NZ Human Rights.
Human Rights Commission
Te Kāhui Tika Tangata

2015/16

Monitoring Places of Detention

Annual report of activities under the Optional Protocol to the Convention against Torture (OPCAT)

1 July 2015 to 30 June 2016

IPCA
Independent Police Conduct Authority
Whaia te pono, kia puawai ko te tika

Manaakitia a tātou tamariki
Children's Commissioner

Office of the Judge Advocate General of the New Zealand Armed Forces

Ombudsman
Fairness for all

Contact

Human Rights Commission InfoLine

0800 496 877 (toll free)
Fax 09 377 3593 (attn: InfoLine)
Email infoline@hrc.co.nz
TXT 0210 236 4253
www.hrc.co.nz
Language Line and NZ Sign Language interpreters available

If you have a hearing or speech impairment, you can contact the HRC using the New Zealand Relay Service. NZ Relay is a telecommunications service and all calls are confidential.
www.nzrelay.co.nz

Tāmaki Makaurau – Auckland

Level 7, AIG Building,
41 Shortland Street, Auckland
PO Box 6751, Wellesley Street
Tāmaki Makaurau Auckland 1141
Waea Telephone 09 309 0874

Te Whanganui ā Tara – Wellington

Level 8 Vector Building
44-52 The Terrace
PO Box 12411, Thorndon
Te Whanganui ā Tara Wellington 6144
Waea Telephone 04 473 9981

Otautahi – Christchurch (temporary office)

Ground Level, Dollan House
Statistics NZ, 401 Madras Street
Otautahi Christchurch 8140
Waea Telephone 03 379 2015

Office of Human Rights Proceedings

Te Tari Whakatau Take Tika Tangata
Email ohrp@ohrp.org.nz
PO Box 6751, Wellesley Street,
Auckland 1141

ISSN: 1179-531X (PRINT)
ISSN: 1179-5328 (ONLINE)

Published February 2017
Auckland, Aotearoa New Zealand

Contents

Foreword

2016 marks the 10th anniversary of the Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT). This is a significant milestone. OPCAT is an innovative and proactive system. It establishes monitoring mechanisms to regularly inspect places of detention, to improve treatment and conditions, and prevent torture and ill treatment, rather than dealing with ill treatment after it has occurred.

This report identifies a number of serious issues within New Zealand detention facilities. These include high levels of unreported prisoner-on-prisoner assaults within prisons, locking of doors in mental health units that house voluntary patients and the lack of responsiveness to mokopuna Maori within CYFS residences. These matters, and the other issues outlined in the individual sections that make up this combined monitoring report, require urgent attention.

The Crimes of Torture Act (COTA) gives effect to New Zealand's international obligations under OPCAT. COTA provides for the designation of a 'Central National Preventative Mechanism' (CNPM) and 'National Preventive Mechanisms' (NPMs). The Human Rights Commission is designated as the Central National Preventive Mechanism responsible for coordinating NPM activities and liaising with the United Nations Subcommittee on the Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT). The Independent Policy Conduct Authority, The Office of the Children's Commissioner, The Office of the Ombudsman, and the Inspector of Penal Service Establishments are designated as NPMs. They have specific statutory duties and functions including the monitoring of detention facilities around the country. The role of the NPMs is to examine, at regular intervals, the conditions of detention and treatment of detainees, and make recommendations for improvement.

The NPMs and CNPM play a key role in protecting the human rights of individuals who are deprived of their liberty. These individuals include prisoners, children detained under youth justice or care and protection legislation, and mental health patients held in hospital inpatient units. These are some of New Zealand's most marginalised and vulnerable people and their circumstances are often 'invisible' to the wider community.

This report summarizes the activities of the NPMs and the CNPM during the period 1 July 2015 to 30 June 2016. This was a particularly busy period and there have been some exciting developments. Increased resources for the Office of the Ombudsman have allowed the monitoring team to be expanded and a new team member with a clinical background has been recruited. Additionally, both the Office of the Ombudsman and the Human Rights Commission were successful in obtaining funding from the Office of the United Nations High Commissioner for Human Rights under the OPCAT Special Fund to progress projects aimed at implementing recommendations from the SPT visit to New Zealand in 2013. The Office of the Ombudsman will be piloting the inclusion of consumer representatives in monitoring visits and the Human Rights Commission is undertaking a major project looking at seclusion and restraint practices in facilities across all detention contexts.

We welcomed two new chairs to the NPMs. Judge Peter Boshier began his term as Chief Ombudsman on 10 December 2015, replacing Dame Beverley Wakem. We thank her for the work she has done

towards the ongoing success of the NPMs. In July 2016, we welcomed Judge Andrew Becroft as Children's Commissioner, replacing Dr Russell Wills. We thank Dr Wills for his work particularly for being a strong voice for children who are detained.

2017 will mark the tenth anniversary of New Zealand's ratification of the OPCAT and ten years since the NPMs and CNPM commenced their monitoring activities. This will provide a timely opportunity to reflect on the changes that have taken place and also to highlight the challenges that still lie ahead. There are significant areas of concern.

Places of detention were often in the media, both in New Zealand and internationally, for problems such as fight clubs, prisoner assaults, and the use of restraints on youth at a children's detention centre. The NPMs will continue to monitor international developments and assess how monitoring and inspections can be improved to ensure unreported and underlying issues are identified and remedied.

Māori are disproportionally detained in all detention contexts. It is clear to all agencies involved in the OPCAT monitoring activities that there are complex issues underpinning this disproportionate detention rate and this issue needs urgent attention.

Mental health and disability in detention continues to be a concern. Sixty to seventy percent of people in prison have either a learning disability or a mental illness. Overall there is a higher prevalence of mental health issues among people in detention compared to the general population. New Zealand also has a history of under-provision of care to this patient group, resulting in suboptimal care, injury or self-harm while in detention and, in some cases, suicides in detention.[1] Furthermore, the NPMs have increasing concerns about the overlap between those with both mental health issues and intellectual disability.

The NPMs will continue to raise these and other issues, and will continue to monitor the situation of those who are deprived of their liberty and are often marginalised and vulnerable.

David Rutherford
Chief Commissioner,
Human Rights Commission

Judge Andrew Becroft
Children's Commissioner,
Office of the Children's Commissioner

Judge Peter Boshier
Chief Ombudsman,
Office of the Ombudsman

Robert Bywater-Lutman
Inspector of Service Penal Establishments,
Office of the Judge Advocate General

Judge Sir David Carruthers
Chair, Independent Police Conduct Authority

Human Rights Commission
Te Kāhui Tika Tangata

The Crimes of Torture Act 1989 (COTA) designates the Human Rights Commission (the Commission) as the Central National Preventive Mechanism (CNPM).

This role entails coordinating with NPMs to identify systemic issues, liaising with government and the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT). The Commission is an independent Crown Entity with a wide range of functions under the Human Rights Act 1993. One of the Commission's primary functions is to advocate and promote respect for, and an understanding and appreciation of, human rights in New Zealand. The Commission's function includes advocacy, coordination of human rights programmes and activities, carrying out inquiries, making public statements and reporting to the Prime Minister on any matter affecting human rights. The Commission also administers a dispute resolution process for complaints about discrimination. Commissioners are appointed by the Governor General, on the advice of the Minister of Justice, for a term of up to five years.

Overview

The fundamental premise of OPCAT is based on international evidence highlighting the deterrent and preventive effect of independent monitoring and oversight.

The Commission's role as CNPM is established under sections 31 and 32 of COTA. COTA outlines, in general terms, the coordination role played by the CNPM. The CNPM's responsibilities, as developed by the NPMs and CNPM, include:

- Consulting and liaising with NPMs and coordinating the activities of the NPMs, including:
  - facilitating biannual meetings of the NPMs
  - meeting with international bodies
  - making joint submissions to international treaty bodies, and
  - providing communications and reporting/ advocacy opportunities.
- Providing human rights expert advice
- Maintaining effective liaison with the SPT
- Coordinating the submission of annual reports prepared by NPMs to the SPT
- Reviewing annual reports prepared by NPMs to advise them of any systemic issues arising from those reports and, in consultation with NPMs, making recommendations to government on systemic issues arising from NPMs' reports through media releases and thematic reports or briefing papers, and
- Coordinating and facilitating engagements with international human rights bodies and civil society consistent with the Commission's broader mandate under the Human Rights Act 1993 section 5(1) to "promote respect for, and an understanding and appreciation of, human rights in New Zealand society".

Activities

The Commission convened a roundtable meeting of the NPMs chairs, and numerous official level meetings with NPMs. The chairs meeting focused on the sharing of information, and discussion of key issues and projects. Key issues raised include mental health, private prisons, national standards for custodial facilities, the mandate of the NPMs, and the need for a preventive approach.

The Chief Commissioner attended New Zealand's examination by the Human Rights Committee. Concluding observations following this examination included that New Zealand Government should ensure that the human rights of persons deprived of their liberty are respected and protected in all places of deprivation of liberty and that adequate resources are given to the Office of the Ombudsman for its OPCAT monitoring functions.

The Human Rights Commission coordinated the NPMs input to the one-year response following New Zealand's examination by the Committee Against Torture. The Committee Against Torture requested follow-up information about the development of the NPM, funding of the NPM, the independence of the Independent Police Conduct Authority, and the use of seclusion/solitary confinement.

Seclusion and restraint

A successful application was made for funding from the Office of the United Nations High Commissioner for Human Rights, through the Special Fund of the OPCAT. The Special Fund of the OPCAT supports projects implementing recommendations of the SPT after a country visit. The project involves a review of seclusion and restraint practices in detention settings, including youth justice and care and protection facilities, mental health units, and prisons, and the public release of a report with recommendations for improving these practices. This important piece of work follows on from an initial Commission overview of Mental Health in Detention: Duties of the State which was included in the Optional Protocol to the Convention Against Torture Annual report released in December 2015.

In their 2013/14 annual report NPMs recommended that the government develop a cross agency plan to improve capability for the appropriate management of individuals with high and complex needs, specifically highlighting individual cases of long-term seclusion. The lack of a standardised approach may result in variance in practice between institutions to the detriment of detained persons. Consistent approaches amongst staff and facilities will support seclusion and restraint occurring in a manner compliant with international standards. The NPM's overall knowledge of current seclusion and restraint policies and practices across the varied detention environments remains incomplete.

This report will document the current state of seclusion and restraint in the New Zealand detention context and will make recommendations that will be monitored by the NPMs. This report will be publicly released in 2017.

Torture Ambassador Project

A highlight of the year has been the release of the Torture Ambassador Project report. This report was prepared by Michael White of the Human Rights Commission in collaboration with the Association for the Prevention of Torture and the Asia Pacific Forum. It was funded by the European Union. The report recommended that an NPM be designated to monitor a wider range of places where people may be deprived of their liberty in the aged care and disability services sectors. The recommendations were endorsed by the NPMs and discussions have been taking place with the Ministry of Justice to encourage them to review the scope of the current monitoring arrangements in light of the recommendations.

Going forward

Both the seclusion and restraint project and the work on the recommendations of the torture ambassador project continue in the 2016/2017 year and are of high priority to the Commission.

The National Plan of Action (NPA) sets out the actions the Government is taking to protect and promote human rights as a result of the commitments it made though its second Universal Periodic Review. Ongoing development and enhancement resulted in an updated tool with additional functions (including enabling users to create their own customised reports from the commission's data) being launched in early March 2016. The NPA will be expanded to include recommendations from other international monitoring bodies, including the Committee Against Torture.

Office of the Children's Commissioner

Manaakitia A Tātou Tamariki

The Children's Commissioner is a designated National Preventive Mechanism (NPM) under the Crimes of Torture Act (2006). In this role, the Children's Commissioner has responsibility for monitoring places of detention for children and young people to ensure compliance with the Optional Protocol to the Convention against Torture (OPCAT).

The Children's Commissioner also has a broader monitoring function under the Children's Commissioner Act (2003). Under that Act, the Children's Commissioner is an independent crown entity appointed by the Governor-General. In this role, the Commissioner monitors activities under the Children, Young Persons and Their Families Act 1989 (CYPFA), including the policies and practices of Child, Youth and Family (CYF); undertakes systemic advocacy functions; and investigates particular issues with potential to threaten the health, safety, or wellbeing of children and young people.

The Children's Commissioner has a range of statutory powers to promote the rights and wellbeing of children and young people up to 18 years of age.

Overview

The Children's Commissioner's NPM role under OPCAT overlaps with his general monitoring function under the Children's Commissioner Act, both of which involve regularly monitoring CYF residences.

The Office of the Children's Commissioner (OCC) currently monitors four care and protection residences and four youth justice residences managed by CYF, and one care and protection residence for young people with harmful sexual behaviour, managed by a non-government organisation, Barnardos. The OCC also monitors three Mothers with Babies Units (MBUs) within prisons, operated by the Department of Corrections. The OCC's monitoring visits to MBUs are conducted jointly with the Office of the Ombudsman (OO). The OCC focuses on the wellbeing and treatment of babies in the MBU, while the OO monitors the wellbeing and treatment of prisoners in the wider prison environment.

Summary of NPM Activities

Monitoring approach

The OCC assesses residences' compliance with OPCAT requirements within the context of our broader monitoring, having regard to factors such as leadership, organisational culture and values, operational management, quality of social work practice (including staff capability), and strength of partnerships and networks. All monitoring visits include interviews with young people, staff, management, and key stakeholders. We assess the extent to which the treatment of children and young people is focussed on enhancing their wellbeing and rights, as well as ensuring that fundamental OPCAT requirements are being met.

The magnitude of change anticipated from CYF's transformation into a new agency, Oranga Tamariki, over the next few years means that there must be careful attention to ensure ongoing compliance with minimum standards to prevent ill treatment, cruelty or torture. We also need to ensure the strengthening of quality, child-centred residential care practice with a focus on positive and aspirational goals for children and young people in CYF residential care.

In 2016 we produced our second public aggregated State of Care report. That report summarised the key findings from both our OPCAT and general monitoring work over a 12 month period. It informed the public and key stakeholders about CYF's strengths and areas for development. It also provided evidence-based monitoring information to support our findings and recommendations and aimed to inform the design of the new operating model for Oranga Tamariki.

The OCC uses the same five-point rating scale for OPCAT monitoring as we use for our general

monitoring. Our evaluative rubric for general monitoring includes content about best practice in residences and supports consistency and transparency in ratings. The rubric prioritises both the voices of children and young people and responsiveness to Māori, supporting our assessment of CYF's performance in how well they are improving outcomes for children and young people.[2] Evidenced-based ratings provide CYF with clear information about what they need to do to improve their services for children and young people. As shown in Table 1, ratings of 'transformational', 'well placed' and 'developing' indicate a facility is compliant with the standard required for the relevant OPCAT domain, while ratings of 'minimally effective' or 'detrimental' indicate a facility is non-compliant with an OPCAT domain.

NPM monitoring visits

Between July 2015 and June 2016 the OCC assessed seven residential facilities: three youth justice residences, three care and protection residences, and one MBU. Two of these visits were unannounced, as shown in Table 2.

Table 1: Guide to the ratings provided for each domain

Rating	Assessment	What it means	Compliant with OPCAT
	Transformational/ outstanding	Exceptional, outstanding, innovative, out of the norm	Yes
	Well placed	Strong performance, strong capability, consistent practice	Yes
	Developing	Some awareness of areas needing improvement; some actions to address weaknesses, but inconsistent practice; pockets of good practice	Yes
	Minimally effective/weak	Low awareness of areas needing improvement; lack of action to address weaknesses; significant concerns exist	No
	Detrimental	Actively causing harm, negligent, ignoring, rejecting, undervaluing, undermining practice	No

Table 2: Facilities visited by the OCC in 2015–16

Name of facility	Type of facility
Epuni	Care and Protection residence
Te Oranga (unannounced)	Care and Protection residence
Whakatapokai	Care and Protection residence
Korowai Manaaki	Youth Justice residence
Te Maioha o Parekarangi	Youth Justice residence
Te Puna Wai o Tuhinapo	Youth Justice residence
Arohata Women's Prison (unannounced)	Mothers with Babies Unit

Table 3: Summary of the OCC's OPCAT ratings for facilities visited in 2015-16

OPCAT domain	Facility 1	Facility 2	Facility 3	Facility 4	Facility 5	Facility 6	Facility 7
Treatment							
Protection system							
Material conditions							
Activities and contact with others						N/A	
Medical services and care		N/A				N/A	
Personnel							
Overall OPCAT rating							

Issues

Key OPCAT findings

Overall compliance with OPCAT

All residences in New Zealand are compliant with OPCAT requirements. The OCC has found no evidence of intentional cruelty and no incidents of torture in any of the facilities. In general, children and young people in New Zealand residences have their rights upheld and are usually treated well. Children and young people eat well, participate in a range of sporting, leisure, and cultural activities, have reasonable access to family and whānau, have good access to medical services and care, and generally understand the complaints system. However, areas for development have been identified and these have resulted in recommendations for improvement.

The OCC's ratings for each of the seven facilities visited in 2015–16 are shown in Table 3. Five of the seven received an overall OPCAT rating of 'well placed' (three with developing elements), and the other two received a lesser rating of 'developing' (with well placed elements).

Three of these facilities had been visited in the previous year (2014-15) and two in 2013-14. Four of these five received improved overall ratings from their previous assessments (in several cases, significant improvements), while one had remained the same, with improvements in some aspects but deterioration in others. This general improvement was also apparent in the specific domains. This year we found no evidence of detrimental or minimally effective elements whereas in 2014-15, two facilities failed to reach the compliance level for elements related to two OPCAT domains.

Note: To protect the anonymity of each facility, they are listed in a different order in Table 3 compared with Table 2. The three domains shown above as N/A were not assessed this year: they had all been rated as well placed in the previous year, so our focus this year was on monitoring progress against areas for development.

Despite the generally positive findings, across the visits to CYF residences, the OCC found room for improvement across all domains. The remainder of this report describes the four key themes that have emerged from an analysis of our OPCAT monitoring findings for the 2015-16 year.

1 Inconsistent treatment of children and young people

Across all the residences we visited, staff relationships with the children and young people are generally warm, positive, and engaging. However, there is considerable variability across residences in the quality of day-to-day practices young people experience, and in staff capacity and capability to meet children and young people's needs. This is particularly so with respect to managing challenging behavioural, emotional, and mental health problems. Young people in some residences were aware of inconsistent expectations and responses from individual staff, and across different teams. Inconsistent staff responses result in young people acting out more often, with some staff over-reacting and coming down too hard on young people and other staff under-reacting and not doing enough. This pattern reduces the safety of the environment for both young people and staff. Access to specialist mental health treatment also remains variable across residences.

There is also inconsistent treatment of young people related to the implementation of new therapeutic practice models. Although several residences are moving in the right direction, introducing more therapeutic models of treatment and care, operationalising such models requires clear communication, common understandings amongst staff and regular training and supervision. Several residences were finding the implementation of new practice models challenging, with barriers including difficulties in changing previous practices, staff shortages and turn-over, and high numbers of casual staff. As skill levels, leadership and support increases, a reduction in the use of secure facilities and restraint techniques can be expected. It was encouraging to note that such improvements were apparent in several of the residences.

As we noted last year, the Treatment and Personnel domains are closely linked. Five of the seven residences received 'developing' ratings for aspects of both the Treatment and Personnel domains, while one residence showed transformational elements in both domains. The transformational elements we observed were the successful introduction of a values-based behavioural system, known as Positive Behaviour for Learning (PB4L), which replaced the standard Behaviour Management System (BMS), and a practice leader position which has increased formal and informal supervision of staff. These steps have resulted in better integrated and more consistent staff practices, enabling staff to better meet young people's needs, and resulting in improved behaviour by the young people.

2 Lack of responsiveness to mokopuna Māori

One area of development in most residences is a lack of vision, cultural capability, and partnerships with local iwi to address the needs of mokopuna Māori. There is significant variation in cultural capability building, cultural mentoring, and cultural practices across the residences. This is a significant concern given that up to 70% of young people in residences are Māori. For mokopuna Māori, culture is a key element of identity. When cultural needs are met, young people's sense of belonging and connectedness is enhanced. When young people are disconnected from their culture, the opposite is true. Māori cultural competence is therefore crucial to meet young people's needs.

Two of the six residences we visited are committed to upholding Māori culture and values, and have plans in place to build cultural capability. One of these has plans to develop a kaupapa Māori unit (by Māori, for Māori), which aims to enable young Māori to engage with their culture by immersing themselves in cultural activities and learning. At the second of these residences, young people have the opportunity to meet regularly with a kaumatua (Māori elder) to enhance cultural connectedness. However, even at these residences, such plans and practices are vulnerable to competing organisational and financial priorities and rely on limited numbers of skilled staff to implement. We expect to see further development in this area across all residences in the next year.

3 Material conditions in residences are adequate but not always child and youth friendly

Our visits this year found material conditions generally better than last year – no facilities received minimally effective ratings, and three residences which had been visited last year had all improved their ratings, with changes such as building repairs, better mattresses, and fresh paint. Nevertheless, most residences have an institutional feel that is not youth friendly or 'home-like', and is not conducive to the well-being of children and young people. The secure units, even in care and protection residences, are prison-like and unwelcoming. In addition, we found problems with: faulty air-conditioning units in a couple of residences, making study and sleep difficult; inadequate fencing in one residence, which reduced the use that could be made of facilities; and old and worn furniture and furnishings in most of the residences.

While CYF operates the residences, they are maintained and upgraded by MSD's property services. We understand that a 10 year asset management plan has been developed, with all residences scheduled to be upgraded. However this will not help with some of the immediate repair needs, or current physical surroundings which do not provide the child and youth friendly environment needed. There is also a risk of additional delays to repairs and maintenance during CYF's restructuring period, even if the changes to CYF residential practices address our concerns in the longer term.

More positively, we did find examples where staff and young people in several residences had achieved transformational improvements with small changes and imaginative redecoration. Stark 'time out' spaces had been turned into quiet withdrawal spaces which the young people perceived as supportive rather than punishing. Young people in another facility which was generally run down were very proud of their

achievements in decorating their own bedrooms, and staff had achieved impressive refurbishment of communal spaces.

4 **The protection system is working, but there remains a lack of responsiveness to young people's voices**

As was the case last year, four of the six residences received a predominant rating of 'well placed' for their protection system, reflecting that the grievance system, known as Whaea Te Maramatanga, is generally working. The rules, regulations, and grievance process are regularly explained to young people, and most of the young people we interviewed understood how to access the system. However, many young people reported being unwilling or unsure about making a complaint about another young person or staff member. The reasons given included concern about adverse consequences from other young people or staff and lack of action about previous complaints or suggestions. Although young people know they can ask for a youth advocate to help them make a grievance, this rarely happens in practice, because youth advocates do not have sufficient engagement with residences for young people to establish relationships with them.

Greater commitment to giving young people a voice and consistency of response from staff is needed in some residences, and in some cases, ensuring better communication and feedback about why suggestions can or cannot be acted on would improve confidence in the system. There are proposals for new approaches to encourage feedback from children and young people in CYF care but, in the meantime, more could be done to ensure young people have a stronger voice in the current system.

About 600 grievances were reported in the last year (up until 31 March 2016), and the vast majority were investigated within the compulsory two week time frame. As at March 2016, only 35 requests had been made to take a complaint to the next level up, a Grievance Panel, suggesting most young people were happy with the outcome of the initial investigation. Finally, young people may escalate their concerns to the OCC if they are not satisfied with the outcome of the Grievance Panel review. The number escalated to the OfCC has increased from one in 2014-15 to seven in 2015-16. This increase may be due to new videos which clearly explain to young people all the steps in the Whaea Te Maramatanga grievance process.

Going forward

Over the next year, the OCC will continue to monitor the recommendations and plans already identified. The OCC acknowledges that CYF is currently facing significant change following the external review of CYF that was completed in early 2016. Major reforms have been announced by the Government to increase child-centred practice.

A new agency, Oranga Tamariki, will commence in April 2017, but this is just the beginning of a longer series of changes and significant details are yet to be developed. It is possible that the approach to residential care may be significantly revised. The lifting of the age at which young people will leave the care of the state, and a possible raising of the age at which young offenders move into the adult criminal justice system, will certainly place new demands on both care and protection and youth justice residences. We have made recommendations in our State of Care report 2016 that CYF develop a clear plan to guard against any deterioration in the quality of care and treatment which could result from such significant organisational change and accompanying uncertainty for staff. The OCC is committed to support the new agency to work in more child-centred ways. We will be monitoring carefully and as often as we can during the transition period.

Office of the Ombudsman
Tari o te Kaitiaki Mana Tangata

Overview

Under the Crimes of Torture Act (COTA), the Ombudsmen are a designated National Preventive Mechanism (NPM) with responsibility for monitoring and making recommendations to improve the conditions and treatment of detainees, and to prevent torture, and other cruel, inhuman or degrading treatment or punishment, in:

- 18 prisons
- 80 health and disability places of detention[3]
- one immigration detention facility
- four child care and protection residences; and
- five youth justice residences.

The designation in respect of child care and protection and youth justice residences is jointly shared with the Children's Commissioner. This year we undertook a joint visit to the Mothers with Babies Unit at Arohata Prison.

We are funded for three Inspectors and specialist advisors to assist us in carrying out our NPM functions under COTA. In 2015/16 we committed to carrying out 32 visits to places of detention. We exceeded this commitment and carried out a total of 42 visits, including 21 formal inspections and one findings report arising from multiple formal inspections. Thirty-eight visits (90%) were unannounced.

Table 4

Name of facility	Type of facility	Recommendations made
Manaakitanga IPC, West Coast DHB	Adult Mental Health	2
He Oranga Kahurangi, West Coast DHB	Mental Health—Older Adults	1
Te Whetu Tawera, Auckland DHB	Adult Mental Health	11
Tiaho Mai, Counties Manukau DHB	Adult Mental Health	14
Arohata Prison	Prison	17
Ward 21, MidCentral DHB	Adult Mental Health	9
STAR 1, MidCentral DHB	Mental Health—Older Adults	10
Manawatu Prison	Prison	23
Purehurehu, Capital & Coast DHB	Forensic	6
Rangipapa, Capital & Coast DHB	Forensic	11
Tawhirimatea, Capital & Coast DHB	Regional Forensic Rehabilitation Unit	6
He Puna Wairoa, Waitemata DHB	Adult Mental Health	10
Waiatarau, Waitemata DHB	Adult Mental Health	6
Te Puna Waiora, Taranaki DHB	Adult Mental Health	9
Te Whare Hohou Roko, Canterbury DHB	Forensic	5
Alexander, Nelson Marlborough DHB	Mental Health—Older Adults	-
Wahi Oranga, Nelson Marlborough DHB	Adult Mental Health	5
Rolleston Prison	Prison	11
Otago Corrections Facility	Prison	16
Invercargill Prison	Prison	18
Whare Ahuru, 3 DHBs	Adult Mental Health	8

Table 5

Recommendations	Accepted	Not accepted	No comments received
Prisons	61	24	–
Health and disability places of detention	82	12	19

Each place of detention we visit contains a wide variety of people, often with complex and competing needs. Some detainees are difficult to deal with—demanding and vulnerable—others are more engaging and constructive. All have to be managed within a framework that is consistent and fair to all. While we appreciate the complexity of running such facilities and caring for detainees, our obligation is to ensure that appropriate standards are maintained in the facilities, to avoid the possibility of torture or other cruel, inhuman or degrading treatment or punishment occurring. In line with our power to make recommendations with the aim of improving the treatment and the conditions of persons deprived of their liberty, we also review and comment on proposed policy changes and legislative reforms.

This year we commenced a practice of extensive surveying of facilities as part of the visiting process.

The 21 formal inspections were at the sites set out in the table below. In addition, the findings report involved formal inspections at multiple sites throughout the year (see table 4).

We reported back to 22 places of detention (100%) within three months of conducting an inspection. This brings the total number of visits conducted over the nine year period of our operation as an NPM to 381, including 158 formal inspections and one findings report.

We made 198 recommendations, of which 143 were accepted or partially accepted (as set out in the table below). We intend to report separately on the specific recommendations which were not accepted and not responded to (see table 5).

Of the 24 recommendations not accepted by the Department of Corrections, 16 concerned four common matters that were repeated across several sites, namely:

- the use of cameras and prisoners' right to privacy (six recommendations);
- a lack of privacy screens around some toilets (three recommendations);
- prisoner meal times (three recommendations); and
- insufficient dental care (four recommendations).

Prisons

In last year's annual report, we identified two key areas which raised concerns following our inspections:

- the use of cameras and prisoners' rights to privacy, and
- segregated prisoners being placed in unsuitable cells.

Both of these issues continued to be of particular concern in the 2015/16 reporting year and Inspectors will continue to monitor and make recommendations for improvement on a site by site basis if necessary.

This year, we identified further areas of concern. These relate to:

- the high number of unreported prisoner-on-prisoner assaults
- a lack of purposeful activities and poor quality cell standards for remand prisoners
- the use of tie-down beds and waist restraints to manage some prisoners considered to be at risk of suicide and self-harm, and
- a lack of adequate dental care for prisoners.

Prisoner safety

As part of the inspection process, Inspectors distribute an anonymous questionnaire to prisoners at the commencement of each visit. The table below details the responses on prisoner safety received from the five prisons surveyed in 2015/16.[5]

The number of prisoners advising that they had been assaulted is high, particularly in Manawatu and Invercargill Prisons (just under half of the respondents). The number who chose not to report the assault is even greater. The Department of Corrections notes that it manages some of New Zealand's most difficult and challenging citizens and that not all assaults are reported as some prisoners fear further or escalated violence as retaliation.

Written and oral feedback from prisoners suggests they have little confidence in the complaints system, which was reflected in the questionnaire responses received (see table below).

Table 6: Prisoner survey results—safety

	Arohata	Manawatu	Rolleston	Invercargill	OCF
Muster on the day of inspection	62	270	256	158	432
Number of questionnaires handed out	62	241	221	143	417
Number of questionnaires completed and returned	56 (90%)	140 (58%)	174 (79%)	126 (88%)	287 (69%)
% of prisoners reported being assaulted at that prison	18%	46%	13%	44%	32%
% of prisoners who **did not** report the assault	18%	80%	61%	84%	71%
% of prisoners who had felt unsafe in current prison	30%	55%	22%	53%	45%
% of prisoners who felt unsafe at the time of inspection	9%	25%	6%	23%	15%
% of prisoners who felt they had been victimised in prison	31%	56%	18%	42%	37%
% of prisoners who felt they had a member of staff they can turn to	77%	69%	74%	87%	72%

Table 7: Prisoner survey results—complaints process

	Arohata	Manawatu	Rolleston	Invercargill	Otago
% of prisoners that reported **not knowing** how to raise a complaint	*Question not asked*	*Question not asked*	27%	11%	13%
% of prisoners reporting it **was difficult** to access a complaint form (PCO1)	14%	32%	17%	45%	38%
% of prisoners reporting to **have faith** in the complaint system	11%	8%	26%	14%	25%

We made recommendations that Otago Corrections Facility, Manawatu Prison, and Invercargill Prison carry out a safety survey to identify where prisoners feel least safe and address the findings in a context that includes prisoner representation.

Remand prisoners

We found that remand prisoners at both Invercargill Prison and Manawatu Prison were housed in unacceptable conditions. The majority of remand cells at these two prisons are double-bunked. We observed run-down accommodation and a lack of staff supervision, particularly at Invercargill Prison, and a culture of intimidation amongst prisoners, especially in the remand exercise yards. There was a lack of internal recreation space and purposeful activity. Remand prisoners had the option of either being locked in their cell or in the exercise yard (a basic yard-to-cell regime).

Remand prisoners at these sites were denied access to dining facilities and were required to eat their meals in their cell, next to uncovered toilets. A new dining facility is being built at Invercargill Prison. However, management has stated that remand prisoners will not be allowed access as they are all managed as high-security prisoners by default.

The lack of purposeful activity for remand prisoners was not unique to Manawatu Prison and Invercargill Prison. It was also evident at Otago Corrections Facility, and to a lesser degree at Arohata Prison, where Inspectors observed a small number of remand prisoners undertaking employment training.

The Department of Corrections advises that it has increased the courses available to remand prisoners. In relation to Invercargill Prison, it advises that it has increased the number of staff allocated to the remand unit.

Mechanical restraints

In April 2016 COTA Inspectors learned about the extended restraint of a male prisoner in the At Risk Unit (ARU) in Auckland Prison.[6] The prisoner was strapped to a tie-down bed by his legs, arms, and chest following several episodes of self-harm. Chief Ombudsman Judge Peter Boshier raised concerns about the ongoing restraint of this specific prisoner with the Deputy Chief Executive of Corrections on 27 April 2016. The Department of Corrections confirmed that it would conduct a review into this case, given our concerns over the length of time and frequency the prisoner had been secured to the tie-down bed, and that it would release the report findings.

In addition, our COTA Inspectors undertook to examine the management of several prisoners in other ARUs and safe cells across the country who presented a high risk of self-harm.

In August 2016 the Chief Ombudsman released his Findings Report on the use of mechanical restraints in ARUs to the Department of Corrections for comment. He will finalise and publish the report upon receipt of the Department's comments.[7]

Health services

Prisoners had mixed views on the overall quality of primary health services, but we found them to be reasonably good. Clinical governance was well advanced in most sites. The range of primary care services was appropriate, with acceptable waiting times for most clinics except dental and some GP clinics. Issues include:

- The limited availability of health promotion information in a range of accessible formats across all sites
- The absence of a robust process for making confidential health care complaints, and
- Poor medicine management in certain areas, including the supervision of medicine queues.

Secondary mental health services are provided by regional forensic psychiatry services (RFPS) to assess and treat prisoners with high and complex mental health needs. Prisoners may be transferred to a secure forensic mental health facility for treatment in a therapeutic environment. Although available, secondary mental health care was not always effective.

Acute forensic units accept referrals from a number of sources including the courts and community. At times, these admissions appear to take priority over prisoners being admitted for assessment and treatment (otherwise referred to as *'waitlisted'* prisoners) on the basis that the prison environment is a relatively controlled and secure environment.

Table 8: Prisoner survey results—health services

	Arohata	Manawatu	Rolleston	Invercargill	OCF
% of prisoners reported having difficulty accessing the nurse	13%	30%	2%	20%	37%
% of prisoners reported having difficulty accessing the dentist	59%	65%	40%	79%	73%
% of prisoners reported having difficulty accessing the doctor	35%	48%	16%	60%	62%
Overall quality of healthcare service					
Good	84%	62%	86%	42%	44%
Bad	16%	38%	6%	43%	42%
Don't Know	-	-	8%	15%	14%

Good practices at the prisons visited

- All prisoners at Rolleston Prison are unlocked for more than 12 hours a day. The majority of prisoners are involved in meaningful activity, including employment, training or rehabilitation programmes.
- Otago Corrections Facility operates a clear prisoner progression system. Prisoners can see a pathway through the prison from high-security units through to self-care units. This pathway incentivises pro-social behaviour and engagement in rehabilitation opportunities.
- At Invercargill Prison, two of the prison's four units are unlocked for more than nine hours a day.
- Good staff-prisoner relationships were evident at Arohata Prison. Prisoners were complimentary about staff and felt there was a member of staff they could turn to if they had a problem.

We found there to be limited therapeutic engagement, either individually or in groups, for prisoners under the care of forensic mental health care within a prison setting. This may be because RFPS are only required to provide primary mental healthcare to those prisoners waitlisted for a forensic bed.

Service Level Agreements (SLAs) between RFPS and prisons were found to be out of date, and lacking in specificity. They are also managed regionally rather than at individual sites. The SLAs make no reference to prisoners with challenging behaviour such as personality disorders.

Health and disability places of detention

Mental Health (Compulsory Assessment and Treatment) Act

We found areas of good practice and many positive findings across the older, adult acute, and forensic services around New Zealand. Generally, service users[8] were complimentary about the staff in their unit and felt there was someone they could turn to if they had any concerns.

He Oranga Kahurangi (West Coast DHB) and Alexander Unit (Nelson Marlborough DHB) provide assessment and treatment for older people with

mental health needs. Generally, we observed service users receiving good quality care, led by managers with the required skills and knowledge to support continuous improvement. All service users had the necessary paperwork for their committal and treatment.

Accommodation in some adult inpatient units was considered to be unfit for purpose—the seclusion area in Purehurehu Unit (Capital & Coast DHB), the intensive care unit in Te Whare Ahuru Unit (three DHBs), and Te Puna Waiora Unit (Taranaki DHB).

STAR 1 (Elderhealth) is a 15 bed ward that provides services for the treatment, assessment and rehabilitation of older people (over 65), including those with mental health issues. There are nine beds in the open ward and six in the secure care unit (SCU). There was evidence of some service users being arbitrarily detained without documentation, and some service users were being subjected to prolonged and excessive use of mechanical restraints.

Ward 21 is a 24 bed ward with dedicated wings for both men and women. The High Needs Unit (HNU) is a secure, nine bed unit for clients under the Mental Health (Compulsory Assessment and Treatment) Act who are exhibiting severe symptoms of mental illness. Inspectors found that the ward design, in particular the HNU, was not conducive with providing safe and effective mental health care; the DHB's complaints policy, including information on access to the District Inspectors, was not readily available in the ward; and the seclusion and restraint registers were incomplete and some seclusion records were missing.

Visits to STAR 1 and Ward 21 (MidCentral DHB) in December 2015 resulted in 19 recommendations across both facilities.

Although MidCentral DHB did not comment on our report, it now advises that the issue of arbitrary detention in Star 1 has been addressed, a proposal to upgrade or rebuild Ward 21 has been initiated, and the seclusions register and records have been addressed.

In last year's annual report we expressed concern about bed occupancy rates, the lack of restraint training for staff, and seclusion rooms being used as long-term bedrooms—the latter issue generating much publicity during this reporting year. These key issues remain a concern for Inspectors who will continue to monitor and make recommendations for improvement on a site-by-site basis.

This year, there were further areas where improvements need to be made. These relate to:

- all DHBs adopting a zero-tolerance approach to violence (to service users, staff, and visitors) by automatically referring assaults and other serious incidents to the Police
- service users being asked, as a matter of routine, if they want to attend their multi-disciplinary team (MDT) review, and
- the number of acute adult facilities arbitrarily detaining informal service users.

During a visit to He Puna Waiora (Waitemata DHB), Inspectors came across a service user in the seclusion facility who had been seriously assaulted 10 days prior, while an inpatient at Waiatarau Unit (Waitemata DHB). The incident was not reported to the Police, despite the service user's injuries requiring surgery. The Clinical Director for both units advised that the decision whether to involve the Police was:

> …one that was very carefully considered. There has not been a decision that Police would at no stage be involved, but there was careful consideration of his mental and physical state and his fitness to participate in any interaction with the Police which would inevitably follow laying a complaint, whoever made such a complaint.

We recommended that the DHB should adopt a zero-tolerance approach to violence and refer all assaults to the Police.

Inspectors found that many service users, as a matter of routine, are not invited to attend their MDT meeting and do not always receive written feedback following the meeting. We recommended that service users should be routinely invited to attend their MDT meeting and provided with a copy of the minutes.

Of the nine adult acute facilities inspected this year, only one was open. Few facilities had a locked door policy (otherwise known as environmental restraint), detailing when and why doors would be locked and

the review process for unlocking doors. Signage was poor for informal service users wishing to exit the facility, who found themselves having to negotiate all leave requests with staff. A number of units held voluntary patients with 'no leave' status. Service users expressed concerns that they would be placed under the Mental Health (Compulsory Assessment and Treatment) Act if they wished to take leave. We were concerned that this could be considered coercive practice and not in keeping with recovery-based principles. It could also potentially amount to arbitrary detention. We recommended that locked door policy be developed, detailing the process for entry and exit into the Unit for informal (voluntary) service users (and visitors). This should be displayed in prominent areas, including the unit entrance.

At He Puna Waiora (Waitemata DHB) Inspectors found the doors to the internal courtyards locked due to several high profile absconders some months earlier. Service users were reliant on staff availability and facilitation to go outside, and so did not always receive their minimum entitlement to daily fresh air.

Follow-up to previous recommendations

In 2012/13 we reported on the practice of using outdated 'night safety procedures' in some units in the Mason Clinic (Waitemata DHB) to justify locking service users in their bedrooms overnight. We raised the issue at that time with the Director of Mental Health who confirmed that guidance for DHBs was currently being developed around reducing restrictive practices within the mental health area (including night safety orders). We followed up with the Director's office in June 2016, who confirmed that the restrictive practice guidance had not yet been completed.

In February 2016, we found a blanket policy approach being applied to service users in Purehurehu and Rangipapa units (Capital & Coast DHB) who are subject to a *'night safety order'*. We recommended that if night safety orders are to continue in the Unit, they should be captured as seclusion events and reported as such.

Good practices at the health and disability facilities visited

- Manaakitanga Unit (West Coast DHB) was the only open facility where the doors were not routinely locked.
- At Te Puna Waiora Unit (Taranaki DHB) they operate and promote a zero-tolerance approach to violence. All violent incidents are reported to the Police.
- At Capital & Coast DHB, Vaka Pasifika and Maori Cultural Advisors provide one-on-one and group activities across several units. Clients are encouraged to participate in healthy lifestyles by engaging in sporting/ leisure activities and choosing healthier food options.

Other activities

United Nations OPCAT Special Fund

Following the publication in 2014 of the SPT visit report, New Zealand became eligible for the SPT/ OPCAT Special Fund for projects implemented between 1 January and 31 December 2016.

We were successful in an application this year for funding to provide training and monitoring skills to a group of people who have personal experience of using or caring for someone who uses mental health services in New Zealand. These 'Experts by Experience' will assist our Inspectors to undertake visits to places of detention.

Locked dementia facilities

We are concerned about the vulnerability of those detained in privately run dementia units. Such units are not subject to independent oversight by any NPM. This is a matter that we will consider further.

Inspector of Service Penal Establishments

The Inspector of Service Penal Establishments (ISPE) is the National Preventive Mechanism (NPM) charged with monitoring New Zealand Defence Force (NZDF) detention facilities. The Registrar of the Court Martial is appointed ISPE as set out in section 80 f the Court Martial Act 1989 in respect of service penal establishments (within the meaning of section 2(1) of the 1971 Armed Forces Discipline Act).

Facilities

The NZDF currently has one facility that caters for the military punishment of detention. The punishment can only be used for naval ratings of able rank, Army privates, and Royal New Zealand Air Force leading aircraftmen, that is Private soldier equivalents. The facility is the Services Corrective Establishment (SCE) at Burnham Military Camp, Christchurch. It has the capacity to hold up to 10 detainees at any one time, however no more than two can be female. It has a professional full-time staff of Non Commissioned Officer wardens drawn from all three Armed Services. They are supported by the Commanding Officer of the Southern Regional Support Centre (SRSC) in Burnham Camp, who holds a dual appointment that includes the position of Commandant SCE in their job description. The SRSC has a medical officer on call to SCE and on the rare occasions when detainees require specialist treatment, referral to relevant health professionals in Christchurch is readily arranged.

There were 36 detainees in SCE in the 2015/2016 annual year. Forty-two percent were related to drug offending and alcohol was a factor in 25% of the convictions. Given the size of the Regular NZ Defence Force, (over 10,000,) this is not a significant problem overall.

In addition, each of the more significant NZDF base or camp facilities has a limited number of holding cells, used to briefly confine any members of the Armed Forces for their own protection or for the maintenance of good order and military discipline.

Although no detention facilities off-shore are currently available to the NZDF on New Zealand Navy Ships, they can be arranged relatively readily when required as the Armed Forces Discipline Act section 175(1) permits the Chief of Defence Force from time to time to:

- set aside any building or part of a building as a service prison or a detention quarter; or
- declare any place or ship, or part of any place or ship, to be a service prison or detention quarter.

Inspections

In the year ending June 2016 the ISPE inspected this facility on three occasions. The inspections were unannounced and included a physical review of the facilities, a discussion with the manager of the facilities, reviewing documentation, and a private interview with those undergoing punishment. Feedback is provided routinely after the inspection to the Commandant of SCE and to the Chief Warden. Any significant concern identified is reported in writing, without delay, directly to the Chief of Defence Force. There was nothing untoward to report from these inspections.

Of some interest, the management of SCE has changed. In April 2016 the facility moved from an Army sponsorship arrangement that had existed for many years, to be placed under the management of the NZDF Provost Marshal and the Commanding Officer of the Service police Unit. This decision was taken in order that the SCE facility be managed in line with the other 'five eyes' partners (Britian, United States of America, Australia, and Canada) who all place their corrective establishments and military prisons under the management of Service Police. This decision was not driven by any concerns in the NZDF that the former management regimen was unsafe it terms of OPCAT.

Issues

The SCE opened 20 years ago. While the facilities are in good order it is being to show signs of wear and tear in places and some routine maintenance may well be timely.

The balance of Camp and Base facilities throughout New Zealand are generally old and spartan but they remain open as they are adequate for purpose. These facilities are under review by the NZDF. They rarely confine members of the Armed forces for longer than 12 hours at a time and they are closely supervised by service escorts. Those confined in these cells may not be too comfortable, but their treatment is short lived and does not reach the threshold of cruel and unusual punishment.

The cell facilities in NZHMS PHILOMEL, that have been acknowledged by as dire for some time by the NZDF leadership, have now been closed and a temporary arrangement will remain in place in the Devonport Naval Base, using a designated barrack room, until a new purpose built facility can be delivered.

Going forward

The ISPE will continue 'no notice' inspections of SCE in the 2015/16 year. The number of inspections will depend to some extent on the numbers detained in the SCE facility and the duration of sentences. There is no value in an inspection of the facility when no members of the Armed Forces are undergoing punishment and limited value when detainees have been detained for the first few days of a sentence of about 14 days detention.

Independent Police Conduct Authority

Whaia te pono, kia puawai ko te tika

The Independent Police Conduct Authority (the Authority) is the designated NPM in relation to people held in Police cells or otherwise in the custody of the Police.

The Authority is an Independent Crown entity, which exists to ensure and maintain public confidence in New Zealand Police.

The Authority does this by considering and, if it deems necessary, investigating public complaints against Police of alleged misconduct or neglect of duty and assessing Police compliance with relevant policies, procedures and practices in these instances.

The Authority also receives from the Commissioner of Police notification of all incidents involving Police where death or serious bodily harm has occurred. It may investigate those incidents and other matters involving Police policy, practice and procedure where it is satisfied that it is in the public interest to do so.

In addition, the Authority has entered into a Memorandum of Understanding with Police under which the Commissioner of Police may notify the Authority of incidents involving offending or serious misconduct by a Police employee, where that matter is of such significance or public interest that it places or is likely to place the Police reputation at risk. The Authority may act on these notifications in the same manner as a complaint.

Judge Sir David Carruthers is the Chair of the Independent Police Conduct Authority, having been appointed for a five-year term in April 2012.

Overview

In the whole of its work the Authority is intent on shifting its general focus from one of blame to prevention. This philosophical shift has informed the way in which the Authority has fulfilled its NPM function in this reporting year and will continue to do so.

There are two aspects to the Authority's NPM work. The first involves consideration of the quality and nature of Police custodial facilities and the second concerns the operation and management of both those facilities and other places in which custodial management is the responsibility of the Police.

Police operate 437 custodial management facilities nationwide. The majority of these are cell blocks contained at police stations. In addition, however, Police have responsibility for prisoners in District Courts. Although the Police are not responsible for the construction of Court cells, which are the responsibility of the Ministry of Justice, the Authority acting under its OPCAT jurisdiction has responsibility for the quality and nature of these cells.

Summary of activities

Monitoring of police compliance with National Standards

The Authority has been working with the Police to establish an agreed National Standard for all Police custodial facilities. The Standard has two components. The first component comprises standards governing the management and care of detainees in Police custody. These standards have now been adopted by Police in the form of a new policy labelled the 'People in Police Detention' policy. The policy came into effect in November 2015.

The second component comprises standards governing the physical infrastructure of Police cells. These are currently contained in the Police Accommodation Code. Work is required to update and expand this Code in a number of respects, but it has been delayed by other Police priorities. The Authority continues to engage with the Police to ensure that the work is undertaken as soon as practicable.

During the 2015/16 financial year the Authority worked with Police to develop a joint programme of monitoring compliance with the agreed standards, both on a national basis and on a District–by–District basis. This work was well advanced by year end, and it is expected that the agreed programme will be operational by January 2017. Accordingly, in the next Annual Report the Authority will be able to report on the effectiveness of this monitoring programme for a six month period.

The auditing process will enable the identification and prioritisation of areas where capital expenditure is required. It will also enable the systematic identification of custodial facilities where management and care is falling below the required standard, and of policies and procedures that require refinement or change.

Oversight of Police custodial management

Through the fulfilment of its statutory role in investigating complaints against the Police and incidents involving death or serious injury that arise from Police action, the Authority is able to identify and address not only individual instances where Police officers have failed to perform their duty of care but also broader systemic issues with Police custodial management.

Of the 2,441 complaints and referrals received by the Authority during the reporting period, 67 were identified as having OPCAT–related issues. Many of these cases exposed systemic issues that needed to be addressed by way of changes in policy or procedure in custodial facilities. Where required, these were raised with the District concerned, and the Authority monitored the District response to ensure that the issue was addressed. For example, as a result of an attempted suicide in the Police District Custody Unit in Christchurch, it was discovered that many of the cells had previously unidentified ligature points that provided an opportunity for self-harm. The Authority worked with both the District and Police National Headquarters to ensure that the ligature points in the Christchurch cells were removed and that cell blocks elsewhere in the country were checked to ensure that a similar problem did not exist.

The Authority also applies an OPCAT perspective to its independent investigations and reviews. While independent investigations and reviews are a separate statutory function of the Authority, the human rights principles and standards applied in the OPCAT context are equally relevant to the Authority's general oversight role. During the reporting period, the Authority conducted eight independent investigations that included consideration of OPCAT issues, and referred a further six cases back to the Police for investigation or other action.

The Authority also undertook two more general projects to improve the management and care of detainees in Police custody. First, the Authority continued to work with Police and Mental Health Services to improve the way in which those experiencing a mental health crisis are dealt with by Police and to minimise the numbers who are taken to Police cells for a mental health assessment. To that end, the Authority facilitated workshops involving Police and Mental Health staff in three District Health Board areas. At each workshop a number of actions to improve practice were identified, and these are subsequently being worked on.

Secondly, as noted in last year's Annual Report, the Authority became aware of the substandard physical conditions of most Court cells throughout the country that are posing an ongoing risk to the safety and wellbeing of prisoners. As a result, the Authority worked with the Ministry of Justice in the 2015/16 financial year to ensure that urgent action is being taken to address the problem. The Ministry undertook an audit of all Court cells according to criteria agreed with the Authority, and reported the results of that audit to the Authority. A prioritised programme of work to address the deficiencies identified through the audit was then developed, and the Authority and the Ministry have had regular meetings to monitor the implementation of that work programme. While the required remediation work is substantial and will take a substantial period of time to achieve, the Authority is satisfied that good progress is being made and that the Ministry is committed to ensuring that court cells are brought up to standard.

Site visits

Where possible during the reporting year, the Authority has visited Police custodial facilities in the course of its ordinary work. Where an incident requiring investigation comes to the attention of the Authority, staff often visit the facility to discuss the issues with custodial staff. In addition, the Authority takes the opportunity to make unannounced visits of custodial facilities when it is visiting a Police District for other reasons.

During the 2015/16 financial year, visits were undertaken to the Auckland, Counties Manukau and Rotorua Police District Custody units and to the Porirua, Waitakere, Papakura, and Hutt Valley Court cells.

Appendix: OPCAT background

Introduction to OPCAT

The Optional Protocol to the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT) is an international human rights treaty that is designed to assist States to meet their obligations to prevent torture and ill-treatment in places where people are deprived of their liberty.

Unlike other human rights treaty processes that deal with violations of rights after the fact, OPCAT is primarily concerned with preventing violations. It is based on the premise, supported by practical experience, that regular visits to places of detention are an effective means of preventing torture and ill-treatment and improving conditions of detention. This preventive approach aims to ensure that sufficient safeguards are in place and that any problems or risks are identified and addressed.

OPCAT establishes a dual system of preventive monitoring, undertaken by international and national monitoring bodies. The international body, the United Nations Subcommittee on Prevention of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (SPT), will periodically visit each State Party to inspect places of detention and make recommendations to the State.

At the national level, independent monitoring bodies called National Preventive Mechanisms (NPMs) are empowered under OPCAT to regularly visit places of detention, and make recommendations aimed at strengthening protections, improving treatment and conditions, and preventing torture and ill-treatment.

Preventive approach

The Association for the Prevention of Torture (APT) highlights the fact that "prevention is based on the premise that the risk of torture and cruel, inhuman or degrading treatment or punishment can exist or develop anywhere, including in countries that are considered to be free or almost free from torture at a given time".[9]

On the principle of prevention, the SPT noted that:

> "Whether or not torture or other cruel, inhuman or degrading treatment or punishment occurs in practice, there is always a need for States to be vigilant in order to prevent ill-treatment. The scope of preventive work is large, encompassing any form of abuse of people deprived of their liberty which, if unchecked, could grow into torture or other cruel, inhuman or degrading treatment or punishment. Preventive visiting looks at legal and system features and current practice, including conditions, in order to identify where the gaps in protection exist and which safeguards require strengthening."[10]

Prevention is a fundamental obligation under international law, and a critical element in combating torture and ill-treatment.[11] The preventive approach of OPCAT encompasses direct prevention (identifying and mitigating or eliminating risk factors before violations can occur) and indirect prevention (the deterrence that can be achieved through regular external scrutiny of what are, by nature, closed environments).

The UN Special Rapporteur on Torture remarked that:

> "The very fact that national or international experts have the power to inspect every place of detention at any time without prior announcement, have access to prison registers and other documents, [and] are entitled to speak with every detainee in private … has a strong deterrent effect. At the same time, such visits create the opportunity for independent experts to examine, at first hand, the treatment of prisoners and detainees and the general conditions of detention … Many problems stem from inadequate systems which can easily be improved through regular monitoring. By carrying out regular visits to places of detention, the visiting experts usually establish a constructive dialogue with the authorities concerned in order to help them resolve problems observed."[12]

Implementation in New Zealand

New Zealand ratified OPCAT in March 2007, following the enactment of amendments to the Crimes of Torture Act 1989, to provide for visits by the SPT and the establishment of NPMs.

New Zealand's designated NPMs are:

1. the Independent Police Conduct Authority – in relation to people held in police cells and otherwise in the custody of the police
2. the Inspector of Service Penal Establishments of the Office of the Judge Advocate General – in relation to Defence Force Service Custody and Service Corrective Establishments
3. the Office of the Children's Commissioner – in relation to children and young persons in Child, Youth and Family residences
4. the Office of the Ombudsman – in relation to prisons, immigration detention facilities, health and disability places of detention, and Child, Youth and Family residences
5. the Human Rights Commission has a coordination role as the designated Central National Preventive Mechanism (CNPM)

Functions and powers of National Preventive Mechanisms

By ratifying OPCAT, States agree to designate one or more NPMs for the prevention of torture and ill-treatment (Article 17) and to ensure that these mechanisms are independent, have the necessary capability and expertise, and are adequately resourced to fulfil their functions (Article 18).

The minimum powers NPMs must have are set out in Article 19. These include the power to regularly examine the treatment of people in detention, to make recommendations to relevant authorities and submit proposals or observations regarding existing or proposed legislation.

NPMs are entitled to access all relevant information on the treatment of detainees and the conditions of detention, to access all places of detention and conduct private interviews with people who are detained or who may have relevant information. NPMs have the right to choose the places they want to visit and the persons they want to interview (Article 20). NPMs must also be able to have contact with the SPT and publish annual reports (Articles 20, 23).

The State authorities are obliged, under Article 22, to examine the recommendations made by the NPM and discuss their implementation.

The amended Crimes of Torture Act enables the Minister of Justice to designate one or more NPMs as well as a Central NPM and sets out the functions and powers of these bodies. Under section 27 of the Act, the functions of an NPM include examining the conditions of detention and treatment of detainees, and making recommendations to improve conditions and treatment and prevent torture or other forms of ill treatment. Sections 28-30 set out the powers of NPMs, ensuring they have all powers of access required under OPCAT.

Central National Preventive Mechanism

OPCAT envisions a system of regular visits to all places of detention.[13] The designation of a central mechanism aims to ensure there is coordination and consistency among multiple NPMs so they operate as a cohesive system. Central coordination can also help to ensure any gaps in coverage are identified and that the monitoring system operates effectively across all places of detention.

The functions of the CNPM are set out in section 32 of the Crimes of Torture Act, and are to coordinate the activities of the NPMs and maintain effective liaison with the SPT. In carrying out these functions, the CNPM is to:

- consult and liaise with NPMs
- review their reports and advise of any systemic issues
- coordinate the submission of reports to the SPT
- in consultation with NPMs, make recommendations on any matters concerning the prevention of torture and ill-treatment in places of detention.

Monitoring process

While OPCAT sets out the requirements, functions and powers of NPMs, it does not prescribe in detail how preventive monitoring is to be carried out. New Zealand's NPMs have developed procedures applicable to each detention context.

The general approach to preventive visits, based on international guidelines, involves:

1 Preparatory work, including the collection of information and identification of specific objectives, before a visit takes place

2 The visit itself, during which the NPM monitoring team speaks with management and staff, inspects the institution's facilities and documentation, and speaks with people who are detained

3 Upon completion of the visit, discussions with the relevant staff, summarising the NPM's findings and providing an opportunity for an initial response

4 A report to the relevant authorities of the NPM's findings and recommendations, which forms the basis of ongoing dialogue to address identified issues.

NPMs' assessment of the conditions and treatment of detention facilities takes account of international human rights standards, and involves looking at following **six domains:**

1 Treatment: any allegations of torture or ill-treatment; the use of isolation, force and restraint

2 Protection measures: registers, provision of information, complaint and inspection procedures, disciplinary procedures

3 Material conditions: accommodation, lighting and ventilation, personal hygiene, sanitary facilities, clothing and bedding, food

4 Activities and access to others: contact with family and the outside world, outdoor exercise, education, leisure activities, religion

5 Health services: access to medical and disability care

6 Staff: conduct and training.

Endnotes

1 See Office of the Auditor General, 2008, Mental health services for prisoners; Simpson, New Zealand Provision of Forensic Mental Health Services.

2 The latest version of the rubric is available on the Children's Commissioner's website at: http://www.occ.org.nz/assets/Publications/Living-evaluative-rubric.pdf.

3 This year, a new forensic youth facility has increased the number of health and disability facilities we visit from 79 to 80.

4 MidCentral DHB did not respond to recommendations made following a visit to Ward 21 and STAR 1 (19 recommendations in total). These 19 recommendations, which were not responded to, have been deemed as not having been accepted for the purposes of calculating the overall percentage of recommendations accepted, which is why the performance measure is below the Budget Standard.

5 Prison inspections 2015/ 16: Arohata Prison, Manawatu Prison, Rolleston Prison, Invercargill Prison and Otago Corrections Facility.

6 Auckland Prison is the only prison in New Zealand that holds maximum security prisoners.

7 *A Question of Restraint? Care and management for prisoners considered to be at risk of suicide and self-harm: observations and findings from COTA inspections July 2015–June 2016*.

8 The term 'service user' encompasses patients, clients and care recipients.

9 APT (March 2011) *Questionnaire to members states, national human rights institutions, civil society and other relevant stakeholders on the role of prevention in the promotion and protection of human rights*, p. 10.

10 Subcommittee on Prevention of Torture (May 2008). *First Annual Report of the Subcommittee on Prevention of Torture*, CAT/C/40/2, para 12.

11 It sits alongside the obligations to criminalise torture, ensure impartial investigation and protection, and provide rehabilitation for victims.

12 UN Special Rapporteur on Torture, Report of the Special Rapporteur on torture to the 61st session of the UN General Assembly, A/61/259 (14 August, 2006), para 72.

13 OPCAT, Article 1.

NPM contacts

Independent Police Conduct Authority

0800 503 728 (toll free)
Language Line available
Telephone 04 499 2050
Email enquiries@ipca.govt.nz
Website www.ipca.govt.nz

Level 10, 1 Grey Street,
PO Box 5025, Lambton Quay
Wellington 6011

Inspector of Service Penal Establishments

Office of the Judge Advocate General
Headquarters
New Zealand Defence Force
Private Bag, Wellington

Office of the Children's Commissioner

0800 224 453 (toll free)
Email children@occ.org.nz
Website www.occ.org.nz

Level 7, 110 Featherston St
PO Box 5610, Lambton Quay
Wellington 6145
Telephone 04 471 1410

Office of the Ombudsman

0800 802 602 (toll free)

Email info@ombudsman.parliament.nz

Website www.ombudsman.govt.nz

Auckland
Level 10, 55-65 Shortland Street
PO Box 1960, Shortland Street
Auckland 1140
Telephone 09 379 6102

Wellington
Level 7, 70 The Terrace
PO Box 10 152
Wellington 6143
Telephone 04 473 9533

Christchurch
Level 1, 545 Wairakei Road
Harewood
Christchurch 8053
Telephone 03 357 4555

Human Rights Commission
Te Kāhui Tika Tangata