DEPARTMENT OF
CORRECTIONS
ARA POUTAMA AOTEAROA

07 September 2015

C73320

Emmy Rākete
fyi-request-3041-ab0a0707@requests.fyi.org.nz

Dear Ms Rākete

Thank you for your email dated 13 August 2015, requesting information about prisoner deaths in custody. Your request has been considered under the Official Information Act 1982 (OIA).

Public safety and reducing re-offending are the ultimate goals for the Department of Corrections. In accordance with the Corrections Act 2004, we make public safety paramount when managing offenders, and administer all sentences in a safe, secure, humane and effective manner. All prisons are operated in accordance with New Zealand legislation and having regard for other agreements, such as the United Nations Standard Minimum Rules for the Treatment of Prisoners.

All deaths in custody are reported to the New Zealand Police and are the subject of a Coronial Inquest and an investigation by an Inspector of Corrections. The Coroner ultimately determines the cause of a person's death.

The Department reports on deaths in custody in two categories:

- Apparent Unnatural Deaths – this can include death as a result of self harm, an accident, foul play, or a death where the cause is unable to be initially confirmed.

- Apparent Natural Deaths – The death while in custody of any prisoner, as a result of natural causes.

The Department is committed to preventing unnatural deaths and life threatening incidents of self-harm in prisons. As you are aware, prisoners have a higher risk of mental health disorder and illnesses than the general population. In order to understand and address a prisoner's medical condition, we conduct health screenings when a prisoner is received into prison, and when they are transferred between prisons. We have also introduced a specialised Mental Health Screening Tool and developed a suicide prevention framework to support the review of practice and reduce the risk of self-harm and suicide by prisoners and community based offenders.

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If a prisoner is screened as 'positive' during the Mental Health Screening Tool they will be referred to Forensic Services for further specialised assessment of their mental health needs. Prisoners assessed by Forensic Services as having mild to moderate mental health needs are referred back to the prison health centre where a decision is made to refer the prisoner to a medical officer, a nurse or to a contracted provider for a Package of Care. Packages of Care are interventions offered to prisoners, which can include self guided tools, group sessions or individual sessions. The content of the packages include education about healthy lifestyles, mental illness, medications, recovery and resilience, advice and support about mental health well being, problem solving strategies, solution focused therapy and cognitive behavioural therapy. Prisoners who were assessed as having serious mental health issues receive treatment directly from Forensic Services.

Despite our efforts to reduce suicide and self harm in prison it is incredibly difficult to stop someone who is determined to harm themselves. In saying this, our staff have saved the lives of approximately 85 prisoners over the last five financial years. These prisoners were involved in self harm incidents where the individual would have been unlikely to survive without staff intervention.

You have requested information on the causes of death and ethnicities of all people who have died in custody since 1990. You have asked for this information to be broken down by year

As highlighted above, the Department reports on deaths in custody as apparent unnatural or apparent natural deaths, and the Coroner is responsible for determining the cause of a prisoner's death. The Department does not record the ethnicity of prisoners who have died in custody within its centrally collated records. We are also unable to provide you with data showing the number of deaths in custody before the 2000/01 financial year as this information is not centrally collated in our electronic records. In order to identify this type of specific information, we would be required to manually review a large number of files.

In accordance with the OIA, we have considered whether to affix a charge or extend the time limit for responding. However, given the scale of the request we do not consider that this would be an appropriate use of our publicly funded resources. Therefore, this part of your request is declined under section 18(f) of the OIA, as the information cannot be made available without substantial collation or research.

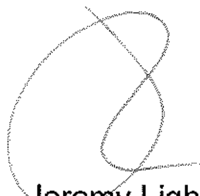
The number of apparent natural and unnatural deaths as per our reporting categories, since 2000/01 are provided as Appendix One.

Please note that the Department reports by financial year, being 1 July to 30 June, and the parameters of your request have been altered accordingly.

I trust the information provided is of assistance. Should you have any concerns with this response, I would encourage you to raise these with the Department.

Alternatively you are advised of your right to also raise any concerns with the Office of the Ombudsman. Contact details are: Office of the Ombudsman, PO Box 10152, Wellington 6143.

Yours sincerely



Jeremy Lightfoot
National Commissioner

Appendix One – Deaths in Custody from 2000/01 to 2014/15

Financial Year	Natural Deaths	Unnatural Deaths
2000/01	6	6
2001/02	5	7
2002/03	9	6
2003/04	6	9
2004/05	6	6
2005/06	5	8
2006/07	5	6
2007/08	5	5
2008/09	12	5
2009/10	9	6
2010/11	11	12
2011/12	8	5
2012/13	7	3
2013/14	10	3
2014/15	10	8