FINAL REPORT
OF THE
COMMITTEE TO REVIEW SUICIDE
AND OTHER SELF-HARM IN PRISON

KEVIN WALLER
Chairman

OCTOBER 1993
Dear Minister,

I have the honour to present the Final Report of the Committee charged with inquiring into suicides and other forms of self-harm in prisons.

I am pleased to be able to advise that the picture relating to suicides in the gaol system is not as bleak as is often portrayed in Parliament and by the media. In the period covered by our inquiry, the six months to 30 June 1993, there were only two suicides. This is the lowest figure for many years, and when taken with the rising prison population represents a rate of suicide comparable with or better than that of other States and countries. There has been one additional suicide since 30th June.

Recent initiatives by the Department of Corrective Services, particularly the introduction of unity and case management practices, the establishment of the Crisis Support Unit and new reception screening procedures, found great favour with the Committee. We recommend extensions to these programs.

The Committee nevertheless found several areas where improvements can be made. These may be found in our final recommendations, and relate mainly to transfers, relationships between officers of the Corrective Services and Health Departments, extended hours for the reception and treatment of prisoners, files and other documentation, and certain matters peculiar to Mulawa Women’s Prison. There are also areas where further study is needed, and these are noted in the body of the Report.

Nevertheless, the Committee found the attitude and innovations of your Department encouraging. The current approach and the implementation of our recommendations should see suicides and self-mutilation reduced to a minimum, although no doubt anomalous incidents will occur.
Referring as they did to "Projected strategies for the handling of 'at risk' inmates", our Terms of Reference necessitated investigations into the workings of the Prison Medical Service and its relationship to prisoners and to your Department. The quality of co-operation between the two government bodies was a constant theme of our interviewees, and comprises a significant part of our Report. We have noted a recognition among senior officers that there must be a more harmonious relationship between the Departments, and we have recommended to this effect. The Report does therefore contain material relative to the area of responsibility of the Minster for Health.

The Committee received every assistance during its deliberations, and we would especially like to thank Mark Elliot, Andrew Clucas, Russell Lillie and Superintendent Michael Vita for their generous support.

Having found the subject matter of our inquiry both interesting and rewarding, the Committee looks forward with a sense of anticipation to an appropriate reaction to its recommendations.

Yours sincerely,

Kevin Waller AM
Chairman
<table>
<thead>
<tr>
<th>TOPIC</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Summary</td>
<td>1</td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>The Problem</td>
<td>5</td>
</tr>
<tr>
<td>The Committee</td>
<td>7</td>
</tr>
<tr>
<td>Terms of Reference</td>
<td>7</td>
</tr>
<tr>
<td>Statistics - Suicide</td>
<td>10</td>
</tr>
<tr>
<td>Self Mutiliation</td>
<td>17</td>
</tr>
<tr>
<td>Secondary Gain</td>
<td>18</td>
</tr>
<tr>
<td>Prisoners at Risk</td>
<td>20</td>
</tr>
<tr>
<td>Current DOCS Approach</td>
<td>21</td>
</tr>
<tr>
<td>Crisis Support Unit</td>
<td>24</td>
</tr>
<tr>
<td>Prison Medical Service</td>
<td>25</td>
</tr>
<tr>
<td>Training</td>
<td>30</td>
</tr>
<tr>
<td>Mulawa Women's Prison</td>
<td>32</td>
</tr>
<tr>
<td>Aboriginal Prisoners</td>
<td>34</td>
</tr>
<tr>
<td>Juveniles</td>
<td>36</td>
</tr>
<tr>
<td>Can Suicide be Eliminated?</td>
<td>37</td>
</tr>
<tr>
<td>Coroners</td>
<td>38</td>
</tr>
<tr>
<td>Prison Officers</td>
<td>39</td>
</tr>
<tr>
<td>Transfers</td>
<td>40</td>
</tr>
<tr>
<td>Files</td>
<td>41</td>
</tr>
<tr>
<td>Documentation and Accountability</td>
<td>42</td>
</tr>
<tr>
<td>Research and Collection of Data</td>
<td>45</td>
</tr>
<tr>
<td>Findings and Recommendations</td>
<td>47</td>
</tr>
</tbody>
</table>
The Committee to review suicide and other self-harm in Prisons was established by the then Minister for Justice, The Honourable Wayne Merton MP in February 1993. Up to that time the Department of Corrective Services had conducted a number of in-service studies into suicides within its system, and had had recourse to research undertaken in other states and countries. The appointment of this Committee constituted the first independent, extramural inquiry into the problems mentioned. The Committee commenced its activities in April 1993. During its investigations a change of Minister occurred when John Hannaford MLC assumed the responsibility for Corrective Services. He directed that the work of the Committee continue. This task was completed shortly after 30 June 1993, but preparation and printing of the Report was delayed somewhat by the necessary absences of some of its members. The Report is based on observations made and material collected for the period ending on 30 June 1993.

This work was commissioned by the Minister for Justice who has the responsibility for the running of prisons, but the terms of reference, referring as they did to "at risk" inmates with deliberate self harm tendencies dictated that the Committee inquired closely into the relationship between prisoners and officers of the Prison Medical Service, and the adequacy of the treatment and management of prisoner-patients by that Service. The Prison Medical Service is administered by the Department of Health, whose Minister is politically responsible for its operations. By necessity, the substance of this Report will intrude into areas under the control of the Minister for Health.

So far as suicides are concerned, the number occurring in the first six months of 1993, two, is within the range of expectation, and the suicide rate compares favourably with that of comparable Western countries. Nevertheless, the Committee has identified several areas which, if addressed as recommended, may well result in even fewer deaths.

The subject of self-mutilation falling short of suicide has also been scrutinised, although this examination was hampered by the fact that figures have only recently begun to be collected by the Department. Techniques directed to reducing the "reward" element inherent in much of this type of activity are discussed.

The Committee recognises the complexities involved in attempting to control episodes of self-harm in a custodial situation, and supports the initiatives already introduced by the Department of Corrective Services in an endeavour to meet the difficulties. The implementation of unit and case management practices, the new screening procedures at reception prisons and the establishment of the Crisis Support Unit are among these praiseworthy developments.

The compiling, presentation and communication of proper records are the subjects
of several recommendations of the Committee. The importance of the prompt transfer of the history of a prisoner when the prisoner is himself transferred has been long neglected within both the Department of Corrective Services and the Prison Medical Service. New protocols must be set in place. The impending transfer of a prisoner is often seen to be a precipitating factor in a suicide. Transfers should be kept to a minimum. The Committee believes that there is a need to extend the medical, psychiatric and nursing services available to prisoners. Other recommendations have been made in the fields of prisoner screening, observation of "at risk" inmates, prison construction, women prisoners, training of prison officers and data collection. The text of the Report contains many further subjects which need to be addressed in the future. Statistical material is displayed at length, and there are comments with regard to Aboriginal prisoners and juvenile detainees.

It is the opinion of the Committee that implementation of its recommendations will go a considerable way towards the lessening of tensions within the prison system, will provide much improved health services to prisoners, will support Departmental initiatives towards improving the interpersonal relationships between prison officer and prisoner, will enable the more prompt identification of prisoners at risk, and will contribute to a lowering of the incidence of suicide and self-harm in goals.
INTRODUCTION

Of necessity, the terms of reference for this review were appropriately broad. It was recognised that in order to assess the occurrence of deliberate self-harm within the institutions of the Department of Corrective Services in New South Wales, it was necessary to examine many of the complex factors which may ultimately find expression in acts of deliberate self-harm. With this philosophy in mind, the Review Committee was able to meet with a wide range of personnel and to examine closely a similar wide range of services and activities within the Department of Corrective Services.

On review of the files of those gaol inmates who had suicided in the past three years, it was apparent that there was seldom a simple or single predetermining factor involved. Instead, each suicide could be seen to have occurred on the basis of complex and often subtle interactions between that inmate, the inmate population, the institution and its staff, and the outside community as it related to that inmate.

Initiatives by the Department of Corrective Services to limit incidents of deliberate self-harm range from specific and practical measures pertaining to cell accommodation, to much less direct interventions such as alterations in management structures or even changes in the basic philosophy concerning the well-being of inmates. As one moves away from direct practical interventions, it becomes increasingly difficult to conceptualise and then formulate policy and procedures which are aimed to decrease the incidence of self-harm overall.

In the community at large, acts of self-harm occur universally. Their frequency varies in different societies and these differences have been closely examined over many years. A large body of data exists which gives us useful predictors for suicide in specific societies, and the gaol society can be seen as one of these. Within gaols there are many basic differences concerning fundamental issues, the most obvious of which is lack of personal liberty. Another important reality is that one is dealing with a particularly impeded and impaired section of the population. The gaol population is dominated by those whose education is poor, whose literacy and numeracy are likewise poor, whose family and domestic experiences have been turbulent and disrupted and whose capacity to communicate distress, seek help and make adaptive changes in the face of adversity, seems to be distinctly limited. This group is then involved in a physical environment where privacy is minimal, the place of the predator and manipulator ranks high in the hierarchy and where the senses of empowerment and autonomy are severely curtailed. Together with the degree of impulsiveness which is evident amongst the inmate population and other complications such as drug and alcohol
impairment, one is struck by the many risk factors associated with deliberate self-harm, which are present amongst the inmate population. In contrast to this, it is of note that the actual number of suicides is surprisingly low in this population. The most significant protective factor seems to be that of the controlled environment in which imprisonment occurs. The active application of departmental policy also plays a significant role in providing alternatives to vulnerable individuals within the system. The current procedures for protecting those who are at risk from acts of deliberate self-harm rely heavily upon identifying risk factors. The inherent weakness is that the reporting is highly subjective and it is made to people who may not have the necessary clinical skills or judgment to decipher the meaning of the communication made. A brief example of this is that of the interview on reception. At that time an inmate may be new to the system, highly anxious and loath to disclose any vulnerabilities to anyone. Those naive to the system would not readily differentiate Health personnel from Corrective Services personnel and may believe it in their best interests to say little to anyone. On the other hand, those who are overwhelmed by the present situation may communicate their distress in such a way as to provoke a punitive attitude towards them or to be singled out for victimisation by other inmates. This phase of imprisonment is by all accounts a highly charged time and assessments made at that time can vary dramatically from day to day. It is at this time that particular expertise is required. It is also at a time when least is known about a particular inmate and there are likely to be rapid movements from the reception area into other parts of the gaol system.

It can therefore be seen that despite careful attention to procedures to identify those at risk, there are problems within the system which are best understood in terms of human resources and in terms of expertise. Experience amongst prison officers plays a major role in delivering services which can be impressive. Experience however is not enough and this has to be coupled with adequate training and an opportunity to develop skills in a manner which is in keeping with the overall strategic planning philosophy of the Department of Corrective Services. There is a section in this report which deals specifically with the initiative to develop unit and case management practices throughout the Department.

Within the realm of philosophy and attitudes towards the well-being of inmates, one must take into account the anachronisms and aberrations which are part of the prison culture. Intrinsic to the institutions is the conflict which must arise between prison officers and inmates. Both groups are caught in a clash of subcultures. At present the fundamental components required to resolve conflict-laden situations do not readily exist. Nevertheless, there is clear indication that this situation is changing and there is further evidence that departmental policy-makers understand the necessity to enhance communication and mutual trust between inmates and prison officers.
In the public mind, a death in custody differs from other deaths in a number of significant ways. The first major difference is that when somebody dies in custody, the shift in responsibility moves away from the individual towards the institution. When the death is by deliberate self-harm, the responsibility is seen to rest largely with the institution. By contrast, a civilian death or even a suicide is largely viewed as an event pertaining to an individual. The focus there is far more upon the individual and that individual's pre-morbid state. It is entirely proper that any death in custody, from whatever cause, must be meticulously examined. Imprisonment with all of its encumbrances, must be known to contribute only in the smallest possible way, if any, to any act of deliberate self-harm. The blaming of institutions for the death of their inmates by the media is not to be confused with the truth. This reality is not always appreciated and results in the repeated need for institutions to exonerate themselves from any perceived role in the death of their inmates.

It may be that this process is required by the community in order to demonstrate that there is ongoing monitoring of the way in which we, as a society, incarcerate some of our members. This position may further be supported because we have, as a society, rejected the practice of capital punishment. When an individual dies in custody, it must be demonstrated that that person's death did not result from the practices of incarceration. Given the difficulties faced by anybody deprived of liberty, it becomes of the utmost importance that society is repeatedly reassured that its practices are humane. This process can best be served by striving to achieve the impossible goal of having no suicides or acts of deliberate self-harm in gaols.

The culture of prison itself does not easily lend itself to communication about personal vulnerability. When distressed or suicidal inmates are identified there may not be the resources or facilities to respond adequately to them. It means that distressed people are sometimes dealt with by a system which is structured to deliver discipline rather than to promote emotional well-being. More subtle issues such as the attitudes of prisoners themselves towards prison officers and vice versa may impede the intervention programs that have been designed. Cultural, religious or judgmental issues may affect the actual reporting and the response to suicidal cues. These communications are currently sometimes too difficult to monitor in a gaol system which at present is only beginning to structure itself along the lines of unit and case management philosophies.

Vulnerable individuals within the gaol environment may lack the wherewithal to communicate their needs. They may have little experience in gaining access to assistance, particularly for emotional problems, or may lack the communication skills required to do so. It is also likely that at the times of greatest potential distress, individuals may be naive to the gaol system, be recently incarcerated or be overwhelmed by their new surroundings. All of these phenomena play a part in making it difficult to apply the usual civilian suicide prevention practices within the gaol system.
Differentiating threats or acts of suicide from deliberate manipulation is never entirely accurate. A useful notion about threats or acts of deliberate self-harm is to view these as behaviours which occur when that individual's capacity to communicate or negotiate more appropriately has become exhausted. This view covers those acts which can be seen as clearly suicidal in their intent as well as those which, in retrospect, turn out to have been largely manipulative. It should be noted that at the time of an act of deliberate self-harm, or a threat, that individuals may not be clear in their own minds as to what their actual objectives are. They may not be sure whether they actually do want to kill themselves or whether there are other, less clearly defined motives present. Of importance is to understand that each entity constitutes a communication. Furthermore, the sooner it is received and interpreted the better. The actual process of responding, in some way, not necessarily the way the individual intends, may constitute the most effective form of intervention at that time.

It is with an understanding of these many complicated and interrelated issues that the Review Committee approached the task of evaluating the practices for the prevention of deliberate self-harm within the New South Wales prison system. It is understood from the outset that simple and single solutions are not likely to be of much value but that it could be helpful to approach the problem from an appropriate philosophical and practical standpoint so as to arrive at recommendations which would aim at facilitating those ongoing positive initiatives which are currently part of departmental policy.
THE PROBLEM

No doubt there have been suicides in prisons ever since the construction of the first dungeon. There is no evidence that they ever aroused much public concern. In the not so distant past, the numbers of suicides of persons in custody were so small as to pass virtually unnoticed. The following figures represent inquests heard in Sydney during the 1970's of persons who died in both prison and police custody -

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>nil</td>
<td>nil</td>
<td>nil</td>
<td>1</td>
<td>4 (one female)</td>
<td>3</td>
<td>2</td>
<td>1</td>
</tr>
</tbody>
</table>

Figures supplied by DOCS indicate the actual number of suicides in gaols throughout the State to be six in 1977/78, two in 1978/79, four in 1979/80 and one in 1980/81. In 1983/84 the number jumped to nine, and in 1987/88, when a world-wide escalation of deaths in custody was noted, there were ten deaths by suicide in the prisons of this State. In the year 1987 an outcry by Aboriginals and people speaking on their behalf, supported by huge publicity in the media, to the effect that Aborigines were dying in custody in numbers wholly disproportionate to their incarceration, led to the formation of the Royal Commission into Aboriginal Deaths in Custody. It eventuated that no Aboriginal persons had died because of criminal activity by gaolers, and that Aborigines were not over-represented in the custodial deaths, which were in near proportions to their custody populations. What the Royal Commission did prove was that Aborigines were grossly over-represented in their numbers in custody compared to their 1.5% makeup of the total Australian population.

The prison suicide rate during the years 1980-1985 for the whole of Australia was measured by Hatty and Walker in "A National Study of Deaths in Australian Prisons". The Northern Territory had the highest rate, at 1.9 suicides per 1000 prisoners per year, followed by Victoria at 1.8, New South Wales at 1.6, Queensland 1.5, South Australia 1.2 and Western Australia 1.1. A subsequent comparison from within the Department of Corrective Services for the years 1982/83 to 1991/92 showed a suicide rate of 1.99 for N.S.W. prisoners, 1.81 for those of Victoria and 1.38 for Queensland inmates. Victoria managed to reduce suicides in their penal system to nil for the years 1989/90 and 1990/91. There was one suicide in 1991/2 and there have been two suicides in their prisons in this current year. The daily average gaol population of Victoria is much lower than that of N.S.W., at about 2000 per day, or 30% of ours.

Coroners statistics show that there were 11 suicides in the N.S.W. gaol system in 1989, 8 in 1990, 5 in 1991 and 7 in 1992. These figures represent suicide rates per one thousand prisoners of 2.37, 1.60, 0.88 and 1.15 respectively.
To 30 June 1993 there were two deaths by way of prison suicide, a rate of 0.65.

In light of the fact that the rate of suicides in the system has been decreasing, it is of interest as to just why this committee was established. Concerns as to recent deaths in custody, not all involving suicide and not all occurring in prisons, were expressed by the Opposition in Parliament, and were highlighted in media reports. Newspapers seem to take delight in sensationalising death in custody and other prison issues. The Committee noted substantial articles appearing in Sydney newspapers on events in prisons this year on 7 January, 26 February, 7 March, 20 March, 25 March, 12 April, 17 April, 23 April, 5 May, 12 May, 25 May and 6 June. The concerns expressed do not seem to reflect those of the general community, as far as the Committee could ascertain.

However, an investigation into self harm in gaols is certainly justified on humanitarian grounds alone, and is supportable as being part of the significant amount of research being conducted in the western world upon the themes of prison suicide and self mutilation, and staff-inmate relationships. The Department of Corrective Services guided by its Minister is in the process of developing innovative management strategies to deal with prisoners, especially those who might harm themselves. The then Minister the Hon Wayne Merton MP was desirous of testing the theory and practice of these new procedures by reference to a committee independent of the Department and of the Government. Following a parliamentary reshuffle the Hon John Hannaford MLC became Minister for Justice with responsibility for prisons. He directed that the Committee continue its deliberations.
THE COMMITTEE

The then Minister for Justice the Hon Wayne Merton MP contacted the chairman in February, 1993, asking whether he would head a committee to be formed for the purpose of examining procedures which may better identify prisoners likely to harm themselves. Upon the chairman's acquiescence the Minister issued a press release on 25 February announcing "a package of measures designed to prevent suicides in the N.S.W. prison system", and also the establishment of "an independent three-person committee, chaired by former State Coroner Kevin Waller, to review all aspects of suicide prevention strategies in N.S.W. prisons".

On 16 March 1993 the Minister wrote to the chairman noting his agreement to act, and advising that the other members of the committee would be Dr Michael Diamond FRANZCP, and Major Errol Woodbury of the Salvation Army. Dr Diamond is a psychiatrist in clinical practice at the Northside Clinic, Director of PostGraduate Training in Psychiatry in the South-West Sydney Area Health Service, and Consultant to Sections within the N.S.W. Police Service and the Federal Attorney General's Department which deal with high risk policing and hostage negotiation. Major Woodbury is one of three Senior Chaplains with the Police Service, and is the Public Relations Secretary of the Salvation Army.

The Committee met for the first time on Monday 29 March 1993. We were handed Terms of Reference as follow :-

TERMS OF REFERENCE

REVIEW - DELIBERATE SELF HARM PREVENTION
MEASURES

DEPARTMENT OF CORRECTIVE SERVICES

1. The review team is to examine:

   a) The identification processes for those with deliberate self harm tendencies during reception procedures;

   b) Documentation from all sources;

   c) Subsequent handling of documentation identifying those at risk within institutions;

   d) Projected strategies for handling of "at risk" inmates and assess effectiveness; and

   e) Any other matters considered relevant
2. The review team is to make recommendations for the rectification of identified shortcomings in procedures and material measures to minimise the risk of self harm. As far as possible, such recommendations should be achievable without major changes to the existing budget.

3. Recommendations are to be forwarded to the Minister for Justice by 30 June 1993.

The committee convened 12 times during its deliberations. It was handed a mountain of reading material by the Department, augmented by publications produced from its own sources. Those of particular significance were considered to be -

- Review of Suicide and Suicide Attempts by Prisoners in Victoria, by Professor Richard Harding (1990)
- Deaths in Australian Prisons, Hatty and Walker (1986)
- Case files of prisoners who suicided.
- Reports of coronial inquests.

The Committee visited a number of institutions during the course of its investigations, some more than once. These were

- Prison Hospital, Long Bay
- Reception Centre, Long Bay
- Special Care Unit, Long Bay
- Goulburn Training Centre
- Kirkconnell Prison Farm
- Mulawa Women 's Prison
- Cessnock Correctional Centre
- John Morony Correctional Centre, Windsor
- Minda,
- Corrective Services Academy, Eastwood.

Interviews were conducted with the Superintendents of these establishments, plus prison officers, welfare officers, education officers, psychologists, Drug and Alcohol Program staff, education officers, registered
nurses and prisoners.

Assistant Commissioner Operations Mr R. Woodham was interviewed at length, as was Dr Tony Sara, the Director of the Prison Medical Service, together with other senior officials both past and present. The Chairman attended the Conference on Suicide in Custody at the Hilton Hotel on 2/3 June 1993.
STATISTICS

The committee decided to collect and collate figures for the nineties, i.e. from 1 January 1990 to 30 June 1993, a period of 3½ years. The results have been compared with the Australia wide surveys of Hatty and McDonald covering 1980-1985, and the Royal Commission into Aboriginal Deaths in Custody, 1980-1988. We have also looked at the study of N.S.W. figures done by Dr T.O. Clark for the year 1989.

Numbers

1987 was a particularly bad year for deaths in custody, noted both in Australia - "In 1987 there was a drastic increase in both Aboriginal and non-Aboriginal deaths (from all causes) in prisons" - Royal Commission Research Paper 10, and overseas - "1987 was by far the worst year to date for suicides in prison in England and Wales" (Dooley).

In New South Wales there was again a relatively high number of 11 deaths by suicide in 1989, but the numbers then reduced to 8 in 1990, 5 in 1991, 7 in 1992, and there were two deaths to 30 June 1993, a total of 22 deaths in the 1990’s.

Gender

Every suicide was male. Males outnumber females in the prison system by about 20 to one. In the normal population, Males commit suicide about three times more often than females.

Age

None of the 22 was under 18 years of age. There was one additional hanging not included in these figures of a boy aged 17 in 1990, when juvenile institutions were controlled by another government department. Note that 70% of gaol inmates are under 30 years of age.

Aboriginality

Only one of the 22 was an Aboriginal. Aboriginals were thus under-represented in the statistics, which is consonant with findings of the Royal Commission that in the period 1980-1988 there were eight Aboriginal deaths in custody by hanging, compared with 100 non-Aboriginal such deaths.
The Rate of Suicide

The rate of suicide in Australian prisons for the years 1980-1985 was 1.6 per 1000 prisoners (Hatty and McDonald). In the abnormal year 1989 the N.S.W. rate rose to 2.37 (Clark). Following a diminution in the numbers of suicides and an increase in gaol populations, the N.S.W. rate has been considerably lowered, as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>1.6</td>
</tr>
<tr>
<td>1991</td>
<td>0.88</td>
</tr>
<tr>
<td>1992</td>
<td>1.15</td>
</tr>
<tr>
<td>to 30.6.1993</td>
<td>0.65</td>
</tr>
</tbody>
</table>

based on average daily prison populations as follow:

<table>
<thead>
<tr>
<th>Year</th>
<th>Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>5002</td>
</tr>
<tr>
<td>1991</td>
<td>5712</td>
</tr>
<tr>
<td>1992</td>
<td>6056</td>
</tr>
<tr>
<td>1993</td>
<td>6125</td>
</tr>
</tbody>
</table>

The average rate of suicide over the past 3.5 years has been 1.07. Suicide rates for overseas countries for 1992, as supplied by DOCS were:

- England and Wales: 0.56
- Scotland: 0.52
- Italy: 0.8
- Whole of Australia: 0.9 - 1.8
- U.S.A.: 2.0

The New South Wales rate for the past 3.5 years has been superior, in terms of fewer suicides, to the whole of Australia, and about half that of the U.S.A. The current rate in 1993 is the equivalent of the best of the above rates, any small difference being insignificant. It must be remembered that the numbers are so small that an addition or subtraction of one or two deaths can mean a substantial variation in rates.

According to Professor Robert Finlay-Jones, of the University of N.S.W. Department of Forensic Psychiatry, the N.S.W. rate over the past "couple of years" represents 3-10 times that in the general community. As the prison community is largely male, young, suffering personality disorders and psychiatric illnesses, and inmates are under personal, family and environmental stresses, this is hardly surprising. Many prisoners have been drug and/or alcohol abusers, which is considered another risk factor where suicides are concerned.
Status

Fourteen suicides were sentenced prisoners (63.6%) and eight were remand prisoners (36.4%). The normal proportion of remand prisoners in a gaol is 13%. Remand prisoners are therefore over-represented in the figures for suicide, although not to the same extent as in England, where it was found in 1987 and 1988 that no less than 74% of suicides were on remand (Dooley). Hatty and McDonald found that remandees and persons unfit to plead were grossly over represented in the Australian statistics. Our findings do not support such extreme statements. Nevertheless the fact that a prisoner is on remand is obviously to be taken into account as a possible risk factor.

Note that none of the suicides was in periodic detention and none was in prison solely as a fine defaulter.

Method

Hanging was the method much preferred, totalling 20 of 22 suicides. One inmate died of blood loss following cut wrists, and one suffocated himself with a plastic bag.

Place of Incarceration.

There was no particular institution where it could be discerned that suicide was more probable than any other. The figures show suicides at

- Bathurst 2
- Goulburn 2
- LB Hospital 2
- Maillard 2
- Cessnock 3
- Grafton 1
- LB Industrial 1
- Parklea 1
- Cooma 1
- LB Remand 1
- LB Assessment 1
- P'matta 3
- LB Reception 2

Hatty and McDonald found that maximum security gaols were grossly over-represented in the numbers.

Type of Offence

Eight were in prison for an offence of non-violence (41%) thirteen for an offence of violence (59%) with one unknown.

Length of Sentence

The length of sentences imposed upon convicted prisoners who suicided were as follows:

<table>
<thead>
<tr>
<th>Sentence Duration</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-3m</td>
<td>1</td>
</tr>
<tr>
<td>4-6m</td>
<td>-</td>
</tr>
<tr>
<td>6-12m</td>
<td>1</td>
</tr>
<tr>
<td>1-2y</td>
<td>5</td>
</tr>
<tr>
<td>2-5y</td>
<td>1</td>
</tr>
<tr>
<td>5 yrs+ Life</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>14</td>
</tr>
</tbody>
</table>

12
Hatty and McDonald found that persons sentenced to life imprisonment were not over-represented in suicides. The numbers are too small to compare.

Time in Custody before Suicide

Hatty and McDonald found that the period following reception is most critical, in that 50% of suicides occur within the first three months of a sentence. Our figures show the period the prisoner was in custody before suicide following his initial reception into prison, either as a remandee or sentenced person, (or both,) was --

<table>
<thead>
<tr>
<th>Time</th>
<th>0-24h</th>
<th>1-2d</th>
<th>3d</th>
<th>4d</th>
<th>5d</th>
<th>6d</th>
<th>7d</th>
<th>8d-14d</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>15d-1m</td>
<td>1</td>
<td>3</td>
<td>6m</td>
<td>6</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>22.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Twelve out of 22 suicided within 3 months of their entry into the system. A recent reception into prison is therefore another possible risk factor.

Age at Death

The average age was 29 years; youngest 18, eldest 57.

<table>
<thead>
<tr>
<th>Age</th>
<th>18-19y</th>
<th>20-25</th>
<th>26-30</th>
<th>31-40</th>
<th>41-50</th>
<th>51+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>9</td>
<td>4</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>22.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Seventy percent of inmates are under 30, and 72% of suicides were 30 years old or younger.

Month of Death

The 1993 figures were not included, as only half the year had passed. The 1990-1-2 statistics were

<table>
<thead>
<tr>
<th>Month</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
<tr>
<td>Total</td>
<td>20.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

By way of comparison the 1989 figures were -

<table>
<thead>
<tr>
<th>Year</th>
<th>1</th>
<th>-</th>
<th>1</th>
<th>-</th>
<th>-</th>
<th>2</th>
<th>2</th>
<th>1</th>
<th>1</th>
<th>2</th>
<th>1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>11.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
There is no discernible pattern. Hatty and McDonald wondered, tongue in cheek, whether there was any astrological significance in the suicides, Virgo being an over-represented birth sign in their statistics. This preponderance did not carry through in our study.

First time in an Institution?

It is believed that first-time prisoners are more at risk of suicide. A prisoner who previously had been detained in a juvenile institution was NOT regarded as a first time confinee. Hatty and McDonald found that those who suicided appeared far more likely to have not been imprisoned before, although their calculations showed an 48% unknown category. Our numbers were

First time Yes 5, No 15, unknown 2.

About 25% of suicides were first time prisoners. Again this indicates a risk factor. However, our figures were not as high as Dr Clark's 1989 paper, which showed that 5 out of 11 suicides had "no previous convictions".

Was the Prisoner facing an impending Transfer?

Yes 5; No 17.

Again the Committee sees this as a possible risk factor, even though Mr Woodham tells us that it has been normal for as many as 17,000 transfers to pass through the system annually. This subject will be addressed elsewhere in the report.

Had the Prisoner been recently Transferred?

Yes 2; No 20.

Did the Prisoner share a Cell?

Yes 2; No 20.

It is unusual, but not unknown as the figures demonstrate, for a prisoner to be sharing a cell when he takes his life. All hangings examined by the Royal Commission occurred in single cells. These were, of course, deaths of Aborigines, and it has been the policy for some time that Aboriginal prisoners be housed in shared cells where possible. This is sound policy.

One would expect that few prisoners would attempt suicide whilst sharing. There were several suicides in our sample which happened on the same night that a prisoner's cellmate left, either because he was released from custody or the suicide had requested that he be placed in single accommodation. It is considered that these circumstances merely facilitated a suicide already under contemplation, and were not the cause of a suicide.
Was the Prisoner in Segregation?

Yes 5; No 17.

We received one or two complaints about the use of segregation as a tool of punishment. This statistic would seem to prove that segregation constitutes another risk factor, despite the fact that each prisoner in segregation is case-managed. The Committee did not have the opportunity to study alternative forms of punishment, but merely notes the factor as relevant.

Likewise we were unable to isolate the number of prison suicides who were on protection at the time they took their own lives. The filing system did not permit easy resort to that sort of information, which should be part of a special document at the head of each file. See the later section on prison files. Some 1200 prisoners out of 6100 are usually on protection, an extraordinary number.

Item used in Hanging?

They were - sheet 7, blanket 3, towel 2, cord 2, T shirt, jacket, belt, wire coat hanger, webbing, one each. Total 20.

Was a Suicide Note left?

Suicide may not be presumed. It must be proved by the evidence. The circumstances surrounding the death, of course, provide some evidence, but statements of intention are very important. A note was located in 5 cases out of the 22 deaths.

Did the Suicide have a History of Psychiatric Treatment?

According to Professor Finlay-Jones 10% of prisoners suffer a severe psychiatric illness, and many more have severe personality disorders. We were able to find eight cases who had undergone psychiatric treatment, nine who had not, and five were unknown. A known psychiatric history is another indicator of the possibility of self harm.

Was the Deceased known to have Attempted or Threatened Suicide in the Past?

This is, of course, another strong indicator of suicide. Professor Finlay-Jones has said that a person who attempts suicide is ten times more likely to eventually succeed than a person who has not done so. Our inquiries showed that 13 had attempted or threatened suicide before completing the act; eight had not done so, and one was unknown.
Did the deceased Prisoner have a record of Escaping?

Our findings - Yes 5, No 15, unknown 2.

This is in stark contrast to the findings of Hatty and McDonald, whose study showed that only one suicide out of 50 was an escapee. Our figures show that a history of escaping or attempting to escape from gaol is a possible risk factor in assessing the likelihood of self-harm. In 1992 no less than four out of seven suicides had a record for escaping from lawful custody.

Miscellaneous

The finding of Hatty and McDonald that a large proportion of suicides had been returned to prison for breach of parole was not apparent in our examination. We did not look into the birthplaces of the deceased prisoners, but the impression gained was in agreement with Hatty and McDonald that there is no significant difference between the suicides of Australian born prisoners and those born elsewhere. Victorian Professor Paul Mullen spoke at a Conference of the "clustering" effect in prison suicides. In 1989 nine out of eleven suicides occurred in the second half of the year. In 1990-2, 14 out of 20 suicides occurred in the first half of the year. We have observed that suicides do sometimes happen in smaller clusters - for example 6 out of 8 suicides in 1990 occurred between January and May, all five suicides in 1991 happened between April and June, and three out of seven suicides in 1992 took place in November. What is unusual, though, is that there seems to be a clustering only as to time and not as to place.

There were no suicides in the 3.5 year period among women, fine defaulters or periodic detainees.

ADDENDUM

Following the collation of statistics to 30 June 1993 there was one further suicide in prison to the date of submission of the report, 25 August 1993. A male prisoner aged 32 hanged himself by means of a sheet in his single cell on 13 July 1993. He had been classified at Long Bay Reception Prison to go to Lithgow on the following day. The prisoner had been arrested on 4 February 1993 for break enter and steal, assault and attempting to escape from police custody. He was also charged with use of an offensive weapon and malicious wounding. He had been sentenced at Newcastle to 5 1/2 years gaol. He had a history for escaping, for attempting suicide and had undergone psychiatric treatment. He was a strict protection prisoner. He was not Aboriginal.
ALLIED TO THE PROBLEM OF SUICIDE IS THAT OF SELF-HARM BY MUTILATION. INCIDENTS OF THIS KIND ARE QUITE COMMON IN THE PRISON SYSTEM AND PRESENT GREAT DIFFICULTIES OF MANAGEMENT TO OFFICERS OF BOTH THE DEPARTMENT OF CORRECTIVE SERVICE AND THE PRISON MEDICAL SERVICE. NOT LEAST OF THE DIFFICULTIES IS THAT OF DIAGNOSING WHETHER THE SELF-INJURY IS MERE ATTENTION-SEEKING, OR IS AN INDICATION OF THE NEED FOR SUBSTANTIAL INTERVENTION, OR IS A GENUINE ATTEMPT AT SUICIDE. THE CURRENT APPROACH IS THAT ALL SUCH INCIDENTS ARE TO BE REGARDED AND DEALT WITH AS INDICATORS OF THE POSSIBILITY OF A REAL SUICIDE ATTEMPT IN THE NOT TOO DISTANT FUTURE, AND THIS APPROACH IS SUPPORTED BY THE COMMITTEE. THE SECONDARY GAIN ASPECT OF THIS BEHAVIOUR IS DISCUSSED IN THE NEXT CHAPTER.

SELF MUTILATION USUALLY TAKES THE FORM OF "SLASHING-UP", OR WILFUL CUTTING OF THE ARMS OR WRISTS OF THE PRISONER. SWALLOWING OF OBJECTS LIKE RAZOR BLADES AND METAL PIECES IS FORTUNATELY MORE RARE, AND HEAD-BANGING, REPORTED IN SOME OVERSEAS PUBLICATIONS, Rarer still. SUPERINTENDENTS ARE NOW REQUIRED TO REPORT SUCH INCIDENTS TO THE ADMINISTRATION. IT IS FELT THAT SOME OCCASIONS OF SELF-HARM MAY NOT BE REPORTED Owing TO THEIR APPARENT TRIVIALITY, BUT FIGURES COLLECTED SHOW THAT IN 1990 THERE WERE 119 SUCH INCIDENTS (43 AT MULAWA). IN 1991 THERE WERE 227 INCIDENTS (30 AT MULAWA). IT IS CONSIDERED THAT THIS LARGE INCREASE WAS DUE TO MORE WIDESPREAD REPORTING. THE 1992 STATISTICS SHOW 283 OCCASIONS OF DELIBERATE SELF-HARM, INCLUDING 47 AT MULAWA, AND THERE WERE 127 MUTILATIONS TO 31 MAY 1993, ACCORDING TO PROFESSOR FINLAY-JONES. THE RATE OF SELF MUTILATION IN GAOLS IS 20 TIMES HIGHER THAN THE SUICIDE RATE, AT ABOUT 50 PER 1000 INMATES PER YEAR, AGAIN ACCORDING TO PROFESSOR FINLAY-JONES.

REWARDS FOR SWALLOWING OBJECTS AND OTHER ACTS OF SELF-HARM MAY INCLUDE SELF-STIMULATION, EXIT FROM THE NORMAL PRISON ENVIRONMENT AND INCREASED ATTENTION FROM BOTH PRISON AND MEDICAL STAFF (KARP). MANIPULATION AND SUICIDAL INTENT ARE NOT MUTUALLY EXCLUSIVE (KARP 1991).)

THE WORST PLACES FOR SELF-HARM ARE MULAWA, LONG BAY RECEPTION PRISON AND THE LONG BAY HOSPITAL - PROFESSOR FINLAY-JONES.
THE QUESTION OF SECONDARY GAIN

Every act or threat of suicide causes the prison system to make some response. It is essential that the response should of itself not be an inducement to repeat such behaviour in any circumstances. Conversely it is also important that the system should be responsive enough to the threat so as not to overlook potential danger or disaster. In a system such as the prison system, the flexibility to respond to threats is curtailed. There is a strong need to maintain discipline and to ensure that matters of security are not overlooked. On the other hand the institution of an appropriate and prompt response to a threat of suicide will invariably be more effective than no response or frustrating responses. This dilemma confronts prison officers frequently in the course of their duties. There is no simple answer.

A useful approach in dealing with the above dilemma is to develop procedures or facilities which can rapidly and effectively deal with inmates who are expressing suicidal intent. These procedures or facilities need not be overly complex nor do they require expertise in excess of that shown by mature, experienced prison officers.

Within the system as it currently stands, an inmate has to make a gesture or threat of such magnitude as to establish either significant danger to himself/herself or others or to exhibit symptomatology which is in keeping with a psychiatric diagnosis. Many acts of suicide and threatened suicide are not as a result of psychiatric illness or of extreme dangerousness but are communications of distress or sometimes are an attempt to coerce others.

The system deals with these communications in a way where they are either validated or not validated. It is a difficult decision to make and it is often made by individuals who feel ill equipped to make the decision. There can be no blanket rule as to how every situation should be handled but the underlying suggestion is that there should be a very simple and predictable set of alternatives available at the time. These could include such activities as a brief counselling session with the inmate's case manager, removal to a quieter and less stressful environment within the wing itself or consultation with specialists from the gaol health team or from the Prison Medical Service. It is important to build as much flexibility and option into the system without turning every communication or threat of suicide into a special event. It would be useful for both inmates and prison officers to know very clearly what their options were every time a communication was made. It is also important for the inmates to know that their communication about suicide will result in something useful and not punitive, whilst at the same time the actual benefits of what is offered are not so great as to disrupt normal discipline or to create for them an extraordinary response. In order to maintain such a system it means that the reporting of threats of suicide should become part of the normal case management meetings. The overall strategy here is to demonstrate that it is acceptable to communicate one's suicidal feelings and a predictable and safe response is likely to ensue. It is also necessary that when behaviour or communication is seen to be unusual or especially disturbing that greater and more expert resources are drawn in but that these occurrences are few and far between.
Within each wing or in close proximity to the night supervisor’s accommodation, it would be useful to have a safe cell with visual access to the inmate. These special cells could be used for those prisoners who do not respond to the less dramatic and more routine intervention. The experience for them would be that they were under direct observation and able to make verbal communication with senior officers. For the inmate it would mean that his/her safety would be a high priority whilst a senior officer could more carefully assess his/her state over a period of time. It would also mean a lack of privacy and scrutiny over a lengthy period which in the longer term would not be entirely desirable from the inmate’s point of view. In other words, the secondary gain potential would be significantly curtailed.

Implicit within these considerations is the notion that inmates in gaols will from time to time harbour suicidal thoughts and some, a very small number, of inmates will attempt suicide. Whilst it is mandatory that every effort is made to ensure that this does not happen, it is inevitable that at some stage it will. It is incumbent upon those who run the gaols to demonstrate that due care and consideration is a part of normal practice but that when suicide emerges, it is dealt with in a calm and organised fashion. By having a repertoire of options, experienced prison officers can deal with the situation and assess dangerousness according to their experience and training without it generating undue crisis and thereby limiting the potential for secondary gain to those inmates who will exploit this scenario.
According to Hatty and Walker, "Unconvicted, violent offenders, with a history of previous suicide attempts or self-harm incidents, with psychiatric/psychological consultation during their current imprisonment, and who are in maximum security, are most at risk."

Suicide is commonly associated with depressive illness and alcoholism, a history of past psychiatric treatment and previous attempts at suicide (Kitchener 1992).

Prisons contain high proportions of persons at risk of suicide and self-harm - depression, drug abuse, heavy drinkers, males (Prof Finlay-Jones).

The Committee believes that it is not possible to present an accurate profile of a prisoner who is at risk of attempting to take his own life. Such a person may be young or old, on remand or sentenced, a short term or long term prisoner, or Caucasian, Aborigine, Chinese or Turkish. What we can do is set out those characteristics which have been found to be predominant in persons who have succeeded in killing themselves in gaol, as being symptomatic of the type of prisoner who may well attempt suicide. Those characteristics are:

The prisoner is:

- Male
- On remand
- Has been in custody for less than 3 months
- First time in prison
- Is facing a transfer
- In a single cell
- In segregation
- Has a history of psychiatric treatment
- Has threatened or attempted suicide in the past
- Has a record for escaping from custody.
- Has drug and/or alcohol problems.

Gaol authorities should also watch the "clustering" effect. A suicide occurring anywhere within the gaol system might well result in further attempts being made shortly thereafter.
The upsurge in deaths in custody, particularly suicides, in the latter part of the 1980’s triggered the Australian Royal Commission into Aboriginal Deaths in Custody and numerous examinations by State and overseas bodies and academics into the phenomenon. The Committee studied reports from Great Britain, New Zealand, Canada, the United States and the Netherlands dealing with suggested ways of reducing the incidence of suicide and other self-harm in prisons.

In 1992-3 the DOCS became active in seeking methods of achieving such a reduction. Much work was done and recommendations were made championing the implementation of many of the findings of the overseas studies. Foremost among the changes of direction was the decision to introduce the concepts of unit management and case management into the prison system. Under unit management each correctional centre is divided into defined areas, or units, each of which is under the control of a unit manager. Each unit is serviced by teams consisting of prison officers, Drug and Alcohol Officers, psychologists, welfare officers, education officers, and so on. Under the principles of case management, each correctional officer designated as a case officer will be given the responsibility of monitoring and documenting the behaviour of some 12-15 inmates. The officer periodically talks with and counsels each prisoner, and later discusses his reports at a unit management meeting, which is also documented.

This arrangement should lead to much closer interpersonal relationships between staff and inmate. The hope is that tension and conflict will lessen, and the environment will be less stressful for both prison officer and prisoner.

The Committee strongly supports the concepts of unit and case management. Greater communication between prisoner and prison officer should lead to the desired goals; and on a more practical level the Committee notes several cases of suicide where the prisoner has informed fellow inmates of his intention to kill himself, but neither he nor the person to whom he confided has passed on the information to correctional staff or to medical staff. Regular interviews between staff and inmates should lead to this sort of intelligence coming more readily to official notice so that there might be an appropriate intervention.

Such information should be documented, of course, when received. Likewise the result of the deliberations of the Case Management Review Committee should be in writing and on file. This requirement is designed to ensure that the case officers and managers are kept alive to the importance of this work, and to provide information for other staff in their dealings with the particular prisoner.

So far as administrators are concerned, the Committee wishes to emphasise the importance of the case management meetings, and that time must be allowed for the writing up of case notes. Concerns have been expressed to the Committee that the introduction of unit management and case management will meet considerable resistance by some inmates, and more importantly, by some of the
more experienced correctional officers. We have been told that officers may provide obstacles to the new approach by intimidating junior staff to prevent fraternising. While it is clear that the most senior levels of the Correctional Service are enthusiastic supporters of case management, the "trickle-down" effect to the lower echelons may be more difficult.

Commissioner Smethurst has said that "Those who are not committed to case management should look elsewhere for employment." Assistant Commissioner Woodham has given examples where the concept has been unexpectedly well received, and is optimistic for its future. The various superintendents interviewed by the Committee strongly favoured the new ideas. New recruits to the Corrective Services Academy are prepared for case management, and courses are provided there for the more senior officers. Training officers at the various prisons will provide on-the-job education about the new scheme.

While the Committee does not doubt that there will be pockets of resistance to change within the prison system, we believe that the goodwill and determination of the bulk of correctional personnel will ensure a wide acceptance of unit and case management. It is a project well worth trying not only to attempt a reduction in suicide and self-harm, but also to create easier and more humane management of prisoners for the benefit of inmates, staff and the community.

Screening upon Reception.

In order to more accurately identify prisoners at risk of self-injury, improved reception procedures were advocated in departmental reports. Upon reception prisoners are to be interviewed by a welfare officer or a senior prison officer, and the answers to questions relevant to the well-being of the prisoner recorded upon an appropriate form. The prisoner will also be seen by a member of the nursing staff, who will likewise record relevant information and observation. If the prisoner is then considered to be at risk, he will be referred to a suitable area for treatment, like the hospital or Crisis Support Unit, or be seen by a doctor, psychologist or psychiatrist. If a prisoner needs special care, a notification form is sent to the Wing Officer or Night Senior. This new system commenced in June, 1993, at the Reception Centre, Long Bay. The Committee believes that there should be a reduction in the number of suicides occurring within the first days of reception into prison as a result. The period immediately following reception has been described as the most critical (Hatty and Walker). The information collected will greatly assist the classification committee in its deliberations.

The Committee fully supports the new screening procedures, and recommends that they be introduced at all reception prisons as soon as practicable. The Committee further recommends that staffing arrangements be made to enable proper screening and referral in the evening to 11pm, and on Saturdays.
Placement Committee

A special placement committee was established in 1993 to ensure that inmates discharged from the Prison hospital are sent to suitable institutions. The Committee is in full support of this measure. We would additionally urge that in all cases the placement committee ensure that a proper discharge summary prepared by the hospital should accompany the prisoner to his or her next placement. This summary need not breach privacy considerations, but must contain all relevant information going to the health and safety of the prisoner, and which will alert the officers receiving the prisoner of material relevant to the inmate’s physical and mental health, and of any likelihood of self-injury.
THE CRISIS SUPPORT UNIT

In 1981 DOCS instituted a special gaol known as the Special Care Unit. This was conceived as a place for re-education, concentrating on attitude change and skills training for both prisoners and prison officers. The model chosen for the Unit was that of a therapeutic community in which prison officers were the therapeutic agents who would be responsible for the day-to-day programming, in consultation with psychologists, medical staff etc (Schwarz and Propper). The Unit opened in 1981. It was the first example of small unit management to be introduced into the N.S.W. prison jurisdiction.

In 1992 the decision was made to inaugurate a special place for people who were well enough to leave Long Bay Hospital but who were not yet psychiatrically and emotionally stable enough to be returned to general prison discipline; a sort of half-way house. Such a facility had been needed for some years. A specialised gaol was created, now known as the Special Care Centre, incorporating the Special Care Unit, for prisoners with behavioural and attitude problems, a Lifestyle Unit for HIV positive prisoners, and the Crisis Support Unit, the half-way house as mentioned above. The superintendence of this Unit was entrusted to Mr Michael Vita.

This Unit has been highly successful. The Committee congratulates the Minister and the Department for its initiative in this direction, and for devoting the considerable resources necessary for the introduction of the new service for prisoners. The Unit was favourably reviewed in an article in the Sun Herald of 7 March 1993. The recovering prisoners receive intensive care and supervision, and are nurtured until the risk of self injury is so reduced that they may return to ordinary prison life. A similar area known as the Hamilton Hume Unit has been put in place at Goulburn, and a unit on somewhat the same lines is being tried at Kirkconnell. It is generally agreed that there is a crying need for a therapeutic unit along similar lines at Mulawa, and this should be established by the end of 1993. The Committee is of the opinion that such a unit would work well at Cessnock. There are quite a lot of prisoners on protection at Cessnock, and to progress them through the unit might well allow many of them to return to normal discipline. The Committee believes that the existence of a therapeutic zone within a prison is a handy tool for management, as it allows more options to prison authorities when trying to assess the best course for dealing with a difficult inmate.
DOCS AND THE PRISON MEDICAL SERVICE

A continuous thread running through the Committee’s inquiries has related to the necessity of branches of two government departments, Corrective Services and Health, working in close contact in prisons. This type of amalgamation of departmental cultures often leads to problems. The clashes between Police and Fire Officers in Emergency Services activities a few years ago was solved only by dividing N.S.W. into zones and giving the various Emergency Services, including Ambulance, hegemony in each district. Over the years attempts have been made to bring the PMS under the umbrella of DOCS, but they have all failed. The Royal Commission into Aboriginal Deaths in Custody recommended that the PMS remain separate and apart from DOCS, and Dr Noel Wilton’s Report to the then Minister for Health, John Hannaford MLC, in August 1991, said likewise.

This Committee was not formed to make any recommendation about this issue, and we refrain from doing so. However, our inquiries have thrown up some problems which need addressing.

The cultures

DOCS exists primarily to keep prisoners properly secured. Everything else is subservient to this goal. Its systems have been developed to ensure that prisoners entrusted to its control remain in lawful custody. The Prison Medical Service, on the other hand, is patient orientated, and sees its role as catering to the health needs of the individual inmate. The report of Dr Wilton predicates the principle that “equality of service with that of the general community be reaffirmed as the guiding principle for health care in prisons.” The Committee believes this latter tenet to be somewhat unrealistic, but in any event the aims of each arm of service are so far apart that some conflict seems inevitable. The extent of cooperation between the factions is to at least some extent personality dependent.

Confidentiality

As part of its wish to treat inmates as though they were people of the ordinary community, the PMS some years ago adopted procedures to preserve confidentiality between PMS staff and prisoners. The Royal Commission originally supported this idea, but in its final report left the issue open. Meanwhile various N.S.W. coroners had criticised implementation of any such policy which deprived Prison authorities of important information regarding the health and well-being of prisoners. The N.S.W. State Coroner and Deputy State Coroner heard a number of inquests where the failure of PMS staff to pass on information about the health of a prisoner, or his likelihood to self-harm, were contributing factors in that person’s death. For a time Coroners held off making formal recommendations while awaiting the deliberations of the Royal Commission. The Westmead Coroner, Mr John Hiatt, then heard a series of inquests where failures to provide relevant material was a substantial element in some deaths of prisoners.

In the inquest into the death of prisoner Robert Redford Mr Hiatt criticised “a
system which separates the duties and responsibilities of the custodial staff from that of the medical staff in such a way that effective notice is not given to the custodial staff of any inmate at risk or in need of follow-up treatment or observation or special supervision”. In the inquest concerning the death of Bradley Rose he commented on the apparent breakdown in communication between the custodial services and the medical services, and said that a failure to warn of relevant details on grounds of confidentiality “would be clearly outweighed by the public interest that prisoners ought to be properly and safely incarcerated”. Those cases were heard in 1990, but there was no discernible success in endeavouring to coerce the PMS from parting with confidential information about prisoner-patients. In 1992 Mr Hiatt returned to the theme. In the inquest into the death of Mark Nicholls, he formally recommended that PMS staff should give “sufficient relevant medical information to the custodial officer then in charge of the prisoner to enable the proper and appropriate placement of the prisoner”. He also recommended that proper records be kept of telephone calls, and that a prisoner’s medical file should accompany him on any transfer.

The failure by the PMS to pass on relevant medical information over the past few years was most unfortunate. Other coroners made recommendations and comments similar to those of Mr Hiatt, but very little was achieved. The supposed principle of medical confidentiality remained paramount. There is no doubt that the rigid adherence to the principle contributed to some deaths. The stage was being approached where a nurse or doctor who refused to pass on matters which went directly to the health or safety of an inmate may have found himself or herself charged with a serious criminal offence.

It is now clearly established that DOCS and PMS personnel working with prisoners owe to those prisoners a duty of care. A wilful breach of that duty could lead, at worst, to the staff member facing a criminal charge of manslaughter, or at least to a civil action for damages based on negligence against the Department and possibly the officer concerned. The Committee has itself seen within the files cases where there has been a failure to inform.

It is pleasing to note that, even if belatedly, there is now a recognition among senior officers of both Departments that there must be a transfer of relevant information, and that the two arms of government must work together in the interests of the welfare of prisoners. The Health Services Board has been established. This Board will oversee the whole operation of the PMS and hopefully Senior DOCS staff will be on the Board which is chaired by Professor Ron Penny. Reception procedures at gaols will now ensure that incoming prisoners are seen by both DOCS and PMS people in order to determine the "risk status" of those prisoners. There is a move towards setting up "gaol health teams", i.e. multi-disciplinary groups which will meet and compare notes on inmates whom they have treated or counselled. We were told, and we accept, that there remains a modicum of hostility between officers of DOCS and PMS. Whilst it is likely that a difference in approach of the two bodies will remain inevitable, the Committee strongly urges that movement towards rapprochement continue, that the more the officers of both instrumentalities meet and work together the better, and that senior
continue to emphasise the necessity for co-operation and harmony among them.

It is considered among some PMS people that any official form passing on information about a prisoner should contain provision for the prisoner's consent or otherwise to this course. Privacy principles are thought to be at stake. It is the considered opinion of this Committee that it would be dangerous to adopt such a procedure. The consent of the prisoner is irrelevant. If the duty of care towards an inmate requires that material relevant to his health or safety be given to those responsible for his custody that material must be conveyed. To insert a piece dealing with the consent of the prisoner may mislead both the prisoner and the caregiver completing the form. It may result in the proper advice not being handed over. It may place a life at risk. This Committee strongly recommends that no such consent be sought or indicated in writing. There is no objection, of course, to the prisoner being informed verbally of the reasons for recording the material.

Health Services Board

Following the Report of Dr Wilton, the Health Services Board has now been established. This Board oversees the operations of the Prison Medical Service. It will monitor the operations of the Service, recommend changes and set policy. In order for it to operate at full efficiency legislation will be needed to confer the necessary authority. The Service is already somewhat underfunded, and more resources will be required if the board is to operate near top capacity, and if the Service is to provide adequate treatment and management of staff and prisoners.

The Committee supports the concept of the Health Services Board, and requests that it receive sufficient funding to ensure its success.

Long Bay Hospital

The Committee received a deal of information about Long Bay Prison Hospital, and many opinions as to how its services may be improved. The Hospital is running better now than at any time in the past, and its management of patients has been greatly improved by the creation of the Crisis Support Unit within the Long Bay Complex. Serious incidents within the Hospital are reviewed by a multi-disciplinary committee. There were many suggestions as to how the efficiency of the hospital and the services to prisoners could be improved. Here are some of them -

1. Doctors are needed at the Long Bay complex until 11pm on weeknights.
2. Doctors are needed there also on Saturdays.
3. D ward needs to be expanded.
4. Some diagnoses are done by telephone - indicating a need for night and weekend services.
5. Little diagnostic work is done at the Hospital. Most patients have to be transported elsewhere for this service.

6. There should be a formalised weekly meeting between the psychiatrist and the nursing staff.

7. Visiting Medical Officers at the Hospital should spend more time on training other staff.

8. There should be more use made of experienced psychiatric registrars.

9. More 'on call' doctors and psychologists are needed.

10. There should be another ward at Long Bay Hospital for respite.

11. A separate and secure psychiatric hospital is needed for proper, ongoing treatment of prisoners.

The Committee appreciates the need for these additional services, and appreciates also that the resources necessary to implement them may be difficult to procure. Nevertheless each proposal is worth consideration and could be prioritised for attention in the future. The Committee strongly supports the recommendation that doctors should be available at night and on Saturdays, a change which might well result in fewer self-harm incidents.

Goulburn

The PMS situation at Goulburn is seen as unsatisfactory. Nursing staff are on duty only five days per week. There should be an increase to six days. We were told that doctors will not visit Goulburn gaol. Any prisoner needing attention must be escorted to the local hospital. Doctors are not available at night. The Committee believes that investigations could be made as to whether it may be possible for registrars to attend the gaol, and possibly psychiatrists from Kenmore Hospital. The present situation has continued for some years, and it is time some positive steps were taken to establish a proper medical service for the gaol.

Other shortcomings

The Committee also received other complaints and advice to the effect that psychologists do not provide copies of their reports to psychiatrists; that the psychologists should be brought from DOCS into the Prison Medical Service (opposed by the Director of Psychological Services); that insufficient transport is available to take prisoners to medical appointments; that prisoners are sometimes transferred when medical appointments are pending; that every reception should be seen by a doctor; that correctional nursing should be a separate and recognised discipline; that each transfer of a prisoner should be accompanied by a PMS discharge summary; and that prisoners miss medical appointments because no
escort is available.

No time was available in which to investigate and determine the justification for most of commentaries. However, the Committee recommends that DOCS recognise that prisoners' medical appointments are important, and that staff should be provided for escort duties as needed, and that pending medical appointments are earnestly examined when a transfer is under consideration. We agree that every prisoner received should be seen by a doctor, and that each transfer should be accompanied by a PMS discharge summary.

The Committee thought that a better understanding between Departments may be attained by having PMS lecturers address DOCS personnel both during training and afterwards, and that perhaps similar undertakings could be carried out by DOCS speakers to PMS staff.

In the smaller institutions personnel from both departments work together harmoniously. The same spirit of co-operation must be pursued at the larger facilities.
TRAINING

The Committee was unable to spend much time in examining the training of Correctional Officers in relation to the prevention of suicide and self-mutilation, and the investigation of those incidents. We did attend the Academy and spoke to the Principal and other senior officers. We were supplied with training manuals. The training officers were enthusiastic about unit and case management, and we were satisfied that they would endeavour to pass onto new recruits and in-house trainees the virtues of these innovations.

The time allowed for training as regards suicides, two hours by the Academy and a one-hour lecture by a member of the Coronial Investigation Unit, was not great, but seemed adequate at this time.

It was suggested to us that the Academy should engage in proper data collection and devote time to research into penology and related fields of study. It was also put forward that the teachers themselves should spend periodical terms on active duty within prisons. The Committee thought that both of these ideas commended themselves for further consideration.

It was pressed on us that a “buddy” system, that is one where a senior prison officer becomes a mentor to a new officer, would reap benefits, particularly by preventing the more cynical senior men from undermining the new principles of unit and case management. We did not have enough evidence to determine whether this proposal is worth following up.

There is a substantial section of the Training Manual devoted to suicide awareness and how to deal with an attempted suicide, which seemed sufficient on examination.

The training of prison officers, has undergone some fundamental changes in the past few years. The entry point into training requires completion of the HSC. Additionally, the existence of the Department of Corrective Services Academy means there is now a focus for training throughout the state.

At the Academy, which is in its infancy, the necessary structures, training policies and procedures and teaching material are being assembled and upgraded continually. It is a training facility which requires adequate resources and which requires a position of status and value.

Since the Academy is now established as an entity and has consolidated its function within the Department, there may now be a time to look beyond its own personnel for resources both insofar as delivering, teaching and in creating education initiatives which are in keeping with the strategic planning which occurs at the highest level of the organisation. In this way there could be an ever-increasing level of expertise amongst the departmental personnel which could constitute a truly academic entity. The potential for this to generate an academic
presence which in due course could attract more skilled and more innovative personnel into the service should not be overlooked. This model has been embraced by the Prison Medical Service and the University of New South Wales who have a Chair of Forensic Psychiatry attached to the unit at Long Bay Prison Hospital. The presence of a credible academic figure and the associated research and service-oriented personnel could, in the long term, add valuable planning and development resources into the Department.
MULAWA WOMEN'S PRISON

Mulawa is unique among New South Wales prisons, and presents unique problems. It is the only correctional institution for women, with the exception of those who are temporarily housed in the Long Bay Prison Hospital or in the Special Care Unit at Long Bay or those at the Norma-Parker Detention Centre. Women prisoners are generally considered to be more difficult to manage than their male counterparts, and Mulawa is regarded by many prison officers as a workplace to be avoided.

It is anomalous to record that there has been no suicide at Mulawa for many years. As opposed to this encouraging statistic, women prisoners mutilate themselves at a higher rate than men. In 1992, 284 incidents of self-mutilation were recorded throughout the prison system, 47 of which happened in Mulawa; that is, 16% of self-injury happened in Mulawa, which accommodates about 4% of the State's prisoners. This may be only a reflection of what happens in the ordinary community, where men suicides outnumber women's by about three to one, while women are treated at hospital for "attempted" suicide at a much greater rate than males. Hanging is, of course, by far the most employed method of suicide in gaols, and within the general community is much more often used by men as a means of ending their lives than is the case with women.

At Mulawa there are in fact a multitude of hanging points throughout the institution. These may have been tolerated on the basis that women prisoners very rarely suicide. It is recommended though that future modifications to the buildings which comprise the gaol, and that any buildings to be erected for women prisoners in the future, should contain as few hanging points as possible.

An article in the Sydney Morning Herald of June 5, 1993, said that the number of women in the gaol have increased from 137 in 1982 to 330 in 1992. However, on our visit in April, 1993, the Superintendent advised that there were 210 prisoners at Mulawa on that particular day. (27.4.93). One problem with the institution is that all women prisoners go there-remand prisoners, long term, short term, maximum, medium and minimum security prisoners are all in the same area. There is no Crisis Support Unit. There is no inpatient psychiatric facility. When the new remand prison is erected at Silverwater in a couple of years' time there will be space allocated for women prisoners, and this is welcomed by the Committee.

It has been proposed by the DOCS that a new crisis, or therapeutic centre, along similar lines to that at Long Bay, be created within the Mulawa complex. The Committee strongly supports this initiative. The amount of self harm which is taking place within the gaol demonstrates that such a facility is urgently required. There should be regular visits there by psychiatrists. Problems have been experienced in the past in having persons scheduled under the Mental Health Act removed to a psychiatric hospital within a reasonable time. There are problems with mentally ill prisoners being locked in their cells for lengthy periods, and with correction officers trying to cope with them without sufficient training. The creation of a properly
staffed and visited therapeutic unit should alleviate many difficulties.

Special mention should be made of the methadone programme at Mulawa. On our visit we were informed that no less than 87 out of 210 prisoners were on methadone maintenance. This is a huge number. It leads to the suspicion that prisoners are being controlled by means of the drug. The figures relating to mutilation would not seem to support such an approach. The Committee was informed that women will injure themselves in order to be accepted into the programme. The methadone programme is supported within the Prison Medical Service on the basis that it reduces resort to heroin and other drugs involving needle-sharing which increase the possibility of HIV infection. The Committee does not seek to dispute this, but nor do we support the overuse of methadone within the prison system. It may be necessary in the future for an outside evaluation of the programme at Mulawa.

Dr Yvonne Skinner has suggested that there should be a follow up programme for women prisoners once they are released. Appropriate subjects would be mentally ill prisoners, prisoners with behaviour problems, women with a drug dependence, mothers, those without family support and those who might be subject to abuse. The Committee supports the implementation of such a programme.

It has been further suggested that Prison Officers appointed to Mulawa should receive special training, and this idea also found support within the Committee.

Prisoners received at Mulawa are subjected to screening, but no written record is kept of this process. Relevant information is given verbally to the Reception Committee next morning.

The Committee strongly recommends that each incoming prisoner be screened by both DOCS and PMS staff, and that the results are committed to paper, along the lines of the Long Bay Reception system.

Other problems have been raised regarding the imprisonment of women. They have their particular medical and obstetric needs, and are separated from their babies and other children. Opposition politicians have raised several of these points in the media (SMH 5 June 1993, 30 May 1993). This latter report stated that the NSW Ombudsman is investigating complaints about Mulawa.
ABORIGINAL PRISONERS

The Royal Commission into Aboriginal Deaths in Custody found that Aboriginal prisoners died, and committed suicide, at about the same proportion to their numbers in prison custody. Research Paper 10 said "Both in absolute and relative terms the evidence suggests that considerably more non-Aborigines than Aborigines were likely to be regarded as committing suicide in prisons". The study of Hatty and Walker found that Aboriginals are at no greater risk of suicide in prison than non-Aboriginals. These figures were for the whole of Australia. Separate statistics for N.S.W. for the period covered by the Royal Commission are not readily available. However, the trend noted is consistent with our findings. Since 1 January 1990 there have been 22 suicides in institutions under the control of DOCS, of whom only one was Aboriginal. In 1989 there were 11 suicides, of whom two were Aboriginal (juveniles included), so that for the whole period 1989 to 30 June 1983 there were 33 suicides, three of whom were Aborigines, i.e. about 9%. The current rate of Aboriginal prisoners is about 10% of the gaol population, so that equilibrium has been maintained.

That being said, it is clear that as the original inhabitants of Australia, Aboriginals claim to be entitled to special consideration, which has been afforded to them by most governments. The Committee has no quarrel with that attitude.

It may be of interest to note that for the period 1983-1987 a New Zealand study found that there were no significant differences in suicide rates between Maori and non-Maori prisoners.

There are no figures of the incidence of self-mutilations among Aboriginals in prison custody. However a Police study says that Aboriginals made up 24% of all "custody incidents", i.e. attempts at suicide, suicides and self-harm in Police cells.

At the request of the Minister's staff, the committee interviewed members of the Aboriginal Deaths in Custody Watch Committee, an unfunded and unauthorised group, which takes an interest in issues concerning Aboriginals in custody and their welfare. The chairman is Mr. Arthur Murray, and spokesman Mr. Ray Jackson. They expressed requirements that the rate of arrest and imprisonment of Aboriginal persons must be lowered; that the 339 recommendations of the Royal Commission need to be implemented in every area; that prisoners should not be kept in segregation "like animals"; that there should be less movement of prisoners; that separation from families is important to Aboriginals; that the policies of DOCS are not explained to the Watch Committee; that self-harm is seen by some frustrated Aboriginal prisoners as "the only way out", and that seven Aboriginal prisoners have been taken to Junee against their will.

This Committee acknowledged that Aborigines were arrested and imprisoned at a far greater rate than their percentage of the general population, which we understand is 1.5% for the whole of Australia, and 2% in New South Wales. The Police study showed that 16.2% of persons in lockups were Aboriginal, and their
custody rate in police cells was 1246 per 100,000 of the population compared with 79 per 100,000 of non-Aboriginals. However, it is not the role of this Committee to provide answers to that problem.

The Committee interviewed Ms Colleen Sutherland, Senior policy and Project Officer of DOCS dealing with Aboriginal matters. She advised that 64 recommendations of the Royal Commission had been isolated as affecting DOCS. Of this number, 41 had been implemented, 6 were being reviewed and 17 were in progress. She explained that it had been accepted that Aboriginals should have a voice in the Department, and to this end there had been established in March 1992 an Aboriginal Task Force which provides advice on policy, resources, directions and priorities concerning Aboriginal prisoners. Funds are obtained from the Federal Government to assist projects benefiting Aboriginals in prison. The Task Force consists mainly of known and respected Aboriginal members of the community, plus Ms Sutherland and Mr Ron Woodham, Assistant Commissioner. Ms Sutherland advised that the Corrective Services Academy does have a training officer who teaches aspects of Aboriginal culture. It is difficult to find trained and qualified staff from among the Aboriginal people themselves, but the aim is to recruit more indigenous officers in the future.

The Committee welcomes establishment of the Task Force and the efforts being made for Aboriginal prisoners.
JUVENILES

Juvenile detention centres are within the control of the Department of Juvenile Justice. Since the 1 January 1990 a number of juveniles hanged themselves in various places. In 1991 boys aged 16 and 17 hanged themselves in Tamworth Training Centre and Maitland Prison. In 1990 a 17 year old hanged himself at Bidura, Glebe, and in January 1991 a 14 year old girl hanged herself in Maitland Police Station. It is apparent that juveniles are at risk of taking serious self-injury action. There is no room for complacency. Information supplied to the Committee show that there were four self-harm episodes in Juvenile Justice Centres between October 1992 and March 1993. No serious injury was sustained.

The Committee visited Minda Centre during April, 1993. We spoke to Mr Ian Graham, Director-General of Juvenile Justice, other officers of his Department and of the Centre. We were presented with material relevant to the training of officers dealing with young offenders, and a document showing a high degree of compliance with the recommendations of the Royal Commission into Aboriginal Deaths in Custody. The Department has adopted a case management approach to dealing with detainees. Facilities are being upgraded and there is a high ratio of personnel to detainees. Self harm incidents are examined with appropriate seriousness and each incident looked at critically so that improvements in security and management may be made.

Inspection of the revamped security cells at Minda showed that there was a bar over each bed-end, about 65 cms above floor level. These constitute possible hanging points. The Committee believes that all new work should aim at reducing a hanging points to zero, and that it is unnecessarily risky to provide beds of this kind.

The Committee also believes that the Department could take steps to minimise the secondary gain achieved by those who harm themselves. This could be achieved by adopting the steps set out elsewhere in this report.

Otherwise it appears that the motivation of the Department to reduce tension with detention centres and to reduce the likelihood of self-mutilation is following the right paths, to the extent that completed suicides should become a rarity within the system.
CAN SUICIDE BE ELIMINATED FROM PRISONS?

"Suicide is probably impossible to prevent in men who have been in prison for more than a year, and who, without any warning, appear to take a rational decision to kill themselves." (Dooley 1990). Well known prison suicide, Bill Vandenburgh, who killed Mrs Kalajzich, fits this category.

"Even though all the steps to reduce the risk of suicide take place, an individual who is intent on committing suicide will likely be successful. Despite preventive measures, unique and bizarre suicides will occur." (Porter and Jones 1990).

"I believe that if a person is really determined to kill himself he will succeed, despite all the good intentions of those who see it as part of their job to prevent him." (Professor Finlay-Jones in his report on the death of Danny Lai, 1992).

"The real solution (to suicides in prisons) will always be found to be elsewhere, in broad social and economic changes." (SMH leader 7 January 1993).

The Committee accepts the opinions of the experts that it is not possible to entirely eliminate suicide from gaols. However, the Committee also believes, from studying the 22 cases in our survey, that an opportunity exists to substantially reduce the number. In retrospect, most of the suicides studied were preventable. Proper communication of risk factors between PMS and DOCS staff, and between inmates and PMS and DOCS staff, will enable timely intervention during the progress towards self-destruction. This sort of advice, and the implementation of the other recommendations made in this report, should diminish the level of suicides within the system to a bare minimum.
CORONERS

The role of the coronial inquiry has undergone an expansion. At one time its main task was to investigate whether the suicide might have been caused by ill-treatment or privation within the prison. Now the Coroner will examine the system for improvements in management or physical surrounds which may reduce the risk of suicide in the future.

Inquests into deaths in prisons are heard almost exclusively by the State Coroner or a Deputy State Coroner, and this practice may become a requirement of law by the end of 1993. Recommendations regarding prisoner safety made by a Coroner should be addressed promptly and earnestly, in order to avoid adverse publicity which may flow from a failure to take action by the DOCS or the PMS. The response of the DOCS to comments and recommendations in the case of the suicide of Anthony Rapson-Coe is a model which should be followed.

The Westmead Coroner deals with deaths in gaols within his catchment area.
PRISON OFFICERS

It was conveyed to the Committee that correctional staff is itself sometimes depressed and demoralised. They see many programmes aimed at improving the health and lifestyle of prisoners, while little is done for them. Alcoholism, it is said, is a common problem among officers. It has been pressed upon us that there is an urgent need for staff counsellors to care for DOCS staff.

While the introduction of case management techniques will hopefully improve the emotional environment of prisons, the Committee was sympathetic to the idea that staff counsellors be appointed to tend the needs of officers, and we recommend accordingly.
A recurring theme of complaint throughout the Committee's investigations was the high number of transfers which take place within the prison system. The complaints emanated from prisoners, prison officers, PMS staff and outside bodies. Pending transfers may well be a factor in prison suicides (see 'Statistics'). It is undeniable that stability promotes contentedness, and movement creates uncertainty and anxiety.

Assistant Commissioner Mr Woodham advised us that there were approximately 17,000 transfers per year within the system. The Committee believes this number to be excessive. Programmes mapped out for prisoners are interrupted, medical appointments cannot be kept, relatives complain that they cannot travel long distances to see their gaol kin. The Committee recognises of course that some movement is inevitable in a system where gaols are outside the metropolitan area. Transfer is sometimes necessary for disciplinary, security or medical reasons. Reclassified prisoners may have to be taken to a different category prison. Mr Woodham advised that the altered classification procedures should reduce these movements by half over the next two years. The Committee earnestly hopes that this is so, and urges the DOCS to examine closely each transfer to ensure it is desirable before putting it into effect.

A new remand centre is to be built at Silverwater. The Committee recommends that if any further gaols are to be constructed and run by either DOCS or by private companies, they should be placed either in the Metropolitan area or close to Sydney.
For at least the past 5 years coroners have urged DOCS, PMS and Police to ensure that proper written material accompanies prisoners on transfer. It is considered that a failure to inform receiving institutions of all matters going to a transferred prisoner's health and safety have contributed to that prisoner's death in some cases. Deaths have occurred which were avoidable. Instructions have been issued to correct the problem, but it is disappointing to record that the Committee still received complaints that "prisoners are arriving without paperwork". The time has come to put an end to this unsatisfactory approach. DOCS and the PMS must make clear to staff that there be NO transfers unless proper documentation accompanies the prisoner. If it is desired to remove a recalcitrant prisoner, he should be detained in a holding cell until all paperwork is complete. He should be accompanied by his DOCS file and his PMS file. Claims that appropriate information is made known by telephone are regarded as doubtful. There is no instruction that any such call be recorded. The Committee cannot emphasise too strongly that it expects that no prisoner in future will depart his gaol unless accompanied by the appropriate files from both DOCS and PMS.

Whenever a prisoner is transferred the PMS staff should prepare a document in the form of a discharge summary setting out matters relevant to the health and safety of that prisoner, so far as is known to the PMS. This should be placed at the head of that prisoner's medical file and go with him on transfer. In situations of medical emergency the summary only need accompany the prisoner.

The Committee has received complaints about the state of the DOCS files and the PMS files relating to prisoners. It is said that they are very bulky, and it is difficult to find specific information in a reasonably short time. From our observations, the Committee agrees with this criticism. It is our contention that the files should be periodically reviewed. There should be placed at or near the top of the file on distinctively coloured paper a history of the prisoner showing the usual demographic features, but clearly indicating also whether the prisoner is exhibiting symptoms which would render him at risk of self-harm. Such factors as his type of offence, sentence or remand, whether he is on segregation or protection, whether he is an escapee, whether he is a known self-harmer, whether he is a recipient of psychiatric treatment, whether there is a record of suicidal threats or behaviour, whether he has been in prison before, whether he is on medication or the methadone program, are all matters which should appear and be readily ascertainable by proper DOCS and PMS staff.

We understand that the new Chief Executive Officer of the Prison Medical Service, Dr Phillip Brown, wishes to review the system of filing. We recommend that such a review take place within both DOCS and PMS.

The Committee is of the view that the provision of a distinctive document showing the salient features of a prisoner's circumstances would not breach privacy principles, as the matters shown will be in short form, and in existence to promote
the health and well being of the inmate.

The convenient storage of files is another aspect which could be looked at by administrators. Files are sometimes remote from the place where they are needed. At Cessnock, the clinic is in one area, and the medical records in another. The files should be handy to facilitate them travelling with the prisoner, or for ordinary access.

ACCOUNTABILITY

An associated and worrying consideration arises as a result of the shortcomings in documentation which are discussed below. Hand in hand with documentation goes the notion of accountability. The understanding amongst prison officers that every notation will be accompanied by a legible identifying signature and date means that those within the system not only have the responsibility of producing the documentation but also remain accountable for their actions in a far more direct way. Unfortunately, one suspects that the resistance to appropriate documentation is also a resistance to the accountability which accompanies it. That this is recognised as an important statement and the measures to incorporate accountability into the day-to-day practices of prison officers should be encouraged at all levels. One should not infer that there are not other measures which promote accountability simply recognise that appropriate documentation and the flow of information throughout a system are indicative of the health and strength of that service.

DOCUMENTATION

Throughout the gaol system there are problems concerning documentation. These problems include the nature of the material that is documented, the frequency with which documentation occurs, the content of the documentation and the flow of information through the system. As with many issues within the prison system one has to constantly evaluate the need for security and confidentiality as against those needs of the organisation which require clear communication in order to function, optimally.

Most of the documentation we saw reflected issues which had to do with the custodial status of inmates. There was little in the files to indicate the state of well-being of individuals and furthermore there was little in the way the documentation practices were organised to allow for the appropriate noting of an inmate’s psychological state. This contrasted with the verbal communication which was forthcoming when prison officers were asked to comment about inmates in their particular wings or units. It was apparent that where unit and case management practices were not well developed, it was simply not in the present day-to-day culture of the job for prison officers to document their opinions and observations concerning inmates, particularly as regards their emotional well-being. By way of contrast, the procedures for documenting issues to do with custodial status or the whereabouts of prisoners’ belongings are clearly far more developed within the system. These practices are obviously necessary and should in no way be
compromised, but it is obvious that prison officers show far more awareness of
their inmate group than the documentation would indicate. It becomes an
imperative to encourage them to document what they already know and to
establish the practices and attitudes within the prison service which enhance this
process. This is entirely in keeping with the policy towards unit and case
management.

It is understood that prison officers are not trained primarily to assess
inmates’ psychological states nor are they expected to do so in an overly academic
or sophisticated fashion. On the other hand, when directly asked, most were
forthcoming and competent in conveying the relevant opinions derived from their
day-to-day interaction with the inmate group. Training and encouragement in this
process are seen as essential and particularly to develop a reporting procedure
which makes use of the information which has been documented.

Review of the case files of inmates who have suicided, repeatedly showed a
paucity of documentation concerning the social and emotional state of that inmate.
The comments present usually were those which accompanied a report concerning
a disciplinary action or were retrospective in that they were written by those officers
who had seen the deceased in the shift or two before the suicide. Understandably
there is a propensity to not document incriminating information and uniformly the
documentation which appeared seemed to denote a remarkable state of well-being
in the soon-to-suicide individual. This situation would represent the least desirable
form of documentation and represents a failure to institute preventative measures
along the lines analogous with risk management within organisations.

The frequency of notations in prisoners’ files is very variable. The system is
gear towards tracking prisoners’ movements and towards issues to deal with
disciplinary matters. This means that if prisoners spend large amounts of time in
one institution or when their conduct is unremarkable, little is known about their
actual state of well-being. In an indirect way it also means that the system is more
sensitive to aberrant behaviour than towards those inmates who may well be
capable of making a positive response to the processes which involve them in gaol.
It also means that opportunities for rehabilitation and for preparation for release
may be missed or not exploited optimally. Similarly the gradual development of
psychological distress, which may not be accompanied by dramatic threats or acts,
can easily pass unnoticed. These are all problems generated by the lack of any
required frequency of documentation concerning individual prisoners. The process
of case management lends itself towards remedying many of these problems.

A particular problem arises when inmates are deemed to be so
psychologically distressed that they require specialist attention. This may occur in
a number of ways. They may, if referred to a Special Crisis Unit, be treated by
more experienced and more highly trained personnel. These may be members of
the special crisis unit staff or may be psychologists employed by the Department of
Corrective Services. In that environment the assessment of the inmate and the
documentation which is generated is processed within the Department and any
ensuing information flows more freely throughout the prison system. On the other
hand, an inmate who is considered to be so distressed as to be mentally ill may be referred to the Prison Medical Service or transferred to the psychiatric facility at Long Bay. In that case the details about the inmate's condition and the clinical assessment and treatment is all documented in a separate file which is outside of the Department of Corrective Services.

That documentation may be comprehensive and it is deemed to be confidential and subject to the same views and rules concerning confidentiality as any other person, involved with the medical profession, would have. This means that there is a conflict of ownership concerning that information and that information is guarded, sometimes justifiably and sometimes not, by the medical personnel. Although there are currently efforts under way to resolve this issue the reality is that there is still inadequate communication between the two departments and that for those inmates who are most psychologically disturbed, there is a greater likelihood of breakdown of communication concerning them. This is clearly an untenable situation in its present form.

An alternative view to the above would be to focus upon the issue of duty-of-care rather than to focus entirely upon the issue of confidentiality. The two concepts never exist individually and each issue of confidentiality has to be weighed up against the issue of duty-of-care. A useful approach could be to debate the duty-of-care issue more fully and not to allow transfers of individuals from one environment to the other until it was clearly ascertained who exactly was taking over the responsibility for the well-being of that individual and that such transfers could not occur until there had been a full and meaningful passing of information, in accordance with the ethics of duty-of-care as well as those of confidentiality. This is not intended as a simplistic notion and it is recognised that within this suggestion lie a number of difficult issues. It is however seen as a more constructive approach to the practical management of disturbed and difficult individuals as opposed to the status quo.
THE ROLE OF RESEARCH AND THE COLLECTION OF DATA

In order to adequately assess risk factors involved in suicide in New South Wales gaols, we need a comprehensive data-base which can be assembled over many years. With the implementation of unit and case management procedures, far more data will accumulate concerning individuals within the gaol system. It is timely that careful thought is given to making this data accessible and also in ensuring that key information is documented in the files of inmates. With some appropriate consultation, the Department of Corrective Services could institute a program to collect data over the coming years so that research programs can be undertaken which in turn will test the various hypotheses concerning risk factors for prisoners in New South Wales.

To date most of the analyses done are based upon small numbers of suicides overall and in research terms the data generated does not assume statistical significance. Whilst the project may be a long term one, the results could prove to be highly beneficial. If such an endeavour is undertaken, then it is mandatory that the research methodology be carefully thought out in advance and that the information recording systems are convenient and reliable. In order to achieve this an experienced researcher could be engaged to structure long term research programs. Similarly the advice of a computer expert could be invaluable in acquiring the appropriate equipment to service this initiative.

A long term project as described above would be one worthy of serious academic consideration. It is these sorts of research questions which may well attract an academic presence into the system. Research of this nature could be conducted conjointly with a University department of forensic psychiatry and would foster better relationships between the Department and the Prison Medical Service and the affiliated academics and professionals.
Computers

Further impediments to the flow of information throughout the gaol system arise as a result of the lack of integrated, secure computing throughout the Department of Corrective Services. It was explained that security and the need to maintain limited access to much confidential material prohibited the use of computing in the way one would see it operating in other large organisations. This problem needs to be considered by those who are expert in the available computing technology and whose expertise extends to information services within prisons elsewhere. The cumbersome and unsystematic manner in which information is assembled, documented and stored is disadvantageous for all concerned within the gaol system. The process of computerisation and the way in which information is handled within the Department of Corrective Services is not in keeping with other large organisations. Despite the special considerations which are required, the introduction of appropriate technology would produce benefits which far outweigh the perceived disadvantages. This is of particular importance in an organisation such as Corrective Services which deals with a particularly difficult portion of the population and whose services and facilities are presently widespread and diverse.

The use of computers will improve communications in the years ahead, but the system is not yet sufficiently effective to replace the documentary files which should accompany each prisoner on transfer.
FINDINGS

The Committee has indicated support, throughout this report, for many initiatives taken by the Department of Corrective Services under various Ministers over the past few years. We have made recommendations and suggestions which we believe will assist the Department and the current Minister in their aim to better pinpoint those prisoners who are most at risk of self-harm. In addition we are mindful that the task will be assisted by those actions which generally reduce tensions within the correctional system overall. There are some subjects which are selected for further consideration or further study. Throughout these findings the Committee remains mindful of the admonition that in respect of each recommendation, attention must be paid to the availability of resources.

THE COMMITTEE RECOGNISES THAT:

1. Acts of deliberate self-harm are endemic to any prison system.

2. The inmate population is one in which almost all the recognised predictors of self-harm are highly prevalent.

3. The gaol environment produces specific problems which intensify the likelihood of acts of deliberate self-harm.

4. There is a need for continued evaluation of those highly complex factors which combine to produce acts of deliberate self-harm. It is not realistic to expect this level of expertise to emanate entirely from within the Department of Corrective Services.

5. Currently the Department of Corrective Services is in a phase of major structural and philosophical reorganisation which involves many changes to ongoing management practices.

THE COMMITTEE SUPPORTS:

1. Unit management of prisons.

2. Case management of prisoners.

3. The new screening procedures as described at Long Bay Reception Prison which involve both the Department of Corrective Services and the Prison Medical Service personnel.

4. The establishment of a Crisis Support Unit within the Special Care Centre.

5. The creation and functioning of the Health Services Board.

7. The current approach to juvenile detainees.

8. Those practices which soften the harshness of prison life and which are aimed at deceasing tension amongst prisoners and prison officers.

9. The emphasis upon formal training procedures which are being developed, administered and delivered via the Department of Corrective Services Academy.

THE COMMITTEE MAKES RECOMMENDATIONS PERTAINING TO:

1. Case Management
   
a) The deliberations of case officers and the proceedings of case management committees must be recorded in writing.

b) Case management meetings are to be mandatory and they must occur with a designated frequency.

c) Time must be allowed by the administration for the writing up of notes and attendances at case management meetings. Such notes are to be legibly signed and dated by the relevant officers.

2. Screening Procedures
   
a) The new screening procedures which are current at Long Bay are to be replicated at all reception prisons, including Mulawa.

b) There is to be alteration to the hours and staffing levels at reception prisons so as to provide the full screening procedure for all new inmates up to 11:00 pm, including Saturdays.

3. Transfers
   
a) The overall number of transfers in the gaol system should be limited to the minimum possible number.

b) With each transfer the inmate is to be accompanied by both his department of Corrective Services file and his Prison Medical Service file. In addition when the patient is discharged from the Prison Medical Service back into the prison system the transfer must be accompanied by an up to date discharge summary from the Prison Medical Service.
c) When information is exchanged at the time of transfer, the content of that information should be governed by the principle of duty of care rather than by issues dominated by considerations of individual confidentiality.

4. **Health Care and Facilities**

a) New therapeutic units should be established at Mulawa and Cessnock.

b) Gaol psychologists should have the required clinical training in addition to their basis psychological qualification.

c) Concerted and continued effort should be forthcoming from the department of Corrective Services to achieve greater working harmony with the Prison Medical Service.

d) A special observation cell to be provided which is close to the Night Supervisor's office and is for the use of inmates who are actively suicidal at that time.

e) At Long Bay Hospital doctors should be available for extended hours and at weekends. In country gaols local medical services should be accessed to provide services within the gaol, for example Goulburn. Nursing staff should be available at Goulburn on six days per week.

f) Officers of the Department of Corrective Services should recognise that it is important to prisoners that medical appointments be kept, and provide escorts as a priority.

g) Staff health services should be upgraded and developed for the benefit of prison officers.

5. **Communication Procedures, Data Collection, Documentation, Research and Computing.**

a) Outside specialist opinion should be sought in relation to the standard of information processing throughout the Department.

b) The role of computing for the collection and use of data within the Department should be examined and relevant long term research projects should be designed using outside specialist help.

c) The data generated must be reviewed in order to evaluate the effectiveness of the various procedures which have recently been instituted in an attempt to decrease the incidence of deliberate self-
harm in the gaols of New South Wales.

d) Files should display, at their front, a distinctively coloured master sheet, to be updated regularly, showing details of the prisoner plus indicators of possible self-harm.

6. Mulawa Women’s Prison

a) There should be regular visits by psychiatrists to Mulawa.

b) There should be a follow-up programme for prisoners released from Mulawa.

7. Prison Construction

a) Where possible, all new work should be free of hanging points, including work at Mulawa and juvenile detention centres.

b) Future prisons should be built in or near Sydney.