

Ref. 179829

**INVESTIGATION BY DAVID MCGEE, OMBUDSMAN,
OF THE
DEPARTMENT OF CORRECTIONS
IN RELATION TO
AN INCIDENT OF SELF-HARM AT
NEW PLYMOUTH PRISON
AND
THE DEPARTMENT'S DISPOSABLE SAFETY RAZOR
POLICY**

Table of Contents

Annexes and abbreviations

Executive Summary

SECTIONS

1. Introduction
 - Responsibility
 - Incident
 - New policy
 - Objectives
 - Summary of findings
2. Investigation Methodology
3. Self-Harm Incident
4. Disposable Safety Razor Policy
 - Date of implementation
 - Communication of rationale for the policy
 - Method of implementation
5. Execution of Policy
 - Method of recording at New Plymouth Prison
 - Enquiries at Manawatu Prison
 - Enquiries at Auckland Central Remand Prison
 - Enquiries at Eden Prison
6. Collecting Disposable Razors Issued To Prisoners
7. Audit Processes
8. Review of Policy
 - Policy reasoning - summary
 - Speed of implementation - summary
 - Reasoning for variations - summary
 - Explanation of dedicated containers - summary
 - Department objectives – summary
 - Summary of razor blade incidents – prior and post implementation
 - Report on policy to Minister of Corrections due – May 2010
9. Conclusions
10. Recommendations

ANNEXES

Annex 1 Summary of Razor Blade Incidents Prior & Post
Implementation of Disposable Razor Policy

ABBREVIATIONS

ACRP Auckland Central Remand Prison

Department Department of Corrections

Protocol Agreement between the Chief Ombudsman and the Chief
Executive of the Department of Corrections made pursuant
to section 160 of the Corrections Act 2004

The Policy Disposable Razor Policy

iCAT Internal Control Assessment Tool

EXECUTIVE SUMMARY

On 11 May 2009, the Department of Corrections instituted a new national policy on razor blades for prisoners.

The purpose of the policy was to reduce the number of incidents involving razor blades. It applied to those prisoners accommodated in High Security, Remand and Youth Units. These prisoners would no longer be allowed to stockpile or keep issue razor blades. The aim of the policy was interpreted as intending to limit the opportunity for self-harm by misuse of razor blades.

Incident

In July 2009, I received notification from the Department of Corrections, of an incident of prisoner self-harm that had occurred in a Remand Unit of New Plymouth Prison.

A prisoner was found to have used a prison-issued razor blade to self-harm by cutting his wrist in his remand cell.

The prisoner required hospitalization and underwent surgery due to the severity of the cut.

Own motion investigation

Given that the Department's "*Disposable Safety Razor Policy*" had been in operation for almost three months at the time of the incident, I decided to carry out an own motion investigation into the occurrence. My investigation was later expanded to include consideration of how the new policy had been implemented.

The principal objectives of the investigation were to:

- establish the circumstances and events surrounding the incident at New Plymouth Prison;
- examine the implementation of the Department's Disposable Safety Razor Policy;
- examine whether any change in the Department's operational procedures, policy, and practice regarding the Disposable Safety Razor Policy needed to be considered.

The investigation was conducted by, among other things, carrying out inquiries at New Plymouth Prison regarding the self-harm incident, interviews with relevant departmental staff, viewing documentation relating to the policy and making inquiries at other departmental prisons concerning the implementation of the policy.

My investigation found no concerns as to the actions carried out by departmental staff in responding to the discovery of the incident at New Plymouth Prison, where a prisoner was found to have self-harmed in his cell.

My investigation did find inconsistencies in procedures adopted for the purpose of implementing the policy. I consider that the efficacy of the policy had been diminished by some of the variations in procedures adopted for the purpose of implementing the policy. I formed a view that the policy was implemented without sufficient practical guidance for departmental staff involved in executing the policy.

I found that:

- there were different variations at prisons in procedures adopted for the purpose of implementing the policy;
- there were various errors and omissions in certain records that were kept, at prisons, where enquiries were made, regarding the policy;
- there were supervisory failings in that errors and omissions were not noted;
- that any failures to implement the policy correctly and adequately were due to lack of guidance as to how the policy was to be implemented;
- that departmental staff executing the policy, were left to decide themselves what they considered constituted a dedicated disposable container;
- at New Plymouth Prison, lower-ranking staff had an inadequate understanding of the policy and what was expected of them;
- the audit of the policy at New Plymouth was ineffective;
- overall, insufficient specific operational procedural guidelines and instructions to assist staff in the implementation of the policy were provided.

On 24 May 2010, I advised the Department of Corrections of my findings, which were provisional at that time. It responded by letter dated 28 July 2010, the material parts of which are quoted in the body of the report.

The present final report reflects my consideration of the Department's reply.

Various criticisms, are made in the report. However, these should not distract from the fact that most recent statistics indicate a significant reduction in incidents involving razor blades.

Procedural considerations

Section 22(3) of the *Ombudsman Act 1975* provides that, when conducting an investigation, the Ombudsman shall report his opinion, and his reasons therefore, to the appropriate Department or organisation, and may make recommendations as he thinks fit. In any such case he may request the Department or organisation to notify him, within a specified time, of the steps (if any) that it proposes to take to give effect to his recommendations.

Since concluding my investigation, the Department has advised that it has had an opportunity to review the implementation of the razor policy and lessons learnt. It has also implemented a new tool – Internal Control Assessment Tool (iCAT) – to improve auditing requirements.

Having been advised that the Department has:

- (i) reviewed the implementation of the policy;
- (ii) established new effective audit practices.

I now make three recommendations to the Department for future action.

Recommendations

- (i) That the Department review:
 - (a) what is best practice with regard to the place and time of issue of new razors;
 - (b) what is best practice for recording the issuing and collection of razors;
- (ii) That the Department establish clear guidelines as to what standards are required for safe and hygienic used razor containers;
- (iii) That the Department provide further guidance and advice to staff engaged on execution of the policy in order to ensure that they understand what is required and why.

1. INTRODUCTION

Responsibility

- 1.1 In 2007 the Government requested that the Ombudsmen enhance their presence in the prison sector. The Ombudsmen agreed to do so.
- 1.2 Pursuant to section 160 of the Corrections Act 2004, an agreement dated 6 May 2009, has been entered into between the Chief Executive of the Department of Corrections (the Department) and the Chief Ombudsman. Clause 6 of the Protocol records that the Ombudsmen will investigate "*Selected Serious Incidents*" in the prison sector. The agreement is subject to the Ombudsmen Act 1975, the Corrections Act 2004, and the Corrections Regulations 2005.
- 1.3 "*Serious Incident or matter*" under the Protocol "*means an incident or matter notified to an Ombudsman by the Department, or of which an Ombudsman becomes aware by another means, that an Ombudsman determines is sufficiently serious to warrant investigation by the Ombudsman*".
- 1.4 Under the Protocol, the Department has agreed to notify the Ombudsmen of potentially serious incidents that occur in prisons. In July 2009, I received notification of an incident of prisoner self-harm that had occurred in a Remand Unit of New Plymouth Prison.

Incident

- 1.5 It was reported that a Corrections Officer discovered a prisoner in his cell who was bleeding profusely. The prisoner had cut himself deeply on his wrist.
- 1.6 The prisoner received first aid at the scene and was taken to hospital by ambulance, where he was admitted for further medical treatment. He underwent surgery due to the severity of the cut.
- 1.7 During a search of the prisoner's cell by Corrections Officers, a prison-issued razor blade was recovered. The prisoner had used this to cut his wrist.

New policy

- 1.8 On 11 May 2009, the Department of Corrections instituted a new national policy on razor blades for prisoners. I refer to the Department's National Policy B.02.01.R3 "*Disposable Safety Razor Policy*", which I have viewed.
- 1.9 The purpose of the policy was to reduce the number of incidents involving razor blades. It applied to those prisoners accommodated in High Security, Remand and Youth Units. These prisoners would no longer be allowed to stockpile or keep issue razor blades. I have interpreted the

policy as intending to limit in particular the opportunity for self-harm by misuse of razors.

- 1.10 Each prisoner in the affected units was to be provided with a single use safety razor upon request when he wanted to shave. Within one hour, the razor was to be collected by staff for disposal. Prisoners were no longer to be allowed to purchase their own razors.
- 1.11 The prisoner who self-harmed was in the Remand Unit. Given that the policy had apparently been in operation for almost three months at the time of the incident, I decided to carry out an investigation into the occurrence. My investigation was later expanded to include consideration of how the policy had been implemented.

Objectives

- 1.12 The objectives for my investigation are:
 - to establish the circumstances and events surrounding the incident at New Plymouth Prison;
 - to examine the implementation of the Department's Disposable Safety Razor Policy;
 - to examine whether any change in the Department's operational procedures, policy and practice regarding the Disposable Safety Razor Policy needs to be considered.

Summary of findings

- 1.13 My investigation has found no concerns as to the actions carried out by the Department's staff in immediate response to the discovery of the incident.
- 1.14 However my investigation did find inconsistencies in procedures adopted for the purpose of implementing the policy. I consider the efficacy of the policy has been diminished by some of the variations. I am of the view that the policy was implemented without sufficient practical guidance.
- 1.15 I record that all departmental staff co-operated fully with my investigating officer, Anthony Martin, who assisted me with this investigation and undertook various inquiries on my behalf. I am grateful for the frankness of those staff.

2. INVESTIGATION METHODOLOGY

- 2.1 I notified the Department of my decision to investigate the matter as a selected serious incident. As my inquiries progressed, I notified the Department that I intended to expand my investigation, saying, "*I wish to advise you of my intention to continue with inquiries relating to the*

implementation of the new 'Razor Blade Policy' that was introduced by the Department."

- 2.2 Inquiries at New Plymouth Prison regarding the reported self-harm incident were carried out.
- 2.3 The two high medium security units Remand Unit and Unit One at New Plymouth Prison were inspected.
- 2.4 Departmental staff involved in the discovery of the self-harm incident and its immediate aftermath, were interviewed with regard to the occurrence and general interviews were also undertaken with other staff at managerial and lower levels.
- 2.5 The prisoner was not interviewed. I did not consider this necessary for the purposes of my investigation, and I did not want to risk causing him any further emotional disturbance.
- 2.6 Documentation relating to the policy and its implementation was inspected.
- 2.7 For the purposes of considering the wider issue of the new policy, inquiries were also made into the implementation of the policy at other randomly selected prisons. These included Manawatu, Auckland Central Remand and Mt Eden Prisons.

3. SELF-HARM INCIDENT

- 3.1 The prisoner in question was found in his cell. The prisoner had used a razor blade to cut his arm.
- 3.2 The razor blade had been removed from a prison-issued double blade razor. A later search of the prisoner's cell discovered such a razor with one blade intact and one blade missing. Separately, a single blade with blood on it was located.
- 3.3 The blade was believed to be from a razor that had been issued at some time prior to the implementation of the policy. There was no record of the prisoner being issued a razor on the day of the reported incident. The prisoner told departmental staff after the incident that he had located the razor amongst his possessions in his cell, and used it spontaneously without any forward planning. Given that my investigation was concerned with the operation of the new policy, I decided that it was not relevant for me to investigate earlier searching procedures. However, I pause to note that single razor blades are extremely easy to conceal, e.g. in the pages of a book, or a crack in cell fittings.

- 3.4 I was told that the prisoner was aware of, and had previously participated in, the new razor issue process of the policy.
- 3.5 I am fully satisfied that as soon as the injured prisoner was discovered, all staff responded swiftly and appropriately. Indeed, I compliment them. The professionalism of departmental staff who, are all too often called upon to deal with difficult and stressful situations, is frequently unrecognised by those outside the prison system.

4. DISPOSABLE SAFETY RAZOR POLICY

- 4.1 The policy was introduced with the aim of reducing incidents of self-harm involving razor blades in prison. The Department issued a media release on 5 May 2009 regarding the policy, which was to be implemented from 11 May 2009. It applied only to High Security, Remand and Youth Units.

Date of implementation

- 4.2 A New Plymouth Prison Internal Memorandum dated 10 August 2009 to Assistant Regional Manager; Subject: Razor Policy, advised, that the policy was implemented at New Plymouth Prison on 11 May 2009. The opening paragraph reads, *“On Monday 11th May 2009, the issuing of Shaving Razors Policy was implemented at New Plymouth Prison. Prior to implementation date, the Prison Manager New Plymouth Prison forwarded details of this policy for staff information and for subsequent implementation. This was implemented in the two high medium security units; Unit One (40 maximum capacity) and Remand Unit (32 maximum capacity).”*
- 4.3 The memorandum discusses the self-harm incident and implementation of the razor policy in question and concludes:
- *“The issuing of shaving razors to prisoners in Unit One and the Remand Unit of New Plymouth Prison was implemented and checked following implementation;*
 - *Notwithstanding the issuing processes in place, a prisoner was able to have in his possession a razor which he used to self-harm with”.*
- 4.4 In fact the memorandum appears to be incorrect in assuming that the policy had been implemented at New Plymouth Prison on 11 May 2009. There is some conflict as to when it was actually implemented.
- 4.5 A departmental internal email was sent to the Prison Managers at New Plymouth and Manawatu Prisons on 21 May 2009, requesting a response to queries regarding the implementation of the razor policy.
- 4.6 On 22 May 2009, a New Plymouth Prison internal email was sent to staff, advising, *“As from today all razor blades will be taken out of Unit One cells...Prisoners ask and have it for only an hour before returning to an*

officer for destruction. SCO's in unit one to work out a system where they issue razors and get them back for destruction."

- 4.7 This would indicate that the policy had not been implemented in Unit One at that time. Departmental staff spoken to at New Plymouth Prison during inquiries in August 2009 could not recall exactly when the policy was implemented at the Prison. In fact there was one internal email sent on 29 July 2009 from a Senior Officer at New Plymouth Prison to the Prison Manager at New Plymouth commenting, in answer to a query; *"The process of issuing razors for a set period each day and on a one for one basis has been in place since the beginning of July"*.
- 4.8 For the purposes of my investigation, I decided it was not necessary to determine exactly when the policy was implemented at New Plymouth Prison. Whatever the precise date, the policy had not impacted on the ability of the prisoner to self-harm in the incident under investigation. Nevertheless, staff confusion or lack of recollection so soon after the implementation of the policy does support my concerns as detailed below about lack of clear guidance to staff.

Communication of rationale for the policy

- 4.9 Departmental staff at managerial level expressed the firm view that the policy had been well and clearly explained to the lower-ranking staff who would be personally undertaking the front line work. However, some managers did question whether the policy would be useful, or achieve its objectives.
- 4.10 Conversely, most lower-ranking departmental staff thought that there was little or no explanation or guidance from managers as to how the policy was to be implemented, or why they should be doing it.
- 4.11 Criticism of the policy was often along the lines that it only takes a moment for a prisoner to self-harm with a razor blade, and the one hour time limit for possession achieves nothing. That criticism may, or may not, be misconceived and I express no opinion on it. However, for the purposes of my investigation, my concern is that the reasoning behind the detail of the policy was not fully accepted or even understood by all ranks of staff.

Method of implementation

- 4.12 It was left up to individual Unit managers to implement the policy in their own ways as they might individually devise. This resulted in Unit staff being delegated with the task of working out a system whereby they might issue razors and retrieve them for destruction within the permitted time limit.
- 4.13 The lack of guidance was criticised. One staff member commented, *"It was insane. How we did it was up to ourselves. As long as we could give it to them and have a record. We were not directed as to how it happen, just that you had a policy to introduce. Make it happen."*

- 4.14 Another departmental staff member commented, *“We were never told how to implement the policy. We just came up with our own procedures including our own containers for collecting used razors”*. This comment reflected a shared view amongst departmental staff who spoke to my investigators.
- 4.15 Regrettably, I am reminded of the penultimate paragraph of the *“Concluding Remarks”* of the 2005 *“Ombudsmen’s Investigation of the Department of Corrections in relation to the Detention and Treatment of Prisoners”*. Former Chief Ombudsman John Belgrave and Ombudsman Mel Smith said (albeit in a somewhat different context);

“...we...remain disturbed at the gulf that emerged between the understanding of the Department’s National Office and its staff in the prisons. We consider that this is something that needs to be addressed and that there needs to be greater meaningful liaison between National Office and front-line staff. Put another way, National Office should obtain the views of staff more often, and listen more attentively to staff.”

- 4.16 In response to my provisional findings (which appear unaltered in this report), the Department said:

“When an operational change is decided, National Office advises managers of the policy in the simplest terms, states the mandatory expectations, and explains the rationale behind the change. The expectation is that prison managers will take responsibility, and that each prison and affected unit will use its discretion with regard to the actual implementation, based on what best suits the resources, routines, staffing, and safety considerations of that unit — matters they — not National Office - are best placed to decide. New policies and changes are communicated to regional managers, assistant regional managers and prison managers in the first instance, with the expectation that they will cascade, disseminate and reinforce the information.

You have commented that there was a lack of guidance about the policy implementation. Prior to implementing the policy, an email was sent from National Office to prison managers informing them that the new policy had been agreed, the main implications, and providing contact details for any queries. A further email was sent from National Office staff informing of the implementation date, including a link to the policy on the Department’s intranet, and providing a notice to be displayed to prisoners. Further, in September 2009, a Management of Change presentation was made to all prison managers and assistant regional managers, using the razor blade policy as an example. The purpose of this example was to reinforce to the Department’s expectations - namely to thoroughly and completely implement any change. It was also an opportunity to review our implementation of the razor policy and any lessons learnt”

5. EXECUTION OF POLICY

- 5.1 When the policy was first implemented at New Plymouth Prison, the practice adopted was for staff to issue razors to prisoners as they entered the exercise yards (where there are washing facilities). This was contrary to the advice in the policy, which states, *“Where possible, disposable safety razors should be issued to prisoners locked in their cell.”*
- 5.2 On 4 August 2009, staff at New Plymouth Prison, were advised of a change in procedures in an internal email. Staff were advised; *“Razors will only be issued whilst the prisoner is in their cells. Not in the exercise yard”*. My investigation indicated that the change was as a consequence of the incident. One staff member commented, *“We stopped issuing the razor blades to prisoners in the yards because of the incident”*. Another staff member commented, *“Issuing razor blades to prisoners in the yards was found to be problematic where they were sharing and trying to hide them”*.

Method of recording at New Plymouth Prison

- 5.3 The policy instructed that unit staff must record that a disposable safety razor has been issued to a prisoner, and the Daily Muster Sheet should be used to record the issuing of disposable safety razors.
- 5.4 When the policy was first implemented at New Plymouth Prison, unit staff recorded the issue of razors on a single sheet form they had devised themselves. This again was contrary to the advice given in the policy which stated that the Daily Muster Sheet should be used for this purpose.
- 5.5 The method of recording was changed subsequently so that records were kept on the Muster Activity Log Sheet Records as the Daily Muster Sheet is known at New Plymouth Prison. A senior staff member explained, *“An audit person from head office came from somewhere and immediately said it was not robust enough because there was no proof. This person came to check out what we had done. This was when I decided to put it in the log book. The auditor came around about six weeks after the policy was introduced to see how we were implementing the policy. When the auditor came around it was indicated that our system had no proof to show when and who the razor had been issued”*.
- 5.6 It appears the method of recording was changed because staff realised they needed a more permanent record, and not because anyone had realised the single sheet form was not in accord with the policy.
- 5.7 The same staff member also commented, *“She has not come back to check that we have implemented the right procedure. No one has come back”*.
- 5.8 I was unable to ascertain exactly how the initial method of recording had operated as none of the single sheets of paper forms had been retained – either completed or blank. A staff member commented, *“We have not got*

copies of the old log records that we were keeping. We threw away the old log sheets we were using”.

- 5.9 Certain Muster Activity Log Sheet Records were inspected during my investigation at New Plymouth Prison. Poor practice, inconsistencies and omissions were discovered.
- 5.10 The Muster Activity Log Sheet Records had been amended to include a table “*Razor Record*” with four columns headed, “*Prisoner*”, “*Blade in*”, “*Officer Sign*” and “*Key No.*” This was intended to reflect the new policy.
- 5.11 However, there was no column for the actual time of razor issue. This is most basic information for the purpose of the policy, which is geared to ensuring that prisoners do not have razors for more than one hour. When this was pointed out during my inquiries, staff at New Plymouth took immediate steps to amend the Muster Activity Log Sheet Records table so as to capture this information for the future.
- 5.12 Inspection of the Muster Activity Log Sheet Records also discovered that not all times had been recorded, and on occasion staff had not signed the record. It appeared that the Muster Activity Log Sheet Records were not being adequately checked or monitored by supervising staff. The recording of such information could prove vitally important in the investigation of any serious incident involving prison-issued razors.

Enquiries at Manawatu Prison

- 5.13 By way of comparison, inquiries were also carried out at Manawatu Prison.
- 5.14 Razors at Manawatu Remand Unit were issued to prisoners when they were going for a shower. Once more, this is contrary to the advice given in the policy, although I am not aware of any practical difficulties with the variation. Indeed, it may have merit in that a prisoner who self-harms in the shower will likely be very quickly discovered.
- 5.15 Inspection of the Daily Muster Sheets at Manawatu Prison Remand Unit showed inconsistencies and omissions. It appeared that the Sheets were not being adequately checked by supervisors.
- 5.16 Manawatu Prison Daily Muster Sheets collected information under three sub-headings for “*Razor*”. These sub-headings were listed as, “*Out*”, “*In*” and “*Sign*”. It was noticed that staff were recording information differently. Under “*Out*” they might use a tick, or a number to indicate the number of blades issued or a time that a blade was returned. Information was not always entered.
- 5.17 Proper standardised forms issued centrally, together with proper explanation and guidance to lower-ranking staff, would likely have avoided these variations.

Enquiries at Auckland Central Remand Prison

- 5.18 Inquiries into the method of recording regarding the implementation of the Policy were carried out at Auckland Central Remand Prison (ACRP). This Prison had devised a simple and effective process.
- 5.19 The information required by the policy was recorded on a locally devised template form retained in what was labelled, "*Razor Issue and Retrieval Register*". The information is under the headings, "*Date*", "*Officer*", "*Prisoner*", "*Time Out*", "*Time In*", "*Officers Initial*" and "*Officer Tag Number*".
- 5.20 In my view, the Department should consider standardising the recording format of information for the Disposable Safety Razor Policy along the lines of the "*Razor Issue and Retrieval Register*" of ACRP. It is simple and effective.
- 5.21 Interestingly, ACRP only issued razors during periods of unlock. Staff experience has led ACRP to the view that prisoners are most likely to self-harm while in seclusion, rather than in periods when they might be visited in their cell by another prisoner. Although this is at odds with the policy which states, "*Where possible, disposable safety razors should be issued to prisoners locked in their cell*", ACRP's thinking may well have merit.

Enquiries at Mt Eden Prison

- 5.22 Mt Eden Prison was also visited for the purpose of my investigation. Mt Eden had also employed a simple procedure for recording the required information. Staff had purchased a notebook of a type that can be obtained at any stationers. A simple series of columns captured the information. As for ACRP, the procedure does not follow the advice given in the policy which, states that, the Daily Muster Record should be used for the purpose. However, Mt Eden Prison's system seemed to work effectively. No errors or omissions were found on inspection of the book.

Recommendation (i)

I therefore make the following recommendation:

That the Department review:

- (a) what is best practice with regard to the place and time of issue of new razors;**
- (b) what is best practice for recording the issuing and collection of razors;**

6. COLLECTING DISPOSABLE RAZORS ISSUED TO PRISONERS

- 6.1 The policy states, *“Used disposable safety razors must be placed in a dedicated container immediately after they are received and have been checked.”* My enquiries found, that no approved *“dedicated”* purpose built containers, had been supplied by the Department to staff at New Plymouth and Manawatu Prisons.
- 6.2 My investigation found that staff at both New Plymouth and Manawatu Prisons had of their own initiative utilised old margarine and butter plastic containers, with slots cut in the lids for insertion of collected used razors. By comparison with the *“sharp”* bin used in health facilities, an old margarine container is a poor substitute and in my view wholly unsatisfactory. Razors are not only sharp, but may be contaminated with blood from shaving cuts.
- 6.3 I observe that guidance is given for the ultimate disposal of the razors as waste, following collection by staff. Certainly at that stage, the policy assumes suitable rubbish containers will have been issued for use of staff. I refer to the Departments Policy for Disposing of Waste (Local Procedure) B.02.02 which states:

“The disposal of waste is undertaken in a way which meets sanitation and hygiene needs, and which fulfils legislative and regulatory requirements.

Waste from units is disposed of in a safe and hygienic manner using the containers provided.

....

Waste containers are allocated and supplied to each unit.

Waste containers are collected and taken to designated collection point.”

- 6.4 The policy goes on to instruct unit staff:

“Ensure that waste is disposed of in an appropriate and timely manner in the containers supplied.

Ensure that waste containers are emptied and cleaned on a regular basis by the prisoner in charge of waste disposal.

Ensure that waste containers are returned to their designated locations within the unit.”

- 6.5 The failure of the Department to provide approved *“dedicated”* containers for collection of razors reinforces my view that front line staff could have received more guidance.

6.6 The Department, in its letter of response dated 28 July 2010 advised:

“With regard to the disposable container, this is the type of detail that is left to local staff. Razors are not “sharps” in terms of medical sharps — therefore it was not deemed necessary to prescribe a particular container”

6.7 I disagree with this view. A clearly written policy describes procedures and provides guidance to ensure that the expectations of a policy are understandable. This limits the opportunities for conflict or misinterpretation as it is important that a policy contains information that assists in providing answers and not allowing individual interpretations as to what is meant. What constituted a designated container should have been clearly defined to avoid incorrect methods or unsafe containers being used.

Recommendation (ii)

I therefore make the following recommendation:

That the Department establish clear guidelines as to what standards are required for safe and hygienic used razor containers

7. AUDIT PROCESSES

7.1 I refer again to the New Plymouth Prison Internal Memorandum dated 10 August 2009. It includes an excerpt from a report of an Internal Control Officer regarding internal control monitoring activities at New Plymouth Prison. The excerpt reads, *“The internal control monitoring activities at New Plymouth were conducted between 18-21 May 09. At that time the policy had only been in operation for seven days, no issues were identified.”*

7.2 The memorandum further reported that on 18 June 2009, a Department Internal Control Officer had requested a spot audit check on the policy at New Plymouth Prison. Due to *“limited resources”*, the prison manager was asked to complete a *“snap shot”* razor questionnaire on the Internal Control Officer’s behalf. The questionnaire was duly completed by a unit manager of the prison.

7.3 The Institute of Internal Auditors (IIA) has developed a globally accepted definition of internal auditing, as follows: *“Internal auditing is an independent, objective assurance and consulting activity designed to add value and improve an organisation’s operations. It helps an organisation accomplish its objectives by bringing a systematic, disciplined approach to evaluate and improve the effectiveness of risk management, control, and governance processes.”*

7.4 The *“snap shot”* questionnaire failed to highlight deficiencies in the procedures and processes that had been implemented by the prison in regards to the policy.

- 7.5 A satisfactorily conducted audit by an independent internal control officer could have pointed out deficiencies in the procedures that were present in the issuing, collection and recording methods of razors at New Plymouth, and provided reasons.
- 7.6 The responses to the questionnaire that was completed by the unit manager at the prison were accepted. It was assumed that prison management clearly understood the policy and its requirements, and had implemented adequate procedures accordingly. I am not persuaded that any such assumption was justified.
- 7.7 I am satisfied that the unit manager, on this occasion, was responding to a questionnaire and was not carrying out the actual audit.
- 7.8 As an example the questionnaire asked, *“The unit records the issue and collection of disposable safety razors”*, invited the response, *“Yes or No”*, and comments.
- 7.9 The response to the question was recorded as, *“Yes”*, and a comment added, *“checklist used, covering time in/out, names”*. This response did not give a clear overall picture as to how the prison was recording the information. What was required was an independent physical audit of the recording methods being used and how that information was being collated. Some questions were merely answered with a *“Yes”*, with no comment added.
- 7.10 The internal audit carried out at New Plymouth was deficient and in my view was not effective in helping the Department achieve the objectives of the policy.
- 7.11 In its letter dated 28 July 2010, the Department accepted that the audit policy followed in New Plymouth Prison was ineffective. It said

“It is accepted that the audit policy followed in New Plymouth was ineffective. A new - Internal Control Assessment Tool (iCAT) - was implemented by Prison Services in November 2009 and I am confident this new process, which runs in a 4-monthly cycle, will improve the quality of the Service’s audits.

The significant difference between the former process and iCAT is a shift from compliance or ‘tick box’ checking, to observation. Both models measure the successful application of risk controls, however iCAT not only asks whether the activity was completed, but observes how effectively it was done and whether it addressed the identified risk.

With respect to the razor policy, in the past records were retrospectively checked to ascertain that the unit was compliant with the requirements (a document check). The iCAT process not only checks the documentation, but also witnesses the Officers supplying the razor to the prisoner, managing the prisoner’s use of the razor, and the return and disposal of the used.”

8. REVIEW OF POLICY

8.1 Comments were sought from the Department regarding its reasoning for the *“Razor Policy”* and my concerns as to how the policy was implemented. A meeting was attended by my Investigator Anthony Martin, with senior departmental management staff in January 2010.

Policy reasoning - summary

8.2 In summary the Department indicated:

- it had identified concerns with the risk that the availability of razors imposed in prisons;
- that the availability of razors to prisoners had been around for over one hundred years with no changes;
- there was a need for better management and controls of razors issued to prisoners, to reduce incidents of self harm;
- a pilot program in high security units in the Southern Regional Prisons was trialled;
- the results of the trial indicated that a policy to minimise the availability of razors to high security classification prisoners, would see a reduction in the number of incidents involving razor blades;
- the policy was approved also to accommodate Remand and Youth units;
- the policy was devised in consultation with Prison Services, Regional and Prison Managers, with feed back from Health and Safety Staff;
- there was a need for the policy to be developed and implemented as soon as practically possible;
- full support for the policy was obtained from the Minister of Corrections, Prison Service Management Team and Regional and Prison Managers;
- the policy was a new type of Department policy regarding the speed and mode it was implemented;
- the policy was fairly straight forward and had been implemented relatively smoothly;
- no major issues or concerns had been identified as a result of an initial internal audit review carried out in June/July 2009, after the policy had been implemented.

Speed of implementation - summary

8.3 In summary the Department indicated:

- that the policy was introduced and implemented within a short time frame;
- the Department advised its prison managers of the implementation of the policy in an Internal Memorandum dated 27 April 2009, which I have viewed;
- there was a media release regarding the policy on 5 May 2009;
- the policy was formally implemented throughout the Department's Prisons on 11 May 2009 by email, which I have viewed;
- that some departmental staff who were on leave during this period, may not have been advised of the policy;
- that the new policy was considered a major change to the availability of safety razors to prisoners;
- there was an urgent need for the policy to be developed and implemented into the prisons as quickly as practicable;
- a notice, containing information regarding the New Disposable Safety Razor Blade Policy, was prepared for provision to prisoners, as part of the implementation process;

Reasoning for variations - summary

8.4 In summary the Department advised:

- that it considered there was no room for misinterpretation of the policy;
- the policy was purposely not overly descriptive in the procedures as to how to implement it;
- Prison and unit managers were considered to be the best people to devise systems and procedures for implementing the policy into the prisons;
- that each Prison Site and units, have particular differences regarding their design, processes, and procedures;
- that Prison management should have the autonomy to implement procedures into their systems regarding the policy and should not be specifically instructed as to how to implement it;

- that Prison and prison units may have different variations in practice and procedures as to the issuing and collection of razors under the policy due to the particular differences of each Prison site and unit;
- that although the policy recommended that where possible a disposable safety razor should be issued to prisoners in their cell and collected no later than one hour after issue, it was accepted that this may not be the best practice for all prison sites;
- that the issuing of razors could be in a place other than to a prisoner in their cell or the allowable time frame could be expanded to fit in within a unit's particular processes;
- it was accepted that there could be different variations in recording the information expected under the policy between individual Prisons and units;
- that the Department had outlined its expectations sufficiently in the policy and what information was expected to be recorded;
- it was left up to the Prison and unit managers to devise the best recording methods to fit in with their own procedural practices;
- that a template for recording such information was not considered as the Department did not wish to add another administrative form;
- it had been stipulated in the policy that the information "*should be recorded*" on the Daily Muster Sheet and not, "*must be recorded*". How this was recorded was left up to individual Prison and unit managers.

Explanation of dedicated containers - summary

8.5 In summary the Department indicated:

- that it did not provide specifically purpose built dedicated containers to the Prisons, for the collection of razors;
- that it was presumed that Prison and unit managers would acquire suitable purpose containers on their own accord and that the containers would be safe for use;
- that National Office had responded to initial queries by departmental staff when the policy was implemented, advising that either a sharp or lead type container was recommended as being suitable;

- the Department held no concerns with a modified plastic margarine or butter container being used, as long as it would meet health and safety requirements and meet the purpose of being a safe and secure container for the collection of used razors.

Department's objectives - summary

8.6 In summary the Department indicated:

- that the objective of the policy was to reduce self harm incidents and to increase security and safety for staff;
- that the monthly monitoring had shown that the policy was effective.

Summary of razor blade incidents – prior and post implementation

8.7 The Department provided a summary of razor blade incidents for eight months post implementation of the razor blade policy and a summary of incidents six months immediately prior to the implementation. **(Attached at Annex 1.)**

8.8 The number of incidents for six months prior to implementation of the policy ranged from between 15 – 24 reported incidents per month.

8.9 The number of incidents for eight months post implementation ranged from between 10 – 30 reported incidents per month. It was noted that the month where 30 incidents were recorded was in the first month of implementation where 20 of those reported incidents related to razors “found or “removed”. This was likely due to the action taken by prison management, where searches were instructed to be carried out of those units and prisoners’ cells prior to implementation of the policy, in order to recover any razors.

8.10 There were 20 reported self harm razor blade incidents in the six months prior to implementation of the razor blade policy, which averaged out at 3.3 incidents per month.

8.11 There were 20 reported self harm razor blade incidents in the 8 months post implementation of the razor blade policy, which averaged out at 2.5 per month. These figures indicated that there had been a reduction in self harm razor blade incidents.

Report on policy to Minister of Corrections

8.12 The Department told me that a review of the policy would be carried out after the first year of its implementation and that a report is expected to be submitted to the Minister of Corrections.

- 8.13 The policy was considered a “*developing policy*”, where further procedural and practical guidelines, instructions or a model could be considered in future for similar type policies.
- 8.14 The Department, in its letter dated 28 July 2010 advised:

“In the 12 months before the policy was put in place there were 60 incidents recorded by Corrections where a blade had been used as a weapon, and 51 incidents involving a prisoner using a blade to harm themselves. The table below shows razor-related incidents for the 12 months post-implementation of the new policy. We are confident prison staff are making this policy work well.”

Criteria	Self Harm	Weapon	Other Device	Other	Total
Incidents for twelve months prior to razor blade policy	51	26	34	56	167
Incidents for twelve months post implementation of the policy	28	10	4	51	93
Percentage Reduction	45%	61.5%	88.2%	8.9%	44.3%

- 8.15 I acknowledge that the results shown in the above table do show a reduction in self harm incidents involving the use of razor blades. However this does not change my view that the razor policy could have been implemented more efficiently.

Recommendation (iii)

I therefore make the following recommendation:

That the Department provide further guidance and advice to staff engaged on execution of the policy in order to ensure that they understand what is required and why.

9. CONCLUSIONS

- 9.1 The staff of New Plymouth Prison responded swiftly and appropriately to the self-harm incident. They are to be commended.
- 9.2 The self-harm incident did not result from the new policy or any failures in its implementation.
- 9.3 I accept the Department’s argument that Prisons and units should have as much autonomy as possible to implement the policy in a way that pays due regard to their own particular circumstances. But this cannot apply to those aspects of the policy that were non-discretionary, imposed standards or required to be reported comprehensibly. Nor can it excuse variations that resulted simply from misunderstandings or

misinterpretations of the policy, rather than conscious decisions to implement it in the light of local circumstances.

- 9.4 At New Plymouth, Manawatu, ACRP and Mt Eden Prisons there were variations in procedures adopted for the purpose of implementing the policy. Some of these variations were contrary to the advice given in the policy.
- 9.5 At New Plymouth and Manawatu Prisons there were various errors and omissions in certain records that were kept.
- 9.6 ACRP and Mt Eden Prisons had maintained records that appeared fully accurate and satisfactory.
- 9.7 At New Plymouth and Manawatu Prisons there were supervisory failings in that errors and omissions were not noted.
- 9.8 At New Plymouth, Manawatu, ACRP and Mt Eden Prisons, any failures to implement the policy correctly and adequately were due to lack of guidance as to how the policy was to be implemented
- 9.9 Staff executing the policy, were left to decide themselves what they considered, constituted a dedicated disposable container. There was a lack of descriptiveness or guidelines in the policy, as to what standards were to comply for such containers.
- 9.10 Given the variations and errors I identified from all four prisons that were visited, I conclude that procedural deficiencies regarding the implementation of the policy may exist throughout the prison network.
- 9.11 At New Plymouth Prison, lower-ranking staff had an inadequate understanding of the policy and what was expected of them. Although management expressed the firm view, that this should not be the case, I find no reason to dispute the views expressed to me.
- 9.12 The audit of the policy at New Plymouth Prison was ineffective.
- 9.13 Overall, insufficient specific operational procedural guidelines and instructions to assist staff in the implementation of the policy was provided.
- 9.14 The speed with which the policy was developed and implemented may have been a factor in the variations and errors that were identified. A two week time frame is, in my view, quite short for implementing a wholly new policy that affects daily routines and administration procedures.

10. RECOMMENDATIONS

10.1 I recommend that the Department:

- (i) Review:
 - (a) what is best practice with regard to the place and time of issue of new razors;
 - (b) what is best practice for recording the issuing and collection of razors;
- (ii) Establish clear guidelines as to what standards are required for safe and hygienic used razor containers;
- (iii) Provide further guidance and advice to staff engaged on execution of the policy in order to ensure that they understand what is required and why.

David McGee
Ombudsman
11 August 2010