrence types

Occurrence Type	DOJ Definition	Critical Incident Applicability
Self-harm – Threat	The threat to commit acts of self-injury, such as self-laceration, self-battering or deliberate recklessness and are done without suicidal intentions.	Not applicable
Self-harm – Actual	Acts of self-injury by which prisoners/detainees purposely harm themselves, such as self-laceration, self-battering or deliberate recklessness and are done without suicidal intentions.	When the self-harm incident requires medical treatment, involving: overnight hospitalisation (which includes being admitted to as an in-patient) at a medical facility such as a prison clinic, infirmary or hospital, where overnight is considered being from one day to another; or on-going medical treatment (which includes treatment by a medical practitioner on multiple occasions). Note: medical treatment does not include medical assessment only.
Attempted Suicide	An act performed by a prisoner/detainee where the circumstances indicate there was an intent of the act was to take their own life through: self-inflicted injury; or self-asphyxiation or hanging; or intentional self-poisoning (including drug overdose); or other intentional acts intended to take one's own life. For acts of self-injury without suicidal intention refer to Self-harm – actual.	Every attempted suicide is recorded as a critical incident.
Source: *COPP 13.1 Incident Notifications, Reporting and Communications* (DOJ 2020)		

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Appendix D Department of Justice's Response

Response to Review:

Snapshot Series: Recording and Reporting of Self-Harm and Attempted Suicides in Custody

March 2024

Version 2.0

Response Overview

Introduction

The Snapshot Series Review into *Recording and Reporting of Self-Harm and Attempted Suicides in Custody* (the Self-Harm Review) was announced by the Office of the Inspector of Custodial Services (OICS) on 31 October 2023. The Self-Harm Review was a desktop analysis of self-harm and attempted suicide incident data retrieved from the Total Offender Management Solution (TOMS) system.

The draft Self-Harm Review report (draft report) was issued to the Department of Justice (the Department) on 13 November 2023 for review and comment. The draft report highlighted the key findings and made three recommendations.

Following receipt of the draft report, the Department invited OICS to discuss the findings and consider further contextual information as part of the review. This meeting was held on 18 December 2023.

On 22 December 2023, OICS advised the Department to proceed with providing a response to the draft report which included a minor amendment to recommendation two.

The Department has reviewed the draft report and provides below the contextual information and responses to the recommendations.

Review Comments

The Department takes incidents of self-harm and attempted suicide very seriously as they have the potential to lead to a death in custody and welcomes OICS' review into the Department's recording and reporting of these incidents.

The Department is committed to taking all possible actions to prevent or reduce occurrences of self-harm and attempted suicide incidents in custody.

Accurate recording and reporting of these incidents in custody is essential to preventing and reducing such occurrences. It enables the Department to review and analyse the data to identify areas of risk, further develop targeted prevention programs and strategies to minimise these incidents, and to divert critical resources to manage and support at-risk prisoners and detainees. It also enables the Department to fulfil its reporting obligations to national suicide and death in custody reporting agencies.

Definitions can play a key role in accurately classifying incidents for recording and reporting and the Department has given due consideration to OICS' recommendation to align the definition of 'attempted suicide' to that of the Mental Health Commission of Western Australia (MHC).

The MHC definition of attempted suicide is broad as it is intended to guide mental health policy development for government, non-government, communities and private organisations. The definition caters for a multitude of services and client groups which are not specific to the needs of a correctional environment.

The Department's existing definition of attempted suicide is aligned to Gatekeeper Suicide Prevention Training (Gatekeeper), its preferred suicide prevention training program for several years. This training helps staff develop an understanding of the reasons behind suicidal behaviours and the differences between suicidal behaviours and non-suicidal self-injury. The MHC is the custodian of Gatekeeper and trains the facilitators of the training program. Information on Gatekeeper can be found on the MHC website.

Furthermore, the Department's definition is aligned to national reporting guidelines which allows Western Australia's self-harm data to be compared with other jurisdictions in national reports such as the Productivity Commission's Report on Government Services.

The Department has made several changes to policies and procedures in relation to self-harm and attempted suicides over the years, including changes to the incident reporting module in the TOMS system, making it simpler for staff to categorise and accurately record and report on such incidents.

In youth custodial settings, changes have been made to the At-Risk Management System (ARMS) and the Support and Monitoring System (SAMS) which further support staff in the identification and management of young people who are at risk. This allows more accurate reporting through the transparent recording of the identification, referral, interim management plan and case management of the young person. More importantly, it enables appropriate supports and services to be facilitated for the at-risk individual.

A tiered governance process has been implemented whereby a number of people at the local level review the self-harm and attempted suicide incidents for accuracy purposes before the occurrence type is finalised. In addition, the Department's Data Integrity Working Group reviews incidents as part of regular quality assurance checks of the incident data to ensure the recording and reporting is accurate.

Incidents of self-harm and attempted suicide unable to be clearly categorised due to their subjective nature and/or lack of recorded information are referred back to the custodial facility for clarification. At times, they are also referred to the Prisoner Risk Assessment Group (PRAG) for adults and the At-Risk Assessment Group (ARAG) for young people for further assessment of the level of risk and necessary monitoring and supports that may be required to manage risks.

The PRAG and the ARAG comprise multidisciplinary teams, including clinical staff. The core role of clinical staff is to provide clinical interventions and assessments which support the delivery of at-risk management in prisons.

A clinical review process for all self-harm and attempted suicide incidents as recommended by OICS would redirect the clinical resources available to deliver essential clinical services to prisoners and detainees across the custodial estate. It would not only blur the lines between operational and therapeutic roles, but also add a significant burden on clinical staff who already have competing priorities and high workloads.

To differentiate between a self-harm threat and a suicide threat, the Department has recently introduced a new *suicide – threat* occurrence type within TOMS. This is to accurately capture incidents involving threats of suicide that may require clinical intervention and threats of self-harm that do not escalate into actual acts of self-harm and/or attempted suicide.

The correct application of the new occurrence type is a priority for the Department, including ongoing education and training for staff on incident recording and reporting, along with refining its incident review and monitoring governance processes.

It is also the view that a desktop review when considering the complex nature of suicide attempts, suicidal ideation and self-harm is not an appropriate form of review mechanism and does not allow for the consideration of the inherent complexity needed to provide recommendations regarding self-harm or suicide attempts within a custodial setting, even within a data analysis perspective. A desktop review would usually be utilised as a research methodology for statistical clarification and oversight and not a recommended standard methodology for policy development when considering the complex nature of mental health issues and suicidal ideation that may occur in some cohorts of young people within youth detention. This desktop review has also referred to assumptive statements regarding

unrecorded incidents, YCO behaviours and digital literacy that have likely influenced OICS recommendations that the Department has not supported.

The Department however remains committed to working with relevant stakeholders to improve its systems and processes for accurate recording and reporting of self-harm and attempted suicide incidents and giving at-risk prisoners the best level of mental health care and treatment possible to ensure their continued safety and wellbeing.

Response to Recommendations

1 Review the definition of 'attempted suicide' in COPP 13.1 Incident Notifications, Reporting and Communications and in the At-Risk Management System (ARMS) Manual and align with the Mental Health Commission of Western Australia.

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

The MHC's attempted suicide definition is broad and guides mental health policy development for government, non-government, communities and private organisations. The definition caters for a multitude of services and client groups which are not specific to the needs of a correctional environment.

The Department's existing definition of attempted suicide is aligned to its preferred suicide prevention training program called Gatekeeper Suicide Prevention Training. It guides staff in developing an understanding of the reasons behind suicidal behaviours and the differences between suicidal behaviours and non-suicidal self-injury. The MHC is the custodian of Gatekeeper and provides the training to the Department. The recommendation was reviewed against the current training provided by MHC and COPP 13.1 and the ARMS Manual and the current policy is supported to remain in place.

Changing the definition of attempted suicide would also cause confusion for custodial staff as it would be inconsistent with the training material and departmental messaging in at-risk management. The current governance processes in place enable any anomalies to be rectified and ensure oversight of recording of these types of incidents is maintained.

2 Introduce a clinical review process of all self-harm and attempted suicide incidents to ensure the classification applied is accurate, enabling the Department to have accurate and informative oversight. *(Amended post receipt of draft report)*

Level of Acceptance: Not Supported
Responsible Division: Corrective Services
Responsible Directorate: Offender Services

Response:

The practicality of a clinical review process is not feasible due to the shortage of clinical resources in the community and the challenges faced by the Department in recruiting clinical staff to adequately provide essential clinical services to prisoners and detainees across the custodial estate.

The core function of clinical staff is to provide clinical interventions and assessments which support the delivery of at-risk management in prisons. If a clinical review process is

introduced, this would divert the already limited clinical resources from this core role and reduce the available support for at-risk individuals in custody.

3 Introduce a 'suicidal behaviour' occurrence type for incident reports to accurately report incidents of prisoners or detainees thinking, planning or threatening suicide.

Level of Acceptance:	Supported – Current Practice / Project
Responsible Division:	Corrective Services
Responsible Directorate:	Operational Support

Response:

The Department has recently implemented a new *suicide – threat* occurrence type in the TOMS system. This new occurrence type would work in the same way as the proposed suicidal behaviour occurrence type and is expected to improve the accuracy of self-harm and attempted suicide incident recording and reporting.

The new occurrence type differentiates self-harm threats from suicide threats, noting that not all self-harm incidents have suicidal intentions. It also aligns with the Department's ARMS manual and increases reporting and awareness of a prisoner or detainee verbalising suicidal intentions but not actually self-harming.

The actions undertaken by staff in accordance with policy and procedures for threats or acts of self-harm are consistent across the two categories and include the referral to ARMS, increased monitoring, review and facilitation of contact with services and supports.

Appendix E Serco's Response

23 February 2024

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Mr Ryan Quinn
Office of the Inspector of Custodial Services
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469 Wellington Street
Perth WA 6000

Dear Ryan

Self-harm and Attempted Suicides Reporting

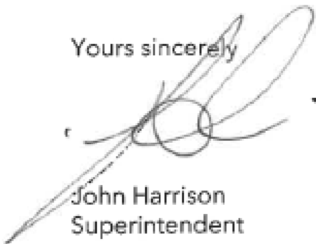
Thank you for the opportunity to comment on the above report.

By way of response, there is certainly merit in reviewing the reporting of suicides and self-harm. I would recommend caution when comparing the management and definition of self-harm/suicide with essentially community-based models which inform the MHC's experience base. The situational context of prison provides the prisoner with a predictable response to self-harming behaviour which places the duty of care very much on the institution. Community based models typically share the duty of care with the patient. For eg, a person presenting with suicidal thoughts to a community-based clinician is likely to be provided with a Safety Plan to which they are expected to comply. Such community-based models of care assume the patient has access to communications with providers such as Lifeline.

To this end, over time, the situational context has allowed for entrenched patient self-harming behaviours particular to the prison environment. Historically, some consideration of intent has been utilised in order for the site to assess the appropriate reporting level and response. In the context of a prison, simpler is usually better although the simpler MHC definition of attempted suicide has the potential to skew the data.

I concur with the recommendation of having Incident Reports reviewed by the PRAG to ensure clinical accuracy, though I note this will likely require adjustments to reporting and finalisation timelines in the COPP.

Yours sincerely



John Harrison
Superintendent
Acacia Prison

Appendix F Methodology

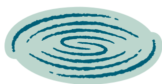
Data sets for this review were obtained from the Department of Justice's (the Department's) offender database through a series of extractions using SQL Server Management Studio. We also used a series of pre-constructed reports from the Department's Reporting Framework and from the offender database. We examined data between 1 January and 30 September 2023.

We also examined departmental documentation including policy and procedures.

A draft version of this report was sent to the Department and Serco in November for comment and to respond to recommendations. A formal response was received from Serco in February 2024 and from the Department in April 2024, as shown in Appendix C.

This report was a review of a custodial service in accordance with Section 22 of the *Inspector of Custodial Services Act 2003*.

Key dates	
Review announced	31 October 2023
Draft report sent to Department of Justice and Serco	14 November 2023
Response received from Department of Justice	22 April 2024
Response received from Serco	23 February 2024
Declaration of prepared report	24 April 2024



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