The Optional Protocol to the Convention against Torture (OPCAT) in New Zealand 2007−2012

## A review of OPCAT implementation by New Zealand’s National Preventive Mechanisms – April 2013


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## **Foreword**

2012 marked five years since New Zealand ratified the Optional Protocol to the Convention Against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (OPCAT).[[1]](#footnote-1) It is timely, therefore, to review our progress, and to highlight and address ongoing challenges.

As we reflect on the last five years, and look ahead, the objective of OPCAT should be kept in mind. It is to *establish a system of regular visits undertaken by independent international and national bodies to places where people are deprived of their liberty, in order to prevent torture and other cruel, inhuman or degrading treatment or punishment.[[2]](#footnote-2)*

Despite its title, the protocol is not limited solely to preventing torture. The mandate it provides is broad and preventative. It encourages collaborative efforts to ensure systems and processes within places of detention are such that people who are detained, many of whom are amongst our most vulnerable citizens, are treated with dignity and respect, and that they are protected from ill-treatment or harm. International experience tells us that preventative monitoring minimises the possibility of ill-treatment or harm. It also reminds us that where ill-treatment or harm is found, prompt and impartial truth finding and acknowledgement of that truth, rehabilitation of the affected person and compensation for the affected person are critical to recovery from ill-treatment or abuse. As is the case with New Zealand’s accident compensation scheme this is often achieved without recourse to the courts and related burdens of proof.

OPCAT is significant in that it offers a means to translate human rights concepts into action, and it is by giving effect to human rights that we make them meaningful.

As chair of the Central National Preventive Mechanism (NPM) I would like to take this opportunity to draw attention to and acknowledge the work of New Zealand’s other designated NPMs. The Ombudsman, the Independent Police Conduct Authority, the Children’s Commissioner and the Inspector of Penal Service Establishments have all demonstrated unwavering commitment to ensuring detainees in New Zealand are treated in accordance with our international obligations, and contributing to the ongoing improvement of detention facilities in New Zealand. Much progress has been made due to the care and effort NPM personnel have applied to their work.

Since 2007 when OPCAT came into force in New Zealand our understanding of what is required to meet OPCAT’s objective has deepened. As NPMs we now have five years experience of what it takes to effectively monitor places of detention and we are very aware of the particular opportunities and challenges posed by OPCAT implementation in the New Zealand context. Although we are proud of our progress we also know that there is room for continual learning and improvement. Monitoring places of detention and preventing ill-treatment is an on-going task. Our hope is that this review will provide a solid basis for ensuring that we continue to carry out this important work in the most effective way possible.

**David Rutherford
Chief Human Rights Commissioner**

**Central National Preventive Mechanism**

## Executive summary

The Optional Protocol to the Convention against Torture (OPCAT) is a unique human rights instrument, which focuses on preventing human rights violations of people who are deprived of liberty. It establishes international and national monitoring mechanisms to visit places where people are detained, with the overall aim of preventing torture and ill-treatment. At the international level a Subcommittee on Prevention of Torture (SPT) is mandated to visit States Parties and make recommendations. At the national level, OPCAT obliges States parties to establish NPMs to monitor the conditions of detention and work collaboratively with all those involved to ensure respect for the human rights of detainees.

New Zealand has established a multiple body NPM comprising four bodies – the Ombudsman, the Independent Police Conduct Authority, the Children’s Commissioner and the Inspector of Service Penal Establishments – each responsible for specific places of detention, and a central NPM, the Human Rights Commission, responsible for providing coordination.

New Zealand’s NPMs have ensured that they meet the requirements of independence under OPCAT, and have established staff and systems to carry out their role. Visit procedures follow the approach set out in international guidelines, and NPMs’ assessment of the conditions and treatment of detention facilities takes account of international human rights standards.

## The first five years

The first five years of OPCAT in New Zealand has established a very solid foundation for future development. Following an initial establishment phase, the NPMs’ practice continues to develop. Altogether there are over 559 places of detention in New Zealand. In the first five years NPMs have undertaken 383 visits to places where people are detained. NPM practice has developed to include, for example, the use of different types of visits and policy work to address systemic issues.

A considerable degree of cooperation has developed amongst NPM members, including participation in each others' visits. Regular meetings of NPMs provide a forum for sharing information, experience and ideas.

### Progress

As a result of implementing OPCAT there have been improvements in the conditions of detention and in the way that detainees are treated within New Zealand. The fact that detaining agencies have been so willing to take OPCAT on board has been a significant factor in the success of implementation so far.

Examples of the positive difference that has been made through OPCAT monitoring include: upgrades and modifications to facilities; changes to policy and practice; and in a number of instances, identifying and addressing issues or problems relating to the situation of individuals in detention.

### Challenges

Many of the challenges in implementing OPCAT have arisen from the practical realities of establishing a new monitoring system. These include timetabling and working out the optimum frequency and duration of visits, what resources are required, and the standards and measures to be applied.

OPCAT is not only a relatively new instrument in terms of being recently adopted, it is also new in terms of the approach it takes and the framework it establishes. Awareness and acceptance of OPCAT monitoring has grown through efforts to raise awareness of the role and function of NPMs, and after institutions have had the opportunity to see how it works in practice.

The overarching challenge faced by NPMs is how to function most effectively within the limited resources they have available. The answer is most likely to lie, at least in part, in further developing the collaborative ways of working that have become the basis of OPCAT implementation in New Zealand.At the same time it must be recognised that maintaining independence and continuing to build credibility are crucial to NPM effectiveness. Furthermore, the potential costs of not investing in OPCAT prevention include compensation claims for breaches of rights, legal medical and rehabilitation costs, and wider detriment to public trust and confidence in the detention systems.

## Issues going forward

The knowledge, experience and understanding of NPMs has strengthened over the last five years. However, it is widely accepted that OPCAT implementation is a continual and evolving process. NPMs welcome the opportunity provided by this five year milestone to review progress and look ahead. The following aspects of NPM operation have some potential to enhance the impact of OPCAT in New Zealand.

### Resources

NPMs have had very limited additional resourcing to carry out their OPCAT functions. To manage within the funding available, NPMs have smaller visit teams and undertake visits with less frequency than is envisioned by the OPCAT. In particular, there is a need for additional resources for NPMs to enable the frequency and coverage of visits required to meet the objectives of the OPCAT, and to hire the services of experts to assist with those visits.

### Publication of visit reports

To date NPMs have published an annual report outlining their activities, achievements and any issues of concern. Information relating to individual visits is not made public. There are different views amongst New Zealand’s NPMs as to whether visit reports can and should be published. This is an issue which NPMs are currently working to resolve.

### Increased engagement with civil society

An engagement strategy is currently being developed by the NPMs to provide an overall framework for communicating about, and engaging with others, on OPCAT. It is hoped that engaging better with others, especially civil society, will help NPMs to create a culture of support for OPCAT work and the importance of treating people who are detained fairly.

### Increased levels of expertise within the NPM

NPMs have identified gaps in their expertise, particularly in mental health (psychological) and medical expertise. NPMs are also exploring how they might develop relationships with other organisations and professional bodies to access the expertise they require on a no-cost or minimal cost basis, while maintaining the necessary degree of independence. It is not yet clear how feasible or sustainable this will be.

### Improving how the NPM works

#### There are some challenges in a multiple NPM model and issues to do with developing the NPM as an institution. Many of these merely reflect the nature of collective enterprises. They include, for example, establishing and maintaining:

#### the institutional practices of the NPM as a collective, including the management of knowledge and information

#### decision-making processes

#### the means to respond collectively to cross-cutting issues.

There are other issues too which impact on how the NPMs’ functions are carried out such as the scope of monitoring, including the definition of ‘place of detention’ and ensuring designations remain relevant and useful. As noted already there are significant resourcing issues, and related to this are also questions about how to measure impact.

## OPCAT in New Zealand 2007−2012

*The development of national preventive mechanisms should be considered an ongoing obligation, with reinforcement of formal aspects and working methods refined and improved incrementally.[[3]](#footnote-3)*

## Introduction

The Optional Protocol to the Convention Against Torture (OPCAT) is a unique human rights instrument because it focuses on the prevention of human rights abuses rather than redress after the fact. This approach is based on the simple, well-founded[[4]](#footnote-4) idea that the best way to prevent the ill-treatment of those who are detained is to make the operations of places of detention more transparent through systematic and regular monitoring.

Since New Zealand ratified OPCAT in 2007 there have been a number of developments, both nationally and internationally. As a result there is a growing body of knowledge and understanding about OPCAT implementation, including the establishment and practice of National Preventive Mechanisms (NPMs).

OPCAT acknowledges that truly effective prevention work requires more than just monitoring. Its broad preventive mandate recognises that work to promote and protect the human rights of detainees is also essential. A proactive, collaborative and constructive approach to OPCAT compliance is encouraged by the protocol itself and this is the way it is being implemented in New Zealand.

The purpose of this review is to reflect on the progress of New Zealand’s NPMs over the last five years and to lay a foundation for planning future OPCAT implementation.

Specifically, the objectives of this review are to:

1. explain the New Zealand monitoring system, and outline its development
2. reflect on the progress, challenges and lessons learnt, and
3. identify ways to strengthen the effectiveness and impact of OPCAT monitoring in New Zealand.

## OPCAT

After a thirty year gestation period OPCAT was adopted by the United Nations in December 2002 and came into force in 2007 after 20 countries had ratified it. There are currently 65 States parties to OPCAT, 21 additional state signatories and 46 states have designated their NPMs.[[5]](#footnote-5)

The use of torture and cruel, inhuman or degrading treatment or punishment had long been prohibited by the international community.[[6]](#footnote-6) In 1689 the UK Bill of Rights outlawed “cruel and unusual punishments”. This provision was copied into the US Constitution on 1791. THE 1689 UK provision is still part of New Zealand’s law. The United Nations Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) was adopted in December 1984. However OPCAT is significant because it establishes the means to implement the aspirations set out in these earlier treaties. It does this by establishing a framework for monitoring places of detention through regular visits by NPMs.

Establishing a system of regular visits by monitoring bodies, some of which are unannounced, has a deterrent effect. However the main objective, rather than identifying and redressing violations is to “*analyse the overall functioning of places of detention and provide constructive, systemic recommendations aimed at improving the conditions and treatment of detained persons.*” [[7]](#footnote-7)

The overall aim is to prevent torture or other ill-treatment by “*reducing risks and creating an environment where violations (torture and other ill-treatment) are less likely to occur*.” [[8]](#footnote-8)

In this way the protocol establishes a pre-emptive approach whereby regular visits, followed by constructive feedback to the facility being monitored, are used to promote full respect for the human rights of those deprived of their liberty and to protect them from torture or other cruel, inhuman or degrading treatment or punishment. Monitoring also enables the identification of systemic issues relating to conditions of detention.

The OPCAT framework uses the “twin pillars” of international and national monitoring. At the international level a Subcommittee on Prevention of Torture (SPT) is mandated to provide an international dimension to preventive monitoring. As well as conducting visits and making recommendations itself, the SPT provides advice and support to NPMs which strengthens their capacity. It also liaises with others in the field, nationally, regionally and internationally, to enhance torture prevention.

In 2010 the membership of the SPT was expanded increasing its capacity to provide guidance and assistance to NPMs and generally contribute to the growing body of understanding as to what constitutes best practice under OPCAT. However, the SPT has noted that:

*… it is not possible to devise a comprehensive statement of what the obligation to prevent torture and ill-treatment entails in abstracto.* *It is of course both possible and important to determine the extent to which a State has complied with its formal legal commitments as set out in international instruments and which have a preventive impact but whilst this is necessary it will rarely be sufficient to fulfil the preventive obligation: it is as much the practice as it is the content of a State’s legislative, administrative, judicial or other measures which lies at the heart of the preventive endeavour.[[9]](#footnote-9)*

As at the date of this report, the SPT has just undertaken its first visit to New Zealand (29 April – 8 May 2013).

At the national level, OPCAT obliges States parties to establish NPMs to monitor the conditions of detention and work collaboratively with all those involved to ensure respect for the human rights of detainees. OPCAT envisages that, in reality, the NPM will carry out most OPCAT monitoring work within a country as they are better placed than the SPT to establish the necessary relationships and conduct regular visits.

Internationally, a number of NPMs have been established. Two other States, the United Kingdom and more recently the Netherlands, have chosen multi-body NPMs such as are in place in New Zealand.

Recent guidance from the SPT emphasises the need for ongoing evaluation and development of NPM processes and practice, and provides some direction on how this may be done.[[10]](#footnote-10) This approach fits with the overall spirit of OPCAT which is one of continually working together to prevent torture and other ill-treatment of people who are detained.

In addition to visits and monitoring, it is increasingly being recognised that effective prevention also requires work to protect and promote human rights. The preamble to OPCAT states:

*“… the effective prevention of torture and other cruel, inhuman or degrading treatment or punishment requires education and a combination of various legislative, administrative, judicial and other measures.”*

## OPCAT in New Zealand

### Ratification

New Zealand ratified OPCAT on 14 March 2007, the 21st State to do so.

As is the usual process prior to ratification the Ministry of Justice assessed New Zealand’s ability to comply with OPCAT and whether any change to legislation would be required to implement it. Those organisations which had existing complaints and monitoring responsibilities regarding people in detention were examined. They included, for example, the Ombudsman, who was able to investigate complaints and deal with the rights of people in prisons and the Children’s Commissioner who had oversight of residential facilities for young people.

Following consultation with existing bodies the [Crimes of Torture Act 1989](http://www.legislation.govt.nz/act/public/1989/0106/latest/DLM192818.html?search=ts_act_Crimes+and+Torture+Act_resel&sr=1) (COTA) was amended to ensure that those organisations which were to be designated as NPMs would have the required powers and functions. The amendments were passed in 2006. New Zealand ratified OPCAT and it entered into force in New Zealand in April 2007. The NPMs and Central National Preventive Mechanism were formally designated by the Minister of Justice in June 2007.

### Legal framework

The amendments to COTA prior to ratification provided for visits by the SPT and the establishment and operation of NPMs. A new Part II was added to the Act[[11]](#footnote-11), with the stated purpose of meeting New Zealand’s obligations under the OPCAT[[12]](#footnote-12) and with provisions which closely reflect the text of OPCAT. For example the definition of detention, and NPM criteria, functions, powers and rights of access are all consistent with OPCAT.

The legislation:

1. provides for visits by the SPT
2. defines ‘deprived of liberty’, places of detention[[13]](#footnote-13) and NPMs (this includes references to the type of places covered and the organisations that may be designated NPMs but these lists are non-exhaustive and so allow for changes if gaps are identified).
3. sets out the powers and functions of NPMs, and the process for their designation
4. establishes confidentiality and reporting requirements including the publication of at least one written report annually
5. provides for the designation of a Central National Preventive Mechanism, and sets out its role and functions.

The text of OPCAT is attached in full as a schedule to COTA. While this does not make the protocol part of domestic law it does signify Parliament’s commitment to meeting its OPCAT obligations.

The Act also reflects the OPCAT requirements that NPMs must:

1. be functionally independent
2. be comprised of experts with the required capabilities and professional knowledge and strive for gender balance and adequate representation of minority and ethnic groups
3. be authorised to regularly examine the treatment of persons in places of detention
4. have access to all relevant information and to all places of detention, including the opportunity for private interviews with those detained or any other person who the national preventive mechanisms believe may supply relevant information
5. have the authority to make recommendations to the relevant New Zealand authorities about the treatment of detained persons and conditions of detention
6. publish and disseminate annual reports
7. be adequately resourced
8. have the right to make contact with the SPT.

Under COTA, the Minister of Justice has the power to designate NPMs for specified places of detention[[14]](#footnote-14) at any time, by notice in the Gazette. While designations can be made, varied and revoked by the Minister at any time, and the process is an administrative procedure rather than legislative, the benefits of this are that any gaps or problems with the designations can be amended quickly and simply. This was demonstrated when, after the first year of operation, NPMs recommended changes to clarify the designations, and the Minister of Justice acted upon those recommendations. The designations of the Ombudsman and Children’s Commissioner were amended to clarify that their role covered care and protection residences as well as youth justice residences. The wording of the designation relating to Defence Force facilities was also amended to better reflect and clarify that the role is carried out specifically by the ISPE.

Both the COTA and OPCAT also contain provisions regarding confidentiality of information. In particular, information about an identifiable individual cannot be disclosed without that person’s consent.

### The scope of monitoring

The scope of monitoring under OPCAT is broad and flexible.

OPCAT applies to *any place under [the State’s] jurisdiction and control where persons are or may be deprived of their liberty, either by virtue of an order given by a public authority or at its instigation or with its consent or acquiescence.[[15]](#footnote-15)*

Deprivation of liberty is broadly defined as *any place where any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order of any judicial, administrative or other authority*.[[16]](#footnote-16)

The definition contained in section 16 of COTA closely reflects the OPCAT definition. Under s 16, “deprived of liberty” means *any form of detention or imprisonment or the placement of a person in a public or private custodial setting which that person is not permitted to leave at will by order or agreement of any judicial, administrative, or other authority.*

The SPT has made it clear that it envisages OPCAT applying to a non-exhaustive list of places of detention.[[17]](#footnote-17) Accordingly COTA lists currently designated NPMs but leaves open the possibility of further designations being made. The specific places that each NPM is responsible for monitoring are noted in their designations.

## New Zealand’s NPMs

New Zealand has established a multiple body NPM with the [Human Rights Commission](http://www.hrc.co.nz/human-rights-environment/monitoring-places-of-detention), as the designated central NPM, taking a co-ordinating role.

Using established organisations to create a multiple NPM model has enabled New Zealand to take advantage of the expertise, experience and relationships that already existed. In addition to their mandate under OPCAT, COTA[[18]](#footnote-18) expressly incorporates the NPMs pre-existing powers into their OPCAT role which greatly strengthens their operational capability.

Most of the NPMs already had statutory independence but some changes were required to ensure that they all fully met the NPM criteria under OPCAT.

A new entity, the Inspector of Service Penal Establishments (ISPE) was created through legislative change, and given responsibility for monitoring NZ Defence Force facilities. This ensured that the NPM was independent of the Defence Force and that military detention was opened up to regular, independent scrutiny for the first time.

The NPMs with designated monitoring roles are the:

1. [Ombudsman](http://www.ombudsmen.parliament.nz/internal.asp?cat=100121)
2. [Independent Police Conduct Authority](http://www.ipca.govt.nz/)
3. [Children’s Commissioner](http://www.occ.org.nz/)
4. Inspector of Service Penal Establishments of the Office of the Judge Advocate General [[19]](#footnote-19)

### Human Rights Commission

The Commission is an independent Crown entity with a wide range of functions under the [Human Rights Act 1993](http://www.legislation.govt.nz/act/public/1993/0082/latest/DLM304212.html?search=ts_act_human+rights&sr=1). 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 society.

The Commission’s functions may be undertaken through a range of activities, including 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. This includes the desirability of legislative, administrative or other action to better protect human rights. The Commission also administers a disputes resolution process for complaints about unlawful discrimination.

Commissioners are appointed by the Governor-General, on the advice of the Minister of Justice, for a term of up to five years.

The Commission’s primary functions in its capacity as the Central National Preventative Mechanism are to coordinate the activities of the NPMs and liaise with the SPT. In carrying out these functions it consults and liaises with NPMs, reviews their reports, identifies systemic issues, coordinates the submission of information to the SPT, and makes, in consultation with NPMs, recommendations to Government. The Commission also publishes the combined annual report of the five OPCAT organisations. It convenes regular roundtable meetings of the NPMs, and meetings with civil society. The Commission’s OPCAT team consists of a Policy and Legal Analyst at approximately (0.5 FTE), reporting to the Manager, Strategic Policy and Chief Commissioner.

### Ombudsman

The Ombudsmen are independent Officers of Parliament, with wide statutory powers to investigate complaints against central and local government agencies. The functions and powers of the Ombudsman are set out in several pieces of legislation, including the [Ombudsmen Act 1975](http://www.ombudsmen.parliament.nz/internal.asp?cat=100094).

The Ombudsman’s role includes providing an external and independent review process for individual prison inmates’ grievances, as well as the ability to conduct investigations on their own motion.[[20]](#footnote-20)

The Ombudsman, as Officers of Parliament, is responsible to Parliament but independent of the government of the day. Ombudsmen are appointed by the Governor-General on the recommendation of the House of Representatives.

The Ombudsman is the designated NPM for prisons, immigration detention facilities, health and disability places of detention, and jointly with the Children’s Commissioner, child care and protection residences and youth residences established under section 364 of the Children, Young Persons and Their Families Act 1989. A total of 104 facilities.

There are also an additional 161 aged care facilities with dementia units that may fall within the Ombudsman’s designation in respect of health and disability places of detention. The Ombudsman is currently examining the jurisdictional and resource implications should this be the case. If the Ombudsman was expected to include these facilities within its monitoring programme and the extended jurisdiction into private sector was acceptable to Parliament, the Ombudsman would need to seek additional funding in order to conduct regular inspections of these facilities.

The Ombudsman has appointed two (full time) Inspectors who have delegated authority to exercise the Ombudsman’s powers under COTA. Between them, the Inspectors have extensive managerial and investigative experience in both penal and health care systems, in New Zealand and the UK. One team member is female and one male.

Members of the other NPMs often accompany the two inspectors on site visits. The Ombudsman has also on occasion contracted experts to assist with visits, namely a mental health expert who assisted in early visits to mental health facilities, and a social worker. Even with this additional support, the Ombudsman’s inspectors have noted that unless the team is extended considerably, prison inspections will only continue to focus on high risk areas, as opposed to the whole site.

Currently the Ombudsman aims for at least 26 visits per year[[21]](#footnote-21), and in 2012 revised that to 50 visits. A mixture of full inspections, informal visits, announced and unannounced visits are undertaken. Given the size of the sites they visit, the Ombudsman focuses on individual units, rather than the whole facility, which would require a much greater team over a longer period. For example, Rimutaka Prison has 29 units and holds close to 1000 prisoners. Therefore, high risk areas, such as: at risk units, management wings and special needs units are prioritised.

The budgeting, scheduling and arrangement of visits is determined by the Ombudsman on the inspectors’ advice. One inspector is based in Wellington and the other in Christchurch. The second inspector did not take up the position until March 2010, and therefore, two full years of inspections were only completed in June 2012 at which stage all facilities[[22]](#footnote-22) had been visited at least once, repeat visits had been undertaken to several facilities and places requiring more frequent visits had been identified.[[23]](#footnote-23)

### Independent Police Conduct Authority

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

The Authority is an independent Crown entity, which exists to ensure and maintain public confidence in the New Zealand Police. The Authority does this by considering and, if it deems it 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 notification of all incidents involving police where death or serious bodily harm has occurred from the Commissioner of Police. The Authority may undertake an investigation of its own motion, where it is satisfied there are reasonable grounds in the public interest, and any incident involving death or serious bodily harm.

The Authority evolved from the Police Complaints Authority, which was established in 1988. The Independent Police Conduct Authority Act 2007 marked a major shift in the direction of the Authority. This started with its name change and the change in the body of the Authority from an individual to a board of up to five members, comprising both legal experts and lay people.[[24]](#footnote-24)

The IPCA is responsible for places where people may be held in the custody of the Police. This includes 437 sites, including 371 police cells and 66 court cells.

The IPCA OPCAT team reports to the Authority Chair. It currently consists of the Legal Advisor to the Chair and an OPCAT Coordinator, who between them have experience in investigative work and human rights law. Both carry out other work, with their OPCAT functions making up approximately 1.2 FTE. They are assisted by the Communications Manager and other staff as needed. The IPCA’s visit team generally consists of two members, and is occasionally supplemented with staff of other NPMs.

The IPCA has also developed a ‘specialist site visit’ model which involves engaging with other national organisations that have particular expertise in order to respond to acute issues at a site. The IPCA has used this approach to good effect. In one case a multi-agency visit included members of the NZ Fire Service, the Department of Labour and the Human Rights Commission and facilitated solutions to long-standing issues at the site.

The IPCA has undertaken an average of 25 visits per year. In 2012 the number of visits was reduced to 15, to align with the funding available. With over 400 sites to visit and limited resources, the frequency with which each site can be visited is low. At the current rate, it would take 29 years for each site to be visited.

### Children’s Commissioner

The Children’s Commissioner is an independent Crown entity appointed by the Governor-General and operating under the Children’s Commissioner Act 2003. The Commissioner has a range of statutory powers to promote the rights, health, welfare, and well-being of children and young people from 0 to 18 years.

The Office of the Children’s Commissioner (the Office) monitors activities under the Children, Young Persons and Their Families Act 1989 (CYPFA), undertakes systemic advocacy functions and investigates particular issues with potential to threaten the health, safety, or well-being of children and young people.

The Commissioner’s role as a NPM has some overlap with other statutory responsibilities to monitor the policies and practices of Child, Youth and Family. These responsibilities include visits to residences on a regular basis.

The Children’s Commissioner is, jointly with the Ombudsman, responsible for monitoring nine residences for children and young people established under section 364 of the Children, Young Persons and their Families Act 1989 (four care and protection, four youth justice and one specialist residence) In effect, the Office carries out residence visits and refers reports and findings to the Chief Ombudsman for input, including recommendations they wish to make.

The Children’s Commissioner has an OPCAT team of one Senior Advisor from the Office’s Monitoring Team, who has a background in social work and youth justice. OPCAT work takes up approximately 0.3 FTE of her time. Work with other NPMs is managed by the Senior Advisor and General Manager. All decisions and reports are signed off by the Children’s Commissioner.

The Office regards all its visits as NPM visits; they are conducted by a minimum of two people, although occasionally three people will attend.

In carrying out the NPM work, the Senior Advisor is assisted by NPM staff from other agencies within New Zealand and occasionally other staff from the Office who are experts in particular fields, for example, education or health. Data collected in the course of NPM work is stored electronically and in hard copy in the Office’s filing systems. Access to that data is available to Office employees.

The Office of the Children’s Commissioner (OCC) visits each of the nine section 364 residences every two years, and accordingly has visited each at least once. This meets the minimum recommended level of visiting places of detention at least once every four years. The OCC has however found that residences can undergo significant change (in residents, staff, culture) between biennial visits, and ideally they should be visited more frequently, so that any problems arising from these changes are picked up.

### The Inspector of Service Penal Establishments

The Inspector of Service Penal Establishments (ISPE) is the NPM charged with monitoring New Zealand Defence Force (NZDF) detention facilities.

The appointment of the ISPE has opened up military detention to independent scrutiny for the first time. However the importance of recognising and adhering to human rights principles has long been an integral part of the way the NZDF operates. The Laws of War and the Geneva Convention are emphasised in training for all ranks, including as part of all pre-deployment training for contingents. The culture within the NZDF is based on the values of courage, commitment, comradeship and integrity coupled with the ethos of serving New Zealand loyally and honourably. So although the OPCAT mechanism for monitoring the treatment of military detainees is relatively new, the strong pre-existing commitment to treating detainees well, and in accordance with internationally agreed principles, means that OPCAT implementation in this area has been seamless. It may also explain why there has been no evidence of OPCAT breaches by NZDF to date.

The ISPE is responsible for monitoring one Service Corrective Establishment (SCE), cell facilities at eight New Zealand Defence Force base or camp facilities and any buildings or ships (or parts thereof) set aside as a service prison or detention quarter.

The SCE is in a purpose built facility in Burnham Military Camp, on the outskirts of Christchurch. It is small with the capacity to detain up to 10 detainees at any one time[[25]](#footnote-25). The Commandant of SCE is a staff officer with the rank of Major from the local Army Headquarters. The day to day operation of the SCE is carried out by the Chief Warden and it is his sole focus. The Chief Warden is a Warrant Officer and he or she is supported by a tri-service staff of non-commissioned officers who are all volunteers.

While up to two years detention can be imposed by a Court Martial, sentences are rarely of more than six months. The vast majority of those detained at the SCE are sent there following conviction at a summary hearing, for offending that is on the lower end of the scale that did not warrant a trial by court martial. The powers of punishment available to Disciplinary Officers under the Armed Forces Discipline Act 1971 are more limited, confined generally to 28 days detention or less.

Against that background, the ISPE inspects SCE without warning periodically throughout the year. The inspection takes no longer than about three hours and involves discussions with the Commandant and Chief Warden separately, and interviews with all detainees individually (in the absence of SCE staff) and any of the wardens who wish to see him. The ISPE always includes an inspection of the facility. The ISPE provides feedback to the Commandant and Chief Warden, and can, if he has concerns, raise these with the Chief of Defence Force.

The inspector also takes an active interest in the holding cells scattered throughout New Zealand's bases and camps. These facilities are not in constant use, but can detain members of the Armed Forces for up to 48 hours. Unlike the SCE, these bases are not staffed by professional warders.

The ISPE consists of one person, and OPCAT monitoring is carried out alone as a small part of his role.

The ISPE has not found any need for expert assistance. If any medical or mental health concerns are identified the ISPE can call upon the SCE’s Resident Medical Officer to assist. There are psychiatrists available in Christchurch if the need arises.

The ISPE is able to undertake regular, random visits to the SCE several times per year, as well as visiting other NZDF facilities alongside other travel.

## Working methods

NPMs make strategic use of available resources in order to effectively monitor places of detention and prevent ill-treatment while adhering to the principles that underpin OPCAT such as independence and constructive dialogue.

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. The NPMs have each established the methods of operation most suited to the places of detention they are responsible for monitoring, and their level of OPCAT resourcing. More detail about each NPMs’ operations are contained in Appendix 1.

At the policy level, NPMs have developed strong collaborative relationships with each other enabling them to share their expertise and experience and reflecting the notion that effective OPCAT implementation is a collective endeavour.

### Monitoring visits

Visits are generally carried out by between one and four people. Of necessity, New Zealand’s NPM visit teams are small and, as NPMs are aware, not fully reflective of a truly pluralistic team as envisaged by the OPCAT.

However, visiting team sizes need to be proportionate to the size and nature of the facility involved. At times it is most appropriate to have only one or two people visiting, particularly for the ISPE and the Children’s Commissioner. Defence force facilities are small and will only have a very few detainees at any one time. Similarly, places for detaining children and young people are relatively small and having more than one or two people inspecting could be intimidating and disruptive for the young people who are detained.

In cases where it is desirable to have visiting teams of more than one or two people, collaboration amongst NPMs and participation in each others’ visits has, to a certain extent, helped to augment the small teams. This also enables different perspectives and expertise to be taken into account in the monitoring process.

Visits by NPMs may be announced in advance or unannounced. They may cover the whole institution, or focus on specific areas or issues, such as healthcare or education. During a visit, NPMs can inspect facilities, view records, interview staff and people who are detained, and make recommendations.

Planning and scheduling of visits is done by each NPM independently. Criteria for choosing and prioritising places to visit, can include:

1. potential or actual risks, for example places where people are interrogated, or where there are particularly vulnerable groups such as women, children or young people, or asylum seekers
2. complaints and other information regarding any problems at particular places of detention
3. selecting a sample of places to include different regions, types of facilities, and categories of people detained, and places that are representative of a type or region.

A significant factor in how places to visit are selected has been information gathered through visits to facilities both through the regular monitoring visits, as well as scoping and introductory visits undertaken in the early stages of the OPCAT role.

The number of visits carried out per year is largely determined by what is achievable within available resources while trying to meet international guidelines. Drawing on guidelines published by the APT[[26]](#footnote-26), NPMs aim to visit facilities at least once every four years. Visits can be undertaken more frequently if the need arises and for those sites which are considered to be high risk such as those containing particularly vulnerable detainees like children or young people.

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

1. Preparatory work collecting information and identifying specific objectives, before a visit takes place.
2. The visit itself, during which NPM visitors speak with management and staff, inspect the institution’s facilities and documentation, and speak 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,[[27]](#footnote-27) and involves looking at:[[28]](#footnote-28)

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 care
6. staff − conduct and training.

NPMs use the indicators and standards they have developed to guide their visits and ensure a level of consistency is maintained across all the sites and NPMs. Rather than adhering to a checklist approach they have maintained a degree of flexibility to accommodate the differences in the places of detention visited and the NPMs themselves. For example, the Ombudsman visiting a prison with hundreds of inmates will use a different focus and approach to one used by the Children’s Commissioner visiting a facility for ten or so young people.

As well as the standards they have developed, NPMs are guided by the principles set out in the United Nations Training Manual on Human Rights Monitoring[[29]](#footnote-29) when conducting their visits and aim to:

1. do no harm through poorly planned or conducted visits
2. understand and respect their mandate and know the applicable standards
3. exercise good judgment and consult with others
4. respect the authorities and the staff in charge and respect security
5. be credible and respect confidentiality
6. be consistent, persistent and patient
7. be accurate and precise in the work that they do.

Over the first five years of operation, New Zealand’s NPMs have ensured that they meet the requirements of independence under OPCAT, and have established staff and systems to carry out their role.

# The first five years[[30]](#footnote-30)

## Development of the OPCAT preventive monitoring system

Establishing a system of regular, independent monitoring of places of detention has been a significant development in New Zealand’s human rights framework. It has opened up closed institutions to proactive, preventive monitoring, and in the case of the New Zealand Defence Force opened up facilities to regular, external scrutiny for the first time.

Implementation of the OPCAT system has made the human rights standards relating to detention more visible, and with greater awareness has come improved understanding and application of those standards.

NPMs have identified issues that may not otherwise have come to light. Because detaining agencies have been so receptive and responsive to OPCAT, there have been many improvements in both the conditions of detention and the way detainees are treated.

The establishment of preventive monitoring has been an evolving process. As OPCAT is a relatively new instrument, and New Zealand was one of the early States Parties to establish NPMs, some of the key challenges have been determining practical issues such as timetabling, the frequency and duration of visits, the resources required, and the standards and measures to be applied.

New Zealand’s NPMs have taken the opportunity to respond to these challenges positively and constructively, in line with the spirit of OPCAT, and have grown their practice and expertise in the process.

The information, resources, and advice of the APT have been particularly helpful in this establishment phase, and have been drawn on heavily. These form the basis of the methodology and standards used by NPMs. NPMs have also drawn on the experiences and lessons learnt from overseas NPMs and other international bodies like the European Committee for Prevention of Torture[[31]](#footnote-31), and other inspectorate bodies from the UK and Western Australia.

During their first year the NPMs’ primary focus was on planning and scoping their roles, resources and the places of detention involved. Standards and processes were developed, relationships established, and visits began, although most of these were initial scoping visits rather than full, formal visits.

In the second year of operation, full visiting programmes were underway. Processes and practice were refined on the basis of that monitoring experience.

Since the initial establishment phase, the NPMs’ practice and understanding about how to be most effective in their prevention work has continued to develop. By the third year, some significant improvements had been achieved, and NPMs began greater use of joint visits and unannounced visits. Also, different approaches to prevention were applied with the instigation of the joint thematic review of issues for young people in police custody.

These developments continued to be built on in the following year, and further, policy-based activities were also carried out. In the past year, a big focus has been, as throughout the five years, finding ways of working more effectively and collaboratively, and making the most out of the available resources.

### Activities

Overall, in the first five years, NPMs have undertaken 383 visits to places where people are detained (over 559 places altogether).

**Number of visits 2008−12**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **OCC** | **IPCA** | **Ombudsman** | **ISPE** |
| **2008** | 3 | 25 | 43 | 5 |
| **2009** | 2 | 37 | 64 | 5 |
| **2010** | 4 | 30 | 19 | 5 |
| **2011** | 5 | 20 | 23 | 2 |
| **2012** |  6 | 15 |  70 |  2 |
|   | 20 | 127 | 219 | 19 |

Nine meetings have been held with civil society, and numerous meetings with government agencies. NPMs have also participated in events and exchanges with international bodies and networks.

While some NPMs already make submissions to Parliament on draft legislation, NPMs have agreed to consider making joint submissions as part of their OPCAT role. They have cooperated in making separate submissions on the recent Corrections Amendment Bill 2012.

As well as an OPCAT joint thematic review into issues for children and young people in police detention, relevant work undertaken by NPMs alongside their OPCAT roles include:

1. a 10 year review of deaths in police custody
2. investigations into prison health services
3. prison transport and prison employment complaints processes
4. legal intervention in court proceedings about the detention of intellectually disabled offenders
5. research on human rights in prisons
6. a five year review of the rights of people in detention.

### Good practices

As is to be expected, the practice of the NPMs has developed and evolved over the first five years as their understanding about implementing human rights in closed environments within the New Zealand context has increased.

Initially, international guidelines such as the APT’s materials were the basis of NPMs’ policies and working methods. As NPMs have gained experience, and been required to work innovatively within their limited resources to effectively meet OPCAT requirements, they developed their own practice.

Examples of these practice developments include:

1. each NPM having only very small visiting teams and using other NPMs to provide additional perspectives and expertise, including on site visits
2. careful prioritising and planning of monitoring activities, informed by complaints and other information, and using a “risk management” approach to prioritise the institutions, and parts thereof, to be visited
3. using questionnaires sent to detainees prior to a visit
4. expanding information collection to include people from outside an institution, such as lawyers, contracted doctors and family or visitors
5. focusing initially on “formal” places of detention
6. using a mix of full, in depth visits and shorter, “informal” visits
7. carrying out a cluster of visits to several places within a given city/region over a two or three day period
8. undertaking policy work to address systemic issues
9. establishing processes to discuss draft reports with key stakeholders
10. distinguishing between recommendations where actions are required and suggestions where action is not essential but desirable (and needs to be considered in light of available implementation funds and alongside competing priorities)
11. specialist site visits involving specialists from other agencies and NPMs
12. conducting a joint thematic review on young persons in Police detention.

### Working collaboratively

A considerable degree of cooperation has developed amongst NPM members, including participation in each others' visits and working together to submit on proposed law or policy changes, or to address cross-cutting issues like those raised by the detention of children and young people in police custody.

Regular meetings of NPMs provide a forum for sharing information, experience and ideas, and for discussing issues of concern. The establishment of a shared online workspace (within the secure service run by the Department of Internal Affairs) is planned to further improve the sharing of documents and information.

Given their interest in the treatment of children and young people across detention contexts, the Children’s Commissioner has memoranda of understanding with both the Ombudsman (with whom they are jointly gazetted to monitor those residences for children and young people which fall within OPCAT) and the IPCA, outlining how they will work together and provide support on issues regarding children and young people.

It is not just within the NPM that a culture of working collaboratively has developed. A similar approach is taken to managing external relationships. Each NPM meets bilaterally with the relevant government agencies they monitor. The Ministry of Justice is also involved, as the coordinating government agency, and can assist in following up recommendations as well as being a valuable source of advice and information at the NPM ‘table’.

Meetings with members of civil society are held each year in the main centres of Auckland, Wellington and Christchurch. This has been a useful process for NPMs, and issues raised and contacts made at these meetings have helped to inform NPMs’ activities.

### Progress made

Reflection on the past five years raises the main question: what difference has OPCAT made?

As a result of implementing OPCAT there have been improvements in the conditions of detention and in the way that detainees are treated within New Zealand. The fact that detaining agencies have been so willing to take OPCAT on board has been a significant factor in the success of implementation so far.

#### Improved care and custody

Although effective implementation of OPCAT is important in terms of New Zealand’s standing in the international community, the ultimate measure of its success is the impact it has on people who are detained.

A striking example is that there have been no deaths in Police custody since 2007/8, which is when the IPCA began NPM monitoring. The Ministry of Justice has noted:

*This is a significant and tangible achievement. It highlights the importance of the preventive and educational approach under the OPCAT regime. In addition to the human distress surrounding a death in police custody, which can affect both the family of the deceased person and police staff, the cost of investigations by Police (criminal and disciplinary), the IPCA and the Coroner following a death in custody can cost tens of thousands of dollars.[[32]](#footnote-32)*

The potential impact on the day-to-day experience of those who are detained, as well as the long term benefit of effective OPCAT monitoring, were also made evident by the joint thematic review of young persons in Police detention.[[33]](#footnote-33) The 24 recommendations made in the review address policy and practice issues that directly impact on young people’s experiences in Police detention, including information collection and management, Police training and reporting practices, and transport arrangements.

*The worst thing is you just stare at the walls. It is you, a bed, a toilet, and the walls. You sit and stare at the walls all day. You can’t have books because they think that if you have a book you will block the toilet with it. If you are lucky you sleep (young person detained in Police custody)[[34]](#footnote-34).*

#### Improved policy and practice

There are many examples of the positive difference OPCAT has made to the treatment and conditions experienced by those in custody. For instance:

1. A facility was upgraded to meet minimum health and safety standards, and stopped using substandard cells.
2. A prison exercise area was altered to allow greater access to the outdoors.
3. Children and young people have been provided with feedback boxes so they can have a say in how residences could be improved.
4. Following careful monitoring, input has been provided on how a Behaviour Management System in residences could be improved.
5. Improvements have been made to the way certain orders (which involve both a sentence of imprisonment and compulsory treatment) are recorded and monitored to ensure timely access to parole hearings.
6. Police policies and training have been changed in order to better identify and manage risks and prevent deaths in custody.
7. Cases of prolonged seclusion and restraint have been identified resulting in better management of those concerned, and their placement in more suitable facilities.
8. Child, Youth and Family have
	1. implemented an analysis system to track their ‘use of force’ and ‘search’ procedures
	2. strengthened the individual care planning processes for young people
	3. improved mattresses for all young people
	4. put curtains on bedroom windows for privacy
	5. made nutritional food audits standard practice.

#### Awareness of OPCAT

Overall, awareness of the OPCAT process within agencies has developed, although the preventive aims and rationale behind some of the recommendations made in visit reports are not always understood. To address this NPMs have conducted OPCAT training with staff from detaining agencies but, particularly in those areas with a high turnover of staff, this need is ongoing.

#### Constructive relationships with detaining agencies

The positive changes that have been made have largely resulted from the constructive working relationships established between NPMs and the agencies monitored. A high level of cooperation by the detaining agencies and institutions, and their willingness to engage with the NPMs has been a consistent feature of the OPCAT experience. This is important because good working relationships enable constructive dialogue, which is fundamental to effective prevention. It also demonstrates an evolving culture of respect for the human rights of people who are detained.

#### Positive responses to identified issues

NPMs have found that “breaches” of OPCAT are unlikely to be intentional. Ill-treatment is more likely to be a result of capability or resourcing issues[[35]](#footnote-35). The monitoring programmes and collaborative relationships that have been established mean that the issues can be identified and addressed constructively, minimising the risk of ill-treatment.

One example is unlawful detention. The Ombudsman has noted

 *In New Zealand, unlawful detention of an individual in any place of detention risks financial liability for the relevant agency, and in turn, the Crown (and of course, the taxpayer). Given that New Zealand supposedly had the necessary systems in place to minimise instances of unlawful detention, it was of significant concern to find that substantial potential financial liability had been accruing over previous years due to numerous instances of unlawful detention occurring that existing audit and inspection processes had failed to identify.[[36]](#footnote-36)*

In one case a patient in a mental health facility was discovered to have been detained for six years without any lawful documentation and been frequently subjected to seclusion and restraint as part of their treatment.

In another cas,e a prisoner was found to have been unlawfully recalled to prison for 31 days because none of the agencies involved[[37]](#footnote-37) properly understood the parole limitations or restrictions on people detained under the Criminal Procedure (Mentally Impaired Persons Act 2003). Discussions between the Ombudsman, in its NPM capacity, and the Ministry of Justice resulted in courts and the Department of Corrections being able to record details about individuals covered by the Act in a shared database and helped a collective understanding of the relevant legislation and its implications. Although the legislation had been in place for five years the issue was not identified until OPCAT inspectors uncovered it.

These examples underscore the importance of effective preventive monitoring. In addition to the risk of substantial financial liability for the Crown, unlawful detention has significant implications for the person detained and is a clear breach of their rights.

## Challenges

The progress made in implementing OPCAT has not been without its challenges. Many of these have arisen from the practical realities and constraints posed by the New Zealand context.

### Practical issues

The sorts of practical issues faced in establishing a new monitoring system include timetabling and working out the optimum frequency and duration of visits, what resources are required, and the standards and measures to be applied. NPMs have been fortunate to be able to draw on the advice and expertise of the APT, as well as the experiences and reports of international bodies like the European CPT, and other inspectorate bodies such as those from the UK and Western Australia.

### Understanding about OPCAT and the role of NPMs

NPMs faced some initial resistance to external monitoring in certain areas, largely due to the fact that there were already a number of accountability mechanisms operating in that sector. This resistance quickly diminished as a result of efforts to raise awareness of the role and function of the NPM, and after institutions had the opportunity to see how it worked in practice.

OPCAT is not only a relatively new instrument in terms of being recently adopted, it is also new in terms of the approach it takes and the framework it establishes. Unsurprisingly there is a lack of public awareness and understanding of the role and function of the NPM. A strategy is being developed by NPMs to help increase the level of engagement they have with civil society.

### Resourcing

NPMs have had very limited additional resourcing to carry out their OPCAT functions. In the case of the Children’s Commissioner and the ISPE no money has been allocated for OPCAT work and they meet their responsibilities within their existing budget which means, effectively, having to forgo other aspects of their operation.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **NPM** | **Money initially allocated for OPCAT work** | **Actual costs of OPCAT work (2010/11)** | **Places of detention** | **Visits made (2011/12)** |
|  Ombudsman | $127,000  | $250,000 (including $50,000 operating expenses) | 104  | 23 |
| IPCA | $55,000 | $160,000 (including $28,000 operating expenses) | 437 (371 police cells and 66 court cells) | 30 |
| Children’s Commissioner | 0 | $30,000 (including $5,000 in operating expenses) | 9 | 6 |
| Inspector of Service Penal Establishments | 0 | Negligible  | 1  | 3 |

NPMs have advised the Government that the use of resourcing from other work streams is unsustainable and poses a substantial risk to core functions.

Compounding limited baseline resourcing levels the current climate of fiscal restraint has impacted on both NPMs and on the places of detention visited including their ability to maintain standards and respond to recommendations. Monitoring and prevention is, therefore, all the more important in such circumstances.

### Monitoring priorities

Since taking on their OPCAT roles, and without (for the most part) additional resources, NPMs have needed to prioritise where and how visits are undertaken. NPMs have focused on the ‘formal’ places of detention where they have a clear mandate, and where, generally, there is robust legislation and policy governing conditions and treatment, as well as complaint and audit mechanisms, which can all be used to help plan monitoring visits. As a result, NPMs can focus on specific units and areas within larger facilities, making it possible to use small visiting teams.

### Complaints / monitoring roles

An initial challenge was the need to carefully manage the relationship between existing complaints and investigation roles of NPMs, and the new preventive monitoring role under OPCAT. Within the resources available, care has been taken to keep these roles as separate as possible.

In particular, OPCAT visits have a distinct process and methodology and a clear preventive focus. Nevertheless, due to the limited resources and small teams that NPMs have, for the most part, NPM staff carry out OPCAT monitoring alongside other work with the exception of the Ombudsman, whose inspectors do OPCAT work only.

The complaints role has in fact been helpful. Analysis of complaints data can help to flag issues and inform OPCAT planning. Given the limited resources, and the impact that this has on NPMs’ ability to carry out visits, complaints information becomes even more important.

### Access to expertise

NPMs have identified the lack of access to independent experts, particularly medical and mental health experts, as a significant issue. NPMs have been, and continue to, explore ways to address this challenge. This is discussed in more detail below.

## Summary

In summary, the first five years of OPCAT in New Zealand has established a very solid foundation for future development. However, challenges do remain. This report now turns to a discussion of the issues that need to be addressed to further cement the place of OPCAT within New Zealand’s human rights framework.

# Looking ahead – strengthening the effectiveness and impact of OPCAT monitoring in New Zealand

The knowledge, experience and understanding of NPMs has strengthened over the last five years. However, it is widely accepted that OPCAT implementation is a continual and evolving process. NPMs welcome the opportunity provided by this five year milestone to review progress and look ahead. In doing so, as well as drawing on their own experiences they have looked to advice and guidance from international bodies, particularly the APT and SPT.

The overarching issue facing the NPMs is how to function most effectively within the limited resources they have available. The answer is most likely to lie, at least in part, in further developing the collaborative ways of working that have become the basis of OPCAT implementation in New Zealand.At the same time it must be recognised that maintaining independence and continuing to build credibility are crucial to NPM effectiveness.

It should also be noted that the four monitoring NPMs are very different from each other with strengths and limitations that reflect the particular context in which they operate. Some of the issues discussed in this section of the review will apply to some NPMs more than others. Other issues relate to the effective functioning of the NPM as a collective.

That said, there are four aspects of NPM operation which have some potential to enhance the impact of OPCAT in New Zealand. They are:

1. publication of visit reports
2. increased engagement with civil society
3. increased levels of expertise within the NPM
4. improving how the NPM works − issues to do with developing the NPM as an institution, working with others, and the scope of monitoring including the definition of “place of detention”, and ensuring designations remain relevant and useful.

#### While strengthening any of these aspects of the NPMs’ operation would have resource implications, there are opportunities to enhance the overall effectiveness of NPMs within limited budgets. NPMs intend to do some strategic planning in order to decide where it is best to focus their efforts. To inform the strategic planning process, this part of the five-year review looks at each of these issues in turn, discussing their potential to improve the effectiveness and impact of OPCAT monitoring.

## Resourcing

For all NPMs, their designations are adjuncts to existing, related, roles and responsibilities, and were undertaken with little or no additional funding. NPMs have worked pragmatically, using the resources they had available and funds from other work programmes, to establish and operate the OPCAT monitoring system. However the under-resourcing of their OPCAT functions impacts on their capacity to carry out monitoring to the full extent required by the protocol and, by diverting resources form other work streams, also impacts on their core functioning.

From the outset, NPMs have viewed OPCAT implementation as an evolving process. Without the resources to establish larger, multidisciplinary teams and to increase the level of monitoring, NPMs began their monitoring using very small teams (often just one person). An incremental approach was taken, in the knowledge that the system did not initially meet international best practice standards, but with the expectation that it would eventually develop and grow to do so.

International best practice guidelines recognise that, while OPCAT requires States to “make available the necessary resources for the functioning of the NPM” (Art. 18(3)), in practice the resources provided are rarely sufficient for an ideal preventive programme to be undertaken.

While the type of incremental, developmental approach adopted by New Zealand is a recognised reality in the initial stages of NPM establishment, it is not seen as acceptable on an ongoing or long term basis.

*The number and frequency of visits to places of detention, as well as the production of reports, will depend on the resources available. Although Article 18(3) of the OPCAT requires States Parties to “make available the necessary resources for the functioning of the NPM”, in practice the resources (financial, human and logistical) provided are rarely sufficient for an ideal preventive programme to be undertaken. It is important to note that resources will probably have to be increased over time, as the NPM develops. It is also vital that the NPM has the autonomy to decide on their use independently[[38]](#footnote-38)*.

Over the last five years, NPMs have demonstrated the gains that can be achieved with limited resources but this manner of operating is not sustainable or acceptable for a prolonged period. The limited ability of NPMs’ to meet OPCAT requirements, due to under-resourcing, leaves New Zealand open to international criticism, has very real consequences for those who are detained, and risks potential financial liability for the Crown.

#### One of the most pressing needs is for additional staff in the offices of the Children’s Commissioner, IPCA and Ombudsman, in order to enable them to expand the frequency and coverage of their monitoring visits.[[39]](#footnote-39) Current resources, specifically in relation to the IPCA, do not enable the frequency of visits required to meet the objectives of the OPCAT. With the exception of the ISPE, other NPMs are also stretched to complete the number of visits they would like.

The Children’s Commissioner has received no funding for taking on its NPM role, which it has funded from other work streams. The funds allocated to the IPCA cover 34 per cent of their OPCAT costs, and in the past they have also covered the difference. In the last year the IPCA has reduced its NPM budget to align with the actual funding provided by government. This has meant a significant reduction in their activities, with visits in 2012 cut by half to 15. For these NPMs resource pressures are significant, and inhibit the full performance of their OPCAT function.

The Ombudsman is in a slightly different but equally difficult position. Although 100 per cent of its OPCAT work is funded it is unable, within its existing budget, to monitor all the places of detention that fall within its designation.

The NPMs consider that funding levels should be increased to cover the actual costs of their OPCAT work. They have also sought additional resources to enable them to carry out more site visits and hire the services of experts to assist with those visits.

### ****Costs of not investing in prevention****

These issues are not unique to New Zealand. The APT Global Forum noted that one of the persisting challenges in ensuring the effective prevention of torture in practice is guaranteeing investment in torture prevention. The Forum highlighted the need for more work to be done “*to show the economic, social and political costs of not preventing torture. In addition, better coordination and creativity can open doors for action without increased budgets.”[[40]](#footnote-40)*

Enumerating the costs of not adequately resourcing preventive monitoring is a challenge. A rough indication can be attained by looking at the costs of compensation paid to prisoners for breaches of their rights.

Between 2006 and 2011, 25 compensation payments were made to prisoners, amounting to over $300,000. These include 18 payments for unlawful detention, five for improper treatment, and one each for lost property and breach of privacy. Payments for unlawful detention range from $700 to $27,000 (for unlawful detention for a period of three months).

As well as the potential costs of compensation, there may be legal, medical and rehabilitation costs, as well as human costs to those involved, and wider detriment to public trust and confidence in the detention systems.

The under-resourcing of NPMs is an on-going issue. NPMs will continue to liaise with the Government to try and find solutions. In the meantime there are some areas where the effectiveness of OPCAT monitoring could be further enhanced, through continued collaboration and creative use of resources, to ensure NPMs carry their OPCAT functions to maximum effect.

## Publication of visit reports

#### At present NPMs publish an annual report outlining their activities, achievements and any issues of concern. However, information relating to individual visits is not made public.

#### In part this has been because, until now, NPMs have focused their energy and resources on establishing their monitoring programmes. Now that their monitoring programmes are well underway NPMs are able to turn their attention to the issue of publishing visit reports.

### What would be the purpose and benefit of publishing?

It has been argued[[41]](#footnote-41) that publishing visit reports would increase both the effectiveness and accountability of NPMs. The argument is that publishing visit reports would make places of detention more transparent and that increased transparency is key to the effective prevention of ill-treatment. Keeping other places of detention, civil society, and the media informed about the sorts of issues raised by visits widens the dialogue and equips others to help monitor any recommendations made.

Publication would also have the added benefit of helping to grow a culture of prevention by increasing the levels of understanding about OPCAT and the work of NPMs, including by allowing places of detention to assess their own conditions and practice in relation to others.

Finally it would allow NPMs themselves to “walk the talk” by increasing the transparency of their work.

However, others argue that if the purpose of publishing is to increase transparency, and therefore effectiveness, then reports should not be published the outcome would limit OPCAT effectiveness. It follows that publication should not happen if it would result in personal information being disclosed without consent, confidentiality being breached [[42]](#footnote-42) or constructive dialogue between NPMs and places of detention being undermined, as these are all fundamental to OPCAT implementation. Effective monitoring visits are predicated on people being able to share their views and information with NPMs without fear of recrimination, and on NPMs being able to have constructive dialogue on issues of concern with those agencies who are responsible for the care and custody of others.

There are differing views amongst New Zealand’s NPMs as to whether visit reports can and should be published. This is an issue which will be worked on and resolved this year.

### The implications of publication

If it was decided that NPMs should publish their visit reports this would have a number of implications that would need to be considered and worked through.

First, there are resource implications. Unless OPCAT resourcing is increased, the time involved in preparing reports for publication, including consultation with the relevant authorities in accordance with the principles of natural justice, may result in the number of visits NPMs are able to conduct being reduced. Whether the preventive effect of publication is sufficient to warrant a reduction in visits is something the NPMs will need to assess.

The other practical ramifications of deciding whether to publish include deciding on a format and whether each NPM should publish separately or whether publication should be done as a collective. There are also questions about who will bear the costs of publication, what form it will take and how reports will be disseminated once they are published.

While none of these issues are insurmountable, they will need due consideration. It may be that there are alternatives to publishing visit reports which would avoid some of these issues but still enhance OPCAT effectiveness. Some options are the inclusion of more detail in the annual report, or NPMs using their powers to report under other statutes by virtue of section 34 of the COTA.

## Engagement with civil society

An engagement strategy is currently being developed by the NPMs to provide an overall framework for communicating about, and engaging with others, on OPCAT. It is hoped that engaging better with others, especially civil society, will help NPMs to create a culture of support for OPCAT work and the importance of treating people who are detained fairly.

The goals of the engagement strategy are to:

1. raise awareness and understanding of OPCAT, and the role of NPMs
2. provide a basis for working with others to meet OPCAT objectives and maximise NPMs’ effectiveness.

### Raising awareness

Raising awareness about human rights involves more than the provision of information or the passing on of knowledge. It involves enabling people to see beyond rights as abstract aspirations and helping them to understand what respect for human rights means in practice.

To achieve this aim, the draft engagement strategy recognises that information about OPCAT needs to be clear, accessible and consistent across all NPMs. One way to do this would be for NPMs to consider whether to develop a communications plan which sets out key messages about OPCAT and answers frequently asked questions. This would help to ensure there is a clear “baseline” of information which can be presented by all NPMs and can then be tailored for particular audiences or purposes.

Rather than general awareness raising about OPCAT, a targeted approach, taking into account the different needs and interests of different audiences, could be most effective. NPMs intend to look for opportunities to present information about OPCAT in ways that are relevant and meaningful to particular audiences. Being positive, telling success stories and illustrating why OPCAT is important and relevant have all been identified as ways to facilitate engagement with OPCAT.

### Working with others

NPMs aim to foster three different categories of relationships. Some are already established, and just need to be maintained and built on, and others are new relationships.

1. *Relationships with places of detention and the Ministries/Departments responsible for them*: having strong, respectful relationships with detaining organisations and the agencies responsible for their oversight is critical to NPMs’ effectiveness.
2. *Other organisations and agencies with aligned interests*: working in partnership with other organisations and agencies with complementary objectives or roles (for example the Mental Health Commissioner) would help ensure NPMs are well informed before conducting visits and provide potential sources of expertise and advice.
3. *Civil society*: strengthening relationships with NGOs and individuals who work with, or are concerned about, people who are detained (for example human rights groups, refugee/immigration support groups, mental health consumers groups, organisations that support prisoners and their families, ex-detainees) would extend the reach of OPCAT. Civil society is well placed to gather and pass on information and concerns to NPMs and to help monitor progress on meeting recommendations.

Once again, although it is clear that increasing engagement with civil society will enhance OPCAT effectiveness, there are issues with resourcing.

As part of their strategic planning, NPMs will consider whether, and if so how, to develop a communications plan and use this as the basis for updating existing information and raising awareness. They have also identified a need to prioritise which agencies they will develop relationships with and to begin that process.

## Levels of expertise within the NPM

Through supporting each other on site visits, meeting regularly and generally establishing a collaborative approach to carrying out their OPCAT functions, NPMs are making the most of their collective expertise. However, NPMs have identified gaps in their expertise, particularly in the areas os mental health (psychological) and medicine.

OPCAT obliges the NPM to have experts that:

1. have the required capabilities and professional knowledge
2. represent a gender balance and adequate representation of ethnic and minority groups.[[43]](#footnote-43)

To function effectively, the NPM, collectively, is required to have particular expertise and experience. If there are gaps in the capabilities or professional knowledge of any of the NPMs then they need to access that expertise either from elsewhere within the NPM or externally. Otherwise, their ability to monitor places of detention and prevent torture or other ill-treatment in accordance with OPCAT can be compromised.

The requirement to have expertise arises from the need for NPMs to understand and appreciate the subtleties of the different places and circumstances of detention including those things that might reduce the occurence of torture or other ill-treatment.

The SPT has suggested that NPMs take a multi-disciplinary approach and include people with the following specialties or expertise: medical, psychology, disability, legal, children, gender or military.

As well as having the requisite knowledge and capabilities, experts must be independent. This poses a potential challenge in New Zealand, because the relatively small population increases the likelihood that experts in a particular field may have a connection with the place being monitored or with staff within that place of detention.

There are several ways that access to experts could enhance the work of New Zealand’s NPM:

1. providing expert advice at a planning and policy level
2. attending monitoring visits (this could be regularly or on an “as needed” basis)
3. in an advisory capacity when the NPM is
	1. planning monitoring visits
	2. de-briefing after monitoring visits
	3. developing constructive feedback to places of detention on issues of potential concern
	4. identifying systemic issues to be addressed.

The need for expertise varies between NPMs, with both the IPCA and Ombudsman having identified a particular need for mental health expertise within their NPMs.

Options for accessing specialist expertise, including the costs involved, are being considered. NPMs are looking at whether it might be feasible to establish a panel of experts who could be “on-call” to help as needed.

NPMs’ participation in each other’s visits has been used to good effect to augment the very small visiting teams, and to make use of others’ expertise and perspectives. This type of collaboration amongst NPMs is a helpful way of sharing experience and developing good practice. Given these benefits, NPMs have persisted with this practice, despite their already heavy workloads. On occasion, NPMs have also contracted specialists (for example, in mental health), or called on experts (such as the Fire Service and building inspectors) to assist in visits.

Within the NPM bodies are staff with a range of knowledge and experience, including: legal, social work, nursing, investigative and managerial. However, rather than being dependent on the background of personnel within the NPMs at any given time, NPMs would prefer to have systems for accessing expertise established as part of the way the mechanism operates.

NPMs are exploring how they might develop relationships with other organisations and professional bodies to access the expertise they require on a no-cost or minimal cost basis, while maintaining the necessary degree of independence. It is not yet clear how feasible or sustainable this will be.

The Ombudsman has had some initial discussions with a mental health expert who is interested in providing assistance on monitoring visits. This initiative is an opportunity for the NPM to work through the practical implications of using unpaid experts on monitoring visits.

### Māori representation

Both the Treaty of Waitangi and OPCAT requirements to have appropriate ethnic representation would suggest that there should be Māori input into NPM work at both the policy and operational levels.

The Human Rights Commission has an Ahi Kā team of Māori staff, including te reo speakers, who work on Treaty and Indigenous Rights and who are keen to be involved in OPCAT work.

If a NPM considered that Māori representation was required on a site visit, then this could be facilitated by seconding the required expertise to the team from within the NPM’s own office or from, for example, the Human Rights Commission.

It should be noted that during the first stage of OPCAT implementation, there was quite high representation of Māori within NPMs but with personnel changes,this level of representation is now much less. As with the other areas of expertise this highlights issues about the structure and functioning of the NPM as an institution as opposed to the components of its personnel at any given time.

## Improving how the NPM works

The internal organisation and work practices of the NPMs, both individually and as a collective, have evolved over the five years of their operation. It is timely to reflect on how the strengths of having a multiple NPM model might be used and the weaknesses mitigated.

Having multiple NPMs means that monitoring processes can be tailored to suit the type of facility being inspected. It also makes the most of pre-existing relationships and knowledge bases. For example, when monitoring the detention of young people, the Children’s Commissioner can draw on a great deal of institutional knowledge about children’s rights while having a well established relationship with Child, Youth and Family, the agency responsible for detaining young people.

However there are some challenges in a multiple NPM model and issues to do with developing the NPM as an institution. Many of these merely reflect the nature of collective enterprises. They include, for example, establishing and maintaining:

1. the institutional practices of the NPM as a collective, including the management of knowledge and information
2. decision-making processes
3. the means to respond collectively to cross-cutting issues.

There are also other issues which impact on how the NPMs’ functions are carried out such as the scope of monitoring, including the definition of “place of detention” and ensuring designations remain relevant and useful. As already noted, there are significant resourcing issues, and related to this are also questions about how impact is measured.

### Working as a collective

The issue remains of how NPMs continue to develop and maintain their collective identity and methods of operating, including the management of institutional knowledge, while being flexible enough to meet the particular requirements of their specific designation.

The SPT talks about systemisation of experiences and suggests:

*The NPM should ensure that important concrete and contextual observations arising from its visits to institutions, its recommendations and the responses from the authorities are categorised, filed and regularly processes for use in dialogue with the authorities and for the ongoing planning of work and for the further development of its strategies.[[44]](#footnote-44)*

The NPMs are working through how best to systematise experiences in a multi-body NPM. Questions about the best way of working as a collective are also relevant to capacity building and apply at the policy as well as the operational level. Some of the issues raised are discussed below.

#### (i) Making good use of information

The availability of information about a facility is a significant factor in NPM’s decision-making about what places to visit. Sources of information vary, which reflects the different designations of each NPM. For example, in order to obtain information prior to visiting, and to inform their focus on visits, the Ombudsman has trialled a short questionnaire for prisoners, to get a better idea of their experiences of prison life. The confidential questionnaire is distributed and collected by the inspectors and to date the response rate has been very good. The Ombudsman has found this to be extremely useful in identifying common themes of concern for prisoners, which they can then explore further when they visit.

In general, there is scope for greater, and more systematic, collection and sharing of data by NPMs. Information from relevant complaint or inspectorate bodies can help NPMs to identify places to visit or particular areas of focus within facilities and, as already discussed, NPMs are developing a plan to improve their engagement with civil society. This may help to identify other sources of information about facilities, such as individuals or groups who visit on a regular basis, which could be used to inform and plan monitoring visits.

#### **(ii) Presenting information − recommendations**

The issues around the publication of visit reports have been discussed previously. In addition to reporting there is a general issue about how information generated by the NPMs, individually and as a collective, is presented.

For example, finding a balance between promoting compliance, by producing reports and recommendations, and being flexible enough to maintain constructive dialogue with the authorities can be challenging. The Ombudsman has modified the form of their recommendations so that urgent or important recommendations are identified, as well as less urgent or longer term recommendations.

Issues like this one are discussed by the NPMs when they meet together and it is hoped that the development of a shared on-line workspace will facilitate even better sharing of information and experiences and ensure a degree of consistency in the way NPMs operate.

#### (iii) Dealing with cross-cutting and policy issues

The IPCA, Children’s Commissioner and HRC have recently completed a joint thematic review on young people in police detention[[45]](#footnote-45). This was a useful and well received initiative indicating that there could be merit in the NPM, as a collective, developing some criteria as to when and how similar exercises should be taken in future particularly in relation to “cross-cutting” issues. The IPCA’s *Deaths in Police Custody- a ten year review[[46]](#footnote-46)* is another example of this approach to preventive work.

However, thematic reports are resource intensive and the extent to which they enhance OPCAT effectiveness needs to be balanced against any reduction in the capacity of NPMs to conduct monitoring visits.

In a similar vein, the Children’s Commissioner has been encouraging Child, Youth and Family to develop a guide that outlines examples of best practice that could be learned from and adopted by other residences. Again NPMs need to assess, on a case-by-case basis, what the impact of doing policy work like this is, and whether, in light of their limited resources, it is worth it.

### Scope of monitoring

As OPCAT has becomeembedded, issues to do with the scope of monitoring and the extent of each NPM’s responsibility have emerged. The Children’s Commissioner and the Ombudsman, in particular, have grappled with issues to do with the scope of monitoring.

Having carried out several cycles of visits, it is timely to consider whether there is a need to monitor other ‘less traditional’ places of detention such as aged care facilities and group homes for children and young people and whether there is a need to further prioritise visits and shift the focus to what some describe as the ‘forgotten places’, where there is less oversight and potentially greater risk for those detained.

### Custody of children and young people

As noted above, the NPM designations were amended in 2009, at the NPMs’ request, to ensure that both care and protection and youth justice residences were explicitly included in the Children’s Commissioner’s designation. Since then the Children’s Commissioner has identified additional situations that potentially fall within the scope of OPCAT, where children and young people may be placed by an order of the court.

The Children’s Commissioner’s designation relates specifically to residences established under section 364 of the Child, Youth and Family Act 1989, of which there are nine. Yet under the Act, a ‘residence’ can be “*any residential centre, family home, group home, foster home, family resource centre, or other premises or place, approved or recognised for the time being by the Chief Executive as a place of care or treatment... whether administered by the Crown or not”*.[[47]](#footnote-47)

Based on their experience over the last five years, the Children’s Commissioner’ office has identified one area in particular that it would like to monitor under OPCAT. These are places where young people may be directed to attend programmes under Supervision with Activity orders. They are concerned because these settings do not have the same degree of monitoring and external oversight as the section 364 residences. Supervision with Activity programmes in particular can be held in relatively isolated places, such as bush camps, and accordingly entail some of the risk factors that OPCAT aims to deal with.

Despite its concerns, at present the Children’s Commissioner is unable to carry out its existing programme with the frequency it would like to. This is due to a lack of resources which means that any expansion of its monitoring programme, which would further impact on the frequency and effectiveness of existing monitoring, is unlikely.

A final issue is whether the Children’s Commissioner should be designated to monitor all children in detention, including those falling within the mandate of other NPMs, such as children in immigration facilities. In practice it is very likely that the Children’s Commissioner would be consulted if, for example, a group of asylum seekers included children. They also have a memorandum of understanding with the IPCA regarding their joint interest in children and young people detained in Police cells.

### Joint designation

Currently, the Children’s Commissioner has joint responsibility with the Ombudsman, to monitor children and young people in residences established under section 364 of the CYPF Act.[[48]](#footnote-48)

The rationale for this dual jurisdiction in relation to youth justice facilities had to do with concerns at the time (2007) about whether the Children’s Commissioner had the necessary powers to undertake proactive, monitoring visits. The Ombudsman was therefore included as a ‘safety net’. Since then, all the necessary powers have been confirmed in COTA and as the Children’s Commissioner has not had any problems in exercising those powers, the original concerns are no longer an issue.

Currently the Office of the Children’s Commissioner carries out residence visits and refers reports and findings to the Chief Ombudsman for input, including recommendations they wish to make. The two NPMs have established a Memorandum of Understanding setting out how they work together. This joint mandate is managed well and without any major difficulty. As a result, while the NPMs might consider asking for the designation to be altered in the future, it is not a priority at present.

### Aged care

There are also an additional 161 aged care facilities with dementia units that may fall within the Ombudsman’s current designation in respect of health and disability places of detention. The Ombudsman is currently examining the jurisdictional and resource implications should this be the case. If the Ombudsman was expected to include these facilities within its monitoring programme and the extended jurisdiction into the private sector was acceptable to Parliament, the Ombudsman would need to seek additional funding in order to conduct regular inspections of these facilities.

### Measuring impact

Case studies and examples of positive changes made as a result of monitoring, demonstrate the impact of OPCAT but, overall, the measurement of progress and impact remains a challenge.

Initially, a detailed framework of standards and indicators was developed for the ongoing tracking and monitoring of progress. These were adapted by the NPMs for use in the different detention contexts they monitor but the detailed indicators have proven too unwieldy for regular use.

The difficulties of assessing the impact of human rights initiatives are not unique to New Zealand. In the outline of an APT research project[[49]](#footnote-49) on the effectiveness of torture prevention, some of the difficulties noted as inherent in evaluating human rights initiatives include:

1. The difficulties entailed in evaluating *prevention*. By definition we are interested in the non-occurrence of certain events and the reasons for this.
2. The difficulties inherent in the fact that the issue being investigated is torture – the nature of the violation is that there are no generally accepted figures for its incidence and the secrecy in which it occurs makes reliable data almost impossible to obtain.
3. The problem of measuring risk. The main danger here is that many of the indicators often proposed to suggest reduced risk are the very same preventive interventions that are the subject of the inquiry.

One way of tracking progress could be to score institutions on each area monitored (for example treatment, protection measures, activities and access to others, health services and staff) and then assign an overall score. The scores of each institution could then be recorded and tracked and an overall view of the institutions inspected could be obtained. This would be much less onerous than using the detailed indicators but would still give an indication of how well the rights of detainees are protected.

There are overseas examples of this sort of approach to measuring impact. Her Majesty’s Inspectorate of Prisons(HMIP) in the United Kingdom rates the prisons it visits against indicators of a ‘healthy prison’.[[50]](#footnote-50) These are: safety, respect, purposeful activity and resettlement. Under each test HMIP assesses outcomes for prisoners and therefore of the prison’s overall performance, and gives a rating on a four point scale: 1 Outcomes poor, 2 Outcomes not sufficiently good, 3 Outcomes reasonably good, 4 Outcomes good.

HMIP also tracks both the take up and implementation of its recommendations: the percentage of recommendations accepted, partially accepted and rejected; and those achieved, partially achieved and not achieved.

Similarly, the Western Australian Inspector of Custodial Services produces a scorecard on each institution, using a five point scale: excellent, more than acceptable, acceptable, less than acceptable and poor. It classifies its recommendations (for example, care and wellbeing, human rights, rehabilitation). It also uses acceptance of recommendations as an indicator of its effectiveness.

NPMs already use different methods to track recommendations and there could be merit in extending this practice. For example, the Ombudsman records the recommendations made in each visit, and whether they were accepted, partially accepted, or rejected by the agency concerned. The Ombudsman has made 121 recommendations regarding prisons. Of these 77 were accepted, 17 were partially accepted and 21 rejected by the prison authorities.

In 2011-12, the Children’s Commissioner made 74 recommendations regarding six residences. Of these, 39 recommendations had been implemented (27 of these were ongoing), 23 were in progress, 10 were planned for implementation, and only two were considered by CYF to be current ‘business as usual’.

There is scope for more use of the various methods for measuring impact here in New Zealand but, once again, the effort and resource required to develop a workable rating system would need to be balanced against the extent to which it strengthens the application of OPCAT. It may be that more qualitative approaches, such as continued self–evaluation using feed-back from the agencies monitored, civil society and detainees themselves, are better suited to the New Zealand context.

# Conclusion

The first five years of OPCAT in New Zealand can be characterised as an establishment phase. NPMs have invested in setting up the collaborative relationships and methods of working needed to provide a solid foundation for continued application of OPCAT.

This five year review marks a transition from establishment to the on-going effective operation of NPMs within the New Zealand context. Reflecting on the last five years enables NPMs to consolidate and draw on their experiences as they look to the future.

The biggest challenge facing NPMs is the adequacy of current funding levels. However, as has been demonstrated by the first five years of OPCAT in New Zealand, by working together and with others and identifying where their efforts can have most preventive effect, NPMs are very well placed to continue ensuring the rights of people who are detained are respected.

1. OPCAT was adopted by the United Nations in December 2002. [↑](#footnote-ref-1)
2. OPCAT, Article 1. [↑](#footnote-ref-2)
3. Subcommittee for Prevention of Torture, (2011), Analytical Self-Assessment Tool for National Preventive Mechanisms, 18 October 2011, CAT/OP/12/8, para 3. [↑](#footnote-ref-3)
4. The preventive OPCAT model has its origins in the monitoring model of the International Committee of the Red Cross (‘ICRC’). For more information about the history and development of OPCAT both internationally and in New Zealand see *Natalie Pierce “Implementing Human Rights in Closed Environments: The OPCAT Framework and the New Zealand experience” (2012) Law in Context (forthcoming)* [↑](#footnote-ref-4)
5. As at December 2012 OPCAT database; [www.apt.ch/en/opcat-database/](http://www.apt.ch/en/opcat-database/) [↑](#footnote-ref-5)
6. See for example article 5 of the Universal Declaration of Human Rights [↑](#footnote-ref-6)
7. APT, submission to the OHCHR questionnaire on the role of prevention in the promotion and protection of human rights, p. 3. [↑](#footnote-ref-7)
8. Ibid, page 2 [↑](#footnote-ref-8)
9. CAT/OP/12/6 *The approach of the Subcommittee on Prevention of Torture to the concept of prevention of torture and other cruel, inhuman or degrading treatment or punishment under the Optional Protocol to the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment.*  [↑](#footnote-ref-9)
10. Above, n3. [↑](#footnote-ref-10)
11. Part II, COTA [↑](#footnote-ref-11)
12. s15, COTA [↑](#footnote-ref-12)
13. Section 16 COTA specifies that the Act applies only to places of detention *within* New Zealand. [↑](#footnote-ref-13)
14. s 26, COTA [↑](#footnote-ref-14)
15. Article 4.1, OPCAT [↑](#footnote-ref-15)
16. Article 4.2, OPCAT [↑](#footnote-ref-16)
17. Murray, R., et al, (2011), *The Optional Protocol to the UN Convention Against Torture*, Oxford: Oxford University Press. [↑](#footnote-ref-17)
18. s 34, COTA [↑](#footnote-ref-18)
19. The appointment of the ISPE is tied to the appointment of the Registrar of the Court Martial of New Zealand, an official appointed independently by the Chief Judge of that jurisdiction by the provisions of the Court Martial Act 2007 (ss79 (1) and 80). [↑](#footnote-ref-19)
20. Section 13(3) of the Ombudsmen Act enables the Ombudsman to instigate “own motion” investigations in the absence of a complaint being made. Recent own motion investigations include investigations into: the Department of Corrections in relation to the detention and treatment of prisoners (2005); prisoner transport (2007); and the Criminal Justice Sector (2007). [↑](#footnote-ref-20)
21. This excludes private sector aged care facilities, which we cover in more detail below. [↑](#footnote-ref-21)
22. Excluding aged care facilities. [↑](#footnote-ref-22)
23. These are the Mangere Resettlement Centre, the maximum security unit at Auckland Prison, women’s prisons, youth units and forensic facilities. [↑](#footnote-ref-23)
24. Foreword to Independent Police Conduct Authority Statement of Intent 2009/10–2011/12. [↑](#footnote-ref-24)
25. There are some limitations on total numbers if any of the detainees are female. [↑](#footnote-ref-25)
26. For example APT, *Monitoring places of detention: a practical guide*, 2004, pages 65-68 available at <http://www.apt.ch/en/resources/monitoring-places-of-detention-a-practical-guide/> [↑](#footnote-ref-26)
27. A list of key human rights instruments is set out in Appendix 2. [↑](#footnote-ref-27)
28. A copy of the monitoring standards framework is attached as Appendix 3. [↑](#footnote-ref-28)
29. OHCHR, Training Manual on Human Rights Monitoring, Professional Training Services no 7 (OHCHR, 2001) pp. 87-95 Cited in Pierce “*Implementing Human Rights in Closed Environments: The OPCAT Framework and the New Zealand experience” (2012) Law in Context (forthcoming) above, n4* [↑](#footnote-ref-29)
30. For further description and analysis of the first five years of NPM operation in New Zealand see Natalie Pierce *Implementing Human Rights in Closed Environments: The OPCAT Framework and the New Zealand experience* (2012) Law in Context (forthcoming) [↑](#footnote-ref-30)
31. <http://www.cpt.coe.int/en/> [↑](#footnote-ref-31)
32. Briefing paper to the Minister of Justice, 23 November 2011, file reference HUM 06 13, para 16 [↑](#footnote-ref-32)
33. <http://www.ipca.govt.nz/Site/media/2012/2012-October-23-Joint-Thematic-Review.aspx> [↑](#footnote-ref-33)
34. Ibid, para 133 [↑](#footnote-ref-34)
35. This point was made by Amy Dixon, an LLM student at the Victoria University Faculty of Law in her presentation entitled *Increasing the effectiveness of OPCAT in New Zealand through the publication of visit reports* given on 22 November 2012 at the VUW cross campus human rights symposium. [↑](#footnote-ref-35)
36. Dame Beverley Wakem, Chief Ombudsman, comment made in address to 2013 International Ombudsman’s Conference, Wellington, New Zealand [↑](#footnote-ref-36)
37. The NZ Parole Board, Departments of Corrections and Courts, and the Ministries of Health and Justice were all involved. [↑](#footnote-ref-37)
38. APT, *Optional Protocol to the UN Convention against Torture Implementation Manual (revised edition)* 2010, page 248. [↑](#footnote-ref-38)
39. Given the nature and scope of his role, the ISPE is able to carry out his NPM role without additional funding. Likewise, the HRC has adequate resources for its Central NPM role, as it does not have the operational costs of other NPMs. [↑](#footnote-ref-39)
40. <http://www.apt.ch/en/outcomes-and-conclusions/> paragraph headed “Ensuring effectiveness” [↑](#footnote-ref-40)
41. Amy Dixon *Increasing Effectiveness of OPCAT through the Publication of Visit reports* (paper presented to Human Rights Symposium, Victoria University, 2012). Amy Dixon can be contacted on dixon.amylou@gmail.com and intends to publish a paper on this issue in the near future. [↑](#footnote-ref-41)
42. Article 21(2) OPCAT [↑](#footnote-ref-42)
43. Part IV (2) OPCAT [↑](#footnote-ref-43)
44. Above n27, page 8, para 34. [↑](#footnote-ref-44)
45. <http://www.ipca.govt.nz/Site/media/2012/2012-October-23-Joint-Thematic-Review.aspx> [↑](#footnote-ref-45)
46. Independent Police Conduct Authority, *Deaths in Police Custody – a ten year review, 2012* <http://www.ipca.govt.nz/Site/media/2012/2012-June-30-Deaths-in-Custody.aspx> [↑](#footnote-ref-46)
47. s2(1), CYPFA [↑](#footnote-ref-47)
48. Child, Youth and Family are responsible for nine residences for children and young people, established under s364 of the CYPFA. These include four care and protection residences, four youth justice residences and a specialist residence for young men who have displayed sexually inappropriate behaviour (the day-to-day running of which is undertaken by Barnardos). [↑](#footnote-ref-48)
49. Carver, R., *Outline of a 3 year research project commissioned by the APT* *2012-2014*. <http://www.apt.ch/content/files_res/apt_researchproject_2012-14.pdf>

<http://www.apt.ch/en/research-project/> [↑](#footnote-ref-49)
50. For example, see: <http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hmip-annual-report-2010-11.pdf> [↑](#footnote-ref-50)