RECORDING AND REPORTING OF SELF-HARM AND ATTEMPTED SUICIDES IN CUSTODY

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 prevention 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 focused 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 focused 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.

ACKNOWLEDGMENTS

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